

Women's role in reproductive health decision making and vulnerability to STD and HIV/AIDS in Ekiti, Nigeria *



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Abstract

An exploratory study of women's role in reproductive decision making in Ekiti shows that women in the state are increasingly taking active decisions on matters affecting their daily lives. More women than ever before believed that they could take decisions on family size, when to have a baby and choice of spacing period. The cultural barrier against short postpartum abstinence appeared to have diminished and sex during lactation was not considered a major cultural and religious taboo. Knowledge of contraception has become universal in recent years, and the majority of women take decisions on the method and timing of family planning. All women who used family planning considered their decision in this regard very important. The ability of women to take decisions on these issues may not only enhance their bargaining power but also reduce their vulnerability to STDs including AIDS from diseased or high-risk partners.

It is now well recognized that sub-Saharan Africa has been affected by the AIDS epidemic more than any other part of the world. It has also been confirmed that a large proportion of African women suffer from a wide range of reproductive health problems including sexually transmitted diseases such as HIV/AIDS, and from other harmful traditional practices such as female circumcision. In this situation a major social and health concern is the extent to which women take decisions on their reproductive health. In Nigeria and indeed among the Yoruba, there is a very strong link between social and economic factors and the reproductive health problems confronting women. The culture of male dominance means that women seldom take decisions on matters affecting them. Lack of power leaves women unable to negotiate safe sexual practices or effectively seek care for their health problems, while men's unwillingness to control their sexual behaviour and the high incidence of STDs make women vulnerable to infection by men.

The role of women in economic development has become a major issue in recent times. Although most sub-Saharan African women are major producers and are responsible for the greater part of the labour in farming, certain aspects of the culture have traditionally suppressed the ability of women to take decisions even on matters that affect them. The purpose of this exploratory study, therefore, is to examine the extent to which women are involved in decision making on their reproductive health and the extent to which such involvement can reduce their vulnerability to sexually transmitted infection.

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The study

The study reported here was conducted in June-July, 1996 in two locations, one rural and one urban, in Ekiti, which has since 1 October 1996 become a state. The two different locations were selected for purposes of comparison. Ekiti is suitable for the study because women in the area have traditionally enjoyed certain rights and control over their sexuality. In addition, Ekiti has been a major laboratory for the collaborative Ondo State University - Australian National University research program on Sexual Networking, STDs and HIV/AIDS since 1989.

Ekiti state is situated in the northernmost part of the area inhabited by the Yoruba; the capital is Ado-Ekiti where the urban sample was taken. Ado-Ekiti had a population of about 150,000 people in 1991. It is also a major commercial and educational centre in the state. With the creation of the state in 1996, the population of Ado-Ekiti has probably risen to between 200,00 and 250,000. It is a university town and has a polytechnic, about a dozen public secondary schools and a high density of public primary schools. Ado-Ekiti also enjoys a high concentration of both private and public health institutions and an array of patent medicine and pharmaceutical stores. Traditional medical homes also abound.

The rural location with a population of about 1,200 is 20 kilometres from Ado-Ekiti. The village was founded by an Ado-Ekiti farmer and warrior who fought to defend the town during the inter-ethnic wars of the nineteenth century; it has become a major rural weekly market that serves Ado-Ekiti and the neighbouring towns and villages. The historical and economic links between Ado-Ekiti and the village make the choice appropriate.

Since the study is exploratory, a random sample of only 100 respondents was drawn from each of the selected urban and rural locations. Three different types of interview schedule were used. The first contained questions on the household; the second was administered to the primary respondents, and the third to the 'significant others' nominated by the primary respondents. This paper is based on the schedule administered to the primary respondents. In addition to questions on the characteristics of the respondents, decision-making on economic activities and household expenditure, the schedule contains questions on decision-making on education; task allocation; marriage; health; nutrition; circumcision and immunization; fertility and conception; breastfeeding and weaning practices and sexuality.

The findings

Table 1 presents the characteristics of the respondents. Except for education, religion and type of marriage, there are basic similarities in the characteristics of the urban and rural respondents, the majority of whom were aged 30-40 years, had at least primary school education and were in stable marital conditions. While most women in the urban location were in monogamous marriages, a majority of those in the rural location were in polygynous ones. The situation in the village is typical of most rural farming communities in Yorubaland where men need more than one wife to provide additional labour in both farming and marketing of farm products. Although Christianity is the dominant religion in both the rural and urban locations, the proportion of Muslims in the rural area is four times that of the urban area.

Table 1
Characteristics of respondents (percentage distribution)

	Urban (n=100)	Rural (n=100)
Age		
Under 30 years	10	15
30-40 years	80	70

Above 40 years	10	15
Education		
No schooling	0	50
Primary only	35	20
Secondary only	30	20
Tertiary	25	0
No response	10	10
Religion		
Christianity	90	60
Islam	10	40
Type of marriage		
Monogamy	70	40
Polygyny	30	60

Decision-making on family size

The respondents were asked a battery of questions on decision-making on family size and spacing of births. The responses are presented in Table 2. Asked whether women could decide on the number of children to have, more than half the urban and two-fifths of the rural women believed that women have the ability to take such decisions. However, the pattern of responses to whether a woman *should* decide the number of children to have is slightly different. Three-fifths of both urban and rural women thought that a woman should be able to take such decisions without reference to her husband. Nevertheless, three-quarters of the urban and slightly more than half the rural women had ever discussed with their partners when to have a baby. On spacing of births, nearly all the women in the urban area and slightly more than half of the rural ones reported that the decision to space births was jointly taken with their husbands.

The pattern observed in this study represents a major change from the traditional position where the husband took decisions on the number and spacing of children. The change is largely a product of Western education, the increasing economic independence of women and the effects of the structural adjustment program of the last ten years which has led to the gradual erosion of the economic superiority of men over women.

Decision on family planning

Yoruba women have traditionally observed a long period of postpartum abstinence, sometimes as long as 30 months, as a mechanism of child spacing (Orubuloye 1981). During the long postpartum period, sexual relations were prohibited and the woman had the absolute right to refuse sexual advances from her husband. The society protected and guaranteed such rights (Orubuloye 1995). The cultural beliefs supporting long postpartum abstinence appear to be diminishing. Only two-fifths of the urban and one-tenth of the rural women now think that there are still cultural-religious beliefs against a woman having sex during lactation, while a few of both urban and rural women believed that the period of postpartum abstinence should extend beyond 12 months. By 1991, for the majority of Yoruba women, the period of postpartum abstinence had fallen below 12 months (Caldwell, Orubuloye and Caldwell 1992) in contrast to the situation 15 years earlier. The situation has changed. The contraceptive revolution in Ekiti started with the structural adjustment program and the national policy of four children per woman which were put in place in 1986 and 1988 respectively. By June 1996, knowledge of family planning had become almost universal. Only one-fifth of the urban and rural women did not know any method of family planning. Two-thirds of the urban

women and three-fifths of the rural ones knew of one or two modern methods of contraception, the chief being the condom.

Table 2
Family size and birth spacing (percentage distribution)

Questions	Responses	Frequency	
		Urban	Rural
Can women decide the number of children to have?	Yes	55	40
	No	35	50
	Can't say	10	10
Should a woman decide the number of children to have?	Yes	60	60
	No	25	25
	Can't say	15	15
Who decides on the spacing of your children?	Self	0	25
	Husband	5	10
	Self & husband	90	55
	By chance	5	5
	Others	0	5
Ever discussed with husband when to have baby?	Yes	75	55
	No	25	40
	No response	0	5
Do you know any method of family planning?	Yes	95	90
	No	5	10
Are you currently using a method?	Yes	20	10
	No	75	55
	No applicable	5	35

One-fifth of the urban women and one-tenth of the rural ones were currently using contraception. The condom and the rhythm method were used and the decision to use these methods was taken by both partners. Women using family planning considered their opinion in this regard very important. The major sources of information on family planning were antenatal clinics, hospitals, and the media (radio and television). While the school was equally important in the urban area, friends and relations were important sources of information in the rural areas.

The supply of contraceptives, especially condoms, had increased since the campaign against STDs and AIDS began four years ago. The supply is now seriously threatened by the sanctions recently imposed on Nigeria by many foreign international agencies. The shortage has resulted in increase in price, which will probably have serious implications for contraceptive use, especially because of the drop in income and the decline in the value of the Nigerian currency.

Decision-making on health treatment

In recent years, the person taking treatment decisions has become important for health intervention programs because of the progressive deterioration in health care facilities and more importantly because of the social and health problem posed by AIDS. It has now been firmly established that treatment decisions are delayed because of cost, and when the decisions are made by the woman in respect of her own health or that of her children, the woman pays for such treatment (Orubuloye et al. 1991). When decisions on treatment are taken by both husband and wife, they jointly pay for treatment. The result of further investigation on this subject indicates that nearly all the women (95% urban and 90% rural) were involved in the decision to seek treatment when they or their children were sick. All the women considered taking part in the decision as very important to them.

The findings are important, and may have serious implications for health care in the event of STDs and AIDS. It appears that women will be able to take part in decision making for health treatment if they suffer from STDs or AIDS. Because of the economic independence of most Yoruba women, they are far more likely to do this and their families will support this position, and may even take the initiative.

Decision making on sexual activity

The right of African women over their sexual activity has become the subject of debate since the advent of AIDS, partly because the heterosexual transmission of the disease is dominant in the African region, and partly because the majority of HIV-positive women in the world are found in the region (Orubuloye, Caldwell and Caldwell 1993). It has also been established through research that although women have on average fewer sexual partners than do men, they have little control over the sexual activities of their husbands and are vulnerable to infection by these partners. Table 3 presents the results of the series of questions on the possibility of women refusing sex with their partners under varying conditions.

The pattern is as expected. Most rural women are in polygynous marriages and their husbands can always turn to other wives if they refuse them sex. Women in the rural area either live among or close to their family members, so they can always get support or return to them if they quarrel with their husbands on such matters.

When husbands are infected, nearly all women will refuse to have unprotected sexual relations with them. Nevertheless, 45 per cent of urban women compared to 50 per cent of rural women would ask their infected partners to use condoms, while 30 per cent urban and 35 per cent rural were undecided.

Table 3
Ability of women to refuse sex (percentage distribution)

Questions	Responses	Frequency	
		Urban	Rural
Can a woman refuse sex with a partner if she does not want another baby?	Yes	35	70
	No	50	25
	Don't know	15	5
Can a woman refuse sex with an infected partner?	Yes	95	95
	No	5	5
Can a woman ask an infected partner to use a condom?	Yes	45	50
	No	25	15
	Undecided	30	35

Does a woman have the right to refuse sex with her partner?			
	Yes	70	75
	No	30	25

Importance of opinion in reproductive health decision-making

The involvement of women in decisions relating to health treatment, use of contraceptives and breastfeeding was nearly universal. To understand the degree of involvement, an attempt was made to identify individuals whose opinions are important when reproductive decisions are to be taken. The responses are presented in Table 4, which shows that the opinion of women, both respondents and significant others, about reproductive health is considered very important most of the time. Probably such matters are of more concern to them than to men. For instance, during the field investigation, one of the respondents reported that the decision to stop breastfeeding a child rests with the mother. A man can tell his wife to stop breastfeeding so as to resume sexual relations early, but it is usually the responsibility of the wife to decide when to wean a child.

Discussion

The findings of this exploratory study show that women in Ekiti are increasingly taking active decisions on matters affecting their daily lives. More women than ever before believe that they can take decisions on family size, when to have a baby and choice of spacing period. The cultural barrier against short postpartum abstinence seems to have diminished while sex during lactation is not considered a major cultural and religious taboo. Knowledge of contraception has also become universal in recent years and the majority of women take decisions on method and timing of family planning. All users of family planning considered their opinion in this regard very important.

Most women take part in decisions on when to seek health treatment for themselves or their children. Nearly all the women considered taking part in the decision as important to them. The majority of women believed in their right of control over their sexual activity and would insist on this right when their husbands were diseased. A good proportion would refuse sex with infected husbands or if they did not want another baby.

Table 4
Persons whose opinions are important in decision-making on reproductive matters (per cent distribution)

Subject	Relationship to respondent	Sex	Importance of opinion	Percentage	
				Rural	Urban
Child's treatment	Husband	M	1	85	70
	Husband	M	2	-	15
	Respondent	F	1	95	90
	Sister	F	1	5	-
	Daughter	F	1	5	-
	Neighbour	F	1	10	-
	Co-wife	F	1	5	-
Own treatment	Mother	F	1	5	-
	Husband	M	1	80	80
	Respondent	F	1	85	80
	Respondent	F	2	-	10

	Neighbour	F	1	5	5
	Co-tenant	F	2	5	-
	Sister	F	-	5	-
	Co-wife	F	1	5	-
	Son	M	1	5	-
	Daughter	F	1	10	15
	Sister-in-law	F	2	5	-
Having a child	Respondent	F	1	50	75
	Respondent	F	2	25	-
	Respondent	F	3	10	-
	Mother	F	2	5	-
Breastfeeding	Husband	M	1	40	15
	Husband	M	2	5	-
	Respondent	F	1	50	55
	Mother	F	2	5	-
	Co-tenant	F	1	-	5
Contraceptive use	Respondent	F	1	5	20
	Doctor	M	1	5	-

Note: 1 = Very important; 2 = Quite important; % is calculated in terms of the ratio of positive responses to questions relating to the subject matter.

These findings are important for possible intervention programs that can halt the spread of STDs including AIDS. With the current economic situation arising from the structural adjustment program, women were less reluctant to make decisions in respect of family size, family planning and health treatment for themselves or their children. Yoruba women have traditionally received support from relatives when they refuse sex with a husband who is drunk or making a deliberate effort to shorten the period of postpartum abstinence. In recent times, such rights are now being transferred to when a spouse is infected with an STD. This again may be applicable to AIDS. The ability of women to take part in decisions on matters that affect their daily lives will not only enhance their bargaining power but also reduce their vulnerability to STDs including HIV if their partners have a high-risk sex life or are diseased. Certainly, women need the support of the community and possibly that of the government to reduce the dangers posed to them by irresponsible partners.

References

- Caldwell, J.C., I.O. Orubuloye and P. Caldwell. 1992. Fertility decline in Africa: a new type of transition? *Population and Development Review* 18,2:211-242.
- Orubuloye, I.O. 1981. *Abstinence as a Method of Birth Control*. Canberra: Australian National University.
- Orubuloye, I.O. 1995. Women's control over their sexuality: implications for STDs and HIV/AIDS transmission in Nigeria. In *Women's Position and Demographic Change in Sub-Saharan Africa*, ed. P. Makinwa-Adebusoye and A.-M. Jonsen. Liège: IUSSP.
- Orubuloye, I.O., J.C. Caldwell, P. Caldwell and C.H. Bledsoe. 1991. The impact of family and budget structure on health treatment in Nigeria. *Health Transition Review* 1,2:189-210.

Orubuloye, I.O., P. Caldwell and J.C. Caldwell. 1993. African women's control over their sexuality in an era of AIDS. *Social Science and Medicine* 37,7:859-872.