MUSLIM WOMEN's ROLE IN REPRODUCTIVE HEALTH DECISION MAKING AND THEIR VULNERABILITY TO STIs AND HIV&AIDS IN ANKPA LGA OF KOGI STATE NIGERIA

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Abstrak

Pertubuhan Bangsa-Bangsa Bersatu (PBB) telah menamakan tahun 2000 sebagai tahun di mana kesaksamaan gender, pembangunan dan keharmonian terhadap wanita untuk abad ke-dua puluh dijamin. PBB menekankan bahawa isu-isu gender berhubung dengan pembangunan kehidupan wanita diberikan perhatian yang serius dalam meningkatkan Kesihatan Reproduktif Membuat Keputusan (KRMK). Kajian ini meninjau komunikasi isteri antara pasangan di Ankpa LGA yang mana gender menentukan kehidupan manusia. Pernyataan masalah mengandaikan bahawa wanita yang sudah berkahwin mudah terdedah kepada Jangkitan Penyakit Kelamin dan *Human Immunodeficiency Virus* (HIV) dan Sindrom Kurang Daya Tahan Penyakit (AIDS) kerana kurangnya penglibatan mereka dalam KRMK. Objektif kajian ini merangkumi: (a) menganalisis peranan wanita dalam proses KRMK;(b) menjelaskan faktor-faktor utama yang mempengaruhi penyertaan wanita dalam KRMK; (c) menentukan kesan penglibatan wanita dalam KRMK; d) menganalisis cabaran yang dihadapi oleh wanita dalam menyumbang kepada KRMK dan; (e) membangunkan satu model komunikasi yang memudahkan wanita dalam penyertaan KRMK. Melalui penyelidikan kualitatif yang berlandaskan kepada persampelan bertujuan, kajian ini memilih dua puluh wanita yang sudah berkahwin sebagai informan dan dua perbincangan kumpulan fokus. Temubual mendalam telah digunakan untuk pengumpulan data. Hasil kajian telah dianalisis melalui analisis kandungan tematik dan ia menunjukkan bahawa (a) Wanita agak jahil berhubung dengan pengetahuan seminar antarabangasa berhubung dengan populasi dan pembangunan; (b) Wanita menghadapi cabaran dalam usaha mereka untuk menyumbang kepada KRMK; (c) Wanita yang berkahwin tidak menyumbang kepada KRMK; (d) Mereka mudah terdedah kepada STI dan HIV & AIDS ini menghalang mereka terlibat dalamm KRMK; dan (e) kajian ini dapat membentuk model komunikasi untuk meningkatkan sumbangan wanita terhadap KRMK.

Kata Kunci: Wanita, KRMK, Kesaksamaan gender, Komunikasi, STI dan HIV / AIDS

Abstract

The United Nations (UN) named year 2000 as the year in which gender equality, development and peace shall be guaranteed women for the twenty first century. The UN emphasized that gendered issues surrounding the reproductive life of women be paid serious consideration in promoting the Reproductive Health Decision-Making (RDHM) process. This study explored spousal communication between couples in Ankpa LGA where gender dictates the life of people. The presenting problem also implied how vulnerable married women were to Sexually Transmitted Infections (STIs) and Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) due to their lack of contribution to RHDM. The studies objectives were to: (a) analyze women's role in the RHDM process; (b) explain the key factors influencing women's participation in RHDM; (c) determine the impacts of women's involvement in RDHM; (d) analyze the challenges faced by women in contributing to the RHDM and; (e) develop a communication model that facilitates participation RHDM. Through a qualitative research purposive sampling was employed to select twenty married women as informants and two focus group discussions (FGDs). The in-depth interviews were used for data collection. Findings were analyzed using thematic content analysis and showed that objective (1) the analysis of women's role RHDM showed lack of knowledge of RH and reproductive rights, (2) the key factors impeding women's participation in RHDM were explained in the findings of the study (3) for the third objective it was also agreed that married women do not contribute to RHDM due to the challenges faces as shown in the second objective and (4), and finally the fourth objective showed that women are vulnerable to STIs and HIV&AIDS, and finally (5) the study was able to design a communication model that can enhance women's communication ability and facilitate participation on RHDM.

Keywords: Women, RHDM, gender equality, communication, STIs and HIV/AIDS.

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List of Abbreviations

AA	Action Aid
AIDS	Acquired Immuno Deficiency Syndrome
ANC	Ante Natal Clinic
AURA	Auto Reinforcement Accompagne
AU	African Union
CBR	Crude Birth Rate
CWD	Centre for Woman Development
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women (UN)
CRC	Convention on the Rights of the Child
CCPR	International Convention on Civil and Political Rights
FGD	Focus Group Discussion
FOS	Federal Office of Statistics (Nigeria)
ICPD	International Conference on Population and Development
GFR	General Fertility Rate
HBM	Health Behavior Model
HIV+	Human Immuno deficiency Virus +
HIV-	Human Immuno deficiency Virus -
HIV/AIDS	Human Immuno-deficiency Virus Acquired Immunodeficiency Syndrome
IDI	In-depth Interview
IGWG	Inter Governmental Working Group
JMTR	Joint mid-Term Review
KJV	King James Version
LGA	Local Government Authority
MCH	Maternal Child Health
MDG	Millennium Development Goals
MICS	Multi Indicator Cluster Survey
NACA	National Agency for the Control of Aids
NDHS	National Demographic Health Survey
NPC	National Population Commission
NIV	New International Version

NSF	National Strategic Framework
NRR	National Response Review
PBC	Perceived Behavior Control
PLWHIV	People Living With Human Immuno Deficiency Virus
PRB	Population Reference Bureau
RSV	Revised Standard Version
RHDM	Reproductive Health Decision-Making
SCT	Social Cognitive Theory
SCR	Security Council Resolution
SSA	Sub Saharan Africa
SADC	Southern African Development Commission
STIs	Sexually Transmitted Infections
TRA	Theory of Reasoned Action
TPB	Theory of Planned Behavior
TFR	Total Fertility Rate
UN	United Nations
UNAIDS	United Nations Acquired Immune Deficiency Syndrome
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activity
UNHCHR	United Nations High Commission for Human Rights
UNICEF	United Nations Children Emergency Fund
WCW	World Conference on Women
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background

The revolution around the role of women in the social order has been a global one creating more awareness about gender roles in policy making and the need to adopt gender inclusive perspective goals for the purpose of empowering women. According to United Nations Fund for Population Activities (UNFPA), (2005) when these goals are achieved then development, peace and the condition necessary for sustainable development would have been created.

Past United Nation's conferences such as the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW) (1979), the World Conference on Human Rights, Vienna (1993), the International Conference on Population and Development, Cairo (1994), the World Conference on Women, Beijing (1995), and the Security Council Resolution of the United Nations (2000), have all paid serious attention to ensuring equal treatment of men and women.

The widespread existence of discrimination against women prompted resolution 12 of CEDAW in the area of equality of men and women in healthcare including those related to the family worldwide National Action Committee on AIDS (NACA, 2012). Beijing (1995) restates the commitment reached at the 1994 International Conference on Population and Development (ICPD) with special emphasis on women's procreative health and rights. The ICPD (1994) saw procreative health as 'the state of

comprehensive well-being of women, be it social, mental, psychological or physical, not simply the non-appearance of ailment or susceptibility in all matters concerning the procreative systems and to its utilities and processes' united nation aids (UNAIDS) in 2012; UNFPA, 2011).

This definition suggests that spouses can enjoy a more fulfilling life and exercise their right to procreate as well as enjoy safe sex, implying that they are free to decide on their own what method of contraception and when to use such contraception without fear or coercion. In the same way:

> …They are at liberty to decide who to copulate with, whenever they like, at what overtime and in whatever manner. They shall have access to the information and resources needed to plan and regulate their fertility according to their choice and within the limit of the law (WHO, 2012).

Consequent upon this, other commitments bothering on reproductive rights were added such as the liberty to exercise autonomy over their bodies and decide on their own free will and in a responsible manner all issues that concern their reproductive health, without undue influence from others no matter the relationship. A thorough understanding of the Beijing conference from a complete and holistic approach to the health of women, led to the following proposed line of action:

a) Women's access throughout their entire life to quality healthcare in accordance within their means shall be increased, and the information needed to access and benefit from reproductive health shall be available.

b) All programmes that promote women's health shall be strengthened.

c) Programme that address Sexually Transmitted Infections (STIs) and HIV Human Immunodeficiency Virus (HIV) & Acquired Immunodeficiency Syndrome (AIDS) in a gender sensitive manner shall be addressed and promoted.

d) The enhancement of research and distribution of the result to reach all women and communities shall be enhanced.

e) Resources needed for women's health should be increased and the monitoring of such programs shall also be enhanced (UNAIDS & WHO, 2012).

The General Assembly of the United Nations (UN) named the year 2000 as "the year in which gender equality, development and peace shall be guaranteed women for the twenty-first century". The UN requested for strategies and actions to discourse, on an important foundation, the gendered issues surrounding the reproductive life of women on the basis of how they emerge and affect the continuing health challenges that women face disproportionately, and the need to pay serious consideration to promoting a commonly deferential and reasonable relations among the sexes that will ensure adolescents need for education and other services which will enable them deal with their sexuality in a positive and reasonable manner be stressed (UNAIDS, 2012). Despite the controversy surrounding gender, it has become a very important instrument for directing and organizing the society; and it on that bases that members of the UN all adopted equality between males and females and the need to empower women in the Millennium Development Goals (MDG in 2000, UNAIDS, 2012).

Two of the eight MDGs (5&6) adopted in 2000 addressed women's health. MDG5 emphasizes the improvement of women's health through a reduction by three quarters from 1990 to 2015, the mortality proportion while MDG6 emphasize combating

malaria, HIV and AIDS, and other diseases having a disproportionate effect on women (UNAIDS, 2012). Members of the African Union (AU) in 2003 approved an innovative pact identified as the Procedure to the African Charter which put on the same pedestal women's right as human rights too. By March 2007, about 20 African countries signed and ratified the treaty (UNFPA, 2005).

Providing safe-guard for the right of women and protecting their procreative rights as a human right made the AU the primus inter Peres (first among equals) in the community of nations the world over to provide a legal mechanism on an international basis which explicitly gave women the right to abortion when pregnancy results from rape, incest and when continuing the pregnancy threatens the life of the woman (UNAIDS, 2012).

The first strategy on reproductive health to address improving antenatal health and delivery, postpartum and new born care and also provide affordable and qualitative service for reproductive health services, eliminate risky abortion and deal with STIs and HIV & AIDS was adopted by the World Health Assembly in 2004 (UNAIDS/WHO, 2009). In 2005 heads of state made a commitment towards achieving worldwide access to reproductive health by 2015. The ICPD acknowledged that the situation of women worldwide had become debilitating and particularly in the developing countries is precarious and needs urgent action to reduce the discrimination suffered by women just because they are women (UNFPA, 2005).

According to the UN Commission on Women, worldwide, and particularly in developing countries, the unequal treatment of women is manifest in every aspect of their lives. The commission therefore demanded that for "enhanced participation of

women in development: an enabling environment for achieving gender equality and the advancement of women, taking into account, the fields of education, health and work" must be created (UNAIDS/WHO, 2009).

The Commission in 2005 observed the imperative of including a gender, human rights, social and economic viewpoint when crafting strategies that is important to educating women, their health and work and of the need to create a conducive avenue for addressing the unequal status of women worldwide and particularly in the developing countries, with particular reference to Africa (UNAIDS, 2009).

It is also important to acknowledge the place of economic empowerment and independence and that the lack of these increase women's susceptibility to a wide range of unpleasant situations, amongst which are poverty, lack of power and the risk of STIs and HIV & AIDS, malaria, tuberculosis and other diseases that poverty aggravates were stressed at all these international fora (UNAIDS, 2012).

- In spite of all these protocols, agreements and assurances by regional and world bodies towards putting in place legal and institutional programs and procedures guaranteeing women's access to maternal and reproductive healthcare, women the world over and particularly in Africa are still victims of marginalization in decision-making over their own bodies (Taiwo, Olushayi & Adewole 2007; UNAIDS, 2012).
- Generally, the susceptibility of the female gender to STIs and HIV & AIDS can be traced to their anatomical make-up, which allows deposited semen to remain in the vagina for some time thereby increasing their danger of contracting STIs and HIV (UNAIDS/WHO, 2009). Besides, people are vulnerable in different ways and some group of people are vulnerable because

of the role they play in life, amongst which are for example those who are malnourished, open to malaria, expectant mothers, people in dangerous jobs and those who are migrants and refugees.

Jejeebhoy (2000) posited that vulnerability exists amongst subgroups such as homosexuals, street children, school girls. These groups have over time been treated as homogeneous groups. He went further to conclude that the woman in a homosexual relationship is likely to face the same oppression that women in heterosexual relations face as a result of patriarchy and therefore stressed that to understand vulnerability, we must employ gender analytical frameworks.

Orubuloye (1995) observed the danger inherent in forced sex which can cause a variety of emotional, physical and psychological damage to women, injuries such as; disability, depression, health issues; panic or fear; and low self-esteem. He states that women whether in marital relations or outside marriage are vulnerable to STIs and HIV and these are established facts worldwide. In cultures where women are owned or treated as property by their husbands, the tendency for a high level of marital rape or forced sex in marriage relationship is very high and thus exposes women to forced sex on a regular basis. This has been a contentious issue as it affects sexual relationship between spouses leading some women to see sex as another form of male control (UNFPA, 2005).

Aside other key drivers such as socio-economic, religious, cultural, political and environmental factors the UNAIDS in (2012) observed that gender inequality was the major driver of the HIV & AIDS epidemic. Gender norms and values in operation in any given society result in behaviors that puts girls/women and boys/men at risk of STIs and HIV & AIDS.

In patriarchal societies, gender norms related to masculinity can enable men have multiple sexual partners, putting them at high risk of infection. Constructs of masculinity can also encourage sexual relations within spousal age differences between men and women. This contributes to higher infection rates among young women (15 -24 years) than among young men in a continent where culture is a significant factor in female access to reproductive health (Taiwo, et al, 2007).

Violence (emotional, psychological and physical) experienced by 10-60% of women (aged 15-49 years) worldwide, can make women more vulnerable to HIV. Societal constructs of masculinity and femininity impact the ability of different sub-groups of girls/women and boys/men to access prevention, treatment and support and care services (UNAIDS, 2012).

HIV & AIDS impact differently on males and females: level of access to treatment and care are also impacted upon negatively with the impact more negatively felt by women, this scenario has been demonstrated by available statistics. The recent being the Joint UN Program on HIV & AIDS (UNAIDS, 2012) report which names HIV as the leading cause of death among women of child bearing age globally; those aged 15-24 face infection rates that are twice that of the opposite sex of the same age.

According to the report, 1.2 million women and girls were estimated to be newly infected in Africa in 2011 (UNAIDS 2012). About 58% (about 1.72 million) of People Living with HIV & AIDS (PLHIV) in 2011, in Nigeria were women and in the same year 388,864 new infections and 217,148 AIDS-related deaths also occurred amongst women. Of the new infections, 214,483 occurred among women. Each year, 55% of AIDS deaths in Nigeria occur among women and girls (NACA, 2012).

The Government of Nigeria and other international organizations working as partners have demonstrated tremendous political will to stem the tide of the HIV & AIDS epidemic. The National Agency for the Control of AIDS (NACA) and its partners in the national response has adopted a systematic, all-inclusive approach to addressing the epidemic (NACA, 2012). In 2004, the first National Strategic Framework (NSF) for HIV&AIDS (2005-2009) was drafted. Prior to this, a National Response Review (NRR) conducted by NACA and the Expanded Theme Group on HIV & AIDS revealed that previous efforts to stem the tide of the epidemic were gender-blind. The idea to mainstream gender and make it an integral part of planning in the national response was born after this realization. The NSF I (2005-2009), NSF II (2010-2015) and the National HIV & AIDS Policy mainstream gender equality perspectives (NACA, 2012).

One of the key findings of the Joint Mid-term Review (JMTR) for the implementation of NSF I in 2007 was the lack of institutionalization of gender as a critical issue of interest in the HIV & AIDS response. It was argued that some of the gender-related goals, objectives, and strategies in NSF I was highly ambitious and not feasible within Nigeria's patriarchal context without first overhauling the existing structure (NACA 2012).

The tendency to perceive reproductive health to mean women's health has led to a narrow, myopic, clinically focused and limited attention to the delivery and access to health. It is a known fact that the social relationships entered into before sexual relationships goes a long way to affect people's ability to manage and organize their sexual and reproductive lives, with consequences for their health, and a host of other choices in life (NACA 2012).

That the central role men play in reproductive health cannot be overemphasized and the need for male involvement is important if the enshrined rights within and beyond the health sector are to be achieved. The possibility of meeting the woman-centered MDG goals 3 promoting gender equality and empowering women and MDG goals 4 and 5 (improved child and maternal health) are not only mutually reinforcing, they cannot be achieved independently. This much was attested to by a report of the Millennium Project which pointed out that the third development goal of promoting equal gender relations and empowering women "cannot be achieved without the guarantee of sexual and reproductive health and rights for girls and women" (NACA, 2012).

This is because any attempt to measure women's empowerment without addressing their control over sexual relations; such as control over when to have children, which contraception to use and if necessary, access to abortion services cannot be said to be complete. Added to the above is the need for economic independence that will lead women to decide when, with whom and how to engage in sexual relations. It is important that traditional and societal norms and construct concerning sexual relations should be reviewed as this will lead to reducing if not eliminating the spread of HIV & AIDS South African Development Commission (SADC, 1999).

Research carried out on ways of achieving the MDGs shows that a broader interpretation of reproductive health is needed if we must make a head way. The report of Task Force 4 on Child Health and Maternal Health, pointed to the reality that, the social (non-biological) aspects of health and health care are of particular importance in any effort to improve maternal health. HIV & AIDS has achieved the status of a

pandemic disease condition and has claimed the lives of many and stunted growth and development in many countries with sub-Saharan Africa being the worst hit region.

In 2008, 67% of HIV infections worldwide occurred in Sub-Saharan (SSA) Africa (UNAIDS/WHO, 2009). According to the epidemiological report on HIV&AIDS, an estimated 33.2 million persons worldwide were infected with HIV as at 2007, 2.7 million became newly infected with HIV, and 2.1 million people died from sicknesses related to AIDS (World Bank, 2008, UNAIDS/WHO, 2007). Globally, the greatest mortality is found among people from 20 and 40 years of age which have dramatically changed the life expectancy rate in most affected parts of the world (World Bank, 2008). In Nigeria, HIV & AIDS epidemic has continued to be a serious problem ever since it was first reported in the country in 1986 (NACA, 2012, Dudgeon, Inhorn, 2004).

Nigeria's HIV & AIDS epidemic is increasing at an alarming rate (NACA, 2012), and as a result, the crude death rate was about 20% in 2000. (Sentinel survey, 2005). Statistics revealed that Nigeria's national average of HIV prevalence at present is 4.6% with 3.1% of adults between ages 15–49 estimated to be living with the disease condition (NACA, 2009; UNAIDS, 2008). Nigeria's infection rate is lower than that of other African countries such as South Africa and Zambia, but when considered in the context of Nigeria's relatively large population of 170 million (2006 NPC), over 3 million people are infected with the virus while 1 million children have been orphaned by the disease (NACA, 2009; UNAIDS, 2008).

HIV prevalence at regional as well as at state level, also shows marked variation with a prevalence rate ranging from a low of 1.0% in the South-west (Ekiti State) to a high of 10.6% in the North central parts (Benue State) (NACA, 2009). Death due to AIDS

has resulted to a significant decline in Nigeria's life expectancy rate. As at 1991, the life expectancy in Nigeria was 53.8 years for women and 52.6 years for men. In 2007 the life expectancy had further reduced to 46 for women and 47 for men (UNAIDS, 2008; WHO, 2008).

Certain factors such as low literacy level, high rates of experimental and commercial sex without any form of protection, particularly among youths aged 15 – 24, poverty as well as cultural and religious factors have been identified as serious factors in the contraction of HIV in Nigeria (NACA, 2009). The culture of early marriage is an age-old practice in almost all parts of the nation, particularly among the female population. This has brought about a low literacy level among the female gender and an increased vulnerability to infectious sexual diseases. Petchesky and Judd (1998), and Glynn, Whitmore, Glynn, Dominguez, Misch, and Mckeena (2008) reported that in some African countries, married 15–19 years old women's rate of HIV infection is higher than that of their age mates who are unmarried and sexually active.

1.1.1 Kogi State, Nigeria

Kogi State, one of the nine states in North Central Nigeria, has a high prevalence rate of HIV of 5.5% that is higher than the nation's prevalence rate which is 4.6% (NACA, 2007; NACA, 2009), incidentally, Benue state with the highest prevalence rate in the country is also in the North central zone of the country and shares boundary with Kogi state and the study area, Ankpa is a geographical neighbour with some (local Government Areas) LGAs in Benue state. Traditionally, women marry at a young age. However, the average age of marriage varies from state to state. A 2007 study showed that 54% of girls between ages 15–24 from the North West, where the study was located were married by age 15 and 81% were married by age 18. The study showed

that when girls marry at young age they have little knowledge of reproductive health and reproductive life including lack of knowledge on reproductive health rights including STIs and HIV & AIDS (Population Council, 2007).

This practice can contribute to the spread of HIV because the men who are considerably older are likely to have been involved in multiple sexual partnering and therefore concurrent and serial multiple sex and other high risk sexual behaviors (NDHS, 2008). Findings have shown an increasing polygynous family system in the study area. Among the Igala people who are predominantly Muslims and the majority ethnic group in the study area, there is evidence of increase in the number of polygynous marriages (NDHS, 2003, 2008). The desire to have as many children as possible in a family which encourages the culture of marrying more than one wife by most men in Nigeria, results in high susceptibility to STIs including HIV & AIDS infection among females (NACA, 2007).

Polygyny and cultural heterosexual relationships, have negative consequences for the rate of sexual intercourse, and thus, may affect fertility and impact on HIV&AIDS control in Nigeria Demographic Health Survey (NDHS, 2008). Several studies have also linked poverty and the lack of autonomy by women in sexual relationships occasioned by the lack of empowerment of girls marrying at very young age to the spread of the HIV virus in both developed and developing countries (Bureau of Global Health, 2003; Catholic Agency for Overseas Development, 2003).

1.2 Problem Statement

An understanding of the study of women's role in reproductive health decision making in Ankpa shows that women in the LGA do not get involved in decision

making with regards to issues that concern their everyday lives as they women believe that they ought not to take part in matters of marriage, family size, when to have a baby and child spacing period because discussing sexuality and sex issues are a taboo until after marriage to discourage promiscuity. Opposition against short postpartum abstinence is stronger than ever before and is influencing the sexual life of married women. Any attempt to have sex with a nursing mother during the breastfeeding period is considered a major cultural and religious taboo National Demographic Health Survey (NDHS, 2008).

The overall national HIV & AIDS prevalence of 4.6% (NACA, 2007; NACA, 2009) for the country is lower than that of Kogi State with a high prevalence of 5.5% (2007) despite the fact that all around the world now more than ever before more women have knowledge of contraception and more women are getting involved in taking decision about when to get pregnant and which family planning method to use. Women who are involved in this decision making have come to appreciate the importance of the successes associated with a HIV & AIDS free life. Women in Ankpa LGA are however constrained in their effort to benefit from this advancement (UNAIDS, WHO, 2012).

Like all patriarchal societies concurrent polygyny is a common practice in the society and the culture of early marriage, a practice in almost all parts of the LGA, particularly among the female population has brought about low literacy level among the female gender and an increased vulnerability to infectious sexual diseases (UNAIDS, 2008). Discussion with residents in the LGA showed that wide spousal age differences exist between couples which have negative consequences for communication among couples, particularly on reproductive health communication. This trend in the LGA

increases the vulnerability of women to HIV & AIDS and is supported by Petchesky & Judd. (1998), Glynn et al, (2008) when they reported that some married women between 15–19 years old have higher levels of HIV infection compared to unmarried sexually active females of the same age group.

Women in Nigeria and indeed the study area lag behind in family planning decision-making due to the level of poverty in the social and economic livelihood of these women. This has been suggested as affecting their role in reproductive health decision-making in the region (APHRC 2009). A large number of women in the area live most of their lives in social seclusion (purdah), depending on their husbands wholly for sustenance. Yusuf (2001) suggests that this habit impacts negatively on their ability to contribute to reproductive health decision-making in their homes.

Differences may be seen in the practice of contribution by women to reproductive health decision-making by women in the area between urban and rural areas as opined by Zakaria (2001) but even in urban areas educated and influential northerners still maintain the culture of purdah (female seclusion) in order to insulate their wives from the temptation and diversion of urban life. From this disadvantaged position the ability of women to contribute to reproductive health decision-making becomes compromised.

Cultural researchers have also highlighted the role of religion in family decision making in Nigeria particularly Islam which is the dominant religion practiced in the study area and the importance placed on children, and religious politics as key drivers of complete obedience of families to the Islamic mode of life which places a high premium on fertility. Mazrui (1994) links lack of reproductive decision making by women in the family decision-making process in the region to growing reawakening

of Islamic fundamentalism, which places renewed emphasis on women's role of bearing children.

Mazrui (1994) is of the opinion that Muslims refuse to support and practice policies targeting family planning and other developmental programs as challenging their religion and will even go further to encourage their wives to have more children in direct opposition to such western induced policies as a form of jihad. This he says is a strategy to eclipse other religions in Nigeria (Mazrui, 1994).

The spousal age difference between men and women at the time of first marriage creates a problem for women in their bid to contribute to reproductive health decision-making process, as wives who are considerably younger see their husbands who are considerably older as embodiments of knowledge and wisdom and tend to believe and accept whatever comes from them without their making any input to reproductive health decision-making (Solivetti, 1994; Burnham, 1987).

Mostly whether educated or not women in Northern Nigeria see it as the husband's responsibility to cater and provide for them. Muslim women in the region have continued to allow this gender construct of the male as a bread winner to dictate their marital, reproductive, and employment behavior and decision-making.

These societally determined values and norms despite an increase in the number of educated and working women from the north has not changed their perception about the implication of depending wholly on their husbands (Werthmann, 1997, 2000). They still believe that they should be catered by their husbands and that women are not under any obligation to make their incomes available to their families unless they so choose. This dependence on their husbands for sustainability also ensures that their

husbands expectedly also takes over reproductive health decision-making as dependence create a power relation that favors and supports the existing patriarchal relationship in the home (Yusuf, 2001).

Northern Nigerian societies have a proliferation of polygamy; with a large number of women in polygamous marriages, in proportions varying widely by society and age (NDHS, 2003, 2008). The proportion increases with age, decreases with educational level, and is higher in rural settings than urban areas (NDHS, 2003, 2008). This high level of polygamy is compounded by high marital mobility. Divorce rates are high: about 30 to 40% of first marriages end in divorce (NDHS, 2003).

These polygynous marriages result in high levels of divorce especially when coupled with forced marriages/arranged marriages and mostly charaterzed by wide spousal age differences (Isuigo-Abanihe & Uche, 2003), which ensures that most first-marriage divorcees remarry, this polygynous relationship opens women to vulnerability issues and that women in multiple sexual partnering relationships are more vulnerable to STIs and HIV &AIDS (Population council, 2008).

Another factor that drives multiple sexual partnering is the long postpartum sexual abstinence that is a feature of the family context in northern Nigeria. In most societies, sex is forbidden following childbirth for a period of, or extending through part or all of the breast-feeding period, which on average lasts up to two years. This protracted post-natal abstinence is often cited as the main reason for polygamy (Klissou, 1995) and a factor in the increased number of sexual partners.

What is of utmost concern is the extent to which women play decisive role in the process of decision-making on their reproductive health. In Nigeria and indeed among

the Igala people, the nexus between the social and economic factors listed above is a strong one and the reproductive health problems confronting women. Men dominate all aspects of life and this dominance is aided by the people's culture and tradition according to (NDHS, 2008) means that women's role in reproductive health decision-making is seldom on matters affecting them.

The ability of women to negotiate safe sex is dependent on the power relations in their homes and women's lack of power leaves them unable to effectively dictate safe sexual practice or seek care for their health problems, as a corollary to the above, men's refusal to moderate their sexual behaviors puts women at increased risk of STIs on a very high level. Gender dynamics as opined by Isiugo-Abanihe and Uche (2003) is a sex-role differential, which explains the differences in the roles of men and women.

Decision making within the family is influenced by several social, cultural and economic factors, some of which vary over time and space. Certain behaviors and norms expressed as part of traditional cultural roles influence decision making in the family and the exact roles that women play in the decision-making process. Are they active participants or passive recipients of decisions arrived at by others? And how much of women's decision- making at home translates into implementable actions within the family circle?

The problem of this study, therefore, is to examine the extent of women's involvement in reproductive health decision-making and the extent to which such involvement can reduce their vulnerability to STIs and HIV &AIDS.

1.3 Research questions

The following research questions have therefore been crafted for this study. The intention is to through these questions provide answers to the underlying problems of the study. By answering these questions, it is hoped that the roles women play in reproductive health decision making will be clear when questions such as the following are answered:

1. What is the extent of women's involvement in reproductive health decision-making within the family setting in Ankpa Local Government Area (LGA) of Kogi State?
2. What are the factors affecting women's participation in reproductive health decision-making?
3. How much of women's involvement in the reproductive health decision-making translates to action?
4. What are the challenges faced by women in participating in reproductive health decision-making within the family-decision making process?
5. What communication model will facilitate the participation of women in the reproductive health decision-making process in their homes?

1.4 Research Objectives

The overall aim of this study is to understand the reproductive health decision-making process in families. In view of which this study attempts to:

1. Analyze women's role in the reproductive health decision-making process within the family decision-making process in Ankpa LGA.

2. Explain the key factors influencing women's participation in reproductive health decision making in Ankpa LGA.
3. Determine the impact of women's involvement in reproductive health decision-making at home on their vulnerability to STIs and HIV.
4. Analyze the challenges faced by women in contributing to reproductive health decision-making within the family decision making process.
5. Develop a communication model that will facilitate the participation of women in the decision-making process in their homes.

1.5 Significance of the Study

The study is very important because it will add to the existing body of knowledge of the social development of the people in the study area because despite the fact that there are a lot of researches on issues of women, little has been done in the area of spousal decision-making process, amongst which are Isuigo-Abanihe & Uche (1994) "*Reproductive motivation and family size among Nigerian men"* and Oruboloye (1995) "Women's control over their sexuality implications for STDs and HIV & AIDS transmission in Nigeria" It is in the light of this that this research is being carried out in order to add to existing knowledge.

This study is significant as it addresses the overall contribution of women to reproductive health decision-making in a society with differentiated gender roles and expectations. The study was explained the relationship between women's participation in family reproductive health decision-making process and their vulnerability to STIs and HIV & AIDS by women in Ankpa district, a rural area of Kogi state. The nature of reproductive health decision-making process in family

settings in Ankpa and in rural areas and how the gender relations and role expectations and differentials affect, influence and control the behavior of male and female members of the community was be presented in the study.

The area in which discrimination in the reproductive health decision-making process is most manifest was be identified, and portrayed, whether the discrimination is located in the cultural, religious, and/or social sphere in the lives of the rural people and its implication for the contribution of women to reproductive health decision-making and the impact it has on the extent of vulnerability of women to STIs and HIV & AIDS has been shown by the study.

Another theoretical significance of the study is the issue of early marriage and its effects on family reproductive health decision-making process. It has been observed that most of the women in Northern Nigeria in general and Ankpa in particular marry early to people that are older almost like a father figure to their wives as a result of which spousal communication becomes a problem, making it almost impossible for the women to contribute to family decision making particularly in the areas of reproductive health decisions. The significance of the study therefore lies on how to bridge the decision-making gap between the couples, as through the development of a communication model that facilitates quality communication spouses can begin improving family discussion and gradually develop the rapport needed to engage on reproductive health communication.

Early marriage, a traditional phenomenon in the study area like most parts of Nigeria as shown in a 2007 study which revealed that 54% of girls from the North West, between ages 15 – 24 were married by age 15 and 81% were married by age 18 with little or no knowledge of reproductive health including HIV & AIDS (The Population

Council, 2007; NDHS, 2008). When the recommendations of the study are implemented this negative phenomenon will be addressed.

In the area of practical contribution, it is hoped that when this study is completed it will help in drawing the attention of policy makers on how to formulate policies regarding gender equality especially as it influences women in decision making. In addition to the above, the practical contribution of this study lies in drawing the attention of women in particular to identify and play their role in reproductive health decision-making since it is important in reducing their vulnerability to STIs and HIV & AIDS and in recognition of the fact that women play important roles in family development.

Finally, when women are involved RHDM there is a likelihood that family welfare and welfare will improve and by implication the quality of life of women and children who are free from STIs and HIV & AIDS will be the better for it.

1.6 Scope of the Study

This study covered Ankpa district in Ankpa LGA of Kogi state, where respondents were selected from and it focused on the factors affecting the reproductive health decision-making process in the homes particularly rural homes. The study explored the influence of women's involvement in social and economic activities. It also looked at the effect of how gender norms operating in their community affect married women's participation in the reproductive health decision-making process in their homes and how these affect their participation in the decision-making process in their homes and by implication how their involvement in decision-making process in their homes affect their vulnerability to STIs and HIV & AIDS.

Certain identifiable parameters are employed to delineate this research; these are biological, mental, emotional and geographic. The first will focus on married women in their husband's house between the reproductive age, not just any woman, and definitely not just any married woman but married women between the ages of 18 before onset of menopause. Those women who are living in lovers or concubines or even those married but living alone outside the husband's houses is also not included in the research.

This will allow for role clarity of who is in the target population for FGD in this study shall be included in this parameter male and female discussant aged between 30 and 50 years married and living in Ankpa, married and working at the time of this study, not those living with uncles or brothers or forester homes?

The second parameter for this study is that given by geography and nationality and simply put the respondents for this study shall be Nigerians, from Kogi state and from Ankpa in particular, they shall also be Igala by tribe and be residing in Ankpa at the time of the study in their matrimonial homes in Ankpa.

Other women who fit into the first parameter but are not indigenes of Ankpa will not be considered as this will lead to defeating the objective of the research which amongst others is to understand the role of culture and the socialization process of the Igala people and Ankpa in particular on the contribution of women to reproductive health decision-making in Ankpa district.

The researcher also points out that, years of marriage level of education, type of marriage (polygyny or monogamy), religion and profession were not compulsorily necessary conditions for participation in this study but these differences to the extent

to which they exist and affect the outcome of the research shall be noted and their effect on the informant's behaviour shall be recorded.

The third parameter in this study is that they women must be married and living with their husbands at the time of this study, for anything less would detract from the objective of the study which is to analyze the experience of married women involved or otherwise in reproductive health decision-making and the implication of their contribution or not to reproductive health decision-making process on their health status.

They women must be married and they must be involved in reproductive activity. It is when this condition is met that their current experiences with regards to the objectives of the study will impact positively on the outcome of the study. A fourth parameter is that in a society where women are generally expected to be silent and particularly married women are not expected to be seen in the company of non-related males, if they must be seen with unrelated males then, they must be escorted by a male relative of their husband for practical purposes it may become difficult to get women who will either come alone or be willing to share such private sexual experiences in the presence of a relative of her husband.

Secondly in rural and traditional societies sex or reproductive health issues are not talked about, it is a taboo, getting respondents who will talk about sex to strangers will also be a hard task. But assurances of confidentiality and their anonymity went a long way in easing this tension and allowed those who came to participate freely.

A fifth and final parameter refers to the nature of society where men are allowed to engage in polygyny and extra marital relationship without the least consideration

of/for their spouse, women in such situation do not even know the implication of multiple sexual partnering on their reproductive life and have been socialized to mind their own business and do their best to make their marriage work.

Such women are blind and deaf to whatever sexual liaison their spouse involves himself in and have no way of knowing their STI or HIV status or that of their husbands and cannot initiate discussion on this issue, to get women who agree to knowing the sexual life of their spouse may be difficult, this accounts for why most STIs including HIV & AIDS are discovered during antenatal care (ANC) but the researcher however found a way to scale this huddle.

1.7 Summary

In this chapter, the study discussed extensively the background to the study and the presenting problems which necessitate the researcher embarking on this study, also addressed where the objectives and research questions, the significance of the study to women, the society the government and development partners working with women were also discussed, in the next chapter the relevant literature and conceptual framework for the study will be analyzed to give insight into the views of authorities in the field on the nature and diversity of the problem of the problems militating against women's contribution to RHDM in the study area.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the review of related literature on the topic under discussion, the role of patriarchy in influencing, directing and or dictating gender relations in the world generally and the study area in particular is perused extensively, the place of STIs, HIV & AIDS in contributing the myriad of problems faced by women and its attendant causes are also discussed, empowerment as a factor in women's vulnerability and its specific role is identified and discussed and the theoretical framework underpinning the study is discussed and an analysis of other related literature.

2.2 Conceptual Framework

The dominant conceptual framework for understanding reproductive behavior is highly individualistic. In this thesis, it is demonstrated that such a conceptualization could be improved, as behavior is shaped by social relations and institutions. Using content analysis and evidence generated through ideographic and nomothetic qualitative data, the value of a social analysis of the local contexts of reproductive health decision making is highlighted. A framework is set out for conducting such a social analysis, which is capable of generating data necessary to allow married women involved in reproductive health decision making assess the appropriate means of improving their responsiveness to internal and external factors that direct and

strengthen the gender aggregated structures and institutions that perpetuates the inequalities that makes them most vulnerable.

Four key issues were identified in the framework for the analysis of social vulnerability of women involved in reproductive health decision making.

The key issues are:

- Community norms which are manifested in physical restraint of women, women's status and female seclusion
- Culture which dictates Norms and values, Religion, and Polygamy
- Vulnerability this directly perpetuates poverty of women, spousal age gap, spousal communication and early marriage
- Gender discrimination that is manifested in bridal wealth, gender role delineation and man as a bread winner symbol

A phenomenological illustration of how sociocultural, economic and religious factors shape reproductive behavior in relation to thirteen areas: spousal age gap, early marriage, gender role delineation, women status, female seclusion, bridal wealth man as a bread winner symbol, women poverty, polygamy, norms and values religion and spousal communication all these subthemes directly impacts and impede women's capacity to contribute to reproductive health decision making. However, the researcher acknowledges the impact of wider factors on reproductive behavior, such as education, access to healthcare, occupation, marital status, and harmful traditional practices.

The framework for conducting a social analysis is thus set from the beginning of the review of relevant literature to guide and direct data aggregation that will enable a

social analysis that will galvanize the agency power of women to begin to interact with the institutions in the society and at the family level create and sustain the changes needed at that level on their ability to contribute to reproductive health decision making.

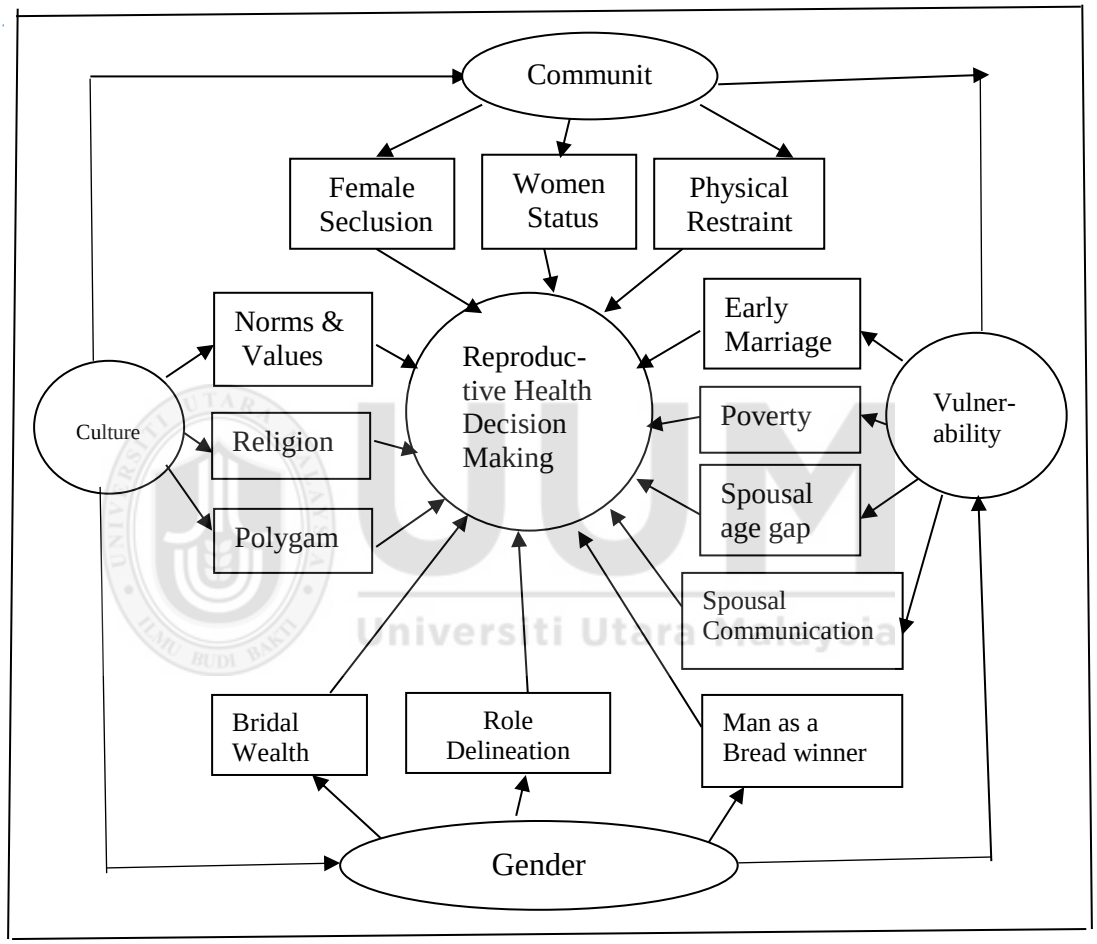

Figure 2.1. Conceptual Framework

2.3 STIs, HIV & AIDS

Sub-Saharan Africa has the highest figure of people living with HIV followed by Asia and the Pacific. By the end of 2013, an estimated 4.8 million (between 4.1 million to

5.5 million) PLWHA live across the region (UNAIDS, WHO, 2013). Six countries China, India, Indonesia, Myanmar, Thailand, and Viet Nam account for more than 90% of the people living with HIV in the region.

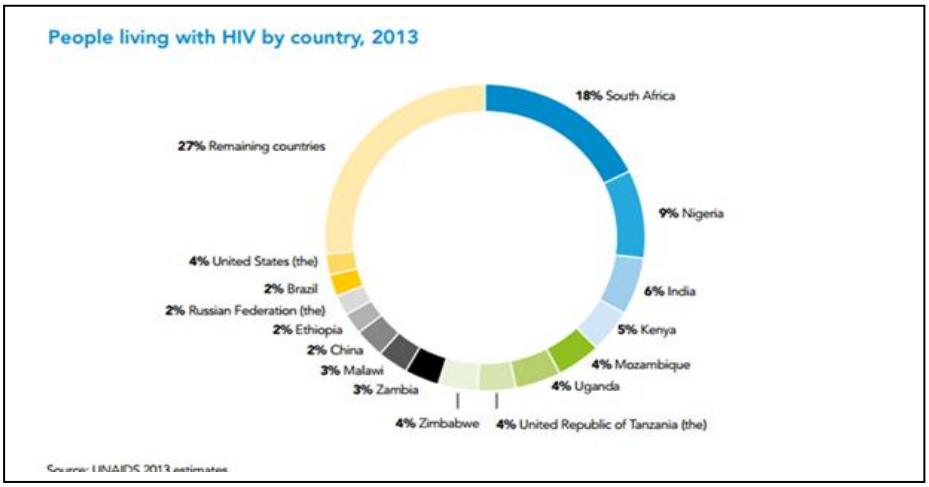

Figure 2.2. Proportion of people living with HIV by Country
Source: UNAIDS 2013 estimates

Cambodia, Malaysia, Nepal and Pakistan make up 6% of the total number of this, areas of Papua New Guinea. India is host to about 2.1 million (1.7 million –2.7 million) PLWHA accounting for the third largest PLHWA in the world by end of year 2013 this represents 4 out of 10 PLWH in the region (UNICEF, 2012).

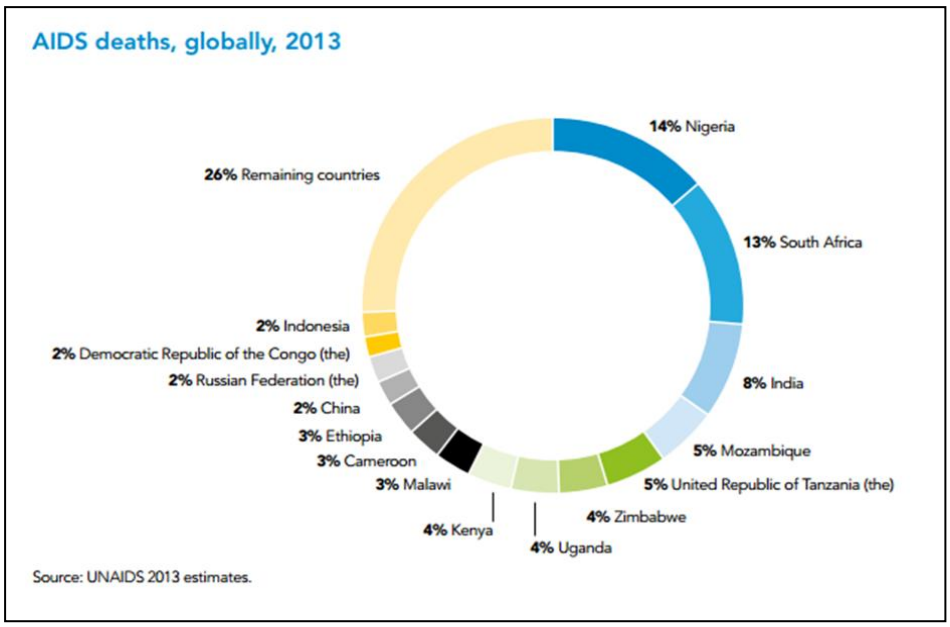

Figure 2.3. Number of people living with Aids Globally Country
Source: UNAIDS 2013 estimates

WHO (UNAIDS, 2013) in 1994, concluded that a total of 1,025,073 AIDS cases (adults and children) were reported worldwide, though the actual number of AIDS cases cannot be ascertained due to under diagnosis, incomplete reporting and delays in reporting (UNAIDS, 2013) However, an estimate of 4.5 million AIDS cases are known to have occurred in adults and children since the start of the epidemic (WHO 2013, UNICEF, 2012).

An estimate of 18 million adults (13 -15 million alive) and 1.5 million children were reportedly infected with the virus. 7-8 million are women among the adults, (WHO, 2013) (most of them within childbearing age). WHO proposes that, by the year 2000, 30-40 million HIV infections would have occurred, almost 90% of these will be in developing countries? Children under 10 years of age orphaned by AIDS would have risen to an estimated 5 million, having lost one or both parents. The following

alarming statistics were reported by WHO when the estimated the AIDS figures these states. 4,500,000+ in the Americas, 12%(excluding USA) Oceania 0.5%, Africa 34%, Europe 12.5%, Asia 2%, USA 39% (UNAIDS, 2015).

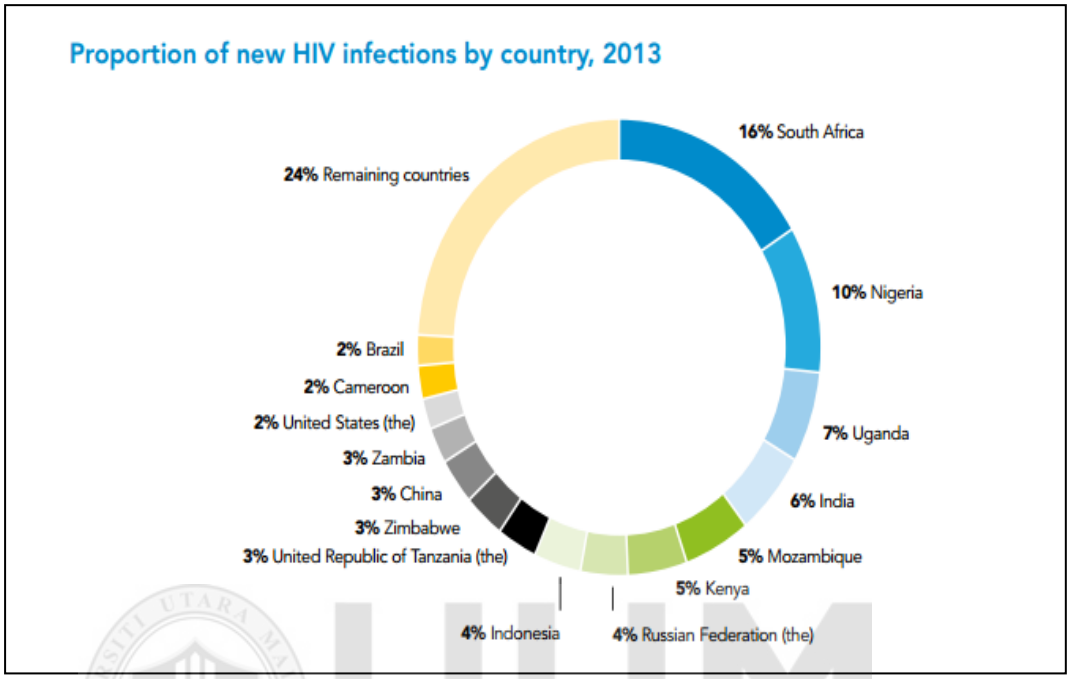

Figure 2.4. **Newly Infected**

Source: USAIDS, 2013 estimates

UNICEF (2012) reports that new infection is one the main problems of the in parts of the developing countries particularly sub-Saharan Africa though there is a continuing decline in other parts of the world a decline of 38% from 2001. Strong and very dramatic progress has been achieved in preventing new HIV infections among children. In 2013, 240 000 (210 000–280 000) children infected with HIV, representing 58% lower than the figure of 2002. AIDS-aggravated deaths have reduced by 35% since 2005, when the world witnessed highest number of deaths. The past three years alone (UNAIDS, 2013), witnessed a reduction in AIDS-related deaths which fell by 19%, representing the largest annual decline in the past 10 years.

About half of the adult population in sub-Saharan Africa about 87% of the people know their HIV status and about 76% have achieved viral suppression which is a welcome development from 2013, and about 12.9 million people are receiving antiretroviral therapy (ART), a serious reduction has been witnessed in the number of people who are not on ART from 90% (90–91%) in 2006 to 63% [61–65%] in 2013, the number of men who opted for medical circumcision has risen in the last two years (WHO, 2015; UNAIDS, 2013).

A reduction of about 36% was noticed from 2004 to 2012, in TB-related deaths among PLWHA worldwide. Access to ART for pregnant women living with HIV has prevented more than 900 000 new HIV infections in children since 2009. ART has since 1995 averted about 7.6 million deaths worldwide, including about 4.8 million in SSA representing a gain of about 40.2 million life years since the beginning of the epidemic (WHO, 2013), just fifteen countries play host to about 75% of the PLWHA in infections that occurred in 2013 (UNAIDS, 2013).

Just about eight male condoms are available for each sexually active individual in SSA per year, for young people, access to condoms is even less, while twenty-two million, or three out of five PLWHA have no access to ART. Out of every four children living HIV three have no access to any form of treatment. In 2012, out of the estimated 8.7 million people that developed TB globally 1.1 million (13%) of the 35 million PLWHA an estimated 2-4 million are also living with hepatitis B and C infection (WHO, 2013).

Worldwide, 15% of women living with HIV are aged 15 years and above, and 80% of them live in SSA. The UNAIDS, 2015, reported that in Africa women acquire the HIV virus at least 5–7 years before than men. Among sex workers HIV prevalence is

12 times higher than the general population, the region is estimated to account for 12.7 million injection drug users (IDU) and these 13% of them are HIV positive. The need for needles per person is estimated to be 200 per year, while only about 90 needles are available for per every IDU (UNAIDS, 2015). A total of almost 120 000 people 50 years and older acquire HIV. (UNAIDS, 2015).

2.4 HIV in Nigeria

The federal republic of Nigeria is a country covering a total area of 356,667 square miles. As at 2011, the international court in the Hague had ceded the Oil rich Bakasi peninsula in present day Cross River State, (Calabar) to the Republic of Cameroun, one of Nigeria's neighbors to the south of the Gulf of Guinea, the country has an estimated population of 187 million; (PRB, 2012). Nigeria is Africa's most populous country, Africa/s largest economy and also the seventh-most populous country in the world. Nigeria is bordered by the Republic of Benin on the west, Chad and Cameroon Republics on the east, and by the Gulf of Guinea and Niger republic to the north Federal office of statistics (FOS, 2002).

The capital of Nigeria is Abuja. Abuja was selected as a virgin territory to replace Lagos on the 12th December 1991. The city is home to major landmark attractions in the country such as the Nigerian National Mosque and the Nigerian National Christian Center. Nigeria is a country of rich ethnic diversity composed of over 250 ethnic groups. The three major ethnic groups in Nigeria are the Hausa, Igbo and Yoruba. Other major tribes in the country include Edo, Ijaw, Kanuri, Ibibio, Ebira, Nupe, Tiv and Igala. Also, there are minority groups of foreigners of different nationalities who live in Nigeria, amongst whom are they British, Americans, East Indians, Chinese,

white and Black Zimbabweans, Japanese, Greeks, Syrian and Lebanese immigrants. Nigeria is a country comprising 36 states and one Federal Capital Territory. The states are further divided into 774 Local Government Areas (FOS, 1992).

English is the official language of Nigeria and is extensively used for education, business transactions and for official purposes. Despite being the first language, English is not spoken at all in some rural areas. Because, the majority of the population of the country stays in rural areas, indigenous languages such as the Hausa, Yoruba and Igbo are spoken by the majority. A derived language called the Nigerian Pidgin English, also called the 'Pidgin' or Broken English is a popular lingua-franca used in communication by the different ethnic communities cohabiting in most urban areas where English is not understood fully for everyday use amongst people especially the uneducated in the country (NDHS, 2007).

Nigeria is a multi-religious country. Over 50% of the population are Muslims and practice Islam while nearly 40% are Christians following the different denominations of Christianity and is home to almost all sects of Christianity (Catholics, Protestants, and different varieties of new generation churches) the rest adhere to other religions, such as Buddhism, Hinduism, African Traditional Religion, and animism (NDHS, 2003).

The educational system has undergone different transformation since independence from the colonial masters in 1960; presently the 6-3-3-4 system of education is in place in Nigeria. Pupils spend 6 years of primary education and then move to the next level which is 3 years of junior secondary education, the government of Nigeria makes this two first level free and compulsory, and then those who cannot continue will drop out to pursue vocational activity which is included in the curriculum at this stage of

the educational program. The next level is another 3 years tagged senior secondary school which the students can thereabout choose which line (trade) to follow again students can stop after this level or continue to another 4 years of tertiary education, this is referred to as the formal education program while the non-formal education program is also run alongside the formal educational system and the two most popular examples of non-formal education are Quranic education and adult education (FOS, 1992).

Being the largest economy in Africa the country is classified as an emerging market because of its rich reserves of natural resources, and developed financial and communications sectors. The transportation sector and stock exchange of the country add to the finances. The Nigerian Stock Exchange is the second-largest in Africa. The country is in the process of diversifying its economy with emphasis on agriculture and mineral resources, petroleum is a major product playing a significant role in the economy of the country despite dwindling oil prices; it is the 12 largest producer of petroleum in the world (FOS, 1992).

Manufactured products like leather, textiles, t-shirts, plastics and processed food enhance the economy of the country. Agriculture is also important, employing almost 60% of Nigerians. Cocoa, sugar cane, yams, maize, palm oil, groundnuts, coconuts, citrus fruits, cotton, millet, and cassava are major agricultural products (FOS, 1992).

Figure 2.5. Map of Nigeria

The first case of HIV in Nigeria was identified in 1985 and reported at an International AIDS Conference in 1986. A sentinel surveillance system conducted amongst pregnant women age 15-49 attending antenatal care (ANC) has been used to track HIV prevalence in the country since 1991. Information obtained from the ANC surveys shows that, nationally, HIV prevalence increased from 1.8 percent in 1991 to 4.6 percent in 2008 the highest prevalence nationally so far. In 2008, state HIV prevalence rates ranged from 1.0 percent in Ekiti and Zamfara States, two very distinct states in level of education and every other health and developmental indices, to 6.7 percent in Kogi state the study area which is more than the national average of 4.6 percent to 10.6 percent in Benue State, a state bordering the study area on the east (FMoH, 2008).

UNAIDS in its 2008 global report stated that although HIV prevalence is lower in Nigeria than in many other African countries such as South Africa and Zambia, the

large size of Nigeria's population meant that by the end of 2007, there were an estimated 2,600,000 people infected with HIV in Nigeria and approximately 170,000 people had died from AIDS related complications in 2007 alone (UNAIDS, 2008). In recent years, life expectancy in Nigeria has declined partially as a result of the effects of HIV and AIDS. In 1991, the average life expectancy was 53.8 years for women and 52.6 years for men (UNFPA, 2005). The 2007 estimate had fallen to 50 years for women and 48 years for men (WHO, 2009).

Poverty, low literacy levels, high rates of casual and transactional unprotected sex in the general population, particularly among youths between the ages of 15 and 24, low levels of male and female condom use, cultural and religious factors, as well as stigma and discrimination are major factors in the transmission of HIV in Nigeria (NDHS, 2008). In 1999, the Federal Government of Nigeria began implementing a multi-sectoral approach, followed by the establishment of the National Action Committee on AIDS (NDHS, 2008) in 2000 to coordinate the national response and to ensure multi-sector and multi-level participation. In 2007 NACA was transformed from a committee to an agency the National Agency for the Control of AIDS (NACA) by an act of parliament, for the purpose of sustainability and improving the effectiveness and coordination of the national HIV response. There are also State and Local Government Action Committees on AIDS (SACAs and LACAs), with 12 state committees already transformed into agencies between 2003 and 2008 by acts of parliament.

National efforts coupled with support from various donors and development partners have contributed to a significant scale up of prevention, care, and treatment programs aimed at combating the disease. Similarly, efforts have been made to strengthen

monitoring and evaluation systems for HIV response activities as the country seeks to continue supporting evidence-based decision-making for a more efficient and effective response.

The future course of the national response to the HIV epidemic depends on a number of factors including levels of HIV and AIDS-related knowledge among the general population; social stigmatization; risk behavior modification; access to quality services for sexually transmitted infections (STI); provision and uptake of HIV counseling and testing; and access to care and anti-retroviral therapy (ART), including prevention and treatment of opportunistic infections (FMOH).

A very high proportion (90 per cent) of women 15-49 years and of women 15-24 years have heard of AIDS, However, only 23 per cent of them nationwide have a comprehensive knowledge of the disease, (know the two ways of preventing HIV &AIDS, reject the two most common misconceptions and know that a healthy looking person can have HIV & AIDS. Only 11 per cent of women with no education have a comprehensive knowledge of HIV& AIDS against 28 half of the reproductive age old female population of Nigeria knows about the three ways of mother-to-child transmission of HIV & AIDS, 57 percent in urban areas and 45 percent in rural areas. Life expectancy is only 52 years (Baba; Rajwani & Hussayn 2014), impacted indirectly by HIV & AIDS. The HIV prevalence rate in 2009 was 3.6% in the general adult population, which gives Nigeria the second largest number of people living with HIV in Africa, after South Africa (PRB, 2012).

Health and socioeconomic indicators are even more dismal in Northern Nigeria. In addition to closely spaced births and pregnancies among older women, teenage pregnancies contribute to high-risk births in this region of the country. While

nationally, the rate of childbearing among women aged 15–19 is 23%, the rate is highest in Northern Nigeria, at about 45% (Macro 2009). Teenage childbearing and its associated problems of obstructed labor in the north is blamed for high incidence of maternal mortality and morbidity, including the high occurrence of bowel and bladder incapacitating fistula (VVF) that is linked to considerable stigma for afflicted women (Ezeh,1991).

Childhood marriage of girls in Northern Nigeria remains the highest in the country, contributing too many social and health problems. The latest available figures (PRB, 2012), indicate that 1 in 5 girls become wives by age 15. But there are large regional differences, with the mean marriage age being over 7 years lower in the North West (15.2 years) than in the South East region (22.8 years). Further, the median age at first marriage is 18.3 for women of reproductive age but it is 26 years for men in the same age range.

This highlights substantial age gaps between spouses, an important correlate of gender asymmetries in marriage in the area of reproductive decision-making. 1 out 3 married women has co-wives in Nigeria, but the figure is highest in the North East region (43%). This high prevalence of polygyny in Northern Nigeria, a phenomenon closely linked to wide spousal age gaps, further highlights gender inequalities within marriage (PRB, 2012).

Nationally, the average woman desires between 1= 6 children, already high compared to most sub-Saharan African countries (NDHS 2012). But the level is even higher in the North Eastern region where the average woman wants 8.1 children (PRB, 2012). This greater desire for large families by women in the North is reflected in married

women's relatively lower use of modern contraceptives (3%) compared to their counterparts in the South West zone (21%).

Despite socio-cultural barriers, family planning providers in Northern Nigeria and elsewhere have found that discussion of fertility and family planning with a spouse or partner has a strong positive association with contraceptive use (Tingstedt, B., Andersson, E., Flink, A., Bolin, K., Lindgren, B., & Andersson, R. 2011). Furthermore, in Islamic cultures, birth/child spacing, that is, encouraging men and women to space their children by 2-3 years, has gained widespread popularity because it is in alignment with religious values promoted by the Quran and by many religious leaders as a means to promote maternal health (JHU 2012). Discussion of sex is traditionally a very private and sensitive issue due to religious and cultural considerations.

2.5 The Role of Religion in Reproductive Health Decision-Making and Vulnerability of Women to STIs and HIV and AIDS

The role religion plays in sustaining gender inequality will be explored, focus will however be placed on the two religions with religious texts that can be verifiably referred to, the reason for selecting the Christianity and Islam is basically because 85 percent of Nigerians practice these religions added to the fact that because of their textual nature all comments can be verifiable in the text of the religions. Through an analysis of the texts of both Christianity and Islam, the researcher will attempt to extrapolate and unmask the web around the origin of patriarchy and why justification about assigning a secondary, less significant role for women seems to find acceptance in textual postulations (Saadallah, 1993, in Stoweser 1994).

From all dimensions of the spectrum of life have come suggestion about the need to properly peruse the unequal and uneven status of both sexes in the world, from the academia, to developmental circles and even at laymen levels, the need to ameliorate the unequal gender relationships between the sexes has been the focus of discussions which seems to suggest that the root of these discrimination could be traced to religion (Saadallah, 1993, in Stoweser 1994).

The Christian bible began with Genesis as the first chapter and it is in this chapter that the creation of Man is discussed: Adam and Eve. Though, there exist two versions of the biblical account of the creation of man, the first version opines that both of them were created at the same time and stand equal before God (Metzer & Coogan, 1993).While in Genesis 2: 7, God "formed only man from the dust of the earth and breathe into his nostril and he became a living soul" and from Genesis 2: 18, we gathered that upon realizing that Adam needed a companion, God then caused Adam to fall into a deep sleep and from his chest took a crooked rib which he used to fashion Eve (Metzer & Coogan, 1993).

This latter version introduces a subordinate and secondary role for Eve {woman} as it implies that she was created upon the realization that Adam needed a companion and being created from a part of Adam also implies a lesser standing in quality to Adam, who was the first creation of God and for whom Eve {woman} was described as his help mate. This term Eve has historically been described as meaning 'inferior status' and in Genesis (2:27), Adam was to assert his authority and intellectual superiority over Eve {woman} by naming her like he named all the other creatures God gave him dominion over (Metzer & Coogan, 1993).

Different versions of the bible such as the King James Version (KJV), the new international version (NIV), and the Revised Standard Version (RSV) all used the word "rule" to describe Adam's role over Eve. According to Metzer & Coogan (1993), "thy desire shall be to thy husband and he shall rule over thee". Other versions of the Bible used the term "master" and "dominion" to describe the relationship between Adam and Eve and opined that the same power imbalance shall exist between their descendants,

The above quotation by Metzer & Coogan (1993) from the Bible ("thy husband shall rule over you") explains the social and power relation in the home where the power balance is established by this quotation (and subsequent verses on marriage) in Genesis (4: 19), "a man shall marry as many times as he desires", thereby consecrating polygyny. Metzer & Coogan, (1993) provided a list of men of God in the bible who practiced polygyny: Lamech with two wives is reputed to be the first polygynist in the bible, followed by Esau; 3 wives, Jacob; 2 wives, Ashur; 2 wives, Gideon; many, Elkanah; 2 wives, Solomon; 700 wives, and so on.

From the fore going, it is safe to conclude that the bible or Christianity permitted polygyny. Apart from Jesus Christ who didn't marry and is not reported in any part of the bible to have engaged in sexual relation, all the other appointed men of God had more than one wife. Therefore, it can be concluded that polygyny King James Version (KJV, ibid), multiple sexual partnering and extra marital sexual relationship were all established biblical acts with its attendant consequences not only for power relations between spouses but also with serious consequences for the reproductive health of women (Metzer & Coogan, 1993).

The position of women in the bible with regards to reproductive decision-making places that burden squarely on the man either as her father or her husband New International Version and Revised Standard Version (KJV, NIV, & RSV, ibid). The woman is expected to comply fully with the dictates of the men in her life either as her father, or husband or next of kin and nowhere in the text of the bible is she expected to either exercise initiative or to express opinion.

The example of Sarah, Jacob's wife is worthy of note when she suggested to her husband Jacob to have sexual relation with Hagar her bond women for the purpose of having a child by her this was because she (Sarah) could not have a child after so many years of marriage and fears divorce. The low status of women in the society meant that she was not even consulted or informed in advance of the couples plan and the child which she was expected to have will belong to Jacob (Metzer & Coogan, 1993).

The above scenario is replicated in another chapter of the bible were Lot offered his virgin daughters to the mob that came to his house wanting to have homosexual relations with his guests. According to Metzer and Coogan (1993) "I have two maiden daughters, let me bring them out to you and you may do unto them as is good in your eyes" allowing ones daughters to be gang raped was considered a minor transgression because of the low status in which women at that time were held.

In Deuteronomy, a women was required at the time of marriage to be a virgin and if the husband complains that she was not a virgin then she is to be stoned to death, no such requirement was expected of the man. In the same Deuteronomy all that a man needed to divorce his wife was to find her no longer pleasing to him and he shall write her a latter of divorcement and send her out of his, Robinson (2012) also concluded

that if a woman was raped it became compulsory that she marries the man who raped her irrespective of how she felt about him.

It is safe to conclude from the foregoing that in an era where a subordinate role was established for women in all matters including RHDM that if HIV/AIDS was prevalent at that time women would have been vulnerable to it due to the life style that the bible encouraged/designed for them. While todays Christianity is more accommodating of changes in the power relationship between the male and female sexes increasing discrimination is noticeable and is more manifest in the Muslim world today, but it is important to find out if it has always been so. Germani (1996) opines that hiding behind Islam to blame or justify discrimination against women amounts to a short-sighted procedure which will only help consolidate these injustices rather than provide a genuine search on how to alleviate them.

The extent of the relationship between the sexes writes Stowerser (1984) (male and female) was laid in the Quran, the (Sunna), and the body of Islamic text or Fiqh, it, these sources provides the basis for any exploration of the dynamism inherent in gender in Islam as a religion. Bodman (1998) emphasizes that "the Quran makes it unmistakably clear that in the eyes of God women are the equal of men". The extent of this equality, however, is hinged to the standing of men and women before God, and their religious obligations and rituals. Other conditions in certain circumstances determine some other exception/considerations according to Bodman (1998) Stowasser (1984), when they confirmed that "both men and women have their full humanity and bear the burden of equal moral responsibility".

The complexity of the situation becomes noticeable when looking at the specified roles for the sexes where man becomes the care taker of the woman and she is put

under the protection of males, this guardianship of man over woman establishes man in higher position and elevates him above her. The Quran in Surah 4 (Women, verse 34): “Men are the protectors and maintainers of women, because Allah has made one of them excel over the other, and because they spend (to support their women) from their means” (Mernissi, 1996).

In the areas of family relationship whether as it relates to divorce or other sundry matters different verses of the Quran proceed to dictate the relationship between man and woman, the same regulation is noticeable in issues of inheritance and testimonial leverage as pointed out by Mernissi (1996), in an attempt to understand the rights of men and women the impression that comes forth is that in marriage, family and divorce, these rights are based on a culturally designated construct of patriarchy and reproduction of gender roles. As shown quite clearly in the text, “Marriage is regarded as a sacred institution where men are economically responsible for the maintenance of their wives.

- Men are able to take up to four wives.
- Men are the natural initiators of divorce, except under specific circumstances.
- Men are allowed to marry women of other heavenly religions, while women are restricted to monogamy and are only allowed to marry Muslims.
- The testimony of one man is equivalent to the testimony of two women, though women are entitled to inheritance this right is distinctly regulated not to equal the share of men” (Stowasser, 1984).

Stowasser (1984) suggests that the Quran be studied against the epoch of the time of its revelation: pre-Islamic society – a ’jahiliya society’ (period of ignorance).– a time where it was accepted that women were inferior to men and considered as property to

be acquired and used as the man deemed fit. According to the Quran Islam instituted marriage as a contract binding on both parties and dictated the terms of engagement which elevated the status of women prior to Islam (Menissi, 1996).

Though Islam granted man a right to more than one wife, in fact he can marry up to four the same verse that allowed it provided conditions which made enjoying that right almost impossible. Thus, "a verse allows (a man) to have four wives, provided he treats them equally, but a later passage casts divine doubt: 'Ye are never able to be fair and just as between women even if it is your ardent desire'" (Bodman, 1998).

> From the initial state men are given the right to initiate divorce, but under certain conditions women too can initiate divorce though by stating in the marriage contract their possession of 'Isma'a. Women can under other circumstances if they so wish agree to divorce if they refuse to claim what is referred to today as alimony and its captured in the marriage contract from the beginning according to the principle of Khul'a (The right to initiate divorce).
>
> – like the practice in all patriarchal societies where the children take the names of their fathers for the purpose of continuing the fathers family lineage Muslim women must therefore marry only Muslim men and are in the same way prevented from marrying non-Muslims.
>
> – The provision of unequal inheritance law for women is hinged on the existing division of labour at the time which sees women's reproductive and domestic roles only and puts the man in charge of providing for his family and since the women upon getting married will be provided for by their husbands their own share of the inheritance is smaller than that of their brothers. This emulates in essence a patriarchal division of labor, and role definition.

To fully grasp the role designed for women in Islam from the foregoing we must peruse the role delineation for women in Islam very clearly, this again must be understood from the period of time in which the evolution of Islam took place, where "women were not allowed the holding, or in any case the uncontrolled disposal, of their possession" (Stowasser, 1984, p. 15, Hanoch, & Levy, 1969). Comparing the

Quran against the time and place of its evolution, the pre-Islamic society, it can be concluded that the little rights granted by Islam greatly improved the social status and the legal rights of Muslim women which in pre-Islamic times were abused with reckless impunity but through Quranic legislation these serial and concurrent abuse were outlawed (Stowasser, 1984).

Stowasser (1984) argued further that woman's essential equality with man is more complete in Islam than it is in Judaism and Christianity". She explains that the initial equality of women to men was reduced by both Christianity and Judaism when they held Eve responsible for the disobedience in the garden, cursing her before Adam, while the Quran portrayed both as having committed the mortal sin and held both accountable before God (Menissi, 1996).

Despite textual and scriptural postulations in favour of women's equal treatment, Mittleman & Pasha, 1997) pointed out the existence of strong conservatism in today's Islam that has overshadowed the rights that the Quran guaranteed women at the beginning of the Islamic era.

The diminished status of women added with the discriminatory treatment and reduction of her space cannot be traced to Quranic texts but from interpretation which could be traced to men who were and are still the interpreters of both the Quran and the hadiths, this has greatly contributed according to (Karam,1984) in entrenching the system of patriarchy in existence in Muslim societies instead of all efforts geared towards removing it.

Commentaries, or explanations (known as Tafseer) or (Hawashi) according to Abdullah (Menissi, 1996) noted the development and justification of confinement and

discrimination against women and through history a progressive erosion of the rights guaranteed women in Islam was noticed. Stowasser confirms that "the process of progressive exclusion and increasing restrictions imposed on women became visible through comparison of the original Quranic legislation with the series of commentaries which later ages produced" (Stowerser, 1984).

That the Hadiths passed through the same process can also be argued and goes to confirm that as Menissi said "the later the source, the more abundant, detailed and normative-restrictive the information on women it contains" (Saadallah, 1992, in Stoweser 1994). Menissi (1996) opines that it is possible to conclude that the status of women has been greatly improved by the Quran today despite the fact that inequality between the sexes is more noticeable today than in the beginning, this is because the Quran is based on man as the bread winner symbol and women the weaker sex symbol, this role play unfortunately puts women in disadvantaged position.

As mentioned above, the Quran is based on the 'man as a breadwinner' model a specified division of labor places the woman as dependent and the weaker sex. This does not, however, negate the equality between men and women unto God, and hence both should enjoy equal gender entitlements to every available opportunity in the family and society (Stowasser, 1984).

Starting from a position above other textual religion the Quran in the treatment meted out to women at the beginning of the Islamic era has today been reduced to becoming more entrenched in discriminating against women than Christianity and Judaism, this relegation can however be traced to interpretations emanating from men who are more patriarchal than scriptural in their approach to the religion (Mernissi, 1996). Mernissi opines that the Quran, in comparison to other texts of scripture religions, proffers a

model of hierarchical relationships and sexual inequality" between men and women (Mernissi, 1996). The assimilation of other cultures and influences during the spread of the Islamic Empire allowed "sexual inequality to reassert itself".

From the literature reviewed so far it is possible to reach a conclusion that the discrimination women face today in contributing to reproductive health decision-making does not arise from either the Quran or the Sunnah but that as concluded by (Menissi1996) arose out of the interpretation of both texts by men who are steeped deep more in their patriarchal roles than in religious tenets.

2.6 Situational Analysis of Women's in the World

Globally the number of women is more than that of by almost 62 million, the number of baby girls at birth during delivery is more than that of baby boys, a by-product of natural selection process that is enduring, progressively, however the slight advantage at birth disappears during childhood and young adulthood, due to generally male mortality than female mortality (Panda & Agawal, 2005). The implication of this is that women outnumber men at older age group by a ratio of 54 per cent of the population aged 60 and over 62 per cent of those aged 80 and above Consequently, women outnumber men in older age groups and represent 54 per cent of the population aged 60 and over and 62 per cent of those aged 80 and over. A higher number of women live above 80 years than the number of men by three years, visible differences exist also in the living arrangements of both sexes (World Bank, 1986).

Due to a higher mortality amongst the male population women are more likely to be widowed and live alone. Programmers must take this into consideration especially when planning for and targeting older person, particularly looking at the growing rate

of older persons (ageing population) taking place all around the world. The changing pattern of marriages globally shows that men and women are marrying later than two decades ago, this is a reflection of levels of education of especially the girl child and a later entry into the work force, signifying increasing economic independence and a rise female household autonomy (UNAIDS, 2015).

Women continue to marry a few years earlier than men, at age 25 on average, compared to 29 for men. The rate of child marriage a fundamental violation of human rights that limits girls' opportunities for education and development and exposes them to the risk of domestic violence and social isolation has declined slightly. Almost half of women aged 20 to 24 in South Asia and two fifths in SSA got married before between the 15 and 18 years (World Bank, 1995).

Worldwide the TFR reached 2.5 children per woman in 2010–2015, a reduction from three children in 1990–1995. While higher and medium level fertility countries noticed decline in the TFR. Noticeably therefore the linkage between marriage and childbearing is gradually reducing owing to the increasing number of extra marital childbirths and a rise in divorce rates. The implication of this phenomenon is that single mothers with children account for about three quarters of parents; this is becoming common in both developed and developing countries (UN AIDS, 2014).

Advances in technology, medical sciences and improvements in information technology over the last two decades have extended the life expectancy rates of both sexes to an average of 72 and 68 years, respectively USCB (2014). A cursory glance at mortality data across various age groups and different regions shows a tendency for women and men to die of different causes. All around the different continents,

biological factors and unequal gender relations influence sex in healthcare and access to health services through the life of both men and women.

In every society adolescents and young adults should be a time of general good health with low mortality rates, but in developing countries and SSA in particular complications arising from pregnancy and delivery, STIs in particular HIV continues to wreck untold havoc on the lives of these groups of people due to under developed health systems and gender discrimination and role delineation (Vatanian & McNamara 2002; Baba, Rajwani and Hussayn, 2014).

Poor spousal communication occasioned by early marriage lack of awareness and access to information and education resulting in lack of contribution to decision-making among married girls or those in active sexual liaison increases the vulnerability and exposure of women to STIs and HIV & AIDS, unplanned and unwanted pregnancies and unsafe abortions. Gender role expectations such as male masculinity induces adolescents and young men to indulge in risky behavior's such as multiple sexual partnering and experimental sex that exerts a harmful effect on them (Baba, Rajwani and Hussayn, 2014).

Though reproductive and maternal health witnessed some improvements the biological functions of reproductive age and child birth creates additional demands for young women (World Bank, 1995).

Access to and use of contraceptives has improved particularly in SSA thereby meeting to some appreciable level the global demands for family planning, in all regions of the world the maternal deaths have declined by some 45 per cent between 1990 and 2013. however, in SSA, slightly lower than half of pregnant women receive adequate care

during child birth with only half of pregnant women receiving at least one antenatal care visit in 2014, 83 per cent of pregnant women in developing, an improvement of 19 percentage points since 1990. And according to the (World Bank, 1995), a paltry 52 per cent of pregnant women made the minimum four antenatal care visits.

Non-communicable diseases such as cardiovascular disease, cancer, chronic obstructive pulmonary disease and diabetes are the more common causes of death of older aged people. Gender dimensions dictate and direct the risk factors contributing to these diseases. Though, men smoke tobacco and drink alcohol much more than women: 36 per cent of men aged 15 and over smoke and 48 per cent drink, compared to 8 and 29 per cent of women, respectively (WHO, 2013, UNICEF, 2012).

In the developed countries a large number of women have taken to these habits for varying reasons, obesity though affecting both sexes, women appears to be slightly affected more than men (14 per cent of women aged 20 and over are obese compared to 10 per cent of men) (WHO, 2013 & UNICEF, 2012). Though 44 million people were living with dementia in 2013, women are affected more than men and this figure is expected to double in the next 20 years. Dementia tends to set later in life and women tend to live longer than men and women represent a large number of those involved in the informal caregivers to those living with dementia, in their roles as daughter in-law, mother, daughter or wife. (IGWG &ICF, 2014).

Remarkable progress was witnessed in education particularly access to education in the developing countries with enrolment of primary school pupils nearing universal thereby narrowing the gender gap and in some places girls are faring better than boys. Though for those developing countries that have not achieved gender parity the disparity are very glaring, to globally 58 million children of school age are out of

school, more than half of these numbers are girls and nearly all live in SSA and south Asia (WHO, 2012).

Despite a noticeable reduction in gender parity in secondary school enrolment and completion the gender disparities remain wider in favour of boys than of girls in some regions and in some regions in favour of girls. Though female participation in tertiary education has increased the disparities are stark in favour of boys as globally female participation at this level surpasses that of males in all developed countries and more than half of developing countries (ILO, 2014).

While Jones, Perret., Little., Boothroyd., Cornwell., Feinberg., ... & Burt, D. M. (2005), opined that Illiteracy rates are highest among older people and are higher among women than men. At age 65 and over, 30 per cent of women and 19 per cent of men are illiterate. A large proportion of this number live in Northern Africa, sub-Saharan Africa and Southern Asia, where gender gaps are also noted (World Bank 2008).

As a group, women work as much as men, if not more. When both paid and unpaid work such as household chores and caring for children are taken into account, women work longer hours than men, an average of 30 minutes a day longer in developed countries and 50 minutes in developing countries (ILO, 2014). Finally, the UNWomen (2015) concluded that gender differentials in hours spent on domestic work have narrowed over time, mainly as a result of less time spent on household chores by women and, to a smaller extent, by an increase in time spent on childcare by men.

Only 50 per cent of women of working age are in the labour force, compared to 77 per cent of men. The gender gap in labour force participation remains especially large

in Northern Africa, Western Asia and Southern Asia (ILO, 2014). The tendency for women to be unemployed and to be more likely carrying on the family work is high meaning that they are involved in unremunerated work and have no access income of their own. In Oceania, SSA and Southern Asia, between 30 and 55 per cent of employed women are also contributing family workers, with figures as high as about 20 percentage points than men in the same regions and to be involved in part time employment (ILO, 2014).

In all sectors and all occupations, women are paid less than men for the same quality and quantity of work earning between 70 and 90 per cent of what men earn. Though in developed countries there is a growing mixed decline in the gender pay gap (ILO 2014). World Bank (2015) contended that severity in inequality between women and men is more visible in power and decision-making in most societies the world over, as you go up hierarchy of power women become less visible especially public and private institutions though there are some noticeable advances progress is however slow.

Women across the world are subjected to physical, sexual, psychological and economic violence, regardless of their income, age or education. Such violence can lead to long-term physical, mental and emotional health problems (UNICEF, 2013). Around one third of women worldwide have experienced physical and/or sexual violence by an intimate partner or sexual violence by a non-partner at some point in their lives. Intimate partner violence is the most common form of violence, peaking during women's reproductive years in both developed and developing countries.

More than 125 million girls and women alive today have been subjected to female genital mutilation across countries in Africa and the Middle East where this specific

form of violence against women is concentrated. Prevalence tends to be lower among younger women, indicating a decline in this harmful practice (UN Women 2015). Gender disparities in poverty are rooted in inequalities in access to economic resources; women continue to be economically dependent on their spouses. Lower proportions of women than men have their own cash income from labour as a result of the unequal division of paid and unpaid work. In developing countries, statutory and customary laws continue to restrict women's access to land and other assets, and women's control over household economic resources is limited (UN Women, 2015).

In nearly a third of developing countries, laws do not guarantee the same inheritance rights for women and men and in an additional half of countries discriminatory customary practices against women are found. Moreover, about one in three married women from developing regions has no control over household spending on major purchases, and about one in 10 married women is not consulted on how their own cash earnings are spent (ICF, 2014).

Gender disparities in poverty are more visible with the diversification of family arrangements, including an increase in one-person households and one-parent families. Working-age women in developed and developing countries are more likely to be poorer than men when they have dependent children and no partners to contribute to the household income or when their own income is non-existent or too low to support the entire family (ICF, 2014). At older ages, women in developed countries are more likely than men to be poor, particularly when living in one-person households. The difference in poverty rates between women and men, including among lone parents with dependent children and among older persons, is narrowing in some countries while it remains persistent in others. These points to the need for

social protection systems that take into account the emerging diversification of family arrangements (World Bank, 2014).

From the evolution of the literature on Women in Development in the 1970s, development and feminist scholars have looked at women's empowerment and its linkages to positive results for families and societies (Presser & Sen, 2000). Noting in the process that literature on the empowerment of women is scarce, scholars hold two major factors responsible for the scarcity of literature; one which is the sophistication noticeable in any attempt to conceptualize empowerment and the way in which the varying levels of empowerment relate to each other and secondly the scarcity in the data for empirical research on women empowerment.

Most of the discrimination against women takes place at the lowest level of the society wherein the struggle against discrimination is ignored because it involves local people at the bottom ladder of the society which is where most of the active revolutionary development in the life of women takes place (Batliwala, 1994; Malhotra, Schuler, & Boender, 2002).

In the few studies that studied the impact of community actions, it was discovered that when women act on communal basis, the result is more positive than when they act on individual basis (Jejeebhoy & Sathar, 2001; Kritz & Gurak, 2000; Mason & Smith, 2003). Findings by Kishor, (2000); Kritz et al (2000) show that 50 percent of women do not exercise either the power or the will to seek medical care for their ill children without the express or implied approval of their husband or parents-in-law, and 70 percent cannot also take decisions on their own on simple domestic chores such as the purchase of household materials and personal or children's clothing.

These results are almost the same all over the world. For instance, when there is constraint on women's physical mobility, their ability to make independent decisions are further affected and in countries such as India, Egypt, Bangladesh and some parts of Nigeria, these constraint do exist in different ways and in different degrees. Women in these societies are governed by societal norms and values that determine and curtail their physical mobility, described as female seclusion (Kabeer, 2001, Yusuf 2001).

Thus, from the foregoing, the competence level needed by women to engage in making decisions regarding health seeking ability, personal expenditure and consumption may be lacking in women or they may need to obtain informed consent and permission from some other authority figure before carrying out these transactions (Kabeer, 2001; Yusuf, 2001).

Following land mark development in the 1994 ICPD, the international community has come to fully acknowledge the existence of gender disparities the world over and has come to link the enjoyment of reproductive health and reproductive rights as a human right that must be addressed urgently if men and women are to enjoy a more fruitful reproductive life and as couples share in decision-making (Speizer, Whittle & Carter, 2005).

The understanding that gender based power inequalities has a profound effect on reproductive health by hindering communication between spouses about reproductive health decision-making by couples and prevents the attainment of sexual pleasure thereby increasing their vulnerability to STIs and HIV & AIDS has been attested to by scholars (Population Council & IGWG, 2001; Speizer, et al, 2005).

That gender inequality is a key element in the participation by women in reproductive health decision-making has been shown in a number of researches. Blanc (2001) observed that when spouses cannot come to terms on whether or not to conceive a baby or use contraceptive, men's opinion on the issue will definitely predominate even though women will have to bear the burden of the decision and run a number of life-threatening risks such as pregnancy, labor and delivery, STIs and HIV & AIDS.

The ground for which men oppose their wife's contraception most times is borne out of fear that their authority will be threatened as the leader in the home or the family, or that their control over issues of fidelity of their wives or fear of promiscuity from their wives, and /or that their peers in the community may look down on them. All these reasons are according to Speizer, et al (2005) based on man's inherent weakness disguised and paraded as power over women.

If and when as husbands men approve of contraceptive use, they may be doing so in theory and when faced with putting their words into action, they may either leave implementation to their wives or out rightly refuse to use condom**s.** It now falls on their wives who will have to sacrifice their own desires and wishes in order to meet the desires and wishes of their husbands, (Population council & IGWG, 2001; Speizer, et al, 2005). The tendency of women to use contraception covertly against the expressed wishes of their husbands can put a lot of women at risk of either emotional and physical abuse or a situation where their finances are constrained especially those financially dependent on their husbands. Some husbands have threatened divorce or physical violence over covert use of contraception viewing it as an abuse on their authority (Blanc, 2001; Population council & IGWG, 2001; Speizer et al, 2005).

On a continental level, Africa remains the only world region where fertility is persistently high and on the increase and it trails behind other developing regions in reaching the Millennium Development Goals (MDGs). Although many countries in the region have entered the fertility transition, recent reports indicate unanticipated stalls in the transition in several of these countries in the late 1990s and 2000s (Bongaarts 2008; Guttmacher, 2008).

In sub-Saharan Africa, undertaking HIV testing and counseling and access to treatment have expanded greatly in recent years, though coverage is still limited. Global estimates suggest that only about 34% of women and 17% of men in some small and medium-income countries have been tested and have received their results, which shows that the median percentage of those who are living with HIV and know their status is below 40% (WHO, UNAIDS & UNICEF, 2010).

Despite increasing number of people being tested, research indicates that substantial proportion of individuals diagnosed with HIV does not reveal their serostatus to those around them, including their sexual partners (Obermeyer, Baijal & Pegurri 2011). On expanded bases, scholars, public policy-makers and program planners have come to recognize the importance of HIV disclosure for prevention, treatment and stigma reduction.

When people test positive to HIV and disclose their HIV+ status others may be encouraged to test especially wives, loved ones, and partners to be tested. They also obtain emotional support and care from relatives and friends, and gain partners' cooperation in preventive behaviors such as safer sex, replacement feeding for infants and adherence to treatment (Loubiere, Peretti-Watel, Boyer, Blanche, Abega & Spire 2009).

When HIV+ people do not disclose their status, the consequences could be very grave for prevention of HIV transmission to partners and children (Loubiere, Peretti-Watel, Boyer, Blanche, Abega & Spire 2009; Medley, Garcia-Moreno, McGill & Maman, 2004). For sero-discordant couples, nondisclosure to partners is responsible for transmission to partners and the increasing rate of new infections particularly in Sub Saharan Africa, in the light of evidence that large proportions of new HIV transmission have occurred within HIV-sero-discordant couples (Eyawo, de Walque, Ford, Gakii, Lester & Mills, 2010).

Evidence suggests that there exists a high relationship between individual disclosure behavior and health-care practices with regard to confidentiality and gender norms and power imbalances. For varying reasons, women in sub-Saharan Africa are more likely to be HIV+, and be tested and know their status through compulsory antenatal care (ANC) services before their husbands. Empirical body of evidence suggests that owing to women's low subordinate social and economic position in the region compared to that of men, women may refuse to disclose their status for fear of violence, discrimination and divorce. These reasons are particularly very important obstacles to testing and disclosure for women in many parts of the region (Maman & Medley, 2004).

Ethical and human rights considerations are at the heart of low transmission rate of HIV+ disclosure especially when the confidentiality between patient and doctor comes to light and the safety and well-being of those living with HIV & AIDS are compared to the right of partners and children who need protection from HIV transmission. Worldwide and within the sub-Saharan African region, series of laws,

policies and programs have been enacted to encourage, and/or in some cases, mandate HIV disclosure (Masiye & Ssekubugu 2008; UNAIDS & UNDP, 2008).

As expected, the laws and policies generated heated debate on the ethics of forcing health officials to mandatorily disclose patient's status without their consents and weighing these against policy debates within legal and public health circles. Meanwhile, the health sector has launched initiatives to encourage voluntary HIV disclosure and to increase partner testing in the context of ANC (Conkling, Shutes, Karita, Chomba, Tichacek, Sinkala, et al. 2010; Kululanga, Sundby, Malata & Chirwa, 2011).

In a bid to protect women, punish men and change male behavior, some African countries and women groups have supported criminalizing transmission of HIV to wives and sexual partners (UNAIDS & UNDP, 2008). However, some researchers argue that, in practice, women may be more likely than men to be prosecuted for nondisclosure or criminal transmission, because they are more likely to be HIV+, to be tested before their partner in ANC, and to have limited access to the legal system (Clayton, Schleifer & Gerntholtz 2008; Pearshouse, 2007).

The UNAIDS Reference Group on HIV and Human Rights concluded that, imposing legal punishment to HIV transmission or exposure will do more harm than good (UNAIDS Reference Group on HIV and Human Rights 2008) and called for a supportive social and legal environment conducive and safe for those positive to willingly disclose their HIV status and also ensure those who are not infected to be protected from deliberate infection.

In the light of these arguments, parliamentarians in some parts of Africa have rejected criminalization, but have not removed the provisions from the books and in some other situations these laws are still under consideration in many countries. In addition to legislation, policies, strategic plans and guidelines have been developed to influence health-care providers' behavior with regard to confidentiality, disclosure and partner notification (Clayton, Schleifer & Gerntholtz, 2008).

ANC is one of the main settings in which testing have been scaled up in sub-Saharan Africa. Maman, Groves, King, Pierce and Wyckoff (2008) examined government policies regarding HIV testing in ANC in 19 low and middle-income African countries, amongst which are Kenya, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe (Maman et al, 2008). Assessing if and the extent to which policies addressed consent, confidentiality and partner notification and found that while policies in all these countries mentioned respect for confidentiality, some did so within limits.

The UN High Commissioner for Human Rights is of the opinion that health practitioners maybe authorized but not required to inform sexual partners about their clients' HIV+ status, if they meet eight conditions (Office of the UN High Commissioner for Human Rights & UNAIDS, 2006).

Another type of policy related to HIV confidentiality and disclosure are mandatory premarital HIV-testing policies, required by religious institutions or governments in some sub-Saharan settings. For example, national governments have considered or implemented mandatory premarital HIV testing in parts of the Democratic Republic of Congo (DRC), Ethiopia, Guinea, Senegal and Uganda, while churches have adopted mandatory premarital HIV-testing policies in parts of Burundi, the DRC,

Ghana, Kenya, Nigeria, Tanzania and Uganda (Burns 2010; Luginaah, Yiridoe & Taabazuing 2005; Pearshouse 2007; Uneke, Alo & Ogbu, 2007).

Apart from questions about consent, evidence suggests that test results are sometimes shared with church leaders, local authorities or prospective spouses without the consent or even, in some cases, before they are given to the individuals tested (Luginaah et al. 2005; Uneke et al, 2007). A case study of mandatory premarital testing in the DRC found that local churches in Goma arranged for test results to be sent directly from the laboratory or clinic to the church pastors who would then disclose the results to the couple (Rennie & Mupenda, 2008).

What is clear is that in many parts of the region, HIV services are delivered in a context of severe resource constraints, including staff shortages, a lack of private counselling spaces, and inadequate referral services (Evans & Ndirangu, 2009). Health workers often report heavy workloads and high levels of stress and burnout (Mkhabela, Mavundla & Sukati 2008; Turan, Bukusi, Cohen, Sande & Miller, 2008a). In some countries, to address resource constraints, programs have shifted counseling tasks to lower level health workers or lay counsellors (Zachariah, Ford, Philips, Lynch, Massaquoi, Janssens et al, 2009). Generally, research highlights a need for more support and guidance for HIV counsellors in settings such as Burkina Faso (Sarker, Papy, Traore & Neuhann 2009), Kenya (Turan, Miller, Bukusi, Sande & Cohen 2008b).

Although the UN set 2015 as year in which gender equality in reproductive health will be achieved and that year has come to pass without the target being attained, yet the link between reproductive health and gender equality has never been more imperative as has been reiterated by scholars (Basu 2002, Van Rossem and Meekers 2000;

Vaughan 2000), the all agree that substantive evaluations of mediating gender outcomes using African data are scant because of lack of the kind of systematic gender disaggregated data that permit such evaluations.

Various dimensions of gender as shown in women's socio-economic position as determined by education and employment, age at marriage, decisions surrounding marriage, marriage structure such as polygyny, spousal communication about pregnancy timing, family size, contraceptive behavior, and participation in household decision-making which women's education, paid employment are associated with lower fertility and reproductive health (ICPD 1994; Jejeebhoy 1995; Kritz et al. 2000; Mason 1993; Mason and Smith 2000, Riley, 1997).

Women's and girls' ability to enjoy benefits of family planning is constrained by the overarching socio-cultural milieu, which is rooted in gender inequality (Kritz et al. 2000; Mason and Smith 2000). Husbands and partners interested in having many children are the usual gatekeepers of reproductive decision-making, limiting women's reproductive agency (Isiugo Abanihe, 1994).

Reproductive health desires and intentions of both marital partners are important predictors of a couple's fertility (Bankole et al, 1996). Thus, evaluating the effects of a reproductive health intervention in Northern Nigeria (a region where reproductive indicators have been persistently dismal) is important in identifying issues related to women's reproductive health decision-making abilities. Accordingly, the discussion surrounding background issues will focus on the reproductive health context in Northern Nigeria, highlighting gender differentials and how issues in the Northern part of the country, the target region, differs from other parts of the country.

Nigeria ranks as Africa's most populous country with a population of over 170 million, growing at 2.5% annually and showing no sign of abating this makes Nigeria a very youthful country with 45% of the population aged below 15 (PRB 2012). This high population growth rate is blamed on low contraceptive prevalence, high fertility and lack of spousal communication occasioned by wide spousal age gap in reproductive health decision-making (Macro, 2009).

Only about one in five currently married Nigerian women (21%) intends to use family planning in the future. Reported reasons for future non-use are attributed to religious, spousal, or women's own opposition to family planning and the desire for large families, with lack of contraceptive services or cost being reported by just 0.2% of Nigerians as barriers to future use (Macro, 2009). 87% (Eighty seven per cent) of all children born in Nigeria, were wanted at the time; 7% were wanted later; and only 4% were unwanted (Macro, 2009). Studies conducted in the country have also cited "perceived lack of need for contraception and fear of side effects" as reasons for non-use (Sedgh et al. 2006; Macro, 2009).

The results of NDHS 2008 indicate that the total Fertility Rate (TFR) is 5.7 births per woman. The implication of this is that an average Nigerian woman at the end of her child bearing years should have between 5.7 children. From 2003 the TFR of 5.7 has remained unchanged as reported in NDHS 2003 and 2008. The tendency for fertility to peak within the between 25-29 with 265 births per 1,000 and possibly decline thereafter is likely. The GFR is 194, implying 194 births per every 1,000 women during the three-year period preceding the survey, the CBR was 40.6 per 1,000 populations for the same period (NDHS, 2008).

The TFR of rural areas expectedly is higher than that of urban areas (6.3 compared with 4.7) and though, again large variations exist among urban areas and urban-rural differences in Age Specific Fertility Rate (ASFR) for all age groups. The largest variations are in age groups 15-19 and 20-24; in these groups the rates for rural women exceed those for urban women by 78 and 77 births per thousand women, respectively. These indicators provide a basis for inferring long-term trends in fertility by comparing the TFR with the mean number of Children Ever Born (CEB) to women aged 40-49, (NDHS, 2008). The fertility behavior of older women nearing the end of their reproductive period is also summarized. This serves as an indicator of average completed fertility for those having children in the three decades preceding the survey.

When fertility is stable for a long period of time in a population, the TFR and the mean number of CEB for those between the ages of 40-49 will show some similarities. And when fertility levels are falling, the TFR will show a commensurate reduction from the mean number of CEB. This report shows that the mean number of CEB in Nigeria to women age 40-49 is 6.5 (NDHS, 2008). The above figure shows with one child more than the current TFR fertility has decreased in the last few years some care must however be exercised in doing this assessment as some older women may not state correctly their child bearing experience (Macro, 2009 & NDHS, 2008). These indicators can be used to project long term trends in fertility when TFR is compared to the mean number of CEB to women of age 40-49. 82% representing more than three-fourth of women aged 15-19 have never given birth (Macro, 2009 & NDHS, 2008).

This proportion of women between 30-34 when compared to women 35 and above will decline to 9% and 5% respectively showing the near universality of child bearing

among women in Nigeria, those nearing the end of their reproductive years have achieved a parity of almost seven (6.9) children (NDHS, 2008). When observing those that are currently having children, though the mean children ever born is higher (4.0 children) compared with all women (3.1 children) the difference in the mean number of CEB between all women and currently married women could be traced to a substantial number of young and unmarried women manifesting lower fertility in the former category (Macro, 2009; NDHS, 2008 & NACA, 2012).

Since there is no voluntary childlessness in Nigeria, the minute number of women in their forties who have never had children can be traced to primary infertility since we can assume correctly that married women with no children at all are unable to have them (Macro, 2009 & NDHS, 2008). The 2008 NDHS results suggest that with 3% of women that cannot have children it can be concluded that primary infertility is low in Nigeria. This estimate excludes those who have had one or more children, only those who have not been able to have children at all are considered here. From the foregoing however it can be deduced that fertility rate in Nigeria as a function of reproductive health decision-making follows the trend of literature reviewed so far in its development as at the level of place of residence, education, whether rural or urban, access to and use of contraception which is a function of gender issues operating in the society drives fertility behavior in Nigeria (Macro, 2009 & NDHS, 2008).

The role of women's power in contributing to reproductive health decision-making will to a long way play an important dimension in fertility issues. This will be shown by an understanding of the exercise of power in the sexual relationship in operation in the society. From the literature reviewed above has emerged the relationship between contribution to decision making and development of factors influencing

fertility behavior, and women's role, empowerment and vulnerability to HIV & AIDS (Macro, 2009 & NDHS, 2008).

The role and impact of the various textual religious reviewed above has shed light light on the origin and nature of patriarchy which can be said to be the root cause of all the gendered discrimination against women and in the review of the challenges faced by women, the review of the situational analysis of women it was shown that practically there is evident discrimination against women in all regions of the world and in all aspects of women's life's they have played secondary roles to that played by men these much literature has shown, in the efforts of women to contribute to RHDM, the extent of the influence of patriarchy on the problems that affects women' effort to contribute to RHDM is presented below (PRB, 2012).

2.7 Challenges Faced by Women in Reproductive Health Decision-Making

The Beijing conference in 1995 observed that greater economic empowerment will guaranty women the ability to negotiate safe sex, alter traditional gender based sex roles that compromise women's reproductive health and provide women the opportunity to learn more about reproductive health. From the U.N. conferences in Cairo (1994) and Beijing (1995), effort was made to remove the vagueness surrounding the concept of female empowerment, at best, the concept of empowerment is employed rhetorically implying only broad-based, efforts geared towards ensuring that women have greater personal control over their lives. These documents did not explicitly state the type or aspects of power that will ensure that women take control of their lives and to also point to the inherent complexities in the power relations that influence gender and is influenced by gender (Department of State, 1995; United Nations, 1994).

Available sociological and gender literature can be used to explain the conceptualization of empowerment because, the complexities present in any attempt to define empowerment has been noticed and some form of agreement has also been reached on the theoretical level on some certain basic points, one of which is that access to resources must not be confused with control over resources. And that only control over resources can be seen as an indicator of power (Bradley & Khor, 1993; McDonald, 1980; Mason, 1986; Safilios-Rothschild, 1982).

Given this distinction, to assume that educating women and providing gainful employment are by definition empowering as has been suggested in several literatures and even used in some empirical research that has used measures of education and employment as proxy for women's status can at best be misleading (Mason, 1986 & Seguino, 2000).

No matter the consideration that is applied this indicators do not automatically translate to access to resources and even if the by chance translate to access to resources we must ensure that access and control are not taken as synonymous at all. The connection between access and control must be established and not assumed. The multilocational and multidimensional nature of women's power has almost been universally acknowledged, thus for example any discussion about women acquiring greater control over their lives should specify clearly the location of this power, if it is within the family, the community/social or economic/political spheres and if the control point is within family or within group level outside the family level (Quisumbing, 2003; WDR 2012; Kabeer, 2003; Dwyer & Bruce, 1988).

Women's control over a given aspect such as household domestic decision making for example does not need to overlap with control for example over her ability to make

family contraception decision-making or decision involving family account, this as much explains the multidimensionality of women's control with regards to family decision-making (Kabeer, 2003).

Since the degree of women's control over and above their life is a function of entirely different factors it becomes imperative to specify the particular aspect of power under consideration, rather than continue to envision empowerment in a broad sense, the focus must therefore be on the determinants of each of these aspects if we must understand the gendered power dynamics of the two dimensions within the domestic sphere: decision concerning money and finance and those concerning family and social relations (Kabeer, 2003).

As societies modernize, and women access education they are exposed to ideologies which emphasize independence from the extended family and egalitarian conjugal relationship that women are exposed to, with new paid work outside the home it leads to women's freedom from secondary position at home as they are encapsulated in modern labor economics (Kritz, et al, 2003).

Many gender literatures disagree with modernization theory over the assumption that socio-economic development provides women with opportunities for better education and employment outside the home. Kritz, et al, (2003), have argued that the agricultural and industrial revolution and modern capital accumulation have displaced and reduced women's productive activities, opining that for emancipation of women to take place they must have access to productive resources as a basis of power (Sen, 2008).

There are at least two potential problems in applying this model to gender relations in non-Western settings. First, the link between resources and gender roles that stress power and freedom needed by women to compete and gain access to education and therefore employment must be guaranteed if any reasonable impact is to be made by women. Recent research on gender in developing countries, however, suggests that women's ability to take over the structures in the society that hold women down cannot be gotten by their acting independently stressing cooperation and collaboration (Isvan 1991; Kishor, 1995).

Depending on the acceptability and preferences in a given society regarding conflict resolution, confrontation, and unilateral decisions, women's autonomy may or may not be equitable with empowerment. Second, while the productive sphere in other societies may be as relevant to domestic relations as it has been in the industrialized West, this is not necessarily the case, especially if other bases of gender stratification, such as reproductive, sexual, or familial control, are deeply entrenched (Sen, 2008).

Other bases of which gender stratification such as reproductive, sexual or familial control are entrenched in societies in the developing countries compared to industrialized western societies, to that extent constraints imposed on women in domestic decisions by the larger society or social context are deep enough to make personal accumulation of resources irrelevant in its bid to empower women (Kishor, 1995).

2.7.1 Empowerment

For women to participate in reproductive decision making the must first and foremost arise from an empowered position so that when they will be equipped with the

necessary skill that will enable them enter into the environment for decision making from a position of power that will guarantee a rewarding engagement in family decision making process.

The place of power relation in the home led Atol (2002) to define empowerment as the process through which "power" can be acquired by people acting in their individual and collective capacity, among individuals or a community, it designates first and foremost the ability to act independently, but that when power has been acquired the means needed for the exercise of that power must also be inherent in the acquired power, (Sophie & Lissette, 2007). Empowerment is thus presented as encompassing a two-way dimension seen as a process, a dynamic construction of identity, at the individual and collective level (Action AID and Romano, 2002, & Charliers, 2006). The definitions of empowerment given above goes to show that when women have the means to and act independent of others believing in themselves and their abilities to take decision and follow it through it is only then that we can say they are empowered.

Feminist groups and development Non-Governmental Organizations (NGOs) recognized this definition and further broadened it in the following dimension of empowerment (Action Aid & Romano, 2002).

- "Power over": this brand of power explains a dominion relationship between parties involved. This definition assumes that available power is limited and the holder of that limited power must wield it to subjugate and control his/her subjects;
- "Power to": this dimension of power includes the holders ability to make decision for and on behalf of those for whom power is held including exercise

authority on their behalf and find solutions to problem for them on their behalf, this is the kind of power that husbands exercise on their wife's behalf as they arrogate to themselves an all knowing right over their wives desires and wishes. The implication of this form of power refers can be said to mean cognitive ability involving the use of knowledge and the knowhow as well as economic power which comes from access and control of resources implying assets;

- "Power with": comes with exercise of social or political power in which highlights the group aim and agreement common purpose or understanding, as well as the readiness or the capacity to come together and aggregate and protect shared goals, when people collectively agree and feel they have power they take joint action whenever necessary to fulfill their common and collective vision;
- "Power within": this notion of power refers to self-consciousness that comes from within the individual or group when they come to realize their individual and collective potential and they are willing to take action through self-analysis of their situation themselves (Baba, Rajwani & Hussayn, 2014).

Women's vision to access power, acquire power and use this power to control their lives and choose for themselves is at the bottom of the search for empowerment, this notion of "making choices" has been at the core of the work of Sen (2000) and Kabeer (2001), they both discussed extensively on people's ability to have access to things and to make choices. Furthermore, they opined that institutions and laws design the capacity for empowerment, inculcated in the people's culture, norms and values are the various dimensions of empowerment under discussion.

Through this notion of empowerment often called “power over” according to Sophie and Lissette (2007) when they agreed that other dimensions of power should be integrated into the understanding of power that these other dimensions of power are conceived: “power within” “power to” and “power with”. When women show “self-esteem” psychology describe it as self-love, confidence in their self and ability and deep sense of perception that projects women’s abilities and also seek recognition from others, this much is acknowledged by Sen (2000) when he indicated that their ability to choose life paths as determination of their effort.

When through people’s effort they gain access to resources through the available legal means Sen (2000) called it entitlement. He explained entitlement as the ability to access things through the legal means available to society; this is demonstrated by the right to acquire tangible and intangible things. An analysis of the empowerment process shows people’s ability to seize or to ignore power even when it is beckoning to them. To Sophie and Lissette (2007) this approach works in two ways:

- In relation to its capacity for personal change
- In relation to political and social change.

Taking the aforementioned theoretical framework into consideration, Centre for Women Development (CWD) developed a methodology to draw up indicators capable of identifying the various dimensions of power to be perused in order to follow the process of women’s empowerment in the framework of development cooperation. All development result from change directed by different factors, it is imperative to stress the choice of indicators needed to identify development which include but not limited to technical knowledge, but reflects social and political choices too (Falquet, 2003).

The thread that guides this sense of empowerment is seen as one aspect among many others including capability/independence or weakness/vulnerability, indeed, this notion of empowerment encompasses several concepts: greater choice in directing one's life path and a relationship that transforms power roles between men and women in view of social justice (Oxal & Baden, 2006; Rowlands 1997; ATOL 2002).

Individual and collective approaches are the theories of empowerment perused from the two dimensions which act as basis for constructing the methods through which empowerment can take place. The other aspect called the AURA methodology (Auto-Renforcement Accompagné accompanied self-reinforcement), this approach was designed as an integral part of the ATOL initiative on empowerment, employing this theoretical base to empower women as a basis, suggests that this concept be split down into the following and analyzed. Assets, knowledge, capacity, and will, taking these concepts of empowerment concept into consideration can be useful when analyzing the impact of development Baba, Rajwani &Hussayn, (2014).

Oxal & Baden, 2006; Rowlands 1997; ATOL, (2002) sees asset as a construct of greater economic power as represented in materials such as land, tools, technology and income, opining that economic power does not rely on possession of resources only as it includes social constructs such as more leisure time, good health, access to services such as loans, training information and markets and amusement parks. These allow women to gain greater freedom that will enable them work their way out of debilitating poverty.

The place of knowledge to empowerment is demonstrated in the possession of the 'need to know how in the form of skills and intellectual composure that will enable women or a community make the most of available opportunity to take themselves

out of poverty. With reference to the ability to manage people (leadership) possession of needed technique leading to developing thinking and reasoning capacity is presented as necessary and a must acquire for women (Sen, 2008).

Know-how represents how important it is to apply knowledge or ability to translating one's knowledge to action or resources and turn the life of women around for the better. With knowledge women can therefore take the lead over their lives (Sen, 2008). Sophie and Lissette (2007), this is seen as power within, the inner psychology or strength or spiritual power: one's strengths, values and fears, self-confidence and self-perception. Presented in their work as the ability and will needed by women to make choices for the future, the consciousness of their own life plans as well as the challenges facing them are the task they need this skill to cope with. This concept of "will" also harbors two elements of state of mind (being) and the ability to use it towards others (knowing how to be) Oxal & Baden, 2006; Rowlands 1997; ATOL 2002, 2007).

The World Bank in (2006) suggested that seizing the opportunity to make decisions, take on responsibility, being free to take action as one deem fit and using one's resources (assets, knowledge, will) this kind of decision-making encompasses several aspects:

the ability exercised by women to make their own decisions; exercising this suggest that women have the capacity to, this can be seen when women either take decision or influence decision-making in their favor- the ability to make decisions for others, and to show authority (in situations where someone has to make the final decision).

In addition to challenges faced by women in contributing to reproductive health decision-making and thereby reducing their vulnerability to HIV &AIDS, the relationship between spouses in their homes and the gender issues that affect and direct participation of women in decision making will be reviewed. From the foregoing it came out clearly that power relations occasioned by gender role delineation dictates who does what, enjoys what services and plays certain roles in the society and by implication in the home, it is from this background that women's effort to contribute to RHDM as enthused in research question 1 and 2 respectively are brought to light in these reviews.

2.8 Gender Relations and Reproductive Health Decision-Making

The conflicts of interest between husbands and wife differ greatly from other kinds of conflicts such as class conflicts in that employer and employee do not necessarily cohabit in the same house like couples. The togetherness that characterizes couple relationship and the sharing of practically physical and emotional interest makes the nature of their own conflict completely different (Sen, 2000).

One of these characteristics is the nature of the background of these conflicts which necessitates that it be perused from a pervasive cooperative behavior that is the nature of the relationship that characterizes the togetherness which Sen (2000) prefers to call cooperative conflict. Cooperating allows all members of the team to win some and loose some in a relationship that is mutually benefiting. Even in the existence of substantial conflict different parties have a lot to gain from cooperating in an overtly manner in carrying out their individual activities, in the gender division of labour this cooperative behavior is most manifest as it relates to household chores done to the

benefit of all members of the household especially the enjoyment of benefits derivable from the work done (Fakpohunda, 1985).

When serious conflicts of interest arise occasioned by 'social technology' the character and type of organization the family is in will enable molding and treating of the conflict as an aberration rather than a norm, this treatment or classification of the conflict will allow family members see such deviant behavior for what it is, just a threat, and as such on that bases devise the relevant cooperative behavior needed to move on (Sen & Gowon, 2000).

Manser and Brown (1980), McElroy and Horney (1981) opines that the form of household economy operated in the house should be seen as a bargaining term for problem solving only and women as agents for the survival of all must be viewed strongly as against the well-being of women for their own sake only (a distinction that was pursued in Sen and Gowon (1985). The process of understanding women's well-being may begin from observing their 'functioning' and the 'capability' with which activities are carried out (i.e., what the person can do or can be), all the different capabilities at play must be analyzed, evaluated and compared with women's ability to live well (Sen & Gowon, 1985).

Social norms and values that dictate gender relations allows people to perceive legitimacy for their actions within the societal constructs of these norms and women in pursuing either the agency role will or may be overshadowed by other objectives that may not necessarily be their own. With regards to gender divisions, these norms maybe barriers to seeking a more equitable arrangement for women and even hinder the perception by others of the lack of equality and equity in the engagement Sen and Gowon (1985). The imperative that is growing is to attempt to merge perception with

agency and see how and if it will lead to the realization of better opportunity for women's well-being all over the world. Recent literature in development circles have shown that there exist inequities in gender division of labor in many parts of the world Sen and Gown (1985).

There is an inherent danger in seeing women as a patient instead of an agent as the agency of women may be particularly important in addressing entrenched negative perceptions and biases that sustain the neglect of women's needs and desires Sen (1985a). The need to enhance and make visible the contribution of women to social life in their homes and society has been largely neglected by the society so far, the economic role of women is also an important role in bringing to light the contribution of women to social and societal life (Sen, 2000).

Putting economic value to women's earning outside their homes particularly in Africa and Asia which has been discussed at different levels provides a good example of the instrumental role that women's agency can play in different societies and cultures Sen and Gowon (1985). The information bases emanating from traditional societies though narrow can help substantially in widening the understanding of these roles that the economic contribution of women in these regions and even diversifying the information bases can better help in the understanding of the role of women in development since some of the subject matter are covered in the central issues already discussed (Sen & Gowon, 1985).

Studies about decision-making processes among people in northern Nigeria are few. A study by Adioetomo and Eggleston, (1998) observed that though most couples seek compromise when situation becomes critical or important decision needs to be made the husband's decision is usually implemented.

The northern part of Nigeria has successfully transformed their societal norms and values to a large extent to that of the Islamic norms and values and couple decision-making in the region follows that which Islam dictates generally. The construct in Islamic culture is that women have a duty to obey their husbands and their husbands in turn are expected to respect their wife's it is this give and take consideration that guides the process of decision-making, which dictates that sometimes, unless otherwise the decision-making process seeks some form of compromise and are sometimes dominated by the man (Yusuf, 2001).

Some other studies in the region present the husbands domineering role in decision-making in northern societies, (Berninghausen & Kerstan, 1992) opine that women do not always take decisions on their own even if it is about their welfare such decisions and any other are taking in consultation with their husbands. A model of women's decision-making power and contraceptive use designed by Kritz and Makinwa-Adebusoye (1997) on women's' power and reproductive behavior showed that cultural, economic and social considerations shape and direct gender inequality across different societies and divide.

In gathering data, all demographic data was grouped and called individual level factors among women status in societies. The relationship between these individual level factors that guides or affects wife's contributions to decision-making includes those categories that affect the wife's decision-making autonomy, as determined by demographic outcomes in marriage (Fapohunda, 1985; Basu, 2002).

Fikree, Khan, Kadir, Sajan, and Rahbar, (2001) classified two models of independent variables calling one proximate determinants and the other distant determinants and went ahead to show how the affect women's contribution to decision-making. On the

basis of these two models Dodoo (1995) formulated a composite model of the three areas with the intention of showing how the affect women's intention on family planning decision-making power and actual family planning decision-making power (Bawah, 2002). In their model listed the nine areas that direct the life of women were compressed into two and they went ahead to analyze how decision-making is related to family reproductive health decision-making and family planning decision-making power (Doo, 1995).

That a direct relationship existed between intention on decision-making power in fertility and contraceptive use and that this can predict actual contraceptive use the researcher tested the decision to use contraceptive and actual contraceptive use to see if there is a direct relationship. These factors were further divided into three viz, basic factors, factors related to the couple's relationship, and fertility-related factors (Kritz & Makinwa-Adebusoye, 1997).

The analysis resulted in their conclusion that those factors designated individual factors affect contraceptive use, the analysis were based on the model which led the researchers to understand pathways of women's power that allows contraceptive use (Dodoo, 1995). The relationship between the husband and wife as far as power to decide is concerned and their fertility preference need be strengthened in order to understand obstacles to contraceptive use (Dodoo & Van Landejwik, 1996).

These two writers were very critical of the analysis concerning the gap between family planning needs in sub-Saharan Africa for that the ignored the place of gender roles and couple communication, and the lackadaisical attention that was paid to family size and wife's agreement in the conceptualization.

However, qualitative FGD data for both men and women were included in order to understand the aspects of perceived gender roles in family planning and couple negotiations to use contraceptives. Observing varying areas of power play in household decision-making for the purpose of comparing women's relative power by measuring non-reproductive health-related areas Dodoo (1995) posed the following questions "Whose say is final on…," and provided four answers to choose from: primarily husband, husband and wife primarily, the wife, or someone else (Kritz et al, 1989).

When domestic decision-making autonomy is aggregated women's domestic power may affect decision-making power on the use of contraceptives. Studies have shown that, women's freedom of movement and their autonomy over control of finances are necessary factors for contraception (Govindasamy & Malhotra 1996; Hogan & Haililmariam 1999). Literature is also replete with women's examples of how involvement in family planning decision-making promotes contraceptive use (Govindasamy & Malhotra, 1996; Kalipeni & Zulu, 1993), the women in Egypt involved in family planning decision making significantly were those who enjoyed more significant association with contraception decision by couples.

The interaction between decision-making power, reproductive and non-reproductive issues and their effect on contraceptive use was shown by Govindasamy (1996) to be greatly affected by women's freedom of movement. There exist a significant relationship between the tendency for women who participated freely in general decision-making at home to be able to participate more qualitatively to or are likely to contribute to reproductive health decision-making (Zulu, 1998). In patriarchal

societies with high level of gender stratification, the levels to which men dominate decision-making need further investigation (Zulu, 1998).

Couple communication has been observed to be important in decision of family size and contraceptive use. Though in most areas the husband is seen as the main decider on all matters especially reproductive issues and in some cases husbands are presented as frustrating their wife's effort with regards to using contraceptives (Mason & Smith, 2000). Literature from SSA opine that when spousal communication on general issues is good the tendency for reproductive health decision-making by women to be high is great and the possibility for them to agree on choice of, and preferences of fertility choices that will lead to meeting fertility objectives will also be high (Hogan & Haililmariam, 1999).

The 1989 Demographic and Health Survey data from Kenya showed spousal communication is statistically related with contraceptive use after controlling for background demographic information (Nylhde et al, 2003). From Ghana, studies also showed that the association between spousal communication and contraceptive use is manifest when other intervening factors are controlled (Bawah, 2002). Studies by other researchers also found spousal communication to be strongly related to contraceptive use by women (Gage, 1995).

Researchers such as Jejeebhoy (1995), Kritz et al. (2000), Mason (1993), Mason & Smith (2000) and Riley (1997) agreed that various dimensions of gender can be seen in women's socioeconomic position as determined by education and employment, age at marriage, decisions surrounding marriage, marriage structure such as polygyny, spousal communication about timing of pregnancy, family size and contraceptive behavior, and participation in household decision-making.

The association between women's education and paid employment and lower fertility and reproductive decision-making is high and secondary and higher education of women is associated with the small family norms, which in turn leads to women's greater use of contraception to achieve desired fertility (Castro-Martin & Juarez, 1995; Caldwell 1980; Eloundou-Enyegue, 1999; Gage, 1995; & Jejeebhoy, 1995). This education/fertility association is linked to education's role as a source of knowledge and information and an opportunity for women to moderate attitudes and the question of gender norms and power structures in existence around their society (Castro-Martin & Juarez 1995).

The nature of this relationship though complex and may be indirect may further condition the gender/marriage nexus as has been shown in studies (Basu, 2002). Educated women employed outside the home use contraception for fertility regulation more than their non-educated peers and therefore have lower fertility (Balk, 1994; Mason, 1993; & Kritz et al, 1997). Other studies have shown also that they enjoy better reproductive and child health because they engage in positive maternal and child health care behaviors.

Education is seen as an engine of socio-economic mobility that leads to greater reproductive agency. Women who delay marriage as a result of schooling and employment have been hypothesized to enjoy greater autonomy in their marriage decisions and an increase in consensual unions/cohabitation (Gage, 1995). This enhanced autonomy is expected to translate into women's greater control of their contribution to reproductive health decision-making.

When polygyny is associated with large poverty/illiteracy the effect will be noticed in gender inequality represented in less spousal communication about reproductive

preferences, intensions and behavior (Ezeh 1997; Pebley & Mbugua 1989). A sign of women's empowerment can be seen in their contribution to reproductive health decision and control over their earning which could lead to more equitable gender relation in the home. However, Eloundou-Enyegue and Calves, (2006) opines that, this may hold only where women are both equally or more educated than their husbands and engaged in paid employment.

Reviewing the role of power in spousal relationship Stephen & Roscoe (1998) observed that understanding the concept of 'power to' (ability to act) and 'power over' (despite opposition from others, women should be able to assert their wishes and demands), are important for purposes of examining the role of power in sexual relationship noting that it does not imply absolute power of either member of the couple, but the comparative influence of members relative to each other.

The type of inequalities operating in other types of power imbalances such as those in polygamous relationships, wealth, age, and the influence of extended family members and male child preferences where some of the observed imbalances in the power relations in marital arrangements (Bawah, 2002). Inequalities on the bases of gender can direct the balance of power and can affect or influence the access to and use of reproductive health services where available as these power relations can affect the ability of partners to acquire information, make decisions, and take actions on their reproductive health, safety and wellbeing (Elizabeth & Madeleine, 1993).

The relationship existing between reproductive health decision-making and gender based power roles is a complex one, partners may not agree on the need for pregnancy or the use of contraception, there however, is a need for more research on whose opinion carries more weight at the end of the day since various studies have wide

variations across cultures and societies, even in the same setting results have not been very consistent (Bawah, 2002). In the same way it has been shown that while a majority of men approve of family planning; they have always had reservation about their partner's use of contraception, (Elizabeth & Madeleine, 1993) these reservation stem from the fear that they may lose their role as head of the family, promiscuity and adultery of their partner, and that they will be ridiculed by their peers in the community.

Though men like to be seen as decision-makers in their families they prefer to leave implementation of their contraception decision to their wives this much was pointed out by Annick (1998). This attitude is reinforced by reproductive services designed exclusively to cater to women (Elizabeth & Madeleine 1993) when women want to use contraception and they perceive opposition or outright refusal by their husbands they may decide to use contraception surreptitiously, as open defiance may connote negative consequences for most women, especially those who are economically dependent on their husbands, and those whose partners can and do threaten them with divorce or violence (Bawah, 2002).

Studies in northern Nigerian communities have shown a significant rise in the age at first marriage with commensurate increase in school attendance by girls since the 1980s these developments have important implications for gender issues in the area, one of the outcome of these developments is that greater involvement in decision-making by women has been achieved (Yusuf, 2001, Kritz, et al, 2000). This has ensured that more girls attend higher levels of education and the rate of girl child marriages has continued to decline implying that spousal age difference is also on the decline. The tendency of this development to increase spousal communication is very

high and it can also lead to reduced vulnerability of women to HIV & AIDS and other STIs.

The reviewed literature also agrees with the research question in establishing that women face challenges in their bid to contribute to RHDM and went ahead to establish where the discrimination is located which is in gender disaggregated role delineation orchestrated by the peoples culture and religion and finally sustained by the lack of empowerment of women thereby putting women in a vicious circle of dependence on men leading to a perpetuation of the discrimination. Next is presented the conceptual framework that guided the collection of literature for the study and the inter-relatedness of variables for literature review (Kritz, 1919).

2.9 Theoretical Framework

Over the past years three theories viz, the Theory of Reasoned Action (TRA), the Social Cognitive Theory (SCT) and the Theory of Planned Behavior (TPB) have been adopted to foretell and explain behavior. Though Wang (2005) opined that they have not been tested against themselves to see which of them is the most effective in predicting and explaining behavior. At one time or the other researchers have combined in an eclectic manner the strong points of these theories in different studies such as (Charon-Prochownik, et al, 2001; Janz, et al, 1995; Selvan, Rose, Kap, 2005).

The beauty of composite models is their ability to fuse variables and enhance the predictability power of the model. Schazer, (1992), & Poss, (2001) believed that combining models incorporates the best features of the model. The three theories share a related theoretical approach, the expectancy value theory which suggests that one is likely to start a behavior associated with strong value (Wan, 2005). Additionally, these

three theories are rooted in the SCT, (Barronowski, perry & Percel, 2002), agreed that with a strong emphasis on the reasoning operations upon decision-making process; that explain and foretell behavior one would likely get better if the behavior is hinged on strong value (Baronowski, et al, 2002).

Wan in 2005 opined that it is the reasoning activity that involves perceptions ever susceptible threat in HBM, noticeable principles and result evaluation in TRA and outcome expectancy in SCT, that led to the conclusion that these basic paradigms are same and share fundamental meaning despites the different names.

2.9.1 The Theory of Reasoned Action

Beginning from the assumption that humans are sensible and make decisions for every action by analyzing all the information at their disposal and contemplating possible implication for their action, Conner and Sparks, 1995 concluded that the TRA explained how intention converts into behavior and what specific subjective norms, attitudes and beliefs, influence this transition. The TRA is comprised of the following:

2.9.1.1 Behaviour

Ajzen and Fishbein (1977) saw behavior as involving four elements: action, directed at a target, the time and context in which the action occurs.

2.9.1.2 Intention

They authors define intention as gap between when reasoning and evaluative composition of attitude and behaviour that takes place (Ajzen & Fishbein, 1980). They (Ajzen & Fishbein, 1977) explaining further agreed that intention determines behavior as the outcome of intention.

2.9.1.3 Personal Attitude

Is presented as one person's positive or negative disposition towards a behavior the extent of an individual's openness or otherwise directed at a particular behavior (Ajzen & Fishbein, 1977).

2.9.1.4 Subjective Norm

The quantity or quality of social pressure exerted by the significant others or the society as perceived by an individual on an expected action. The individual's perception of this influence will determine whether he/she will carry out the said action (Ajzen & Fishbein, 1980).

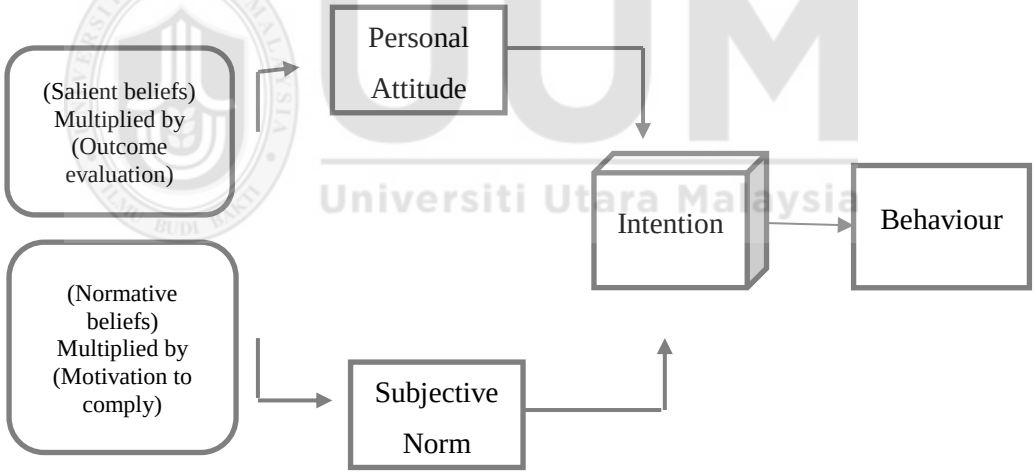

Figure 2.6. Theory of Reasoned Action from Poss (2001)

Accordingly, the TRA concludes that the behavioral desires are the best determinant of the behavior while intention is a linear regression function of the person's attitude toward the behavior and the subjective norm. W_1 and W_2 are scientifically determined

points showing differences of the effect on intention from attitude and subjective norm upon the behavior.

Ajzen and Fishbain (1980) for them some behavior is dependent on the concept of assertiveness which may share more points in shaping intention, whereas for other behaviors the importance of the prevailing subjective norm maybe apparent when the action is to be performed.

2.9.2 Social Cognitive Model

Developed from the field of Social Learning Theory (renamed as Social Cognitive Theory in 1986), Bandura (1977a) used self-efficacy to explain behavioral change. That Individuals anticipatory response can help to understand incentives arising from definite particular practices or accompanying mastery presentations. Arising from which, Bandura concluded that reasoning mechanism called self-efficacy as an imperative moderator of behavior. Bandura later (1986) instituted the concept of self-efficacy into the social cognition domain. (Bandura, 1992) Cognitive self-evaluations influence all kinds of human experiences, including the goals that people strive towards achieving, the energy expended toward goal achievement, and likelihood of attaining particular levels of behavioral performance.

In addition, employing these processes people according to Wang (2005) evaluate their thoughts and experiences, and sharpen their sense of self belief. A High order of acceptable belief in one-self followed by a high sense of self control can lead to higher performance attainment. The SCT concludes according to Wang (2005) change in behavior determines the expected mechanism that will lead to the expected outcome and expected self-efficacy.

2.9.2.1 Outcome expectancy

When one expects that a given behavior will lead to a certain outcome in a certain given situation, the authors concur that outcome expectancy has taken place. The performance of behavior therefore could lead to either a positive or negative outcome (Schwarzer & Fuchs, 1995).

2.9.2.2 Self-efficacy

Here an individual's perception of his/her strength to plan and carry out a course of action that will lead to an expected outcome is termed self-efficacy. Varying levels of self-efficacy include generality, greatness, and strength (Bandura, 2001). Magnitude refers to the individual's perception on the degree of difficulty of a given task. Following an exhaustive study of the three theories the researcher found out that it is only the TPB that discussed the role of attitude in behavior relationship with expectancy value approach (Godin., & Kok, 1996). The TPB presents the determination to adapt a specification as the individual's attitude towards performing that action (Ajzen and Fishbain, 1997).

Attitude is viewed by Ajzen and Fishbain (2003) as evaluative appraisal of including personal belief regarding the perceived consequences of taking the action. Ajzen and Fishbain (1997) also stressed that attitude should be seen as consisting four elements: Target, Context, Time and Action. It is for these reasons that the researcher chose the TPB as model of choice to attempt an analysis of why women would want to play a more active role in reproductive health decision-making.

2.9.3 Theory of planned behavior

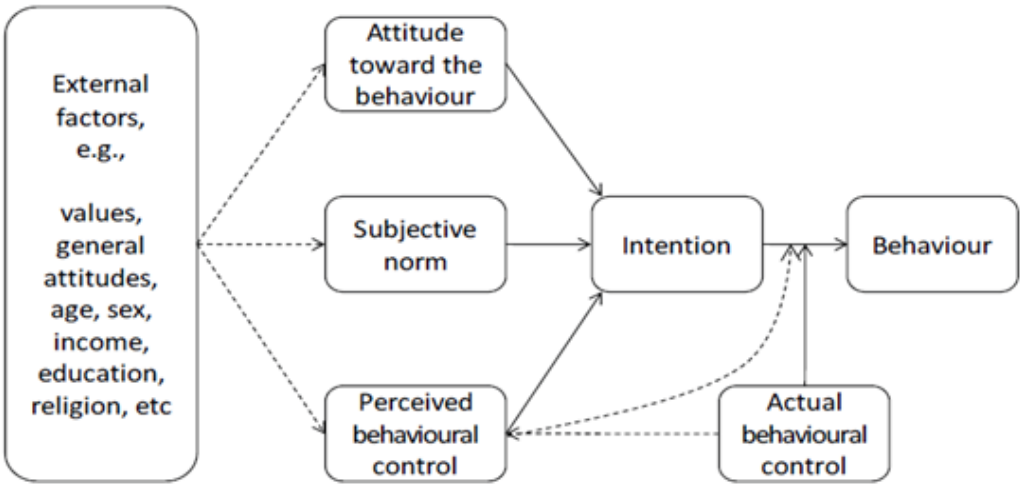

Figure 2.7. Theory of Planned Behavior

The theory of planned behavior adopted from Ajzen (1991) and Poss (2001)

The theories explaining how people arrive at decisions are mostly about reasoning, how they think and what is the heart of their intention, it is directed by their perception of the social and personal consequences of the expected actions. Social psychologists are particularly concerned with the masking of relations between cognitions, decisions and actions (Azjen & Fishbain, 2003). The making of decisions in their social context is of particular interest to social psychologists who study the relationship between individual cognitions, decisions and actions (Azjen & Fishbain, 2003).

One of the most important modern theories in social psychology is the theory of planned behavior (TPB: Ajzen 1991, 2003), over the years the importance of this theory to demographers concerned with reproductive decision making at micro, and macro levels can never be over emphasized. In the TPB framework, human behaviors are modelled as reflexive decisions, which are characterized as *intentions*. Intentions

are formed through cognitive and emotive processes which lead to three kinds of evaluations (TPB: Ajzen 1991, 2003), commonly described as:

The possibility of using the TPB to explain how aggregate-level conditions influence the evaluation system, intention and behavior is also envisaged. Perused from the model is the possibility of seeing intention as a willingness to act and may be transformed into actual behaviors when conditions are right (Billari et al., 2009).

PBC the reflection of an individual's evaluation of the external conditions and if those external factors will necessitate taking the planned action is what the model refers to as PBC (perceived behavioral control), the presence of other external conditions such as psychological factors, including personality traits and values, age, gender, education, cultural background, income, social class and religion, information such as experience, media exposure and knowledge have all been posited by Ajzen (2003) to influence attitudes, perceived norms and perceived behavior control.

Demographers have shown many of these factors to be associated with fecundity of intentions and behavior, and early investigation indeed established that they are probability to act as contextual issues, while approaches and professed rules explain an important percentage of the alteration in fertility intentions and arbitrate the effects of such background factors as religion, religiosity and age (Jaccard & Davidson 1975).

The importance of predicting a behavior accurately is based on a clear and concise definition of the behavior in terms of expected key variables leading to accurate prediction of behavior is a clear and precise definition of the behavior in terms of the goal and *action* that will define the behavior, the *context* in which the behavior occurs

and elements of the *time* within which the behavior should occur (Azjen & Klobas, 2013).

When we symbolize an intention to achieve behavior as a decision, the decision to be made must also be defined in the same terms. Ajzen (2005) calls this the "principle of compatibility", various research efforts targeted at explaining or predicting intention to contribute to reproductive health behavior as in for example how a child must follow the same procedure established (Billari et al. 2009; Jaccard and Davidson 1975). Similarly, the TPB has been shown to be valid for explanation of intentions to achieve outcomes (Ajzen, 2005). From the above it can be explained that, some variables studied in fertility research, including wages, education, belief and equality, become 'external' variables in social psychological studies as they are external to the reasoning structure associated with making clear decision (Ajzen, 2005).

The relationship between timing of behavior and predictions of reproductive behavior has been found when the timing of the behavior has been specified (Philipov et al, 2006). In measuring reproductive decision to have a child for example a predefined and relatively short period, typically within two years (Jaccard & Davidson, 1975) or three years, the possibility of realizing this intention is high compared to longer timed and intentions without timing at all (Kulu, Vikat, & Andersson, 2007).Better prediction of fertility intention has also been observed when the strength or level of certainty of an intention is measured (Morgan 1982; Speizer 2006; Thomson & Brandreth, 1997).

2.9.3.1 Predicting intention: attitudes, normative influences, perceived behavioural control

Studying normative influences on childbearing is an important stream of fertility research. The assumption most of the time is that the intention to have a child is seen as the decision of both couples (Beckman., Aizenberg., Forsythe., & Day, 1983;) Miller, 2004; Rosina & Testa 2009; Thomson, 1997). Despite the fact that having a child have been a standard practice in fertility surveys for some decades (Morgan 1985), demographic researchers working in the social psychological tradition have not explicitly included partners among normative referents in studies based on the TPB or the related theory TRA (Fishbein & Ajzen 1975).

Influential others such as parents, family members and friends have been shown to be important normative referents. Mothers' preferences for their children's timing of childbirth and family size affect their children's childbearing preferences (Axinn et al. 1994) and behavior (Barber 2000). Peers (South and Baumer 2000) and social networks (Bühler & Fratczak, 2007) have also been observed to have a strong influence on childbearing intentions. These influences may be both expressive and injunctive. Recent studies has, for example, identified that women's childbearing intentions are influenced by their friends' experiences as mothers (Bernardi, Keim., & Von der Lippe, 2007).

Despite the link it has with the external circumstances within which fecundity conclusions are made, moderately little is known about the role of ostensible control in expansion of the intention to have a child. Some clues are to the imaginable impact of control on fecundity intentions can be found in recent studies. Aassve (2003) has detected that economic resources are associated with childbearing between young

American women, and research in Singapore has long-established the importance of financial restraints on decisions to have no more children in the island state (Call 2008), but neither of these studies has scrutinized the thoughts linked with perceptions of behavioral control (Ajzen & Klobas, 2013).

In their study of aims to have a child in Bulgaria, Billari et al. (2009) found that PBC had an outcome on the decision to have a second child, and Dommermuth et al. (2011) in a study showed within the REPRO framework, found that PBC explained intentions to have a child in Norway.

2.10 Discussion

Strong male dominant practices exist in Nigerian societies. These practices can be found largely within the family; examples include the role of women as caretaker of all members of the family and the home including women themselves. And with more women employment in public places add to their burden of work within their homes as they still perform both functions for women with the possibility of limiting the attention they pay to themselves and their career development.

Nigerian law and administrative practice recognizes men as the household heads and thereby confers authority solely on the man. That there are examples of previous and present collaborative cooperation where women exercise some form of authority in some households this has not led to the recognition of women as fitting to be conferred some level of authority in the household yet, the statutory law in Nigeria continues to define women from only their reproductive role deliberately ignoring all their productive contribution to the family and the community (NDHS, 2008).

Inherent obstacles in social norms can hinder women from seeking legal redress even when their fundamental rights have been infringed upon. To understand the origin of these problems the study discerned critically the prevailing social norms and values that make it impossible for women to take action if they want to. The level of awareness of women of existing structures for redress and how to seek justice is grossly lacking in women, coupled with legal bureaucratic bottlenecks that frustrate women's effort to access justice.

Equality of both sexes is guaranteed by CEDAW despite being ignored by prevailing practices in Nigeria, in spite of governments program of public enlightenment in the domain of family law and practice many Nigerians are not aware of the provision of the law particularly women. Government programs of collaboration with CEDAW has not gone much beyond ratifying the protocol and by the time Nigeria submitted her report on the situation of women in Nigeria nothing substantial has been achieved (NDHS, 2008).

The role culture and religion play in Nigerian society in consciously ignoring developing programs that encourage women's participation in family decision-making and RHDM thereby perpetuating existing cultural practices is evident in literature reviewed, despite the fact that these practices are not consistent with the position of Islam men who are over the years the interpreters of the Quran and Hadiths have presented these gender based position of women as if these are dictates of the religion and have held women down over the years.

Researches in the past has shown the consequences of modernization and structural changes influencing the decision-making pattern with regards to perusing children from a more economic point of view, and from this material consideration begin to

accept the idea of birth control by women on the individual level is a welcome idea but in practice openly as a right to be enjoyed by women has been a problem over the years as women are seen only from the point of view of their reproductive capacity (NDHS, 2003).

As a theoretical construct women's autonomy and their access and control of resources comes in different dimensions and varying from culture to culture and society to society, the thrust of this thesis therefore was to look at the impact of gendered family structure existing as part of a social system on the life of a woman especially as it affects her power to take decisions concerning her reproductive life, focusing on the household and community level (Sen, 2003)

Despite the proliferation of international treatise the level of discrimination against women has on the contrary continued to increase. This continued persistence can be traced to the existence of patriarchy in the Nigerian society though advances are being made on the individual level, as a whole progress has been very slow as in the effort to preserve culture and way of life has led to oppose cultural practices that hold women down and gender disagreed measures in all aspect of the peoples life have witnessed minimal progress.

Having ratified all conventions targeted at guaranteeing women the enjoyment of equal right on issues such as her consent before marriage, elimination of bridal wealth, minimum age of marriage and custody of children even in divorce yet there exist across the length and breadth of the country significant levels of discrimination in all aspect of women's life, from forced marriages, payment of bridal wealth, and other gender specific discrimination against women in the name of cultural practices.

This gendered role delineation ensures that women's productive rights while her reproductive capacities alone are emphasized all other aspects of her life treated with ignominy be it the social and political spheres. ignoring her productive rights implies her not being allowed to engage in economic activity and thereby enjoying the remuneration that follows, In Nigeria various forms of gender consideration that direct and dictate discrimination exist against women in varying degrees in all aspects of life few women exist in official capacities at decision making level just as in the home women are involved in secondary responsibilities.

When women enjoy rights within their families they are able to define and assert themselves in relation to their society is guaranteed. Article 5 (a) of CEDAW therefore made recommendations that guarantees "social and cultural patterns of conduct of men and women that will lead to a reduction of prejudices or being eliminated completely (NDHS, 2008).

2.11 Conclusion

Textual religion such as Judeo-Christian and Islam has been analyzed in abide to justify the claim that gendered discrimination originated from God when in the various text reviewed man was conferred superiority over woman and presented as a breadwinner role thereby placing women under his care, this position has over the years gained currency as various religion moved out of their traditional abode.

That this position of the superiority of man over woman is also in consonance with the various traditional cultures all over the world is seen with the speed with which the notion was widely accepted and practiced as was showed reviewed literature on empowerment and the modernization theory gendered discrimination of women has

manifested itself in different ways such as physical restraint on women (vailing and restriction of mobility) that has led to women being unable to independently take decision about their lives.

Three theories (TRA, SCT, & TPB) were analyzed in this chapter and the summary from the review of these theories tended to agree that when the subjective norms in society are in agreement with value expectancy of women then intention to carry out the expected behavior by women can and will be possible. On this the continued exclusion of women from participation in household decision making and more importantly RHDM was found not to be consistent with any theory or literature reviewed.

The researcher will in the next chapter discuss the methodology for research and the various sampling procedure that employed in selecting the population of the study and the data aggregation and analysis procedures for the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The main drive of this phenomenological, multiple case qualitative study was to examine the phenomenon associated with Muslim women's role in reproductive health decision-making and their vulnerability to STIs and HIV & AIDS. This study as designed employed a Qualitative Content Analysis (QCA) to analyze responses from the respondents through the semi-structured interview protocol and a structured debriefing protocol, included in this chapter is the discussion of the identified research methodology and design, the selection process by which participants were identified and included as informants and discussants in the study and procedure for ensuring the validity and reliability of not only the data so aggregated but also of the results obtained from the materials and instruments employed in the study. Furthermore, data collection procedures from the informants and discussants, limitations to the study, assumptions of the study, and ethical assurances for the informants and discussants were also presented in this chapter. Finally, a summary of the research methodology and all the procedure and processes followed in this chapter was presented to conclude this chapter.

3.2 The Study Area

Kogi State is centrally located in Nigeria otherwise known as the centre of the middle belt of the nation with a population of over 4.5 million (PRB, 2015) people, and is located in the North-central zone of Nigeria.

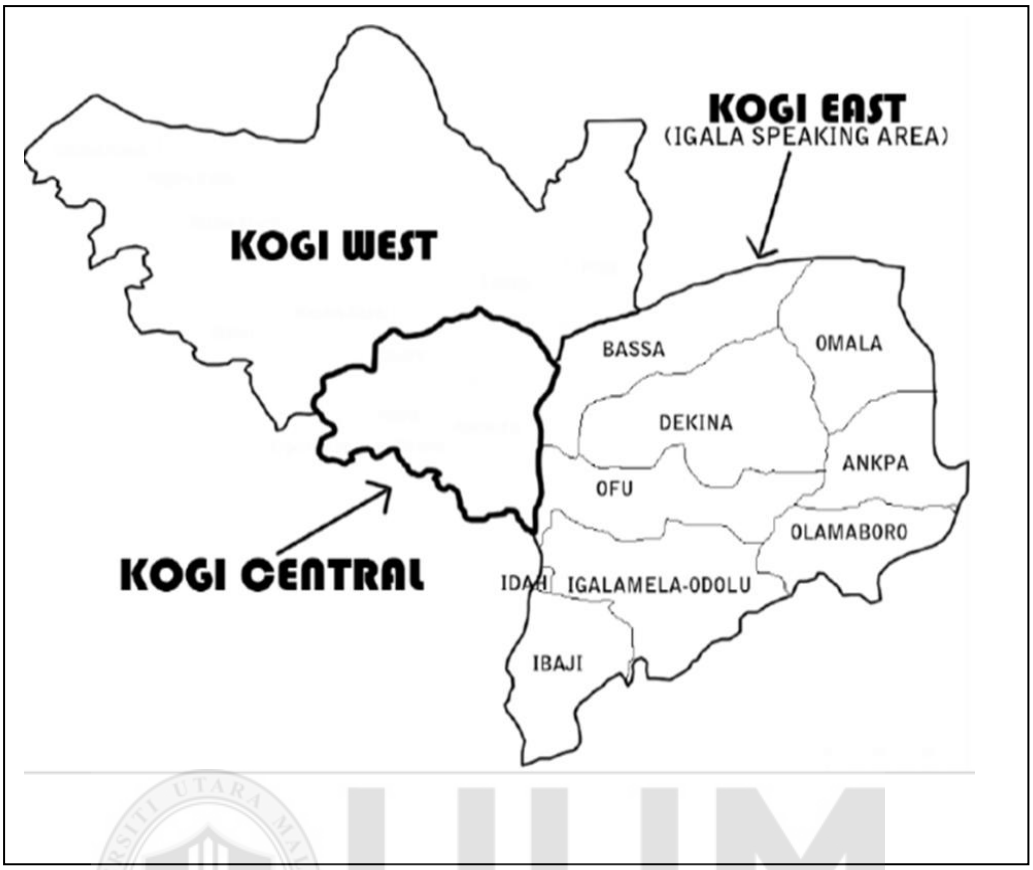

Figure 3.1. Map of Kogi State

It shares common boundaries with other states including Niger, Kwara, Nassarawa and The Federal Capital Territory to the North; as well as Enugu and Anambra to the South and Benue to the east. The state with its capital located in the confluence town of Lokoja, is about 200 kilometers from Abuja (the Federal Capital), it is a major transit town connecting the Northern and Southern parts of Nigeria. It is also a major inland river port and the meeting point of the rivers Niger and Benue for which it derives the acronym 'Confluence State'. Kogi like most states in Nigeria is multiethnic, multicultural and multi-religious. The major ethnic groups are Igala, Igbira and Yoruba while other ethnic groups such as Bassa, Hausa, Koto, and Kakanda amongst others live in the state.

3.2.1 Ankpa Local Government Area

Ankpa Local Government (LGA) is the second largest Local Government area in Nigeria with a total land area of 7,691km2 and a population of 460,312 (PRB, 2015) which represents 9.61% of the total population of Kogi State according to 2016 PRB estimate. The local government is located on latitude 6.30oN and 7.30oN and longitude 7.00oE and 8.00oE in the eastern flank of the Confluence State (Kogi State) where rivers Niger and Benue converged. The principal occupation of the people in this local government is farming on a rich gradually undulating savannah land that favours the cultivation of cereals like rice, maize and bambara nut while tubers like yam and cassava are grown.

A large population of people of Ankpa are of the Igala speaking people who are the 9th largest ethnic group in Nigeria, the people are mostly Muslims over 70%, Christians account for about 25% of the population and animist in that other, enjoying a rich blend of the Islamic religion and the Igala culture which they mix as it pleases them, but the rest of the people in the North central part of Nigeria, they are more inclined towards the Northern part of Nigeria because of the Islamic religion, but most importantly gender consideration and existential circumstances dictate their life pattern.

An element of the extended family structure among the people is polygyny, with men being encouraged to marry two or more women at the same time meaning that polygamy in the manner of being married to more than one wife at a time or openly cohabiting with other women that they are not married to, which explains why they are described as serial and concurrent multiple sexual partnering. Both co-residential polygyny and serial-monogamy are common practices in the study area (National

Population Commission 1998). Being the main beneficiaries of a large family size, men see as desirable their dominance of the reproductive health decision-making process in Ankpa, like the rest of the Igala area and the country in general (Isiugo-Abanihe 1994; 2003).

The entire Igala speaking area of Kogi state is still largely an agrarian economy, and owing to little or low level of technology prevailing in agriculture and the communal land tenure system in practice, especially in the rural areas, emphasis has been strongly placed on large family size (Orubuloye, 1995). In most cultures only male children are allowed to share in family land holdings within the context of the extended family structure and communal ownership of land. Since farming is central to economic life, the most economically rewarding reproductive goal a couple could pursue is a large family size, ideally with many male children.

Against this backdrop couples dread barrenness, and until a "good" number of male children are born, extended family members continue to exert pressure, which may culminate in the man marrying another wife (Wusu, 2001). Of course, emphasis was on quantity and not quality of children; raising children who are to engage in farm work would not be as expensive as giving them quality education. Understandably, therefore, fertility desires in a traditional agrarian society, as in most societies in Nigeria, have been quite high and the adoption of birth control measures minimal.

Being a patriarchal society, Ankpa men enjoy supremacy over decision-making on important issues, including reproductive health, in the family (Isuigo-Abanihe 1994; 2003). In the extended family system, close ties exist between men (husbands) and their parents as well as with other relatives such that men, in conjunction with their parents, take most family decisions (Babalola, 1991). As observed by Orubuloye

(1995:140) “in much of Nigerian society, the great majority of people still live in extended families either with or in close proximity to relatives”; a wife moving into such a home at marriage remains the stranger among the close kin group. This facilitates stronger influence of relatives on the life style and decision making process of husbands. Given the fact that in the society there is a strong cultural urge to maintain the lineage and leave behind offspring, to have as many children as naturally possible is what every couple expects as a reproductive behavior (Ainsworth 1996; Caldwell & Caldwell, 2000).

3.3 Research Methods and Design

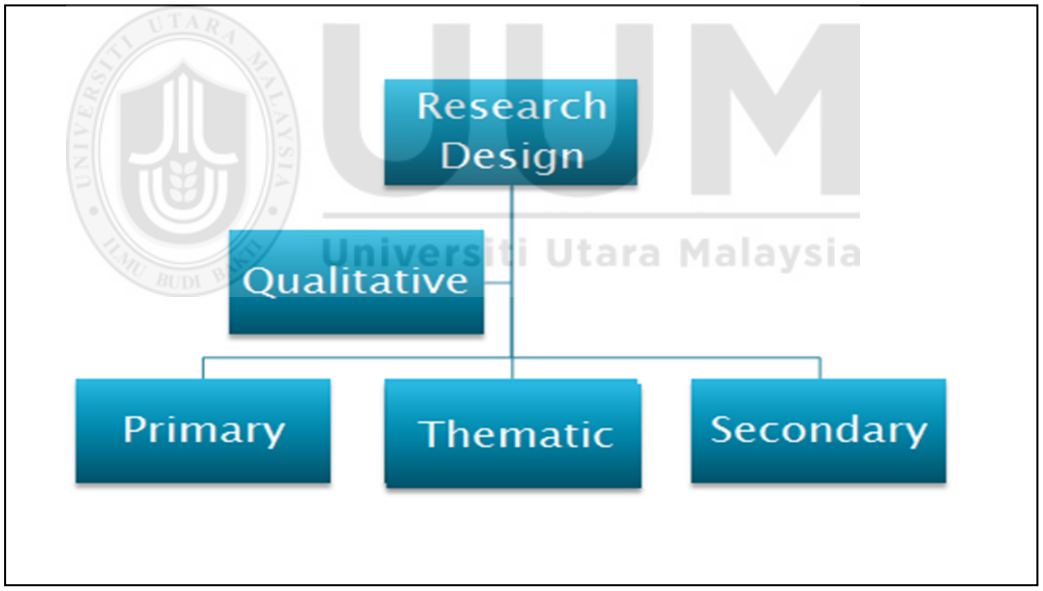

Figure 3.2. Research design

The method of choice that was used in this study was the qualitative multiple case study described by Stake (2000). Collective case study involves the investigation of more than one case in order to “study a phenomenon, population, or general condition”. The assumption of this approach is that investigating a number of cases

leads to better comprehension and better theorizing (Brantlinger, Jimenez, Klingner, Pugach, & Richardson, 2005).

Miles and Huberman (1994) contended that studying multiple cases gives the researcher reassurance that the events in only one case are not "wholly idiosyncratic". Furthermore, studying multiple cases allowed us to see processes and outcomes across all cases and enabled a deeper understanding through more powerful descriptions and explanations.

This study attempts to identify an understanding of the experiences of women concerning the extent to which they perceive their role in reproductive health decision-making in their homes and how this perception contributes to their day to day life amidst the power relations and the cultural expectations that dictated the gendered roles, role delineation and expectations under which the operate. The construct of the research study is that of a phenomenological qualitative design. As defined by Creswell (2007), "phenomenology is a research strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants".

As also described by Moustakas, (1994) "Phenomenology content analysis seek meanings from appearances and arrives at essences through intuition and reflection on conscious acts of experience, leading to ideas, concepts, judgments, and understandings". As such, the focus of this phenomenological research study was to through Qualitative Content Analysis attempt a holistic understanding of the extent to which the gendered role design and role expectations in Ankpa district and indeed rural areas in Kogi state Nigeria provide an environment in which women can engage

in spousal communication which will allow them contribute to reproductive health decision-making within the matrimonial set-up in which they live.

A QCA research design provides an understanding of the themes and patterns portrayed by the study's participants. The participants in the study were asked open ended interview questions, such that their specific experiences can be identified. Moustakas (1994) stated, "The empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essences of the experience".

Groenewald, (2004) opines that "The operative word in phenomenological research is "described". The aim of the researcher was to describe as near accurately as possible the phenomenon, refraining from any pre-given framework, but remaining true to the facts. The phenomenologist is concerned with understanding social and psychological phenomena from the perspectives of the people involved". A variety of methods can be used in phenomenological research that includes but not limited to QCA, Ethnographic Content Analysis, and the Grounded Theory for third study the researcher employed the QCA and the techniques of interviews, observations and focus group meetings. This research employed these methods to address the research questions as stated in chapter one.

The object of QCA can be all sort of recorded communication (transcripts of interviews, discourses, protocols of observations, video tapes, documents ...). Content analysis analyzes not only the manifest content of the material—as its name may suggest. Becker & Lissmann (1973) have differentiated levels of content: themes and main ideas of the text as primary content; context information as latent content. The analysis of formal aspects of the material belongs to its aims as well. As outlined

below content analysis embeds the text into a model of communication within which it defines the aims of analysis. This is expressed by Krippendorff, (1969, pp103) who defines "content analysis as the use of replicable and valid method for making specific inferences from text to other states or properties of its source".

Qualitative content analysis defines itself within this framework as an approach of empirical, methodologically controlled analysis of texts within their context of communication, following content analytical rules and step by step models, without rash quantification.

- Fitting the material into a model of communication: the determined on what part of the communication inferences shall be made, to aspects of the communicator, respondent's opinions, experiences, and feelings, to the situation of text production, to the socio-cultural background, to the text itself and to the effect of the message.
- The next step the researcher determines the rules of analysis: The material was analyzed step by step, following rules of procedure, devising the material into content analytical units.
- Categories in the center of analysis: This aspect of text interpretation, was guided by the research questions, as they are put into categories, which were carefully founded and revised within the process of analysis (feedback loops).

For QCA the criteria of reliability and validity have the pretension to be inter-subjectively comprehensible, to compare the results with other studies in the sense of triangulation and to carry out checks for reliability. For estimating the inter-coder reliability used in this QCA (contrary to quantitative content analysis) only the

researcher conducted the coding as a result of the small sample size and produced the standards of coder agreement this is supported by (Downe, 1992).

For this research study, the researcher conducted an in-depth interview and focus group discussion with women aged 18 – on-set of menopauses in their matrimonial homes and men and women aged 30 -50 in Ankpa district of the LGA. The interview questions were directed at the participant's experiences and feelings. At the root of phenomenology, "the intent is to understand the phenomena in their own terms to provide a description of human experience as it is experienced by the person allowing the essence to emerge" (Cameron, Schaffer, & Hyeon-Ae, 2001, p. 34).

This research method correlates well with the intent of the study to understand the experiences of women as they meander their way through the dual role of productive and reproductive activity in Ankpa district with a view to achieving family and personal goals under the weight of all forms of inequality in the society in which they live, operate and try to claim their rights.

Though small qualitative studies are not aimed at generalization in the traditional sense, some have redeeming qualities that set them above the requirement for generalization (Myers, 2000). The research value of qualitative studies is based on the participant's responses in context to the research questions, as such; the issue of generalization of the research finding needs to be explored. According to Yin (2003) "Qualitative research can be generalized. Analytic data can be generalized to some defined population that has been sampled, but to a theory of the phenomenon being studied, a theory that may have much wider applicability than the particular case studied.

In this, it resembles experiments in the physical sciences, which make no claim to statistical representativeness, but instead assumes that their results contribute to a general theory of the phenomenon" (Yin, 2003). As the construct of the research study would be that of a qualitative phenomenology design, the focus of this research was to understand how effective current practice affect women's effort to contribute to reproductive health decision-making in a society where polygyny/multiple sexual partnering, serial and concurrent extra-marital relationship, cultural practices such as wife inheritance, circumcision, girl child marriage resulting in wide spousal age gaps affects communication between spouses and a variety of other discriminatory practices combined to make the women in a marital relation vulnerable to STIs and HIV &AIDS, and more generally the nature of the experience of women in power relations that exist in their homes (Sen, 2000).

The rationale behind the choice of phenomenological research is that it will help identify accurately how woman perceive through their experiences and the effectiveness of their effort to contribute to reproductive health decision-making. This information was identified through inductive, qualitative methods such as focus group discussions, in-depth interview and participant observation. It is only through employing method of data aggregation that the intimate experience of women on such sensitive issue reproductive and sexual life style can be explored as each woman's experience as perceived by her is quite different from the others and she alone can describe it as she feels it.

Detailed notes were copiously taken to collect the participants' responses. To compile and analyze the data, all of the responses were appropriately coded. Though the responses were qualitative, a classification coding system was designed and

developed that represented a theme for the responses, thus offering the ability to create a coding table allowing for data aggregation and analysis as was consistent with the research each theme and the sub-themes were assigned a code and the transcribed interview analyzed under code on the basis of the frequency in which each response followed.

Phenomenological research methods facilitated the study of women's experiences and perceptions towards gender roles and expectations and current practices in family settings that sustains and perpetuates sexual and reproductive relationship in Ankpa district. It was employed to measure the participant's experiences and the contexts or situations in which they experienced occurred (Creswell, 2007). This research was able to illustrate both the understanding and experiences they women have with the current practices and how these experiences affected their vulnerability or otherwise to STIs and HIV & AIDS.

The research data was identified through various data collection methods. Open-ended questions and written comments were solicited from the above-mentioned participants as well as testimonials through FGD to produce data elements, comprehensive data journals were kept through which all raw data can be identified and used for coding and data aggregation.

Alternative research methods such as quantitative research would not completely address the size and scope of the proposed research questions. Other methods would not offer a comprehensive review of the issues or offer the level of understanding of women's experiences regarding the current practice as it affect the vulnerability to STIs and HIV & AIDS as would the qualitative research method.

Accordingly, Trochim and Donnelly, (2008) “Quantitative research is confirmatory and deductive in nature, while qualitative research is exploratory and inductive in nature”. The value of the selected qualitative method is that the issues and phenomenon are viewed in its context, while a quantitative study is viewed through a narrow hypothesis employing closed ended questions while verifying theories, while a qualitative study allows the respondents through open ended questions to reach deep down and provide insights not even thought of by the researcher to light, it is evident that a qualitative study is best suited for this research.

3.4 Participants

Table 3.1

Participants

S/N	Respondents` Profile	IDI	FGD	
			Male	Female
1	Female	20	-	5
2	Male	-	5	-
3	Primary Education	5	4	1
4	Post primary Education	-	2	1
5	Informal Education (Quranic Education)	19	5	5
6	No Education	1	-	-
7	Occupation outside the house	1	5	3
8	Married 10 years & above	17	5	5
9	Less than 10 years of marriage	3	-	-
10	Age at marriage			

The selection criteria for participants of the in-depth interview was entirely based on the following considerations: (a) that they are women, (b) married (women) between the ages of 18 and above, the age limit of 18 years is set because officially the age consent in Nigeria and marriages before that age is considered illegal and a violation of the CRC. The second sets of participants were also chosen from amongst community member’s women and men as described earlier.

The justification for the number of respondents being between 20 and 10 is merely to ensure that in case of some respondents dropping out of the study there will still be a sufficient number left to complete the study, and importantly throughout the study none of the respondents dropped out so the research was completed with 20 respondents who acted in sharing experiences through the in-depth interview process and 10 men and women who acted as focus group discussants, which according to the researcher is a good enough number for a qualitative research (Sackharan & Creswell, 2009).

These married women and men in Ankpa district were reached through personal contact by the researcher and since through the identified procedure all the informants for the in-depth interview and the focus group discussions were reached there was no need to employ volunteers for the data aggregation, this enabled the researcher deal effectively with the problem of biasness that could have resulted from allowing too many volunteers as informants/ respondents.

3.5 Reliability, Validity, Generalizability and Replicability

3.5.1 Reliability

Reliability has been defined by Carmine & Zeller, (1979) as measuring the extent to which a procedure yields the same results on repeated trials. When human codes are used in content analysis it translates to inter-coder reliability or level of agreement among two or more codes. In content analysis reliability is paramount, without acceptable levels of reliability content analysis measures are useless.

3.5.2 Validity

Validity refers to the extent to which an empirical measure adequately reflects what humans agree on as the full meaning of a concept (Babbie, 1995, pg127). It is generally addressed with the question 'Are we measuring what we set out to measure?'

3.5.3 Generalizability

The generalizability of a finding is the extent to which they may be generalizable to other cases, usually to a larger set that is the defined population from which a study sample has been drawn.

3.5.4 Replicability

Replicability ensures that the result of the study having met the requirements of reliability, validity and generalizability and can be replicated to the larger population in which the samples were pulled from.

3.6 Sampling

The sampling procedure employed for this study was purely purposive being that it concerns a specific population of people in Ankpa district with characteristics and experiences which are different from those of other people in the study area. Purposive sampling is in line with the study and is employed, as convenience sampling will or may not yield the needed number of respondents and because the respondents who are married women may not be able to participate in the study without obtaining informed consent from their husbands, and also because of the cultural issues surrounding

married women in close contact or in close proximity with unrelated male members of the opposite sex in Ankpa during the data collection exercise.

In other to gain access to the respondents therefore an influential female of the community respected by a majority of the people because she was the women leader in a community meeting and was familiar with most community members being a mid-wife in the primary health clinic in the community was selected as the first contact of the researcher and link to the respondents, through active contact with researcher and upon explaining to her the criteria for selection of respondents for the study she facilitated the selection of those who met the criteria and were willing to participate in the research as respondents.

The selection of respondents followed the pattern explained in page 106 and all the conditions under which the IDI and FGD was going to be conducted was explained to respondents, these conditions include that each respondent was free to be a respondent, there shall be material reward of any kind and if at any time any of the respondents wishes to withdraw from participating in the research exercise she/he is free to do so. In a bid to protect the identity of respondents' demographics were used for each respondents and the assurances that the secrecy and sanctity of their information was guaranteed them.

Post initial contact a date, time and venue that is convenient for the respondents was arranged and agreed for the IDI and FGD as is the procedure a modified snowball procedure is followed till the completion of IDI with respondent (modified in the sense that all the participants are known and selected, it is the manner in which they were and are called for the IDI that is different from other snowball procedures) she will then invite the next respondent, no specific order was followed, whoever was next or

was ready was interviewed this circle was repeated until all the respondents were interviewed. The venue of the interview was convenient for both parties and also to reduce to the barest minimum the possibility of outside interference and allow for the control of other intervening variables.

3.6.1 Codebooks and Coding Forms

Content analysts have capitalized on technology advances even in the very construction of their codebooks. Electronically produced codebooks can easily include images, diagrams, and links to instructive online materials (such as specific exemplars, should the researcher choose to introduce them). Most content analysts have switched from traditional paper coding forms to electronic coding forms, such as excel files, but owing to level of literacy, low level of technological adaptation and some other problems the researcher employed manual code development processes.

Combining these types of content analysis allowed the researcher to integrate quantitative content analysis with qualitative message analysis. The researcher thereby observed the locus of control as depicted by Rotters internal/external locus of control construct; an individual holding external locus of control feels that his/her life events are the product of circumstances outside/beyond his/her personal control.

Regardless of who created a traditional media product, whether it was a single book author or a team of thousands working on a major Hollywood film, an underlying assumption was that the end product (e.g., the book or the film) existed in a fixed, objective form that could be documented. Further, the notion of message source had historically been stable. Whether a single author of a series of diary entries, a dyad in a doctor/patient interaction, a team of employees creating a corporate culture

statement, or a reporter on a local TV news story, the sources of messages were clearly identifiable.

3.7 Materials/Instruments

This study is based on 20 primary interview questions that assisted in identifying and understanding the effectiveness of current practices in the role of women in RHDM and their vulnerability to STIs and HIV & AIDS. The test items were subjected to a rigorous critique by a team of Psychologist from the Kaduna Polytechnic who subjected the questions to analysis to test the extent to which the items comprehensively asked questions about current practices in reproductive health decision making, this process of trying to ensure a validated and reliable instrument for data collection was also carried out with lecturers in the School of Social Development at the Universiti Utara Malaysia.

The accuracy and dependability of the test items credibility is relied upon to the extent to which the result of the study can be replicated, in a qualitative study however there is no expectation of replication, it is common therefore to see terms such as" quality, rigour, trustworthiness in qualitative research" (Davies and Dodd, 2002).

Accordingly, Opdenakker (2006) suggested that the "The FGD, offering synchronous communication, can take advantage of social cues. Social cues, such as voice, intonation, body language of the interviewee can give the interviewer a lot of extra information that can be added to the verbal answer of the interviewee on any question".

"As interview guides are developed iteratively, questions are developed, tested, and then refined based on what one learns from asking people these questions" (Creswell,

2013, pg 124-131) the interview questions were developed such that the interview questions addressed phenomenological lived experiences of the respondents.

Van Manen went on to reflect that "there are four existential concepts that may prove especially helpful as guides for reflection in the research process, which are, lived space, lived body, lived time and lived human relations". These concepts were fully considered when developing the phenomenological QCA of life-world experience questions.

3.7.1 Developing Coding Rules

One of the requirements of objectivity-inter-subjectivity is to make all the decisions on variables and their measurement, the coding rules and the code book before the actual observation; this is followed by exploratory review after the codebook was developed before final coding scheme is set for use. This allows the qualities inherent in inductive and deductive inquiry to be present in the bid to assure reliability and validity of the instruments and variables.

3.7.2 Individual Messaging

This study analyzed messages/statements by individuals IDI and two FGD groups to diagnose the state of being of the individuals, level of participation in RHDM, conditions prevailing around the individual state of mind and to assess the credibility of the source, the environment in which RHDM is expected to take place, the conditions surrounding her participation in RHDM and a host of other variables. This was followed by coding responses of the individual as message generator to open-ended questions as employed by the researcher in this multiple case QCA study. The first step was a qualitative review of the message pool and the development of a

coding scheme based on what was represented in the coding pool and the application of the a priori coding scheme to the message pool.

For the face to face procedures Basles 1950's procedure was employed which calls for the coding of each communication act, a verbal act is usually a simple subject-predicate combination whereas a non- verbal act is the smallest overt segment of behavior that has meaning to others. Each act is coded into one of 12 categories shown below:

a) Shows solidarity

b) Shows tension release

c) Agrees

d) Gives suggestion

e) Gives opinion

f) Gives orientation

g) Shows antagonism

h) Shows tension

i) Disagrees

j) Ask for suggestions

k) Ask for opinion or

l) Ask for orientation

This scheme has been widely used since being developed by Basel and Cohen (1979) and has been adapted by Greenberg (1980) for analyzing human interaction in mass media. In applying this scheme clear note and understanding of the norms, values, behaviors religious and cultural constraints and practices within the community was treated with paramount importance.

3.8 Interview Questions

The interview questions presented below were employed to elicit response from all respondents be the primary respondents who were engaged in respond ending to IDI procedures or secondary respondents ie male and female FGD respondents involved as discussants in the FGD. The same set of interview questions were employed in the research to ensure consistency of responses and uniformity and conformity to the research questions and research objectives.

As observed by Van Manen (1990, pg4) the questions are only a guide intended to elicit answers from respondents for the purpose of eliciting information from interviewees in a qualitative QCA. Each set of interview questions addresses each of the research objectives and research questions and also tried to accommodate some of the variables that impact on the major themes that were very prominent in the literature review.

3.8.1 Research Question 1

What is the extent of women's role in reproductive health decision making (RHDM)?

3.8.1.1 Knowledge of Reproductive Health

a) What do married women understand about their reproductive health?

b) How can married women's reproductive health be compromised?

c) What level of control should married women have over their reproductive activities?

d) Should married women discuss reproductive health issues with their spouse?

3.8.2 Research Question 2

What are the factors affecting women's participation in reproductive health decision making?

3.8.2.1 Role of Women

a) What is the role of married women in their husband's home?

b) Do married women have and exercise control over their property and wealth in Ankpa?

c) What are the cultural expectations of married women in Ankpa?

d) Do married women have and exercise the same power on any issues in their homes?

3.8.3 Research Question 3

How much of women's involvement in the reproductive health decision making translate to action?

3.8.3.1 Decision-Making

a) Are married women supposed to participate in decision-making in their homes?

b) When married women take decision or contribute to decision-making are their contributions always implemented in the house?

c) Whose decision should be the final in the house concerning the reproductive life of married women: husband or wife?

d) Can a married woman refuse to have sex with husband for any reason?

3.8.4 Research Question 4

What are the challenges faced by women in their bid to contribute to reproductive decision making?

3.8.4.1 Vulnerability

a) Should a married women be dependent on her husband's finances?

b) Should married women work and earn their own income?

c) Can married women insist on equality with their husbands?

d) What do married women understand about the situation of women generally in Ankpa/ can married women decide to use contraception?

3.8.5 Research Question 5

What communication model can be3 designed that facilitate reproductive decision making by spouses?

3.8.5.1 STIs and HIV &AIDS

a) What do married women know about STIs and HIV &AIDS?

b) Can married women refuse to have sex with their diseased husbands?

c) In case of polygyny or extra marital affair can married ask/insist on their husbands using condom?

d) Can married women ask/insist that their polygynous husbands carry out periodic HIV screening?

3.9 Data Collection, Processing and Analysis Informed consent

3.9.1 Unitizing Interactive Content

Units of data collection in QCA have traditional units in content analysis. It is up to the researcher to decide which units are appropriate for answering particular hypotheses and research questions of interest. Lunk (2008), for example, was interested in comparing communication patterns of U.S. and Hungarian users of social networking sites, so she sampled 300 comments left on MySpace profiles of U.S. and Hungarian users. Each comment was deemed a cod able unit. This unitizing parallels the traditional analysis of sentences, utterances, or turns in real-world communicative interactions (e.g., Bales et al., 1951). Similarly, Martins, Williams, and Harrison (2008) used 368 adult female game characters as units of data collection in their study of women's body type portrayals in popular video games, which parallels work that has looked at body imagery in print media and on television e.g. (Byrd-Bredbenner, 2003; Greenberg et al., 2003).

3.9.2 Coding Interactive Content

Coding of interactive content for this study followed established procedure of manual coding including training the researcher, pilot coding, and inter-coder reliability checks the researcher did the coding in other avoid low reliability between certain coders because of time and level of literacy, the researcher therefore coded and did the inter-coder reliability to ensure reliable coders code certain complicated content and have the other coders handle easier content. This approach is not ideal, but in some cases, it may be the only option to obtain an acceptable level of inter-coder reliability.

3.10 Data Collection Method

This empirical research employed the use of IDI and FGD to gather information from the respondents (Axinn & Pearce, 2006; Wilkinson & Birmingham, 2003). Open-ended questions offered the researcher and the informants and discussants the flexibility and opportunities for respondents to bring to light the other factors that were not mentioned in the surveys (Axinn & Pearce, 2006).

The researcher therefore conducted IDI and 2 FGD discussions with two groups of discussants (5 male and 5 female) to capture the perspectives of these 30 respondents. During the interview process the researcher took notes copiously and also employed the services of a tape recorder in a bid to get every word that comes out of the respondents, probing questions were repeatedly asked in order to record a better understanding of the situation, and participant's thoughts about their experiences.

Once the IDI and FGD were completed and the 20 interview questions have been answered, a structured debriefing protocol was immediately carried out. As illustrated by Cozby (2009, p.47), "Debriefing occurs after the completion of the study. It is an opportunity for the researcher to deal with issues of withholding information, deception, and potential harmful effects of participation". Owing to the nature the sensitiveness of the issues raised during the IDI and FGD which bothererd to very sensitive nature for respondents who had to go through the process, it necessary to ensure that they were traumatized by the experience of discussing such intimate matter with strangers and it was necessary to debrief them and alley any fear of post traumatic condition arising their participation in the research.

The intent of the debriefing was to ensure that "if the research altered the participant's physical or psychological state of mind in any way, as in a study that produces stress,

the researcher will have to through the opportunity of debriefing makes sure that the participants are comfortable about having participated". (Cozby, 2009, p. 47).

Once the data is collected, the next step was the categorization of the information. The objective of this process of categorization was to identify any patterns representing concepts the participants represented during the data collection phase. Data was then organized into logical categories employing the use of specific codes that summarized and provided meaning to the manuscript of notes from that of researcher and the transcribed tapes. These codes allowed the researcher to categorize the response into constructs that the identification of themes and subthemes.

This stage allows for the identification of subcategories that were not identified during the initial stage of the research, they were also coded to be assimilated into the findings.

Though pre-set categories will be defined in the initial phase of the research, setting the initial direction of the study, emergent categories were identified enabling the researcher to ignore the initial pre-set categories. The projected process was to begin the study with pre-set categories adding emergent categories as they become defined. The inclusion of these additional categories offered greater identification of the issues being investigated.

3.11 Data Analysis

Data analysis process is a way to discover "patterns, coherent themes, meaningful categories, and new ideas and in general uncover better understanding of a phenomenon or process" (Sutter, 2006, p. 327). "The purpose of interviewing is to find out what is known to someone or/on someone else's mind… we interview people

to find out from them those things we cannot directly observe" (Patton, 1990, p. 278), while Creswell (2007) suggested that content analysis categorizes, synthesizes and interprets qualitative text data by describing the phenomenon being studied.

Newman (2003) described the process of data analysis as a means for looking for patterns to explain the goal of the studied phenomena. From these sources, the emerging themes were categorized and coded. Once the categorization is completed, the data was coded according to the indicators from the literature.

This study employed an open-coding system to carry a content analysis of participants' narrative responses line-by-line, phrase-by-phrase and word-by-word (Creswell, 2007; Sutter, 2006). As Patton (2002) stated in his book Qualitative Research and Evaluation Methods: Qualitative research is an effort to understand situations in their uniqueness as part of a particular context and the interactions there. This understanding is an end in itself, so it is not attempting to predict what may happen in the future necessarily, but to understand the nature of that setting-what it means for participants to be in the setting, content analysis strives for depth of understanding of the responses of participants.

The analysis identified patterns or similar ideas relevant to the participants' experiences and perspectives about the effectiveness of the current practice as it relates to women's role in RHDM decision-making and their vulnerability to STIs and HIV &AIDS. The final analysis led to the development of a report presenting the interpretation of results, limitations, individual and independent insights, and generalizations of the study.

3.12 Operationalization of Concepts

For the purpose of this thesis the following concepts are defined as presented below and wherever these words/concepts are used in the thesis they shall be taken to mean exactly as presented below. Because of the complex interplay between these concepts in the setting in which they are used in everyday life and so many other variables it is often times difficult to find a simple definition of these concepts in working with community members SAT (2011), it is as a result the possibility of dual meaning that can be attributed to these concepts in every day usage the researcher is defining them specifically for the purpose of these research so that respondents, readers and the researcher can have the same meanings and understanding of the intents and purposes of these words wherever they are employed in this thesis.

3.12.1 Empowerment

Is the process by which people take control and take action in order to overcome obstacles (Stuart & Rao, 1996). A process by which, women mobilize themselves to understand, identify and overcome gender discrimination to achieve gender equality and equity shall be seen as empowerment in this study. This concept run through the length and breadth of this thesis in an interplay of cross cutting impact on the themes and subthemes that impact directly on women's tendency to contribute to reproductive health decision making in the family. It is for that purpose that these concepts are defined clearly or according to Cresswell (2013, pg 49) when concepts are operationalized their true import with reference to the subjects being studied are brought out clearly.

3.12.2 Gender

This is defined as the set of characteristics, roles and behavioral patterns that distinguish women from men socially and culturally, gender characteristics change over time and differ from one culture to another (Saadallah, 2000, SADC, 1999 & Moser, CON, 1993). The roles and characteristics of women and men but also to the relations of power between them in the family shall be included in the parameter to define and identify gender.

3.12.3 Gender Discrimination

When individuals are treated differently but on the basis of their sex (UNAIDS, 2012 Parker, Lorenzo, & Mesner 1999) and any form of structural discrimination against women in the distribution of income, access to resources and participation in decision-making whether it is at the family level or in the society shall be seen as gender discrimination.

3.12.4 Gender Division of Labour

Describes a social pattern where women are assigned one set of roles and men another set (Parker, Lorenzo, & Mesner, 1999). The grossly unequal distribution of reward for instance, in many societies women are expected to perform most of the unpaid domestic work and subsistence food production, whereas men dominate in cash crop production and wage employment is referred to in the study as gender division of labor.

3.12.5 Gender Equality

Meaning the absence of discrimination on the basis of a person's sex in the allocation and control over resources and in the access and control over services (Parker, Lorenzo, & Mesner, 1999) Gender equality may be measured in terms of equality of opportunity or equality of results on the basis of sex in the study.

3.12.6 Gender Equity

Means fairness and justice in the distribution of benefits and responsibilities with a gender equity approach which ensures that women have a fair share of the benefits and responsibilities in society (Parker, Lorenzo, & Mesner, 1999) Equal treatment before the law and equal access to social services including education, and equal pay for work of equal value be it at the family or community level shall be construed to mean gender equity in the study.

3.12.7 Gender Gap

Is a measure of gender inequality, it is a useful social development indicator for example, and we can measure the gender gap between boys and girls in educational levels achieved (Parker, Lorenzo, & Mesner, 1999). Gender gap can be seen in the study where wide differences exist between opportunities and result available for both males and females at all levels of life.

3.12.8 Gender Roles

Are socially defined roles for women and men (Parker, Lorenzo, & Mesner, 1999), for example, most cultures define child-rearing as a female role, and although there is no biological reason why it cannot be done by men, the definitions of gender roles

change over time and differ between cultures. Where in the study roles and responsibility are defined in this manner it shall be seen and described as such.

3.12.9 Gender Sensitivity

Is the ability to recognize gender issues, especially women's distinct perceptions and interests arising from their gender role (Parker, Lorenzo, & Mesner, 1999). Gender sensitivity is the beginning of women and men becoming more gender aware, where they become more analytical, and more questioning of gender disparities around them.

3.12.10 Gender Stereotyping

Occurs when certain characteristics or roles are persistently attributed to men or women thereby creating the belief that these are invariably linked to gender (Parker, Lorenzo, & Mesner, 1999) For instance, the perception that all women are weak and caring and that all men are strong and able to make important decisions are frequently encountered gender stereotypes.

Gender stereotyping reinforces gender inequality by portraying assumptions and conditions that maintain the inequality as biologically or culturally fixed; this can be maintained by oppressive system which is the use of political power to maintain an unjust system.

3.12.11 Women's Oppression

Oppression may exist at the level of the state, the village or the household, women's oppression refers to male domination used for subordinating of women's role in the household or society. When women understand and take steps to avoid this situation then we say gender stereotyping does not exist anymore.

3.12.12 HIV

Human Immuno Deficiency Virus (hiv+) this is a virus that attacks the immune system of its host and it is transmitted through a variety of ways of which sex is one, passing through a window period during which the infected person does not manifest any sign of his/her infection but that lack of sign or symptom does not however preclude him/her from infecting his/her partner (Parker, Lorenzo, & Mesner, 1999), the understanding of this condition and steps taken to avoid by women.

3.12.13 AIDS

This is referred to as the symptomatic stage of the viral infection when a combination of sicknesses begins to affect the infected person; it is this stage that is referred to as the Acquired Immunodeficiency Syndrome, where the infected person is now immunodeficient and susceptible to a variety of sicknesses occurring either simultaneously or concurrently one after the other.

3.12.14 Patriarchy

Is the male domination of ownership and control of resources that maintains the system of gender discrimination (Parker, Lorenzo, & Mesner, 1999), it is maintained by an assertion of male superiority that claims to be based on biological differences between women and men, on cultural values, or on religious doctrines. Practical gender needs are the needs of women and men that can be met without challenging gender inequalities. They relate to the areas in which women or men have primary responsibilities and include the need for access to health care, water and sanitation, education for children, etc.

3.12.15 Reproductive Health

Is the state of physical, mental and social wellbeing in all matters relating to reproduction and to the reproductive system. It includes a satisfying and safe sex life, the ability to have children, and the freedom to decide if, when, and how often to do so. It also includes the right of women and men to be informed and to make choices about their sexuality, to decide when and with whom to have sex, to have access to effective methods of protection against HIV infection and fertility regulation.

Reproductive health care services include family planning services, services for treatment of infertility, obstetric services, and services for the prevention and treatment of reproductive tract infections (ICPD, 1994, WHO 2012).

3.12.16 Reproductive Health Rights

Are the basic rights of women and men to decide freely and responsibly on issues of sexuality and family planning, access to information to make these decisions, and the means to carry them out? Reproductive rights include the right to attain the highest standard of sexual and reproductive health and the right to decide on issues of reproduction free of discrimination, coercion and violence (ICPD, 1994, WHO, 2004).

3.12.17 Sex

Is biologically determined, referring to either being male or female different from the idea of gender whereas gender characteristics are a social construct (Parker, Lorenzo, & Mesner, 1999.). Wherever sex is used in the study it shall refer to characteristics in both male and female that are determined naturally and not socially construed nor change from society to society.

3.12.18 Sex Roles

These are defined by biological differences between men and women (Parker, Lorenzo, & Mesner, 1999). For instance, pregnancy and child bearing are female sex roles that cannot be assumed by men. Wherever sex role is used in the study it shall refer to characteristics in both male and female that are determined naturally and not socially construed nor can change from society to society.

3.12.19 Sexual Health

It represents an aspect of health that is more inclusive than reproductive health. It includes the enhancement of personal relations, respect for security of the person and physical integrity of the human body as expressed in human rights documents (ICPD, 1994, WHO, 2012).

3.12.20 Sexual Rights

Include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality (ICPD, 1994, WHO, 2012).

3.12.21 Sexuality

Is a broad term covering sexual identity (Parker, Lorenzo, & Mesner, 1999) (if you call yourself gay, lesbian or straight or bisexual), sexual orientation (who you are attracted to), sexual behavior (you may describe yourself ‘gay’ but you are bisexual in your behavior), and sexual preferences (with older or younger people or a particular racial group). Wherever in the study sexuality is referred to it shall be used to mean any of the acronyms above.

3.12.22 STIs

These represents a range of infectious that are transmitted in the course of sexual activity, these range of infections can be contracted even without actual penetration of the penis in the virginal opening, while it is easy for a man to know within days of coming in contact with an STI it is not the same for a women, women are most vulnerable to STIs because of their anatomical structure. STIs can have a life threatening situation for women from cervical cancer, tubal blockage to bareness (Parker, Lorenzo, & Mesner, 1999), wherever in the study STI is used it is used with reference to any infection that is sexually transmissible.

3.12.23 Structural Gender Inequality

Exists where gender discrimination is practiced by public or social institutions; structural gender inequality is more entrenched if it is maintained by administrative rules and laws, rather than by custom and tradition alone (Parker, Lorenzo, & Mesner, 1995).

Where women understand and can undertake an analytical understanding of the concept to grade interventions according to their ability to transform lives, to assess the transformatory potential of a program, when women begin to ask the following questions: What needs to be added to the program to ensure that it contributes to such a transformation? Will the program increase the social status of the beneficiaries, enhance their economic or personal empowerment and increase their decision-making capacity? (Parker, Lorenzo, & Mesner, 1995).

3.12.24 Ethical Assurances

Ethical assurance was taking into consideration through providing assurance for the respondents both those involved in the IDI and the FGD that they will not be negatively impacted by this study in any way and should they feel strongly about participating in the study they are informed that posterity will reward them greatly for this noble effort of allowing themselves to be involved in a process that will be beneficial not only to their community but possibly to the whole world. After this assurance, the respondents were provided with a consent form which they willingly signed. They were informed that at any time they chose to end their participation they could do so and whatever information they had provided before would not be used, as it will be destroyed, their real names will not be included in the report and after 5years all recordings of their participation will destroyed.

A structured debriefing process was organized for two reasons one was to gradually allow participants who have shared very intimate part of their lives and may feel negatively afterwards to get hold of their person and not feel bad but know that sharing their experiences could benefit the entire human race or at least their community could be better for it, secondly it allowed the researcher to use that period to find out if any important information was withheld.

3.12.25 Conclusion

This chapter discussed the research methodology that was employed in the qualitative study, which is that of a multiple case phenomenological research design. Also included in Chapter 3 was information on the data collection process as well as data analyses, which included identifying themes from the answers of the participating

women and men IDI and FGD. Finally, this chapter discussed the appropriateness of the research design, the population, assumptions and limitations, and ethical assurances.

In chapter 4 the researcher carried out an analyses of the data that was aggregated, transcribed, categorized and coded, this analyses were done in themes and subthemes.

CHAPTER FOUR

FINDINGS

4.1 Introduction

This chapter presents the findings of the multiple case qualitative data gathered using IDI method and FGD with respondents and discussants from Ankpa, who have met the selection criteria set out for this study in the previous chapter (chapter 3). The data collected will be analyzed employing qualitative techniques. As Cresswell and Miller (2013) supported by Davies and Dodd (2002) opined the accuracy, dependability and credibility of any scientific inquiry of which qualitative and quantitative research are examples is hinged on the strengths of its results being replicated, though, however, in a qualitative study there is no expectation of replication of its result it therefore applies to terms such rigour, trustworthiness and quality in its data aggregation process to provide credibility for the process of data and analysis.

A detailed explanation of the processes employed to sample the population, collect data from respondents and analyze the data in a way that will reduce researcher bias and ensure a more valid, reliable and replicable process for a study employing QCA analysis procedure as described by Neuendoff (2002), is presented in this chapter.

4.2 Content Analysis

The goal of Content Analysis (CA) as employed in this study was aimed at discovering the characteristics of the individuals who created messages for the study, the consideration therefore is their psychology and linguistic capabilities since these two areas are often linked in CA where the goal is to measure psychological characteristics

of the message creators, CA therefore becomes a form of psychometric analysis (Neuendoff, 2002), CA requires that a researcher obtain suitable material, develop a coding protocol and ascertain the reliability and validity of actual coding (Peterson, 1977, p 960).

The main approach to psychometric CA as employed in this study and explained in this chapter is thematic content analysis, though this method according to Neuendoff, (2002), overlaps with clinical CA, as both observes measures of personality and mood factors, open ended coding, linguistic analysis, semantic networks and stylometrics are other areas of overlap.

4.2.1 Thematic Content Analysis

This type of CA attempts to measure the psychological characteristics of the respondent's and discussants, in the IDI and the FGD carried out in the study, the measure of the subject messages stand in for other alternative measures such as self-reporting and index decoding according to Stone et al (1996). Smith (1992) observed that thematic content analysis is the scoring of measures for content or style or both, for the purpose of assessing the characteristics or the experiences of persons, groups or historic periods. As applied in the study the experiences of the respondents on issues of RHDM as moderated by gender concerns and dictates which has been provided and recorded in the previous chapter that was scored and analyzed in this chapter. Smith further opined those thematic content analyses are measures in the values oriented towards the use of previously validated individual differences of measures of particular person's variables. On this bases Smith (1992, p, 4) adapted the following measures in his book:

- Fear of success
- Leadership
- Helplessness
- Responsibility
- Self-definition
- Pride
- Esteem (low and high)

This led to the observation that CA could be approached from a more semiotic analysis of meaning and symbols standpoint, Merkel (1998) provides a bases for the in-depth study of speeches as an indicator of emotions and attitudes in both an ideographic and nomothetic paradigm and using the latter he developed an application of a coding scheme for verbal utterances (Saskin & John, 1963) in Neuendoff (2002).

A very important coding scheme for verbal samples that has received global acceptability in thematic content analysis is the Content Analysis of Verbatim Explanations, (CAVE) developed by Peterson, Luborsky & Seligman (1983), the goal of CAVE is to measure each respondents causal attribution, measuring whether they tend to find explanation in events that are internal versus external, global versus specific and stable versus unstable (Peterson, et al 1988; Schulman et al1989), other related coding methods that could have been employed for this study but were not because of the appropriateness of the CAVE and because of some other observable drawbacks were pessimistic rumination, a measure of the frequency and intensity of pessimistic attributions in emotion and events (Satterfield; 1998 and Zullow; 1991). And criteria based content analysis, a part of statement validity assessment mostly

used in establishing the truth in children's allegation of sexual abuse (Tully; 1998).

Open Ended Written Responses

Both human and computer coding can be applied to the analysis of open ended written responses (Mohler & Zuel; in press) in Neuendoff, (2002), they are two approaches to coding individuals written responses to questions and stimulus materials:

- The use of a pre-set coding (a priori) schemes when the goal is the coding of a psychological construct; it essentially follows the thematic content analysis procedure described earlier.
- The second approach employs emergent coding of the content in which a coding scheme that has been identified after all the responses were collected, this systematic CA is conducted by applying the scheme to the responses with appropriate reliability assessment. Examples of other open ended coding applications are Thematic Apperception Test (TAT), and the Ink Blot Test.

This chapter presents the findings of the qualitative data gathered using thematic content analysis through the technique of open ended written response of the IDI and FGD with respondents, IDI was carried out with 20 married Muslim women from the study area while two FGD's were carried out with 5 men and 5 women in two different settings, the FGD were not carried out together to enable both groups discuss freely without any inhibition.

A profile of all the participants in the IDI and FGD is presented below showing as much of their demographics as possible.

Table 4.1

Profile of Informants for the In-depth Interviews & FGD

S/N	Names	Age	Sex	Occupation	Years married	Educational level	Marriage type	Number of children
1	Ayi	29	F	Full time house wife	11	Quranic Education	Polygynous	4
2	Adi	34	F	Full time House wife	16	Primary school	Polygynous	6
3	Ani	30	F	Full time House wife	15	Nil	Polygynous	5
4	Ada	30	F	Petty trading	9	Quranic education	Polygynous	4
5	Abe	25	F	Full time house wife	10	Quranic education	Polygynous	5
6	Awa	26	F	Full time house wife	10	Quranic education	Polygynous	4
7	Ako	28	F	Full time house wife	14	Quranic education	Polygynous	6
8	Ajo	28	F	Full time house wife	13	Quranic education	Polygynous	5
9	Aja	27	F	Full time house wife	12	Primary education	Polygynous	5
10	Iko	26	F	Full time house wife	10	Quranic education	Polygynous	5
11	Ika	29	F	Full time house wife	13	Quranic education	Polygynous	5
12	Ele	28	F	Full time house wife	13	Quranic education	Polygynous	5
13	Alu	28	F	Full time house wife	10	Quranic education	Polygynous	5
14	Ala	28	F	Full time house wife	12	Primary education	Polygynous	4
15	Umi	27	F	Full time house wife	13	Quranic education	Polygynous	4
16	Ugwa	28	F	Full time house wife	10	Quranic education	Polygynous	5
17	Rabi	29	F	Full time house wife	13	Quranic education	Polygynous	5
18	Rama	30	F	Full time house wife	16	Quranic education	Polygynous	5
19	Rabe	28	F	Full time house wife	14	Primary education	Polygynous	5
20	Robo	30	F	Full time house wife	14	Primary education	Polygynous	5

Table 4.1 (Continued).

FEMALE FOCUS GROUP DISCUSSANTS								
1	Saa	45	F	Ward servant	29	Quranic education	Polygynous	9
2	Sada	50	F	Trader	32	Quranic education	Polygynous	7
3	Saba	50	F	House wife	30	Quranic education	Polygynous	8
4	Sabo	47	F	House wife	29	Quranic education	Polygynous	5
5	Sama	35	F	Teacher	15	G11	Polygynous	3
MALE FOCUS GROUP DISCUSSANTS								
1	Onu	55	M	Civil servant	35	SSCE	Polygynous	16
2	Ona	49	M	Union official	29	Primary education	Polygynous	9
3	Omi	51	M	Retired civil servant	37	Primary education	Polygynous	10
4	Oma	55	M	Teacher	30	G11	Polygynous	12
5	Oga	50	M	Islamic Scholar	30	Quranic Edcuation	Polygynous	14

4.2.2 Content Analysis as Summarizing

The researcher employing CA in an open-ended research can summarize the responses of respondents as concluded by Neuendoff (2002) in his book Guide to Content Analysis. CA summarizes rather than reports all details concerning a message set which is consistent with the nomothetic approach to scientific explanation/investigation i. e., seeking to generate generalizable conclusions rather than the idiographic approach which seeks to focus on a full and precise verbatim report about a particular case. Content analysis is applied to non-mediated investigation though it is very popular with media circles.

When the researcher has considered all the other pertinent criteria and characteristics of CA such as quantitative and qualitative nature of the data, its generalizability and other qualities are like validity and reliability of the message are considered then the study can be seen as having involved content analysis procedure. The message may be mediated that is having some message reproductions or transmittal device interposed between source and receiver, or they may be non-mediated, that is a face to face such as the IDI and FGD involved in this study. The IDI and FGD being analyzed was both mediated and non-mediated as the interview process were recorded.

4.3 Profile of Respondents

Table 4.1 above shows that twenty married women participated in the IDI, all of them were between twenty-four and thirty years ago, they have been married for between eight and sixteen years and have between four and six children, their level of education in the table shows that five of them Adi, Aja, Ala, Rabe and Robo have completed the primary education before marriage, while sixteen completed Quranic education which

is a non-formal uncertificated learning programme and one (Ani) did not complete either primary or Quranic education and so can be described as an illiterate.

Table 4.1 (b) shows that five married women below the ages of thirty-five and fifty participated as respondents for the female FGD they have been married for between fifteen and thirty years and have between them four and nine children, three of them Saa, Sada, & Sama are engaged in occupation outside the house two are teachers in the primary school where one Sama has the Teachers Grade 11 Certificate a minimum qualification to teach at that level and the other teaches Islamic studies with her Quranic education, while one is ward attendant in the primary health care clinic and two are full time house wives.

Table 4.1 (c) shows that the male FGD has five discussants between the ages of forty-nine and fifty-five all of them have been married for between twenty-nine and thirty-seven years, they have between nine and sixteen children and two of them Onu & Oma have post primary educational qualification (SSCE & G11) Senior Secondary Certificate and Teacher's Grade 11 Certificate while two have primary school certificates and one has Quranic education. All of them are Igala speaking and Muslims from Ankpa, they are married to more than one wife, the women involved in both IDI and FGD are also from polygamous homes. .

4.4 Data Analysis

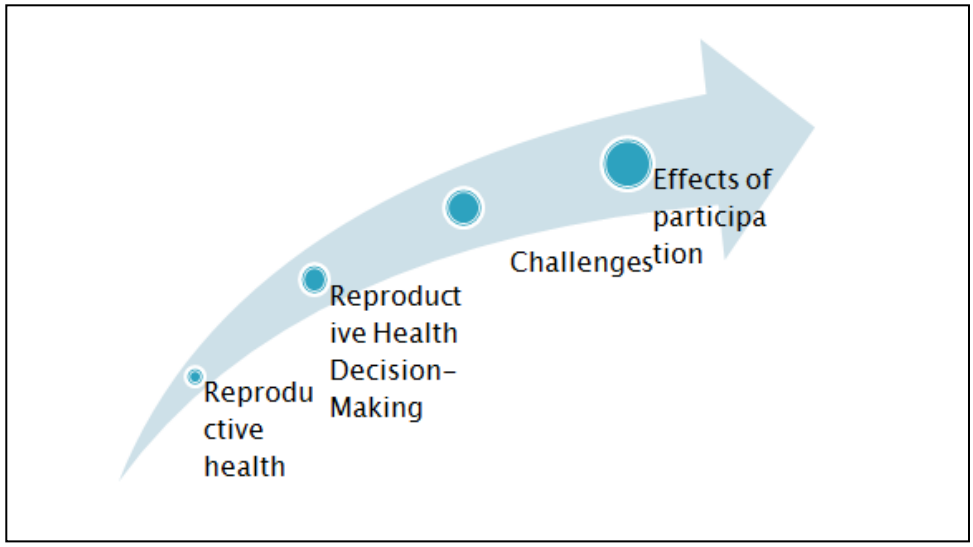

Figure 4.1. Showing the major themes of the study

In order to analyze the data, the researcher has divided the findings into various themes and sub-themes. The process of analyzing qualitative data involves the identification, examination, and interpretation of patterns and themes in textual data and determines how these patterns and themes help answer the research questions that have been identified.

These themes are:

- knowledge of reproductive health and reproductive health rights,
- participation in reproductive health decision-making,
- challenges faced in the attempt to participate in reproductive health decision making and
- the effect of women's participation in reproductive decision making
- Implication for knowledge of RH RR and vulnerability to STIs and HIV & AIDS.

Sub-themes also emerged from these themes that lend a deeper nuance to the experience of the respondents, for the purpose of understanding a list of a few of these sub-themes are necessary here as these sub-themes run through the entirety of the four major themes identified and discussed above, these sub-themes are;

- poverty
- status
- culture
- religion
- extended family
- education
- polygyny
- knowledge of RHDM, participation in RHDM
- power relations and
- spousal age gap

For proper understanding of the issues that affect and direct women's contribution to RHDM the following themes were focused on during the interview with women:

Knowledge of reproductive health as enthused in the ICPD declaration, human beings as reasoning animals believe that to be able to participate in any action or to adopt a behavior their decision will be premised on sound knowledge of that behavior and the expected benefits derivable from adopting that behavior this much is supported by the Social Cognitive Theory (SCT) by Bandura in 1968, the Theory of Reasoned Action (TRA) by Ajzen in 1979 and the Theory Planned Behaviour (TPB) by Ajzen and Fishbain in 1981 when they all concluded that if women knew or had good knowledge

of the benefits enthused in the ICPD definition of reproductive health then they as reasoning and planning human beings the would strive to take part in decisions about their reproductive health, it is on the basis of this understanding that these theories provided direction for this study. This much their humanity can ensure that they will do in their own best interest.

The second theme of this study is concerned with whether women participated in decision-making or not and if they did to what extent did they participate. From the discussion above on knowledge of RHDM it is normally expected that knowledge of the benefits in the expected behaviour will direct their decision in favour of participation in RHDM, so the interview findings showed the extent of participation of women in RHDM and this was naturally dictated whether or not married women in the study contributed to RHDM.

The third theme of discussion in this chapter addressed the extent to which contribution of women to Reproductive Health Decision Making (RHDM) actually matters and in what level can their participation be situated, are their contribution taken into consideration and implemented or are their contributions treated with ignominy to this extent IDI and FGD addressed and extricated from the weight of information provided by respondents whether or not their contribution to RHDM is of consequence in their homes.

The fourth and final theme address challenges women faced in the attempt to contribute to RHDM in a gendered society where role delineation dictated the expectations of both male and female, while issues of vulnerability or otherwise of women to HIV & AIDS as a result of their lack of contribution to or participation in

RHDM was addressed, this theme is important because of the gender consideration that directs their relationship with their husbands because of the implication it has for their vulnerability to STIs and HIV & AIDS.

Along the lines of discussing these thematic areas in this empirical study, the influence of other sub-themes that have likely impact on these themes were addressed to show those areas of likely impact on the themes under discussion; these sub-themes listed above are discussed below:

The importance of spousal age gap in marriage and its effect on couple communication is vital to RHDM and for a fact, it is in the culture of the people being discussed that wide spousal age gaps exist in marriage with its attendant consequences on RHDM this as a sub-theme influences the role women play in RHDM and the IDI and FGD discusses the sub-theme in relation to the themes clearly.

Spousal communication arising from spousal age gap has a direct impact on each of the themes under discussion; the quality of family discussion affects positively the quality of RHDM in the family, IDI and FGD with married women in the study area showed that when women contribute to family discussion processes the possibility of contributing to RHDM is high.

Among the women in the study area poverty is very high Yusuf (2001), this high level of poverty is occasioned by lack of education, female seclusion and early marriage which ensures that women enter their husband's houses without any form of skill or knowledge on the basis of which their status can allow them contribute to family reproductive health decision-making, because of this high level of poverty among

women in the study area they are completely dependent on their husbands thereby making them unable to contribute to RHDM.

Gender consideration in all patriarchal societies ensures that constructs of masculinity that allows for the entrenchment and domination of women in all aspects of life in Ankpa including RHDM about, the role gender plays in the life of the people was reported by both male and female informants who participated in the IDI and FGD, which shows concord with reviewed literature and informants views and opinion.

Power relation between spouses in the homes was also another sub-theme that greatly affected the contribution or otherwise of married women to RHDM in their matrimonial homes, this power relation is greatly affected by constructs of masculinity dictated by gender considerations in the society under study. This power relation in the homes ensures that decisions are made on the basis of role delineation in the society that assigns different roles to both sexes.

Information from respondents was collected on the basis of the interaction between these themes and sub-themes and how they impact the life of the respondents. their views on each of these themes and associated sub-themes is presented in this chapter and where possible summarized/verbatim interview excerpts are also added to provide further texture to the shared experiences of the respondents.

4.5 Knowledge of Reproductive Health

The reproductive health theme dealt particularly with married women's understanding of the full meaning of the concept of reproductive health as enthused by the ICPD 1994 and Beijing conference on women 1995, which is supported by international and

national charters as the accepted bench mark for the realization of reproductive health worldwide. The idea is to identify the role knowledge and/or awareness of a woman's reproductive health and reproductive right has on her participation in RHDM in her matrimonial home.

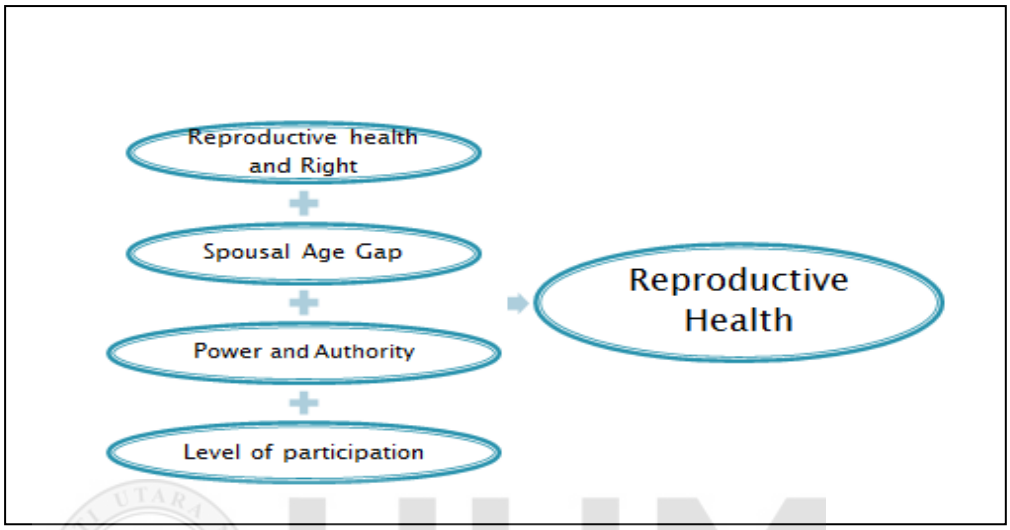

Figure 4.2. Participation of Women in RDHM

The following four sub-themes were identified to guide the collection of respondent's views as far as this theme is concerned:

a) Knowledge of reproductive health and reproductive health rights,
b) Participation in reproductive health decision-making,
c) Power and authority in the home,
d) Spousal age gap.

To discuss these themes four (4) tentative hypothetical questions were asked, each of these questions tried to answer each of these sub-themes.

a) What do married women understand about their reproductive health?
b) How can married women's reproductive health be compromised?

c) What level of control should married women have over their reproductive health activities?
d) Should married women discuss reproductive health issues with their spouse?

For this theme data was gathered and analyzed as presented below, with the research questions acting as a guide to both researcher and respondents on the area of discussion.

4.6 Knowledge of Reproductive Health Rights

4.6.1 Research Question 1: What is the extent of women's involvement in RHDM?

Social status and personal achievement of most women in many patriarchal societies can only be achieved through motherhood, this is the only true role prescribed for women by the socialization process and all social mechanisms operating on this principle severs all other options for the female population from birth. The commitment to providing for the education and any chance of prestigious position or well-paid employment of the girl child will receive little or no attention in such a society. Girls themselves therefore expect their social mobility to be from dependence on their parents directly to dependence on their husbands.

A woman's status and her health are intricately intertwined. Any serious attempt to improve the health of women -if it is to succeed must deal first with those ways in which a woman's health is harmed by social customs and cultural traditions simply because she was born female. The following interview response reported summarized by the researcher is presented to corroborate the assertion by scholars. Thirteen out

twenty of the respondents revealed the following during the in-depth interview and their responses are grouped as reproducing each one will be repetitive.

Out of the twenty respondents for thirteen of their responses are summarized as presented below:

Adi, Ada, Ayi, Ani, Abe, Awa, Ako, Aja, Iko, Ajo, Ika, Ele, and Alu:

> Reproductive health is concerning a woman's ability to have children and if all the factors surrounding her having children such as menstruation, sexual activity, are in good functioning capacity and if she is not barren she should have children and if she can't have children then she cannot reproduce. The ability of a woman to become pregnant and have children anytime she has sex with her husband is what is referred to as reproductive health. If you are not married and you have sex and remove the pregnancy then something will happen to your reproductive health and then you cannot become pregnant again.

While the remaining seven respondents had different view as they revealed that;

Ala, Ummi, Ugwa, Rabi, Rama, Rabe and Robo:

> When a woman gets married she is expected to reproduce because at that time she has started to have sex and that means giving birth to children, she will be pregnant for about nine months and if there is no problem she can then deliver. It is her husband's right that she should give birth to children and she has no right to refuse to do that if she does not want to give birth then she should not get married. The cultural and religious dictate of our people does not favor women with an opportunity to even acquire knowledge of contraceptives and use of it can be disastrous apart from what your husband will do when he finds out, the woman will have trouble giving birth if she is using that kind of a thing.

The informants also revealed that the only available means through which they could acquire knowledge of reproductive health was to listen to their mothers discuss subjects relating to sex and sexuality which is very rare as they ensure that children are not involved or around when reproductive health discussions are being held until

when they are been prepared for marriage and only then will deliberate effort be made to teach them what is expected of them.

Of the twenty respondents who responded to this question five of them revealed that:

Ani, Ayi, Adi, Ako and Ele:

> Before our marriage our mother's sisters, relatives and cousin or other neighbors of the family used to come and tell us what to do when we are married especially about sexual relations with our husbands, how we should be clean, modest and must not allow our husbands to know or see the menstrual blood. We were also told never to make him angry by that it's meant we should for no reason refuse sex, or complain about sex. The issue of delaying or postponing child bearing does not feature in the training in-fact if in the next two months we are not pregnant then it becomes a source of concern.

Whereas another five respondents on the same question revealed differently and their responses are presented below in-depth interview with the following married women from the study area revealed that:

Ummi, Rabe Robo, Rama, Awa, Aja Iko, Ajo and Ugwa:

> We were specifically taught how to please our husbands and when we got pregnant the signs and how to behave, because we could be or were going to be second or third wives, all the reproductive knowledge we acquired was about sex and pregnancy occasionally child bearing issues were also discussed. Discussions about child bearing was not detailed because the traditional system has a culture of sending an older woman to stay with the bride before she puts to bed as an age old practice that predates and survives till date.

Finally, the last set of eight respondents on the same question whose responses slightly differed from the two sets above revealed that:

Ala, Alu, Abe, Ika, Ugwa, Rabi, Adi &Ako:

> The only rights that were discussed then relates to the husbands conjugal rights as having become our husbands they have the right to our reproductive and productive capacities and capabilities, we were not told of reproductive health rights for women. The man is the sole owner of the house and by implication the decider of what happens in the household.

In line with the research design FGD were held with discussants on the issue of the views of the people on knowledge of reproductive health and reproductive rights, the following participated in the FGD and a summary of their views are reported below.

FGD with male discussants showed that:

> We know that reproduction has to do with bringing out a child so a woman's reproductive health refers to her ability to have children when she is married and all the factors that will make it possible for her to have children are present, things like she is seeing her period (menstruation) regularly, she is having sex regularly, then unless something is wrong she should have children. Reproductive health has to do with a woman's demonstrated ability to conceive and deliver.

The female FGD was conducted with 5 discussants who expressed their views on knowledge of reproductive health and reproductive rights and how it shapes the behavior of married women in the study area and their views are reported below:

The female FGD revealed the following:

> When women get married they are expected to conceive and deliver babies this implies that they are having sex with their husbands and nothing is wrong with them, they menstruate regularly and they should have children when it is God's time. If they cannot have children then something is wrong with the woman and she should seek help either from traditional healers, the hospital or prayer houses.

4.6.1 Participation

For the purpose of addressing this sub-theme the following questions were crafted to elicit response from informants.

What is the role of married women in their husband's home?

a) Do married women have and exercise control over their property and wealth in Ankpa?
b) What are the cultural expectations of married women in Ankpa?
c) Do married women have and exercise the same power on any issues in their homes?

Responses for the questions above revealed that it is pertinent to look at the factors influencing participation by women in RHDM. Whether knowledge of reproductive health and reproductive health rights or lack of such knowledge affected the role played by women in RHDM.

Ani, Ayi, Adi Ako and Ele:

> We think that our duty as women is to do whatever our husbands says or expects of us, they are our husbands and we have no wish or direction of our own, that is how it has always been and it has not changed in our time, our own will not be different, our mothers and other sisters that are married behaved and are behaving in the same way'.

Married women who formed the second set of informants also revealed their own views of what informs and guides their participation in RHDM in their matrimonial homes which is presented below.

Ala, Alu, Abe, Ika, Ugwa, Rabi, Adi and Ako:

> Our husbands are the ones that decides what happens in the house, we do not talk about sex or number of children or whether we should have children, except only when one is having menstrual pain or bleeding then sex is out of the question we cannot even think of refusing to have sex with our husbands. It is a duty not a luxury and choice is not an issue.

From the IDI conducted, the information gathered showed that to the extent of their socialization in the culture of their people they participated in the reproductive health decision-making at that time.

Ala, Alu, Abe, Ika, Ugwa, Rabi, Adi and Ako:

> What role married women played in RHDM was to the extent of what we know and what was prevalent in our society before marriage every woman and relative would take turns explaining to the would be bride how to conduct herself before her husband and her in-laws, sex was rarely mentioned but when we were told not to disobey our husbands or make him sad it implies doing the best we can to agree and to please him in whatever way we could and before we have come to know that sex was synonymous with marriage anyway.

The following report was the comments gotten from the FGD with five male discussants who informed that:

> In line with the culture of Ankpa people women were educated on RHDM shortly before marriage as discussing issues of sex and sexuality was not a common practice in our culture. that knowledge is provided to girls just about the time they are ready to get married and this includes issues of good conduct and their roles as wives what to expect of their husbands and how to behave when confronted with the actual reality of their role as wife's and how to handle pregnancy. Early pregnancy is cherished as it is proof of the chastity of the bride and virginity before marriage is highly prized among the Igala people and a thing of pride to parents especially.

A second FGD conducted with women and it revealed that on getting to the time of marriage we were told what to expect of marriage.

While the female FGD concluded thus:

> Our husbands were going to sleep (having sexual intercourse) with us and though the first time it was going to be painful and our parents will be happy of proof of our virginity and if we were not virgins not only will our parents loose face but we may be divorced or remain in our husbands house with little respects before our in-

> laws. Issues of pregnancy and child birth were also discussed marriage was synonymous with sex and sex was synonymous with pregnancy which most times resulted in child birth and we were prepared for all these.

From these interview excerpts it was made manifestly clear that women do not perceive themselves as being in control of either their reproductive ability or their own reproductive health, instead their status as women predisposes them to marry and carry out the prescription of the culture of procreating which they see as ordained by God for them and to obey their husbands wishes, not minding the effect it could have on their health.

4.6.2 Strategic Gender Needs

This definition is premised on the basis of an understanding and analysis of women's subordinate position in society (Parker, Lorenzo, & Mesner, 1999). Addressing strategic needs requires that women understand and take actions to bring about structural social changes. Strategic needs may occur when women understand the need for constitutional equality of women, reproductive rights, a political voice or the protection of women from violence.

4.6.3 Power and Authority

The power relation in the household between spouses is very important in determining to a large extent the role each member plays particularly with respect to reproductive health decision-making, it is in the light of this realization that in-depth interview with married women sought to find out how power relations in the homes affected the participation of women in RHDM in their matrimonial homes.

In general all informants acknowledged that the role of women in the home was to support whatever position their husbands take on any issue and these believe is what the culture and socialization process in their society has prepared them to do. The information from two sets of respondents is presented below.

Twelve out of twenty women who participated in the IDI had excerpts of their responses presented below.

Ayi. Ugwa, Alu, Ala, Ako, Rama, Rabi, Abe, Awa, Iko, Robo, and Ada:

> The woman is the supporter of the man and she is responsible to him, she does exactly as he commands. Whatever his expressed wish is becomes a duty on her to obey as long as he voices it for her compliance she has no will of her own to disobey him.

A second set of in-depth interview involving the remaining eight of the twenty married women is presented below;

Ajo, Adi, Ika, Ele, Ummi, Aja, Robo, and Rabe:

> Serious consequences await the women who disobeys her husband either from him, his people and or her people his word is law, and the society does not support disobedience from wives but it again all depends on the husband or his people he has to make his displeasure known to others before they can intervene but if he reports and she is wrong for challenging or under mining his authority in any way.

FGD with male discussants revealed that:

> In our society men and women have their different roles designed and cut out for them, the man is the head and his wife(s) are under him they do as he wishes and commands it is their responsibility and it is seen as a duty, part of that duty is to give direction to his family that he does by taking decisions on all issues except any he deems not serious enough and he can delegate to others. Reproductive decisions are important decisions which cannot be delegated.

A second FGD with female discussants has the following report which revealed that:

> The power in the house lies with the man it is his house and to that extent his say on all issues is final it is our duty to comply to the best of our ability and in a polygynous marriage whatever wife A won't do, wife B might do it's a competition to please the man'.

The social context of reproductive health decision making is replete with gender inequality. However, the existence of this discordance in a situation of male authority may mean that the man's opinion on this matter will triumph over the woman's, the concomitant result could be women sacrificing their interest for that of their partner/husband.

The literature on social inequality occasioned by gender differences typified in role delineation is in agreement with the FGD and IDI in the community under study, the situation of male authority in the power relation at home is a characteristic of not only the study area but of most patriarchal societies the world over.

4.6.4 Spousal Age Gap

On spousal age gap between husbands and wife, it has been an established tradition the world over for men to marry girls that are younger than them, this habit cuts across different socio-cultural backgrounds. The implication of this attitude is that older men are likely to have been involved in other sexual relations which could impact negatively on the life of the bride; it is also possible that the wider the age gap between the spouses the narrower the spousal communications between them.

The second implication is that older men are likely to be richer, wiser and possibly involved with other women than their younger wives all these have implication for

the younger bride's ability to communicate very well and freely in a qualitative manner with her husband.

The IDI on spousal age gap with married women gave the researcher an opportunity to assess the views of married women and the following married women informed that:

The IDI with twenty respondents is reported below showing the translated version of eight of the respondent's views;

Ajo, Adi, Ika, Ele, Ummi, Aja, Robo, and Rabe:

> The average age gap between wives and their husbands in the society under study is more than ten (10) years, in some cases, that is normal the man must be older than his wife, he needs to have experience and resources which comes with age to manage his family and the age gap allows for there to be respect between the spouses, the age difference automatically ensures that wife's are commanded to respect their husbands, and the bride who sees in her husband a father figure depending on how wide the gap is has her behavior pattern cut out for her from that point of view alone.

A second set of IDI with married women is presented below.

Ayi. Ugwa, Alu, Ala, Ako, Rama, Rabi, and Ada:

> It is normal to have wide age gap between the spouses if not there will not be respect between them. The wider the age gap the narrower the spousal communication and the narrower the spousal age gap the more the respect we were brought to respect our elders and the conjugal relationship between them will command rather than undermine the respect, on the side of the man he sees the wife like either a younger sister or a daughter and so is likely to forgive her excesses a kind of tolerance that younger people do not have and that is why today marriages don't last long because husbands and wife are age mates who will respect and obey who.

While FGD with male discussants revealed that:

> For marriages to succeed there must be some age gap between the couples it is not wrong for them to be the same age, if the woman is of the same age with the husband there is a tendency for disrespect and the perception that they are birds of the same feather flocking together which might have negative consequences for marital harmony, as women grow older chances that they will find husbands become smaller and smaller with advancing age so there is a tendency for them to want to marry early and get married early but a man can marry at any time and you know that men do not have to worry about menopause and things like that. This consideration strengthens the desire of both women and the societal construct which encourages early marriage.

4.7 Reproductive Health Decision-Making

4.7.1 Research Question 2: What are the factors that affect women's participation in RHDM?

Several factors come to bear on the contribution of women to reproductive health decision making in Nigeria beside the influence of the extended family, men and women subscribe to the prevalence of gender ideology of male authority in the homes, exposing the complexity and variability of power within this home, and as such, two types of domestic decisions are possible financial as opposed to social and organizational decisions which are made in the home on a daily basis, depending on the situation certain factors influences those who make these decisions and the conditions under which decisions are made are also impacted on by some other considerations.

It is from this background that the respondents IDI and FGD attempted to explain the reason for their participation or not in RHDM and specific role played by married women in the RHDM within the home sphere.

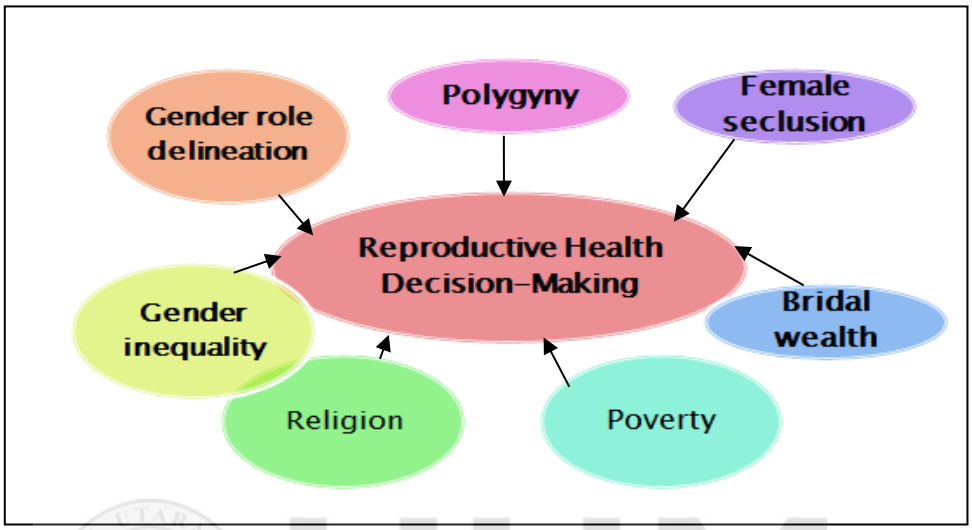

Figure 4.3. Factors Affecting Participation of Women in RHDM

Analysing and understanding the following sub-themes was necessary to explaining why participation or otherwise of women in RHDM in the household were compromised, these sub-themes are:

a) Gender role
b) Poverty,
c) Religion
d) Empowerment

4.7.1 Gender Roles

In patriarchal societies gender norms related to masculinity permits men and women to expect men to dictate the pace of activity in the home, the women also expect the

men to dictate what happens with their lives as well, they have been socialized to accept being told what to do, when to do it and how to live their lives by men.

In such a society where gender consideration guide and dictate relationship between the sexes and roles are prescribed for each sex the dominating culture enforces compliance seriously, especially, against the weaker sex in the relationship.

Constructs of masculinity can and do encourage sexual relations within spousal age differences between men and women as is practiced in the society under study which vary widely between spousal age gaps. Practices such as polygyny, female seclusion, marital rape, wide spousal age gaps, open extra marital relationships both serial and concurrent, little or no spousal communication and authoritarian life style between spouses devoid of all forms of display of positive emotion is encouraged by gender consideration as a means of maintaining the statuesque, these consideration guides RHDM.

4.7.2 Polygyny

IDI informants therefore sought to find the role of polygyny in women's contribution to RHDM and the IDI responses from five of the respondent's views on the role of polygyny in shaping women's behavior is presented below:

Ako, Ajo, Aja Iko, Ika and Ele

> In the culture of the Igala people it is normal that a man should have more than one wife either as wives or as concubines, the culture does not frown at that but frowns seriously at a woman having extra-marital relationship. In the home having paid the bridal-wealth he automatically has the right to dictate the life pattern of his wives. The relationship is designed to favor the man.

A second group of eight women with different views from the one above in their responses to the IDI questions are presented below:

Alu, Ala, Ayi, Adi, Ani, Ada, Abe and Awa:

> 'It is expected that a man should have more than one wife and among men to have just one wife is a sign of either weakness or poverty if you are a man and you are in control of your first wife then you can marry another one'.

The final IDI reported here with regards to marrying more than one wife is a control thing for men and it is a pride amongst your peers that you have more than one wife, it reveals thus:

Ugwa, Umi, Robo, Rabe Rabi and Rama:

> If your husband has only one wife you will be perceived outside as having done magic to stop him from marrying another wife and men will be afraid of marrying your daughter as they will be fearing that she will either charm them and control them as you are controlling your husband or she will be very jealous and not tolerate other women with her husband.

As part of the pattern of the design of this research FGD conducted with men revealed that:

> Marrying more than one wife does not mean you do not love your wife it has nothing to do with emotions of love it has to do with the nature of man, man is naturally polygynous and it's the same with lower Animals, it is a sign of weakness to stay tied to a woman.

4.7.3 Gender Role Delineation

Gender role delineation also dictate the power relation at home between spouses, the man is seen as the head of the family owing to certain roles assigned to man by culture

such role as man as bread winner and as head of the family, this automatically assigns a subsidiary role to the woman in the house.

The IDI shows the informant's opinion concerning the various role delineation occasioned by gender dynamism in the homes and how it affects their contributions as women to RHDM.

Alu, Ala, Ayi, Adi, Ani, Ada, Abe, and Awa:

> In the power relations in the home women are expected to carry out the roles reserved for them by culture which is their way of life just as the man goes about fulfilling his own roles of taking care of the home and providing for every need of the family so the woman should accept her subordinate roles entrusted on her by the society, RHDM and every major decision emanating from the home are exclusively reserved for the man. Even those other decisions considered minor or trivial enough to be left to women are merely delegated to women by the man as a concession not as a right.

A second IDI revealed that the extent of gender discrimination against women in the home with regards to role delineation and constructs of masculinity which allows the man so many privileges and denies women same privileges and also stops her from complaining about her situation is pervasive and not isolated, the opinion of seven women from the study area that is almost similar is presented below:

Ugwa, Umi, Robo, Rabe Rabi and Rama:

> The role of men in our lives are such that we are controlled by them, our life is influenced by the men in our life's the extent of the influence is dependent on the man. Our health is influenced by the attitude of the man in our life; the sexual life of the man can have negative impact on the life of his wife. Where she can neither ask her husband to use condom even when she knows that her husband

> has extra marital relationship or has other wives, and is therefore involved in multiple sexual partnering despite the fact that we can't even pretend to oppose the relationship, we also can't insist on refusing to have sex with him without condoms nor can we divorce him on that basis, instead he threatens us with divorce and he enjoys the support and protection of the society.

4.7.4 Female Seclusion

Scholars of intra-household relations hold that where a society practices social seclusion and restricts the physical mobility of women the capacity of such women to develop the needed competence and psychological capability to take independent decisions or hold an independent view of life is greatly affected.

The responses of IDI of six women from the study area reported verbatim on the impact of physical restraint on their movement is presented below:

Ugwa, Umi, Robo, Rabe Rabi and Rama:

> Movement outside the house must be approved by our husband or mothers in-law, if they are not around no matter the seriousness of the issue or sickness we must wait, even if we were ready to take the risk and go out we cannot afford to do so, because we do not engage in any economic activity of our own and so have no money, the fear of what will happen has stopped so many women from venturing out without permission because that is enough ground for divorce. At any time we are going out we must be accompanied by one of our husband's relative; we have no privacy at all but can't complain because the whole society is agreed on how a woman must behave.

Another IDI with married women in the study area revealed that:

Ako, Ajo, Aja Iko, Ika and Ele:

> Our husband or the society believes that women are not firm and may be easily swayed and so she must be protected and guarded from other men who may wish to lure her into illicit relationship or affair even though they women are married, it is for this reason that

> women are not allowed out on their own except accompanied by older or younger male relatives of the husband.

The next six respondents whose responses to the questions were similar are grouped and presented below:

Ugwa, Umi, Robo, Rabe, Rabi and Rama:

> Most of us were involved in an arranged marriage and most of us didn't really know or like our husband before the wedding, at the time and may have considered running away but we have no knowledge of anywhere to run to and gradually we settled down to accept our fate. Other women in such a situation may decide to have extra marital relationship since they are in forced marital relationships, this explains why seclusion and close monitoring is in place especially in the early days of marriage and such behaviour reduces with advancing age and child bearing by women.

Three other respondents with slightly differing views on the question have their views presented below:

Awa, Ummi, and Adi opined that:

> Female seclusion is another sign of the power relation in the house and men use it to show who is in charge in the house, the wife must take permission before going out, she must be accompanied, she cannot talk to non-relative male within and outside the home, her whole life is monitored and controlled her judgement is questioned and she is not trusted by even her husband let alone his relatives it is another way of dominating women.

4.7.5 Bridal Wealth

On the role of bridal-wealth on women's status in their husband's houses focus group discussion except with both men and women is presented below.

When you have paid your wife's bride price or bridal wealth all responsibilities for her welfare reverts to you the husband, you become responsible for her health, feeding and every aspect of her life, in line with that you take decisions for her in the interest

of your family. The bride price you have paid confers authority on you and she becomes a part of your family from that day so whatever decision you take is in the interest of your family and she is now a part of that family that you are responsible for.

Female FGD revealed that:

> It is not her place to take any decision in your house unless you allow it, she is the wife and should subject her wish, person or social life to yours, and she already consented to that much when she agreed to marry you and received the bride price or bridal wealth. It is therefore to compel women to appreciate the expected responsibility of marriage that as part of the marriage custom/procedure she collects the bride-wealth that is paid for her with her own hands and hands it to her parents, by implication therefore she cannot renege easily on the concomitant obligation enshrined therein.

While IDI with seven of the primary respondents revealed that:

Rabi, Rama, Rabe, Robo, Iko, Ika, and Alu:

> We do not feel that our husbands purchased us with the payment of the bride price or bridal wealth; it is a symbolic gesture they need to show that they appreciate their wife which is treasure. There is no amount of money that is worth any woman. It is intended to show other men that yes someone value women enough to pay some amount of money on them. What allows the man to dictate to us is that we are their wives and custom, culture and the norms of our people already set out who plays which role, one of such role is that the man pays the bride price; it is a value we cherish in our culture which gives him the right to decide for us.

A third IDI with five primary respondents revealed that:

Ani, Ada, Awa, Ayi and Ajo:

> Though some families and culture charge higher bride price and the man or his family can collect such bridal wealth back if the wedding has been annulled even if there were children in such marriages that the man has collected back the money is a sign that it is not the money that matters, the return of the money signifies that all obligations between them have been waived and another man if he so desires can now have her.

4.7.6 Poverty

The pervasive 'feminization of poverty which widens the gap between women and men caught in the cycle of poverty has increased the clamor for more autonomy and improved status of women in the household, the nexus between the status of women and their contribution to decision-making particularly reproductive health decision-making in the house is co-related to other gender considerations that affects women's access to and control of resources, other sub-themes that is affecting the role women play in their matrimonial homes includes but are not limited to empowerment, access to and control of resources, education and work outside the homes, dual responsibility of women and their reproductive and productive roles in the house. The inter play between these variables is a complex web of intrigue that cannot be easily unraveled as each affects and is affected by the other and in turn affects and dictates women's role in household RHDM process.

In patriarchal societies the surest guarantee of upward social mobility for women was and for most women is through either their parents or through their husbands and or both. The preponderance of arranged marriages to rich and powerful men in the society under study buttresses the point of those who practice it.

IDI with eight informants on the possibility of upward mobility of women on the basis of arranged marriage across class is reported is translated below:

Awa, Ummi, Ako, Aja, Ala, Abe, Ako and Ele:

> In our culture a woman has no status outside her home (family) and when she marries, which is her own source of upward social mobility; depending on the status of her husband she either joins the upper or lower class. To avoid losing or falling to lower status girls and their families strive as much as possible to marry someone above their own social class, as to marry below one's social class that was and is still perceived as committing class suicide.

The next reported in-depth interview revealed that most women do not want to fall below their class when they get married go out of their way to arrange marriages with others whose social status are slightly higher than theirs. The interview revealed below buttresses this statement.

Ayi, Rabe, Robo, Adi, Ugwa, Rama, Ani, Ajo and Ada:

> This is what has made spousal age gap very high, because the richer the man the more likely the older he will be. Women are therefore encouraged to move from their father's house to their husband's house, any time spent in between is therefore seen as endangering the possibility of getting married later because of the fear of sexual adventure that comes with age. Even if this time spent was spent acquiring knowledge and not wasted, but in acquiring education for no matter the qualification if you are not married then your life means nothing. The only other way through which a higher status can be acquired by a woman is by having children or a male child for your husband, as male children inherit double the share of their female siblings in case of their father's death, in some cases if you are married without children it still does not guarantee you a higher status though your situation is far better than that of an unmarried woman.

Finally, the last IDI with respondents with similar view on the issue of poverty revealed that:

Ugwa, Rama, Ani, Ada, Awa, Ajo, Rabi, Rabe and Robo:

> Most girls get married without any form of education or skill that can be marketed for income generating activity in their husband's house, how then can they be economically productive and not go to their husbands as complete dependents, when you come as a liability the husband and his family are likely to dominate all process of decision-making in the house.

The researcher is also interested in understanding how the complexity and variability of power within this sphere works, and as such, two types of domestic decisions questions were asked in the FGD and the various IDI: financial as opposed to social and organizational questions. IDI revealed that women who come into their husband's houses from richer parental background or from higher social background (i.e princess) than their husbands are likely to enjoy some form of/or silent respect than their co-wives especially those in polygynous marriages.

One of the respondents of the IDI whose co wife is the daughter of the local chief revealed during IDI that:

> My husband's second wife comes from a rich background compared to that of our husband or my own family but aside from our husband she cannot use that to oppress anybody in the house, she does her duties like every other person in the house, the only difference is she enjoys some material things which she buys with her money, apart from that we are treated in the same way. I have noticed that on some occasion's people defer to her but not openly as to cause disaffection and certainly not by our husband.

Four other participants in the IDI reported similar views which are presented below;

Ala, Alu, Ele, Ummi, and Aja:

> We have co wives whose parents are richer than our parents but in household chores and wifely responsibilities we are treated the same.

The practices of diverging inheritance (giving of property to both sons and daughters) and dowry (transmission of property to a daughter at marriage) arises in low-density Africa, in contrast to other societies like Asia, in Africa and particularly in the study area where land is abundant, extensive agriculture prevails in most parts and requires no technology more complex than the hoe.

Female farming, in turn, is common in areas of hoe agriculture, in hoe cultures therefore, the value placed on women is for their productive as well as their reproductive capacity and labour, women are therefore expected on getting married to display a justification of not only their capacity but their ability to be productive as well as reproduce in their husbands house this much is attested to in FGD and IDI with respondents and discussants in the study area.

The FGD reported below represents the views of male and female FGD discussants who informed the researcher that older married women farm to supplement their income not the family income and they are at liberty to deploy the resources thereby in whatever way it pleases them.

Female informants from the study area, during IDI revealed that:

> Our husbands do not allow us to trade or go outside the house without their permission, when we need anything most times we send our children, mostly the male ones, the girls are also not allowed out except under certain conditions, the same sense of seclusion though not very compulsory is expected of our daughters too, especially those nearing sexual maturity, that way when they grow up and are married they are already used to it.

Female informants from the study area revealed the following during IDI:

> If it becomes necessary for us to go out we will be accompanied by our son or a male relative of our husband usually below (12) years, we are also not expected to be friends with un-related males nor to stand and talk to males on the road as we go out, it is a conduct on-becoming of a married woman. The senior wife who has a grown son does some trading using her son to hawk the goods but she does not go out to sale herself, most times we send her son on errand to the market to make purchases for us.

However, a set of younger wives report that their husband's attitude towards their seclusion is quite different from the one reported above as they do not go out at all and every need of theirs is provided by their husbands, this account is reported by the following married women, eight of them reported below their experience:

Ala, Ako, Ani Alu, Rabe, Rabi, Ugwa and Ummi:

> Our husbands provide for us completely we do not carry out any economic activity, we are full time housewives, we don't even go outside the house unless with their permission, they take decision on whatever happens in the house, even if it is to go to the hospital, or visit our relatives they must give consent if not we will not do it. Our religion, our culture support and encourages us to obey our husbands completely on all matters. They provide for us according to their means and that is expected to be enough for us no matter how small, we are expected to live within their means.

A IDI with married women from the study area revealed that women whether rich or poor should be provided for by the husband as a duty, a fulfillment of religious obligation and not a choice, their views are reported below.

Saba, Sabo, Sada, Sama and Sa'a:

> The responsibility of providing for the household is not a choice a man makes it is a duty enshrined on him as the man in the house and if he is not capable then he should not marry for by marrying he demonstrates his capacity as a man to fulfill not only conjugal responsibility but also to fulfill economic, social and other

> obligations of matrimony conferred on him by both culture and religion. It is as a result of which he pays the bride price as a demonstration of his ability to take care of the family he will raise thereafter.

The views of eight married women on whether the status of the wife will enable her share in the RHDM in the house are reported below.

Ajo, Awa, Ada, Ani, Rabi, Rabbe, Robo and Ummi:

> The decision-making power in the house resides with the man completely if he decides to take decision in consultation with the wife then that is a choice he makes and other members in the society may consider him weak for sharing with his wife the responsibility to make decisions in his house. This has nothing to do with the status of his wife whether she is working, rich or poor unless the man allows it, if they woman does not agree because of her status, either rich, working outside the house, educated or of noble birth then she is not ready to be married yet.

4.7.7 Religion

The religious practice of the people is significant in sustaining gender inequality in the society under study, this is significant enough to be explored and not ignored so that the specific role it plays be identified, recorded and addressed in the next set of interview questions.

From all dimension of the spectrum of life has come suggestion about the need to properly peruse the unequal and uneven status of both sexes in the world, from the academia, to developmental circles and even at laymen levels, the need to reduce the unequal gender relationships between the sexes has been the focus of discussions which seems to suggest that the root of these discrimination could be traced to religion.

Focus was however be placed on Islam, since all the respondents are Muslims through the opinion of the informants the role of Islam which is the dominant religion of practice in the study area is perused seriously. The researcher extrapolated and unmasked the web around the origin of patriarchy and through the responses that patriarchy was traced to religious texts and it provided justification for assigning a secondary, less significant role for women, as is generally accepted in the society and by the people of Ankpa today.

Gender Inequality

The origin of the unequal gender relations that exist between men and women is the focus of the next discussion with eight married women in the study area and their views are presented summarized below:

Ayi, Rabe, Robo Ele, Iko, Ika, Rama and Ummi opined that:

> God designed the unequal relationship between the sexes like that, when God created Adam first and then created Hauwa the mother of the world and handed her to Adam as his wife, it started like and has always been like that, several scriptures of the Quran attest to the strength of the man and God enjoins on the man to feed, clothe and treat his wife with kindness as a duty and in turn the wife should respect, obey and cherish her husband. To do otherwise will be to disobey God, not even the husband only.

While another IDI with married women revealed through the following eight respondents that:

Ugwa, Awa, Alu, Ika Ajo, Aja, Abe and Ako that:

> To attempt to question the superior status enjoyed by the man as enshrined in the Quran was to question the authority of God, and unless you have left Islam you will not contemplate doing that, you

> must follow the dictates of the Quran on the existence of patriarchy as ordained by God, you accept hierarchical position between the man and the woman, you must accept that paradise for the woman lies in her pleasing her husband and she has a duty to her husband to do as he pleases.

The last IDI on this topic was informed by the following married women

Ani, Rabi, Ala, and Ada who reported that:

> Nature agreed with God in giving man a superior role and no matter what is said about it the purpose of God is right, there is no way that the superior position of man can be altered. Man is superior to woman in many more ways than we are ready to agree but that superiority is not a domineering one as the frailty of women and the meekness of women is also needed by man to survive like everything in nature it is complimentary and it all moves towards a balance and that is how order is maintained in the world. It is delicate balance.

An FGD with male discussants from the study area posit that:

On all issues as posited in the Quran and Hadiths of the prophet the place reserved for men and women are different, religion reserves different roles for both sexes, it is not the society that originated patriarchy or gender role delineation it is religion because without ascribed and prescribed roles there will be chaos in the world, man would still have been behaving like animals, look at the societies today that are abandoning religion look at the mess the world is becoming because we are down-playing the role of religion in our lives and the world can't and by implication human relations cannot be the best for it. Men and women are crossing gender barriers it can only lead to moral bankruptcy which will end up destroying the world.

FGD with women from the study also area revealed that:

> The role delineation we grew up to meet was dictated by the religion we practice and it is the same for our culture and tradition, we do not compete for position of authority with our husbands everyone's place has already been designed by God when the world was created, women had their roles clearly cut out and the domain of the men is clear. Trying to alter that arrangement was definitely going too far and the result could be disastrous both at individual and societal level.

On the use of contraception for the sake of family planning Islam provided a guide but if it is contraception for the sake of family size reduction then as far as Islam is concerned it is wrong, again there is a guide for those who wish to learn and follow.

4.7.8 Contraception

The views of eight married women from the study area as presented by them during IDI are that:

Ajo, Rabi ada, Rama, Ugwa, Ala, Abe, and Alu:

> We do not discuss contraception with our husbands, we can't raise the issue as a topic for discussion and so far the men have not raised it, we do not use contraceptives, we do not want to be seen to desire child reduction, family planning is encouraged in Islam and practiced through post-partum abstinence but any effort to carry out child reduction is a different matter and it is not our place as women to desire that, it is those that don't want children that use prevention. We are not having extra marital relations and have no need to protect ourselves from disease. If you don't want children, then don't have sex. Anyway, when our husbands invite us to have sex we can't refuse them.

The respondents provided a guide to the role of religion in their reproductive health when the reported that the guide provided by the religion of Islam is good enough for them as nine of them reported that;

Adi, Ayi, Rama, Robo, Ika, Ele, Awa, Iko and Ako:

> The decision of our husband is final on any issue and with the use of contraception if our husbands want us to use them, to the extent that it agrees with the laws of Islam we will practice it, but if it contradicts Islam then even our command to obey our husbands does not reach the extent to which we will disobey our lord knowingly, we have nothing against the use of condoms both as a prevention or a protection measure, this Islam did not forbid but to remove pregnancy through deliberate abortion or to choose who to have sex with others outside our husband we will not do that here both Islam and our culture are in agreement on what happens when extra marital sex takes place.

FGD with male and female discussants revealed that socio-cultural conditions of the people of Ankpa does not tolerate women doing anything that their husband has not approved and to this extent just like Islam strict sanction is put on covert use of contraceptive use.

The report from married female discussants who participated in the in-depth interview revealed that:

Adi, Ani, Ika, Ayi Awa, Unni, Ele and Rabi:

> We cannot and will not even try to use contraception of any kind without the knowledge and express approval of our husband even if he does not find out God knows and he will definitely find out we do not go out on our own, we do not know these contraceptives, and if we must go out we are always in company of our husbands relatives. The consequences of his finding out that we are using contraceptives covertly are grave and that is enough to deter anyone from trying. There is the possibility that our husbands will find out.

4.8 Effect of Women's Participation in Reproductive Health Decision-Making

4.8.1 Research Question 3: When a woman contributes to RHDM does it translate to action?

Decision making connotes a qualitative process whereby two or more people meet to listen to each other aggregate their varying positions on a subject of interest and agree on what action to take, it is a process of give and take which connotes the capacity of all the parties to marshal out their views on the issues at stake and be able to push their views through to be implemented, when implementation begins participating in the process is useless if at the end of the process of discussion the views of one of the contributors is ignored or out rightly rejected not because of the quality of the contribution but because the sex of the contributor.

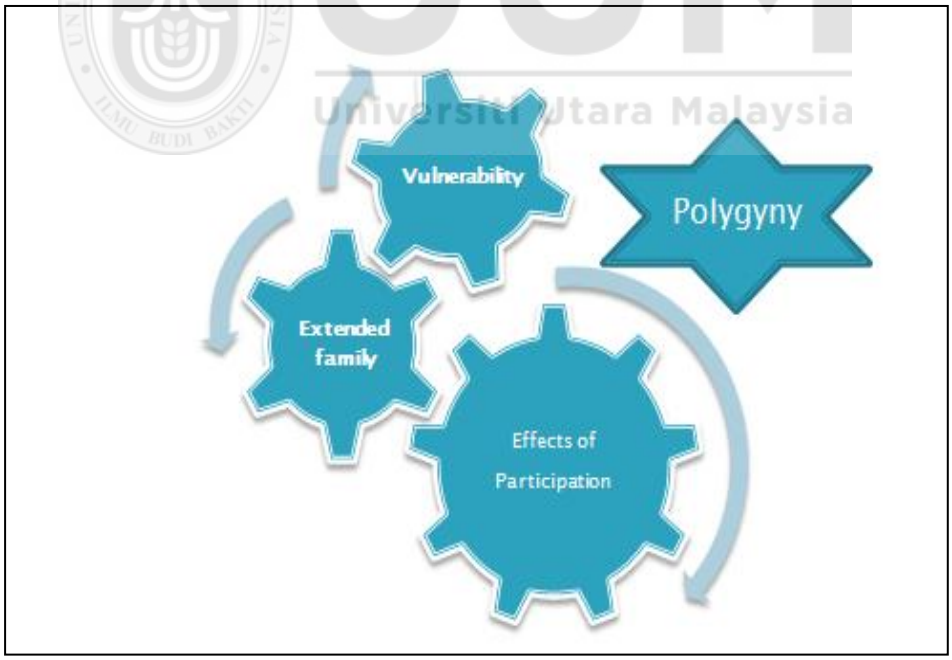

Figure 4.4. Effects of Women participation in RHDM

Under these sub-themes, the following issues that affect women's effort to contribute to the process of arriving at family reproductive health decisions will be looked at: Vulnerability Patriarchy

To gather data that will be used to explain these sub-themes the following questions were designed to guide the interaction between the researcher and the informants.

a) Are married women supposed to participate in decision-making in their homes?
b) When married women take decision or contribute to decision-making are their contributions always implemented in the house?
c) Whose decision should be the final in the house concerning the reproductive life of married women: husband or wife?
d) Can a married woman refuse to have sex with husband?

4.8.1 Vulnerability

On whether the vulnerable situation in which women find themselves as has been discussed so far occasioned by gender, religion, poverty and the power relations that exist in the households ensures that women lack the capacity to participate in decision-making on their RH the researcher found out how this affects married women in the study area, the views of respondents are presented below.

The responses of nine of women who participated in the IDI on the status of women and how it impacts on their ability to contribute to RHDM are presented below.

Ayi, Adi, Alu, Ako, Ala, Ummi, Ada, Ugwa and Aja:

> The sexual relationship with our husbands are initiated by them and unless there is a clear noticeable illness a woman cannot refuse to have sex with her husband, for those of us in polygynous

> relationships the sleeping arrangements are shared not the sexual arrangements, this is a situation in which the husband spends an agreed number of nights in the room or house of one wife and then spends an equal number of nights in the room(s) of the remaining wife(s), while in each woman's room whatever happens there is between the two of them. Every wife generally assumes that while the husband was in the room of the co-wife they have had sex and so the tendency for sex not to take place in her room for any reason other than sickness will not be tolerated by her, for all you know she may not have another chance again in a long time depending on the number of wives her husband has. In this state of competition the fear of infection or pregnancy that will necessitate using contraception is far outside the consideration of the women. The culture, religion and marriage type practiced does not favour the woman with either refusing to have sex with her husband or with dictating the condition under which the sexual liaison will take place and so to say the woman is vulnerable under such condition is an understatement.

Eight other married women interviewed informed the researcher that:

Rabe, Robo, Rabi, Rama, Ajo, Aja, Ummi and Iko:

> The status of the women is that of an assistant who does whatever she has been directed, she cannot refuse to carry out the wish of her husband, the social stigma that is associated with divorce makes sure that no woman wants to be divorced and most times women tolerate unpleasant circumstance to live in matrimony and more over being single or divorced in a patriarchal society carries with a lot of consequences from open discrimination to a state where some services are denied you.

A third set of married women from the study area opined that:

Ala, Ugwa, Ani & Ika:

> To say women are vulnerable is to be charitable or to put it mildly, their entire life is one of complete vulnerability. Denied the basic tenets of freedom such as freedom of association and freedom of movement and lack of privacy, they are living in seclusion, if they must go out they must be permitted, and must be accompanied wherever has been approved for them to go. They have no source of income of their own and can only engage in income generating

> activity if their husbands agree, it can be concluded that being born a woman is limiting enough having to be controlled by people who believe they know better because they are either your father, or your husband or your brother all your life is the full meaning of vulnerability.

It is also important to acknowledge the place of economic empowerment and independence and that lacking these increases women's susceptibility to a wide range of unpleasant situations, amongst which are poverty, lack of power and the risk of STIs and HIV & AIDS, malaria, tuberculosis and other diseases that poverty aggravates, these much was stressed by the focus group discussants who informed the researcher that:

> The number of women involved in income generating activities is very small and the farming activity that they engage in is mostly food crops and not cash crops this situation does not allow women to accumulate resources that will enable them work their way out of poverty, and thereby reduce their vulnerability, this unfortunate situation is compounded by gender consideration which does not allow women to own land and or own and control other resources which will have reduced their vulnerability and allow them participate in RHDM process in their matrimonial homes.

An FGD held with women from the study area revealed that:

> Women are vulnerable for so many reasons their physical and social mobility is restrained and their interaction with other people outside their matrimonial homes is also dictated more by custom than by their husbands as the husbands only implement what the gender roles dictated for them and religion plays a significant role in their vulnerability by assigning the role of bread winner to the man it is under this guise that men stop their wives from engaging in income generating activities, as they expect women to be contented with whatever their husbands are providing no matter how little. This restraint on the physical mobility of women impacts greatly on their mental ability and also women have become accustomed to the man dictating the rules of engagement.

4.8.2 Extended family

Several factors come to bear on reproductive decision making in Nigeria. Chief amongst which is the influence of the extended family system, both men and women subscribe to the prevalence of gender ideology of male authority in matters of family size and composition. The various IDI revealed the role of the extended family system right from the time of courtship to the time of marriage and throughout the life time of the couples, sometimes, the newly wed live in compound houses with his extended families and his wife. The IDI with married women revealed that:

Ajo, Aja, Rama, Adi, Ada and Adi:

> We live in family compound in company of other extended relatives of our husband's family though our own house is different but we cook and eat together we (his wives) and all the women eat together, in the same way they take part in all other decisions concerning the family and most time the mother in-law or some other older relative of the groom takes the final decisions concerning the bride and that decision once taking at that level is final no matter how much the immediate couples concerned disagrees or dislikes the said decision.

A second in-depth interview conducted with married women from Ankpa is presented below:

Ani, Ada, Rabi, Rabe, Ako, Robo Awa, and Ele:

> The desire to have children is so strong that during the marriage process the bride in some Nigerian societies are expected to actually be pregnant before the wedding as a proof to her husband and his people that their wife is actually capable of procreating and if in the first two months of pregnancy she is not pregnant other interpretation of her situation begins though at first very subtly but as time goes on it becomes very loud and to the point where many a man is led to either marry another wife or divorce her if she is not capable of conceiving.

The report presented below represents the informed views of the informants from the study area who participated in the IDI regarding the role of the extended family participating in the decision making process of spouses revealed:

Ayi, Ugwa, Iko, Ika, Ummi, Abe & Ala:

> In the culture of the Igala people it is normal that a man should have more than one wife either as wives or as concubines, the culture does not frown at that but frowns seriously at a woman having extra-marital relationship. In the home having paid the bridal-wealth he automatically has the right to dictate the life of his wife(s). The relationship is designed to favor the man, the power relations in the home, RHDM and every major decision emanating from the home are exclusively reserved for the man and his family (extended) whom he consults as and when due. The women are expected to carry out the roles reserved for them by culture which is their way of life just as the man goes about fulfilling his own roles of taking care of the home and providing for every need of the family so the woman should accept her subordinate roles entrusted on her by the society.

4.9 Challenges Faced by Women in Contributing to RHDM

Research Question 4: What are the challenges faced by women in the effort to contribute to RHDM?

The northern part of Nigeria has successfully transformed their societal norms and values to a large extent to be in consonance with that of the Islamic norms and values and couple decision-making in the region follows the pattern which Islam dictates generally. The construct in Islamic culture is that women have a duty to obey their husbands and they husbands in turn are expected to respect their wife's, to this end decision-making sometimes unless otherwise seek some form of compromise and sometimes are dominated by the man, the husbands domineering role in decision-making in northern societies shows that women do not always take decisions on their

own even if it is about their welfare such decisions and any others are taken in consultation with their husbands.

It becomes necessary at this juncture to attempt to understand the challenges that women face if they must take decisions or contribute to RHDM. The following sub-themes were explained to give direction to exposing those salient factors that stand in the way of women taking decisions about their reproductive health or playing significant role in contributing to the making of reproductive health decisions in the household:

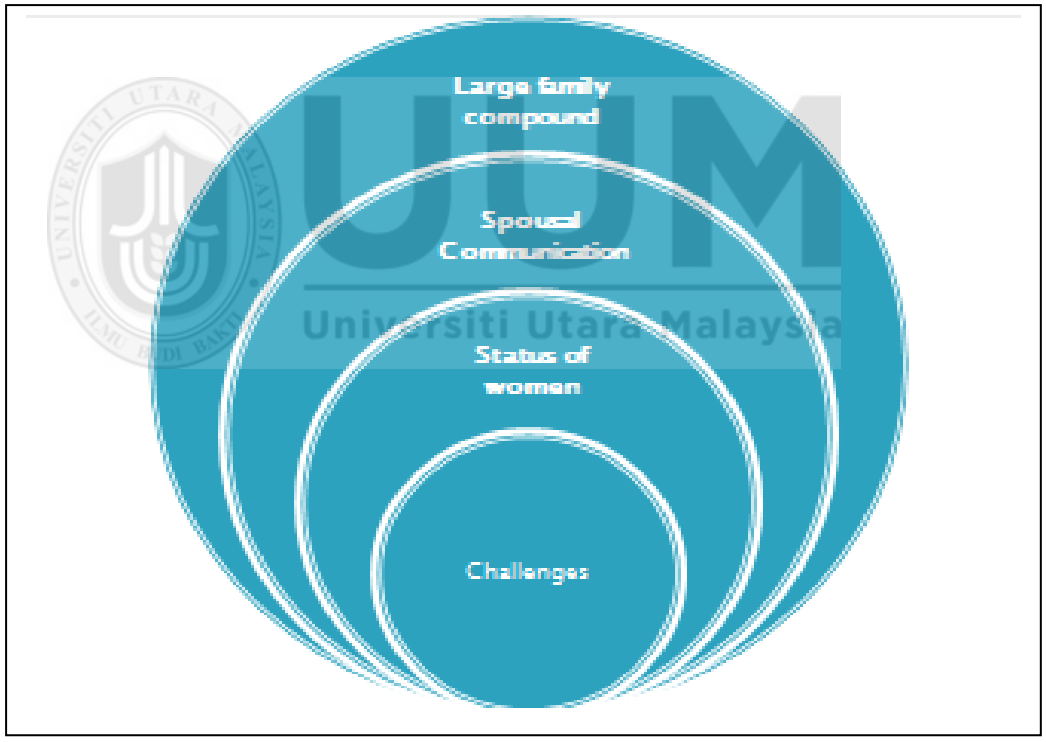

Figure 4.5. Challenges faced by women in participating in RDHM

a) The status of women

b) Spousal communication

c) Large family compound

4.9.1 Status of Women

The status of women in a patriarchal society determines to a large extent the privileges they enjoy, it shows whether they can take RH decisions or be part of the decision-making process. The in-depth interview conducted with seven married women from the study area and is reported below revealed that:

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> As house wife's we have no will of our own on any matter, to some extent we are allowed to take decisions and implement them without recourse to our husbands but these are everyday decisions that our husbands cannot be bothered with, decisions such as what to cook, which child should be involved in what kind of work and personal purchases such as body cream, clothing, jewelry and so on. But when major decisions are to be made like traveling or deciding not to have sex with your husband or not to have children even our husbands don't take such decisions. If he is to marry a second wife the best we expect is to be informed in reasonable time but if he doesn't there is very little that we can do about that.

A second IDI with eight women from the study area reported revealed that:

Ajo, Aja, Iko, Ika, Ele, Alu, Ala and Ummi:

> Decision-making in the house can be divided into two viz major decisions and minor decisions, women do and most times take those decisions that men cannot be bothered with, as regards major decisions we do not even discuss them we have never sat down to plan whether or not to have children, when a women is pregnant it is seen as a blessing, men if they have such plans it is in their minds we do not discuss them unless there is a problem and all are involved in the search for solutions to the problem, like when a married woman is not pregnant within the first 2 years it is quietly a source of concern for the immediate family but as times goes on it becomes a matter of concern for the entire family including both parents of the husband and wife's and all parties are involved in planning and deciding the next line of action, that is how decisions are mostly taken.

The views of another set of married women in their matrimonial home reports that:

Ugwa, Rabi, Rama, Rabe and Robo:

> There is no formal decision taking procedure in our family, decisions are taken depending on the issues at stake and the seriousness attached to it, that it warrants taking note of who is involved in the taking of decision in the family. If it is serious then all members of the family will be involved, issues like divorce is handled by all not just the husband and wife but since wives are fully aware of their reproductive duties and they perform them very rarely do people sit down to decide about that, but if for any reason a wife refuses to have sex with her husband and he is concerned enough to report it then it is a family matter, and her own people and the husbands people will be involved in resolving the problem and she had better have a very good reason, if not she is looking at serious sanctions.

4.9.2 Spousal Communication

The culture of marrying at early age is an age old practice in almost all parts of the nation, particularly among the female population, this practice is prevalent in the study area and one of its obvious implication is that of low level of communication between the couples, it is posited that the wider the age gap the smaller and of less quality the communication, this therefore has a tendency to impact negatively on couple communication generally and on reproductive health communication particularly. The extent of this spousal communication gap is attested to in the following IDI and FGD, the level of communication between couples was revealed by five respondents during in-depth interview to be low, sometimes very low and it is presented below:-

Ugwa, Rabi, Rama, Rabe and Robo:

> Most times our husbands are like our senior brothers friends or in some cases our father's friends, so the respect we give to our senior brothers and fathers are what we give them, there is hardly any conversation aside greetings and because there are other wives the

> privacy that will force conversation is not there. The only time you are alone with him is when it is your turn to spend the night with him and the time he comes to your room or you go to his room depending on the arrangement is when its sleep time and little or no time is spent for conversation so even after 4 to 5 years of marriage in some situation you are still literarily speaking strangers.

Other informant's opinion on spousal communication with married women from the study area is reported below:

Ajo, Aja, Iko, Ika, Ele, Alu, Ala, and Ummi:

> Communication mostly is carried on with the senior wives who to us are like our own mothers since they have children whose age difference with us is not very wide; we also believe that they know more than we know on all matters especially on reproductive health matters. We are therefore likely to ask them questions about whatever confusion we have rather our husbands and they are more readily accessible to us than our husbands.

Finally a third interview with seven married women from the study area is reported below:

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> Our husbands are far more knowledgeable than us, we can only seek their views on things that we do not know and reproductive health particularly issues of sex and sexuality we feel very shy to raise such issues with them we will rather raise them with our age mates. There is very little ground for communication between us and our husbands there are always people around and we cannot initiate the conversation if it is just the two of you then there is room for conversation but when you are always surrounded with people reproductive health issues cannot be a topic of discussion.

To have an all-round view of the opinion especially from the socio-cultural point of view the researcher also conducted FGD with opinion leaders in the community female and their responses are reported verbatim below:

FGD with women married from the study revealed that:

> Usually amongst the people of Ankpa we allow our daughters to marry early and we encourage them to marry people who are older because they are more matured to manage the temperaments of young girls if the two of them are of the same age there will be no respect and tolerance between them. Yes they may have communication issues because as little girls they need to know so many things which they may not be able to ask their husbands but they can ask their co-wife's, as they grow older in their husbands houses they can get used to themselves enough to feel free to discuss any issue with their husbands, in the first few years it can be very trying but the traditional system has other measures that will cushion the effect of that communication gap it is filled in by other wife's or members of the extended family who are always around.

While FGD with married women from the study area acting as informants for the study revealed that:

Sa'a, Saba, Sabo, Sada, and Sama:

> Early marriage has been part our life for as long as we can remember and it is to the betterment of the girl in particular and the society in general as it reduces promiscuity and promotes long lasting marital relationships. When girls have experience of sexual liaison before marriage the implications are dangerous for the girl and the society but if she gets married early the possibility of extra marital relationship is greatly reduced and the chances are that as she grows older she may not be able to get a husband with younger girls coming out every day.

4.9.3 Large Family Compound

Most times in traditional patriarchal societies particularly in Africa the groom lives in his family compound in out-houses but within a family compound, it is to this family

compound that the new bride is brought sometimes into the compound of the most senior relative not into her husband's house. In this traditional setting, life is lived in a communal setting and there is very little privacy between couples.

The women usually eat together and the men in the same way eat together and share every other fact of life, in such a setting if the wife for example was not a virgin at marriage it will be a topic of serious family discussion because virginity for a young girl at the time of marriage is a source of pride for all, the girl, her family and the husband but in the same way a young man is expected to have had some sexual experience before marriage.

The interview question for this sub-theme sought to find out the relationship between this living arrangement and couple communication especially on RHDM, the responses of eight women informants are presented below:

Ajo, Aja, Iko, Ika, Ele, Alu, Ala, and Ummi:

> In our compound we the women discuss all issues including sex and social relations surrounding married life and that is how we the younger ones learn certain things that we didn't know before marriage from older members of our husbands families in this situation we learn how other wife(s) talk to their husbands and at what time that such communications takes place.

Below is presented excerpts of interviews with seven married women from the study area:

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> Living in the midst of too many people makes conversation difficult especially very personal communication issues and isolating your husband to have a discussion can sometimes be difficult he is either with relatives or friends and you are either with other wife's who are your seniors in marriage and age or you are busy and the nights are shared between all the wives so you may not see him unless it's

> your turn for him to spend the night with you with the expectation of having waited for your turn it may not be possible to discuss other issue, the presence of too many people can and do affect communication and it's not conducive for reproductive health communication at all.

A third interview with eight married women from the study area is presented below:

Ajo, Aja, Iko, Ika, Ele, Alu, Ala, and Ummi:

> It not very pleasant to be living with people especially people you don't know and joined by marriage alone and the competition that comes from sharing the same man makes everyone secretive to some extent, but if it is a serious issue you will have to track him down and tell him your problem but generally it is not encouraging for reproductive health communication at all.

4.10 Participation in Decision-Making and Vulnerability to STIs and HIV & AIDS

The presence of legal and institutional programs and procedures guaranteeing women's access to maternal and reproductive healthcare has ensured that women, the world over and particularly Africa are still victims of marginalization in decision-making over their own bodies, this increases their susceptibility to a wide range of unpleasant situations, amongst which are poverty, lack of power and the risk of STIs and HIV & AIDS, malaria, tuberculosis and other diseases that poverty aggravates are granted legal and institutional provision that should safe guard them against the vagaries of vulnerability that could lead to HIV & AIDS.

To understand vulnerability, we must employ gender analytical frameworks to explain the cause of a variety of emotional, physical and psychological damage to women, injuries such as; disability, depression, health issues; panic or fear; and low self-

esteem lack of which makes women, whether in marital relations or outside marriage vulnerable to STIs & HIV needs to be understood within the existential circumstance of women in the study area.

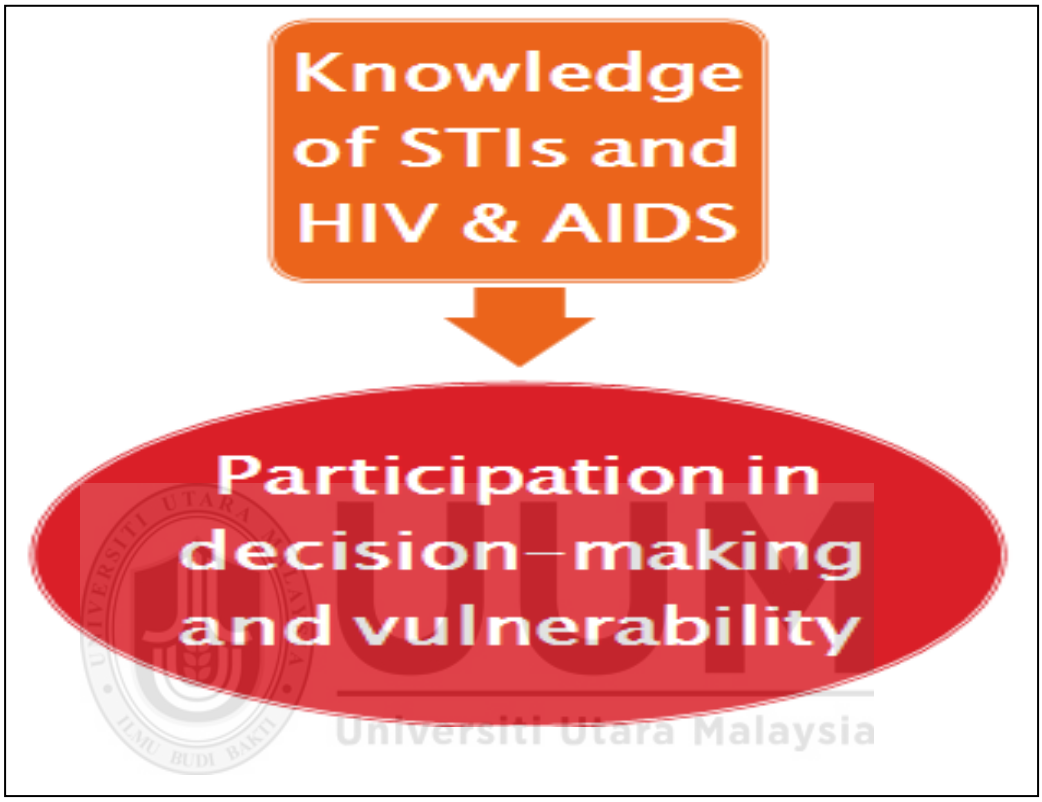

Figure 4.6. Knowledge of RHDM & Vulnerability to RDHM

4.10.1 Knowledge of STIs and HIV & AIDS

The knowledge level of women in the study area with respect to STIs and HIV & AIDS was tested through their answers to IDI questions to see how it affected decision-making with respect to RHDM and their responses are presented below. The following informants revealed that:

Ajo, Aja, Iko, Ika, Ele, Alu, Ala, and Ummi:

> We do not know anything about sexually transmitted infections other than gonorrhea and as far as we are concerned it is an infection synonymous with unmarried men, in the same way we can't remember knowing any women who have ever contracted it. Since our husbands have multiple wives, we have never expected that he will even contract gonorrhea let alone infect us with it as far as we are concerned he is having sex with only us, his wives. There is no protection that we know we should take to protect ourselves from being infected. The thought of refusing to have sex with him will generate so much trouble with their people and we are not interested or are afraid of the consequences of the action or the reaction of our people and their people on that matter, what will we say is our reason, and whether we like it or not if they want to have sex with us they will go ahead and have their way.

Other respondents informed on the use of condom or contraceptives have this to say:

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> None us has not seen condoms before but have heard of a rubber that can prevent pregnancy and that is not for us married women, since we have not seen it knowing the difference between male and female condoms is not possible or pills of any kind what we know of pills is that if one were to take pills and get used to them when you want to become pregnant it will no longer be possible. Our husbands have not talked about either pills or condoms and not brought it home either, if they bring them home and want us to use them we will use them, they know we do not disobey them but we can't initiate the discussion about that.

On knowledge of STIs and HIV & AIDS the views of married women in the study area this is presented below below:

Ugwa, Rabi, Rama, Rabe and Robo:

> The role of men in our lives are such that we are controlled by them our life is influenced by the men in our life's the extent of the influence is dependent on the man. Our health is influenced by the attitude of the man in our life; the sexual life of the man can have negative impact on the life of his wife.

The views of married women in the study area are presented below:

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> Where we can neither ask our husband to use condom even when we know that our husband have extra marital relationship or has other wives, despite the fact that we can't even pretend to oppose the relationship, we also can't insist on refusing to have sex with him without condoms nor can we divorce him on that basis instead he threatens us with divorce and he enjoys the support and protection of the society.

The researcher sought to know how the role of men can affect women and their reproductive health their responses are presented below.

Ajo, Aja, Iko, Ika, Ele, Alu, Ala, and Ummi:

> Discussing (contraceptive use) that with our husband's is not possible first they will rebuke us on being suspicious about their actions and that what they do is not our business and (2) they will be concerned with what will happen should the other wife or his friends find out the source of their using contraceptives is their wife, and (3) it also present another problem, does he use it with one wife only or with his other wife, we all perceive contraceptives as primarily for the prevention of pregnancy and so that angle will affect his opposition to the use of condoms, part of the argument is that currently he does not have an infection and so what is our fear if we do not have a hidden agenda.

Other respondents from the study area also responded and their responses are presented verbatim below.

Adi, Ayi, Ani, Ada, Awa, Abe and Ako:

> Each time we bring up the topic of the extra marital affair for discussion it always leads to quarrel and relatives accuse us of being jealous, for now we don't want to be seen as troublesome/meddlesome wife's a description most of us are not comfortable with or do not like and rather than being perceived as looking for trouble all the time we will rather endure the situation to the detriment of our health. In this situation there are so many things you follow as has always been done either because we don't know

> any other way or because at least no women that we know has entered into trouble because of the husband sleeping with another women.

The role women play in household decision-making affects and are affected by gender considerations, particularly the power relations in the house this in turn is a creation of gender issues which operates in a patriarchal society where role delineation dictate who does what, when and how.

4.11 Summary of findings

Form the discussion so far, the findings from the research can be summarized as follow:

That women do not contribute to RHDM as a result of their lack of a comprehensive knowledge of the benefits enthused in the ICPD declaration and the advantages contained therein and even when they display some knowledge it is myopic, limited only to pregnancy and childbearing.

Gender occasioned role delineation presents the as a breadwinner and provider for the women, that in the study area even where a woman has a source of income she still sees it as her husband's responsibility to provide for every need and as is "to whom a lot is a lot is expected in return" and he who pays the piper dictates the tune. It is therefore commensurately expected that every wish of the husband ia law to the woman.

When women marry early to husbands who are older and possibly involved in other marital relationship the new is often times a novice when it comes to RHDM and as

such whatever the husbands tell is what she believes and that is exactly one of the findings of the study.

Culturally dictated polygamous marriage occasioned by wide spousal age gaps places the young bride at a disadvantaged position from which she has little knowledge RHDM and the power relationship in the home does not favour her with contributing or participating to RHDM

That women are disadvantaged more where they are expected to feel safest in their husbands homes, as a result of their lack of empowerment, it is expected of them to move straight from their fathers houses to their husbands houses, from this background what makes women vulnerable is their dependence on others

Finally, as a result of all these women are therefore vulnerable to STIs and HIV & AIDS because of the sexual habits of multiple sexual partnering husbands and their lack of knowledge of RH.

4.12 Summary

Effort has been to analyze data that was collected in the previous chapter, the data was analyzed alongside the themes and subthemes and in line with the research questions to see the extent each of the research questions was answered through triangulation which is the interplay between content analysis, IDI and FGD. The literature reviewed to a very large extent when analyzed and compared with data analyzed led to answering each of the research questions. A total of 50 IDI's and 22 FGD'S were conducted and the level of participation of the respondents and discussant were richly rewarding as the research questions and the objectives of the study were clearly

brought to light. The interplay between themes and themes through interaction of selected variables was made especially when some subthemes are cross cutting acting on more than one theme.

4.13 Conclusions

Though no specific research question addressed women's vulnerability to STIs and HIV & AIDS, through the content analysis of the very rich literature gathered and the respondents views during the IDI and FGD discussants it became crystal clear that married women were vulnerable to STIs and HIV & AIDS as the data was analyzed it became manifest that they exercise little or no control over their sexuality and the fact that their husbands live in active multiple sexual partnering automatically puts the women at risk, what is even more worrisome is their own risk perception of their HIV status and their health seeking behavior which on the bases of their lack knowledge about their status is compromised, added to this is seclusion and poverty. Women's control over a given aspect of their live such as household domestic decision making for example does not need to overlap with control for example over her ability to make family contraception decision or decision involving family account, this as much explains the multidimensionality of women's control with regards to family decision-making.

Following the completion of the analysis the discussion, implication and recommendation will follow in the next chapter.

CHAPTER FIVE

DISCUSSION, IMPLICATIONS AND COMMENDATIONS

5.1 Introduction

This chapter explains the findings on the role of Muslim women in reproductive health decision-making and its implication for STIs and HIV & AIDS of the respondents and attempts to answer the questions on the respondents' role in the decision-making process in their homes and their contribution or lack of contribution to the decision-making process in their homes which makes them vulnerable or otherwise to STIs and HIV & AIDS.

The chapter began by attempting to establish a linkage between respondents understanding of the concept of reproductive health and how that knowledge or lack of it informs their contribution or otherwise to reproductive health decision-making or not in their matrimonial homes and if the role they play affects their vulnerability or otherwise to STIs and HIV & AIDS, the findings linked respondents roles to the extent to which the findings concur or is contrary to the literature reviewed in the preceding chapter.

From the reviewed literature, a variety of themes and sub-themes were identified that corresponds or is contrary to the literature reviewed. This informs the linkage of contribution to decision-making by women with vulnerability to STIs and HIV & AIDS at the beginning of this chapter. This enabled the researcher establish a link between decision-making by women and vulnerability to STIs and HIV & AIDS and also enables the reader to understand that a linkage exist between whether women

contribute to decisions about their reproductive health or not and if it has a direct correlation with their health status with respect to sexually transmitted infections and HIV & AIDS.

The factors that affect the contribution of women to RHDM are presented to show how issues such as gender, culture, socialization process and religion affects the role women play in the decision-making process in their homes. Closely following the discussion on the factors, the sub-themes of poverty, power relations in the homes, spousal age gap, spousal communication, the status of women, large size compound, women empowerment and the role of the extended family in affecting and/or controlling the participation of women in RHDM is discussed, finally, whether a link exists between these themes and sub-themes and the respondents vulnerability to STIs and HIV & AIDS was discussed.

Finally, the chapter looks at what knowledge the respondents have of STIs and HIV & AIDS how this affects their vulnerability to STIs and HIV & AIDS and thus dictates their contribution or otherwise to RHDM. This chapter is organized in such a way that it presents answers to the various research question crafted for the study as it enables the researcher present the findings in a logical and chronological manner to the reader.

5.2 Extent of Involvement of Women's in RHDM and Vulnerability to STIs and HIV & AIDS

The theme participation of women in RHDM is impacted greatly by the role of the subthemes discussed under the theme, therefore discussing these subthemes are a necessary condition for understanding the factors that influence the participation of women in RHDM, the sub-themes are; knowledge of the concept of reproductive

health reproductive right, participation in RHDM by women, the role of power and authority as a predicate to participation in RHDM and spousal age gaps in marriage as a necessary condition affecting participation in RHDM of women in the study area.

5.2.1 Knowledge of Reproductive Health by Women as a basis for Participation in Reproductive Health Decision-Making in Their Homes

The Population Council in a study in (2007) reported that when girls marry at a young age they have little or no knowledge of reproductive health including lack of knowledge on reproductive health including STIs and HIV& AIDS (The Population Council & IGWG, 2007)

For women to participate in RHDM implies that the woman must have a sound knowledge of the concept of reproductive health, it is this knowledge or lack of it that will inform her decision to play an active role in the RHDM, her participation or lack of participation will therefore be consequent upon her knowledge or the quality of information available to her on reproductive health and reproductive health rights as ratified by various protocols and agreement to which Nigeria is signatory to.

The definition of Reproductive Health (RH) and Reproductive Health Rights (RHR) as given in the 1994 ICPD in Cairo Egypt and reaffirmed by the Beijing Conference 1995, forms the landmark of any attempt to measure knowledge and compliance to the practice and enjoyment of RH and RHR in any country that has signed and ratified the convention (UNAIDS, 2012; UNFPA, 2011). Nigeria having signed and ratified these treaties has agreed that compliance with the set standard shall be guaranteed all her citizens.

The definition suggest that spouses can enjoy a more fulfilling life and exercise their right to procreate as well as enjoy safe sex, implying that they are free to decide on their own what method of contraception and when to use such contraception without fear or coercion. In the same way they are at liberty to decide who to copulate with, at what time and in what manner. They shall have access to the information and resources needed to plan and regulate their fertility according to their choice and within the limit of the law (WHO, 2012).

The IDI and FGD when triangulated with the content analysis revealed respondent's lack of knowledge of RH and RHR, the IDI showed the respondents knowledge of RH is limited to sex, pregnancy and delivery, this is far too narrow and myopic compared to the ideals enunciated in the ICPD and Beijing declaration as reported by UNAIDS & UNFPA in 2011 and 2012 respectively.

In line with the research design which is intended to elicit and provide as much information as possible from informants to allow a reasonable ground for any opinion reached as much as possible on each of the themes and sub-themes an FGD was conducted and the excerpts from the with men and women on the theme are also in agreement with the IDI, and literature reviewed which when put together enabled the researcher to conclude that married women in the study area had very little knowledge of their reproductive health, on the basis of which the first research question was considered answered by the researcher.

From the interview excerpts presented in chapter 4 it is clear that a very narrow understanding of reproductive health is held by the informants of the concept of reproductive health as propounded by the ICPD and the Beijing conference on women

in 1994 and 1995 respectively. From this narrow view of reproductive health as demonstrated by the respondents it becomes clear that the advantages derivable from a sound understanding of the concept of reproductive health will be difficult to be achieved from such a background (NACA, 2007).

Advantages such as the realization of the fundamental human right of a woman that can be achieved through the realization of her sexual right, coined as reproductive health rights of woman which allows her decide responsibly who to have sex with, when and how the sexual activity should be carried out. What is implied in the definition is a choice freely made by the woman in deciding to have sex not as an obligation nor as a duty but that she should decide freely on her own without coercion, fear or favor on whether or not to have sex (NDHS, 2003).

Implied in this RH and RHR is her right to decide on whether or not to have children with respect to which she can choose on her own on the basis of available information what contraceptives to use that will enable her have children when she wants to or delay having children until she is ready to have them.

From the excerpts in chapter 4 it is abundantly clear that informants perception of RH is not only limited but narrow and the available information that will provide them an opportunity to understand their reproductive health rights is lacking and that lack of knowledge affects and directs their reproductive activities, it will be very difficult on the basis of the above for the informants to contribute to reproductive health decision-making.

Bandura's SCT, aided by Ajzen, and Ajzen and Fishbains TBA and TRA respectively gave credence to the conclusion that knowledge was necessary for action (SCT),

expected reward was the bases of (TPB) and (TRA) based all actions of human beings including married women who are therefore not exempt as they would contribute to RHDM in their homes if they knew what they stood to benefit therefrom (WHO, 2005).

5.2.2 Participation of Women in RHDM in Their Homes

One of the key findings of a Joint Mid-term Review (JMTR) of the implementation of NSF I in 2007 was the lack of institutionalization of gender as a critical issue of interest in the HIV & AIDS response. It was argued that some of the gender-related goals, objectives, and strategies in NSF I was highly ambitious and not feasible within Nigeria's patriarchal context without first overhauling the existing gender structure (NACA 2012).

The tendency to perceive RH to mean women's health has led to a myopic, clinically focused and limited attention to the delivery and access to health of the RH programs. It is a known fact that the social relationships entered into between men and women before sexual relationship begins goes a long way to affect people's ability to manage and organize their sexual and reproductive lives, with consequences for their health, and a host of other choices in life (NACA, 2012).

As a result of the narrow and myopic understanding of the concept of RH manifested by respondents, participation in decision-making on RH was limited to decisions concerning having sex, having children, and/or planning to either have children, number of children to have, sex of children and finally decision concerning polygyny and monogamy.

Following the realization of the fact that men and women's understanding of the concept of women's RH and by implication the enjoyment of their RHR is narrow, limited, shaped by gender concerns and clothe in cultural garb which affects their participation in decision-making about their reproductive life, the theme of RHDM was further explored through the sub-theme of participation in RHDM.

FGD with both male and female respondents on this sub-theme did not defer much or in any significant way from the IDI and the content analysis. It was manifestly clear that the culture of the people in Ankpa does not expect women to participate in decision-making in any way and so they were not prepared for that aspect of their life during their socialization process, instead women have been socialized to be obedient to the point of subservience; they accept everything and do not question anything. The gendered social relation crafted by the society is so strong that even if one woman wants to act differently she will be checked by all including members of her own family for wanting to act in such a way that will bring shame to their family.

Societal constructs of masculinity and femininity impact the ability of different sub-groups of girls/women when they enter into marital relationships (UNAIDS, 2012). This entrenched gender division of role and labor is so strongly institutionalized that religion and nature is employed in a bid to trace the ancestral origin of the superiority of "MAN to WOMAN" to God as was substantiated in Judeo-Christian and Islamic texts (NACA, 2012).

In a situation of male authority as is typical of all patriarchal societies including the study area where gendered role delineation and division of labor dictate relationships and patterns of life each sex has its role cut out for it, such societies also clearly map

sex roles and frown seriously at deviation from the accepted status quo, it employs all efforts possible to maintain role clarification clearly and all manners of sanctions are employed to enforce compliance.

Sanctions could be in the form of excommunication, fine or avoidance depending on the level of sophistication of the society. This contributes to higher level of discrimination amongst married women in a continent where culture is a significant factor in female access to RHDM (Taiwo et al, 2007).

That men play a central role in RH cannot be overemphasized and the need for male involvement is important if the enshrined rights within and beyond the health sector are to be achieved. The possibility of meeting the woman-centered MDG goals 3 (promoting gender equality and empowering women) and 4 and 5 (improved child and maternal health) these goals are not only mutually reinforcing they cannot be achieved independently (UNAIDS, 2007).

So far as is noticed in the study area respondents displayed a very narrow understanding of RH and RHR and from this background participation in decision-making cannot be possible, culture and gender have been discussed in different academic programs but the issue of knowledge of RH and RHR of women by women and men was always left, and was shown in this study as a necessary prerequisite for action (NDHS, 2008; NACA, 2012).

5.2.3 Power and Authority in the Homes as Basis for Participation in Reproductive Health Decision-Making

Different protocols, agreements and assurances exist by regional and world bodies towards putting in place legal and institutional programs and procedures guaranteeing

women's equal access to maternal and reproductive healthcare, women, the world over and particularly in Africa are still victims of marginalization in power relations in the places where they should enjoy the safety and security they need to enable them realize the benefits enshrined in the ICPD declaration on RH and RHR, ironically that is where they are discriminated against in decision-making over their own bodies the most because of their lack power (Taiwo, Olushayi & Adewole 2007; UNAIDS, 2012).

The study tended to agree with responses by the population under study on the place of power and authority in the home and the role of the woman in patriarchal societies where the woman's only form of social mobility is "to move straight from their fathers house to their husbands house", they are encouraged to depend completely on their husbands resources, having no resources of their own, they cannot but strive at great personal expense to do whatever pleases their husbands.

It is also important to acknowledge the place of economic empowerment and independence and that lacking these increases women's susceptibility to a wide range of unpleasant situations, amongst which are poverty, lack of power and the risk of STIs and HIV and AIDS, malaria, tuberculosis and other diseases that poverty aggravates, this much was stressed at all these international fora (UNAIDS, 2012).

For women in the study area to contribute to RHDM therefore their level of dependence must be changed for the better, education, skill acquisition and other forms of personal development must be brought to them, as this will enhance their capacity for self-appraisal and their level of consciousness must under-go a radical re-orientation. The FGD and IDI all agree with literature on empowerment and changing

the world view of women and moving them out of poverty, some of the respondents (Awa, Ajo, Aja & Ayi) did agree that women with some form of economic activity outside their homes contribute in some ways to RHDM in their own homes.

5.2.4 Spousal Age Gap at Marriage and participation of women in RHDM

The spousal age difference between men and women at the time of first marriage creates a problem for women in their bid to contribute to RHDM process, as wives who are considerably younger see their husbands who are considerably older as embodiments of knowledge and wisdom and tend to believe and accept whatever comes from their husbands without any input to RHDM even though they are wholly involved in the reproduction process (NACA, 2012).

That men dominate all aspect of life and this dominance is aided by the people's culture and tradition according to (NDHS 2008) means that women's role in RHDM is seldom on matters affecting them. FGD and IDI with respondents tended agree on the fact that when women marry early as they do in the study area, they are likely not going to participate in any form of decision-making in the homes as the girl-or child-wife has little or no knowledge on RH and RHR. She is also lacking on life skills generally needed to survive in the world as she has no education or survival skill, she comes to rely completely on the opinion of her husband and husbands' relatives on all issues.

The lesson inherent in the traditional education system is that it does not address the social aspect of reproductive life that precedes child birth. This is owing to the fact that the societal understanding of RH is limited to issues surrounding conception and delivery only. Had the society appreciated the importance of an all-round

development of the RH system perhaps its approach to reproductive health education would have been different and more holistic than it is at present.

The information gathered from respondents through IDI and FGD tended to agree with reviewed literature that when girls marry at early age they have little or no knowledge of RH or RHR and as such they cannot make any significant contribution to RHDM as concerns themselves thereby making them vulnerable to so many negative issues such as high maternal mortality and morbidity and particularly STIs and HIV & AIDS.

Conclusively therefore the researcher can make bold to say that participation is a function of knowledge to this fact reviewed literature is in agreement with IDI and FGD and this can be tied to Bandura's SCT as it posits that had the people of Ankpa represented by the informants who participated as informants for this study would have participated in RHDM if they had a clear understanding of RHDM, this conclusion is supported by the three theories reviewed for this study which agreed with the ideas enunciated in the ICPD and for the sake of those ideals married women in the study area would have participated in RHDM (Yusuf, 2001).

The researcher can again safely conclude that the second research question has been answered, that married women in Ankpa do not contribute to RHDM.

5.3 Women's Involvement in the RHDM That Translates to Action

In societies where constraint on women's physical mobility exist women's ability to make independent decisions are further hampered as was shown by IDI and supported by content analysis, for women in countries such as India, Egypt, Bangladesh and some parts of Nigeria these constraint do exist in different ways and to different

degrees, they have difficulty making independent decisions, women in these societies are governed by societal norms and values that determine their dress pattern (vailing) and curtail their physical mobility, described as female seclusion (Kabeer, 2001, Yusuf 2001).

Findings by (Kishor, 2000; Kritz et al., 2000) shows that 50 % of women do not exercise either the power or the will to seek medical care for their ill children without the approval of their husband or parent-in-law, and 70 % cannot also take decisions on their own on simple domestic chores such as the purchase of household materials and personal or children's clothing.

These results are almost same all over societies where physical restraint in the form of seclusion or unaccompanied mobility is denied women. Thus, from the foregoing, the competence level needed by women to engage in making decisions regarding health seeking ability, personal expenditure and consumption may be lacking in women or they may need to obtain informed consent and permission from some other authority figure before carrying out these transactions (Kabeer, 2001; Yusuf, 2001).

Following land mark development in the 1994 ICPD, the international community has come to fully acknowledge the existence of gender disparities the world over and have come to link the enjoyment of RH and RHR as a human right that must be addressed urgently if men and women are to enjoy a more fruitful reproductive life and as couples share in decision-making (Speizer, Whittle & Carter, 2005).

The understanding that gender based power inequalities have a profound effect on RH by hindering communication between spouses about RHDM by couples, preventing the attainment of sexual pleasure could thereby increasing their vulnerability to STIs

and HIV & AIDS has been attested to by scholars (population council & IGWG, 2001; Speizer, et al, 2005).

That gender inequality is a key element in participation in RHDM by women has been shown in a number of research, Blanc (2001) observed that when spouses cannot come to terms on whether or not to conceive a baby or use contraception in a situation of male authority, men's opinion on the issue will definitely predominate women's opinion even though women will have to bear the burden of the decision and run a number of life threatening risks such as HIV & AIDS and other STIs.

The review of literature in chapter 2 pointed to two facts, one that women the world over including the study area are impacted negatively by gender role delineation and expectation which constrains their physical and psychological functioning and secondly owing to that fact women even if they want to cannot on their own take decision about their RH nor can they act independently without taking permission from some higher authority, to what extent therefore do women in the study area participate in decision-making, FGD and IDI agrees wholly with reviewed literature that women do not contribute significantly to decision-making in their homes at all except on matters in which their husbands allow them (Bankole, 2000; Blanc, 2001; & Basu, 2005), these matters are issues like household purchases, what to cook and if children can take siesta before doing their homework, important decisions are taken by the husbands, sometimes the woman is the first to know and to even inform others.

Women therefore can be defined as passive recipients of decisions reached by men; the implication of this passivity is that the woman is therefore vulnerable in so many ways especially in patriarchal societies where constraints of masculinity allows the

man to have extra marital relations, the effect of which may impact negatively on her RH.

Thus, from the foregoing, the competence level needed by women to engage in making decisions regarding health seeking ability, personal expenditure and consumption may be lacking in women or they may need to obtain informed consent and permission from some other authority figure before carrying out these transactions (Kabeer, 2001; Yusuf, 2001).

5.4 Challenges Faced Women in Participating in RHDM within the Family-Decision Making Process

The environment needed for women's participation in RHDM must first and foremost arise from an empowered position so that women are equipped with the necessary skill for a rewarding engagement in family decision making. Empowerment is defined as encompassing a two-way dimension seen as a process, a dynamic construction of identity, at the individual and collective level (Action AID, Romano, 2002; Charliers, 2006). The definitions of empowerment given above goes to show that when women have the means to and act independent of others believing in themselves and their abilities to take decision and follow it through we can say they are empowered.

The place of power relation in the home led Atol (2002) to define empowerment as the process through which "power" can be acquired by people acting in their individual and collective capacity, among individuals or a community, it designates first and foremost the ability to act independently, but that when power has been acquired the means needed for the exercise of that power must also be inherent in the acquired power Sophie and Lissette (2007).

The multi-locational and multidimensional nature of women's power has almost been universally acknowledged, thus for example any discussion about women acquiring greater control over their lives should specify clearly the location of this power, if it is within the family, the community/social or economic/political spheres and if the control point is within the family or within a group level outside the family level (Quisumbing, 2003; WDR, 2012; Kabeer, 2003; Dwyer & Bruce, 1988).

Women's control over a given aspect of their life such as household domestic decision making for example does not need to overlap with their control for example over their ability to make family contraception decision, or decision involving family account, this as much explains the multidimensionality of women's control with regards to family decision-making (Kabeer, 2003).

Since the degree of women's control over and above their life is a function of entirely different factors it becomes imperative to specify the particular aspect of power under consideration, rather than continue to envision empowerment in a broad sense, the focus must therefore be on the determinants of each of these aspects, if we must understand the gendered power dynamics of the two dimensions within the domestic sphere: decision concerning money and finance and those concerning family and social relations (Kabeer,2003).

As societies modernize, and women access education they are exposed to ideologies which emphasize independence from the extended family and egalitarian conjugal relationship that women are exposed to, with new paid work outside the home it leads to women's freedom from secondary position at home as they are encapsulated in modern labor economics (Kritz, et al, 2003).

Many gender literature disagree with modernization theory over the assumption that socio-economic development provides women with opportunities for better education and employment outside the home Kabeer, (2001), Yusuf, (2001) have argued that revolution and modern capital accumulation have displaced and reduced women's productive activities opining that for emancipation of women to take place they must have access to productive sources as a basis of power (Sen, 2008).

There are at least two potential problems in applying this model to gender relations in non-Western settings. First, the link between resources and gender roles that stress power and freedom needed by women to compete and gain access to education and therefore employment must be guaranteed if any reasonable impact is to be made by women. Recent research on gender in developing countries, however, suggests that women's ability to take over the structures in the society that hold women down cannot be gotten by their acting independently stressing cooperation and collaboration (Isvan, 1991; Kishor, 1995).

Depending on the acceptability and preferences in a given society regarding conflict resolution, confrontation, and unilateral decisions, women's autonomy may or may not be equitable with empowerment. Second, while the productive sphere in other societies may be as relevant to domestic relations as it has been in the industrialized West, this is not necessarily the case, especially if other bases of gender stratification, such as reproductive, sexual, or familial control, are deeply entrenched (Sen, 2008).

Other bases of gender stratification such as reproductive, sexual or familial control are entrenched in societies in the developing countries compared to industrialized western societies to that extent constraints imposed on women in domestic decisions

by the larger society or social context are deep enough to make personal accumulation of resources irrelevant in its bid to empower women (Kishor, 1995).

5.4.1 The Role of Gender in Shaping the Process of Decision-making on RH amongst couples

The extent to which respondents' existential circumstances agree with existing literature is confirmed in the excerpts of IDI and FGD with members of the population under study, which is in agreement with FGD and reviewed literature and shows the influence of a gendered society on every aspect of life of the people including the men, for the position and actions carried out by men are construct dictated by gender consideration in the society.

It is clear from this interview that reviewed, literature and opinions of members of the society under study as revealed by FGD and IDI which tended to agree that the woman and the man are not created equal and cannot be therefore treated equal, nature did not intend it that way neither did religion ordain it that way, each gender is created for specific purposes and to that extent they are endowed and socialized differently for the realization of the roles each has to play and that is why sex roles are different from gender roles (Mernissi, 1996; Safilos-Roschild, 1992).

But far and large traditional or patriarchal societies have still not made a difference between gender roles and sex roles and have continued to see a man and a woman in that sex differentials and not understanding that there is more to gender than sex differentials in the life of both men and women (Isiugo-Abanihe & Uche, 2003; Kabeer, 2001) and (Yusuf, 2001).

In the society under study, studies have not clearly established how sex differentials affect gender consideration, as research has shown there are sex roles and to that extent the role of a man is different from the role of a woman. Sex roles as are ordained by nature, are permanent and fixed, and are the same everywhere, they are not society specific an example is women get pregnant deliver and breastfeed their babies, these are sex roles and they are the same the world over (Isiugo-Abanihe & Uche, 2003).

Whereas gender roles are not permanent and are culture specific and can change over time. To this extent the researcher established that in the society understudy this difference must be made clear so that progress can be made in addressing gender concerns in development programs for example decision-making is not a sex role it is a gender role which implies that both men and women can take decisions if they are socialized to do so (Kabeer, 2001, Yusuf 2001).

Finally, from this gendered role delineation process aimed at discriminating against women, it is clear that women in Ankpa are not able to make a significant contribution to RHDM and so are vulnerable to STIs and HIV & AIDS (Kabeer, 2001, Yusuf 2001). Gender dynamics as opined by Isiugo-Abanihe and Uche (2003) is a sex-role differential, which explains the differences in the roles of men and women. Decision making within the family is influenced by several social, cultural and economic factors, some of which vary over time and space.

5.4.2 Poverty of Women in Their Matrimonial Homes and Their Contribution to RHDM

Several studies have linked poverty and the lack of autonomy by women in sexual relationships occasioned by the lack of empowerment of girls marrying at very young

age to their inability to take or contribute to decisions concerning their RH to vulnerability to STIs and HIV & AIDS in both developed and developing countries (Bureau of Global Health, 2003; Catholic Agency for Overseas Development, 2003).

Women in Nigeria and indeed the study area lag behind in family decision making due to the level of poverty in the social and economic livelihood of women, this has been suggested as affecting their role in RHDM in the region (APHRC 2009). A large number of women in the area live most of their lives in social seclusion, depending on their husbands wholly for sustenance. Yusuf (2001) suggests that this habit impacts negatively on their ability to contribute to RHDM.

The researcher during the FGD with men and women in the study area sought to find out how their total dependence on their husbands for sustenance affect their relationship at home particularly when there is no unity of desire, the reports of the FGD agreed with IDI and the literature reviewed in the course of the study. Mostly whether educated or not women in northern Nigeria sees it as the responsibility of their husbands to cater for and provide for them, Muslim women in the region have continued to allow this gender construct of the male as a bread winner (Saddallah, 2000) direct and dictate their marital, reproductive, and employment behavior and decision-making.

The need for economic independence that will lead women to take control of their sexuality is needed as concluded by the IDI. It is important that traditional and societal norms and construct concerning sexual relations should be reviewed as this will lead to reducing if not eliminating the level of dependence by women on their husbands (SADC, 1999).

Any attempt to measure women's empowerment without addressing their control over their sexual relations; such as control over when to have children, which contraception to use and if necessary access to abortion services cannot be said to be complete. These societally determined values and norms despite an increase in the number of educated and working women from the north has not changed their perception about the implication of depending wholly on their husbands (Werthmann, 1997; 2000).

Women believe that it is their husband's responsibility to cater for them and that women are not under any obligation to make their incomes available to their families. This dependence on their husbands for sustainability also ensures that their husbands expectedly also takes over RHDM as dependence create a power relation that favors and supports the existing patriarchal relationship in the home (Yusuf, 2001).

5.4.3 The Influence of Religion on the Contribution of women to RHDM

Cultural researchers have highlighted the role of religion in family decision making in Nigeria particularly Islam which is the dominant religion practiced in the study area on the importance placed on children, and religious politics as key drivers of complete obedience of families to the Islamic mode of life which places a high premium on fertility. Mazrui (1994) links lack of reproductive decision making by women in the family decision-making process in the region to a growing reawakening of Islamic fundamentalism, which places renewed emphasis on women's role of bearing children.

Saadallah, (2000) Opines that it is possible to conclude that the status of women have been greatly improved by the Quran today despite the fact that inequality between the sexes is more noticeable today than in the beginning, this is because the Quran is based

on man as the bread winner symbol and women the weaker sex symbol this role play unfortunately puts women in disadvantaged position. Starting from a position above other textual religion the Quran in the treatment meted out to women at the beginning of the Islamic era has today been reduced to becoming more entrenched in discriminating against women than Christianity and Judaism, the relegation can however be traced to interpretations emanating from men who are more patriarchal than scriptural in their approach to the religion (Mernissi, 1996).

As mentioned above, the Quran is based on the role of 'man as a breadwinner' model a specified division of labor places the woman as dependent and the weaker sex. This does not, however, negate the equality between men and women unto God, and hence women should enjoy equal gender entitlements to every available opportunity in the family and society, Stowasser (1984). Mernissi opines that the Quran, in comparison to other texts of scripture religions, proffers a model of hierarchical relationships and sexual inequality" between men and women (Mernissi, 1996). The assimilation of other cultures and influences during the spread of the Islamic Empire allowed "sexual inequality to reassert itself" in translation thereby reducing the space and freedom granted women in the and in the early days of Islam, men who are the interpreters of the quran and the hadiths have tended to be more patriarchal than scriptural in their approach to women (Saadallah, 2000).

At this point having analyzed existing literature on the role religion allows and expect women to play in RHDM the researcher analyzed IDI and FGD alongside and concluded that there is an agreement between all of them. From the literature reviewed so far it is possible to reach a conclusion that the discrimination women face today in contributing to RHDM does not arise from either the Quran or the Sunnah but that as

concluded by (Saadallah, 2000; Menissi, 1996; & Karam, 1998) arose out of the interpretation of both texts by men who are steeped deep more in their patriarchal roles than in religious tenets (Karam, 1998).

From the foregoing different literature reviewed seems to have concluded that the only challenge facing women in contributing to RHDM is basically their level of empowerment, to this extent the various levels of empowerment were perused from the point of views of different scholars and the IDI and FGD presented below explains the extent to which the views of the respondents agree or disagree with the literature existing on the subject of women empowerment.

It is pertinent to conclude that these three (3) sub-themes have posed serious challenges for any effort by women and agents of women, to ensure that women contribute to decision-making will not be possible until these variables have been addressed: Gender, poverty and religion either singly and/or combined play significant roles in dictating household relationship in patriarchal societies that must be addressed if women albeit married women must contribute to RHDM as they need to.

5.5 The Link between Participation in RHDM and Vulnerability to STIs and HIV & AIDS

If and when as husbands men approve of contraceptive use, they may be doing so in theory and when faced with putting their words into action they may either leave implementation to their wives or out rightly refuse to use condoms, it now falls on their wives who will have to sacrifice their own desires and wishes in order to meet

the desires and wishes of their husbands (Population council & IGWG, 2001; Speizer, et al, 2005).

The tendency of women to use contraception covertly against the expressed wish of their husbands can put a lot of women at risk of either emotional and physical abuse or a situation where their finances are constrained especially those financially dependent on their husbands, some husbands have threatened divorce for wife's covert use of contraception (Blanc, 2001; Population council & IGWG, 2001; Speizer et al, 2005).

Evidence suggests that there exists a high relationship between individual disclosure behavior and health-care practices with regard to confidentiality and gender norms and power imbalances. For varying reasons women in sub-Saharan Africa are more likely to be HIV+, and be tested and know their status through antenatal care (ANC) before their husbands.

Empirical body of evidence suggests that owing to women's low subordinate social and economic position in the region compared to that of men, women may refuse to disclose their status for fear of violence, discrimination and divorce. These reasons are particularly very important obstacles to testing and disclosure for women in many parts of the region (Maman & Medley, 2004).

As seen in the previous chapter, the respondents do not see the spousal communication gap as a likely or possible cause of their vulnerability to STIs and HIV & AIDS, the display very little knowledge of the risk factor occasioned by their husband's lack of desire to curb extra marital relations trusting that their husbands have their best interest at heart. These denials can be linked to gender dynamics which does not allow

for spousal communication as the women's spousal age gap makes communication on any issues impossible let alone communication on reproductive healthcare.

Respondent's knowledge of STIs and HIV & AIDS was discussed earlier at the beginning of this chapter but their perception of the risk factor inherent in their lack of communication was not very understood by them. The role played by gender stratification in the society with respect to poverty of women, lack of education, spousal communication, and spousal age gap have all been discussed, almost all the variables addressed earlier in answering the other research questions impact directly on the vulnerability of married women to HIV & AIDS, the constructs of masculinity operating in the society occasioned by gender consideration which allows men to engage in extra marital relations in the form of concubines and wife's is what is referred to as multiple sexual partnering, all through the various IDIs and FGDs it became manifestly clear that this behavior posed the greatest threat to women's HIV risk status.

Gender occasioned social constructs such as spousal age gap which directly creates a communication barrier between couples is capable of increasing the HIV risk status of married women as they can neither discuss their husbands sexual life nor can they refuse to have sex with him in the same way they cannot insist that he uses condoms when having sex with them.

The level of empowerment of women being so low in the study area occasioned by female seclusion, early marriage, lack of education, and debilitating poverty ensures that women are not only very vulnerable but are completely dependent on their husbands resources for sustenance and survival, to this end, they must accept whatever

is dictated by their husbands and from this background therefore their ability to contribute meaningfully to reproductive health decision-making is hampered and if they cannot contribute to RHDM then they are vulnerable to STIs and HIV & AIDS.

The fact that married women are in seclusion in their marital homes implies that they women have no access to information and education about HIV & AIDS and other STIs, in a situation of male authority/superiority whatever information their husbands bring home is what they have access to, this according to literature and supported by the various IDIs and FGDs suggests that their perception of their HIV risk status is flawed, though not directly involved in multiple sexual partnering and being faithful to one is not enough to reduce their HIV risk status as their husbands are not faithful to them, it is therefore necessary for them to be considered as high risk heterosexuals.

Finally married women whose sexual life is expected to be tied to their husband's sexual life as low risk heterosexual are now being classified as high risk heterosexual owing to their husband's inability or unwillingness to curb or moderate their sexual behavior/life; this much was shown in all the IDIs and FGDs and is in agreement with reviewed literature.

5.6 Implications

The findings from the study has obvious implications for the respondents in particular, the people in the study area, women in general and the possibility of achieving sustainable development in the shortest possible time as proposed by the UN, these implications are listed below.

The lack of participation in RHDM by women puts them at risk of STIs and HIV & AIDS, despite their claims of knowledge of STIs, their knowledge of the HIV virus is

very low and their lack of the ability to discuss RH issues and their husbands multiple sexuality puts them at serious risk of HIV infection, especially HIV infection via the sexual route.

Respondents lack of knowledge of the modes of prevention of HIV and their lack of control over their sexuality puts them at the mercy of their husbands whose inability or apparent unwillingness to curb or moderate their sexual life because of constructs of masculinity encouraged by gender dynamics that allows them to engage in multiple sexual partnering, their husbands are also not aware of or do not also wish to use condoms as part of the same construct of masculinity, this puts them both (husbands and wife) at risk of infection.

The relationship between the spousal communication gap of spouses is directly correlated to their vulnerability to STIs and HIV & AIDS, as the unknowingly perceive themselves as low risk heterosexuals as a result of which the engage in risky sexual behavior with their high risk sexual partners, this is also same for those married to husbands with high spousal age gaps since ability to communicate freely is impacted negatively by spousal age gaps.

Women empowerment is impacted negatively when women continue to live under the weight of gender discrimination that encourages physical restrain in the form veiling, seclusion and restriction on mobility of women as was pointed out in the study when women cannot move freely as they wish their capacity for independent thinking and action is greatly undermined.

The continued marginalization of women occasioned by gender norms such as role delineation which hampers equality and equity in the engagement between male and

female members of the household and the society has led to increased vulnerability of women as victims of marginalization in power relations in the place where they should enjoy utmost safety.

Poverty amongst women has continued to increase because of women's lack of access to and control over resources, this situation is encouraged by the continued defense of man as a bread winner model encouraged by patriarchal considerations which has led to the creation of a circle of dependence of women on men thereby perpetuating the feminization of poverty as women in the study area expect men to take care of their needs as his religious and cultural obligation.

That normative structures of the Nigerian societies especially northern Nigeria prescribes a more clearly articulated set of norms regarding appropriate behavior for women should they participate in public life, the extended family system, large family compound and polygamy all combine to erode power of the wife or reduce completely the authority of wife's in the household.

5.7 Recommendations

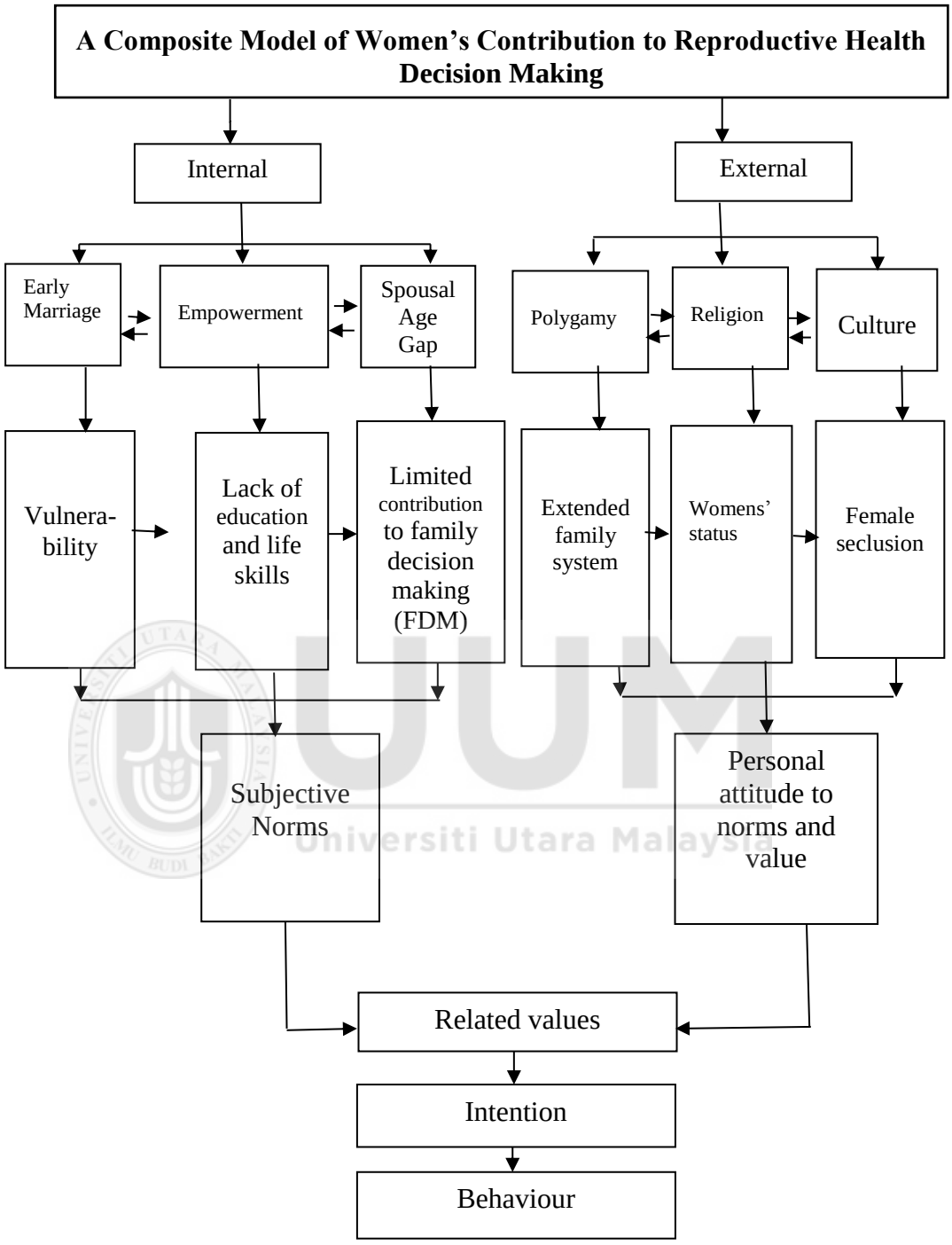

Figure 5.1. Composite Model of RHDM

The composite model shown above is adapted from the three theories studied by the researcher in this study we have adopted this composite model because of its ability to foretell and explain behavior, it is expected that it will be effective in foretelling behavior though it has not been tested before. The beauty of this model is its ability to fuse variables which will enhance its predictability power. The theoretical framework for this model is hinged on the assumption that one is likely to start a behavior associated with strong positive value because of the strong emphasis on the reasoning ability of human beings upon decision making process. As opined by Wan (2005), it is the reasoning activity that involves perception over threat that is noticeable in the Health Behavior Model (HBM).

The composite model of women's contribution to RHDM represents the reflection of a woman's evaluation of the interaction between the external and internal factors will necessitate taking the intention to act or not. The presence of other conditions such as religion, culture, polygamy and other gender consideration in a patriarchal society in concert with the internal factors such as early marriage, spousal age gap, and empowerment that direct and dictate a woman's life.

The possibility of using this model to explain how aggregate level conditions influence the evaluative system, intention and behavior is also envisaged. Intention in the model is presented as a willingness to act and may be transformed into action/actual behavior on the basis of the interaction between subjective norms and personal attitude of the individual to the norms and values which is called related values, in this model ever before the intention to act is taking the interaction during the reasoning process on the consequences or otherwise of the behavior will stop/encourage the woman/individual from taking the intention to act, but where the

related values are inconformity with the relative values then it allows people to perceive legitimacy for their actions within societal constructs of these norms and with regards to gender divisions these norms maybe barriers to seeking a more equitable arrangement for women and even hinder the perception by others that the lack of equality and equity in the engagement between male and female members of the society as subjective norms then the intention to act will take place and the behavior will follow almost seamlessly or simultaneously.

Like all patriarchal societies' concurrent social norms and values that dictate gender brought among the female gender an increased vulnerability and marginalization in power relations in the places where they should normally enjoy utmost safety and security, they are therefore by implication discriminated against in decision-making over their own bodies (Kabeer, 2001).

The role patriarchy plays in ensuring women suffer oppression is such that even the women in a homosexual relationship are discriminated against just as the woman in a heterosexual relationship is, the tendency therefore is not just to make recommendations that will overhaul the institutionalized gender system in the country today which might be counter-productive and not yield the desired result because gender discrimination against women is entrenched deep into the fabric of the society (Yusuf, 2001; Kabeer, 2001).

As many have come to accept the notion of a society with gender dynamism as normal, moreover gender discrimination being a psychological construct cannot be fought through legislation alone but through a radical reorientation and conscientization as opined by Paulo Frere (Sen, 2008).

It is however more practical and in keeping with the advances made in the world today to create situations that will enable women rise above the powers that seek to hold them down through educating women, ensuring they have access to resources and raising their consciousness about themselves to the extent that their perception of their person and self-worth will be high.

From this position they can begin to raise their voices individually and in groups against the powers that seeks to hold them down, for acting in their individual capacity may not only trivialize their effort but the result will be minimal and not impact on the generality of women, but as they act together in groups and in associations they start a social movement that will be hard to put down so that the impact of their action will be noticed and felt by a large number of women, leading to successes that can only be achieved in collaboration with men rather than acting in isolation is recommended (Kabeer, 2007).

It is important to create an enabling environment for organizations that work with women in seclusion to raise their awareness about their risk situation as being in seclusion keeps them away from accessing information that is easily accessible outside, since multiple sexual partnering is a normal existential circumstance for their husbands, there capacity to engage in spousal communication must built so that reproductive health issues can be discussed in their homes.

The foregoing are recommendations about the reproductive decision-making role of married women, the gender issues surrounding spousal age gap and spousal communication difficulties of married women occasioned by spousal age gap of

couples, and their vulnerability to STIs and HIV & AIDS situation of married women in the study area.

5.8 Limitation of the Study

The focal point in this multiple case, nomothetic qualitative study is the tendency to describe one case in such sufficient detail that good comparisons will be made (Stake, 2000). The problem with phenomenological studies is its inability to be generalized. This study can only effectively describe the views of the population under study but like all qualitative studies the specific conditions motivating, influencing and directing action of the respondents are so personal that no other person can be expected to behave the same way and so whatever outcome of this study shall have implication only for the areas under study. Besides, the tools employed in a qualitative study make the interaction between researcher and respondents such a personal one that must be handled with care and consideration if not the effort will be wasted.

The process of rigorous content analyses and synthetization of the literature collected and triangulated with IDI and FGD has guaranteed quality, trustworthiness, reliability and validity of the data collection and analysis process which at least ensures that the study can generalized to the population for sample was drawn, it is therefore hoped that rigorous process employed in data collection and analysis, the back and forth of coding and tape recording to ensure that there are no misunderstanding will grant this study a measure of quality and generalizability at least to the population under study because aside from these efforts the combination of more than one method of data collection and analysis was intended to solve some of the possible limitations of the study as concluded by (Neuendoff, 2002).

Added to the above is modification of snowball method of sampling respondents because of another cultural limitation that would have the study if this modification had not taken place and finally the level of literacy of the respondents would have a serious draw back on the study had the researcher not been able to communicate in the local language of the respondents.

5.9 Recommendation for Future Research

The findings of the thesis pointed out that the spousal communication gap of the couples is not directly correlated to their vulnerability to STIs and HIV & AIDS, because they unknowingly perceive themselves as low risk heterosexual, as a result of which they engage in risky sexual behavior with their high risk sexual partners, same can also be inferred of those married with very high spousal age gaps which hinders spousal communication that can affect their perception of their STIs and HIV&AIDS risk situation. Future research can therefore look at the relationship between the sexual behavior of the husband and the vulnerability level of the wife.

The focus of future research should also be on the gendered social stratification that could affect spousal age gap and spousal communication thereby allowing the kind of couple communication that will facilitate contribution to reproductive decision-making by women which will by implication lead to a reduction if not total elimination of vulnerability to STIs and HIV & AIDS of married women in the study area.

Secondly future research should find out the kind of communication strategy that can be designed that will facilitate quality spousal communication between couples in a socially stratified society like Ankpa or on how to test and improve the composite communication model presented in this study.

In the area of practice, future research could concentrate on finding out the status of on-going national, state and local campaigns by both NACA and her local and international partners in programming that target low risk heterosexual especially married women and discordant couples on reproductive health and behavioral change among married women that could reduce their vulnerability to HIV & AIDS.

An assessment of on-going programs could be the focus of future research to measure the effectiveness or otherwise of such programs geared towards addressing gender discrimination that has over the years held women down and made it possible for women to be socialized into believing that they are subordinates to their husbands and so should play secondary minor roles in their matrimonial homes.

Researchers could attempt in the future to study and understand the needs of stakeholders in designing and executing national STIs and HIV & AIDS programs that will target the needs of low risk heterosexuals especially married women. A longitudinal study of constructs of masculinity is recommended to explain how patriarchy supported by culture allows men to indulge in multiple sexual partnering be carried out to address the factors that perpetuates the husbands and their wife(s) risk of contracting STIs and HIV & AIDS and the gender dynamism that makes such behavior possible and make recommendation that will help solve the problem.

Research on social construction of reality that will make/enable married women appreciate correctly their risk status can be carried out as it is capable of making recommendations that will enable women in multiple marriages begin to perceive themselves as high risk rather than low risk heterosexuals and the need for them to take proactive measures in participating fully in reproductive health decision-making.

That various dimensions of empowerment need to be taught to women in seclusion as it will enable to access to resources and to control those resources which will enable them translate acquired knowledge to their day to day activities in their homes and exercise the needed will power to use the various dimensions of power to take decisions on matters that concern themselves and their families.

5.10 Conclusions

Different paradigms with variations in epistemology and ontology have arrived at different conclusions on the relationship between patriarchal gender consideration and women's contribution to RHDM. In effect the role gender plays in women's contribution to RHDM is contested though not disputable, employing a critical synthesis the researcher synthesized arguments from relevant literature on the role of women in RHDM, the reviewed literature constitutes from both qualitative and quantitative research in heterosexual and same sex behavior. It is based on the synthesis that RHDM appears to be multidimensional and multifactorial and women's contribution also appears to be multilocational and multidimensional and gender consideration is one key component of the interplay between women's attempt to contribute to the discussions about her body, her sexuality and most importantly her health.

The role of gender on RHDM is dependent on the socio-cultural being, social norms and values shape behavior, people are active rather than passive agents of behavior and dyadic contexts either enable or stifle their RHDM efforts. The conventional conceptualization of gender in the context of power dynamics only within the husband and his relatives may conceal an important aspect of power relations among co-wife's

in a co residential polygamous relationship that could play significant role in any effort that will enhance women's ability to contribute to RHDM.

Thus, a holistic approach towards the conceptualization of gender and power dynamics is required to depend the discourse regarding relative spousal power and RHDM, attempts to improve individual attitude and improve their RHDM capacity that do not address underlying sociocultural structures of behavior or decision making may prove futile and probably serve the majority while ignoring the minority or vice versa.

A relationship may be established to depend the interactivity of factors at different levels that affect RHDM. Rather than the static right of one party, RHDM is an emergent function of a myriad processes ranging from the proximate to distal influences, and it could involve the same, different or both parties of a dyad at different times. The argument on gender in RHDM is embedded in the socio-cultural being. It is apparent from the analysis that RHDM is largely determined by sociocultural norms and values similarly gender norms and traits are largely defined by sociocultural norms and values. An individual's gender and their RHDM is a function of the society in which they live, thus, the relation is centered on people belonging to specific society in specific spines.

The crux of the problem toward understanding the determinants of the level of women's contribution to RHDM lies not in the way society frames its laws nor in the extent to which it disagrees or is incompatible with UN conventions either the Beijing or Cairo declarations on women. The conservatism which has for long dominated the peoples thinking pattern puts a lot of weight on the system that is continually

reinforcing the incongruences between law and actual conditions of contemporary families in significant aspects and the society in general.

While all the conventions and protocols offer clear ways for reviewing the potential and reevaluating the gender determined patriarchal society under which men and women operate, the perpetuating thinking pattern of the people weighed down heavily by gender constructs has made any prospect for a review near impossible. The consequence of this is therefore, reservations that are vaguely written to the tenets enthused in the ICPD, AU chatter on human rights and other international protocols and agreements have negatively impacted the possibility of changing or influencing positively application of gender considerations that affects women's participation in RHDM.

By implication therefore gender equality has been undermined by by rulings that are selective and impact negatively any effort aimed at impacting positively the state of the law that will provide opportunity for women to contribute their quota to development and benefit maximally equally from development programs and opportunities This study therefore posits that a legal system grounded in the philosophy of the society and modern philosophy be developed to create the way for strengthening the needs of contemporary women and their families. When you take a cursory look at the Nigerian society you will agree that is not going to be an easy endeavor due to the level of anachronism and incongruence that has eaten deep into the fabric of the gendered society.

As Mamman and Medley (2004) in attempting to explain the problem of law reform in India observed, "Persons who are trained in a particular system, tradition and social

order, and have spent their lives in studying and adhering to the same, are invariably not tolerant of any alternative system, irrespective of its merits." There is a growing need to continually engage through a means that is rational not emotional and sustainable irrespective of political affiliations which will not be left in the lurch in the middle of the road for any reason for any reason until the law has been improved.

Raising awareness of the problems of the gender role in operation on the lives of those involved must persist so that existing gender imbalances, social injustices and maladjustment to contemporary needs and conditions can be better understood and addressed through legal reform aimed at removing the institutionalized structures (NACA, 2009).

Taking the back seat has not in any way helped in removing the problems observed that are inherent in the system that impacts negatively on Muslim women and women generally in different societies across the world. Instead the opportunity to contribute to reviewing the law and the system has been dimmed by that attitude of taking a back seat. Specifically, the thesis addressed how gender dynamism in patriarchal society's impact on these identified themes directly and how the effect of that contact impacts the life of married women and in turn increases their vulnerability to STIs and HIV & AIDS. The spousal age gap, for instance, was significantly related to women's contribution to family reproductive health decision-making in the study area and so the researcher can conclude that the more the spousal age gap the less the couple communication in the family and consequently the higher the vulnerability of the woman to STIs and HIV & AIDS.

The role of the extended family, particularly Mother-in-law presence in the household was negatively related to the authority of wives. Polygyny had the expected negative relationship to women's authority. An argument advanced in this thesis is that the observed differences stem from the normative structures of the Nigerian society and, in particular, from the gender systems. For instance, the Northern societies have a more clearly articulated set of norms regarding appropriate behaviors for women and those norms dictate that women should not participate in public life. However, if women in those societies do gain some formal education or access to work opportunity outside the household, they also gain some level of household authority, but not as much as they would if they had the same characteristics but were an Ibo or a Yoruba from the South and West of Nigeria.

Moreover, because few women in Hausa and Kanuri societies have access to formal education and the labor force, there is little evidence yet of change in those two societies. The few Hausa and Kanuri wives who do have some authority appear to have gained it mainly through traditional means coming from a higher status family background or waiting until they were older before marriage. Kritz and Makinwa-Adebusoye opined that wife's work-related and family characteristics have only modest effects.

Social change in a given society, in turn, opens up the perception for other women that they or their daughters might also be able to attain "modern" statuses in the future. To the extent that women of different social class backgrounds emulate the attitudes and behaviors of others who have adopted modern norms of gender equity, all women benefit and homogeneity sets in, making it more difficult from a statistical standpoint to account for in group differences (Kabeer, 2001).

There is both a pessimistic and an optimistic implication of our work from a policy-making standpoint. The pessimistic message is that ethnicity does indeed matter for reproductive dynamics in Nigeria and probably elsewhere in Africa too. Since ethnicity cannot be changed, this means that we are likely to continue to observe differentials in group processes in future research.

The perspective guiding this work, however, is that sociocultural change will come to all groups, albeit at a different timing. This leads us to the optimistic policy message- for institutions interested in speeding up that process of change, the best avenues for doing so would seem to be ones already well known in the development community- investing in primary and secondary education, promoting gender equity in access to education, and setting in place policies to stimulate economic growth and job creation.

Our findings also suggest that scholars may draw incorrect substantive and policy inferences from national level analyses in sub-Saharan African (SSA) countries if they do not take ethnicity into account. Most SSA countries, particularly ones with large populations, are very ethnically heterogeneous. National identities are still being forged in SSA, and ethnic or tribal groupings continue to speak different languages, maintain separate homelands, and socialize children in accordance with their own sociocultural traditions, this situation therefore impacts negatively for any possibility of a national effort devoid of regional colorations and a dispassionate approach towards finding a lasting solution to gender and religiously dictated discrimination against women.

Ethnic groups differ, however, in the extent to which they are embracing change, and in the years ahead, these differences would be reflected in increasing differentials

within states and regions in the pace of demographic transitions. If demographers neglect the importance of the sociocultural context in shaping reproduction, they will ignore a major part of the demographic transition story in that region.

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List of Appendices

Appendix A

Ethics Approval

Dear Mr. Idris

Letter of support from Kaduna Polytechnic Social Development Department

This is a letter informing you of the approval of the ethics department of the College of Arts and Social Sciences, Kaduna Polytechnic conveying of the ethical consideration for your interview women in Ankpa LGA for the purpose of sampling their opinion in the conduct of your research on "The Role of Women in Reproductive Health Decision Making and their Vulnerability to STIs and HIV & AIDS in Ankpa LGA of Kogi State, Nigeria."

We wish you the very best in your efforts and pray for a successful completion of the your programme

Accept the assurance of the director's highest regards

Thanks and Regards, Gabriel Amana Ochimana

Appendix B

Consent Form

Title of the study:

Muslim Women's Role in Reproductive Health Decision Making and their Vulnerability to STIs and HIV & AIDS in Ankpa LGA of Kogi State, Nigeria.

Researcher:

Hussayn Umar Idris, School of School of Social Development, Awang Had Sallah Graduate College of ARTS and Sciences: yesminama@yahoo.co.uk (Mat N0 s95237, 2348060037498).

Supervisors:

Prof. Dr, Ismail Bin Baba School of School of Social Development, Awang Had Sallah Graduate College of ARTS and Sciences ibaba@uum.edu.my (+60124055315).

Dr Rajwani MD Bint Zain School of School of Social Development, Awang Had Sallah Graduate College of ARTS and Sciences rajwani@uum.edu.my (+60134830900).

Appendix C

Invitation to Participate:

You are invited to participate in a study conducted by Mr Hussayn Idris Umar, who is a student from Universiti Utara Malaysia, being supervised by the above named.

Purpose of the Study: The purpose of the invitation is to conduct an in-depth interview with you on your opinion and thoughts about women's role in reproductive health decision making knowledge of STIs, and HIV & AIDS and gender issues affecting women's matrimonial life generally.

Participation:

You will be asked to participate in a Focus Group Discussion/ with four other married Muslim women/ In-depth Interview, being involved in a discussion with other married women within reproductive age group. This will last for about an hour and half and will take place at the primary health care center in Ankpa there will also be provided refreshments and snacks.

Risks:

Participating in this study might make you feel uneasy and uncomfortable because you will be asked questions about (RHDM) family planning and life as a married wife in a house. Talking with the researcher might take some time away from household duties. But, you are assured by the researcher Mr. Hussayn Idris Umar that you don't have to answer any questions that you are not comfortable about. You can stop the interview anytime you want.

Benefits:

Talking with you will help the researcher understand better life as a married wife and how women take care of their health and it could also help learn things that you didn't know that you ought to know.

Appendix D

Confidentiality and anonymity:

The researcher Mr Hussayn Idris Umar has assured you that whatever information divulged during the interview will not be told to anyone else. Your name or any information that can be used to identify you or family will not be asked or noted down. Everything that you say will be recorded so that we can listen to the tape and write down what you said. Instead, if the researcher wants to use something you have said then he will use the fake name assigned to you. Only the researcher his assistant and his study ‟ supervisor will actually know your identity and they will not reveal that to anyone or write it down anywhere. If you participate in the FGD, the other discussants may know you are, and you will know who they are too. But you will take care about not telling our family members or other friends about who said what during those discussions.

Conservation of data:

The information collected will be kept on computers and notes, questionnaires and other documents will be locked away in the researcher's office only the researcher and his thesis supervisors will be able to have that information. This information will be stored for 3 years but after that will be deleted.

Compensation:

No form of material compensation will be offered for participation in the exercise nor will any material inducement will be given to anyone for participant other the snacks that will be provided.

Voluntary Participation:

You are not being forced or coerced or induced to participate in this study. You know that you can stop talking at any point you wish and you can choose not to give answers to questions that make you uncomfortable. You will not have problems at home if you participate in this study because they have permission from your husband and mother-in law if you choose to stop midway all the information you have provided will be destroyed and used.

Acceptance:

I, (Name of participant), agree to participate in this study with Mr. Hussayn Idris Umar, who is a student from Malaysia and who is here with the Kaduna Polytechnic as a lecturer. If you have any questions about this study, you can contact Mr.Hussayn Idris Umar (080 60037498).

If I have any concerns or requests regarding ethics of the study, I can also contact the Ethics officer at the Kaduna Polytechnic.

There are two copies of the consent form, one is for you and the other is for Mr Hussayn Idris Umar

Participant's signature: Date:

Witness (needed in the case where a participant is illiterate, blind, etc.):

Signature Date:

Researcher's signature: (Signature) Date

Appendix E

Verbal Recruitment Script

You are invited to participate in a study regarding your life as a married wife. If you agree to participate, then you will talk with Mr Hussayn Idris Umar who works in Kaduna Polytechnic but is a student in UUM. Your participation will involve giving us an interview, which will last for around an hour. We will interview you at the primary health care clinic in Ankpa you will participate in the In-depth interview or the Focus Group Discussion. The FGD will last from an hour to an hour and half, and it will take place in the same venue. Participating in the interview and the group discussions may make you feel uncomfortable because we will ask you some personal questions about reproductive health, your relationship with your husband and in-laws, and your ability to take decisions for yourself and your health. However, if you feel uncomfortable or if you don't want to answer the question, you can refuse. If after starting the interview, you feel like you don't want to participate anymore, we will stop it and we won't use any of the information you provided. Also, if you have any problems or if you need any help, we will provide you with more information regarding some of the issues discussed. Would you like to participate in this study?

We are using the term "family planning" instead of sex and reproduction in the verbal recruitment. This is because within the social context of rural Ankpa, the terms "sex", "sexuality" and "reproduction" are considered too direct and almost invasive. "Family Planning" on the other hand includes reference to sex and "reproduction" as well as pregnancy and childbirth issues and overall as a term is less offensive to people's sensibilities.

Appendix F

Verbal Assent Script

I (name of participant) agree to participate in the study with Mr Hussayn Idris Umar who is a student from UUM and who is working here with the Kaduna Polytechnic. I am not being forced to participate in this study. I know I can stop talking at any point I wish and I can choose not to give answers to questions that make me feel uncomfortable. If I chose to stop the interview and decide that I don't want to participate anymore, all the information I have given to them will not be used. If I have any questions about health or anything else, and I need more information or help, I can contact Mr Hussayn Umar Idris. If I have any questions regarding the study, I can contact.

Appendix G

Debriefing Text

Thank you very much for your participation in this study. Your insights are invaluable and they will help us understand better the lives of married women like yourself and their health. You are reassured that all information shared will be kept confidential and will not be disclosed to anybody else except the Researcher and his supervisors in Malaysia. At no point will we use your real name or any information that may reveal your identity. The information that you have provided us will be used to write a report on married women and their life, especially their ability and opportunities to make decisions regarding their health. We will share this report with the UUM and Kaduna Polytechnic. If you have any questions regarding the study, please contact the Researcher or his supervisors and the Director College of Arts and Social Sciences, Kaduna Polytechnic.

Thank you for your participation!