Demographic Research a free, expedited, online journal
of peer-reviewed research and commentary
in the population sciences published by the
Max Planck Institute for Demographic Research
Konrad-Zuse Str. 1, D-18057 Rostock · GERMANY
www.demographic-research.org

DEMOGRAPHIC RESEARCH
VOLUME 12, ARTICLE 2, PAGES 29-50
PUBLISHED 01 MARCH 2005
www.demographic-research.org/Volumes/Vol12/2/

Research Article

Women's sexual control within conjugal union: Implications for HIV/AIDS infection and control in a metropolitan city

Peter O. Ogunjuyigbe

Ezekiel O. Adeyemi

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Demographic Research: Volume 12, Article 2
a research article

Women's sexual control within conjugal union: Implications for HIV/AIDS infection and control in a metropolitan city

Peter O. Ogunjuyigbe [1]

Ezekiel O. Adeyemi [2]

Abstract

This study attempts to examine the extent to which women have control over their sexuality within marriage and its implication for the spread of HIV/AIDS. The survey was carried out in metropolitan Lagos. The study shows that women have some control over their sexuality especially during certain occasions such as during menstruation, breastfeeding, pregnancy and when they are sick. However, only few women could negotiate with their husbands especially by insisting on safe sexual practices. The study therefore shows that women need to be educated on the need for safer sex practices, especially in this era of HIV/AIDS. They should also be economically empowered so as to practice safer sex. Again, men should be educated on the safer sex practices in other to control the spread of HIV/AIDS.

[1] Department of Demography and Social Statistics, Obafemi Awolowo University, Ile-Ife. E-mail: pogunjuyigbe@yahoo.com

[2] Department of Sociology, Lagos State University, Lagos

1. Introduction

Ever since AIDS was first identified, a great deal has been learned about the genetic structure of the virus, the route of HIV transmission and the course of the disease. Yet it remains a major medical problem and a challenge to communicable disease control programme. UNAIDS (2001) reported that globally the pandemic has worsened in the last few years; at the end of 2001, an estimated 40m million people globally were living with HIV. In many parts of the world, the majority of new infections occur in young adults, with young women most vulnerable. This has negative implications for the future of the family.

Sexuality and the family are therefore crucial issues if the many problems women in African countries face due to inequitable sexual relations are to be taken seriously. That the greatest risk of sexually transmitted diseases (STDS) to women in Africa is provided by their husbands and other unstable partners has long been established (Frank 1983). This is evidently different from infection through homosexual transmission characteristic of the developed countries. The issue of concern and control of the AIDS epidemic in Africa must therefore focus on behavioural patterns between men and women in conjugal or other such intimate relationships. A major social and health concern in sub-Saharan Africa should therefore focus on the extent to which women are able to control their sexuality by way of negotiating sex in high–risk circumstances and insisting on safe sexual practices by their husbands and other partners.

Ethnicity is a key stratification dimension within the country that shapes reproductive attitudes and behaviour (Kritz and Makinwa-Adebusoye, 1995). In Nigeria, there are diverse ethnic groups but three major ethnic groups come into focus each time ethnic dimension is being applied. These are the Hausa, Yoruba and Ibo and these ethnic groups located in different zones. These three ethnic groups are not highly diverse within themselves but contrast markedly with each other. For instance, the Hausa practise seclusion and restrict the access of girls to formal education and that of women to employment outside the home. Yoruba and Ibo, in contrast, have been more open to social change and allow girls to be educated and even encourage women to work outside the home. But the dictates of seclusion largely constrain the income-earning activities of Hausa women to activities that can be carried out within the confines of family compounds (Imoagene, 1990). Seclusion is not practised by the Yoruba and Ibo and as such women in these societies tend to participate actively in the informal and formal economies. Socio-cultural differences in the organization of work and family among these ethnic groups have implications for women's decision-making authority and reproduction. Among the Yoruba and Ibo, improved access to education and work outside the home in recent times appear to be correlated with increased authority within household and increased reproductive change. Although few women in

Hausa societies are also gaining access to formal education and work-for-pay outside the home, their authority within the home remains almost unchanged because of the Islamic religious tenets (Kritz and Makinwa-Adebusoye, 1998).

Circumstances under which women in southwest Nigeria may and are indeed expected to refuse sexual intercourse with their partners include the period before marriage, during menstruation, during the postpartum period (when breast feeding), on becoming a grandmother and on reaching menopause. Traditionally women in much of sub-Saharan African societies practised long periods of postpartum abstinence, typically more than one year (Schoenmaeckers *et al.*, 1981) and three or more years in southwest Nigeria (Caldwell and Caldwell, 1977; 1981). South western Nigerian women had a societally backed right to refuse a husband sexual relations in a range of circumstances, but his philandering, though sometimes a cause of bitterness and individual action by a wife, was not one of these (Orubuloye, Caldwell and Caldwell, 1993; Orubuloye, 1994). The existence of prescribed periods of sexual abstinence reveal that culturally women have sexual rights which they are in fact expected and encouraged to exercise. Generally, women are assisted by societal approval and sanctions to comply with maintaining these periods and exercising their rights. Outside these special circumstances, however, it is generally assumed among the Yoruba of southwest Nigeria that women do not have personal choices to make when it comes to sexuality (Harcourt, 1993). This assumption makes it difficult for women to face the reality of lack of decision making power within the family. Isiugo-Abanihe (1994a) study also confirms the generally held view among major ethnic groups in Nigeria (Yoruba, Igbo and Hausa) that as husbands and household heads, men control the sexuality of their wives. Wives are bound to comply with their husband's sexual demands as refusal is a major source of strife, the taking of other wives or the keeping of "outside wives" (Karanja, 1987).

Double standards of sexual morality for husbands and wives with the risks of infection and diseases such as HIV/AIDS limit women's life choices concerning their health, happiness and career. The payment of dowry and bride wealth in many African cultures reinforced the belief that women become the property of their husbands once the bride wealth is paid; they are assumed to have been bought. Isiugo-Abanihe (1994) and Jewkes *et al.* (1999) found that women are perceived as their husbands' property or that of their husbands' families and that their role is to "hatch children like drugs". Among the Yoruba of southwest Nigeria, husbands are referred to as "*olowo ori mi*" (the one who owns me) by their wives. Though the actual level of bride wealth among the Yorubas is minimal and often not paid, but it is symbolically significant. Among the Igbos of southeast Nigeria, until a husband pays the bride price of his wife, the children which the woman gives birth to belong to her (the woman's) father. The reason underlying this practice, it seems, is that the husband is yet to acquire the ownership of

the "machine for producing children"; the transfer of ownership is effected through the payment of the bride price. Isiugo-Abanihe (1994b) suggested as much when he wrote that "among the Igbo, for whom bride wealth payments are high, a woman comes under the authority of her husband and takes instructions from him as the head of the family by virtue of this payment". The finding of Jewkes *et al.* (1999) in Eastern Cape Province of South Africa was similar. Here, it is culturally accepted that if a man pays the *labola* (bride wealth) for his wife, it means that he owns her. This undoubtedly influences women's perception of their persons as a man's property and invariably compromises their power in decision-making. Whereas husbands maintain the right to control their spouses' desires for extramarital sexual activity, most wives do not try to exercise such control over their spouses (Caldwell and Caldwell, 1981; Orubuloye, Caldwell and Caldwell, 1992).

The irony of their situation and position is that southwest Nigerian women, unlike in East Africa, are known to have a relatively high social status derived from a high level of economic independence whereby they can on their own engage in paid job or engage in trading activities and earn income. The ability to keep and control the income that accrues from their trading activities (Karanja, 1983), and the fact that they can obtain a divorce and return to their family of origin after, are important issues that give women in the region some leverage over their African sisters elsewhere. The question then is to what extent is this power transferred to the area of control of their sexuality when men pursue a high-risk sexual lifestyle like having multiple partners and engaging in casual sex, and non-use of condom, especially in an urban setting? How then can an understanding of this influence AIDS control strategies in Nigeria? Answers to these questions would help us to understand the particular conditions of gender equity under which wives can refuse their husbands sex and avoid infection of STDs or HIV.

In Nigeria, metropolitan Lagos is not only most urbanised of all the urban centres, but also the foremost commercial and industrial area of the country. Her heterogeneous population, the reported HIV high level among commercial sex workers put at 20 percent (Rasome-Kuti, 1992) and the observed high degree of sexual networking (i.e. ways by which people are linked together through common sexual partners) expose women dangerously to sexually transmitted diseases (STDs) and HIV infection, even within marriage. The present study therefore would be an important contribution to knowledge in the area of women's control over their sexuality in the face of an impending AIDS epidemic in Nigeria.

2. Methodology

The survey was carried out in metropolitan Lagos, the most heterogeneous city, the most industrialised and the economic nerve centre of the country. Apart from the major ethnic group, which is Yoruba, it consists of representatives of all known ethnic groups in the country with diverse social, economic, political and cultural characteristics. The characteristic of her inhabitants and the long exposure to influences of education, foreign culture and modernisation qualify it as a place where institutional and attitudinal changes may be observed and measured.

Both qualitative and quantitative methods were used to elicit information from the respondents. However, quantitative method preceded the qualitative in order that survey results could be interpreted and investigated in more depth using interviewing techniques. The study aims at the examination of the extent to which women have control over their sexuality within marriage and its implication for the spread of HIV/AIDS. Married women from reproductive age 15 years and above were interviewed. Current use of condom as an outcome variable was used to calculate the sample size for this study. By setting Type I error (α) at 0.05 and Type II (β) at 0.10 (one-sided), and using the data from "National HIV/AIDS and Reproductive Health Survey, Nigeria, 2003 (Federal Ministry of Health, 2003), in order to detect an absolute change of 10 percent in current condom use by spouse now put at 23 percent. This yielded a sample size of 244. In order to make the sample size representative of the whole population in the study area, multistage sampling technique was used. The study area was divided into three zones, the inner city, the middle ring and the outliners. The inner city is oldest part of the metropolis and is made up of the traditional business district organised around the Oba's palace, the modern commercial business district of Marina, Broad Street and environ where the structures are mostly for commercial purposes; and the largely residential Islands of Ikoyi and Victoria. The middle ring consists of the mainland district of Ebute-metta, Surulere, Yaba, Mushin, Apapa-Iganmu, Oshodi, Ikeja, Somolu and Agege. The third zone is made up of the pheripheral districts that have recently developed and almost formed a continuous link with the metropolis. They are mainly residential, made up of Ikotun, Egbe, Ipaja, Akowonjo/Egbeda, Ejigbo, Magodo and Ojo. Within each of the stratum, four streets were randomly selected from the listing of all major streets. The selected streets are ; Simpson street, Herbert marculey, Lawanson, Itire road, Oguntolu, Oyinlola Adams, Ajibade, Old Ojo road, Akonwonjo road, Campbell, Temple road and New era road. From each of the streets, twenty (20) houses were randomly selected from the listing of houses in the street. One household was selected from each of the houses. Within the household, married woman in the reproductive age group 15-49 years was interviewed. In a situation where there are two or more women within the household simple balloting

was used to select the appropriate respondent. In all 224 questionnaires were correctly filled and were used in our analysis. The information sought covered a wide area of respondents' essential socio-economic and demographic characteristics, reproductive health matters and sexual behaviour. The questionnaires were administered by trained and carefully selected research assistants.

While structured interview could usually be employed in tapping information for the major thrust of the research objectives, focus group discussions were held among currently married women within the study community to strengthen the interview on the traditional expectations regarding periodic sexual abstinence and the extent to which women control their sexuality. Six focus group discussions were conducted; two in each of the zones. Focus group participants were selected on the basis of their current age and place of residence. This approach was adopted to accommodate the heterogeneous structure of the women populace and to be able to obtain a representative pattern of social interaction.

Returned questionnaires were subjected to thorough screening, checking for consistency and finally edited. The precoded nature of the questionnaire facilitated easy entry of the data and statistical analysis. The data collected were subjected to basic demographic analytical techniques. In the statistical analysis of the data, a combination of univariate, bivariate, and multivariate analysis were employed. At the univariate level, an examination of the distribution of the respondents according to each of the selected characteristics was carried out. Frequency distribution was adopted. Bivariate analysis was carried out to discover existence of relationship between the dependent and independent variables. Information from focus group discussions were transcribed and organized under broad headings that depict different aspects of the discussions. The transcribed information were analyzed descriptively (qualitatively) and used to explain results of quantitative analysis where and when necessary.

The major background and demographic variables used in this article are education, current age, religious affiliation, occupation, and marital status. Some of these variables were recomputed where necessary. Logistic regression is used to test for the effect of these characteristics on whether women can reject sexual intercourse from their husbands. The ease of interpretation of the odds ratios produced by logistic regression is one of the appeals for using such model (Hoswer and Lemeshow, 1989).

3. Results

3.1 Socio-economic characteristics of respondents

Table 1 shows the socio-economic composition of the respondents. It is observed that the bulk of the population are relatively young. Fifty-eight percent of the respondents are in the age group 15-34 years, while relatively few are above 45 years of age. Just like we have in the Demographic and Health Survey, 2003 (NPC, 2004), the modal group is aged 25-34 years. The table shows that more than half of the population had secondary or lower levels of education. About 48 percent have post-secondary education. This favourably compared with the outcome of the 2003 DHS, where it was reported that about 70 percent of population in South-west has a minimum of primary education (NPC, 2004). Three out of every five respondents are Muslims probably because majority of the Hausas and significant proportion of the Yorubas are adherent of this religion. None of the respondents indicated African religion; this could be as a result of recent proliferation of churches and mosques, in addition to the effect of urbanisation and modernisation in the study area. Three out of every five respondents interviewed were married as at the time of the survey while 16.5 percent and 15.2 percent were divorced and separated respectively.

Lagos, although clearly the Nigerian melting pot, still remains primarily a Yoruba city. The ethnic composition shows a high representation of the Yoruba people (57.1 percent). The Igbo constitute the second largest ethnic group representing about 29 percent of the total respondents. Their comparatively large representation is connected with their dominant occupation, which is trading. The observed proportion of Hausas who are of northern origin may not accurately reflect their real percentage in the city. Their cultural and religious inclinations may perhaps explain such variation. These are predominantly Muslims, with stronger Islamic persuasion in certain respects than their southern Muslim counterparts. Their relatively high conservatism coupled with a low affinity with western education meant that they were not very co-operative when discussing issues related to sex. This also explains the very low level of access to the women.

Examination of the occupational distribution as shown in Table 1 reveals that women are more prominent in trading activities. About 59 percent of the respondents belong to this occupation compared with only 16 percent who are professionals. Among women in the study area and for the three major ethnic groups covered in this study, trading has always been the major occupation, especially for those with low levels of education (NDHS, 2003). Traditionally, among the Yorubas and the Ibos, a non-working wife is considered to be lazy. A typical Yoruba or Ibo woman, unlike other ethnic groups in Nigeria, works to cater for herself, her children and other members of

her extended family. Perhaps this might explain why only 9.4 percent of the respondents reported that they are housewife. Four out of every ten respondents earn less than ₦10,000 ($80) which formed the highest proportion. This is closely followed by those earning between ₦31,000 ($240) - ₦40,000 ($310) (16.8 percent).

Table 1: Percentage distribution of respondents by socio-economic characteristics

Characteristics	Number	Percentage
Age		
15-24	59	26.3
25-34	70	31.3
35- 44	48	21.4
45 and above	47	21.0
Ethnic Group		
Yoruba	128	57.1
Ibo	42	28.6
Hausa	22	9.8
Others	32	14.3
Religion		
Christianity	96	42.9
Islam	128	57.1
Occupation		
Trading	128	58.5
Housewife	21	9.4
Clerical	36	16.1
Professionals	36	16.1
Marital Status		
Married	153	68.3
Divorced	37	16.5
Separated	34	15.2
Level of Education		
Primary	64	28.6
Secondary	96	42.9
Post-secondary	64	48.6
Income		
Less than 10,000	93	41.5
11,000 - 20,000	32	14.2
21,000 - 30,000	31	13.8
31,000 - 40,000	36	16.0
41,000 & above	32	14.3
Total	224	100.0

3.2 Women's sexual control

From table 2 it was observed that 65.6 percent of the respondents believed that a woman has a right to refuse sex with a partner, while 34.4 percent believed that woman does not have such right. These two positions were supported by participants in the focus group discussions. For instance, a 35 year old married female discussant expressed her concern on whether woman can reject sexual intercourse from her husband or not. She said:

> *"A woman has right to reject sex from her husband if she does not want to have it. Women are not log of wood that men can just mount at will".*

Another 43 years old religious woman opined that:

> *"It is not the will of God for a woman to reject sex or deny her husband sexual approach. Our husbands are the owners of our bodies".*

Respondents were further asked to indicate whether they had ever had a cause to refuse sex with their partners. Three quarters reported that they had done so on at least one occasion. The circumstances under which a woman can reject her husband as reported by these women include "when the woman is breastfeeding" (29.5 percent), "menstruating" (28.6 percent), "when sick" (27.7 percent) and on some other occasions such as a punishment for husband's bad behaviour or when the woman is not happy (14.3 percent). However, a 32 year old woman participant in a focus group discussion indicated that:

> *"I can only reject sex from my husband when I am menstruating. Even if I am sick I will still allow him to have sex with me".*

This clearly shows the extent to which women are free to refuse sexual advances from their husbands. On whether women can demand for sex from their husbands, three out of every five respondents interviewed agreed that women could demand for sex if they are in mood to do so. A little over 53.4 percent believed it is natural, while the rest thought it is right to demand for sex when another child is needed (46.6 percent). A 27 year old participant in one of the focus group discussions, however, pointed out that "*often times, women are not courageous enough to ask for sex for fear of being accused of promiscuity*". Only 43 percent agreed that they could decide the number of children they want. Interestingly more than three-quarters of the women believed that they could influence the decision to adopt methods. This is, however, very strange when positions among the study group are put into consideration. However, this might be connected

with the impact of urbanisation and modernisation which are now noticed to be positively impacting on the status of women among the various ethnic groups residing in the city.

Table 2: Percentage distribution of women's sexual control

Characteristics	Number	Percentage
Can women reject sexual intercourse?		
Yes	77	34.4
No	147	65.6
Under what conditions?		
During breastfeeding	66	29.5
During menstruation	64	28.6
When ill	32	27.7
Others	32	14.3
Can woman demand for sex?		
Yes	161	71.6
No	63	28.4
If yes why?		
It is natural	64	53.4
When another child is need	60	46.6
Can woman decide no of children?		
Yes	97	43.3
No	127	56.7
Can woman determine family planning usage?		
Yes	159	71.0
No	65	29.0

3.3 Reproductive decision-making

There is a general belief among the respondents that reproductive health decision-making and attitude differ according to marital status, especially on issue such as role sharing within the family. Married couples may likely show some commitment and respect to their spouses especially on handling such issues related to reproductive decision making. This may not likely hold among unmarried, separated or divorced women. For instance, it is a common practice in Yorubaland that married women should be submissive to their husbands in fertility related matters and that they secure permission from their husbands before taking major decisions such as limiting fertility through contraceptives or other means. Among this major ethnic group, there is a popular proverbial adage which says "*Oko lo lori aya*", literally translated as "husband is the head of the wife". Table 3 shows that men still have the power to determine when to have sexual intercourse. Westernisation and modernisation have not in any way

affected this belief. Forty-two percent of the respondents indicated that their husband would determine when to have sex compared with only 28.6 percent who opined that the decision rests with women. Majority of the women (72.8 percent) reported that they play major role in the decision to use contraceptives. This role was however qualified in the focus group discussion when participants said "*we can take decision to use contraceptive but the permission of our husbands would be sought first before we can adopt contraception*". It was also revealed that men more than women had the final say concerning the number of children (43.8 percent) and when to have the children (44.2 percent).

Table 3: Percentage distribution of respondent by reproductive decision-making

	Decision by:			
Decision on:	Husband	Wife	Both	Total
When to have sex	45.1 (101)	28.6 (64)	26.3 (59)	100.0
When to use contraceptives	14.3 (32)	72.8 (163)	12.9 (29)	100.0
Family planning method(s) to use	28.6 (64)	42.9 (96)	28.6 (64)	100.0
When to have more children	43.8 (98)	14.3 (32)	42.0 (94)	100.0
Desired family size	44.2 (99)	13.8 (31)	42.0 (94)	100.0

3.4 Knowledge of STDs and condom use

It is considered important that knowledge of STDs including HIV/AIDS epidemic amongst the respondents should be ascertained. It is believed that this knowledge of STDs will influence sexual behaviour and the kind of sexual control exercised by women within the conjugal union. Questions posed include whether the respondents have heard of STDs and the kind of STDs heard about, whether they ever discussed HIV/AIDS with their spouses, friends or family, as well as their knowledge about the mode of transmission and risk reduction behaviour.

Table 4 shows that 83 percent of the respondents have heard about sexually transmitted diseases. This indicated that the knowledge of STDs is widely spread among women in the study area. The more commonly heard of the STDs are HIV/AIDS, gonorrhoea, candidiasis, syphilis and herpes. In assessing the knowledge of the respondents about HIV/AIDS, each respondent was first asked whether they have heard about AIDS, and how they have learnt about it. All respondents claimed that they have heard about HIV/AIDS and the sources of their information in descending order are Radio (42.9 percent), Television (29.5 percent), Newspaper (13.8 percent), and Poster (13.8 percent). Respondent's knowledge of the mode of transmission of

HIV/AIDS indicates that they were quite aware of the proper mode of transmission. Major sources of contacting HIV/AIDS indicated by the respondents include sexual intercourse (71.0 percent), unsterilised needles (28.6percent), and blood transfusion (29.5%). However, some believed that the disease could be transmitted by shaking of hands (13.8%); thus introducing some level of misconception into their knowledge.

Table 4: Percentage distribution of respondents by knowledge and attitude towards STIs

Knowledge and attitude of STIs	Number	Percentage
Ever heard of STIs		
Yes	190	83.9
No	34	16.1
STIs heard about		
HIV/AIDS	224	100.0
Gonorrhoea	191	85.3
Candidiasis	66	9.5
Herpes	33	14.7
Syphilis	31	13.8
Sources of information		
Radio	96	42.9
TV	66	29.5
Newspaper	31	13.8
Posters	31	13.8
Ever discussed? HIV/AIDS		
Yes	223	99.6
No	1	0.4
Whom do you discussed HIV/AIDS with		
Husband	97	43.3
Other family	64	28.6
Friends of the same sex	63	28.1
Mode of transmission		
Sexual intercourse	159	71.0
Shaking of hands	31	13.8
Unsterilised needles	64	28.6
Blood Transfusions	66	29.5
Ever contacted STIs	65	29.0
Heard of condom	161	71.8
Ever used condom	70	31.4

Table 4 shows that more than one quarter of the respondents have contacted STDs in the study area. This shows that women in the urban area are in the risk of contacting HIV/AIDS. Majority of focus group participants mentioned their husbands as the main source of STDs. The inability of some of the women to reject sex from their husband

even when the husband is not faithful will have a great implication on the transmission of HIV/AIDS.

A good majority of the women (72 percent) knew of condoms but just a third (31 percent) had ever used them. Only 6 percent always used condoms in the last three months and another 15 percent used it occasionally. For those who used condoms, the main reason was to prevent STDs. Just about 4 percent mentioned HIV/AIDS specifically. Another 10 percent said they used condoms to prevent pregnancy. The main reason for not using condoms was that they "just didn't like it" (27 percent). Another 9 percent felt that condom did not give any protection. About 33 percent did not use condoms because they had faith in their partners and few others said they wanted babies (19 percent).

3.5 Can women reject sex?

As illustrated in Table 2, only 34.4 percent of the women gave an indication that they can reject sexual intercourse from their husbands if and when they so desire, while the remaining majority (65.6 percent) believed it is impossible for a woman to reject sexual advances from her husband. It is considered paramount to examine the background characteristics of women in these categories and. The results are as presented in Table 5. The table reveals that only 13.6 percent of the respondents within age group 15-24 years agreed that women cannot say 'no sex' to their husband. The reason may be due to the fact that this age group are still young in their matrimonial home. The fear of being divorced is another factor that may be responsible. Older women however believed that they could reject their husbands' sexual advances if they are not willing or are not favourably disposed. Traditionally and as indicated above, women have some control over their sexuality on certain occasions especially during pregnancy, breastfeeding, and menstruation, after menopause, and when they perceive that their husbands have contacted STDs. However, most women lack the knowledge or the opportunity to identify infection in their husbands. Table 4 further shows that ethnicity plays dominant role in the perceptions on whether women can reject sex or not. For instance, 42.9 percent of women from the Yorubaland believed that women can say no to sex while 26.2 percent and 27.3 percent of Ibo and Hausa respectively agreed that they can reject sex from their husband. This variation could be due to the varied effect of socialisation and modernisation among the three major ethnic groups.

Table 4 further shows that 91.4 percent of Muslims as against 46.9 percent of Christians believed that it is improper for a woman to reject sexual advances from her husband. This may not be unconnected with their religious doctrine which portends that 'women must give all what she has to their husband'. Some participants in the focus group

discussions also supported this tenet. However the emphasis laid upon was in the Holy Quoran that "*woman must be submissive to her husband*". This position was also supported by the Bible (Ephesians: 5:22). To them submission must be total including their body, even when the woman is aware of the infidelity of her husband.

Occupational status of a woman is also shown to influence her ability to reject sex from her husband. About 58 percent of women in professional jobs indicated that they could say no, followed by those in clerical works (36.1 percent), trading (31.3 percent), and housewife (9.5 percent) in that order (Table 5). The assumption is that those who are engaged in good job will have the financial ability to challenge their husband, as they may not entirely depend on their husband for their needs. Also, the situation where husbands are happy that their wives are working, there is tendency for wives to react strongly against decisions made without consulting them. Findings from focus group discussions also confirmed that economic power of women will determine their extent of insisting on safer sex during risk period. A situation where majority of the women are found to depend on their husband for their social and financial needs, they are unable to say no even when they know that they are at risk. This position was supported by participants in focus group discussion. For instance a 27 year old full-time housewife remarks,

> *"There is no way I can say no to my husband. Anytime I said so, he will not give me money for food. He will go and meet his extramarital partners".*

This clearly implies that it is those women who are economically empowered that can fight for their reproductive rights.

Marital status is another variable that will influence women's sexual control. From the above table, four out of every five women who are either divorced or separated indicated that they can say no to sex to their husband compared with three out of every five for those that are currently married. The reason that could be adduced for this is that those who are divorced or separated cannot be controlled my men. Hence the reason why our society does not give respect to a woman who is not married to a man. Also some of the women believed that women should not to be subjugated. From the focus interview, it was gathered that such women believed that they should be able to determine when they want sex.

Table 5 further shows that there is a positive relationship between the level of education and women's ability to say no to sex About 39 percent and 43 percent of respondents with secondary and post secondary education respectively believed that they had some sexual control compared with only 17.2 percent of respondents with primary education who agreed that they can say no sex to their husbands.

Table 5: Bivariate analysis of socio-economic characteristics of respondents by whether women can reject sexual intercourse

Characteristics	Can woman reject sex?			
	YES (%)	NO (%)	Number	P
Age				
15-24	13.6	86.4	59	
25-34	30.0	70.0	70	
35-44	39.6	60.4	48	
45 and above	61.7	38.3	47	0.000
Marital status				
Married	25.5	74.5	153	
Divorced	40.5	59.5	37	
Separated	67.6	32.4	34	0.089
Level of Education				
Primary	17.2	82.8	64	
Secondary	42.7	57.3	96	
Post secondary	39.1	60.9	64	0.007
Occupation				
Trading	31.3	68.7	131	
Housewife	9.5	90.5	21	
Clerical	36.1	63.9	36	
Professionals	58.3	41.7	36	0.602
Religion				
Christianity (non Catholic)	-	100.0	32	
Christianity (Catholic)	53.1	46.9	64	
Islam	8.6	91.4	128	0.024
Ethnic group				
Yoruba	42.9	57.1	128	
Ibo	26.2	73.8	42	
Hausa	27.3	72.7	22	
Others	15.6	84.4	32	0.989

4. Multivariate analysis

Application of the logistic model to the analysis helps to identify the most relevant variables which in combination, model the incidence of women's sexual control as reflected by the data. It also helps in assessing the relevance of each factor considered in conjunction with all other selected factors in the model. It is therefore a higher-order analysis than the initial dichotomised response patterns analysed above.

Two separate models were fitted (see Table 6). Model 1, the main-effects model, contains the total effect of each factor without any controls. This model also shows that the odds of sexual control increased with age: Older women aged 45 and above were about 3 times as likely to reject sex as were those aged 15-24 years (RC). The odds of

sexual control increase with levels of education. Women with post secondary education are about 2 times more as likely as their counterparts in primary school (RC) to reject sex. The probability of sexual control is higher among professionals and traders than among housewives, among Christians than Muslims and among those that are separated or divorced than among those that are currently in marital union. Ethnicity, though not significant, but is a predictor of sexual control with rejection of sex among the Yoruba being about twice the level among the Hausas (RC).

Table 6: Multivariate coefficient and odds ratio from two logistic regression models of the effects of selected characteristics on sexual control among women in Lagos City

Characteristics	Model 1		Model 2	
	Coefficient	Odds ratio	Coefficient	Odds ratio
Age				
15-24 (ref)	0.000	1.00	0.000	1.00
25-34	1.245	2.31*	0.501	1.65
35-44	1.813	2.08**	0.592	1.81
45 & above	2.514	3.82**	0.407	1.50
Marital status				
Married (ref)	0.000	1.00	na	na
Separated	1.981	2.48**	na	na
Divorced	2.804	2.15*	na	na
Education				
Primary (ref)	0.000	1.00	na	na
Secondary	0.662	1.63**	na	na
Post secondary	0.814	2.14**	na	na
Occupation				
Housewife (ref)	0.000	1.00	0.000	1.00
Trading	0.567	1.42**	0.286	1.33
Clerical	0.158	1.86	0.602	1.82
Professional	1.433	1.53*	0.527	1.69
Religion				
Christianity	2.244	5.27**	0.527	1.22**
Islam (ref)	0.000	1.00	0.000	1.00
Ethnicity				
Yoruba	0.809	2.25	0.825	2.28
Ibo	0.149	0.88	0.337	0.26
Hausa (ref)	0.000	1.00	0.000	1.00

Notes: Model 1 is the main effects model; no control was added. Model 2 controls for the effects of marital status and education on each of the variables in model 1. ref stands for reference category and na for not applicable. The level of significance are:** P< 0.05, *P<0.01

Because of the strong effects of education and marital status, their effects are taken into account in model 2, to see which other factors exert a significant effect on sexual control. Once the effects of education and marital status were controlled, age and occupation were no longer statistically significant. In other words, the rate of rejection of sexual intercourse was higher among older and better educated women because they are more likely to be more experienced and tactical with the way they relate with their husbands. Older women can present more argument such as being grandmothers or show signs of menopause. However, religion remained significant.

5. Discussion and conclusion

The objective of this paper is to examine the extent to which women have control over their sexuality within marriage and its implication for the spread and control of HIV/AIDS. From the qualitative and quantitative data, it is discovered that a significant proportion of women have some control over their sexuality especially during certain occasions such as during menstruation, breastfeeding, pregnancy, and when they are sick. Just about a quarter of the women could negotiate with their husbands especially by insisting on safe sexual practices. Some of the women that reported ever contracted STDs claimed to have been infected by their husbands. This is confirmed in the focus group discussions. In one of the focus group discussion session, one of the participants said:

> *"When I first notice the sign of STDs I contacted the medical doctor and I was told that I have gonorrhoea. Since I did not have any other man except my husband, I know that I contacted the disease from my husband. When I rejected his sexual demand after the visitation I was beaten up".*

The study shows that women with improved socio-economic status tend to exhibit some sort of control within their union. For instance, it is discovered that women with higher education are likely to exercise their reproductive rights than their counterpart with lower education. Occupation and religion are other important variables that can influence women sexual control and reproductive rights. Women's economic participation, even in low skilled, low salary positions, confers a sense of worth to women themselves and to their own families. Through this, women will obtain greater negotiating power within their homes and ultimately re-define gender roles.

Nearly all the respondents interviewed have heard about HIV/AIDS, this show that there is awareness about the disease. On the mode of transmission, the most common modes of transmission mentioned by the respondents are through virginal intercourse, blood transfusion and unsterilised needles. Eighteen percent of the respondents

interviewed indicated that they have multiple partners, which have a great implication for HIV/AIDS transmission. This may be one of the reasons why a 7 percent HIV prevalence rate recorded for Lagos State is higher than the national average of 5.8 percent (Federal Ministry of Health, 2003).

Findings from several studies have shown a low prevalence of condom use (Kapiga et al., 1995; Mbizvo et al, 1994; Pattulo et al., 1994; Kim, Marangwanda and Kols, 1996; Ezeh and Mboup, 1997). With the exemption of those with a high self-perceived HIV-positive risk, who are likely to be most knowledgeable of HIV transmission, women in focus group discussions lamented that "men have not changed their sexual attitude and are very reluctant to use condom". In a society where men paid bride wealth, and regarded wives as acquired possessions, they demanded of women at least the appearance of bridal virginity and marital faithfulness (Orubuloye, Caldwell and Caldwell, 2000). The society also assumed that male sexuality was biologically uncontrollable and hence inevitable. In this respect, women have a big task to convince their spouses to adopt the use of condom when it is essentially necessary, especially when couple are not expecting another pregnancy and when the wife is in doubt about her husband sexual activities. In a sense, condom use may be a creative, modern means to escape an unattractive traditional imperative. This may be a way to circumvent the traditionally prescribed postpartum abstinence periods, which often encourages and promotes risky sexual behaviour.

Many men and women are reporting that they have changed their sexual behaviour in response to AIDS. At the same time, many others who are at risk do not protect themselves and their partners (Population Information Project, 1999). To avoid AIDS, sexually active people who are not mutually monogamous must know about AIDS, know about condoms, know that condoms prevent AIDS, know how to get condoms, and know how to use them correctly. The use of condom is one of the major strategies for combating STDs, including HIV. However, the argument that condoms curtail fertility and save lives has been pitted against condoms as a symbol of immorality and women's uncontrolled sexuality. This discourse reflects genuine conflicts faced by individuals when considering whether to negotiate condom use in each sexual encounter (Bond and Dover, 1997).

Finally, the fear of losing their marital status within their marital homes or concern that their husband may shift to another woman outside or marry another wife will not allow women to practise safer sex with their husbands even when they know they are at risk. Ethnographic studies in Nigeria by Adegbola and Babalola, (1999) Renne, (1993) and Orubuloye *et al.* (1993) show that despite the fact that the society confers on women some right to refuse sex to an infected husband, this right does not extend to refusal on the ground of philandering. This has a great implication for the transmission of HIV/AIDS.

Therefore, women need to be educated on the need for safer sex practices, especially in this era of HIV/AIDS. They should also be economically empowered so as to practice safer sex and to be able to exercise their sexual control beyond the special occasions traditionally sanctioned among various ethnic groups in Nigeria. In our society, women are still not fully represented and recognised as equal partners in major decision-making. The structure of the Nigerian society has not accorded much power to women. For instance, job opportunities, recruitment strategies and political conditions have so much stereotyped the nature of women jobs. It is therefore imperative to go beyond mere words of increasing women status, government legislation must be put in place to enforce some sanctions on those cultural and religious factors that relegate women to the background. Apart from focusing on women's reproductive issues, the study also shows that men should be educated on the safer sex practices in order to control the spread of HIV/AIDS in metropolitan Lagos and Nigeria in general. This is necessary following from our findings that majority of the women cannot negotiate safer sex from their husbands even when they know that they are at risk.

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