Economic, social and cultural factors influence decisions on sexual conduct and family size

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Abstract

This paper examines the economic, social and cultural factors that influence decisions on sexual activities and family size. This was particularly the case when couples were confronted with one or both partners confirmed with HIV positive status. In such cases, decisions to have no more children were aimed to minimize mother-to-child transmission of HIV and also to cut down on living costs. The availability of antiretroviral drugs (ART) has improved the life expectancy and overall health of people living with HIV (PLHIV) in PNG. Moreover, the introduction of prevention of mother-to-child transmission (PMTCT) programs into the country’s health system has improved the overall health of couples in HIV positive relationships. It has also offered them greater opportunities to make decisions on normal sexual relationships and having children. However, the burden of caring for large families influences couples’ decisions to have smaller families. Many abstain from sexual activities or opt to use various contraceptive methods to prevent pregnancies and maintain small families.

Keywords: socioeconomic condition, sexual and reproductive decision-making, contraceptive methods, condom use, cultural taboos, human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), seroconcordant and serodiscordant relationships

Introduction

Recent technological advances in biomedicine such as antiretroviral therapy (ART) have made it possible for people living with human immunodeficiency virus (HIV) to prolong life and experienced an improved and fulfilled life (Puchalski, 2001). They are able to have normal sexual relationships with their partners and have children if they choose to do so. Studies that examined the relationship between ART and HIV positive status people revealed that many couples in HIV positive relationships who were on ART treatment remained sexually active and experienced increased desire for sex and to have children (Ncuba, et al., 2012).

In the past, the focus of public health services such as family planning methods and programs were directed only towards women and girls, because women get pregnant and experience child birth (Steinfeld, et al., 2013). However, studies have shown that husbands are key players on decisions about reproduction and use of contraceptives. Unfortunately, they are generally excluded from
reproductive health programs (Matthews, et al., 2013). Literature also shows that health issues such as sexually transmitted infections (STIs) and HIV and anti immunodeficiency syndrome (AIDS) affect both men and women in intimate married relationships (Kalichman, 2000; Steinfeld et al., 2013).

Improvements in women’s health issues can only be achieved when husbands are active participants in various public health intervention programs. The lack of or minimal male/husband participation in health care programs can hinder couples’ sound decisions on sexual relationships and the number of children they can afford to have. Research from other countries show that countries that have introduced culturally appropriate, ‘gender sensitive’ or ‘gender specific’ reproductive health programs, that also target men have shown that this is an effective strategy to reduce women and children health issues. It has shown that such participation can better inform men about women health issues and are able to support their wives and children’s health better. Additionally, they can make decisions that can minimize risky sexual practices, increase the use of contraceptives and promote positive living (Harris, et al., 2007; Kalembo, et al., 2012).

In Papua New Guinea (PNG), a high proportion of childbearing women between the ages of 15-49 years are HIV positive (National Department of Health, 2008; National Department of Health, 2012; National AIDS Council Secretariat, 2012). Gender-based sexual violence, gender inequities and social acceptance of violence against women and girls are some of the factors that have contributed to the spread of HIV and STIs (Ask a, Chompikul & Keiwkarnka, 2011; Rutenberg, Biddlecom & Kaona, 2000; Wyn, et al., 2013; Amnesty International, 2006). Some of PNG’s strong family and community oriented culture and traditional practices of polygamy and the payment of bride price have also contributed to family health issues. The sociocultural expectations of men to have many children, especially male children for future social support and protection, and the need to continue the family or lineage significantly influence their decisions to have large families. Consequently, wives in such cases are forced by their husbands to have many children. This may lead to women health issues.

This article is based on a study of women and men who were participants of the prevention of mother-to-child transmission of HIV (PMTCT) programs in two major towns in PNG. The study was designed to capture in-depth understanding of socio-cultural factors that influence the participation’s decisions on family health issues and the outcomes of PMTCT programs in PNG.

**Method**

Ethical clearance and approval for this study was granted by the Internal Review Board of the PNG Institute of Medical Research (PNGIMR), the Medical Research Advisory Committee, and the PNG National AIDS Council Secretariat Research Advisory Committee. Ethical approval was also granted by the Ethics Secretariat of the University of New South Wales in Australia.
The study was funded by the Australian Development Research Award Scheme Grant. Qualitative data was collected through interviews during this study. Data collection commenced in January 2011 and ended in December 2011.

The study was informed by the interpretative and descriptive model which seeks to understand the economic, social and cultural factors that influence husbands’ decisions on sexual practices and the size of their families. Eighteen husbands who were involved in the PMTCT programs participated in the study. According to Liamputtong and Ezzy (2002), interpretative descriptive phenomenology reveals the everyday life situations as seen, interpreted and explained from the ‘...viewpoint of the experiencing person’. Using such methods in health research is appropriate as it provides in-depth knowledge and understanding of real life experiences of husbands who are HIV and AIDS positive (Mack, et al., 2005).

The study was conducted in the Western Highlands Province and the National Capital District of PNG. The selection of the study sites was based on the reports of higher prevalence of HIV infections in these provinces which were higher than in other provinces. The convenience sampling was used to select study participants. Health care workers at the antenatal clinics (ANC) were interviewed and data on married couples who attended the clinics were collected. The study included husbands of women who were HIV positive, who had consented to participate in the study. Participants’ consent were established before interviews commenced.

Of the eighteen men (husbands) who participated in the study, fourteen were HIV-positive status. The majority of men in the study were in seroconcordant relationships. A seroconcordant relationships is one in which both partners are of the same HIV status. A serodiscordant relationship is one in which one partner is HIV positive and the other is HIV negative. Only two men in the study had wives who had HIV negative status. One was unsure of his HIV status because he had not been tested for HIV and AIDS. His wife on the other hand had tested HIV positive. For another couple, both partners had negative HIV and AIDS status and therefore were excluded from the study because they did not meet the selection criteria for this study. Most of the participants had low educational levels. They had education levels of grade 10 and below. Only two of the participants had a university/college level education and were formally employed.

Interviews were done mostly in Tok Pisin (one of the lingua francas of PNG). The interviews were digitally and audio-recorded. Interview data were transcribed and translated from Tok Pisin into English. The data were thematically coded and analysed using NVivo 10 data analysis computer software for qualitative research.
Findings

The socioeconomic impacts of HIV and AIDS on husbands’ sexual and reproductive decisions

Studies worldwide have shown that people who have HIV and were initiated on ART were found to be sexually active and experienced an increased desire for sex and children (Yadeta & Deresa, 2012; Keegan, Sarah, & Jenny, 2005). In the current study most participants desired to have children. However, those who already had children were content with the decision to stop having more children. They were of the view that it was unwise to continue to have children when they were HIV and AIDS positive. One of the most common factors that influenced couples’ decisions to stop having children was based on socioeconomic conditions as well. Most of the husband participants stated that they did not want to have more children because they could not afford to take care of them as expressed in the following excerpts.

*Life is hard with the kids; no bus fare to go to and fro, no soap, medicine and everything, so I don’t want to sleep [have sex] with her. I don’t want to have any more children.* (Soko, 45 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

*We [him and wife] think it’s too expensive to pay for bus fare to go back and forth to the hospital. And to buy soap and milk, it’s very expensive so we have decided not to have sex so that we will not have any more children.* (Akowe, age unknown, he is HIV-positive husband of HIV-positive wife, Mt Hagen.)

Many of the husband participants were content with the number of children they already had and therefore decided not to have any more children. Some participants discussed the issue with their wives and made the decision to use condoms or their wives to have tubal ligation to prevent further pregnancies. These decisions are reflected in the following excerpts.

*For me I feel that maybe one [child] is enough because I am HIV-positive, I feel that having one girl is enough. Sometimes I want to use condoms.* (Aba, 24 year old HIV-positive husband, his wife is HIV negative status, Mt Hagen.)

*I talked with her [wife] about not having anymore children and she said it was fine so when she is discharged from the hospital we will go to the doctors and they will do tubal ligation on her so that we will not have any more children.* (Werol, 35 year old HIV-positive husband of HIV-positive wife, Port Moresby)

*I see that the present life is a bit hard. At least one [child] that I already have is enough as he will live on and represent me so there’s no need to have any more children. What we [him and wife] are thinking is probably we will go for tubal ligation but we have not informed the health care*
workers yet that this is what we plan to do. (Igiri, 31 year old HIV-positive husband of HIV-positive wife)

When husband participants were asked if they had had sexual relationships with women other than their wives, some stated they had never done so. Most husbands admitted to having had sexual relationships outside of marriage in the past but this stopped when it was confirmed that they were HIV positive. The participants also expressed concern about the increasing expenses of food, shelter and other necessities. They were also of the view that they should focus on caring for their families more. They felt that this was more important than participating in sexual activities as expressed in the following excerpts.

*No, no, I just stayed [abstained from sexual activities]. I did not go around with women or talk to them. I just stayed. I am focused on earning money for bus fare, soap or kerosene for the family. My focus is on how to get money; my focus is on this.* (Akowe, age unknown, he is HIV-positive husband of HIV-positive wife, Mt Hagen.)

*Like, if I don’t work then how will I look after my two children? At the moment I am really concerned about how I will look after my family in terms of food, money and other little things. I live in the city and life is getting tough so I am really focused on how I should look after my family.* (Albert, 29 year old HIV-positive husband of HIV-positive wife, Port Moresby)

*In the past I used to leave my wife and children, go out with other women, drink beer and had sex with other women. But now I am in a different situation. I am now in this condition [HIV positive] because I was going around with other women. Now I have given up these bad practices and decided to stay home and look after my family.* (Akowe, age unknown, he is HIV-positive, husband of HIV-positive wife, Mt Hagen).

The husband participants described their HIV positive status as a matter of life and death situation. The fear of death of their partners and the concern for their children’s future influenced the changes in their attitude towards sexual behaviours as reflected in the next set of excerpts.

*I can sleep [have sex] with my wife but I am afraid she might die. She has the sickness [HIV positive] too so if she becomes pregnant then she will run short of blood because the little that she has will go to the child and she might die. I am worried about this so I do not want to sleep with her.* (Albert, 29 year old HIV-positive husband of HIV-positive wife, Port Moresby)

*I want to take care of my two children myself and see them grow up. When my life ends [die], I will leave them behind. However they are HIV-negative and that is a comfort because they will be fine.* (Albert, 29 year old HIV-positive husband of HIV-positive wife, Port Moresby)
I feel sorry for my wife and children. I often wonder that if I die who will take care of them. Who will give them food and money; buy soap and clothes for them? I think about these and feel sorry for them so I have made the effort never to live a bad life again [promiscuous]. (Keho, 34 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

The impacts of cultural beliefs on husbands’ sexual and reproductive decisions

Besides socioeconomic factors, the study also found that the participants’ sexual and reproductive decisions were often influenced by their cultural beliefs and values (Teague, 1996; Wardlow, 2002 & 2007). Most of the participants stated that sex during pregnancy was a cultural taboo and that husbands were obliged to abstain from sexual activities with their wives until the child was two to three years old. This taboo practice is highlighted in the next set of excerpts.

A pregnant woman must give birth and stay away from her husband for three years and after that the husband can have sex with her and can have another child. (Mike, 47 year old HIV-negative husband of HIV-positive wife, Port Moresby)

If a woman is pregnant she must stay away from the man [husband]. The husband must not touch the wife’s body [have sex] until she gives birth; and as I said, after one year and six or some months when the baby is strong enough to eat, talk and move around, then the husband can touch the woman’s body [have sex]. (Kolum, 35 year old husband of HIV-positive wife but he was never tested for HIV, Mt Hagen.)

According to the custom of my village, if you sleep with a pregnant woman you will not find animals [meat] for your family. Or your garden will not produce a good harvest for the family. (Mike, 47 years old HIV-negative husband of HIV-positive wife, Port Moresby)

This data shows that it is a common belief that having sex with pregnant wives would result in unsuccessful hunting and fishing expeditions, or that gardens would not have a good harvest. Other data in this study also showed that, according to cultural beliefs, to have sex during pregnancy can also result in the deformity of the fetus, miscarriages, sicknesses, child malnutrition, and complications during the delivery of the babies.

For some husbands the primary reason for abstinence during pregnancy is because it is a common belief that miscarriages and human deformities are the result of couples’ participation in sexual intimacy during pregnancy as shown in the following excerpts.

If they [husband and wife] break such traditions or customs the baby will be deformed or if you have sex with your wife when is still pregnant then
the child will have some disabilities or such and people will say, ‘See, the child is like this [deformed/disabled] because the parents were having sex when the mother was still pregnant’. (Mike, 47 year old HIV-negative husband of HIV-positive wife, Port Moresby)

If one of you fathers is having sex with your wife when she is pregnant, the people will gossip and laugh at you. Everybody will condemn you; just imagine it’s bad. (Soko, 45 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

Although there were strong traditional taboos against sex during pregnancy, a few husbands who had received formal education stated that because of their western education they were better informed on the causes of miscarriages and human deformities. Therefore, they no longer believed that breaching sex taboos during pregnancy result in the disastrous consequences as advised by their forebears. This is evidence of the changing reality of culture as cultural anthropologists often highlight that culture is not static but is constantly changing (Hall, 1977; Adeney, 1995; Teague, 1996). An example of this change is reflected in the following excerpts.

In our generation, since we are educated, we know that it is fine to have sex with our wives when they are pregnant. This allows women to sleeping with men during pregnancy. Couples can still have sex when the women are pregnant. This was forbidden in the past. (Koko, 38 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

Sexual intercourse was forbidden in the past but now the times have changed and we’re in the modern era. I’m an educated person and I know that it is safe to have sex when my wife is pregnant. There’s no problem with this. (Soko, 45 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

The study also found that traditional sex taboos also encourage couples to practice sexual abstinence when babies and toddlers are still breastfeeding. The cultural belief is that sexual abstinence will prevent illnesses such as diarrhoea and malnutrition in children and prevent mothers from falling pregnant too soon. These views are reflected in the following excerpts.

When the baby is born, the husband must not sleep [have sex] with the wife because the baby will be affected through breastfeeding and will become sick. (Pana, 28 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

If we have sex during breastfeeding, sometimes the mother’s breast milk will become contaminated and when the child drinks it then he or she will have diarrhoea, lose weight and will become malnourished and get sick. (Gapi, 20 year old HIV-negative husband of HIV-positive wife, Port Moresby)
After women have given birth to their babies and return home, the husbands must not have sex with them because the fresh wound has not yet healed. The husband must stay away and give her some time to rest, eat good food, and regain her strength and then it’s between the two of them [wife and husband] to decide [whether to have sex or not]. (Pipi, 29 year old HIV-positive husband of HIV-positive wife, Port Moresby)

If a man has sex with his wife and she becomes pregnant again while the youngest is still breastfeeding then it is not good. This gives an extra burden to the mother to take care of both children. (Timon, 26 year old HIV-positive husband of HIV-positive wife, Port Moresby)

Post partum abstinence is a norm which was practised by many husbands from different parts of PNG. However, when they were asked about when exactly sexual intercourse should resume during breastfeeding, most did not specify any exact time. However, they emphasized that the child must be at the walking and talking stage of child development before the couple could resume sexual intimacy. Having children too close is considered culturally inappropriate because this added extra burdens for the families when they had too many young children to care for. Traditionally, this is viewed as foolish and shows lack of self-discipline.

If for now we keep staying (having sex) and she becomes pregnant again, I would feel ashamed because the first child is still breastfeeding. People will gossip and say, ‘Just recently she gave birth to one child so how comes she is pregnant again so soon?’ People will have such thoughts so we have to be strong and have strong self discipline in order to control our desires. (Soko, 45 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

Despite the history of strong cultural norms that govern sexual practices during breastfeeding, the great majority of participants were of the view that married couples found it difficult to abide by the rules. Many participants reported that they resume a sexual relationship with their wives a few months after their wives had given birth as revealed in the following excerpts.

I continued to have sex with my wife when the baby was two to three months old. The desire is still there and is strong since we are young. I don’t have sex when the mother refuses but if she accepts it, then what shall I do? I just go for it. If the mother says she is fine after she had given birth then that’s all right, we can have sex. (Koko, 38 year old HIV-positive husband of HIV-positive wife, Mt Hagen)

When the baby was two or three months, you know, we slept together (had sex) again. (Albert, 29 year old HIV-positive husband of HIV-positive wife, Port Moresby)
Methods of family planning

Oral contraceptive pills, injectables, intra-uterine devices, condom use and sterilization (e.g. tubal ligation and vasectomy) are some methods of family planning that are made available to couples worldwide (Harris et al., 2007). Participants in this study were of the view that the use of condoms and tubal ligation were the most effective methods for preventing pregnancy. However, tubal ligation was more favoured by men who could not afford to have large families. The consistent use of condom was also mentioned as an important preventative method for unwanted pregnancies and HIV and STI transmission. This study found that despite couples’ knowledge about safe sex, unprotected sex was still prevalent (Yadeta & Deresa, 2012; Perez-Jimenez & Rosaura 2012). The frequency of condom use among the participants varied greatly. Some participants reported inconsistent use of condoms while others revealed that they never used condoms at all.

When my wife was breastfeeding we used condoms until one night, I felt I didn’t want to use a condom so I slept with her without a condom. She thought I was using condom but I didn’t. I went ‘skin to skin’ or ‘flesh to flesh’ [without condom] and when we woke up she touched me and asked, ‘Did you use condom?’ and I said, ‘No,’ and she was shocked [for fear of another pregnancy]. (Gapi, 20 year old HIV-negative husband of HIV-positive wife, Port Moresby)

When she [wife] was breastfeeding, we continue to sleep [have sex] together. When we sleep we never even used condoms. We would just sleep without it. That’s what we do every time we have sex because it always feels good. (Aba, 24 year old HIV-positive husband of HIV-negative wife, Mt Hagen)

The availability and accessibility of ART has improved the life expectancy and overall health of PLHIV. The success of PMTCT programs had allowed PLHIV couples to make choices on normal sexual intimacy and having children (Harris, et al., 2007). The faithful compliance to ART helped the PLHIV patients to regain health and live a normal life so they were able to continue to have sex with their partners and have children. For example, in two occasions two male participants in serodiscordant relationships were well aware of the fact that their wives’ adherence to ART had reduced their viral load and raised their CD4 counts; and therefore it was safe to continue sexual intercourse as highlighted in the following excerpts.

My wife was breastfeeding but since she was on medication her viral load already went down and her CD4 went up so I slept with her. I felt that it was safe to have sex in that way. When my wife and I are together, I always told her that we must always use condoms. (Mike, 47 year old HIV-negative husband of HIV-positive wife, Port Moresby)

Since my wife was on medication her viral load already went down and I slept with her so I felt that it was safe. However, I worry that I may
already have the HIV virus hiding in my body so I go for regular checkups at the HIV and STI clinic. I have a check-up every 3 months and at this stage I am still free of the HIV virus. (Gapi, 20 years old HIV-negative husband of HIV-positive wife, Port Moresby)

Discussion

This data show that economic, social and cultural factors influence husbands’ decisions on sexual intimacy with their wives and family size. The participants were of the view that couples who had HIV and AIDS positive partners found taking care of families burdensome. This was especially the case for those who were low income earners. This was one of the main contributing factors for couples’ decisions to have smaller families or stop having more children. A similar study done on HIV-positive couples in Zambia also showed that couples who were low income earners made decisions to have smaller families. This also allowed them to care for their relatives’ AIDS orphaned children (Rutenberg, Biddlecom & Kaona, 2000).

The majority of husband participants in this study was concerned about their own health and welfare as well as that of their wives and children, and therefore made the decision to stop having children. The younger HIV-positive couple participants on the other hand, wanted to have children in future (Aska, Chompikul & Keiwkarnka, 2011).

Cultural taboos also influenced couples’ decisions on abstinence of sexual intimacies during pregnancy and while babies and toddlers were still breast feeding. It was the belief that violation or breach of these taboos would result in serious child health consequences such as child deformity, miscarriages, birth complications, diarrhoea and malnutrition. As in many developing nations, the people of PNG live in close communities and therefore when such child health issues are noticed, couples are blamed for such ill health. It is generally concluded that the couples have not observed the sex taboos and as a result cause ill health for their children. According to anthropological findings, people in Melanesia (including PNG) do not always ask about ‘what’ causes the health condition but about ‘who’ causes it (Mantovani, 1991; Kuman, 2011).

Therefore, the fear of being blamed for children’s ill health influenced couples’ decisions to abstain from sexual intimates during pregnancy and while babies and toddlers were still breast feeding. However, educated couples no longer observed these taboos because they were better informed on what causes children’s ill health. Contraceptives were being used to prevent pregnancies and for spacing between children. Contraceptive methods like oral pills, injectables, intra-uterine devices, condoms and sterilization (e.g. tubal ligation and vasectomy) are some methods of family planning that are made available to couples globally (Becker, 1996). However, this study found that the participants were only aware of tubal ligation and condom use and were the most frequently used /spoken about. It was generally understood by the participants that the use of condoms is an effective method of protection
against HIV, STIs, and unwanted pregnancies (Worth, 2012; Wyn, et al., 2013; Yeganeh, et al., 2012). However, this study particularly noted that the use of condoms was low among the participants.

Some progress has been made on the use of condoms and other contraceptive, and the ART and PMTCT programs. However, a lot more still needs to be achieved. Research shows that considerable challenges such as major supply chain issues, drug stocks, capacity building and the financing of ART still remain and continue to impede progress (Worth, 2012). The PNG health system has also integrated PMTCT services with maternal and child health services. However, poor quality of services, lack of human resources, inadequate training of staff, inadequate infrastructure, weak management of programs, and limited knowledge on the clinical and scientific nature of the PMTCT programs have continued to hinder progress of the programs (National AIDS Council, 2010; Worth, 2012). PNG’s difficult terrains have also contributed to the challenges encountered with the distribution of ART and PMTCT programs to the majority of the population (85-87%) in rural and remote areas of PNG (Papua New Guinea Global AIDS Response Progress Reporting, 2013; Raynes & Maibani, 2006).

Conclusion

The ART support and introduction of PMTCT programs into the country’s health system have improved the overall health of couples in HIV-positive relationships and offered them the opportunity to live normal lives. Couples in HIV positive relationships, who are low wage earners, are choosing to have small families and making the decisions to stop having children because of the increasing expense of goods and services. Also PMTCT programs that include husband participants have proved to be an effective strategy to support sound maternal and infant health care because husbands are able to improve support for their families because they are better informed about maternal and infant health issues. Public health intervention authorities should seriously consider inclusive public health care system and provide a more comprehensive, culturally appropriate and gender-specific HIV clinics that will encourage men, especially those in HIV positive relationships, to participate in infant and maternal health programs so they can support their families better.

References


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