KNOWLEDGE, OPINION AND ATTITUDE OF HOUSEHOLD HEADS ABOUT REPRODUCTIVE HEALTH RIGHTS IN IBADAN SOUTH WEST LOCAL GOVERNMENT AREA OYO STATE NIGERIA.

by

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DEDICATION

To God the source of all I hold dear: salvation through Christ, Holy Spirit, my beautiful wife (BJ) , our son (TDJ) , the birth of Centre for Health Rights Advocacy(CFHRAD) and the quest to make health not just a blessing to be wished for but a right to be enforced.

ABSTRACT

Reproductive Health Rights (RHRs) comprise two broad human rights namely, the rights to reproductive health and reproductive self determination which are expected to be made legally applicable in all countries. Nigeria is a signatory to conventions on RHRs. Although Household Heads (HHs) are keys to the observance of RHRs at the home, there is no documented information on knowledge, opinion and attitude of HHs on RHRs that can inform appropriate decisions on their local application. The objective of this study was to describe the knowledge, opinion and attitude of HHs on RHRs in Ibadan South West Local Government Area.

The study design was descriptive, explorative and cross-secuonal. A multistage sampling technique was used in selecting 423 HHs in the twelve political wards in the LGA. Instruments for data collection were focus group discussion (FGD) guide and semi -structured questionnaire which were pretested. In all, six FGDs were conducted while 423 copies of questionnaire addressing respondents' knowledge, opinion and attitude on twelve RHRs and reproductive health issues including son preference, child hawking and violence against women were administered by trained Research Assistants.

Survey respondents comprised 75.2% males and 24.8% females, whose ages ranged from 20 and 82 years, (SD ± 11.18). Of the twelve RHRs, the rights to health (58.4%) and deciding the number and spacing of children (29.1%), were well known. Majority (81.8%) did not know of RHRs laws and conventions and this was similar with the findings in the FGDs. RH issues perceived as important for inclusion in the bill on RHRs in Nigeria include Employment and prompt payment (99.1%), Health as a right (98.3%), Sexuality education in the school setting (97.6%), Birth control (95.7%), Rape (93.1%) and Battery during pregnancy (92.0%). Although, opinions were split along gender lines on the inclusion of polyandry (51.9% males, 44.8%

females), polygyny (34.0% males, 23.9% females) and marital rape (47.5% males, 42.9 % females), the differences were not significant ($p > 0.05$). However, significant gender differences ($p < 0.05$) were found on son preference (50% males, 62.9% females) and child hawking (74.5% males, 62.9% females) Majority of respondents expressed favourable attitude towards the adoption of the rights to health (98.1%), consent to marriage (94.3%), education and information on reproductive health (94.1%), minimum standard of living adequate for health and well being (94.6%), prevention from torture or other cruel, inhuman or degrading treatment (92.4%) and deciding the number and spacing of children (86.3%) as part of RHRs in Nigeria. Suggested measures to ensure compliance to RHRs include responsible governance (41.8%) and public enlightenment (40.8%).

In conclusion, the level of knowledge of RHRs, its laws and conventions among respondents are low. Opinion is less favourable towards the inclusion of issues that border on deep cultural practices in a bill on RHRs. There is the need for awareness and sensitization program towards the adoption and observance of RHRs in Nigeria.

KEY WORDS: Knowledge, Opinion, Attitude, Reproductive Health Rights, Household Head

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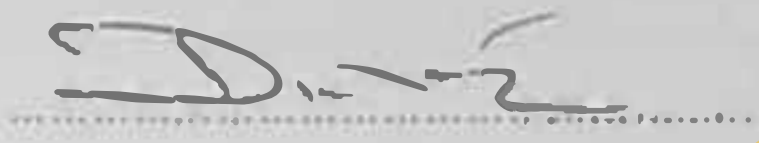
A trillion thanks!

CERTIFICATION

I certify that this project was carried out by JEGEDE Ademola Oluborode in the Department of Health Promotion and Education, Faculty of Public Health, College of Medicine, University of Ibadan under my supervision.



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GLOSSARY OF ABBREVIATION

CEDAW:-Convention on the Elimination of all forms of Discrimination Against Women

CERD:-Convention on the Elimination of Racial Discrimination

CIOMS:-Council for International Organizations of Medical Sciences

CRC:-Convention on the Rights of the Child

CRR:-Centre For Reproductive Health

FCT:-Federal Capital Territory

FGD:-Focus Group Discussion

FGN:-Federal Government of Nigeria

HHs:-Household Heads

HIV: - Human Immunodeficiency Virus

IBSWLG:-Ibadan South West Local Government

ICCPR: - International Covenant on Civil and Political Right

ICESC:-International Convention on Economic, Social and Cultural Rights

ICPD:-International Conference on Population Development

IMG:-Ibadan Municipal Council

IPPF:-International Planned Parenthood Federation

LGs: Local Governments

LRRDP:-Legal Research and Resource Development Centre

NARHS:-National HIV/AIDS and Reproductive Health Survey

NUJ:-Nigerian Union of Journalist

OAU: Organization of African Unity

RHRs: - Reproductive Health Rights

UDHR:-Universal Declaration of Human Rights

UNEPA: - United Nations Environmental Protection Agency

UNICEF:-United Nations Children Emergency Fund

WRAPA:-Women Rights Advancement and Protection Alternative

OPERATIONAL DEFINITION

1. Reproductive rights - "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights and other relevant United Nations Consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free from discrimination, cohesion and violence as expressed in human rights document" (Principle 7.3 of the ICPD)
2. Household – shall refer to a dwelling unit where individuals share basic domestic activities. It is also a consumption unit for a variety of goods. (UN 1973, NPC,1991)
3. Household head – shall refer to the person who makes decision in the household notwithstanding his/her marital status.
4. Domestication – refers to making something legally applicable.
5. Knowledge – refers to the awareness of respondents about Human rights, reproductive health rights and what constitutes violation of reproductive health rights.
6. Opinion – refers to the judgement of respondents about issues of RHRs, extent of promotion and measures to be put in place to ensure enforcement of RHRs.
7. Attitude – refers to the position of respondents on the adoption of twelve types of RHRs in Nigeria.

CHAPTER ONE
INTRODUCTION

1.1 Background to the Study

Reproductive health rights (RHRs) are now recognized as forming part of the spectrum of human rights. RHRs exist in several international instruments on human rights such as the Universal Declaration of Human Rights (UDHR) and the International Convention on Economic, Social and Cultural Rights (ICESCR). It was not until 1968 when they became legitimized as an entity at the Tehran World Conference on human rights. Only recently were they brought to the forefront of debate, at the Internationnl Conference on Population Development (ICPD) in Cairo in 1994, and subsequently at the 4th World Conference on women in Beijing in 1995. The Center for Reproductive Rights (CRR) has categorized reproductive rights as encompassing two broad human rights principles, nnmely:

(i) The right to reproductive heahh care, including the right to regular access to safe, high quality reproductive and sexunl health care services; and

(ii) The right to reproductive self-determination which includes: the right to plan one's family and make decisions about one's reproductive health; the right to physical integrity; nnd the right to be free from all forms of violence, discrimination and coercion that affect women's sexual or reproductive life (CRR,2002)

Signatories to the ICPD and other Conventions as well as Treaties nre urged to ensure that information and services for reproductive and sexual health care are nvnilnble, accessibh: and affordable and thnt any legnl or informal barriers to such access are removed (CRR, 2002). Nigeria is a party

to conventions and treaties embodying human rights principles of reproductive health rights and has pledged support for the domestication of the same. Generally in Africa, attitudes and cultural beliefs, combined with other factors, influence the observance of RHRs. Due to cultural beliefs, women are often expected to ask permission for almost every activity they undertake and little difference exists between the way women were treated in feudal Europe and the way they are being treated today (Trueman, 2002).

The social setting in Africa plays a vital role in depriving women of the opportunity to exercise their RHRs. In Nigeria, the predominant patriarchal social system is a factor that has accounted for the low status of women and their apparent powerlessness in controlling their fertility (Oyekanmi, 1998).

1.2 Problem statement.

Nigeria is the seventh most populous country on earth but has been ranked among countries with the poorest health care services by the World Health Organization (PathFinder, 2002). The gravity of the problems is reflected in the statement credited to Professor Adetokunbo Lucas, a distinguished Professor of Public Health and an international scholar as follows: " The Nigerian health system is sick and in urgent need of intensive care. It is blind, lacking in vision of its goals and strategies; it is deaf, failing to respond to the cries of the sick and dying, and it is impotent, seemingly incapable of doing things that neighbouring states have mastered" (Gureje, 2005). Life expectancy at birth at 48 years for males and 50 years for females (NDHS, 2003) compare poorly with the respective figures of 56 and 59 years for Ghana, 54 and 57 for Senegal, and 55 and 59 years for Gambia.

According to the 2003 NDHS, survey estimates on infant mortality is 100 per 1,000 live births while the rural infant mortality rate (121 per 1,000) is considerably higher than the urban rate (81 per 1,000). Low maternal

education, a low position on the household wealth index, and shorter birth intervals are reported as strongly associated with increased mortality risk. Of 1,000.Of every 1000 children born in Nigeria, about 201 of them will die before the age of 5years (NDHS, 2003). The figure for Ghana is about 110, for Senegal, it is about 135 and for Gambia, it is about 125 (WHO, 2005).

One-third of women age 25-49 reported that they had had sexual intercourse by age 15. By age 20, more than three-quarters of women, and by age 25, nine in ten women have had sexual intercourse. One-quarter of teenage women has given birth or is pregnant. Early childbearing is more of a rural phenomenon, with 30 percent of rural women age 15-19 having begun childbearing compared with 17 percent of urban women in the same age group. Overall, median age at first birth is increasing (NDHS, 2003).This mises a question about the quality of our health care and government stewardship to the people.

Gennan Dixcon Mueller (1992) had observed that without safe abortion as a back up, the use of less effective contraceptive methods will not meet women's needs for fertility regulation. An attempt was first made in 1982 by the Nigerian Society for Gynaecology and Obstetricians to liberalise abortion law in Nigeria's through a bill entitled "Termination of Pregnancy." The said bill was thrown out of the National Assembly as it was vehemently opposed by religious leaders and by the Council of Women Societies, whose contention was that the passage of such a bill would encourage sexual promiscuity. Presently, the position of the law is that by virtue of sections 228, 229, 232 and 235 of the Criminal Code of Nigeria, abortion is prohibited. The result of this is that abortion is carried out clandestinely by quacks in conditions that are most unsafe. Looking for records in this regard is an arduous task.

Most Nigerians, irrespective of their number of living children, want large families. The ideal number of children is 6.7 for all women and 7.3 for currently married women. Nigerian men want even more children than women. The ideal number of children for all men is 8.6 and for currently married men is 10.6 (NDHS, 2003). Clearly, one reason for the slow decline in Nigerian fertility is the desire for large families (NDHS, 2003).This raises a serious concern for population increase.

Interwoven cultural and religious factors exist that militate against women's development of their full human potential (Uchem, 2002). Also, there are customs which have reproductive health implications and which devalue women and girls. These result in various acts of violence against women such as: son preference, polygyny, sex-selective abortion, battery during pregnancy, incest, rape, sexual abuse in the work place, forced prostitution, dating and courtship sexual violence, forced suicide of elderly women, trafficking of women, female genital mutilation and sex with sugar daddies in return for school fees. It has been reported that women who believe that a husband is justified in hitting or beating his wife for any reason at all may also believe themselves to be of low status both absolutely and relative to men. Such perceptions by women could act as a barrier to accessing health care for themselves and their children, could affect their attitude toward contraceptive use, and could impact their general wellbeing (NDHS, 2003).

Among married women, decision making on wide range of issues is highly dominated by husbands. According to the NDHS, 2003, for each specified decision, the majority of women state that their husband has the final say. At least two-thirds of women state that their husband alone makes decisions regarding the children's health care and education, large household purchases, and even the respondent's own health care.

Female child abuse is a serious concern. Female child hawkers are exposed to unprotected sexual relationships between them and older men who are sexually experienced. Such men easily take advantage of the environment to abuse the girl hawkers. Also, early marriage is a barrier to female education and deprives them of the opportunity to attain their full potential. It erodes their reproductive rights and exposes them to premature death (WRAPA, 2001).

An emerging reproductive health concern is the issue of marital rape which became a crime in New Zealand as far back as 1985. In 1993, it became a crime in Cyprus and all the 50 states of the United States (Saurabh and Sarvesh, 2003). However, in Nigeria, the Criminal Code Act in its Section 357 only makes provision for rape, not marital rape. (Saurabh and Sarvesh, 2003) were of the view that the crime of marital rape has been least reported due to lack of legal support for its criminality.

According to the 2001 National Reproductive Health Policy, on the issues of reproductive health rights, the state of the Nigerian laws is not impressive and generally inadequate to meet reproductive health concerns of people. For instance, section 55 (10) of the Penal Code applicable in northern Nigeria provides that: "Nothing is an offence which does not amount to infliction of grievous hurt upon any person and which is done...by a husband and wife being subject to any native law and custom in which such correction is recognized as lawful." In effect, this provision allows infliction of hurt on women by their husbands provided the same is not grievous. Most importantly it does also affect the autonomy of women. It has been argued that it is unhelpful for the status of women where legal codes, based on strict interpretations of customary law, require that wives always obey their husbands, fathers, or sons (Colliver, 1992).

1.3 Justification

The position of head of the household is crucial to decision-making in an African setting. Therefore, there is the need to assess the knowledge, opinion and attitude of household heads on reproductive health rights with the view of generating information for law and policy making.

The study will assist in targeting issues relating to the subordination of women for which the state might be responsible.

Reproductive health rights are emerging as a subset of human rights; this study will assist in documenting the level of awareness of the population and their desire to safeguard those rights. This is imperative, considering the fact that abuse of reproductive health rights has life-threatening consequences.

The investigation of this phenomenon will be of assistance to other research into reproductive health because the knowledge, opinion and attitude of household heads in relation to laws peculiar to reproductive health will be explored. The result emanating from this will be of useful guidance to future research into reproductive health.

The study will assist in evolving parameters with which the enforcements, compliance or otherwise of reproductive health rights (RHRs) can be measured. This will have broad implications politically, socially and economically as it affects a wide interest of many people such as administrators, politicians and the general public.

Lastly, the results of the study will point towards the intervention strategies required for the purpose of making these rights legally enforceable in Nigeria, and by those advocating their enforceability.

1.4 Research questions

This research is based on the following underlying questions:

1. What constitute reproductive health rights (RHRs) in the knowledge of household heads?
2. What is the extent of the knowledge of household heads (HHs) about RHRs laws in Nigeria?
3. To what extent have the FGN, State and LGS promoted RHRs in Nigeria?
4. In the opinion of HHs, what issues need to be included in a bill on RHRs in Nigeria?
5. What factors influence the opinion of HHs on RHRs issues?
6. What measures are to be put in place to ensure enforcement of RHRs?
7. What is the attitude of household heads to the adoption of RHRs in Nigeria?

1.5 Goal

The goal of this study is to assess the knowledge, opinion and attitude of household heads in Ibadan Southwest Local Government Area Oyo State Nigeria, about Reproductive health rights.

1.6 Objectives

The specific objectives of this study are to:

1. describe the extent of the knowledge of household heads on (a) what RHRs constitute and (b) RHRs' laws, conventions and treaties.
2. document the opinion of household heads on issues of RHRs in Nigeria.
3. determine the factors influencing the opinion of HHs on RHRs.
4. ascertain the extent to which RHR's are being promoted in Nigeria

5. identify measures to be put in place to ensure the enforcement of RHR's.
6. document the attitude of household heads to the adoption of RHRs in Nigeria.

1.7. Hypothesis

Based on the variables to be measured, the following null hypotheses were formulated:-

1. There is no association between respondents' gender and opinion on son preference as an issue to be addressed in a Bill on RHRs.
2. There is no association between respondents' location and opinion on son preference as an issue to be addressed in a Bill on RHRs
3. There is no association between respondents' gender and opinion on child hawking as an issue to be addressed in a Bill on RHRs
4. There is no association between respondents' religion and opinion on child hawking as an issue to be addressed in a Bill on RHRs.
5. There is no association between respondents' gender and attitude to the adoption of the right to decide the number and spacing of children as part of RHRs in Nigeria

1.8 Limitation of Study

This study focused mainly on household heads and not all members of the population. The result of this design is that adolescents whose views about this body of rights are equally important were excluded from the study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Overview of Rights

Reproductive choice involves a choice about human rights (The State of the World Population 1997). However, no singular human rights instrument completely encompasses the spectrum of reproductive rights. Reproductive rights are human rights which are inalienable and important to mankind. The concept of reproductive rights was legitimized at the Teheran conference on human rights and more recently at the International Conference in Population Development in Cairo in 1994 and 4th World Conference on Women in Beijing in 1995. In much more recent times, reproductive rights are emerging as a distinct body of rights.

2.2 Historical background

Reproductive rights have a chequered history traceable to the adoption of the Universal Declaration of Human Rights (UDHR) in 1948 by the General Assembly Resolution 217 (III). Article 25(1) of the said Declaration provides:

> "Everyone has the right to a standard of living adequate for the health and well being of himself and of his family including food, clothing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

Article 25(2) further provides:

> "Motherhood and childhood are entitled to special care and assistance. All children are entitled to special care and assistance. All children

whether born in or out of wedlock shall enjoy the same social protections".

Other international instruments have popularized the concept of Reproductive health rights. The International Convention on Economic Social and Cultural Rights of 1966 was the first treaty to require nations to recognize the right to health and to take steps to achieve the realization of that right for the benefit of families. This was followed by the Convention on the Elimination of the Forms of Racial Discrimination (CERD) of 1969. This Convention protects the right of each person to enjoy and exercise in one 'one equal footing' the human rights and fundamental freedoms in the political, economic, sexual and cultural or any field of public life (CRR, 2002).

The Convention of the Elimination of all forms of Discrimination against Women (CEDAW) of 1981 addressed the rights of women to health and family planning and other issues crucial to the realization of the same. Articles 3, 16 and 26 of the said convention are quite instructive;

"Everyone has the right to life, liberty and security of the person (A.3)...State parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and ...the right freely to choose a spouse and to enter marriage only with the free consent of the intending spouse (and the) same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means (needed) to exercise these rights (A.16)...Everyone has the right to education"(A.26).

As at 2002, one hundred and seventy countries including Nigeria are signatories to this convention. CEDAW is the strongest legal support for the right to reproductive health, according to the Legal Research and Resource Development Centre (LRRDP, 1999).The Convention on the Rights of the

Child (Children's Rights Convention) of 1990 was another milestone in the history of reproductive rights. Article 24 of the Convention reiterates the right to maternal health and identifies it as intimately and intrinsically related to the right to health of children.

1994 was a remarkable year in the history of reproductive rights worldwide. For the first time at the International Conference on Population and Development (ICPD), it was noted that reproductive rights embrace certain human rights already recognized in national laws and international human rights documents. Paragraph 7.3 of the ICPD provides that:

> "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights and other relevant United Nations Consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free from discrimination, cohesion and violence as expressed in human rights documents... In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community. The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government and community supported by policies and programmes in area of reproductive health including family planning".

Principle 8 further states:

> "Everyone has right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure on a basis of equality of men and women universal

access to health care services, including those related to reproductive health care which includes family planning and sexual health. Reproductive health care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and the means to do so.

Most significantly, paragraph 7(2) defines reproductive health as:

"A state of complete, physical, mental and social well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes... Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so; implicit in this last condition are the rights of men and women to be informed and have access to safe effective, affordable and acceptable methods of their choice for regulation of fertility which are not against the law and the right of access to appropriate health care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance for having a healthy infant"

At Beijing, several nations met to follow up on ICPD experience and formulate a plan of action in terms of recognizing a woman's right to control her sexuality and sexual relations on an equal basis with man. Significantly, in the same year, the International Planned Parenthood Federation (IPPF) and its associations provided a charter on Sexual and Reproductive Rights based on international human rights instruments. The charter provides for the following rights:

- The Right to life
- The Right to liberty and security of person
- The Right to equality and to be free from all forms of discrimination
- The Right to privacy
- The Right to freedom of thought
- The Right to information and education
- The Right to choose whether or not to marry and found and plan a family
- The Right to decide whether or when to have children
- The Right to health care and health protection
- The Right to freedom of assembly and political participation
- The Right to be free from future and all degrading treatments(IPPF, 1995)

A five year review of the ICPD program of action was considered in 1999. The resulting document reaffirms the 1994 position and prescribes crucial strategies for advocacy on reproductive and sexual rights (CRR, 2000).Another review was held in 2000 after the Beijing conference, when delegates from more than 180 countries gathered to review progress in the implementation of the 1995 plan of action. The review upheld reproductive and sexual rights provisions formulated in Beijing and also included key gains in the area of HIV/AIDS, crimes of sexual and gender-based violence and human rights (CRR, 2000).

2.3 What do Reproductive health rights constitute?

Having regard to all the foregoing international instruments, it can be safely stated that reproductive health rights include the following:

- The right to life

- The right to liberty and security of person
- The right to decide the number and spacing of ones children
- The right to privacy
- The right to consent to marriage and to equality in marriage
- The right to be free from discrimination
- The right to enjoy scientific progress and to consent to experimentation
- The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment
- The right to education and information on reproductive health
- The right to a standard of living adequate for health and well being
- The right to health
- The right to freedom of assembly and political participation

2.3.1 The right to life

The right to life protects women whose lives are currently endangered by pregnancy (IPPF, 1999). Fried (2000) on the need to protect the lives of women and their pregnancy noted that:

> "No country sends its soldiers to war to protect their country without seeing to it that they will return safely and yet mankind for centuries has been sending women to battle to renew the human resource without protecting them".

In 2001, an estimate developed by international organizations namely WHO, UNICEF and UNFPA, indicated that a life time risk of death is associated with pregnancy in all regions of the world (Table 1).

Table1

Life time risk of death associated with pregnancy in all regions of the world

Region	Lifetime Risk of Death
Sub-Saharan Africa	1 in 13
South Asia	1 in 54
Middle East and North Africa	1 in 55
Latin America and the Caribbean	1 in 157
East Asia/Pacific	1 in 283
Central East Europe/Commonwealth of Independent States and Baltic States	1 in 797
Industrialized Countries	1 in 4,085

Source: (Estimate developed by WHO, UNICEF and UNFPA (Geneva, WHO 2001).

Tragically, Nigeria, with an estimated population of 140 million, has an unacceptable maternal health service and consequently, one in every 100 women died as a result of pregnancy, delivery or the aftermath (National HIV/AIDS and Reproductive Health Survey (NARHS, 2003)).

2.3.2 Right to Liberty and Security of the Person

The right to liberty and security of the person guarantees that women should be protected, for example where they are currently at risk of genital mutilation, or subject to forced pregnancy, sterilization or abortion (IPPF, 1999). Demographic and Health Survey (DHS) data collected between 1989 and 1996 showed that 97% women in Egypt, 95% in Eritrea, 94% in Mali, 89% in Northern Sudan and 43% in Cote d'Ivoire, have undergone some form of female genital mutilation (Olenick, 1996). In Nigeria, particularly in Oyo

state, it has been reported that there exists 60 to 70% prevalence of type I female Genital Mutilation i.e. excision of the clitoris.

Abortion raises a question of choice which may not be exercisable where the right to liberty and security of person is not guaranteed. There is a considerable literature on the issue of abortion particularly in Nigeria: In 1996, the results of a study on health professionals' knowledge on abortion shows that 66% and 34 % of respondents in the public and private sectors had experienced abortion cases experience (Makinwa-Adebusoye, *et.al.*, 1997).

Though abortion is prohibited in Nigeria, the women obtained thousands of safe and unsafe pregnancy terminations each year. In a study conducted in Nigeria with a sample including physicians from 672 private and public medical facilities and teaching hospitals, 252 facilities performed abortions and 427 provided treatment of abortion-related complications. It was found that 73% of abortions were performed by non- specialist practitioners (Henshaw *et. al.*, 1998). Unwanted pregnancies and abortions are common among women in Nigeria (Mahler, 1999).

2.3.3 Right to decide the number and spacing of one's children

One of the most obvious differences between the world of men and women is the woman's child-bearing role and their near total responsibility for family care and household management (Society for International Development, 1995). The right to decide the number and spacing of one's children is therefore not only imperative, it is a non-negotiable reproductive preference. Among other things, the right is required to protect the right of all persons to reproductive health care services which offer the widest possible range of safe, effective and acceptable methods of fertility regulation (e.g. contraceptive use) and which are accessible, affordable, acceptable and convenient to all users.

Bankole and Singh (1998), in a cross-cultural study involving the reproductive preferences and behaviour of married men and their wives in 18 (eighteen) developing countries, showed that husbands' Desired Family Size (DFS) was higher in western compared to eastern Africa and was higher than women's (DFS). In Nigeria, particularly in the South West, a national survey has shown that 77.4% of female support family planning while 71.8% of male support it (NARFH, 2003). This may well be due to the fact that Nigerian men want more children than women (NDHS, 2003)

2.3.1 The right to consent to marriage and to equality in marriage

The right to consent to marriage is a fundamental issue of reproductive health. Its absence is often the basis for the abuse of reproductive rights. The right among other things discourages child marriage and guarantees protection of persons against any marriage entered without the full, free and informed consent of both partners. Four types of child marriage are identifiable:

1. Promissory marriage, which is arranged before a child is born
2. A form of marriage in which a female child is placed in the custody of in-laws from the age of 10, growing up until she is matured and ready to be formally married.
3. Another form involves a female child between 10 and 14 years old; she starts to bear children immediately after formal marriage.
4. The fourth is marriage in late adolescence, which takes place when a female child is aged between 15 and 19.

The first, third and fourth types are the most widely practiced in Nigeria, according to the Women's Rights Advancement and Protection Alternative (WRAPA, 2001). The median age at first marriage in years for females is reported as 18 for the North Central region, 15 for the North East, 14 for the North West and 19 for the South West (NARHS, 2003).

2.3.5 The right to privacy

The right to privacy safeguards the right of all clients to sexual and reproductive health care, information, education and service to a degree of privacy and confidentiality with regard to personal information given to service providers.

2.3.6 The right to be free from discrimination

The right to be free from discrimination protects all people, regardless of race, colour, sex, sexual orientation, material status, family position, age, language, religion, political or other opinion, national or social origin, property, birth or other status to equal access to information, education and services related to development and sexuality in reproductive health.

Inequity in health stemming from gender-related determinants arising from the difference in the societal view of males and females is a real phenomenon (Timothy, *et. al.*, 2001). Discrimination poses a major challenge to reproductive health rights. It reflects societal disregard for human rights which creates, amplifies and sustains vulnerability to preventable disease, disability and premature death (Mann, 1995). Also, discrimination has implications for education. In Nigeria, it has been shown that the number of girls enrolled compared to the number of boys is different. The ratio is 0.82, i.e. for every 100 boys in school there are 82 girls (Esan, 1996).

Equally important are the issues of sex-selective abortion and the cultural preference for a son which have led to a disproportionate number of males relative to females, a phenomenon that Amartya Sen has labeled as "missing women" (Timothy, *et al.*, 2001). In another study, it was found that couples with sons would be less likely to have another child; girls would be

breast fed for a shorter period than boys. and that birth intervals were more likely to be shorter if the first child was a girl (Graham and Larsen, 1998).

In Nigeria, particularly in the South West, the percentage of the married population preferring male children is 33.5% of the study sample (NARHS. 2003). Semenitari (1997) has further argued that the social division of labour between males and females makes the access of women to resources – social and material – unequal to that of men.

The issues of polygyny and polyandry also raise an interesting argument about discrimination. Culture and customs allow the marriage of a man to more than one wife. It has been observed that women in most polygamous homes in Nigeria are often saddled with the sole responsibility of catering for their children (Semenitari, 1997). A fatal consequence is that a child is denied and deprived of the care needed for responsible growth, thus making him or her vulnerable to crime, aggression and greed. (Esan, 1997).

2.3.7 The Right to Enjoy Scientific Progress and to Consent to Experiment

This protects the right of all persons to access the available reproductive health care technology which independent studies have shown to have an acceptable risk/benefit profile and where to withhold such technology would have harmful effects on health and well being (IPPF, 1999). Consent to experiment is an important issue to research in reproductive health. International Codes, particularly the Nuremberg code of 1947, the Helsinki declaration of 1964, the Belmont report of 1974 and the CIOMS (Council for International Organizations of Medical Science) 1993 have highlighted principles that should govern research ethics:

i. Respect for persons
ii. Beneficence

iii. Non-malfeasance (do no harm)

iv. Justice

Drawing on the basic philosophies underlying major Codes, Declarations and other documents relevant to research with human subjects, it has been suggested that there are seven (7) principles governing science and experimentation. These are:

- Value: enhancement of health or knowledge deriving from the research;
- Scientific validity: research must be methodological and rigorous;
- Fairness: subject selection must not be biased;
- A favourable risk-benefit ratio: potential benefits to the individual and the knowledge gained by society must outweigh the risks;
- Independent review;
- Informed consent: individuals should be informed about the research and provide their voluntary consent;
- Respect: for enrolled subjects.

It is debatable whether these requirements are followed at all times by scientists in the conduct of their research on reproductive health. An incident still fresh in Nigeria is the suit by 30 Nigerian families against a pharmaceutical giant Pfizer, Inc. alleging that the company unethically tested an antibiotic on their children during the 1996 meningitis outbreak (Malakoff, 2001). It is instructive to observe that due to an inadequate legal code and system, the suit could only be filed abroad.

2.3.8 The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment

The right safeguards children, women and men from all forms of sexual violence, exploitation and abuse (IPPF, 1999). Violence against women has been shown to occur throughout the life cycle (See Table 2)

Table 2

Violence against women throughout life cycle.

Phase	Type of violence
Pre-birth	Sex-selective abortion, battering during pregnancy on birth outcome
Infancy	Female infanticide, physical, sexual and psychological abuse
Girlhood	Child marriage, female genital mutilation, physical, sexual and psychological abuse, incest, child prostitution and pornography
Adolescence and adulthood	Dating and courtship violence (e.g. acid throwing and date rape), economically coerced sex (e.g. school girls having sex in return for school fees); incest; sexual abuse in the workplace; rape; sexual harassment; forced prostitution and pornography; trafficking in women; partner violence; mental rape.
Elderly	Forced "suicide" or homicide of widows for economic reasons; sexual; physical and psychological abuse.

Source: WHO, 1997

In Nigeria, available national data shows that in the Southwest, 11.4 percent of respondents are of the belief that the husband is justified in beating his wife for refusing sexual intercourse, 29.4% believe that the husband is

justified in beating his wife if she feels unfaithful, while 16.9% believe that husband is justified in beating his wife for arguing with him (NARHS, 2003). Women who believe that a husband is justified in hitting or beating his wife for any reason at all may also believe themselves to be of low status both absolutely and relative to men. Such perceptions by women could act as a barrier to accessing health care for themselves and their children, could affect their attitude toward contraceptive use, and could impact their general wellbeing (NDHS, 2003).

With respect to marital rape, it has been argued that marital rape violates the right of a woman to the dignity of her person (Saumbh & Sarvesh 2003). Thornhill & Thornhill (1989) had earlier stated that the physical effects of marital rape include injuries to private organs, lacerations, bruising, torn muscles, fatigue and vomiting. Hence, Saurabh & Sarvesh (2003) viewed that the right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment will provide a supportive mechanism for women to exercise bodily integrity and sexual autonomy.

On child labour, over 250 million children today are at work worldwide. African children constitute 32 percent of this number. A recent international labour report estimated that 41 percent of African children between the ages of 5 and 14 years are labourers. The percentage of child labourers in Nigeria ranges between 20 and 30 percent of the population of children (Oloko, 1998). Interestingly enough, as far back as 1989, the Convention on the Rights of the Child had addressed issues such as education, health, nutrition, social security and the responsibilities of parents as they affect children. The said convention states that in all actions concerning children, their best interests should be taken fully into account. Article 33 of the said Convention recognizes a child's right to be protected from work that

threatens their health, education or development. It enjoins state parties to set a minimum age for employment and to regulate working conditions.

However, despite this, children work in the most visible places possible. They can be found everywhere on the streets of developing cities and towns hawking in markets and darting in and out of traffic jams, plying their trade at bus stops and train stations, and in front of hotels (WHO, 1997) . Nigeria is signatory to the Convention on the Rights of the Child and the 1979 OAU Charter on the rights of the African child. The charter states:

> "Every child has an inherent right to a life and this life shall be protected by law. A child has the right to be protected, the right to an identity, the right to a name, a parent and a home".

2.3.9 The right to information and education on reproductive health

This guarantees access to full information on the benefits, risks and effectiveness of all methods of fertility regulations in order that any decision they take on such matters are made with full, free and informed consent (IPPF, 1999).The right to information and education on reproductive health encompasses information on contraception and family planning, sexual education, abortion and sexually transmitted infection (STI) including HIV/AIDS (CRR, 2002).

In Nigeria, particularly in the Southwest, though awareness of family planning methods is high, 91.5% for females and 92.4% for males, (NARHS, 2003), the legality or otherwise of information on abortion appears unsettled and confusing. Section 230 of Criminal Code Act stipulates that such information is forbidden. The said section provides that;

> "Any person who unlawfully supplies to or procures for any person anything whatever knowing that it is intended to be unlawfully used to

procure the miscarriage of a woman whether she is or not with a child is guilty of a felony and is liable to imprisonment for 3 years"

On the issue of sexual education, it has been canvassed that, in Nigeria, the 'family life' curriculum in schools needs to enshrine moral values in youth and teach them to delay sex. This is helpful for adolescent reproductive health (NARHS, 2003). Education's role as a determinant of health cannot be overemphasized; survival chances are greatest in the highest educational classes (Hasegawa, 2001). NARHS shows that while 88% of adults have heard of HIV/AIDS, and 71% have knowledge of conditions indicative of STI, the younger sector of the population was reported to be more ignorant.

2.3.10 The right to standard of living adequate for health and well being

Though not mentioned in the IPP Charter, the right to a standard of living adequate for health and well being guarantees the availability of food, the provision of employment and security. In Africa, it has been found that there exists both moderate and high prevalence of underweight people which is due to either transitory or long term food insecurity. At the end of 1995, 39.4% of pre-school children in the sub-Saharan African were stunted in their development (WHO, 1995). Nigeria is listed among countries where the number of under-5s in this category is above 40% (UNICEF, 2001). This is pitiable when it is considered that over a lifetime, there are cumulative adverse health effects that result from living in persistent poverty (Kuh and Ben-Shlomo, 1997).

The link between employment and health lies in whether individuals can generate an income sufficient to sustain well-being. In Russia, it has been found that the unemployed have the highest mortality rates in the adult population while in Bangladesh; there is evidence of health benefits in the

provision of employment. Good employment is likely to ensure lasting food security (Timothy *et. al.*, 2001).

2.3.11 The right to health

The right to health is not part of HPP but was considered by the ICPD and the Convention on the Rights of Child. This right can be invoked to safeguard/protect the Environment and provision of health services. Safeguarding the environment entails the provision of safe drinking water, sanitation, and the prevention of pollution while provision of health services encompasses the availability of drugs and the provision of wholesome care.

Environmental law and human rights have traditionally been treated separately. Environmental rights are not explicit in most international human rights instruments (Kiss and Shelton, 1991). The Universal Declaration of Human Rights of 1948 did not take environmental impacts into consideration. The same applies to the UN Covenant on Civil and Political Rights of 1996 which abstractly states in its Articles 6, that "every human being has an inherent right to life".

The Convention on Child Rights 1989 only mandates the states to take appropriate measures to combat disease and malnutrition taking into account the dangers and risks of environmental pollution (Art. 24, para. 2c). The African Charter on Human and People's Rights of 1981 expressly provides that "All peoples have the right to a general satisfactory environment favourable to their development" (Art. 24). However, this may only be enforced as a collective right rather than an individual one (Rest, 1998).

The link between human rights and environmental protection is clearly established by principle 1 of the Stockholm Declaration on the Human Environment of 1972 which states that "man has the fundamental right to freedom, equality and adequate conditions of life, in an environment of a

quality that permits a life of dignity and well being". The Rio Declaration on Environment and Development of 1992 also did not formulate a concrete, operative and enforceable individual right to a decent environment.

Evidently the link between the environment and man is strong and has a bearing on reproductive rights. The rights to reproduce and develop can only be realized in a healthy environment and under a legal system which guarantees health, especially environmental health as a right. This is more so when it is considered that quite a number of diseases can be controlled or eliminated, given a healthy environment. It has been revealed by study that all over the world, 1.1 billion people still lack access to safe drinking water. In Nigeria, it is reported that in the 1990, 53% of the population had access to safe drinking water while 62% had access in the Year 2000 (WHO, 2001).

Accessibility to health facilities and services is equally of great concern, particularly in Nigeria. A good test of this is the under five mortality rate where more than half of all the under fives mortality are expected to occur in the sub-Saharan Africa before 2010.This situation is aggravated by the increasing number of under-five deaths due to HIV/AIDS and low levels of immunization as a result of weak health care systems (WHO, 2001).

2.3.12. The right to freedom of association and political participation.

The right to freedom of association and political participation guarantees formation of associations, groups and movements with the view of promoting issues relating to reproductive health .

2.4. The observance of RHRs in Nigeria.

2.4.1 Government Obligations towards RHRs

A diagnostic analysis of the performance, or lack thereof, of a given national system must consider, if not start with, how well the government is performing

its stewardship role (WHO, 2002). Stewardship has been defined as the careful and responsive management of the well being of the population and thus the very essence of good governance in health (WHO, 2002). National governments have obligations towards setting standards and guidelines for RHRs. These include eliminating unnecessary medical barriers, incentives, and disincentives; and ensure that people have access to the methods they prefer (Population Report, 2001). National governments can help ensure the right to RHRs by putting principle into law. For example Article 4 of the Mexico's Constitution states that every individual has the right to decide in a free, responsible, and informed manner the number and spacing of his her children. In several other countries, including Malaysia, Peru and Zambia, laws explicitly protects informed choice on reproductive health, a crucial concept in RHRs. A city law in Buenos Aires, Argentina passed in 2000 recognises "sexual and reproductive rights free of violence and coercion as basic human rights" and guarantees women's and men's access to contraceptive information, methods and services (Zamberlin, 2000). The implication of this is that when governments incorporate informed choice standards into their laws, the courts can enforce them (Coliver, 1995).

The experience of Nigeria with regard to the foregoing is discussed in the paragraphs below:

2.4.1.2. Inadequacies in the 1999 Nigerian Constitution.

In Nigeria, absence of legal and constitutional backing for certain rights has been a major impediment to their realisation.The Constitution is the organic instrument of governance of every nation. In post independence Nigeria, several attempts have been made in the past to improve the quality of the nation's Constitution. These efforts have produced the 1963, 1979, 1989 and presently the 1999 Constitution. The most instructive chapter in the

constitution on citizen's rights is the chapter IV which provides for basic human rights which are enforceable by individual against individual and government in Nigeria. These rights are namely:

- The right to life (Section 33)
- The right to dignity of the human person (Section 34)
- The right to personal liberty (Section 35)
- The right to fair hearing (Section 36)
- The right to private and family life (Section 37)
- The right to freedom of thought conscience and religion (Section 38)
- The right to freedom of expression and the press (Section 39)
- The right to peaceful assembly and association (Section 40)
- The right to freedom of movement (Section 41)
- The right to freedom from discrimination (Section 42)
- The right to acquire and own immovable property anywhere in Nigeria (Section 43)

A careful review of these rights in terms of applicability for RHRs show that unlike the case with the Constitution of Mexico and Argentina and the law in Zambia, which makes specific provisions on sexual and reproductive rights, the 1999 Constitution of Nigeria does not guarantee the realisation of certain reproductive health rights in the instruments to which Nigeria is signatory. These rights are namely;

- The right to decide the number and spacing of children
- The right to a standard of living adequate for health and well being
- The right to enjoy scientific progress and to consent to experimentation.

Equally too, certain rights in the Constitution are abstract and too narrow to avail the protection as reproductive rights. These are as follows;

- The right to be free from discrimination: this imposes criteria which is rather onerous to establish.
- The right to dignity of the human person: This apparently does not envisage the broader issues of child labour, female genital mutilation or the concept of 'marital rape'.
- The right to privacy: This does not safeguard the right to decide in a free, responsible, and informed manner the number and spacing of his her children

A major regional instrument on human rights which complements the application of national Constitutions in Africa is the African Charter. The Charter became applicable in Nigeria by virtue of the African Charter and Peoples Rights Act (Ratification and Enforcement) of 1983. Significant in the provisions of the Charter for reproductive health are the following: Article 17 of the Act which guarantees the individual right to education; Article 18(1) provides that the family shall be protected by the state which shall take care of its physical health and morals; Articlel 8 (2) states that the State shall have the duty to assist the family which is the custodian of morals and traditional values recognized by the community and Article 18(3) provides that the State shall ensure the elimination of discrimination against women and also ensures the protection of the rights of the woman and the child as stipulated in International Declarations and Conventions.

However, a major weakness of the Charter is that its provisions are only enforceable in so far as they are not inconsistent with the provisions of the Nigeria Constitution. Thus, lack of appropriate recognition of the larger part of these rights by the Constitution is a major constraint making it impossible for people to demand enforcement.

Another national instrument with significant provisions for reproductive health rights is the Children's Rights Act passed by the National Assembly in the year 2003. Section 13 of the said Act guamntees a child's right to heahh and heahh services and provides that "every child is entitled to enjoy the best attainable state of physical, mental and spiritual heahh". Section 13(2) provides that "every Government, parent, guardian, institution service, agency, organization or body responsible for the care of a child shall endeavor to provide for the child best attainable state of heahh." According to section 13 (3) "every govemment in Nigeria shall; (a) endeavor to reduce infant and child inortality rates: (b) ensure the provision of necessary medical assistance and the development of primary health care; (c) ensure the provision of adequate nutrition and safe drinking water; (d) combat disease and malnutrition witbin the framework of primary health care through the application of technology; (e) ensure appropriate heahh care for expectant and nursing mothers; and (f) support through technical and financial means the mobilization of national and local community resources in the development of primary heahh care for children".

Again, the main pitfall in the foregoing provisions is their enforceability .The Act does not make provision for the enforcement of Section 13 of the Child's Act which essentially relates to child health.

2.4.1.3 Commitment of Government to Policies on RHRs.

Government policies for social and economic development can improve people's ability to realize their reproductive rights where there is commitment. Policies that improve women's status help them to make decisions for themselves, no matter what their age, class, race, or educational status (Dixon-Mueller, 1993). According to the 2003 NDHS, Almost three-quarters of women who receive cash earnings report that they alone decide how their

earnings are used. Also, policies governing women's autonomy can foster their status and ability to make decision for them including decisions about family planning. In 1995, research in Bangladesh found that participants in a micro credit program for women were more likely to communicate with their husbands and to have more autonomy and more decision making authority than other women (Amin, Becker and Bayers, 1998).

In other to achieve the national goal of health for all Nigerians, attempts have been made to target specific disease burden through appropriate health intervention guided by required policy. This is in line with Sections 13 to 24 of the 1999 Constitution which provides for the fundamental obligations of the state which include economic, social, educational, and environmental objectives of the State. Hence, the Government has made several policies including the following:

- National health policy (1996)
- National Women Policy (2001)
- National Reproductive Health Policy (2002)
- National HIV/AIDS Policy (2002)
- National Health Promotion Policy (2006)
- National Policy on the Elimination of Female Genital Mutilation
- National Policy on Adolescent Health
- National Policy on Drug

Without doubt, the foregoing policies have great prospects for the status of women and their reproductive health. However, a policy does not alone on itself evidence strong commitment. Commitment is measured by practical steps put in place by government to realise its policy as well how possible it is for the citizenry to hold government accountable for non-performance. A major short coming of policies is that, having been made under the state

directive principles, they do not carry the force of law and as such they are not actionable or justiciable in Court. Also, an absence of constitutional backing for this major policy thrusts and the misleading assumption that health is on the concurrent list in the constitution has been identified as a major problem to the Nigerian health system (FMH, 2005).

2.4.1.4. Inadequate Legal frame work.

According to the 2001 National Reproductive Health Policy, although various statutory, customary and religious laws which are in force in Nigeria address different areas of reproductive health, many of these laws do not reflect reproductive health concept and so are inadequate to meet the needs of actualising reproductive rights. Certain provisions in the Criminal Code Act of Nigeria confirm the foregoing report. In this regard, sections 228, 229 and 230 of the Criminal Code stand out. Section 228 provides:

> "Any person who with intent to procure miscarriage of a woman whether she is or not with child, unlawfully administers to her or causes her to take any poison or other noxious thing or uses any force of any kind, or uses any means whatever, is guilty of a felony and is liable to imprisonment for fourteen years".

Section 229 provides:

> "Any woman who, with intent to procure her own miscarriage whether she is or she is not with child unlawfully administers to herself any poison or other noxious thing or uses any force of any kind, or uses any other means whatever or permits any such thing or means to be administered or used to her is guilty of a felony and is liable to imprisonment for seven years".

Section 230 provides:

> "Any person who unlawfully supplies to or procures for any person anything whatever knowing that it is intended to be unlawfully used to procure the miscarriage of a woman whether she is or not with child is guilty of a felony and is liable to imprisonment for three years".

The concomitant effect of the aforesaid sections is that impediments are placed on certain rights relating to reproductive health as guaranteed by certain provisions in some Conventions to which Nigeria is signatory. Such provisions are as follows:

- The right to decide the number and spacing of ones children.
- The right to education and information on reproductive health.
- The right to health

Of importance too are sections 353 and 360 of the Criminal Code Act which prescribe differential and discriminatory punishment for indecent assault for males and females. Section 353 provides:

> "Any person who unlawfully and indecently assaults any male person is guilty of a felony and is liable to imprisonment for 3 years".

while Section 360 provides:

> "Any person who unlawfully and indecently assaults a woman or girl is guilty of a misdemeanor, and is liable to imprisonment for 2 years"

Section 357 of the same Act does not in its definition of the offence of rape envisage the occurrence of sexual violence at home (marital rape). It states:

> "Any person who has unlawful carnal knowledge of a woman or a girl without her consent, or with her consent, if the consent is obtained by, force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act or in the case of a married woman by personating her husband is guilty of an offence which is called rape".

In 1991, the House of Lords in England confirmed the conclusion of the Court of Appeal that 'a rapist remains a rapist subject to criminal law, irrespective of his relationship with his victim'. Also in September 2005, a sexual violence civil bill was passed in India which allows women to seek redress on a wide range of forms of sexual violence including marital rape.

Section 221 of the said Act also constitutes an impediment to Reproductive health rights. It provides:

1) Any person who has or attempts to have carnal knowledge of a girl being of or above 13 years and under sixteen years of age; or
2) Knowing a woman or a girl to be an idiot or imbecile has or attempts to have unlawful carnal knowledge of her;

is guilty of n misdemeanor and is liable to imprisonment for 2 years with or without cnning. A person can not be convicted of nny of the offences defined in this section upon the uncorroborated testimony of one witness".

The requirement for corroboration by a witness is onerous Rape may or may not occur in the presence of a witness. Also in its definition of prostitution, Section I of the said Act provides:

"Prostitution (with its grammatical variations and cognate expressions) includes the offering by a female of her body commonly for acts of lewdness for payment although there is no act or offer of an act or ordinary sexual connection".

Evidently the above statutory definition of prostitution does not include criminal liability for a man who participates in the offence of prostitution. The result of this is that the provision is discriminatory against a woman as man can not be charged with prostitution.

These inadequacies are pointers to loopholes deserving legislative intervention. It has been said that law has a foundational role in framing public

health (Mensah *et al.*, 2004). It can be used to make available a structure that will allow for monitoring of legal interventions for appropriateness and effectiveness. Law helps in assisting its makers to ensure that whatever rules, orders and regulations specified within it are implemented and enforced (Mensah *et al.*, 2004).Also, law can bolster other public health strategies when they are prudently used by public health practitioners who have a clear understanding of how it shapes public health infrastructure and can promote program goals, complement not supplement other principles of public health (Centre for Disease Control and Prevention, 2003).

Many countries have adopted the program of action drafted at the 1994 International Conference of Population and Development (ICPD) held in Cairo. The program of action emphasizes the need for law and policy changes in order to address the challenges of population and development. Interviews conducted in 1997 with stakeholders revealed that countries like Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica and Peru have began to reform policies in bid to reflect a new focus (Hardee *et al.*, 1999)

Nigeria is also presently taking steps to enact an Act which would among other things; set out the duties and rights of Health care providers , health workers and health establishment users; and protect, respect, promote and fulfill the rights of the people of Nigeria to the progressive realisation of access to health care services (FMH,2005). The Bill is yet to be passed and consequently, its significance can not yet be fully assessed. The hope however is for the Bill not to become spent with the expiration of the term of the Obasanjo's administration.

2.4.1.5. Policies on Incentives and Disincentives for family planning.

It has been argued that offering of incentives and creating of disincentives to influence people may affect their exercise of choice on reproductive health

(Isaac, 1995) and thereby violate their right to decide freely the number and spacing of children. Between the 1975 and 1977, extreme population policy was introduced in India when the government suspended the Bill of rights (Srinivasan, 1999). Mass Sterilisation program was introduced and forced by government with the offer of incentives such as jobs for men (Warwick, 1990). These policies led to public criticism and a national fear for family planning. They also contributed to electoral defeat for the party in power (Srinivasan, 1999). In Bangladesh, government policy supports the provision of clean garments, subsidized food at the hospital. However whether this influences planning decision is unknown (Kabir, 2001).

Disincentives may include loss of maternity leave, restrictions on access to public housing, limits on schooling choices and increased taxes (Short and Zhai, 1998). Iran's national assembly approved a law that went into effect in 1994 banning public benefits such as paid maternity leave and social welfare subsidies to low income women for the birth of any child after a third (Aghajanian and Merhyar, 1999). Recently the Supreme Court of India upheld the decision to disqualify a member of a village council in the north –western India state of Haryana for violating the region's two child norm, even though the norm is not legally binding. The apex court held that "it is in the national interest to check the alarming growth of India's population through legislative disincentives." The Nigerian law is silent on population control through disincentives.

2.4.2 Social - Cultural practices.

Social - cultural norms influence people choice of reproductive right (Bosveld, 1998). To a large extent, community norms determine individual child bearing preferences and sexual and reproductive behaviour. Community culture affects

a person's attitudes towards family planning, desired sex of children, preference about family size, family pressure to have children (Vickers, 1974).

- **Gender**

Women experience subordination on the grounds of sex and gender. Sex is the expression of biological difference; gender is the social accommodation of biological difference (Lerner, 1986).In the traditional legal environments of many societies. women lacked legal capacity and received entitlements according to disposition of men (Cook, 1994). Patriarchy was considered the natural order of society and women were perceived to be acting unnaturally if they presumed to engage in the affairs of men (Cook, 1994). Feminist scholars have identified this history of patriarchy and recorded its oppressive impact on women (Cook, 1994).No doubt, the protection of sexual and reproductive health right of women and men are both important. However, women reproductive health requires legal protection and promotion is imperative, considering the fact that they bear the burden of gestation (Progress, 1999)

In Nigeria, cultural biases and entrenched patriarchy are major challenges to the implementation of reproductive health rights. Women are seldom recipients of the benefits meant for them. These benefits are usually taken over by men because of a number of socio-cultural traditional and economic reasons which present men as the head of the family unit and therefore the first in line of authority (Akintunde, 2002).

This is further confirmed by the National Policy on Women (2001). In paragraph 8.4.1 of the policy, it is noted that patriarchy and its related practices constitute major impediments to the full integration of women into the Nigerian economy. It is further stated that as practiced in Nigeria, patriarchy gives ascendancy in inheritance; authority and decision-making in and outside the home to the male. Certainly, decision making in and outside the home will involve decisions that affect the general health particularly the

reproductive health of the woman. Adamchack and Adebayo (1987) had earlier given the opinion that a culture of male superiority together with a man's authority over his wife's reproductive rights has implications for women's total wellbeing. Adewuyi (1999) had observed that Nigeria is a patriarchal traditional setting which recognizes the husband as a factor even when he is not the primary breadwinner in the household. He also observed that husbands are the key to improving reproductive health. There is growing understanding in the international public health community about the role of gender in reproductive health and the need for professionals to develop creative strategies to address this role (Wegner *et al.*, 1998).

The cultural habit of son preference also influences reproductive health choice. It has been found that couples who prefer sons tend to have their child soon after the birth of a daughter. For instance a study in China showed that among women who had given birth to a girl, most had their child within 37 months .Conversely, among women who had a boy, most had their next child within 46 months (Graham, Larsen and Xu, 2002). Also there is strong evidence that in many countries including Nigeria, women are more likely to have a next child within three years after the birth of a daughter than after the birth of a son (Populations Reports, 2002). Reasons adduced for the foregoing trend include the fact that sons continue the family lineage, perform prayers to ancestors and can support parents in their old age (Larsen, Chung and Das Gupta, 1998). In India, sons tend to have higher economic, social and religious value to their parents (Arnold, Choe and Roy, 1998) while girls may be considered as economic liability (Kishor, 1995)

Culture is also a real factor in the issue of Female Genital Mutilation. It continues to pose threat to women autonomy in Nigeria. According to the 2003 NDHS, continuation of female circumcision finds greater support among southerners than northerners and among those who are circumcised than those

uncircumcised. Generally, Paragraph 8.1.12 of the National Policy itemizes the reproductive health concerns of women as including: high maternal mortality rates associated with pregnancy, child birth and unsafe abortion, reproductive tract infection (RTI), sexually transmitted diseases, HIV/AIDS, cervical and breast cancer, female genital mutilation, traditional practices that are inimical to good health, teenage pregnancy, Vasico Vaginal Fistula (VVF), insufficient information on body structure and functions, poor access to health facilities, poor distribution of trained medical personnel and low level of socio-economic development. The policy concludes that all the aforementioned issues contribute to the poor health status of women in Nigeria (National Policy on Women, 2001). It has been said that when women gain autonomy, they are better able to claim their rights, including the right to act to protect their own reproductive health (Heise, Ellsberg and Gottemoeller, 1999).

Also social economic factor has been considered of relevance to the issue of child hawking. A debate in this regard is whether child hawking is a form of child labour or not. While Commenting on the relationship between social background and the issue of child hawking, Okokon and Charles (2004) concluded in their study that Child hawking only becomes exploitative when it attracts stringent negative sanctions: otherwise it is like any other "child service" to a family that is in need of such assistance.

In all, scholars have observed that one way to bring out women's voices is to ask women questions. Asking questions from women facilitates understanding of the nature of their subordination. In their view, the experiences of women's oppression and liberation within their own societies must inform the enforcement of human rights (Armstrong, 1993, Bunting, 1993, Lazreg, 1990). This is because what appears to an 'outsider' as oppression may be found to be tolerable or even advantageous to women

involved; conversely, what they find discriminatory and subordinating may not be apparent to the 'outsider' (Abu-Odeh, 1992).

2.4.3 Influence of Social Networks and Household.

Every body belongs to informal social networks that influence their behaviour to some degree (Valente, 1995). Social networks include the extended family, friends, neighbours, political groups, church groups, youth groups and other formal and informal associations. Most people seek approval of others and modify their own behaviour to please others or to meet others expectation (Valente, Watkins, Jato, Van Der Straten and Tsitsol, 1997).

Household and community influences can be so powerful that they can obscure the line between individual desire and community norms. For instance in some cultures, many people reject contraception because bearing and raising children is the path to respect and dignity in the society (Ladjali, 1991). Also, a person's marital status, the stability of the marriage , communication with the person's partner and status within the family influence reproductive choice (Kazi and Sathar, 1986).For instance some women say that contraceptive use is not an individual decision but one made by the couple or family(Dixon-Mueller, 1993). In the Philippines 88% of women surveyed in 1994-1995 said that family planning is often a family decision (Adair, Polyhamus, Guilliano and Avila, 1997). Young people often decide not to seek family planning because they do not want their parents or other adults to know that they are sexually active (Jejeebhoy, 1999).

In Nigeria, according to the 2003 NDHS, information on currently married women who know a contraceptive method by the number of times they discussed family planning with their husbands showed that almost two-thirds of women reported that they never discussed family planning with their husbands. Lack of discussion, as reported, may reflect a lack of personal

interest, hostility to the subject, or customary reticence in talking about sex-related matters (NDHS. 2003).

Also among married women in Nigeria, it has been reported that decision making is highly dominated by husbands. For each specified decision to respondents during the NDHS survey, the majority of women stated that their husband has the final say. At least two-thirds of women stated that their husband alone makes decisions regarding the children's health care and education, large household purchases, and even the respondent's own health care (NDHS, 2003).

2.4.4 Individual Values and Personal Characteristics.

People differ in their reproductive intentions, awareness of reproductive rights, perceived risk of becoming pregnant, attitudes about contraception and ability to make decisions on reproductive health (Rutenberg, Biddlecom and Kuona, 2000).For instance, on contraceptive use, the nature of a person's sexual relationship whether in a long term monogamous marriage or occasional sexual contacts influence the choice of contraception (George Town University, 2000)

2.4.5. Level of education.

Education is an important variable which tends to influence nearly every aspect of behaviour. Education is a major socio-economic variable (NPC, 2001) Studies have shown that formal education has impact on fertility levels. Educational status affects reproductive health status in several ways. The more educated a person is the more likely she/he is to marry late (Mamdani, Gamer, Harpham and Campbell, 1993), to know about reproductive health services and their location (Lee, 1992), to want fewer children (Mamdani, Gamer, Harpham and Campbell, 1993), to use contraception and thus to have low

fertility (Robey, Rutstein, Morris and Blackburn), to justify wife beating (NARHS, 2003). When girls receive education, policies and programs impart new attitudes and skills that enhance their reproductive health. Also women with more education typically have more autonomy and are better to make decisions for themselves (Moulton, 2001). Also people who can read have more access to printed materials about reproductive health concept including family planning and contraceptives (Seats Project, 1999). The ability to read is an important personal asset allowing women and men increased opportunities in life (NDHS, 2003)

2.4.6 Location

Aside from education and other social cultural factors, place of residence influences reproductive choice (Cohen, 1998, Curtis and Neitzel, 1996). For instance, according to a study carried out in Bangladesh, urban residents usually have more interest in family planning, more access to modern contraception and better education. Children in urban areas are less of an economic asset to the family, living costs are higher, and social norms that favour large families are weaker than in the country side (Cleland and Mauldin, 1991). Also women who live in rural areas are more likely than women in urban areas to have birth intervals shorter than 3 years (DHS, 2002)

2.5. Reproductive health rights practices in Ibadan South West Local Government.

The investigator observed during his field work exercise that all the PHC (with the exception of the one at Awodifa) do not have enough space for female reproductive health services, particularly family planning. The PHC at Bolumole, Molete and Akere compound are more or less shops which hardly

contain the service provider and his/her table let alone the patient/client. Attendance for reproductive health counseling, which the staff of the clinics are expected to render, is low. Also, the centers are not generally equipped to offer satisfaction to those who may wish to patronize them for reproductive health concerns. In one of the clinics, when asked if there was ever a complaint about the state of affairs, the investigator was informed that no one has ever made such complaint but the source agreed that attendance could increase if the quality of the service improves. On the issue of abortion, another source observed that with the rate of promiscuity and decadence around, abortion is rampant but admitted that no case of unsuccessful abortion has been brought to the clinic and that in any event such cases will be immediately referred to the University College Hospital which is better equipped to handle such matters.

With regard to the extent of reports of domestic violence in the local Government, base line sources at the police stations visited, including that of Iyaganku, did not at first understand what domestic violence is until it was explained. The general idea of these informants was that domestic violence includes beating of women by their husband or grievous punishment of children by their parents and teachers. However, the unanimous view was that except when it relates to very serious crime, domestic violence is seldom reported. When asked if any concerned individual has ever come to report an incidence of domestic violence, the response of informants was that it happens but most of such cases often ended up abandoned due to lack of follow-up on the part of the concerned informant. It was also generally viewed by the informants that those who are victims of this violence at home are often reluctant to report at the station because it is seen as usual and nothing criminal except when it involves grievous bodily harm. An informant wondered who would report to the station in the case of a father maltreating

his child or wife. The opinion was that the victims would rather suffer in silence than have to report to the police. However, according to him, on some instances where neighbors have reported such incidents at the station, such cases are often settled without going to court, provided there is no serious harm involved. Where the police consider court to be inevitable, such cases are often frustrated when the complainant refuses to turn up in court to prove his/her case against the accused person.

The same sources also revealed that though rape is at times reported, most times the investigation is inconclusive. They distinguished between rape and the crime of defilement of an under age girl. According to the sources, people are more willing to prosecute defilement than rape but also admit that on most occasions even the crime of defilement can be settled out of court. With respect to crime of rape, on rare occasions when the matter is taken to the court, it is often difficult to prove. On the issue of abortion, another source at the police station observed that at times, quack doctors who engage in such practices have been reported and where an allegation appears genuine it would be prosecuted. Sources could not, however, give how many of such cases have been prosecuted.

Most legal practitioners with offices in the area are not familiar with the concept of reproductive health rights. It was generally viewed that health issues are of public interest but with little or no monetary gain for professional lawyers. However, some could recall that on rare occasions, they have had cause to render legal aids to victims of sexual crimes such as rape and defilement. They noted that such matters are often frustrated due to the stigma associated with the crimes. Relating how such cases are conducted in the courts situated in the area, some of the litigation lawyers hinted that they are conducted in the same manner everywhere. Expatiating further, sources revealed that cases of rape and other offences relating to minors are often tried

in camera, where the public is kept out of the trial. On legal reporting of the case, mention is not made of the name of victims. However, it was observed that the essence of trying the case secretly is often defeated by the fact that criminal trials are not speedy. Therefore it can not be guaranteed at all times that such matter will not get to the knowledge of the public thereby defeating the purpose of trial in camera.

The investigator also observed during the field work exercise that in the major markets of the IBSWLG, notably Alesinloye and Oja oba, and the major commercial motor parks, child hawkers are visible. Female engagement in this is predominant. A source confirmed that poverty is the root cause. It was also noted that mobile courts do routinely arrest such hawkers and upon proof of guilt impose a fine on them. This, however, hardly stops the habit, as most locations frequented by these hawkers are not accessible to the mobile van of the mobile courts. Also, some parents in IBSWLG associate marriage of under age girls in the area with teenage pregnancy, which they also believe leads to dropping out from school. The foregoing highlights the reasons for selecting IBSWLG as the study site

2.6 Conceptual Framework

2.6.1 Preamble

The ecological model is a comprehensive health promotion model that is multifaceted, concerned with environmental change, behaviour and policy that helps individuals make healthy choices in their daily lives (Parry *et al*., 1996). Many of the predominant theories and models of behaviour focus on one dimension of health promotion, such as knowledge, attitudes or skills (Green *et al*., 1996). However, the ecological model addresses multiple layers of influence on behavior which provides a comprehensive approach for health

promotion. Also, the ecological model offers promising results in preventing many public health problems (Breslow, 1996)

The defining feature of the ecological model is that it takes into account the physical environment and its relationship to people at individual, interpersonal, organizational, community and policy levels (McLeroy, *et al.*, 1988). The ecological model operates on the premise that health choices do not exist in vacuum. The assumption of the ecological model at the intrapersonal level are that characteristics of the individual such as knowledge, attitudes, skills, self esteem, behaviour and developmental history may affect health choices (McLeroy, *et al.*, 1988). Implicit at the interpersonal level are the assumptions that formal and informal social networks and social support systems, including family, work group and friendship networks affect health choices.

At the institutional or organizational level, it is considered that institutional factors, formal or informal rules and regulations for operation affect a health choice or behaviour. The model also takes into account certain factors referred to as community factors which entail the relationship among organizations, institutions and informal networks within defined boundaries. Finally, it is assumed by the ecological model that policy level factors including laws at local, regional and national levels affect health choices.

2.6.2 Application

Applying the foregoing to this study, a person is likely to demand the realization of his reproductive health rights (RHRs) if he has knowledge of the rights. Also, attitude to RHRs might be informed by gender, location, values and personal preferences. These are referred to as intrapersonal factors which affect health choice (Table 3). Apart from these factors, formal or informal

social networks such as family, peers and friends (interpersonal factors) that a person enjoys may influence his / her reproductive health right choices. The institutional factors that may affect the reproductive health right choice of a person include: poor accessibility to information on RHRs, the availability of legal aid, the police and reproductive health clinics. Another set of factors (community factors) which may affect RHRs choice are namely double standard norms for males and females while at the public policy level the inadequacy or otherwise as well as type of sanctions of policies and laws may affect RHRs' choices as seen in Table 3.

These factors were studied by means of focus group interviews and a survey of the target populations. In carrying out this study, FGD was used to gain insight into the opinion and attitude of respondents on RHRs and related issues. This was followed by a survey using a semi-structured questionnaire.

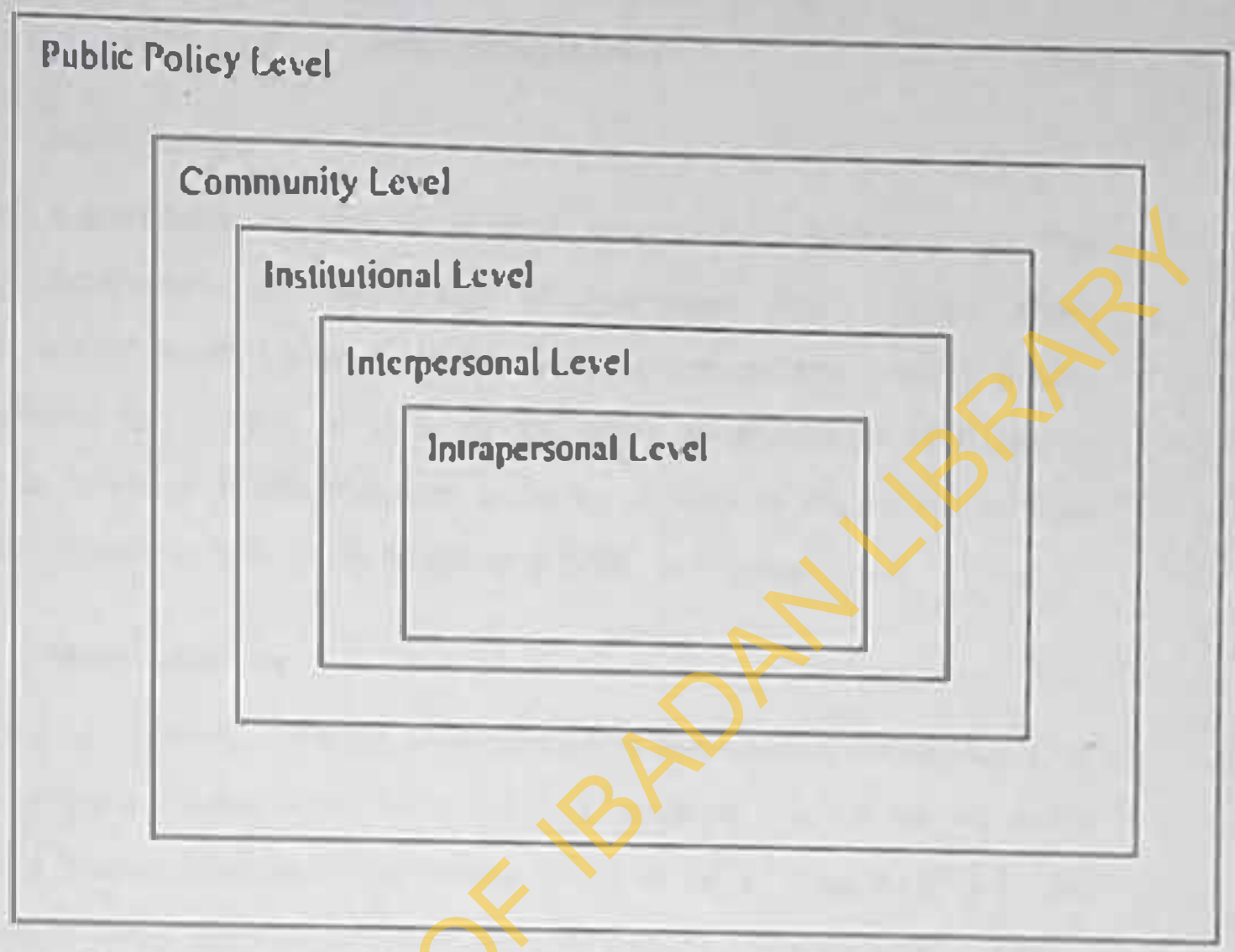
Table3

Application of Ecological model: Reproductive Health Right choice.

Intrapersonal Level	Willingness to demand actualization of Reproductive health rights (RHRs) : knowledge . ottitude to RHRs informed by gender difference, location, values and personal preferences.
Interpersonal Level	Family peers and friends that a person has may influence his / her reproductive health right choices.
Institutional Level	Poor accessibility to information on RHRs, legal aid, the police and reproductive health clinics.
Community Level	Double standard nonns for males and females.
Public policy Level	The inadequacy of sanctions, policies and laws which may affect RHRs.

Source: Change Process, A social Behavioural foundation for Health Education (Unpublished)

Figure 1: Ecological Model



Source: Change Process. A social Behavioural foundation for Health Education (Unpublished)

CHAPTER THREE
METHODOLOGY

3.1 Study design

This is a descriptive and explorative study using a cross sectional design. The study determined the knowledge of Household heads (HHs) about Reproductive health rights (RHRs), laws, conventions and treaties. It also determined the opinion of HHs on the extent of promotion of RHRs in Nigeria, issues of RHRs, measures to be put in place to ensure enforcement and the attitude of HHs to the adoption of RHRs in Nigeria.

3.2 Study Location

The site of the study is Ibadan Southwest Local Government (IBSWLG), Oyo state, Nigeria. Ibadan South West Local Government was carved out of the defunct Ibadan Municipal Government (IMG) on the 27 August, 1991 by the regime of former military President, General Ibrahim Babangida (rtd.). It has a land mass of about 244.55km, which makes it one of the largest local government in Oyo State. IBSWLG is approximately 150km from Lagos by the most direct route and 659km from Abuja, Federal Capital Territory (FCT). The local Government is bounded in the north by Ibadan North and Ibadan North East Local Governments; in the east by Ibadan South East and Oluyole Local Government, in the south by Ido Local Government and the west by Ibadan North West Local Government. The administrative headquarters of the local Government is at Oluyole Estate within the office complex of former Ibadan Metropolitan Planning Authority along Bashorun M.K.O Abiola Way (Former Ring Road) Ibadan.

Ibadan South West Local Government is largely urban; the communities in the LGA possess typical characteristics of urban areas which according to Brieger (2002) include affluence, slums and shanty towns. The 1991 National Population census put the population figure of the local government as 277.047. Using a growth rate of 2.83 per cent per annum (NDHS, 2003), the population at 2005 is 386.813. A greater percentage of the inhabitants of the LGA are Yorubas, although there are pockets of Igbos, Hausas and foreign nationals, especially the Lebanese who also reside within the local government. Most inhabitants are traders, artisans who are either self-employed or working in manufacturing industries, or civil servants. There are few inhabitants of the IBSWLG who engage in farming activities.

3.2.1 Political Structure

Politically, based on the information collected from its Community Development Department, the Ibadan South West local government has twelve political wards, namely: Ward 1 consisting of Orita Merin, Bere, Onisiniyan, Oje-Oba, Alekuso and Akere compound areas; Ward 2 consisting of Isale Osi, Bom Photo, Gege, Aladorin, Elesin Meta, Apampa compound areas; Ward 3 consisting Isale ijebu, Idi-Arere, Itaragba omo, Iyana Asuni areas; Ward 4 consisting of Bode, Popoyemoja, Gbodu street, and Asuni compound, Ward 5 consisting of Akuro, Atasoku, Itamaya and Apana areas; Ward 6 consisting of Foko, Foko Agba, and Olesuku compound; Ward 7 consisting of Agbokojo, Methodist, Agbeni and Iyana Foko areas; Ward 8 consisting of Okebola, NTC Road, Iyaganku areas; Ward 9 consisting of Ososami, Imolefalafia, Idi-Ape, Anlani, College Crescent and Molete areas; Ward 10 consisting of Oke-Ado and Liberty areas; Ward 11 consisting of Challenge, Idi-oro, Challenge, Elewuin, Agbaje, Orita Challenge, Alade Layout, Olusanya street, Adeoyo state hospital and Foolasis; and Ward 12

consisting of Ringroad, Quarters, Apata, Odo-Ona, Oke-Ayo, Jericho and Alesinloye areas. About seven wards under local Government, namely wards 1,2,3,4,5,6,7, possess characteristics of the inner core. Three of the Local Government wards, namely 8, 9 and 10, display the features of transitory settlement, while wards 11 and 12 exhibit characteristics of peripheral settlement.

3.2.2 Notable establishments

IBSWLG has notable establisliments such as the Divisional Police force headquarters and the Press Centre of Nigerian Union of Journalist (NUJ) Oyo State Council located at Iyaganku. Different levels of courts in the local government include the Juvenile Court at NTC road, the Magistrate Courts at Iyaganku, the State High Courts at ring road and the Court of Appeal also at Iyaganku. The important markets of the local government include the markets at Alesinloye, the Oja Oba, Oke Ado Owode and the Ring road multi purpose market. Notable hotels in the local government include the D-Rovans Hotel at M.K.O. Abiola way, Kankanfo Inn at Joyce B road, Liberty Motel at Ring road, K.S. Motel at Molete and Lafia Hotel at Apata. Ibadan South West also has notable Sport Centres which include Liberty stadium at liberty road, Olubadan Stadium and Ibadan Tennis Club both at Iyaganku. In IBSWLG, there are 12 Primary Heath Care Centre at Ring road, Akere, Oja Oba, Molete, Bolumole, Awodife, Elewura, Alesinloye, Apata, Foko and Oluyole.

3.5 Study population

The population under study includes the household heads who live in the area controlled by Ibadan South West Local Government. By the NPC 1991 Census result, out of a population figure of 277,047 in this area, the population

size of household heads was put at fifty eight thousand, one hundred and sixty four(58.164). The break down of this population size is: Female-13,020 and male- 45,144. Using a growth rate of 2.83 per cent per annum (NDHS, 2003), the population of the household head at 2005 is 81,208, female household head population is 18,178 while it is 63,030 for the male household head.

3.7 Sample Size Determination

At 2.83% annual population growth 2005 population of household heads of IBSWLG was expected to be 81,208. A sample size of approximately 400 was calculated using the statistical formulae: $n=z^2 pq/d^2$ for the 81,208 population of Household heads in IBSWLG.

Where: n= The desired sample size (population > 10,000)

z= The Standard normal deviate, set at 1.96 at 95% Confidence level

p= The proportion in the target population estimated to have a particular characteristic at 50 % or 0.50 estimate

q=1.0-p

d=degree of accuracy desired, i.e.0.050

$n= (2)^2 (0.50)(0.50)/(0.50)^2 = 400$ sample size

(Source: Araoye, 2003)

In all, considering attrition, 423 questionnaires were administered on respondents.

3.7.1 Sampling procedure

A multistage sampling technique was used. Firstly, IBSWLG was divided into political wards across the strata of inner core, transitory and peripheral. Proportional and simple random techniques was used to select three wards from the inner core, two wards from the transitory and two wards from the

peripheral areas. At the end of this stage 7 wards were selected. The details of the Balloting result are as shown below:

Inner Core

Wards	Areas
4	Bode, Popoyemoja, Gbodu, Asuni Compound
6	Foko, Foko Agba, Otesuku Compound
7	Agbokojo, Methodist Agbeni, Iyana Foko.

Transitory Area

Wards	Areas
8	Okebola, NTC Road, Iyaganku
10	Oke Ado, Liberty

Peripheral

Wards	Areas
11	Challenge, Idi-odo, Elewura, Agbaje Orita Challenge Alade Layout, Olusanya Street, Ade Oyo State Hospital, Fodasis.
12	Ringroad, Quarters Apata, Odo Ona, Oke Ayo, Jericho, Alesinloye.

At the second stage, the areas in each of the selected wards were divided into two halves. Loader joint was cited in the streets or compounds which constituted each of the halves and using a balloting technique, an order for administration of questionnaires was determined

At the final stage, an estimate of the number of houses in the street or compound was made. Using a systematic sampling technique, an interval was

generated which informed every choice of house in which the questionnaires were administered. In all, a total of four hundred and twenty three questionnaires were administered.

3.8 Eligibility Criteria.

The questionnaires were administered on household heads. By the operational definition of the project, household head refers to the person who makes decision in the house hold notwithstanding his\her marital status.

3.9 Instruments for data collection

A combination of qualitative and quantitative methods were developed and used for data collection.

3.9.1 Qualitative Method.

Focus Group Discussion (FGD) was used as a diagnostic tool to gain insight into the knowledge, opinions and attitude of Household heads to RHRs in the IBSWLG. For this purpose, an FGD guide was developed with input from my supervisor and the guide consisted of ten questions. The questions were meant to gain insight to the knowledge of the community about the following namely:

(1) General health problems of the area
(2) Human rights and what constitutes their violation;
(3) The experience of the Community in respect of human rights violation;
(4) What are Reproductive health rights and what constitutes their violation;
(5) Which of the RHRs should be made into laws in Nigeria and the reasons for this;
(6) Laws, Conventions and Treaties on human rights and RHRs;

(7) The opinions of participants on the commonness of issues such as Son preference, Child hawkers, Abortion, Employment, Polyandry, Polygyny, Health services, Family planning contraceptive use, The beating of women, Sexual violence, Health as a right, Early marriage, Decision making on birth control, Sexual education at home and school, A healthy environment, The right to food, Alcohol consumption, Ladies dress and The right to good water;

(8) Which of the said issues should be addressed in a bill on RHRs;

(9) What can be done to ensure that these rights are adhered to after they have been recognized by law; and

(10) How should RHRs be arranged after they have been codified.

3.9.2 Quantitative Method

The quantitative method used in this study was a semi-structured questionnaire. The information generated from the FGD informed the design of the semi-structured questionnaire. The questionnaire was corrected and pre-tested before being administered. The questionnaire consists of two major sections, A and B. Section A consists of eleven main questions. Questions 1 to 5 of section A dealt with the knowledge and understanding of respondents about human rights, Reproductive health rights, their laws, conventions and treaties and what constitutes violation of RHRs.

Questions 6 to 11 dealt with respondents' opinion on the extent to which RHRs are being promoted in Nigeria by the three levels of government, opinion on issues of RHRs in Nigeria, opinion on measures to be put in place to ensure the enforcement of RHRs in Nigeria, how issues constituting RHRs should be arranged, with reasons, and the attitude of respondents to the adoption of RHRs in Nigeria.

Section B consists of nine questions which covered demographic information of the respondents including sex, age, religion, denomination, marital status, local government, location, education, occupation and ethnic group.

3.10 Ethical Considerations

The study was conducted on household heads who voluntarily indicated willingness to participate in the study after being duly informed of the purpose of study and their right to consent. Respondents were also informed in their first language where necessary and the English language about the confidentiality of the exercise and their option to refrain from answering any question they were uncomfortable with. The confidentiality of information obtained from the study was safeguarded by not requesting respondents to give their name. Apart from being duly informed, the questionnaires convey the details about these considerations, which any of the respondents could read on request. The integrity of the study was also maintained throughout the process of data collection, coding, entry and analysis. This was done by ensuring that experienced assistants were recruited for the exercise. Finally, interpretation and analysis was done without compromising the ethical aims of fairness, justice and benevolence.

3.11 Validity and Reliability of Instrument.

In order to ensure the validity and reliability of the qualitative and the semi-structured tools, the set of tools was pre-tested in the area under the control of Ibadan North Local Government. The Ibadan North Local Government area possesses similar features to the Ibadan South West Local Government area and is equally stratifiable in terms of an inner core, and transitory and peripheral areas. Where open questions were asked, such as in questions 1 to

5. respondents were requested to give examples within their knowledge. Also where closed questions were asked, such as in questions 6 to 8, respondents were requested to give reasons in support of their view. This was designed into the questionnaires in order to prevent guesswork and to guarantee quality responses especially to closed questions.

The qualitative instrument pre-test was carried out at Agodi community. Two focus group discussions (one male group and one female group) were conducted in the local government. During the pre-test, attention was paid to the reaction of participants to question, understanding of the question and the time duration. After the pretest, the result was used to develop the guide for the main study.

A pre-test was also carried out for the semi-structured tool which was administered at Agodi. The semi-structured questionnaire was administered on 40 respondents. When administering the questionnaires, attention was paid to responses given by respondents, in order to note whether the questions were properly understood, how long it took each questionnaire to be administered and the general view of respondents about the questions. During the pretest, it was observed that respondents were only able to answer seven items of the questionnaire namely; Questions 6 h (i), (iii), (iii), p and 7(i) after long explanation was given on each. When requested for their views, respondents suggested that the questions are time consuming .It was also suggested that questions 6p and 7(i) should be split into two.

The suggestions of the respondents were subsequently built into the toolset. The issue of time was discussed with my supervisor who advised that the questionnaire should be re-structured and re-tested on eighteen of the respondents that participated in the first pre-test. Result on the reliability co-efficient test carried out on the seven items of the questionnaire indicated a

high alpha value of 0.7082 i.e. 70.82% meaning that there is no significant difference between the pretest and retest results.

3.11.1 Translation

Both the FGD tool and semi structured questionnaire were translated from English to Yoruba and back to English with the help of language experts with experience and a background in public health promotion.

3.12 Data Collection

3.12.1 Training of interviewers

The six interviewers who administered the questionnaires were trained to administer them. The one-day training programme took place at the Department of Health Promotion and Education, UCH Ibadan. In attendance were the investigator and five research assistants with input from research assistants to the Head of Department. During the training, the recruited interviewers were intimated with the objectives of the study, the procedure of the study, the research design and how to conduct interviews effectively. They were informed on the criteria for eligibility for interview and the ethical considerations to be borne in mind at all times, namely, that the questions were only meant for the household heads in the community, whose participation must be voluntary. The need for interviewers to probe questions was emphasized; attention was particularly drawn to questions 5, 7, 10 and 11 in the questionnaire. Opportunities were given to them to ask questions about the tool which the investigator clarified to their satisfaction. The Yoruba and English questionnaires were then reviewed and demonstrated at the training.

3.12.2 Focus group discussion.

Focus group discussions with the aid of a guide were conducted in Ward 2 in the inner core; Ward 8 in the transitory area and Ward 11 in the peripheral area (which were chosen by balloting) of the IBSWLG. Participants from each of these wards were representational and were household heads: each of the areas in the ward sent a representative for the FGD. In all, six FGDs were conducted in the local government area. Two focus group discussions were conducted in each of the strata, namely the inner core, the transitory and peripheral areas in the ratio of 1 female group to 1 male group. Each discussion session had between six to eight participants and lasted for 45 to 1 hour. The investigator served as a moderator in all the FGDs. Two other trained assistants served as observer and keeper of time.

The participants contributed freely but were interrupted once in a while on such occasions when it was observed by the moderator that the discussion was becoming loose. Tape recorder was also used during the session to support recording of responses.

3.123 Semi - Structured Questionnaires.

After the re-test of the semi-structured questionnaire, a total of 423 questionnaires were administered in IBSWLG. Trained interviewers went with both English and Yoruba versions of the questionnaires which they administered after they had introduced themselves to the respondents, explained the objective of the study and obtained the requisite consent for interview. Information given by the respondents was clearly written down by the research assistants who were also requested to submit their work every day with a contact person at the Department. Each filled questionnaire was reviewed to ensure that it was properly filled. The administration of each of

the questionnaires lasted between 55 minutes and 1 hour 30 minutes while a period of three weeks was used to collect the data.

3.13 Data Analysis

The tape recorded responses during the FGD were transcribed and written down in narrative form. After final administration of the interviewer-administered questionnaire, manual editing was carried out to ascertain completeness of questionnaires and to check for consistency, accuracy and uniformity. A coding guide was developed which the researcher used to organize responses into categories. The guide helped at managing the open-ended questions. A numerical figure was attached to each of the responses in order to aid their tabulation and analysis. The data were subsequently fed into the computer. The data were entered and analyzed using the SPSS statistical software. Frequency was generated by the analyst from which findings of the study were explored and on which the subsequent discussions of findings were based.

The statistical chi (x^2) test was used to elicit the probabilities and chances of occurrence of differences in the variables. The statistical test was carried out on a 95% Confidence level.

CHAPTER FOUR
RESULTS

4. Demographic characteristics of respondents.

4.1 Respondents' age, sex and marital status.

The majority of the respondents, 143, (33.8%) were between 30-39 yrs, followed by 129 (30.5%) respondents in the 20-29 yrs bracket (Table 4) .The mean age was 37.12 years while standard deviation was 11.18. More than two third of the respondents, 318, (75.2%) were male household heads and 105 (25.8%) were female. The majority of the respondents 296 (70.0%) were currently married while 109 (25.8%) respondents were single (Table 4).

4.2 Respondents' religion, denomination and ethnic group.

The majority of the respondents, 285, (67.4%) were Christians, followed by 138 (32.6%) respondents who were Muslims. The predominant Christian denomination was Pentecostal, 117, (41.1%), followed by orthodox, 102, (24.1%) respondents and African 20 (7.0%), while the majority of the Muslim respondents, 104, (75.4%) said they worship in any denomination, followed by 20 (14.5%) respondents who were of Ansardeen denomination (Table 4)

4.3 Respondents' location, level of education and occupation

About one third of the respondents, 158, (37.4%) were from the inner-core area, followed by 140, (33.1%) from the peripheral, while 125 (29.6%) were from the transitory area (Table 4). The majority of the respondents, 409, (96.7%) have attended school, while 14 (3.3%) have not attended any form of school. The predominant level of education was secondary education, 216, (51.1%), followed by primary education, 71, (16.8%) and HND/University education, 58 (13.7%), (Table 4)

Table 4: Demographic characteristics of respondents

		Frequency	Percentage %
Sex	Male	318	75.2
	Female	103	24.8
	Total	423	100
Marital Status	Married	296	70.0
	Single	115	27.2
	Divorced	5	1.2
	Widowed	7	1.7
	Total	423	100
Age	20-29	129	30.5
	30-39	143	33.8
	40-49	84	19.9
	50-59	39	9.2
	60-69	15	3.5
	70 and >	13	3.1
	Total	423	100
Ethnic group	Yoruba	375	88.7
	Igbo	39	9.2
	Hausa	1	0.2
	Edo	6	1.4
	Ijaw	3	0.5
	Total	423	100
Educational level	Post graduate	8	1.9
	HND/University	53	13.7
	NCE/OND	56	13.2
	Secondary	216	51.1
	Primary	71	16.8
	Never Attended	14	3.3
	Total	423	100
Occupation	Traders	207	49.0
	Artisan	140	33.1
	Professionals	28	6.6
	Farmers	20	4.7
	Civil servants	13	3.1
	Unemployed	15	3.5
	Total	423	100
Religion	Christianity	285	67.4
	Islam	138	32.6
	Total	423	100
Location	Inner core	158	37.4
	Transitory	123	29.0
	Peripheral	140	33.1
	Total	423	100

4.2 Knowledge of HHs on (a) what RHRs constitute and (b) RHRs' laws, conventions and treaties.

4.2.1 Respondents' understanding of human rights.

Most respondents, 308(43.4%) as seen in Table 5, gave examples of what they believe to constitute human rights which fell outside those specified in the Nigeria 1999 Constitution. 188 respondents (26.5%) mentioned examples of human rights that fell within the context of the 1999 Nigerian Constitution, while 109 (15.3%) understood human rights to be benefits from government i.e. what the government must do for its citizens, what you should enjoy as a citizen of a country, your rights as an individual.

These views corroborated with FGD findings from participants in the three communities. Some male participants at Akere Community defined human rights as "entitlements of people from government" while a participant in the Female FGD at Awodife Bolumole Community referred to it as "benefits which the law should provide for its citizens."

Table 5

Knowledge of house hold heads on human rights in IBSWLGA.

N=709

Examples of Human Rights	n	%	Examples Within/ Outside 1999 Constitution
Right to life	22	(3.1%)	Within
Right to dignity of human person	4	(0.5%)	Within
Right to personal liberty	28	(3.9%)	Within
Right to fair hearing	1	(0.1%)	Within
Right to private and family life	5	(0.7%)	Within
Right to freedom of Expression and the Press	61	(8.6 %)	Within
Right to peaceful assembly and association	34	(5.0%)	Within
Right to freedom of movement	26	(3.6 %)	Within
Right to freedom from discrimination	13	(2.0%)	Within
Right to acquire and own property anywhere in Nigeria	1	(0.1%)	Within
Right to health	47	(6.6%)	Outside
Right to social amenities, water, shelter, electricity, good road etc.	95	(13.4%)	Outside
Right to enjoy good standard of living	96	(13.5%)	Outside
Right to free education	69	(10.0 %)	Outside
Benefits from Government	109	(15.3%)	
Rights from parents to children	54	(7.6%)	
Rights from God	17	(2.3%)	
Right to Culture	1	(0.1%)	Outside
Don't know any human right	26	(3.6%)	
Total	709	(100.00%)	

Multiple responses

4.2.2 Respondents knowledge of Reproductive health rights (RHRs)

When respondents were asked to mention all the RHRs they knew, the right to health was the most cited, 247(58.4%) followed by 123(29.1%) who mentioned the right to decide the number and spacing of children, and 33 (7.8%)respondents who mentioned the right to a standard of living adequate for health and well being (Table 6). However, when prompted, an increase in the respondents' knowledge (range 20-40%) was recorded in almost all the rights with a substantial knowledge increase on the right to freedom of association, 329, (77.7%) followed by the right to consent to marriage (62.0%). Details in (Table 6).

For the most part, these views agreed with the FGD findings in the three communities. At Akere Community most participants in the male group mentioned adequate and well-equipped maternity hospitals, the provision of jobs, immunization and the provision of drugs as examples of reproductive health rights while the female group mentioned access to contraceptive use, birth control, harmony at home and in the community as examples. In Awodife Boluinole Community, nearly all the participants in the two groups agreed that reproductive health rights consist of access to health facilities, the availability of drugs and family planning and the procreation of children. A female participant in a female FGD group in that community said "reproductive health rights are rights associated with reproduction"

Table 6: Knowledge of Some Bold Heads of Reproductive health rights (RHRs).

N=423

Types of RHRs	Without prompting		With prompting		Types within or Outside 1999 Constitution
	Yes	No	Yes	No	
i. Right to life i.e. (Reproduction comes from God)	1(0.2)	422(99.8)	174(41.1)	248(58.5)	Within
ii. Right to liberty and Security of person i.e (Freedom to do what ever you like with your self, to be insured against disease)	3(0.7)	420(99.3)	170(40.1)	250(59.1)	Within
iii. Right to decide the number and spacing of children i.e (right to protect oneself from unwanted pregnancy, right to give birth to the number of children you can cater for, right to contraceptive use, right to procreate according to financial capacity).	123(29.1)	300(70.9)	198(46.8)	102(24.11	Outside
iv. Right to privacy i.e.(confidentiality in getting reproductive health services)	2(0.5)	421(99.5)	96(22.7)	325(76.8)	Within
v. Right to Consent to marriage i.e (one should not be married against ones will, there should be no family interference, ladies should appreciate marriage before getting married)	16(3.8)	407(96.2)	262(62.0)	145(34.3)	Outside
vi. Right to equality in marriage	0	423(100)	137(32.4)	286(67.4)	Outside
vii. Right to be free from discrimination	0	423(100.)	186(44.0)	237(55.6)	Within
viii. Right to enjoy scientific progress and to consent to experimentation	0	423(100.)	75(17.7)	348(82.3)	Outside
ix. Right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment	0	423(100.)	165(39.0)	258(61.0)	Within
x. Right to a standard of living adequate for health and well being i.e. (right to fund to eat square meal daily, right to employment, right to allowances for maintenance of ones family	33(7.8)	390(92.2)	175(41.4)	215(50.8)	outside
xi. Right to education and information on RH i.e. (information on contraceptive use, information on abortion and information on safe delivery).	28(6.6)	395(93.4)	193(45.6)	202(47.81	Outside
xii. Right to health i.e.(right to antenatal care , right of nursing mothers to health, right to free delivery, right to hospitals, right to free drugs, right to provision of drugs and health services at a subsidized rate)	247(58.4)	176(41.6)	131(31.0)	45(10.6)	Outside
xiii. Right to freedom of Association i.e.(belonging to different society of health, the activities of NGO on reproductive health issues.	3(0.7)	420(99.3)	329(77.7)	91(21.5)	Within
xiv. The Right to Social Amenities i.e.(right to water, right to electricity, right to good road and shelter	24(5.7)	399(94.3)	0	0	Outside

4.2.3 Respondents knowledge of RHRs' laws, treaties and conventions.

When asked about their awareness of laws, conventions and treaties on human rights and RHRs, most respondents, 346(85.0%) stated that they did not know of any; only 34 (8.3%) respondents had some knowledge (Table 7). FGD findings in all the FGD groups in the communities corroborated these findings which revealed that the level of awareness is low. In Awodife Bolumole Community, a male participant in that community cited the law against abortion and said "there are no such laws and conventions in Nigeria: it is only in the advanced countries".

Table 7

Knowledge of respondents about laws, conventions and treaties on RHRs and content (N=407)

Examples of laws, Conventions and Treaties	n	%
1. Laws Law prohibiting hawking of goods by children, China policy of one child to one spouse, law against abortion, United Nations Charters on Human Rights, African Charter on Human Rights, Law against rape, Indian policy on one child to one family, Britain policy on one child to one family, United States policy of one child to one family, the law that pregnant woman should go for antenatal care.	24	6.0
2. Conventions Convention on mothers and Child health which emphasizes giving birth to a number of children you can cater for, Convention on HIV/AIDS, Universal Basic education, Convention of blood test before marriage.	34	8.3
3. Treaties Treaty on environmental and sanitation, treaties on water and social amenities 1 (0.2%), treaty on free education	3	0.7
8. I don't Know	346	85.0
Total	407	100.00

Multiple responses

4.2.4 Respondents' knowledge of what constitutes violation of RHRs

Results revealed diverse knowledge by respondents of what constitutes violation of RHRs. One hundred and three (24.0%) respondents mentioned health-related crimes such as the stealing of drugs, bribe-taking by health officials, rape, abortion, vandalisation of health equipment, and the giving of fake drugs. Ninety respondents (21.0%) stated insensitivity to health issues as violation of RHRs, citing examples such as insensitive leadership, the non-availability of hospitals, lack of access to health care facilities, inadequate staffing of hospitals, lack of census, unemployment, no known stipulated law on reproductive health rights, unavailability of drugs in the hospitals. Fifty two respondents (12.0%) stated that poor health service delivery and management constituted violation of RHRs with examples such as mismanagement of hospital funds by health managers, lack of supervision, improper attendance to pregnant women, the nonchalant attitude of health workers, and improper management of hospitals. Details are presented in (Table 8). These views corroborated with the FGD findings in the three communities.

Table 8: Knowledge of what constitutes violation of RHRs (N=431)

Examples of violation of RHRs	n	%
i. Health related crimes: Stealing of drugs, bribe taking by health officials, rape, abortion, vandalisation of health equipment, giving of fake drugs	103	24.0
ii. Leadership insensitivity to Health issues: Insensitive leadership, non availability of hospitals, lack of access to health care facilities, in adequate staffing of hospitals, lack of census, unemployment , no known stipulated law, unavailability of drugs in the hospitals	90	21.0
iii. Poor health service delivery and management: Mismanagement of hospital funds by health managers, lack of supervision, improper attendance to pregnant women, non challant attitude of health workers, improper management of hospitals	52	12.0
iv. Ignorance: lack of awareness on diseases, ignorance of basic hygiene, ignorance about the use of family planning, drug abuse	41	9.5
v. Poverty	20	4.6
vi. Irresponsibility of parents: No sexual education at home, child labour, undisciplined parents	14	3.2
vii. Cultural beliefs: polygyny, belief in having too many children, ethnicity	8	2.0
viii. Diseases and sickness: HIV/AIDS and STI	6	1.3
ix. Unbelief in God teachings on sex Abstinence, faithfulness to ones spouse.	6	1.3
x. Don't know	91	21.1
Total	431	100.00

Multiple responses

4.3.1 Respondents opinion on the promotion of reproductive health rights in Nigeria

Only two reproductive health rights are reportedly being promoted in Nigeria. These are the rights to health and freedom of association and political participation. Most respondents viewed that all other RHRs are not being promoted at all. See Table 9 for details.

Table 9

Opinion on extent of promotion of RHRs in Nigeria (N=423)

Types of Reproductive health rights	Extent to which RHRs are being promoted at all levels of Government								
	Federal government			State government			Local government		
	To a large extent	To some extent	Not at all	To a large extent	To some extent	Not at all	To a large extent	To some extent	Not at all
The Right to life	24(5.7%)	79(18.7%)	320(75.7%)	20(4.7%)	83(19.6%)	320(75.7%)	17(4.0%)	66(15.6%)	340(80.4%)
The Right to Liberty and Security of person	14(3.3%)	104(24.6%)	305(72.1%)	12(2.8%)	98(23.2%)	311(73.5%)	12(2.8%)	73(17.3%)	336(79.4%)
The Right to decide the number and spacing of ones children.	47(11.1%)	136(32.2%)	240(56.7%)	39(9.2%)	132(31.2%)	252(59.6%)	35(8.3%)	106(25.1%)	282(65.7%)
The Right to Privacy	11(2.6%)	77(18.2%)	335(79.2%)	10(2.4%)	74(17.5%)	337(79.7%)	9(2.1%)	61(14.4%)	351(83.0%)
The Right to Consent to marriage	24(5.7%)	133(31.4%)	266(62.9%)	21(5.0%)	122(28.8%)	280(66.2%)	22(5.2%)	109(25.8%)	292(69.0%)
The Right to equality in marriage	26(6.1%)	88(20.8%)	309(73.1%)	18(4.3%)	86(20.3%)	309(73.1%)	18(4.3%)	75(17.7%)	330(78.0%)
The Right to be free from discrimination	47(11.1%)	112(26.5%)	264(62.4%)	31(7.3%)	114(27.0%)	277(65.5%)	29(6.9%)	108(25.5%)	287(67.8%)
The Right to enjoy scientific progress and consent to experimentation	55(13.0%)	85(20.1%)	283(66.9%)	22(5.2%)	98(23.2%)	301(71.2%)	18(4.3%)	84(19.9%)	319(75.4%)
The right not be subjected to torture or other cruel, inhuman or degrading treatment or punishment	44(10.4%)	103(24.3%)	276(65.2%)	30(7.1%)	98(23.2%)	293(69.3%)	27(6.4%)	88(20.8%)	306(72.3%)
The Right to a Standard of living adequate for health and well-being	48(11.3%)	121(28.6%)	254(60.0%)	40(9.5%)	107(25.3%)	275(65.0%)	38(9.0%)	91(22.2%)	290(68.6%)
The Right to education and information on Reproductive health.	72(17.0%)	130(30.7%)	221(52.2%)	53(12.5)	136(32.2%)	232(54.8%)	52(12.3%)	112(26.5%)	257(60.8%)
The Right to health.	142(33.6%)	147(34.8%)	134(31.7%)	117(27.7	161(38.1%)	143(33.8%)	115(27.2%)	141(33.3%)	165(39.0%)
The Right to freedom of Association and political participation	135(31.9%)	139(32.9%)	149(35.2%)	115(27.2	150(35.5%)	158(37.4%)	113(26.7%)	134(31.7%)	175(41.4%)

Table 9

Opinion on extent of promotion of RHRs in Nigeria (N=423)

Types of Reproductive health rights	Extent to which RHRs are being promoted at all levels of Government								
	Federal government			State government			Local government		
	To a large extent	To some extent	Not at all	To a large extent	To some extent	Not at all	To a large extent	To some extent	Not at all
The Right to life	24(5.7%)	79(18.7%)	320(75.7%)	20(4.7%)	83(19.6%)	320(75.7%)	17(4.0%)	66(15.6%)	340(80.4%)
The Right to Liberty and Security of person	14(3.3%)	104(24.6%)	305(72.1%)	12(2.8%)	98(23.2%)	311(73.5%)	12(2.8%)	73(17.3%)	336(79.4%)
The Right to decide the number and spacing of ones children.	47(11.1%)	136(32.2%)	240(56.7%)	39(9.2%)	132(31.2%)	252(59.6%)	35(8.3%)	106(25.1%)	282(65.7%)
The Right to Privacy	11(2.6%)	77(18.2%)	335(79.2%)	10(2.4%)	74(17.5%)	337(79.7%)	9(2.1%)	61(14.4%)	351(83.0%)
The Right to Consent to marriage	24(5.7%)	133(31.4%)	266(62.9%)	21(5.0%)	122(28.8%)	280(66.2%)	22(5.2%)	109(25.8%)	292(69.0%)
The Right to equality in marriage	26(6.1%)	88(20.8%)	309(75.4%)	18(4.3%)	86(20.3%)	309(75.4%)	18(4.3%)	75(17.7%)	330(78.0%)
The Right to be free from discrimination	47(11.1%)	112(26.5%)	264(62.4%)	31(7.3%)	114(27.0%)	277(65.5%)	29(6.9%)	106(25.1%)	287(67.8%)
The Right to enjoy scientific progress and consent to experimentation	55(13.0%)	85(20.1%)	283(66.9%)	22(5.2%)	98(23.2%)	301(71.2%)	18(4.3%)	84(19.9%)	319(75.4%)
The right not be subjected to torture or other cruel, inhuman or degrading treatment or punishment	44(10.4%)	103(24.3%)	276(65.2%)	30(7.1%)	98(23.2%)	293(69.3%)	27(6.4%)	88(20.8%)	306(72.3%)
The Right to a Standard of living adequate for health and well-being	48(11.3%)	121(28.6%)	254(60.0%)	40(9.5%)	107(25.3%)	275(65.0%)	38(9.0%)	94(22.2%)	290(68.6%)
The Right to education and information on Reproductive health	72(17.0%)	130(30.7%)	221(52.2%)	53(12.5)	136(32.2%)	232(54.8%)	52(12.3%)	112(26.5%)	257(60.8%)
The Right to health	142(33.6%)	147(34.8%)	134(31.7%)	117(27.7	161(38.1%)	143(33.8%)	115(27.2%)	141(33.3%)	165(39.0%)
The Right to freedom of Association and political participation	135(31.9%)	139(32.9%)	149(35.2%)	115(27.2	150(35.5%)	158(37.4%)	113(26.7%)	134(31.7%)	175(41.4%)

4.4 Respondents' opinion on issues of RHRs to be made legally enforceable in Nigeria.

Respondents perceived certain issues to be very common/common, for example provocative dressing by ladies, 388(91.8%), child hawking, 382(90.3%), sex with sugar daddies in return for school fees, 281(84.1%), family planning contraceptive use, 325(76.9%), son preference, 289(68.3%), polygyny, 282(66.7%) and trafficking of women, 274(64.7%). See details in Table 10. Also, birth control 405(95.7%), trafficking of women, 391(92.4%), provocative dressing by ladies, 383(90.5%), sex with sugar daddies in return for school fees, 299 (70.7%) and family planning contraceptive use, 374(88.4%) were some of the issues viewed as important for inclusion in a bill on RHRs. See details in Table 11. However, the opinion of respondents was split along gender lines on the inclusion of issues of polyandry, 212(50.1%), son preference, 225(53.2%) and marital rape, 196 (46.3%) but this was significant only for child hawking and polygyny (Table 12). Most respondents, 284(67.1%) especially those living in the inner core areas, 117 (74.1%) did not support polygyny for inclusion in the bill on RHRs. See Table 13. Also, people living in traditional settings, 103(65.2%) did not support the inclusion of marital rape in a bill on RHRs. (Table 13).

In giving supporting reasons for the inclusion of provocative dressing in a bill on RHRs, 188(44.4%) respondents believed that provocative dressing by ladies is indecent and 122 (28.9%) viewed that its inclusion will reduce incidence of sexual abuse. Two hundred and thirty eight (56.3%) viewed that sex with sugar daddies in return for school fees should be included because it is exploitative. See details in Table 14

Table 10

Opinion of respondents on the level of commonness of RHRs' issues (N=423)

N	RHRs Issues	Opinion of respondents		
		Very common	Common	Not common
		n %	n %	n %
a	Male dominance	200 (47.3%)	89 (21.0%)	134(31.6%)
b	Child hawking	329(77.8%)	53(12.5%)	41(9.7%)
c	Abortion	160(37.8%)	108(25.5%)	155(36.6%)
d	Employment and prompt payment payment	28(6.6%)	19(4.5%)	376(85.7%)
e	Polygamy	180(42.6%)	102 (24.1%)	141(33.3%)
f	Polyandry	104(24.6%)	48(11.3%)	271(61.1%)
g	Family planning contraceptive use	180(42.6%)	145(34.3%)	98(23.2%)
h	i. Sex selective abortion	5(1.2%)	6(1.4%)	412(97.4%)
	ii. Battery during pregnancy	33(7.8%)	29(6.9%)	361(85.3%)
	iii. Incest	10(2.4%)	16(3.8%)	397(93.9%)
	iv. Rape	58(13.7%)	65(15.4%)	300(70.9%)
	v. Sexual abuse in the work place	150(35.5%)	111(26.2%)	162(38.3%)
	vi. Forced prostitution	106(25.1%)	69(16.3%)	248(58.6%)
	vii. Dating and courtship sexual violence	34(8.0%)	52(12.3%)	337(79.7%)
	viii. Forced suicide of the elderly women	58(13.7%)	7(1.7%)	358(84.6%)
	ix. Marital rape	18(4.3%)	33(7.8%)	372(87.9%)
	x. Trafficking of women	182(43.0%)	92(21.7%)	149(35.2%)
	xi. Female genital mutilation	75(17.7%)	77(18.2%)	271(64.0%)
	xii. Sex with sugar daddies in return for school fees	281(66.4%)	75(17.7%)	67(15.8%)
	xiii. Early marriage	137(32.4%)	114(27.0%)	172(40.6%)
i	Health as a right	146(34.5%)	59(13.9%)	218(51.5%)
j	Birth control	225(53.2%)	149(35.2%)	49(11.6%)
k	Quality health services	36(8.5%)	83(19.6%)	304(71.8%)
l	Sexual education at home	75(17.7%)	114(27.0%)	234(55.3%)
m	Sexual education at school	98(22.2%)	185(43.7%)	144(34.0%)
n	Bad dressing by ladies	359(84.9%)	29(6.9%)	35(8.2%)
o	Alcohol consumption	293(69.3%)	46(10.9%)	84(19.8%)
p	Smoking of hemp	166 (39.2%)	103(24.3%)	154(36.4%)
q	Using of hard drugs	133(22.1%)	85(20.1%)	205(48.4%)

Table 11: Opinion on issues to be addressed in a RHRs' bill (N=423)

	RHRs issues for Bill	Opinion of respondents		
		Respondents supporting inclusion	Respondents not supporting inclusion	Total
		n %	n %	
a.	Sex preference	225(53.2)	198(46.8)	423
b.	Child bearing	303(71.6)	120(28.4)	423
c.	Abortion	365(86.3)	58(13.7)	423
d.	Employment and prompt payment payment	419(99.1)	4(0.9)	423
e.	Polygyny	139(32.9)	284(67.1)	423
f.	Polyandry	212(50.1)	211(49.9)	423
g.	Family planning contraceptive use	374(88.4)	49(11.6)	423
h.	i Sex selective abortion	301(71.2)	122(28.8)	423
	ii Battery during pregnancy	389(92.0)	34(8.0)	423
	iii Incest	299(70.7)	124(29.3)	423
	iv Rape	394(93.1)	29(6.9)	423
	v Sexual abuse in the work place	370(87.5)	53(12.5)	423
	vi Forced prostitution	294(70.0)	126(30.0)	423
	vii Dating and courtship sexual violence	264(62.5)	159(37.5)	423
	viii Forced suicide of the elderly women	281(66.4)	142(33.6)	423
	ix Marital rape	196(46.3)	227(53.7)	423
	x Trafficking of women	391(92.4)	32(7.6)	423
	xi Female genital mutilation	278(65.7)	145(34.3)	423
	xii Sex with sugar daddies as means for school fees	299(70.7)	124(29.3)	423
	xiii Early marriage	244(57.7)	179(42.3)	423
i.	Health as a right	416(98.3)	7(1.7)	423
j.	Birth control	405(95.7)	18(4.3)	423
k.	Quality health services	418(98.8)	5(1.2)	423
l	Sexual education at home	408(96.5)	15(3.5)	423
m.	Sexual education at school	413(97.6)	10(2.4)	423
n.	Bad dressing by ladies	383(90.5)	40(9.5)	423
o.	Alcohol consumption	241(57.1)	181(42.9)	423
p.	Smoking of hemp	392(92.7)	31(7.3)	423
q.	Using of hard drugs	393(92.9)	30(7.1)	423

Table12: Respondents level of support on issues to be addressed in RHR's bill by Gender.(N=423)

RHRs' issues for Bill	Opinion of respondents					
	Respondents supporting inclusion			Respondents not supporting inclusion		
	Male	Female	Overall Total	Male	Female	Overall Total
	n %	n %	n %	n %	n %	n %
Son preference	159(50.0)	66(62.9)	225 (53.2)	159(50.0	39(37.1)	198 (42.8)
Child hawking	237(74.5)	66(62.9)	303(71.6)	81(25.5)	39(37.1)	120(28.4)
Abortion	278(87.4)	87(82.9)	365(86.3)	40(12.6)	18(17.1)	58(23.7)
Employment and prompt payment payment	314(98.7)	105(100.)	419(99.0)	4(1.3)	0(0.)	4(1.0)
Polygamy	108(34.0)	31(23.9)	139(32.8)	210(66.0)	74(70.5)	284(67.2)
Polygamy	165(51.9)	47(44.8)	212(50.1)	153(48.1	58(55.2)	211(49.9)
Family planning contraceptive use	279(87.7)	95(90.5)	374(88.4)	39(12.3)	10(9.5)	49(21.6)
Gender Based Violence issues.						
i Sex selective abortion	227(71.4)	74(705)	301(71.1)	91(28.6)	31(29.5)	122(28.9)
ii Battery during pregnancy	290(91.2)	99(94.3)	389 (91.9)	28(8.8)	6(5.7)	34(8.1)
iii Incest	222(69.8)	77(73.3)	299(70.6)	96(30.2)	28(26.7)	124(29.4)
iv. Rape	299(94.0)	95(90.5)	394(93.1)	19(6.0)	10(9.5)	29(6.9)
v Sexual abuse in the work place	278(87.4)	92(87.6)	370(87.4)	40(126)	13(12.4)	53(22.6)
vi Forced prostitution	222(70.3)	72(69.2)	294(69.5)	96(30.1)	33(31.4)	129(305)
vii. Dating and courtship sexual violence	196(61.6)	68(64.8)	264(62.4)	122(38.4)	37(35.2)	159(37.6)
viii Forced suicide of the elderly women	215(67.6)	66(62.9)	281(66.4)	103(32.4	39(37.1)	142(33.6)
ix. Marital rape	151(47.5)	45(42.9)	196(46.3)	167(52.5	60(57.1)	227(53.7)
x. Trafficking of women	291(91.5)	100(95.2)	391192.4)	27(8.5)	5(4.8)	32(7.6)
xi.Female genital mutilation	202((63.5)	76(72.4)	278(65.7)	116(36.5	29(27.6)	145(34.3)
xii.Sex with sugar daddies in return for school fees	224(70.4)	75(71.4)	299(70.6)	94(29.6)	30(28.6)	124(29.4)
xiii Early marriage	179(563)	65(61.9)	244 (57.6)	139(43.7	40(38.1)	179(42.4)
Health as a right	314(98.7)	102(97.1)	416(98.3)	4(1.3)	3(2.9)	7(1.7)
Birth control	303(95.3)	102(97.1)	405(95.7)	15(4.7)	3(2.9)	18(4.3)
Quality health services	314(98.7)	104.98.8)	418(98.8)	4(1.3)	1(1.0)	5(1.2)
Sexual education at home	309(97.2)	99(94.3)	408(96.4)	9(2.8)	6(5.7)	15(3.6)
Sexual education at school	314(98.7)	99(94.3)	413(9761	4(1.3)	6(5.7)	10(2.4)
Bad dressing by ladies	283(89.0)	100(95.2)	383 (90.5)	35(11.0)	5(4.8)	20(9.5)
Alcohol consumption	173(54.6)	68(64.8)	241(56.9)	145(45.4)	37(35.2)	182(43.1)
Smoking of hemp	297(93.4)	95(90.5)	392192.6)	22(7.7)	9(6.5)	31(7.4)
Usage of hard drugs	297(93.4)	96(91.4)	393(92.9)	21(6.6)	9(8.6)	30(7.1)

Table 13: Respondents level of support on issues to be addressed in RHR's bill by settlement pattern (No=423)

RHR's issues for bill	Opinion of respondents by settlement pattern							
	Respondents supporting inclusion				Respondents not supporting inclusion			
	Inner core	Transitory	Peripheral	Overall Total	Inner core	Transitory	Peripheral	Overall Total
	n %	n %	n %	n %	n %	n %	n %	n %
Sex preference	109(69.0)	61(48.8)	55(39.3)	225(53.1)	49(31.0)	64(51.2)	83(60.7)	198(46.9)
Child bearing	97(61.4)	101(80.8)	105(75.0)	303(71.6)	61(38.6)	24(19.2)	35(25.0)	120(28.4)
Abortion	139(88.0)	111(88.8)	115(82.1)	365(86.2)	19(12.0)	14(11.2)	25(17.9)	58(23.8)
Compulsory and prompt payment payment	158(100.0)	123(98.4)	138(98.6)	419(99.0)	0(0)	2(1.6)	2(1.4)	4(1.0)
Polygyny	41(25.9)	37(29.6)	61(43.6)	139(32.8)	117(74.1)	88(70.4)	79(56.4)	284(67.2)
Polygamy	80(50.6)	59(47.2)	73(52.1)	212(50.1)	78(49.4)	66(52.8)	67(47.9)	211(49.9)
Family planning contraceptive use	145(91.8)	109(87.2)	120(85.7)	374(88.4)	13(8.2)	16(12.9)	20(14.3)	49(11.6)
Gender Based Violence Issues								
i Sex selective abortion	109(69.0)	92(73.6)	100(71.4)	301(71.1)	49(31.0)	33(26.4)	40(28.6)	122(28.9)
ii Statory rape pre puberty	149(94.3)	115(92.0)	125(89.3)	389(91.9)	9(5.7)	10(8.0)	15(10.7)	34(8.1)
iii Incest	128(81.0)	79(63.2)	92(65.7)	299(70.6)	30(19.0)	46(36.8)	48(34.3)	124(29.4)
iv Rape	154(97.5)	110(88.0)	130(92.9)	394(93.1)	4(2.5)	15(12.0)	10(7.1)	29(6.9)
v Sexual abuse in the work place	148(93.7)	103(82.4)	119(85.0)	370 (87.4)	10(6.3)	22(17.6)	21(15.0)	53(12.6)
vi Forced prostitution	125(79.1)	77(61.6)	92(67.2)	294 (69.5)	33(20.9)	48(38.4)	45(32.8)	129(30.5)
vii Coercive and controlling sexual violence	88(55.7)	82(65.6)	94(67.1)	264(62.4)	70(44.3)	43(34.4)	46(32.9)	159(37.6)
viii Forced suicide of the elderly women	113(71.5)	74(59.2)	94(67.1)	281(66.4)	45(28.5)	51(40.8)	46(32.9)	142(33.6)
ix Marital rape	55(34.8)	67(53.6)	74(52.9)	196 (46.3)	103(65.2)	58(46.4)	66(47.1)	227(53.7)
x Trafficking of women	151(95.6)	114(91.2)	126(90.0)	391 (92.4)	7(4.4)	11(8.8)	14(10.0)	32(7.6)
xi Female genital mutilation	99(62.7)	91(72.8)	88(62.9)	278(65.7)	59(37.3)	34(27.2)	52(37.1)	145(34.3)
xii Sex with virgin children in return for school fees	122(77.2)	81(67.2)	93(66.4)	299(70.6)	36(22.8)	41(32.8)	47(33.6)	124(29.4)
xiii Early marriage	112(70.9)	60(48.0)	72(51.4)	244(57.6)	46(29.1)	65(52.0)	68(48.6)	179(42.4)
Women right	156(98.7)	123(98.4)	137(97.9)	416(98.3)	2(1.3)	2(1.6)	3(2.1)	7(1.7)
Birth control	150(94.9)	119(95.2)	136(97.1)	405(95.7)	8(5.1)	6(4.8)	4(2.9)	18(4.3)
Quality health services	157(99.4)	125(100.)	136(97.1)	418(98.8)	1(0.6)	0(0)	4(2.9)	5(1.2)
Sexual education at home	155(98.1)	121(98.4)	130(92.9)	408 (96.4)	3(1.9)	2(1.6)	10(7.1)	15(3.6)
Sexual education at school	154(97.5)	124(99.2)	135(96.4)	413(97.6)	4(2.5)	1(0.8)	5(3.6)	10(2.4)
Counselling by leaders	145(91.8)	109(87.2)	129(92.1)	383(90.5)	13(8.2)	16(12.8)	11(7.9)	40(9.5)
Medical care provision	93(60.5)	65(52.0)	81(57.1)	240(56.9)	62(39.5)	60(48.0)	59(42.1)	182(43.1)
Sex change at birth	148(93.7)	116(92.8)	128(91.4)	392(92.6)	10(6.3)	9(7.2)	12(8.6)	31(7.4)
Caning at hard drugs	147(93.0)	118(94.4)	128(91.4)	393(92.9)	11(7.0)	7(5.6)	12(8.6)	30(7.1)

Table 16: Reasons in support of the inclusion of gender based violence issues in RHIRs' bill (N=423)

Gender based violence issue	Reasons for supporting inclusion in a RHIRs' Bill
a Sex preference	(i) Both sexes are useful 106 (25.1%), (ii) Both sexes should be treated equally 87 (20.6%), (iii) Preferring male to female child is bad 16 (3.8%), (iv) It will foster peace in the home 7 (1.7%), (v) It will end enlightenment 6 (1.4%)
b Sex selective abortion	(i) Sex selective abortion is bad 226 (53.4%), (ii) Every child is God's handiwork 16 (3.8%), (iii) It leads to barrenness 24 (5.7%), (iv) Sex selective abortion is discrimination 7 (1.7%), (v) It is caused by desire for male child 2 (0.5%), (vi) It is illegal 1 (0.2%)
c Battery during pregnancy	(i) Battery during pregnancy is wickedness i.e. (evil, terrible, bad) 31 (7.3%), (ii) It should be made a punishable crime 40 (9.5%), (iii) It is an abuse on women 31 (7.3%), (iv) Is to safeguard mothers and children health 3 (0.7%)
d Incest	(i) It is against religion 160 (37.8%), (ii) It is against culture 123 (29.1%), (iii) It is child abuse 10 (2.4%), (iv) Incest leads to (a) Biological abuse 3 (0.7%), (b) It is a crime 2 (0.5%)
e Rape	(i) Rape is immoral i.e. (it is wrong, it is bad, it is immoral) 258 (61.0%), (ii) It is a crime 76 (18.0%), (iii) It leads to emotional trauma 34 (8.0%), (iv) It is women abuse 16 (3.8%), (v) Addressing it will enlighten people against it 16 (3.8%)
f Sexual abuse in the work place	(i) It is immoral 291(68.8%), (ii) It can be used to make enlightenment 33 (7.8%), (iii) It is a form of women abuse 13 (3.1%), (iv) It slows down productivity in the work place 17 (4.0%), (v) It leads to frustration for women 13 (3.1%)
g Forced prostitution	(i) Forced prostitution is bad 237 (56.0%), (ii) It is human abuse 17 (4.0%), (iii) For enlightenment 16 (3.8%), (iv) It is already a crime 11 (2.6%), (v) It will reduce the incidence of unwanted pregnancy 6 (1.4%), (vi) It will reduce the spread of disease 6 (1.4%)
h Battery and wounding sexual organs	(i) It is immoral 236 (55.8%), (ii) It will enhance enlightenment 14 (3.3%), (iii) It will reduce the incidence of unwanted pregnancy 4 (0.9%), (iv) It is already a crime 7 (1.7%)
i Forced suicide of the elderly women	(i) It is bad 211 (49.9%), (ii) It is important to take care of the elderly women 48 (32.9%), (iii) To outlaw and prevent it 18 (4.3%), (iv) It will help in enlightenment 1 (0.2%), (v) It violates the elderly 1 (0.2%)
j Marital rape	(i) It is a moral wrong 175 (41.2%), (ii) It should be made illegal 11 (2.6%), (iii) It has bad effects on the women i.e. (it injures them, it makes women enjoy less, it causes emotional trauma 16 (3.8%), (iv) It should be regarded as inevitable in marriage 5 (0.7%), (v) It will enhance enlightenment 1 (0.2%)
k Trafficking of women	(i) It is immoral, 236 (55.8%), (ii) It will help to prohibit it 49 (11.6%), (iii) It is spoiling the country's name 47 (11.1%), (iv) It is inhuman 36 (8.5%), (v) It can lead to spread of disease 10 (2.4%)
l Wife / female genital mutilation	(i) FGM endangers the life of the female child 194 (45.9%), (ii) It is against religion 29 (6.9%), (iii) It will help to enlighten people against it 14 (3.3%), (iv) Government has banned 24 (5.7%), (v) It can infect girl child with diseases 5 (1.2%), (vi) It is painful 2 (0.5%), (vii) It is inhuman 10 (2.4%)
m Sex with young children as reason for rape than	(i) It is unpleasant i.e. (it is bad, it is wrong, it is terrible, it is unproper, it is not decent) 229 (54.1%), (ii) It infects with diseases 30 (7.1%), (iii) It amounts to child abuse 9 (2.1%)
n Early marriage	(i) It is child abuse 81 (19.2%), (ii) Early marriage is not good, due to health related reasons i.e. (it leads to premature death during child labour 79 (18.7%), (iii) It causes beating and injuring of women due to emotions) it causes miscarriage 18 (4.3%), (iv) It leads to divorce 1 (0.2%), (vi) It will help in enlightenment 5 (1.2%)
o Harassment during exams	(i) It is indecent i.e. (it is wrong, it offends good sense, it is bad) 185 (44.4%), (ii) Addressing it is necessary to reduce sexual abuse 122 (28.9%), (iii) It should be addressed because even the children of leaders are involved 23 (5.4%), (iv) It is against culture 5 (1.2%), (v) It will encourage enlightenment against it 4 (0.9%)

*Multiple responses possible

4.4.2 Opinion on how issues on RHRs should be arranged.

The dominant view on how RHRs issues should be arranged is that the issues on RHRs should be arranged in one document 214(51.3%).The reasons given by respondents being that it will make it handy for enlightenment and facilitate ease of reference .See details in Table 15.The views of participants in the three communities where FGD were conducted agreed with this result; the opinions of participants were divided when asked how the issues should be arranged. Some participants were of the view that it should be arranged in one document; however, the viewpoint of others was that it should be arranged in a separate document.

Table 15

Opinion on how issues of RHRs should be arranged (N=417)

Suggested arrangement for RHRs' issues	n	%	Reasons in support of suggested arrangement.
One document	214	(51.3)	Having the issues arranged in one document will make it handy for enlightenment, it will facilitate ease of reference, the issues are interwoven,
Separate document	126	(30.2)	They are different issues, having it separately will make it to be more circulated, it will enhance monitoring, it is because of prize.
Not at all	16	(4.0)	It should only be broadcast through the media because every body is not literate, government should just make life comfortable, whether put in one document or not, it will not be enforceable
Anyone that is suitable	24	(5.7)	Reproductive health rights are personal, government should just improve the standard of living.
I don't know	37	(8.8)	There is no faith in Nigeria law, it is the government that can decide that.
Total	417	(100.00)	

Multiple responses

4.5. Opinion on measures to ensure the enforcement of the reproductive health rights in Nigeria.

4.5.1 Steps to make RHRs legally enforceable in Nigeria.

Opinion of respondents on desirable steps to be put in place to ensure that RHRs are made legally enforceable in Nigeria are diverse .The most dominant suggestion was responsible governance 177(27.0%) with examples such as enacting rights as law, inserting them into the constitution, monitoring their compliance, eradicating corruption in the hospital, the provision of free medical care, getting ideas from other countries. This was followed by respondents who mentioned enlightenment of the populace, 173 (35.8%) through means such as television, radio and posters. See Table 16.

Table 16

Steps suggested by respondents to make RHRs legally enforceable in Nigeria (N=482)

Suggested steps for enforceability of RHRs	n	%
i. Responsible governance (enact rights as law , insert them into the constitution, monitoring its compliance. eradicate corruption in the hospital, equip hospitals properly, give people incentives, form a Committee on it, provide free medical care, get ideas from other countries.)	177	37.0
ii. Enlightenment (Television, Radio ,posters, symposium, counseling)	173	35.8
iii .People must first be made comfortable before talking about rights	81	16.8
iv. Nigerians should turn to God first ,	4	0.8
v. There should be cooperation between citizen and government on health matters.	1	0.2
vi. It should be taught at home and school	1	0.2
vii There should be freedom to do whatever you like	1	0.2
viii. The rights can not be enforced	8	1.6
ix. I don't know	36	7.4
Total	482	100.00

Multiple responses.

4. 5.2 Opinion on how to ensure adherence to RHRs.

A third of the respondents, 143(36.3%) viewed that those who violate the RHRs should be jailed, followed by 119 (28.1%) respondents who suggested the imposition of fines and 59(15.0%) who said that the standard of living should first be improved (Table 17).

The FGD findings in the three communities corroborated with these views. Participants agreed that sanctions of a fine and jail will serve as deterrence. At Awodife Bolumole Community, the female group is of the position that sanctions and fines should be imposed depending on the gravity of the offence. The male group stated that sanctions cannot work without enlightenment; enlightenment is believed to be the best option. A male participant in that community said "people must first know the right thing before talking about punishment" At the Oluyole Community; a male participant in the male FGD said "without encouragement or sort of reward who will observe the rights".

Table 17

Opinion of respondents on how to ensure adherence to RHRs (N=394)

Suggested measures to ensure adherence	n	%
Jail terms, imprisonment	143	36.3
Sanctions of fine	119	30.2
Standard of living should be improved; make people comfortable	59	15.0
Enlightenment (Enlightenment at the grass root level, counseling, advocacy to people to fight for their rights).	57	14.4
Government should perform its functions i.e. (government should fight corruption among service providers, government should practice Sharia, government should monitor the rights, they should address it in a bill).	14	3.6
It is only God can help us	2	0.5
Total	394	100.00

Multiple responses

4.6. Attitude of respondents to the adoption of RHRs in Nigeria.

Generally, a substantial number of respondents expressed a favourable attitude towards the adoption of each of the rights as part of RHRs in Nigeria. The right to health 418 (98.1%) was the most favoured, followed by rights to the minimum standard of living adequate for health and well being, 400(94.6%), consent to marriage, 399(94.3%) and education and information on reproductive health 398 (94.1%). Details in Table 18. When adducing reasons to support adoption of the right to health, the most cited reason was that adopting it will guarantee good health services 300(70.9%). On the right to a minimum standard of living adequate for health and well being, 175(41.4%) respondents viewed that the right is important for good health of people while 117(27.7%) viewed it as government responsibility to ensure a minimum standard of living. See Table 19.

Table 18

Attitude of respondents to the adoption of RHRs in Nigeria (N=423)

Types of RHRs	Respondents supporting adoption.	Respondents not supporting adoption	Don't Know
	n %	n %	n %
i.Right to life	359(84.9)	18(4.3)	46(10.9)
ii.Right to liberty and Security of person	348(82.3)	15(3.5)	60(14.1)
iii.Right to decide the number and spacing of children	365(86.3)	50(11.8)	8(1.9)
iv.Right to privacy	324(76.6)	16(3.8)	83(19.6)
v.Right to Consent marriage	399(94.3)	17(4.0)	7(1.6)
vi.Right to equality in marriage	255(60.3)	162(38.3)	6(1.4)
vii.Right to be free from discrimination	387(91.5)	23(5.4)	13(3.1)
viii.The right to enjoy scientific progress and to consent to experimentation	354(83.7)	12(2.8)	57(13.4)
ix.The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment	391(92.4)	4(0.9)	28(6.6)
x.Right to a standard of living adequate for health and well being.	400(94.6)	9(2.1)	14(3.3)
xi.The Right to education and information on RH	398(94.1)	19(4.5)	6(1.4)
xii.The right to health	418(98.1)	2(1.2)	3(0.7)
xiii.The Right to freedom of Association	388(92.7)	14(3.3)	17(4.0)

Table 19: Reasons cited by respondents for the adoption of RHRs in Nigeria (N=423)

Types of RHRs	Reasons in support of adoption
i.Right to life	(i)Life comes from God 254(60.0%), (ii) Right to life is important for reproduction 46(10.9%), (iii) Life will be more appreciated i.e. (it is for the protection of life, its because life is important, it is good) 50(12.0%).
ii.Right to liberty and Security of person	(i) It will improve quality of living 182 (52.2%), (ii) Liberty is a right to choice 91(26.1%) (iii) Every citizen has a right to be protected by government 23 (6.6%).
iii.Right to decide the number and spacing of children	(i) It is needful for prevention overpopulation 259 (61.2%), (ii) Spacing children make quality life possible 30 (7.1%), (iii) it enables quality life for children 26 (6.1%)
iv.Right to privacy	(i) Confidentiality is important in reproductive health 156(36.9%), (ii) Right to privacy should be a reproductive health right in Nigeria 109(25.8%), (iii) It is already our human right 5(1.2%), (iv) It is for peace of mind 5 (1.2%).
v.Right to Consent marriage	(i) Marriage is a choice 256 (60.5%), (ii) Consent to marriage is good for both parties 60 (14.2%), (iii) It reduces sexual immorality 44(11.0%), (iv) It reduces divorce 36(8.6%)
vi.Right to equality in marriage	(i) Adopting it will encourage peace in the home 162 (38.3%), (ii) Women are the same with men 91(21.5%), (iii)It is biblical 13(3.0%), (v) It will allow women to express themselves freely 1 (0.2%)
vii.Right to be free from discrimination	(i) Everybody is the same 184(43.4%), (ii) It is bad to be discriminated against 102 (24.1%), (iii) It already in the constitution 50 (11.8%), (iv) It will promote peace and love 37 (8.7%).
viii.The right to enjoy scientific progress and to consent to experimentation	(i) Scientific progress is necessary for development i.e. (human development, economic development, information development) 141(33.3%), (ii) It is good for quality living and comfort 112(26.5%) (iii) Protection in research is necessary for life 79(18.7%).
ix.The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment	(i) It will guarantee a life of dignity and reduce cruelty 216(51.1%), (ii) It is a fundamental human right 79(18.7%) (iii) It is not available in Nigeria 30(7.1%) (iv) It is necessary for the prevention of cheating 22(5.2%).
x.Right to a standard of living adequate for health and well being.	i) It is necessary for good health, 175(41.4%) (ii) Right to a standard of living adequate for health and well being is the responsibility of government 117(27.7%),(iii) It is available in other countries 12 (2.8%) ,(iv) It will reduce crime rate 1 (0.2%)
xi.The Right to education and information on RH	(i) It is good for enlightenment on reproductive health issues 191(45.2%), (ii) Information on health is very important 165(39.0%), (iii) Information on health is a right to everybody 6(1.4%)
xii.The right to health	(i) It will guarantee good health services 300(70.9%) (ii) People can not afford the cost of health services 60 (14.2%), (iii) health is important 40(9.5%), (iv) To guarantee the safety of mother and children 37 (8.7%) ,(v) It will aid good health education 11 (2.6%), (vii) It is necessary for monitoring of the access to health 6 (1.4%) , (viii) It will help the elderly who are retired 1(0.2%)
xiii.The Right to freedom of Association	(i) To express ourselves on reproductive health issues 158(37.3%), (ii) It is our right as citizens 143(33.8%),(iii) Our opintons on issues differ 40(9.5%), (iv) For peace to reign in the country 29(6.9%) ,(v) To get your right from government 13 93.1%),(vi) For freedom of association 11 (2.6%)

Result of Hypotheses Testing

The first hypothesis stated that there would be no association in respondents' gender and son preference as an issue to be addressed in a Bill on RHRs.

Table 20 shows that while 62.9% of females support the inclusion of son preference in a Bill that will address RHRs in Nigeria, 50% of male respondents supported it. Statistical test gave a significant difference (p=0.02) indicating an association between the respondents' gender, particularly female and support for son preference as an issue to be addressed in a Bill on RHRs.

Table 20: Respondents' gender and opinion on the issue of son preference

Son preference to be included in a Bill on RHRs	Male	Female	Total
Yes	159 (50.0%)	66(62.9%)	225
No	159 (50.0%)	39(37.1%)	198
Total	318 (75.2%)	105(24.8%)	423

Chi Square= 5.24

Degree of Freedom=1

P-value=0.02206306

Hypothesis two stated that there would be no association between the respondents' location and opinion on son preference as an issue to be addressed in a Bill on RHRs.

From Table 21, the respondents who were from the inner core area, 69.0% followed by 48.8% of the respondents in the transitory and 39.3% of respondents in the peripheral were in support of the inclusion of son preference as an issue to be addressed in a Bill on RHRs. The statistical test shows a highly significant difference (p= 0.00) suggesting that there is an association between location, especially from the inner core setting and respondents support for son preference as an issue to be addressed in a Bill on RHRs.

Table 21: Respondents' location and opinion on the issue of son preference

Son Preference to be addressed in a Bill	Inner Core	Transitory	Peripheral	Total
Yes	109(69.0%)	61(48.8%)	55(39.3%)	225
No	49(31.0%)	54(51.2%)	85(60.7%)	198
Total	158 (37.4%)	125(29.6%)	140(33.1%)	423

Chi square = 27.67

Degrees of freedom = 2

p value = 0.00000098

Hypothesis three stated that there would be no association in respondents' gender and child hawking as an issue to be addressed in a Bill on RHRs.

Of the 318 male respondents in Table 22 below 74.5% were of the view that child hawking should be included as an issue in a Bill on RHRs while out of the 105 females, 62.9% viewed that it should be included. The outcome of statistical test gave a p-value of 0.02 indicating an association between respondents' gender, especially male and support for child hawking as an issue to be addressed in a Bill on RHRs.

Table 22: Respondents' gender and opinion on the issue of child hawking

Child Hawking to be included in a Bill on RHRs	Male	Female	Total
Yes	237 (74.5%)	66(62.9%)	303
No	81(25.5%)	39(37.1%)	120
Total	318 (75.2%)	105(24.8%)	423

Chi Square= 5.29

Degree of Freedom= 1

P-value=0.02143244

Hypothesis four stated that there would be no association in respondents' religion and child hawking as an issue to be addressed in a Bill on RHRs.

Table 23 shows that of the 285 Christian respondents, 76.5% indicated support for the inclusion of child hawking in a Bill on RHRs while of the 138 Muslims, 61.6% supported. There is statistical significance(p= 0.01) demonstrating a relationship between the respondents religion, especially Christianity and support for child hawking as an issue to be addressed in a Bill on RHRs.

Table 23: Respondents' religion and opinion on the issue of child hawking

Child Hawking to be included in a Bill on RHRs	Christianity	Islam	Total
Yes	218 (76.5%)	85(61.9%)	303
No	67 (25.5%)	53 (37.1%)	120
Total	285 (67.4%)	138(32.6%)	423

Chi Square= 10.15

Degree of Freedom=1

P-value= 0.00143984

The fifth hypothesis stated that there would be no association between respondents' gender and attitude to the adoption of the right to decide the number and spacing of children as part of RHRs in Nigeria.

According to Table 24, 85.8% male respondents and 87.6% female respondents were in support of the adoption of the right to decide the number and spacing of children as part of RHRs in Nigeria. Statistical test shows a difference of (p=0.5) suggesting that respondents' gender do not affect their support for the adoption of the right to decide the number and spacing of children as part of RHRs in Nigeria.

Table 24: Respondents' gender and attitude to the adoption of the right to decide number and spacing of children as part of RHRs

The right to decide number and spacing of children as part of RHRs	Male	Female	Total
Yes	273(85.8%)	92 (87.6%)	365
No	40(12.6%)	10(9.5%)	50
Don't Know	5(1.6%)	3(2.9%)	8
Total	318(75.2%)	105(24.8%)	423

Chi square = 1.34

Degrees of freedom = 2

p value = 0.51149821

CHAPTER FIVE
DISCUSSION

5.1 Demographic characteristics and Issues of RHRs

The sex of the respondents has a significant relationship to their opinion on son preference as an issue to be addressed in a bill that will protect the reproductive health rights of the people of Nigeria. The statistical difference gave a p-value of 0.02. Reasons adduced in support for the inclusion in a RHRs Bill validates the view of Akintunde, (2002) that benefits are usually taken over by men because of a number of socio-cultural traditional and economic reasons which present men as the head of the family unit and therefore the first in line of authority. Earlier positions of scholars such as Adamchack and Adebayo (1987), and Adewuyi (1999) are also in agreement with the finding that a culture of male superiority together with a man's authority over his wife's reproductive rights has implications for women's total wellbeing. Cook (1994) had also observed that in the traditional legal environments of many societies, women lacked legal capacity and received entitlements according to disposition of men.

The fact that more percentage of women supported the inclusion of son preference also shows how important the issue is esteemed by women. This confirms the views that one way to bring out women's voices on reproductive health issues is to ask women questions Asking questions from women facilitates understanding of the nature of their subordination (Armstrong, 1993, Bunting, 1993, Lazreg, 1990).

Gender of the respondents was also significantly related to support for the inclusion of child hawking as an issue to be addressed in a Bill on RHRs. The statistical difference gave a p-value of 0.02. Quite interesting, more males than females supported its inclusion. A possible reason for this may well be

that most child hawkers are often encouraged by women who used the gains to augment the financial resources of the home. The fact that less women were in support of its inclusion appears to support the suggestion that what others find discriminatory on women may be tolerable on women or even advantageous to women (Abu-Odeh, 1992). For instance, Okokon and Charles (2004) had found in their studies that child hawking unless it is accompanied by negative sanctions is nothing other than "child service" to a family that is in need of such assistance.

In all, the foregoing has confirmed that gender has a role to play in reproductive health and that there is need for professionals to develop creative strategies to address this role (Wegner *et al.*, 1998).

Also, location is an important factor which influenced respondents support for the inclusion of son preference in a Bill of RHRs. The p value = 0.00000098 shows an extreme significance. This corroborates the position of writers that place of residence influences reproductive choice (Cohen, 1998, Curtis and Neitzel, 1996). A possible reason for this is that cultural beliefs in support of son preference may have varied according to level of access to information, enlightenment and type of social networks. According to Valente (1995), every body belongs to informal social networks that influence their behaviour to some degree. Also, most people seek approval of others close to them and modify their own behaviour to please others or to meet others expectation (Valente, Watkins, Jato, Van Der Straten and Tsitsol, 1997).

Religion was also found to have relationship with support for inclusion of child hawking in a Bill on RHRs. This is rather surprising since the dominant view on child hawking has for long been that child hawking is largely influenced by socio-economic background of children (Okokon and Charles, 2004). This again suggests that there the need for public health

practitioners to pay attention to religion in designing strategies that will address the social challenge of child hawking.

5.2 Knowledge of Respondents on what constitutes RHRs.

Generally, respondents mentioned the right to health and the right to decide the number and spacing of children as constituting RHRs. The understanding of respondents about RHRs include the rights to social amenities i.e.(the right to water, the right to shelter, the right to electricity, the right to a good road), the right to enjoyment of good standard of living and the right to health i.e. the right to a hospital, the right to health care services for pregnant women, the right to free drugs, the right to a healthy environment. These rights form the plank of social and economic rights which are non-justiciable rights under the constitution. The non-justiciable status accorded these rights under the 1999 Constitution is worrisome considering the fact that conventions on human rights to which Nigeria is signatory provide for their protection. The foregoing thus confirms the inadequacy of the 1999 Nigerian Constitution which essentially did not redress these concerns which are important to the people reproductive health.

Also of the twelve variables on RHRs, none of the respondents mentioned the rights to be free from discrimination, enjoyment of scientific progress and consent to experimentation, prevention from torture or other cruel, inhuman or degrading treatment or punishment as examples of rights constituting RHRs. while less then 10% of responses were recorded on each of the remaining six types of RHRs. This indicates an unimpressive comment on the state of reproductive health in Nigeria as a people with low understanding of rights are far less likely to take advantage of it or conscious of its violations. No doubt, reproductive right is a right to make a choice. The ability to make decisions or choices will largely depend on level of individual awareness (Rutenberg, Biddlecom and Kaona, 2000).

Knowledge of Respondents on Reproductive health rights laws, conventions and treaties.

The awareness of respondents regarding laws, conventions and treaties on human rights and RHRs is low. About four fifth of the respondents (85.0%) did not know of any laws, convention or treaties on human rights and reproductive health rights in Nigeria. This agrees with the observation that various statutory laws which are in force in Nigeria do not reflect reproductive health concept and so are inadequate to meet the needs of actualising reproductive rights (National Reproductive Health Policy, 2001).

The foregoing is pathetic considering that in other African countries, including Malaysia, Peru and Zambia, the laws at least explicitly protects informed choice on reproductive health, a crucial concept in RHRs. In Mexico, for example Article 4 of the Constitution states that every individual has the right to decide in a free, responsible, and informed manner the number and spacing of his her children. Also, a city law in Buenos Aires, Argentina passed in 2000 recognises "sexual and reproductive rights free of violence and coercion as basic human rights" and guarantees women's and men's access to contraceptive information, methods and services (Zamberlin, 2000).

It is also particularly worrisome in view of the fact Nigeria is signatory to the various conventions which the foregoing countries have taken steps to make applicable in their respective legal systems. The implication of this is that non existent laws can not be enforced by the courts nor the government made accountable to their observance. Coliver (1995) has observed that when governments incorporate informed choice standards into their laws, the courts can enforce them. Law also helps in ensuring that whatever rules, orders and regulations specified within it are implemented and enforced (Mensah *et al*. 2004).

5.4 Extent of promotion of RHRs in Nigeria.

Results at all levels of government indicated that except for the rights to health and freedom of association and political participation, each of the rights is not being promoted at all in Nigeria. This raises a serious issue about the stewardship of the government, a crucial factor in analyzing the performance of any program, policy or law. According to (WHO. 2002), a given national system must consider, if not start with, how well the government is performing its stewardship role. Low extent of promotion of RHRs is a sad comment on the nation health system. A possible reason for this may well be the unsettled state of Nigerian Law on reproductive health rights which consequently do not avail an effective legal frame work through which the government can be held accountable for the upholding of these rights.

5.5 Measures to ensure the enforcement of the RHRs in Nigeria.

The result of the study showed that the most dominant step suggested by respondents (41.8%) was responsible governance i.e. enact rights as law, insert them into the constitution, monitor compliance, eradicate corruption in hospitals, provide free medical care, get ideas from other countries. This opinion supports the suggestions that RHRs are first and foremost the responsibility of the state and that it is the ultimate responsibility of the state to create an enabling environment with a supportive legal frame work to enable RHRs to take effect. This view agrees with the position in countries like Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica and Peru where governments have begun to reform policies in bid to reflect a new focus. (Hardee *et al*., 1999).

5.6. Attitude of respondents to the adoption of RHRs in Nigeria.

Generally, there were substantial results showing a favourable attitude towards the adoption of RHRs in Nigeria. This attitude seems justified in the light of

serious violations which are likely to persist if not adopted. Also, adopting these rights will add Nigeria to the list of Committee of Nations that has already been adopted notably India and Mexico which have Sexual Rights Act.

Gender was found not to be associated with the adoption of the right to decide the number and spacing of children as part of RHRs in Nigeria. This signifies that the right is as important to male as it is to females. It also suggests an unwillingness to have birth controlled by legislation. It is unlikely that a nation where the right to decide the number and spacing of children is recognized will formulate and apply legislative disincentives. It has been argued that offering of incentives and creating of disincentives to influence people may affect their exercise of choice on reproductive health (Isaac, 1995) and thereby violate their right to decide freely the number and spacing of children. Before legislative disincentives were introduced in India between the 1975 and 1977, Bill of Rights were suspended (Srinivasan, 1999).

5.7. Implications for health education and promotion

Major challenges to the implementation of RHRs are the low level of knowledge, entrenched cultural practices and an inadequate legal frame work. Health education and promotion strategies can be used to promote the understanding of RHRs, to prevent their violation, to improve the extent of their promotion and to encourage positive attitudinal change on RHRs.

Problems relating to the understanding of RHRs, the laws, conventions and treaties can be addressed through an awareness raising and sensitization programme. To achieve this, the mass media can be used, namely television, radio, bill boards and newspapers. In using the media, emphasis should be placed on what constitutes this body of rights, the relevant laws, conventions and treaties. Target groups would include existing groups to which the respondents may belong, namely trade associations, religious groups and social clubs which

exercise social influence on the respondents. Other health education strategies that may be adopted include interpersonal and group communication which may entail organizing seminars and discussions for respondents.

With respect to violence against women and RHRs, provisions within the existing legal framework which address issues such as rape, battery during pregnancy, forced prostitution, trafficking of women, incest and child hawking are merely punitive but not self-supporting and effective. Health education strategies which may include mass media channels such as radio, television, bill boards should be used to educate victims or complainants about the issues as well as the supportive facilities and resources in the society. These may include counselling centers, rehabilitation homes and legal aid offices.

The prevention of violation of RHRs, their wider promotion and the adoption of RHRs are issues which require extensive legal and policy reform. Health promotion intervention strategies may involve building alliances with as many people as possible so as to create a movement for policy change. This may be facilitated through meetings and seminars with household heads by working with groups to which they belong. With this, people can be mobilized and public pressure built so that many people will contact decision-makers to sponsor appropriate bills in this regard. It may also entail the holding of rallies and writing of advocacy letters calling for policy change on reproductive health rights issues.

5.8 Conclusion

This study described the knowledge, opinion and attitude of household heads about reproductive health rights in Ibadan South West Local Government of Oyo State. Findings revealed that gender and location influence support of respondents for its inclusion in a Bill on RHRs. Also, according to the findings of the study, gender and religion have an effect on the respondents' view on son preference as an issue to be addressed in a Bill on RHRs. The knowledge

of RHRs, laws, conventions and treaties is very low. Opinion on the extent of promotion RHRs substantially indicated that four fifth of the rights are not being promoted at all in all the levels of government. Notable steps were suggested for adherence to RHRs and there was a positive attitude expressed towards the adoption of RHRs in Nigeria.

5.9 Recommendations

In the light of these findings, the following are recommended:

1. Rapid sensitization on what RHRs constitute, their laws, conventions and treaties and what constitutes their violation is imperative for respondents and all the levels of government affecting them. To achieve this, Community Based Organizations, Non Governmental Organizations and Research Institutions on population studies should be encouraged to work with existing groups to which respondents belong in the community.
2. Mobilization of people and building of alliances that will encourage the domestication of RHRs is imperative. Meetings and rallies may involve encouraging respondents to get in touch with their decision makers with the view of taking steps to evolve legislation that will address RHRs and their concerns.
3. Reproductive health rights should either be contained in one document or inserted in appropriate sections of the Constitution where easy reference can be made to them. Where issues involved in the rights are already covered by existing law, appropriate reference can be made to such existing laws in such documents or the constitution as the case may be.
4. Policy and the law on RHRs should not only be punitive but also educative accommodating incentives and sanctions which will promote

healthy reproductive choice and discourage negative attitude towards RHRs.

5. Policy and law should make appropriate allowances for certain determinants of healthy reproductive choice such as poverty, gender, location and education.
6. There is the need for more research to be encouraged by donors and government about how societal perception of gender can affect choice and access to reproductive health and the incentives and sanctions that can be adopted in order to promote or encourage healthy reproductive choice.
7. Reproductive health rights should be effectively communicated to the people it is meant to benefit. To achieve this, it will be necessary to put these rights in hand bills and posters for distribution in all the communities. The bills should be made in different local languages in order to attract popular appeal. Also the rights should be discussed with different languages on the mass media.

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APPENDIX I

KNOWLEDGE, OPININON AND ATTITUDE OF HOUSEHOLD HEADS ABOUT REPRODUCTIVE HEALTH RIGHTS IN IBADAN SOUTH WEST LOCAL GOVERNMENT, OYO STATE, NIGERIA

REPORT ON FOCUS GROUP DISCUSSION CONDUCTED IN:

i. AKERE COMMUNITY, AKERE PALACE, OJA-BA, IBADAN (inner core)

ii. OLUYOLE COMMUNITY, OLUYOLE ESTATE AND (Peripheral)

iii. AWODIFE BOLUMOLE COMMUNITY, CHALLENGE, (transitory).

This is the report on the focus group discussion respectively conducted on the 14th, 15th and 16th of August, 2004 at Akere Community, Akere-Oja oba, Oluyole Community, Oluyole Estate and Awodife Bolumole Community, Ibadan South-West Local Government Ibadan, Nigeria. The discussion was conducted in order to investigate the knowledge, opinion and attitude of Household heads about Reproductive Health rights. A total number of six (6) focus groups were constituted; namely one male and female group in each of the sites; each of the group comprises household heads made up of an average number of six (6) participants who were engaged in discussion of about an hour.

The two groups at Akere Community agreed that the peculiar health problems of their area are Malaria, Diarrhea. The female group however added measles and small pox into the list. The two groups in Oluyole Community

agreed on Malaria as peculiar problem. A female participant at the Akere Community said *"Gbogbo eniyan lo mo pe aisan gbigbo eyan ni iba"* meaning every body knows that malaria is everybody's sickness. However while the female group added Jaundice to the list of peculiar diseases, the male group of that community added early marriage, HIV / AIDS and Gonorrhea to the list of peculiar diseases. The two groups at Awodife Bolumole Community also agreed that malaria is the peculiar heath problem of the area; the female group in that community added typhoid to the list.

At Akere Community (inner core), when asked about what human rights are, the two groups agreed that human rights are rights which people should not be deprived of. The female group added that such rights are guaranteed by law and they include right to work and be paid and right to education. In describing what human rights is, a male participant at Akere noted that *"Eto omoniyan ni Olun ti o to si yan lori ada ijoba"* meaning human rights are benefits due to the citizens from government. The male group added that those rights are operative between person to person and government to person. At Awodife Bolumole Community (Transitory), the two groups viewed human rights in the light of freedom that one is supposed to enjoy and cited right to freedom of expression as an example. While at Oluyole Community (peripheral), the two groups agreed that these are rights, which are expected by citizens to be given by their government to them. The female group added that human rights are the ways we expect to be treated without maltreatment while the male group added the right to freedom of expression as an example.

It appears that there is an agreement across strata about the meaning of human rights; though participants were only able to give few examples of such rights.

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It appears that there is an agreement across strata about the meaning of human rights; though participants were only able to give few examples of such rights.

When asked about the experience of their community in respect of human rights violation, both groups in the Akere Community cited different instances. While the female group mentioned that: education is not free, health is not free, there is no job and inadequacy of drugs as instances of human rights violation, the male group mentioned discrimination and bad leadership as instances of human rights violation. In Awodife Bolumole Community, the two groups agreed that intermittent electricity supply and lack of good water supply as breaches of their human rights. When the same question was asked in Oluyole Community, the female group mentioned: wrongful ejection of tenants by landlord, inadequate supply of drugs, selling of drugs by medical personnel for personal gains, establishment of private clinics by government medical officers as constituting human rights violation. The male group however mentioned violation of freedom of speech as a breach of human rights and right to vote.

It appears here that across state, access to health facilities and conduct of medical personal is seen as human rights violation. Akere Community however has more instances of human rights violation.

On the question, what are reproductive health rights, the two groups in the Akere Communities mentioned diverse issues as constituting reproductive health rights. The male group mentioned: adequate and well equipped maternity hospitals, provision of job, immunization and provision of drugs as constituting reproductive health rights. The male group mentioned: access to family planning contraceptive use, birth control, harmony at home and community as constituting reproductive health rights. In Awodife Bolumole Community, the two groups agreed that the right to reproduce safely constitutes Reproductive health rights. The female group added access to health facilities, availability of drugs and family planning as associated with

reproductive rights while the male group posited that Reproductive rights are given by God to man and that marriage and reproduction of children are related to it. A female in that community indicated that "*There can be no life without reproductive health rights because reproductive health rights are rights associated with reproduction*. At Oluyole Community, it is agreed by the two groups that family planning, contraceptive use, birth control, maternal care, access to health service constitute Reproductive health rights. The male group however made harmony in the family and improvement of status of family as useful additions while the female added the issue of baby cloning to it.

Across the strata, it is discernible that maternal health care and access to health services, drug supply, contraceptive use and birth control, early marriage, employment, harmony in the family are regarded as associated with Reproductive Health rights. The definition of reproductive health rights by the female group in Oluyole community is useful and its examples are broader than what is obtainable at Akere Community and Awodiſe Community.

Regarding which of the reproductive health rights should be backed by law in Nigeria and which should not with reasons, the two groups in Akere Community have different responses. The female group mentioned that supply of drugs as at when due, provision of employment and payment of salary as at when due should be backed by law as same will make life easier for women and children and home peaceful. The male group in that community mentioned: the use of family planning contraceptive use, religious training, prohibition of smoking of Indian' hemp and alcoholism as issues to be backed by law because they will help the family at the home. A participant took the view that "*Igbo ati ati amupara ko j'owo okunrin raye fun'le ati oya won*" meaning that men do not have time to take care of their wives and home owing to smoking of hemp and excessive alcohol. In Awodiſe Bolumole

Community, the two groups agreed that decision-making on birth control, family planning, contraceptive use and health facilities are rights which should have the backing of the law. The Male group added that their community is ripe enough for the provision of a state hospital. In the Oluyole Community, when the same question was asked, the female group and the male group agreed that early marriage, family planning and birth control are reproductive health rights, which should be backed by law. The male group added prohibition of polygamy. Proffering reasons in justification, the two groups agreed that early marriage can lead to premature death and that birth control is necessary to regulate number of children and prevent overpopulation. The male group added that polygamy affects the welfare of the family.

Across the strata, the dominant views were that the welfare of family/home is a determinant of which Reproductive health rights should be backed by law, the Akere Community emphasised religious training, prohibition of smoking of Indian hemp and alcoholism as major problems to be addressed by reproductive health rights while the Awodife Bolumole Community's groups position agreed in details with some of the responses by the groups in Oluyole Community. In all, Oluyole Community has a more detailed response.

When asked about what constitutes violation of Reproductive health rights, the female group in the Akere Community posited that lack of drugs, inadequate clinics, unhealthy environment are violative of reproductive health rights. The male group viewed that alcoholism, its sale and smoking of Indian hemp as violative of reproductive health rights. In Awodife Bolumole Community, the female group posited that: lack of enough health facilities having too many children, non-availability of family planning contraceptive and expensive drugs constitute violation. The male group mentioned rape as violation. Answering the same question, the groups at Oluyole Community

agreed that too many wives, too, many children are violative of reproductive heath rights. The female group added that procuring and spreading of HIV / AIDS and tuberculosis infringe on reproductive health rights while the male group added uncleanliness of the environment as a violation.

It appears that each of the strata, there is a different view of what constitutes violation of Reproductive heath rights. The spread of HIV / AIDS and tuberculosis (deliberate) mentioned in Oluyole" Community as violative of reproductive health rights is a useful addition.

When asked about the laws, conventions and treaties on human rights and reproductive health rights that the community members are aware of, the two groups in Akere Community generally posited that they are not aware of any law, convention or treaties on human rights and reproductive health rights which the community members are aware of, except one person in the male group who said he is sure of criminal law on rape. In Awodife Bolumole Community, only the female group made mention of the criminal law on rape, trespass and armed robbery as the laws that community members are aware of. The male group of that community was of .the position that such laws and conventions on Reproductive health rights are not in Nigeria; it is only in the advanced country e.g. the law on abortion. Answering the same question, the female group in Oluyole Community said that they are not aware of any law, convention or treaties; what community members know is based on physical observation. The male group however said that there is the Babangida Directive of 1992 which directs that people should not have more than 4 children but participants did not know whether it was gazetted or not. Also participants mentioned Beijing Conference held in China as a conference that addressed issues of Reproductive health and women rights.

Across strata, the female groups' response on knowledge/awareness in respect of law, convention and treatise seems to be nil in Akere and Oluyole

Communities, whereas there is a measure of response in respect of knowledge, though scanty, by participants of the female group in Awodife Bolumole about law, convention and treatises on human rights and reproductive health rights. Awareness seems to be high judging from the response among the male group of Oluyole Community. In all responses in respect of awareness of reproductive health rights and human rights coavention, law and treatises appear generally low.

Concerning the opinion of members of the community on son preference, the two groups at Akere Community agreed that it is a common practice and the reason for it is that ladies do not remain in the family. The female group added that *"Okunrin l'olori ile, b'olorun se fe ni"* meaning that sons are the heads of the house, it is divine. At Awodife Bolumole Community, the two groups were of the same position with Akere Community and attributed the cause to culture: the female group however was of the belief that it is a wrong practice stemming from ignorance. The two groups in Oluyole Community mentioned culture and religion as community members' reasons for son preference in their community.

On the opinion of members of the Community on female genital mutilation, the two groups agreed that it is considered not common again as it used to happen; campaign against it by Government was thought to have been responsible. There is a minority view by the male group of Akere Community that viewed if circumcision is not done for females, there may be serious repercussion. At Awodife Bolumole Community, the two groups agreed that it is viewed as only common in the olden days and that it has been discouraged by various campaigns by government. At Oluyole Community, the two groups are of different view on this practice; whereas the female group believes that it is viewed as no longer common due to campaigns by Government, the male

group is of the view that it is still considered common and that culture and religion are often accounted as responsible for the trend.

About the opinion of members of the community on child hawkers, the two groups in Akere Community shared the same view that it is considered common in that community and that poverty is viewed as the true cause of it. At Awodife Bolumole Community, members are of the view that it is considered not common in that community because the said community is an enlightened and educated community. The male group added that it is viewed as child abuse and that children that sell in their community are not from that community but from elsewhere. At Oluyole Community, members agreed that community people see child hawkers as common and that poverty and hunger are the causes of it.

On the opinion of members of the Community on Abortion, the two groups in Akere Community agreed that it is common as far as community members are concerned. On what can be responsible for it, the two groups agreed that in view of members, waywardness/greed of ladies can cause it and so are poverty and peer pressure. At Awodife Bolumole Community, the female group said that it is common and stated that it is viewed that poverty is responsible for it while the male group was of the view that they may not be able to say for certain what is considered as responsible; but the group was categorical in stating that unwanted pregnancy is viewed as the cause of it. At Oluyole Community, the two groups agreed that it is viewed as common and mentioned unwanted pregnancy as the factors considered responsible for it. The female group added that it is viewed by members to have been reduced due to family planning contraceptive use while the male group contributed that too many children is viewed as encouraging abortion.

Regarding the opinion of members of the community on employment, the two groups in Akere Community agreed that unemployment is seen as a

common phenomenon and the two groups agreed that it is viewed that government is to be blamed for unemployment. At Awodiſe Bolumole Community, the two groups also agreed that unemployment is considered common in the community by community members; they also stated that lack of planning by government is considered as the cause of it. This is also the view of the two groups in Oluyole Community.

On the opinion of members of the community on polyandry, the two groups in Akere Community agreed that it is considered as common in that community and the female group stated that greed, failing of husbands in their responsibilities are seen as factors responsible for it. A female participant noted that polyandry is against the Yoruba's culture but said "*Ko si k'obinrin f'oko o m'oju to o ma yun ale*" meaning that polyandry can not be ruled out for a wife who is not well cared for by her husband. The male group agreed that it is considered in their community that due to poverty, there is responsibility shift, which has foisted on the female the need to look outside their matrimonial home for the meeting of their needs. The groups at Awodiſe Bolumole Community agreed that it is considered not common in their community as members see themselves as enlightened and educated. Answering the question in Oluyole Community, the participants in the female group was divided in their response on the issue: some viewed that it is considered as common and that poverty is seen as the cause while others said it is not common. The male group however observed that it is seen as common in that community.

Regarding the opinion of members of the community on polygyny, the two groups at Akere Community agreed that it is seen as common in the community and that religion and customs are viewed as the cause of it. The male group added that it is considered that women at times can be blamed since their behaviours at times makes that option unavoidable to their

husbands. At Awodife Bolumole Community, the two groups agreed that it is not considered as common in their community as community members see themselves as enlightened and educated. In Oluyole Community, the two groups agreed that it is viewed as common among adherents of certain religion e.g. Islam. The male group added that culture is perceived as a major factor responsible for that.

In commenting on the opinion of members of the community on health service, the two groups in Akere Community agreed that clinics and hospitals are viewed as not well equipped and that drugs are still expensive when available. At Awodife Bolumole Community, the groups agreed that community members viewed health services as inadequate and that people patronize their family doctors. At Oluyole Community, the same view was confirmed about health services by the two groups; government was also stated as being viewed to be responsible due to its ineffectiveness.

As regards the opinion of members of the community on family planning contraceptive use, the two groups in Akere Community agreed that people are using it and stated that campaigns by government is considered as responsible. However, in the male group there is the dissenting view that members see it a western idea which should not be encouraged since it offends against divine injunction to procreate. At Awodife Bolumole Community, the female group stated that community members use it and that there is a family planning centre in the community while there is a minority view in that group that its usage is not considered by community as rampant. The male group stated that they would be unable to state the extent of patronage of family planning contraceptive use by community members since they don't poke their noses into the affairs of others. At Oluyole Community, the two groups are of the view that there is a wide usage of family planning contraceptive as a means of birth control by community members; government campaigns are

given by members to have made the same popular and so are the efforts of non-government organisations such as ARFH. There is however a minority view in the group that the use is considered not widespread; "people still live it for nature to determine."

Concerning the opinion of members of the community on beating of women, the two groups in Akere Community agreed that it happens a lot and that drunkenness is considered to be a major cause of it. The male group added that "*Agidi obinrin ko le je won a ma f'iya*" meaning that women would not be spare from beating due to their fool hardiness. At Awodife Bolumole Community, the opinion of the female group is divided on it; some participants were of the view that it is not considered common by community members while the others were of the view that it is considered common among the few members of the community who are not enlightened. The male group of that community is however of the position that it is viewed by community members as not common. At Oluyole Community, the two groups stated that it is viewed by members as sometimes occurring due to misunderstanding in marriage and lack of affection is lacking and when marriage is forced.

On the opinion of the members of the community on sexual violence, the two groups in the Akere community were of the view that it is considered common in that community. The female group was of the position that way wardness of women is seen by members as responsible for this while the male group was of the position that bad dressing and civilisation are considered responsible. When probed whether sexual violence can occur between married couples, two groups viewed that in the opinion of community members marital rape occurs when women are not willing to cooperate with their husbands. A female participant referred to it as " *Iso inu eku, omu mara ni* " signifying that marital rape should not be a subject matter of complaint to

married couples. At the Awodife Bolumole Community, the two groups agreed that it is not considered common and that maturity and enlightenment are viewed as responsible for this. When probed whether sexual violence occurs between married couples, the two groups agreed: female group stated that it is considered by community members as possible in situation where the wife is not cooperating; while the male group stated that it is viewed by members that it is possible for a man to rape his wife. At Oluyole Community, the two groups agreed that it is considered not common in the community and also shared the same view with other communities that in their community it is considered a possibility that a married man can force sex on a wife without her consent.

On the opinion of the members of the community on health as a right, the two groups in Akere Community were of the position that health is viewed as a right by the community and that it is being denied by government. According to the male group, community members consider that government fails to provide hospital with drugs and medical personnel as well as healthy environment. At Awodife Bolumole Community, health is also viewed as right by the community members as stated by the groups and that government is hindering the same by their failure to ensure good facilities and programme that will make the same to be enjoyed as a right. The two groups of the Oluyole Community also agreed and stated that health is viewed as a right in the community and the reasons attributable for that are similar with the other communities.

About the opinion of the members of the community on early marriage, the two groups in Akere Community agreed that early marriage is considered as existing by members because of religious beliefs. Some participants in the female group posited that it is due to "*the waywardness of girls*" in the community. At the Awodife Bolumole Community, the two

groups agreed that early marriage is considered not common in their community since children go to school and get matured before they get married. The two groups at Oluyole Community stated that it is viewed as common sometimes in the community especially due to teenage pregnancy and certain religion that allows for that.

On the subject matter of decision-making on birth control, the dominant view among the female groups is that it is viewed by the community as something that should be jointly taken. Some participants in the female group however stated that females alone are considered to take decision at times when they realise that their husbands are promiscuous. The position in the female group appears divided; some said that community members viewed it *as "needless since other nations are more populated than us and they are living well."* To others, community members viewed that it is the man that have the final say. At Awodife Bolumole Community, the two groups agreed that members view decision making on birth control as somehow automatic; the community needs not be told, the economy itself does not encourage too many children. At Oluyole Community, participants in the two groups agreed that it is viewed by the community that wives and husbands take joint decision on it.

Pertaining to the opinion of members of the community on sexual education at home and school, the female group in the Akere Community posited that in the community, it is viewed that sexual education takes place at home while the male group posited that it is viewed that it no longer takes place at home nowadays. At the Awodife Bolumole Community, the groups agreed that it is viewed that it takes place at home since people in the Community are enlightened and educated. They do not however know the opinion of the community on what happened in school. At Oluyole Community, the two groups agreed that it is viewed by members as common

at schools in the community since government has introduced it into the school curriculum while it is not common at home because parents most times don't have time; as some think it is prohibited and leave it for the peers to give to children bye and bye.

Regarding the opinion of members of the community on healthy environment, the two groups in the Akere Community agreed that in their community, the environment is considered to be unhealthy; it is viewed that failure of government to provide facilities for disposal and enforce environmental laws is responsible. At the Awodife Bolumole Community the same view was shared by the two groups and they added erosion as a peculiar environmental problem considered by the community members as existing. At Oluyole Community, the two groups agreed that government is considered a major hindrance to healthy environment by virtue of its failure to supply enough facilities needed for healthy environment.

When asked for the opinion of members of the community on right to food, the two groups in Akere Community agreed that in their community, food is viewed as a right. This according to them however is being hindered due to poverty occasioned by bad economy which has also made the cost of livelihood too high for community members. At Awodife Bolumole Community, the two groups agreed that it is felt by members of the community that government has a duty to ensure that food is affordable and available. The male group however lamented that "*social security is not present in Nigeria as a result of lack of foresight on the part of government*". At Oluyole Community, it was also agreed that food is considered as a right and that it is being hindered by government whose programs and policies have made food expensive.

On the issue of alcohol consumption, it is viewed by the two groups in Akere Community as considered to be common; female group observed that

members are of the opinion that when people get drunk in the community, they misbehave at home. Some participants in the male group viewed that members of the community are justified in this view because "*government promotes alcoholism by licensing people to sell.*" At Awodife Bolumole Community, the female group said that it is considered not common in the community since members are enlightened and are Christians. The male group however stated that members view that alcohol is not bad when it is not excessive. At Oluyole Community, the two groups agreed that Alcohol consumption is considered common and that it is taken in order to relax the nerves. In the male group, it was stated that some members viewed that alcohol consumption is common but not alcoholism.

On the opinion of the members of the community on ladies dressing, the two groups in Akere Community stated that members view that most ladies still dress in an offensive way in the community. They attributed civilisation and lack of fear of God and attitude of parents as factors responsible for it. They however agreed that there are ladies that dress moderately. At Awodife Bolumole Community, it was agreed that in the community, bad dressing by children is a problem; they also blamed it on civilisation. The two groups at Oluyole Community agreed that most ladies, especially unmarried ones are considered as still wearing provocative dress. they traced it to the same factors of civilisation and added family background. Some members in the male group viewed that ladies dressing in the community is considered by some as not offensive compared with what obtains in other community.

On the opinion of members of the community on right to good water, the two groups at the Akere Community stated that good water is viewed as a right though it is often hindered by government, which is failing to ensure it. At the Awodife Bolumole Community, the two groups also agreed that it is the

view of community members that good water is a right hindered by government. According to participants, community members now make do with well water since water is not being supplied regularly. The two groups in Oluyole Community observed that due to the failure on the part of government, good water is considered by members as a hindered right.

Across the strata, it appears that all the communities have the same view on son preference, abortion, unemployment, health services, beating of women, health as a right, decision making on birth control, healthy environment, right to food, ladies dressing, right to good water with few dissents from group members responses on abortion (by some Awodife male group members), on family planning contraceptive use (by some Akere male group members), on beating of women (by the male group of Awodife Community). There appears to be some contrast between the position of male and female groups responses in both Akere and Oluyole Communities while the Awodife groups agreed that female genital mutilation is a thing of the past. The position of Akere groups on child hawkers is in contrast with the position in Awodife Community which is similar with the Oluyole groups' observation.

On polyandry, while it is observed as common in Akere and Oluyole Communities; Awodife Bolumole Community groups stated that it is not common in their community. On the issue of polygyny, the Akere and Oluyole groups agreed that it is common particularly among people who share faith that believe in it. This position is however in contrast with the position in Awodife Bolumole Community. On the issue of sexual violence, but for the exception of the male group of Awodife Bolumole community, participants in the groups from all the strata agreed that sexual violence occurs between married couples. Whereas sexual violence is stated to be common in Akere and Oluyole Communities (except the divergent view of the female group in

Oluyole community); the two groups in Awodife Bolumole community stated that it does not happen in their community. On the issue of early marriage, Akere Community's position is in contrast with Awodife Community whilst at Oluyole Community, it is viewed as common at times. On sexual education at home and school, there is a contrast between the views of the groups in Akere Community about sexual education at home. Awodife Bolumole Community is of the position that sexual education takes place at home and not at school, which can be contrasted with the position in Oluyole Community which holds that it takes place at school not at home. On alcohol consumption, all the groups except the female group in Awodife Bolumole agreed that alcohol consumption is common.

When asked about which issues should be addressed by Reproductive health rights in Nigeria, the female group in Akere Community stated that the issues of son preference, female genital mutilation, child hawkers, abortion, employment, polyandry, health services, family planning, contraceptive use, beating of women, sexual violence (including marital rape), health as a right, early marriage, decision making on birth control, sexual education at home and school, healthy environment, right to food, alcohol consumption, ladies dressing, right to good water should all from part of reproductive health rights. According to them, son preference, female genital mutilation, child hawkers, abortion, alcohol consumption, polyandry, beating of women, sexual violence (excluding marital rape) early marriage and bad dressings should be sanctioned under the rights because they are harmful to health. It is however viewed by group members that nothing can be done concerning polygyny and marital rape since cultural beliefs allow them.

Commenting further on the foregoing, the male group agreed on all items but disagreed on the issue of son preference on the ground that it cannot be changed by law, early marriage on the ground that enlightenment will be

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Commenting further on the foregoing, the male group agreed on all items but disagreed on the issue of son preference on the ground that it cannot be changed by law, early marriage on the ground that enlightenment will be

more effective, alcohol consumption on the ground that government itself permits it. The female group of Awodife Bolumole Community shared the same position with the female of Akere on all issues but disagreed on the issue of marital rape on the ground that it is harmful and hence, it should be sanctioned. The male group shared the same position with the female but disagreed on certain issues namely; son preference on the ground that it cannot be sanctioned by law, provocative dressing on the ground that it can only be corrected by enlightenment, marital rape on the ground that you can do anything with your marriage by virtue of your marriage with her. The female group of Oluyole Community is of the same position on the issues that should constitute reproductive health rights with the female in Awodife and its position disagreed also with the female groups of Akere and Awodife's position on marital rape, polygamy and polygyny. The male group of Oluyole Community shares the same position with the female on which issues should constitute or be used as Reproductive health rights in Nigeria.

Across strata, it appears that but for marital rape, polygamy, polygyny, alcoholism, son preference, bad dressing and abortion in respect of which there are divergent views across strata, the position of the groups on what should constitute or be used as reproductive health rights in Nigeria is the same.

When asked about what can be done to ensure that the rights are adhered to after same have backed by law, the female group in Akere Community stated that government should set good examples in every law they make; the male group is of the position that people should make contributions to it otherwise they will not be followed. The group also suggested penalties and sanctions, which they believe will serve as deterrence. At Awodife Bolumole Community, the female group is of the position that sanctions and fines should be imposed depending on the gravity of the

offence. The male group stated that sanctions cannot work without enlightenment. At the Oluyole Community, while the female group is of the position that the rights should be enforced and that they should be accompanied by good enlightenment, the male group posited that apart from enlightenment, sanctions of imprisonment, lines and incentives can be given by government to those complying with the said rights.

When asked how the issues should be arranged, the female and the male groups agreed that they should be put together in the same document in order to facilitate access to it. At Awodife Bolumole Community, the female group position is divided on the issue; some participants viewed that it should be arranged together while others viewed that it should be separately arranged. The male group participants are also divided in their responses; some participants were of the view that they should be placed separately because vast issues are involved while some said that placing them together will facilitate access to it. Those who were of the position that it should be separate would not mind one document containing everything provided it is well laid out as different items. At Oluyole Community, the two groups agreed that it should be separately arranged.

APPENDIX 2

QUESTIONNAIRE ON KNOWLEDGE ,OPINION AND ATTITUDE OF HOUSEHOLD HEADS ABOUT REPRODUCTIVE HEALTH RIGHTS IN IBADAN SOUTH WEST LOCAL GOVERNMENT AREA, OYO STATE, NIGERIA.

Note. Only Household heads(female or male) are eligible to participate in the interview .

Good day sir/Madam, My name is ..... from Department of Health Promotion and Education, UCH Ibadan Nigeria. I am a post graduate student carrying out a research on the knowledge, opinion and attitude of household heads to Reproductive Health Rights in Ibadan South West Local Government, Ibadan, Nigeria. I wish to discuss with you a number of questions on the said subject. Your response will help in building this body of rights.

I will ensure that all the information that is given is kept confidential and should you feel uncomfortable with any question, just ask me to move on to the next question. Are you willing to participate or not? Thank you

Section A Knowledge, Opinion and Attitude about Reproductive health rights

1. What do you understand by Human rights?
.....
.....

2. What do you understand by Reproductive Health Rights? (Give all examples that you know)
.....
.....
.....
.....
.....
.....
.....

3. Which of the mentioned Reproductive Health rights should be made applicable and legally enforceable in Nigeria? Why? Which should not and why?

.....

.....

.....

.....

.....

.....

4. What in your view constitute violation of Reproductive Health rights?

.....

.....

.....

.....

.....

5. Which law, convention and treaties on human rights and Reproductive Health rights are you aware of? (Probe for content and dates of enactments)

.....

.....

.....

.....

.....

6a. What is your opinion about the issues raised below grade for how common the issues are and the reason for their choice
b. Which of the issues mentioned below should be addressed when drafting a bill that will protect the Reproductive Health Rights of people in Nigeria?

	Issues	How Common			Reason	Should be addressed in a draft bill?		Reason
		Very common	Common	Not common		Yes	No	
A	Son preference							
B	Child bearing							
	Abortion							
D	Employment and prompt payment of salary							
	Polygyny (marriage of a man to more than one wife)							
	Polyandry (marriage of a woman to more than one husband)							
C	Family planning contraceptive use							
H	Violence against women i. sex- selective abortion (aborting of pregnancy due to the gender of foetus)							
	ii. battery during pregnancy							
	iii. Incest (sexual relationship between father and daughter or mother and son)							
	iv. Rape							
	v. sexual abuse in the work place							

	vi. forced prostitution							
	vii. dating &courtship sexual violence							
	viii. Forced suicide of the elderly women due to economic reasons. sexual ,physical and psycho logical abuses							
	ix. Marital rape.							
	x. Trafficking of women							
	xi. female genital mutilation							
	xii. Sex with sugar daddies in return for school fees							
	xiii. early marriage							
I	Health as a right							
J	Birth control							
K	Quality health services							
L	Sexual education at home							
M	Sexual education at school							
N	Bad dressing by ladies							
O	Alcohol consumption							
P	Smoking of hemp							
Q	Using of hard drugs							

7 (a)Please mention all the reproductive health rights that you know (interviewers to check the Reproductive health rights as mentioned in Question 2 and tick as appropriate and applicable under the column for "without prompting" (b) Which of the following rights are you aware of? Interviewers should listen to responses and tick as appropriate under the column for 'with prompting' (c) Which of the following rights should or should not be adopted as Reproductive health rights in Nigeria and why? (d) To what extent are the following rights being promoted in Nigeria(federal Government, Oyo state and your local Government?)

	RIGHTS	AWARENESS				SHOULD BE ADOPTED?			REASON	EXTENT OF PROMOTION							
										Federal Government			Oyo state			Local government	
		Without prompting		With Prompting		YES	NO	Don't Know		1	2	3	1	2	3	1	2
		Yes	No	Yes	No												
i	The right to life																
ii	The right to liberty and security of person																
iii	The right to decide the number and spacing of ones children																
iv	The right to privacy																
v	The right to continue to marriage																
vi	The right to equality in marriage																
vii	The right to be free from discrimination																
viii	The right to enjoy scientific progress and to consent to experimentation																
ix	The right not to be subjected to torture or other cruel, inhuman or degrading treatment or punishment																
x	The right to a standard of living adequate for health and well being																
xi	The right to education and information on reproductive health																
xii	The right to health																
xiii	The right to freedom of Association and political participation																

Key: 1 To a large extent 2 To some extent 3 Not at all

8. What steps should be taken to make applicable and legally enforceable the rights listed in table (7) as reproductive health rights in Nigeria?

.....

.....

9. What can be done to ensure that Reproductive health rights are adhered to by the community and the government after same have been made applicable and legally enforceable in Nigeria?(Probe for penalty that should be imposed on any of the rights that may attract sanctions.)

.....

.....

10. How do you think issues constituting Reproductive Health rights should be arranged? (Probe for whether they should be put together in one document or each of the issues should be contained in separate document and reason.)

.....

.....

Section B: Demographic Data

11. Sex 1. Male 2. Female
12. Age (in completed years) _____ (yrs)
13. Religion (1) Christianity (2) Islam (3) Traditional Religion (4) Others (*please specify*)_____
14. What is the denomination of your religion? (*Please specify*)_____
15. Marital status? 1. Currently married (living with spouse) 2.Curently married (but not living with spouse) 3.Divorced 4.Widowed 5.Single
16. Local Government. _____
17. Location _____
18. Have you ever attended any programme (i.e. conference, seminar, and workshop) or listened to any programme (Television or Radio) on reproductive health rights. 1.Yes 2. No
19. If your response to question (18) is Yes, please specify the source. the programme and what the programme is all about. _____
20. Have you ever attended school? (1)Yes (2)No
21. Highest level of education: (1) Primary Education. (2) Secondary Education (3)NCE/OND (4)HND/University (5)Post graduate
22. What type of work do you do presently?.....
23. Ethnic group (i) Yoruba (2) Hausa (3) Igbo (4) Others (*Please specify*)_____

APPENDIX 3

FOCUS GROUP DISCUSSION(FGD) GUIDE ON KNOWLEDGE OPINION AND ATTITUDE OF HOUSEHOLD HEADS ABOUT REPRODUCTIVE HEALTH RIGHTS IN IBADAN SOUTH WEST LOCAL GOVERNMENT, OYO STATE, NIGERIA.

1) What are the general health problems of this area?
(2) What do you understand by Human rights and what constitutes their violation?
(3) What is the experience of the Community in respect of human rights violation?
(4) What are Reproductive health rights and what constitutes their violation?
(5) Which of the RHRs should be made into laws in Nigeria (Probe for reasons)
(6) Which Laws, Conventions and Treaties on human rights and RHRs do you know? (Probe for content)
(7) What is your opinion on the commonness of the following issues?
   a. Son preference
   b. Child hawkers
   c. Abortion
   d. Employment
   e. Polyandry
   f. Polygyny
   g. Health services.
   h. Family planning contraceptive use
   i. The beating of women.
   j. Sexual violence

k. Health as a right

l. Early marriage

m. Decision making on birth control

n. Sexual education at home and school

o. A healthy environment

p. The right to food

q. Alcohol consumption

r. Ladies dress

s. The right to good water

(8) Which of the said issues should be addressed in a bill on RHRs?

(9) What can be done to ensure that these RHRs are adhered to after they have been recognized by law?

(10) How should RHRs be arranged after they have been codified?

APPENDIX 4

IMO ERO ATI IHA AWON OLORI EBI NIPA ETO ILERA IBISI

Akiyesi: Awon Olori ebi (Obinrin tabi Okunrin) nikan ni o Koju Osuwon fun iforo wani lenuwo lori gbogbo ibeere.

Eku deede iwoyi

Oruko mi ni———— Iati ———A nse iwadi lori imo, ero ati iha awon olori ebi nipa eto lori ilera ibisi ni ijoba ibile, gusu iwo orun Ibadan,ipinle Oyo, Naijiria. A o ma bi yin ni ibeere lori awon nkankan eyi ti idahun re yoo ran wa lowo nipa kikojo awon eto ti o ro mo ilera ibisi. A o ri daju pe nkan ti e ba so fun wa yio wa ni ipamo at asiri pelu. Bakana ti a ba bi yin ni ibeere ti e ko fe Iati dahun, e so fun wa pe ki a koja si ibere ti o tele.Nje e fe Iati ko pa ninu ise iwadi yi bi? (Bi idahun ba je beeko, dupe lowo oludahun, ki o si jami lori awon ibere gbogbo. E se pupo.

Akori Kini: Imo, ero ati iha nipa eto ilera ibisi

1. Kini a npe ni Eto omoniyan?
2. Kini a npe ni eto lori ilera ibisi (E so fun wa gbogbo apeere ti e mo)
3. Ewo ninu awon eto yi ni o ye kamu lo tabi ki a fi agbara ofin ti lehin Iati mu se ni ile Noijiria. Kini idi? E wo ni ko ye, ki ni idi?
4. Kini awon ohun ti E le so pe o je mo riru tabi sisesi eto lori ilera ibisi.
5. Awon ofin, apejo tabi iwe akoye lori eto omoniyan ati eto lori ibisi ilera wo ni e mo? (Wadi fun ohun ti o wa ninu won ati igba ti a se tabi ko won).

6 Kini ero yin lori awon nkan ti o wa ni isale yii [illegible]

b [illegible] (Nigeria)

		Bawo lo se wopo				Ki iwo [illegible]		IDI
		Wopo gan an	O wo po die	Ko wo po	Idi	Bosesi	Beeko	
a	Yiyan omo okunrin ni ayo							
b	Lilo omo kekere kan ta oja							
c	Oyun sise							
d	Ise ati owo sisan lasiko							
e	Obinrin ti o ni oko pupo							
f	Okunrin ti o ni aya pupo							
g	Lilo awon ohun ifeto somo bibi (ti aye ode oni ati ti abalaye)							
h	Iwa ipa tabi ika si obirin							
	i. ifipa mu obinrin se oyun nitori pe a ti mo pe obinrin ni yio bi							
	ii. Fifi Iya je oloyun							
	iii. Ibalopo laarin ebi							
	iv. Ifi ipa ba obirin lo po							
	v. fifi ipa ba ara eni lo po larin afesona							
	vi Ibalopo aito ni ile ise							
	vii Fifi ipa muni se owo agbere							
	viii Gbi gba emi ara eni laarin agba obinrin nitori oro aje, ati ainaani ohun ti oye won nitti ara, ibalopo ati ero							
	ix Fifi ipa bani lopo larin oko si aya							
	x. Kiko omobinrin losi oke okun lati se owo aito							
	xi Dida abe fun omobinrin							
	xii Nini ibalopo pelu eni ti o bini ni omo nitori ati san owo ile iwe							
	xiii Titete se igbeyawo							
I	Eto ilera							
J	Ifetosomobibi							
K	Eto ilera ti opeye							
L	Eko ile lori ibalopo							
M	Eko ile iwe lori ibalopo							
N	Iwo aso kelenu sonu laarin obinrin							
O	Oti mimu							
P	Igbo mimu ati ogun oloro							
Q	Lilo ogun oloro							

7.E jowo e daruko eto ilera ibisi ti e mo (ki olubere wo gbogbo awon eto ti oludahun ti mu enu kan ni ibere keji ki o si famin si abe eyi ti o ba ye ni ibiti a ko "laisi leti" si.(b)E wo ninu awon eto won yin ni e ko gba?(ki olubere ki fi eti si awon idahun ki os i fi amin ti o to si abe "lehin ti a si mi leti".(c)E wo ninu awon eto wonyi ni o ye tabi ti ko ye lati gba wole gegebi eto fun ibisi ni ile Naijiria.Kini idi?

	Se e gbo si?				Se ki a to o?			Idi	Ijoba Apapo			Ijoba ipinle			Ijoba ibile		
	Laisi leti		Lehin ti a si leti		Beni	Beeko	N ko mo										
	beni	beeko	Beeni	beeko					Lona tio po	lona die	Rara	lona tio po	Lona die	Rara	lona tio po	lona die	R[illegible]
Eto lati wa ni ase																	
Eto lati wa ni ominira ati laisi ewu																	
Eto lati le se ijosin iye omo ti aje lati bi ati bi ase fe bi won																	
Eto si ipamo																	
Eto lati gba lati se igbeyawo																	
Eto lati wa ni dogba ndogba laarin oko ati iyawo																	
Eto lati bo lowo fifi iyato si laarin okunrin ati obinrin																	
Eto lati gbadun ere ati ilosiwaju imo ijinle ati lati gba lati fowo owo idanwo ti o je mo eto imo ijinle																	
Eto lati bo nino idaloro, ati iwa [illegible], tabi iwa ti o [illegible] omo eniyan tabi fifi iya je ni																	
Eto si [illegible] ti o dara fun ilera ati iranran																	
Eto si eko ati imoran oro lori ibisi ilera																	
Eto si ilera																	
Eto si anfani lati pejopo ati lowo si eto ilera																	

8.Awon igbese wo le ro pe o ye Inti gbe ki a le so awon ohun ti ako gegebi eto ni akori keje di amulo tabi ka fi agbara ofin ti Ichin lati mu se gegebi eto ilera ibisi ni orileede Naijria.

9.Awo nkan wo ni a lese lati je ki awon eniyan ki o tele awon eto yi leyin ti aba so won di mimulo ni orile ede Naijiria. (Wadi fun ijiya ti o ye fun awon eniyan ti o ba ru awon eto yi ti aba ti so won di mimu lo ni ori ede Naijiria).10.Kini ero yin nipa bi a se le to awon nkan ti ati ko sile yii gegebi eto ilera ibisi ni orile ede Naijiria (wadi fun boya ki a ko won po si oju kan naa ni tabi ki won ki o wa ni otooto ati idi).

Akori Keji

11 Okunrin 2. Obinrin

12 Ojo ori (ni kikun ni gbati a se ojo ibi kchin)

13 Esin

1. Omo leyin Kristi 2. Musulumi

3.Ibile 4.Omiran (E jowo e daruko)———

14 Eya esin wo ni ti yin (E jowo e daruko)———

15 Ipo ti e wa ninu eto igbeyawo

1.E wa ninu eto iyawo lowolowo(E hun gbe pelu iyawo/oko 2.E wa ninu eto iyawo lowolowo(E ko gbe pelu iyawo/oko.3.Eti tu igbeyawo ka 4.E ti di opo. 5.Omidan.

16. Ijoba ibile———— 17. Agbegbe.....

18. Nje E ti lo eto kankan (i.e. ipade ajoto, ipade ilimokunmo, ipade ikosemose) tabi gbo eto kan (lori mohunmaworan tabi ero asoromagbesi) lori eto ilera ibisi ri?

1. Beeni 2. Beeko

19 Ti idahun re si ibere keje jabe beeni. daruko orisun, eto naa ati nkan ti eto naa jo mo———————————

20. Nje e lo si ile iwe ri?

1. Beeni 2. Beeko

21 Bawo ni E se ka iwe to?

1.Iwe alakobere 2.iwe mewa 3.iwe olukoni/iwe eko giga OND 4. ile eko giga HND / unifasiti 5.iwe eko giga agba (postgraduate)

22 Iru ise wo ni e nse?.....

23 Eya

2. Yoruba 2.Hausa

3.Igbo 4.Omiran (E jowo. e daruko)