Promoting vulnerability or resilience to HIV? : A qualitative study on polygamy in Maiduguri, Nigeria

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Abstract

Literature on the links between polygamy and HIV and AIDS is limited and the findings inconclusive. Literature to date in Sub-Saharan Africa has relied mainly on case control studies and surveys. This qualitative study aimed to explore different community members' perceptions of the links between the practice of polygamy and vulnerability or resilience to HIV and AIDS in Maiduguri, north-eastern Nigeria. The study used focus group discussions and in-depth interviews with religious and community leaders and different groups of women and men in the community.

Participant views on the links between polygamy and HIV were varied. However, one clear emerging theme was that it is not the practice of polygamy *per se* that shapes vulnerability to HIV and AIDS but the dynamics of sexual relations and practices both within and beyond the marital union – whether monogamous or polygamous. The ways in which these social relationships are negotiated and experienced are in turn shaped by religious traditions, gender roles and relations, education and socio-economic status. Within the religious environment of north-eastern Nigeria, where asymmetrical gender roles and relations and connotations of morality shape experiences of sexual interactions, windows of opportunity to promote behaviour change strategies to support

women and men's resilience to HIV need to be carefully created. Health practitioners and planners should develop partnerships with religious and community leaders and women's groups to construct and deliver behaviour changes strategies.

Key words: Polygamy, HIV, religion, gender, Nigeria

Introduction

Polygamy, a predominant marriage structure in pre-industrial societies (Ukwuani, Suchindran and Cornwall, 2001), is legally and widely practiced in 850 societies [Westoff, 2003]. The HIV/AIDS pandemic has brought renewed interest in the effects of different types of marital unions.

Literature on the relationship between polygamy and HIV transmission is limited and the findings contested. In Kenya, Edwards (1994) found that HIV incidence was higher among polygamous tribal groups. However, Oppong (1995) found that HIV incidence was lower among population groups that had high rates of polygamy in Ghana. Quigley et al (1997) found a higher prevalence of HIV among Muslims in a case-control study in Tanzania but no association with polygamy. Using survey data from 4 urban populations in Kenya and Zambia, Clark (2004) argued that young women in polygamous unions had higher HIV rates than young women in monogamous unions because marriage increased frequency of sexual intercourse, decreased condom use and eliminated a girl's ability to abstain from sex. Adeokun and Nalwadda (1997) considered polygamy as a form of serial marriage that might predispose both men and women to HIV because of increased rates of marital dissolution.

In Nigeria, where 5% of the Nigerian population are living with HIV and AIDS (Nigeria Federal Ministry of Health, 2003), a cross-sectional survey found no clear indication of polygamy being a risk factor in the spread of HIV (Olayemi et al, 2002). A community-based study (Lawoyin and Larsen, 2000) in southwest

Nigeria found that extramarital sexual relationships rather than the practice of polygamy was the main risk for HIV transmission. Research on HIV risk factors has largely excluded north-eastern Nigeria (e.g. Lawoyin at al 2000; Smith, 2007).

Literature on HIV and polygamy to date has mainly used DHS data and quantitative surveys, which are arguably problematic in accessing trustworthy responses on sexual relationships (Mitsunaga et al, 2005). This paper uses an in-depth qualitative methodology to explore different groups of women and men's perceptions and experiences of polygamy and vulnerability or resilience to HIV in the specific context of Maiduguri, north-eastern Nigeria.

Methods

Qualitative research methods provide invaluable insights into people's health related-behaviour that are not readily accessible through surveys (Harding and Gantley, 1998). This study used qualitative in-depth interviews (IDIs) and focus group discussions (FGDs). In-depth, interactive qualitative interviews are appropriate for exploring individual experiences and opinions (Patton, 1987; Britten, 1995), whilst FGDs are useful in understanding group norms and how these are constructed and experienced (Kitzinger, 1995; Krueger & Casey, 2000).

Our sampling frame was purposive, and based on a strategy of maximum variation (Patton, 1990). Participants from different genders, ages, livelihoods and religions were purposively recruited in order to elicit viewpoints from

diverse groups within the Maiduguri population. To ensure maximum variation 4 IDIs were conducted with each of the following 14 groups, totalling 56 interviews: 1. Muslim leaders, 2. Christian leaders, 3. traditional rulers, 4. women opinion leaders, 5. people living with HIV and AIDS, 6. civil servants, 7. housewives, 8. lecturers, 9. politicians, 10. political party followers/supporters, 11. water vendors, 12. mechanics, 13. drivers and 14. traders. Interviewees were consulted on where they would like the interview to take place; most took place at the participants' home, their offices or in a local school.

FGDs were separated by gender to try to enable easy discussion; 6 were carried out totalling 49 participants. Each FGD took approximately 90 minutes. The groups were as follows: women in polygamous marriage; women in monogamous marriage; a mixed group of women in polygamous and monogamous marriages; men in polygamous marriage, men in polygamous marriage and a mixed group of men in polygamous and monogamous marriages. IDIs and FGDs were used to explore participants' perceptions of HIV, factors that promote women's and men's vulnerability and resilience to HIV, how these relate to different types of marital unions and changes through time.

Interviews and FGDs were conducted by AS, a medical doctor from Maiduguri with skills in qualitative research, with support (observation and recording) from a research assistant. Where possible IDIs and FGDs were conducted in the language preferred by the participant(s) and were recorded with the permission of participants. Participant checking was used as a quality assurance mechanism (Pretty, 1993)

Analysis was ongoing and informed by the framework approach to qualitative analysis (Pope et al, 2000; Ritchie et al, 2003). This included transcribing all the data, reviewing the transcripts, identifying key emerging themes, developing a thematic framework, comparing views from different categories of participants and developing explanations. Diverse perspectives informed the analysis. Ethical approval was awarded by the Research Ethics Committee of the Liverpool School of Tropical Medicine, UK. In Nigeria approval was obtained from the Directorate of Medical Services of Borno State Ministry of Health. All participants gave informed consent to participate in the study.

Findings

The findings are presented against 3 key themes, which are discussed in turn as follows: 1. Perceptions of the relationship between polygamy and promiscuity; 2. The role of religious discourses in perceptions and practice of polygamy; and 3. Gender roles, relations and sexual autonomy within marital relationships.

1. Polygamy: Promoting promiscuity or securing faithfulness within a marital union?

The concept of 'promiscuity' strongly emerged as a theme from all the different groups of participants and in both methods. Promiscuity was discussed with strong language that was imbued with moral meaning by all groups, although diverse and opposing views emerged, especially amongst religious leaders.

The Christian clergy were united in the view that in a polygamous marriage the husband might not be able to sexually satisfy or financially provide for all his wives, which would promote female promiscuity, due to women seeking both extra-martial sexual satisfaction and financial support. For instance:

> *"Polygamy predisposes to promiscuity as it will be difficult for the man to take care of many women in all aspects, financial, sexual and any other. If the women are not taken care of, they will take care of themselves from outside. This will therefore increase the probability of spreading the disease."* (A Christian minister, in-depth interview).

Muslim scholars on the other hand thought that the teachings of Islam showed that a woman could accept weeks or months without having sexual intercourse. They concluded that women 'waiting for their turn' in a polygamous home might not necessarily promote female promiscuity. For example:

> *"Because women's desire for sex is less than that of men, they can be patient enough to be satisfied in a polygamous home"* (Male Muslim leader in in-depth interview)

Most Muslim male and female participants thought that polygamy curbed men's extra-marital sexual desires. For example:

"Polygamy prevents men from going after women outside in case of problems like the illness of one of the wives and this reduces the chances of getting and spreading the disease" (A Muslim housewife in in-depth interview)

Many of the participants, particularly Christian leaders, were very sceptical about polygamous marriages and thought they were responsible for promoting vulnerability to HIV amongst women and men, and indirectly their children. For example:

"In polygamous marriages there is no love, no sincerity …girls become prostitutes…" (A Christian minister in in-depth interview)

Women leaders and housewives also held this view but expressed it less strongly.

2. The role of religion in perceptions and practice of polygamy: fulfilling or breaking religious obligations?

Most participants perceived that religious beliefs had a strong role to play in the practice of polygamy. A common observation among female and male participants ,Muslims and Christians, was that those engaging in polygamy did so to fulfil religious obligations. All the Muslim scholars pointed out that even though Islam allowed polygamy, this is based on the tenant that there should be justice for all wives. For example:

"Islam prescribes polygamy of up to four wives if the man can be just. If not he should marry just one. The justice meant here is justice in sharing of conjugal rights not justice of equal love, as no one can love different people equally" (Male Muslim leader in in-depth interview)

However, the majority of female and male participants, especially the Islamic scholars and traditional leaders thought that those engaging in polygamy in Maiduguri did not follow the guidelines laid down in Islam and that this enhanced vulnerability to HIV amongst men and women. For example:

"God-fearing individuals keep to their families and so limit the chances of STIs in general and HIV in particular. While non God-fearing individuals tend to be promiscuous and so have increased chances of acquiring and spreading STI and HIV." (A Muslim male civil servant in in-depth interview)

Christians clearly stated that polygamy was not allowed in Christianity.

3. Polygamy and gender relations: supporting or undermining women's livelihood, autonomy and ability to negotiate sexual interaction?

Most Muslim female and male participants thought that there were more women than men in Maiduguri, resulting in 'excess women in society', who if not 'taken care of' through marital relationships would be living as commercial sex workers. Muslim leaders and most male and female Muslim participants, believed that

polygamy as prescribed by Islam provided a solution to the perceived male-female imbalance in the population.

However, the majority of participants in both FGDs and IDIs felt that polygamy usually led to stiff competition between co-wives over the care of their husband. Most participants thought that men benefited from such competition as the women out-did each other to gain favour from the man. A link between polygamy and broken homes was also widely perceived, leading to a range of potential consequences, including divorce and or/sexual relationships beyond the marital union. For example:

> *"Sometimes there is no unity among the women. They can quarrel, they can be jealous; some of them will go out and sleep with men if he is not lucky to have good wives. They can bring diseases. It can affect the husband and the other wives especially the modern day disease called HIV/AIDS"* (Male Muslim politician in in-depth interview)

Even when there was no competition, many participants from both polygamous and monogamous relationships thought that women would experience problems in a polygamous marriage as a result of the lack of autonomy. The notion of male dominance in marriage emerged as a key theme with regard to all types of marriage. Many community members, and some politicians, as well as a few housewives and women leaders believed that women in both polygamous and monogamous relationships were supposed to be subservient to their men. For example:

"A woman is expected to obey her husband whatever the circumstance"

(A Muslim woman leader IDI)

Although Muslim leaders said that Islam gave room for mutual understanding between couples in a marriage relationship, interpretations of Islamic teachings played a part in the belief in women's subservience, as expressed by a male political leader:

"Islam recommends that a woman should be totally submissive to her husband…"

(Male politician in in-depth interview)

Gender roles and relations that privilege male decision making and male dominance make sexual negotiation within marriage difficult for women. Some study participants perceived that some form of sexual negotiation in polygamous and monogamous marriages in Maiduguri, might be possible in theory. However, polygamous women in FGDs generally agreed that sexual negotiation did occur within marital relationships, but when women tried to negotiate, they were perceived to be 'doing bad things'. Again connotations of morality and promiscuity emerge; women explained that they would be constructed as promiscuous if they made a request for safer sex. Polygamous Muslim female participants also explained that if they did try to negotiate condom use or abstinence with their husbands, this usually failed. Popular interpretations of religious teachings supported the view that it was inappropriate for women to attempt any form of sexual negotiation within marriage. However, Muslim leaders generally expressed

the view that Islam does not prohibit sexual negotiation between married couples; for example:

> *"Islam allows for negotiation in the marriage relationship because it gives room for mutual understanding between couples"*
> (Male Muslim leader, in-depth interview)

Discussion

Qualitative methods enabled the unpacking of diverse groups' perceptions of polygamous marital unions and their implications for vulnerability to HIV. Our methodological approach means that our findings are specific to Maiduguri and cannot be generalised beyond this context. Given the cultural diversity in Nigeria, context specific in-depth studies are needed to inform locally appropriate behaviour change strategies.

Our qualitative findings clearly demonstrate that it is not polygamy/monogamy *per se* that shapes vulnerability or resilience to HIV and AIDS but the interplay between type of marital union and relationships within and beyond this union, religious teachings, perceptions and practice of religious obligations, and the ways in which gender roles and relations are constructed and experienced. This complex interplay of different factors helps to explain why studies to date on type of marital union and risk for HIV have shown diverse findings and reinforces the importance of context specific studies.

Our study findings showed that religious background or beliefs (Muslim or Christian) strongly influenced participants' perceptions of the practice of polygamy and its relationship to the spread of HIV/AIDS. Islam, the predominant religion in north-eastern Nigeria, endorses polygamy through the verse [Qur'an 4:2,3]. Data from the 2003 Nigerian Demographic and Health Survey show a significant positive association between being a Muslim and being in a polygamous marriage (Mistunaga et al., 2005). In contrast, Christian leaders preach about the importance of monogamy (Timaeus and Reynar 1998; Niedermayer and Saskatchewan, 2005). However, many African churches have recognised polygamous relationships in their congregation (Orubuloye, et al, 1997; Elbedour et al, 2002). Unsurprisingly Muslim participants were more positive about polygamy than Christian participants. However, many Muslim participants felt that polygamous marriages were not being practiced according to Islamic doctrine.

Gender roles and relations also strongly influenced the perceptions and practice of polygamy. It is well recognised that asymmetrical gender roles and relations shape women and men's vulnerability to HIV and AIDS. Data from Sub-Saharan Africa, including Nigeria, suggest that married women's greatest risk of contracting HIV is through sexual relationships with their husbands (Smith, 2007). The pronounced double standard for extra-marital sexuality in Nigeria (Smith, 2007) emphasises men's greater sexual needs and puts women at risk.

The difficulties of negotiating for condom use in marriage in Sub-Saharan Africa are also well documented (e.g. Chimbiri 2005). Our findings show that women

living in polygamous relationships in north- eastern Nigeria may face particular challenges in trying to negotiate for condom use. Although Islamic leaders in Maiduguri indicated that Islam allows negotiation of sexual relationships in marriage, they do not condone condom use. Attempts to introduce the condom into sex in marriage are made even more difficult through connotations of condom use with immorality or extra-marital affairs, restriction of conception in a context where children are highly valued, competition between co-wives and restriction of women's bargaining power by very limited independent livelihood options and poverty.

Gender norms also shape both perceptions of the influence of polygamy on sexual behaviour and the interpretation of religious teachings. Both Christian and Muslim leaders' perceptions of the role of polygamy in encouraging or discouraging promiscuity rely in part on particular (and opposing) assumptions about the nature of women's sexuality. Polygamy itself was commonly believed to be rooted in a male-female population imbalance in the context where gender relations offer few social and economic opportunities for women to live independently.

Religion, gender relations, and the interactions between these, shape experiences of sexual relationships within and beyond marital unions and thus influence vulnerability to HIV and other STIs. Gender roles and relations are context specific and fluid and therefore amenable to change. In the longer term there is a need to develop partnerships to promote greater gender equity in sexual relationships. One example is the Stepping Stones training programme,

which uses a participatory adult learning methodology to enable women and men to reflect on the role of gender among other influences in relationships and to identify actions for change (Welbourn, 1995). Impact evaluations have shown that this approach has led to increased condom use, improved inter-personal communication in relationships (Welbourn, 1995; Paine et al, 2002), and changes in male sexual behaviour (Jewkes et al 2008).

The spread of HIV requires urgent and simultaneous short term and pragmatic responses. Health practitioners and partner organisations need to foster close working relationships with religious leaders to develop both the media and messages for behaviour change campaigns. Orubuloye et al (1997) argue that in Nigeria, both Muslim and Christian leaders have discouraged extra-marital affairs but that their messages have focused more on females than males. This is a missed opportunity given that gender norms tend in this context to accept male extra-marital behaviour, and male dominance in sexual relations. A pragmatic response would be to work with both Muslim and Christian religious and community leaders to try reach a consensus on the following two messages 1) remain faithful within a marital union and 2) where this is not possible condoms should be used. Opportunities to situate these messages within religious guidelines should be explored, for example the emphasis of Islam on justice and love could be extended to include an emphasis of loving one's wife(s) and children and keeping them and oneself free from STIs. There may be a difficult balance to be struck between endorsing these messages and avoiding promoting judgemental attitudes towards People Living with HIV and AIDS. Dialogue with religious leaders should also explore the possibilities for encouraging sexual

negotiation within marriage and specifically endorsing women taking the initiative in suggesting and insisting on condom use. These messages need to be aimed at both men and women.

Conclusion

Our qualitative research has captured the previously unheard voices and experiences of diverse groups in Maiduguri, North Eastern Nigeria. We found that it is not polygamy/monogamy *per se* that shapes vulnerability to HIV and AIDS; but the ways in which women and men experience different types of marital union, which in turn is inextricably linked to religious discourses and gender roles and relations. Urgent pragmatic and short term responses require building alliances with religious leaders to reach consensus on key messages to reduce women and men's vulnerability to HIV/AIDS.

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