



The Role of Authority and Power Relations in the home and its implication for the contribution of Women to Reproductive health decision making and vulnerability to HIV & AIDS in Nigeria

By
HUSSAYN U. IDRIS
yesminama@yahoo.co.uk
+2348060037498

SAFYA W AHMADU
safyaahmadu@yahoo.com
+2348023113000

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ABSTRACT :- The importance of acknowledging 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 & HIV & AIDS, malaria, tuberculosis and other diseases that poverty aggravates was stressed at so many international fora such as the Beijing conference on Women, the 1994 Cairo conference on population and development, the MDGs which later became the SDGs and a host other international and regional conferences all over the world.. In patriarchal societies gender norms related to masculinity can enable men have multiple sexual partners, putting them and their spouses at high risk of infection. Constructs of masculinity can also encourage sexual relations within spousal age differences between men and women, these relationships can be disadvantageous to younger women as the men have experience and economic power which gives them more bargaining power over their partners. 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. The study is designed to identify and explain the sources of power and authority in matrimonial homes and its effect on reproductive health decision-making amongst women and it employs empirical procedures in the data collection and analyses, the objectives of the study includes identifying the sources of power in matrimonial relationships and how spouses employ access to power and authority in reproductive health decision making.

I. INTRODUCTION

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

That men play a central role in reproductive health cannot be overemphasized and the need for male involvement is important if the enshrined rights for women 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) can be impacted either negatively or positively by the role men are assigned in reproductive health problems as these goals 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 their sexuality and 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 be reviewed as this will lead to reducing if not eliminating the spread of HIV & AIDS (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 on 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 (NACA 2012).

In 2008, 67% of HIV infections worldwide occurred in Sub-Saharan Africa (UNAIDS/WHO, 2009). According to the epidemiological report on HIV and 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 as a result, the crude death rate was about 20% in 2000 than in 1990 (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, 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) of which over 3 million are people 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 show 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. 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 marrying at early age 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, Judd. 1998 & Glynn et al 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 Statement of Problem

Despite the fact that all around the world now more women have knowledge of contraception and more women are 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 their involvement in taking decisions about their reproductive health and the implications for this involvement such as a HIV & AIDS free life. Women in Ankpa LGA are however constrained in their effort to benefit from this advancement. (UNAIDS. WHO 2012)

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 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.

Difference 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 male dominance on all issues and particularly 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.

The problem of this study therefore is to unravel the remote and immediate factors responsible women's inability to contribute to reproductive health decision making in Ankpa LGA of Kogi State Nigeria. 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 Saadallah (2000), 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.

To fully grasp the role designed for women in Islam from the foregoing we must peruse the role delineation for women in Islam 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, 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 through Quranic legislation (Stowasser, 1984).

Stowasser 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 man was reduced by both Christianity and Judaism when they held Eve was responsible for the disobedience in the garden, cursing her before Adam, while the Quran portrayed both as having committed the mortal sin before God (Saadallah, 2000).

Despite textual and scriptural postulations in favor of women's equal treatment, Mittleman and 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 Abdullah (Karam, 1998) in entrenching the system of patriarchy in existence in Muslim societies instead of all efforts geared towards removing it.

1.2 Research Questions

The following are the research questions designed for the study:

- a. What are the determinants of power and authority enjoyed by spouses in the homes in Ankpa LGA of Kogi State Nigeria?
- b. To what extent does the authority and power relations in the homes affect women's contribution to reproductive health decision making in the homes in Ankpa LGA of Kogi State Nigeria?
- c. In what ways can women in Ankpa be made to exercise more authority and power over decisions concerning the reproductive decision making process in Ankpa LGA OF Kogi State Nigeria?

1.3 Objectives of the study

The following objectives have been crafted for this study:

- a. To examines the determinants and sources of authority and power relations in matrimonial homes in Ankpa LGA of Kogi State Nigeria

b. To analyze the extent to which authority and power relations in the homes affect women's contribution to reproductive health decision making in Ankpa LGA of Kogi State Nigeria..

c. To suggest ways by which women can be made to participate effectively in reproductive health decision making in their matrimonial homes. .

Study Site

1.4.1 Kogi State

Kogi State is centrally located in Nigeria otherwise known as the center of the middle belt of the nation with a population of over 3.5 million people, (2006,NPoC) it is located in the North-central zone of Nigeria. It shares common boundaries with other states including Niger, Kwara, Nassarawa and The Federal Capital Territory in the North; as well as Enugu and Anambra in the South and Benue to the east. The state with its capital located in the confluence town of Lokoja, is situated about 200 kilometers from Abuja (the Federal Capital territory of Nigeria, making it an important access route to the federal capital of Nigeria), 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 from which it inherits the nick name of the confluence state.

1.4.2 Ankpa LGA

Ankpa Local Government is the second largest Local Government area in Nigeria with a total land area of 7,691km² and a population of about 260,312 (2006, NPoC) which represents 9.61% of the total population of Kogi State according to 2006 population census in Nigeria. 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 favors the cultivation of cereals like rice, maize and bambara nut while tubers like yam and cassava are grown.

A large population of the people of the LGA are of the Igala speaking people who are the 9th largest ethnic group in Nigeria, the people are mostly Muslims, Christians and animist in that order, 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 be more inclined towards the Northern part of Nigeria because of the Islamic religion, but most importantly gender consideration and existential circumstances dictate their life patten.

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. 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 polygyny large number of children as desirable, and they dominate reproductive health decision-making 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 in practice, especially in the rural areas, emphasis has been strongly 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 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.

1.5 Methodology

This empirical research employed the use of in-depth interview and focus group discussion to gather information from the respondents. (Axinn& Pearce, 2006) For qualitative research purposes, in-depth interview and focus group discussion from the selected sample group was conducted to gather perceptions, expectations, and beliefs of the target samples (Wilkinson & Birmingham, 2003). The data was gathered qualitatively to allow

for a focused approach for a research that will provide the most descriptive data possible on the basis of responses from informants.

Secondly because of the nature of the subject matter under discussion, it is only through a qualitative approach and a face to face interview that will allow respondents freely provide very sensitive information that will be necessary to unravel the thick web of silence that culture surrounds reproductive issues with in traditional societies, the possibility of probing respondents for clarification and explanation is also guaranteed by the face to face interview added to the fact that the researcher can also observe the mood, and expression on the face of respondents and their body language as they responds to interview questions.

II. SAMPLING METHOD

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.

The researcher selected a total of twenty informants for the in-depth interview and ten discussant/respondents for the focus group discussions for study by employing convenience sampling through a modified snowball sampling technique, this modified technique allowed the researcher to use an influential female member of the district known and respected by all to bring out the women or allow the researcher to access the respondents through their husbands.

III. INCLUSION AND EXCLUSION CRITERIA

To be included in this as a key in-depth informant the respondent has to be female, married within reproductive age, from Ankpa and residing in Ankpa LGA of Kogi state while to be included in FGD (focus group discussion) as a discussant the respondent has to be from Ankpa and be residing in Ankpa, he/she must be above 30years of age at the time of the FGD and must be either influential or an opinion leader in the community. Any person who does not meet this criteria is automatically excluded from participating in the study as a respondent.

A semi-structured interview was conducted based upon an interview guide that was developed. "As interview guides are developed iteratively, questions are developed, tested, and then refined based on what one learns from asking people these questions" (Creswell, 2009) the interview questions will be developed such that the interview questions will address phenomenological lived experiences.

According to Van Manen (1990) "At the most general level of the life world we may find that this grounding level of human existence may also be studied in its fundamental thematic structure". 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 life-world experience questions.

The researcher therefore conducted in-depth interviews and focus group discussion to capture the perspectives of 30 participants. The researcher took down notes, listened, and asked questions in order to achieve a better understanding of the situation, and participant's thoughts about their experiences. Narrative interview text will be analyzed to identify the participants' points of view on the effectiveness of current practices as it relates to the women's role in reproductive health decision-making and vulnerability to STIs and HIV & AIDS.

Once the in-depth interview and focus group discussions are completed and the 20 interview questions have been answered, a structured debriefing protocol was immediately carried out. As illustrated by Cozby (2009), "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".

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) It is at this time that the researcher can inform the participants the purpose of the study and avail them of practical implications of the research study.

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 that summarized and provided meaning to the manuscript of notes.

Specific codes were developed allowing the researcher to categorize the responses into the above-mentioned construct, while identifying emergent themes. During this data aggregation phase, subcategories may be identified, which were not identified during the initial development of the research project. These subcategories were needed to be identified and coded, such that this new information can be assimilated into the research's findings.

IV. DATA ANALYSIS

Data analysis process is a way to discover "patterns, coherent themes, meaningful categories, and new ideas and in general uncovers better understanding of a phenomenon or process" (Suter, 2006, p. 327). "The purpose of interviewing is to find out what is in and on someone else's mind... We interview people to find out from them those things we cannot directly observe" (Patton, 1990, p. 278). Data was reviewed after the in-depth interview and focus group discussion, analyzed, and interpreted into themes and meanings to lay the foundation of codification. Creswell (2005) suggested that content analysis categorizes, synthesizes and interprets qualitative text data by describing.

Newman (2003) described the process of data analysis as a means for looking for patterns to explain the goal of the studied phenomena. The analysis of data used responses from the in-depth interview and focus group discussion. 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 analyze participants' narrative responses line-by-line, phrase-by-phrase and word-by-word (Creswell, 2003; Suter, 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. The analysis strives for depth of understanding.

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 reproductive health 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.

V. RESULTS

Figure 1.1. Concepts map of Women access to power and authority in the home and contribution to decision making

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, severing 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

Figure 1.2 Code and coding details

Reproductive health is concerning a woman's ability to have children and all the factors surrounding her having children such as menstruation, sexual activity, bareness 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 a woman is not barren then her reproductive health is alright and she can become pregnant if she has sex with a man. Many women cannot become pregnant because they are barren because at one time or the other they led irresponsible lives, like removing pregnancy and so now that they are married they cannot become pregnant. 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.

Education

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. A woman is not expected to have sex with anybody other than her husband so choosing who to have sex with and when or why does not apply to a woman. 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 the only available means through which they could acquire power and authority is greatly affected by their upbringing as they have no opportunity 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 as prospective wives, only the basic essentials are discussed. Informant's views on the available institutions in the society for teaching prospective married women reproductive health issues as informants are presented below beginning with the first set

Culture

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 verbatim is presented to corroborate the assertion by scholars. Thirteen of the informants revealed the following during the in-depth interview and their responses are grouped as reproducing each one will be repetitive.

Before our marriage our mother's sisters, relatives and cousins or other neighbors of the family used to come and tell us what to do when we am 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 its meant we should on no circumstance 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, we and our co wives were mustly married in about a month interval and it was a race as to who got pregnant first as each wanted her own child to be the first child of the house.

Whereas in-depth interview with the following married women from the study area revealed that:

We were specifically taught how to please our husbands and when we got pregnant the signs and how to behave, because we were going to be second and third wives as our husbands were already married, all the reproductive knowledge we acquired was about sex and pregnancy occasionally child bearing issues were also discussed and when we were encouraged to ask questions we wanted to know how we will know when we were pregnant as a result of our shyness at that time we were not comfortable discussing sex with our trainers. Discussions about child bearing was not detailed as 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.

Employment

In line with the research design focus group discussions were held with informants who acted as discussants on the issue of the views of the people on knowledge of reproductive health and reproductive rights, the following participated in the FGD as informants the views of the informants are reported here verbatim.

The only rights that were discussed then relates to the husbands conjugal rights as having become our husbands they have the first 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. That is what we were taught as reproductive health education before marriage. Wewere not given opportunity to work.

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 the following serving as discussants they 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:

Religious

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 inline with our religious doctrine, 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.

Table 1.1: Coding summary table

CODES-PRIMARY-DOCUMENTS-TABLE												
Report created by Super - 18/01/2016 08:11:56 PM												
HU: No file												
Code-Filter: All [5]												
PD-Filter: All [11]												
Quotation-Filter: All [38]												
	Women access to power and authority and decision making in the home											
	P 1	P 2	P 3	P 4	P 5	P 6	P 7	P 8	P 9	P10	P11	TOTALS:
Culture	1	2	1	1	0	0	1	2	1	0	1	10
Education	1	1	1	1	1	1	1	0	2	1	0	10
Employment	1	1	1	1	1	1	0	2	0	1	1	10
Religious	0	2	1	1	1	1	1	1	1	0	1	10
	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS:	3	6	4	4	3	3	3	5	4	2	3	40

VI. CONCLUSION

From the analysis above the findings of the study demonstrates that there are many impediments to access to and use of power and authority in the home by women is caused by many factors such as their level of education, level of empowerment, cultural and religious and other gender discrimination factors which constitute impediment to the ability of women to enjoy the reproductive rights intended to guarantee a healthy reproductive life.

Recommendations

1. The findings of the study pointed out that the spousal communication gap dictated by the access to and use of power and authority by the couples is directly correlated to their vulnerability to STIs and HIV & AIDS, thereby enabling them 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.

2. The suggested future research will focus on the gendered social stratification that will affect spousal age gap and spousal communication thereby allowing 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.

3. Secondly future research should find out how communication strategy can be designed that will foster quality spousal communication between couples in socially stratified society like Ankpa.

4. For practice it, future research should find 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 behavioral change among married women that could reduce their vulnerability to STIs and HIV & AIDS.

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