International NGO Journal Vol. 6(5), pp. 113-121, May 2011
Available online at http:// www.academicjournals.org/INGOJ
DOI:10.5897/NGOJ11.007
ISSN 1993–8225 ©2011 Academic Journals

Article

The control of Nigerian women over their sexuality in an era of HIV/AIDS: A study of women in Edo State in Nigeria

Festus Iyayi* R. Osaro Igbinomwanhia, Anthonia Bardi and Omole O. Iyayi

Department of Business Administration, Faculty of Management Sciences, University of Benin, Benin City, Edo State, Nigeria.

Accepted 18 April, 2011

HIV/AIDS remains the world's most menacing disease of the 20th and 21st century. Two-thirds of an estimated 40.3 affected people world-wide live in sub-Saharan Africa and 77% of these are women. In Nigeria, 57% of people living with HIV/AIDS are, according to a 2005 estimate, women. The increasing vulnerability of women/girls to HIV/AIDS has been attributed to many factors. Among these, women's control over their sexuality has been seriously implicated. Unfortunately however, very little attention has been given to this area both in the fight against the spread of HIV and as an academic inquiry. The study examines the extent to which Nigerian women in Edo state have control over their sexuality as a means of reducing their vulnerability to HIV and curbing the spread of the pandemic. Most importantly, the study examines the extent to which conclusions from two previous similar investigations in the South-West of Nigeria can be generalized. The study shows that most Edo women have a considerable level of control over their sexuality in their homes. The conditions under which such control is exercised as well as the factors that predispose the exercise of such control are discussed.

Key words: Human immunodeficiency virus, acquired immune deficiency syndrome, sexually transmitted infections, Edo women.

INTRODUCTION

HIV/AIDS remains the world's most menacing disease of the 20th and 21st century and constitutes a formidable challenge to development and social progress (Gupta, 2000). Since 1981 when the first known cases of Acquired Immune Deficiency Syndrome (AIDS) were reported in the United States (Gupta, 2000), an estimated 40.3 million people have been infected with the virus worldwide and more than 25 million people have been killed by the virus, making it one of the most destructive epidemics in recorded history (Otive-Igbuzor, 2003). Two-third of people living with HIV in the world are in sub Saharan Africa and 77% of these are women (Otive-Igbuzor, 2003). Women, particularly in sub-Saharan Africa appear to be more susceptible to the virus than their male counterparts according to Pennington (2005) study and thus the pandemic is increasingly becoming feminized globally. In Nigeria, 57% of people living with HIV/AIDS are women (Ogunjuyigbe and Adeyemi, 2005; Caldwell et al., 1997). The increasing vulnerability of women/girls to HIV/AIDS has been attributed among other things to some harmful traditional practices such as child marriage, female genital mutilation (FGM), scarification, tattooing, wife inheritance (NIAID, 2004; Online Glossary of Terms, 2007), polygamy, and sexual violence in the form of rape, incest and forced prostitution. Ogunjuyigbe and Adeyemi (2005) reports that 80% of HIV infections in Nigeria are transmitted by heterosexual sex. No doubt that women/girls are biologically more vulnerable to HIV infection (NIAID, 2004).

And as reported by Hannan (2003), the female reproductive system has a larger mucosal surface which remains in contact with genital secretions and seminal fluid for a long time. Thus many sexually transmitted infections are largely asymptomatic in women and when left untreated results in ulcerations of the vaginal wall which act as routes of entry for HIV (Ivancevich and Glueck, 1989). Biological vulnerability however, does not

*Corresponding author. E-mail: festusiyayi@yahoo.com.

provide sufficient explanation for the disparity in the prevalence of HIV between men and women in Africa. Other factors such as poverty, food insecurity (NIAID, 2004), women's control over their sexuality (International Labour Organization, 2001; Heise et al., 1999) have been seriously implicated. Since the commonest mode of transmission of HIV in Africa is through heterosexual sex (Ogunjuyigbe and Adeyemi, 2005), control of women over their sexuality, particularly in the conjugal union, and generally in their sexual relations, will have implications for the control and spread of HIV/AIDS. Unfortunately however, very little attention has been given to this area both in the fight against the spread of HIV and as an academic inquiry. The study examines the extent to which Nigerian women in Edo state have control over their sexuality as a means to reducing their vulnerability to HIV and curbing the spread of the pandemic. Most importantly, the study examines the extent to which conclusions from two previous similar investigations (International Labour Organization, 2001) and (Heise et al., 1999) in the south-west of Nigeria can be generalized.

The study shows that most Edo women have a considerable level of control over their sexuality in their homes. The conditions under which the control is exercised as well as the factors that predispose the exercise of such control are discussed.

Women and HIV/AIDS

The HIV/AIDS epidemic is becoming increasingly feminized globally as women and girls are more vulnerable to infection and bear the burden of care for infected family and community members (NIAID, 2004). Nearly half of the 40 million people currently living with HIV/AIDS are female, up from 41% in 1997 and 35% in 1985. In every region of the world more women are living with HIV/AIDS more than ever before. This number increased by 1 million between 2004 and 2006 (Otive-Igbuzor, 2006). Young people (aged 15 to 24) accounted for 40% of the 4.1 million new HIV infections in 2005 and young women account for 62% of people living with HIV/AIDS (PLWHA) between the ages of 15 and 24. In sub-Saharan Africa, 76% of HIV-positive young people are female (Otive-Igbuzor, 2006). More than four-fifths of new infections in women result from sex with their husbands or primary partners (Population Council, 2004). In Nigeria, heterosexual plays a major role in HIV infection accounting for about 80% of all infections (Ogunjuyigbe and Adeyemi, 2005). For women in their reproductive years, much of the burden of ill health is related to sex and reproduction. In sub-Saharan Africa, 40% of all illnesses affecting women of reproductive age result from the processes of sex and reproduction (Ivancevich and Glueck, 1989). In addition to the increasing rate of HIV infection in women, women are also disproportionately affected by the pandemic in many areas because of their caring roles. Women are often left with the sole responsibility for providing for the sick and dying (Federal Ministry of Health Nigeria, 2004).

The factors that predispose women to HIV/AIDS infection is being increasingly viewed from the context of gender inequality which has serious implications for the power relations that exist in sexual relationships between men and women whether in the conjugal union or outside of it. The vulnerability of women and girls to HIV/AIDS is directly related to the relations between women and men and to the attitudes and behaviour of men and boys, as well as the persistent stereotypes about masculinities and about what is appropriate and acceptable behaviour for women, particularly in relation to reproduction and sexuality. The inequalities which arise from these relations, attitudes, behaviours and stereotypes are critical factors in the spread of HIV/AIDS (Federal Ministry of Health Nigeria, 2004).

Gender, sexuality and HIV/AIDS

Gender is not synonymous with sex. Rather, it portrays the widely shared expectations and norms within a society about appropriate male and female behaviour, characteristics and roles (Dorsett, 2003). It is also seen as an array of societal beliefs, values, norms and attitudes that determine and shape what is acceptable as masculine and feminine behavior (NIAID, 2004). Gender is a culture-specific construct. In other words, there are significant differences in what women and men can or cannot do in one culture as compared to another. But what is fairly consistent across culture is that there is always a distinct difference between women's and men's roles, access to productive resources and decision making authority. While men are typically seen as being responsible for the productive activities outside the home, women are expected to be responsible for reproductive and productive activities within the home (Dorsett, 2003). Socio-cultural factors are a reflection of various norms, roles, beliefs and societal expectations that guide the way of life of people. Cultural norms are considered sacred and inviolable to a large extent especially in set-ups where such norms promote domination by some groups (NIAID, 2004). The African patriarchal system has been implicated as a cultural norm that promotes domination of men over women. Most African societies are patriarchal. Essential elements upon which patriarchy thrives include unequal power relations between men and women, men's assess to women's bodies for sex and women's economic dependence on men (NIAID, 2004). The dominant ideology of femininity in Nigeria casts women in a subordinate, dependent and passive position with virginity, chastity, motherhood moral superiority and obedience as key virtues.

Socio-cultural factors increase women and men's risks

and vulnerability to HIV/AIDS. They also determine access to care, treatment and support. Several harmful traditional practices including child marriages, female genital mutilation, scarification, tattooing and wife inheritance further predispose women to HIV infection (NIAID, 2004). Factors that are driving HIV/AIDS are embedded in the power relations that define male and female roles and positions, both in intimate relation and in the wider society (Baylies, 2000). Gender inequality is a driving factor in the spread of HIV/AIDS; and HIV/AIDS contributes to the entrenchment of gender inequality in societies (Bridge, 2002). Issues of power, human rights and socio-cultural expectations are critical elements in addressing HIV/AIDS from a gender perspective (Federal Ministry of Health Nigeria, 2004). The expert group meeting on "The HIV/AIDS pandemic and its gender implications", under the aegis of UN Division for the Advancement of Women (2000), reported that the inequality and women's disempowerment at different levels – in families, in decision making at community and other levels, in education, in employment and economic opportunities – can be linked to the rate of spread of infection and the severe impacts on families, communities and countries. The feminization of HIV/AIDS do not only reflects women's greater physiological vulnerability to the pandemic, but also their social and psychological vulnerability created by a set on interrelated economic, socio-cultural and legal factors. This increasing feminization of HIV and AIDS also stresses the need for policies and interventions to focus on transforming roles and relations between males and females to support the deep rooted behaviour change necessary to stem the spread of HIV/AIDS (UNAIDS, 2001). Sexuality, though distinct from gender, is nevertheless intimately linked to it (Dorsett, 2003). Sexuality refers to the totality of being a person (NIAID, 2004). Sexuality is concerned with the biological, psychological, sociological and spiritual variables of life that affect personality development and interpersonal relations and includes one's self-perception, self-esteem, personal history, personality, concept of love and intimacy, body image etc (Online Glossary of Terms, 2007).

According to Dorsett (2003), sexuality can also be seen as a structure of ideas, an array of discourses and sensations, an embodiment of pleasures, the forming of sex object choices and the endless unfolding of categories of desire. Sexuality is the social construction of biological drives and it is defined by whom one has sex with, in what ways, why, under what circumstances and with what outcomes (Dorsett, 2003). It is more than sexual behaviour; it is a multidimensional and dynamic concept (Ezeh and Mboup, 1997). Explicit and implicit rules imposed by society, as defined by one's gender, age, economic status, ethnicity and other factors, influence an individual's sexuality (UNAIDS, 2005). Sexuality is understood as consisting of different components which are collectively referred to as the Ps of sexuality – practices, partners, pleasure/pressure/pain and procreation (Dorsett, 2003). The first two refer to aspects of behaviour- how one has sex and with whom; while the others refer to the underlying motives. However, another P of sexuality, which represents power is perceived to be the most important of all the Ps. According to Weiss and Gupta (1998), the power underlying any sexual interaction, heterosexual or homosexual, determines how all other Ps of sexuality are expressed and experienced. It is power that determines whose pleasure is given priority and when, how and with whom sex takes place. Power is fundamental to both sexuality and gender. The unequal power balance in gender relations that favours men, translates into an unequal power balance in heterosexual interactions, in which male pleasure supersedes female pleasure and men have greater control than women over when, where and how sex takes place.

An understanding of individual sexual behaviour, male or female, thus, necessitates an understanding of gender and sexuality as constructed by a complex interplay of social, cultural and economic forces that determine the distribution of power (Dorsett, 2003). As already noted, gender and sexual role stereotyping have negative outcomes. As NIAID (2004) has observed, "while men/boys are positioned to claim, enforce or buy sexual favours, women cannot decide when, how and with whom to have sex… Even when a woman knows that her partner is infected with an STI, she is often unable to refuse advances or negotiate safer sex". This imbalance of power in sexual relations should not be thought of as existing only outside the conjugal union, because for several women, marriage contributes to their risk of infection. As Caldwell et al. (1997) observed in a Nigerian study, women's vulnerability to HIV and other sexually transmitted infections can be traced to the behaviour of their male partners. International Labour Organization (2001) conclude from a Nigerian study on Yoruba women's control over their sexuality that '…women have a considerable ability to refuse sexual relations for a limited time and they are placed at a greater risk of STD infection by their ignorance of whether their partner is infected than by a lack of ability to control the situation when STDs have been identified. In the case of AIDS, this ability may be more limited because of its longer duration.' In a related study, Heise et al. (1999) conclude that women have some form of control over their sexuality but that men still have the power to determine when to have sexual intercourse; when to have more children; and the desired family size.

Other studies have shown that several men and boys harbour serious misconceptions about sexually transmitted infections (Orubuloye et al., 1993). In the Nigerian society, men and boys are expected to be knowledgeable about sex and sexually transmitted infections including HIV/AIDS while women on the other

Table 1. Control over reproductive decision-making.

Decision on:	Decision by { % (No.)}:			
	Husband	**Wife**	**Both**	**Total**
When to have sex	41.8 (66)	6.3 (10)	51.9 (82)	1000.0 (158)
When to use contraceptives	23.0 (20)	36.8 (32)	40.2 (35)	100.0 (87)
Family planning method to use	17.5 (27)	30.0 (46)	52.5 (81)	100.0 (154)
When to have more children	27.3 (46)	12.0 (20)	60.7 (102)	100.0 (168)
Desired family size	30.5 (51)	9.6 (16)	59.9 (100)	100.0 (167)

hand are expected to be virginal and innocent about sex. Even when they know how to protect themselves, it will be a deviation from good behaviour to present a condom or talk about it (NIAID, 2004). The implication thus, is that a woman's vulnerability to HIV is determined to a large extent by the choices made by her male partner.

METHODS

The study was done in Edo State in the South-South geopolitical zone of Nigeria. Three local governments (Oredo, Egor and Ovia North-east) were selected for the study. Apart from convenience, these local governments, particularly Oredo and Egor make up the larger of the Benin City metropolis. Thereafter, seventy (70) married women from reproductive age fifteen (15) and above from each local government were randomly selected to yield a sample size of two hundred and ten (210). The study utilized the questionnaire as the major data gathering instrument. Interview was used as a complementary instrument to obtain more information in some cases. The questionnaire was divided into two sections: Section A consisted of questions covering the demographic and economic characteristics of respondents. Section B addressed the following questions:

1) How much control can women exercise over their sexuality in sexual relations with their spouses?
2) What are the factors that determine the control women have over their sexuality?
3) What knowledge and attitude do women have about STDs and preventive controls?
4) What are the means by which women can be empowered to exercise control over their sexuality in sexual relations with their spouses?

Eighty-two percent of the questionnaires administered were found usable. The data was subjected to both descriptive and inferential statistical analysis. The results of the analysis are presented for each of the four questions above that summarized the object of the study.

The data

The amount of control that women have over their sexuality in sexual relations with their spouses

In operationalising this variable, respondents were asked to state the extent to which they participate in reproductive decision making with their spouses and whether or not they can refuse sex from their husbands. Eighty-two (82) respondents or 51.9% reported that the decision on when to have sex is jointly made by them and their husbands. On the decision on when to use contraceptives, the table shows that thirty-five (35) respondents or 40.2% reported that the decision is taken in conjunction with their husbands. Decision on the family planning method to use was reported by eighty-one (81) respondents or 52.5% as a joint decision by them and their husbands. Similarly, one hundred and two (102) respondents or 60.7% of the respondents reported that the decision on when to have more children was jointly made by them and their husbands. Finally, one hundred (100) respondents or 59.9% reported that they jointly participate in the decision on the size of the family. It appears thus, that most women in this study participate in reproductive decision making with their spouses. From Table 1 we find that one hundred and eighteen (118) respondents or 68.6% reported to have refused sex from their spouses, while forty-one (41) respondents or 23.8% of them said they have not ever refused sex from their husbands. Thirteen (13) respondents or 7.6% did not respond to this item on the questionnaire. When asked under what conditions the respondents refused sex from their spouses, fifty-two (52) respondents or 23.5% which is the modal number, said they refuse when they are ill. Another forty-three (43) or 19.5% said when they are menstruating, while thirty-one (31) respondents or 14.0% said when they are tired. Twenty-nine (29) respondents 13.1% said they refused sex when they are not happy while twenty-eight (28) or 12.7% said they withhold sex from their spouses when their husbands offend them. Another twenty-eight (28) respondents or 12.7% stated other reasons such as when fasting; when the man is suspected of having an affair or when the man is not taking good care of the family. Ten (10) respondents or 4.5% said they refuse sex from their spouses when they are not in a safe period (Table 2).

Respondents that reported not to have ever refused sex from their husbands gave reasons that include religious injunctions to sheer fear of what might happen or what their husbands might do to them if they refuse. One respondent noted that: "It is the commandment of God not to refuse", while another noted that: "Sex is the bedrock of a successful marriage". For the respondents that expressed fear of what might happen, one said: "I do not want to break my marriage", and another stated that she cannot refuse sex from her husband in order: "To have a peaceful home". The respondents that expressed fear of what their husbands might do to them seemed to be fearful of being physically assaulted or ill treated by their husbands. One respondent stated that refusal means that: "He will beat me mercilessly; He has paid my bride price". Another said that: "He will be angry with me; He might not even drop money for food". There were also some respondents who said they cannot refuse sex from their husbands either because they are the only wives or just one of the wives. Thus, while one of the respondents stated that: "There is no other woman in his life", another stated that: "He is my husband I must not starve him with sex; and I am not the only wife he has at home". On whether women can demand sex from their husbands, 74.4% of the respondents responded in the affirmative. Many of the respondents

Table 2. Women's control over sexual acts.

Criteria for evaluation	Number	Percent
Have you ever refused sex from your husband?		
No	41	23.8
Yes	118	68.6
No response	13	7.6
Total	172	100.0
Under what conditions?		
Under menstruation	43	19.5
When ill	52	23.5
When tired	31	14.0
When not happy or not in good mood	29	13.1
When not in safe period	10	4.5
When he offends me	28	12.7
Others	28	12.7
Total	221*	100.0
Can a woman demand sex from her husband?		
No	24	14.0
Yes	128	74.4
No response	20	11.6
Total	172	100.0

*Most respondents stated more than one condition.

said they could demand for sex if they are in the mood, while some said they could do so if it is time to have another child. Also, some of the respondents who said they cannot demand sex from their husbands stated that: "He is the one that is supposed to demand it from you". Some affirmed that it was against tradition for a woman to demand sex from her husband.

One respondent stated that: "I am not taught in that way. I do not have such feelings". Despite the reasons given by respondents who said they cannot refuse sex from their husbands or demand for it, the aforementioned analyses show that most women appear to have a considerable level of control over their sexuality.

Factors that determine the control that women have over their sexuality

Out of the eleven factors presented (age, ethnic group, religion, occupation, marital status, family structure, first husband, level of education, level of income, discussion of relationships and sexuality issues with parents; and maiden family structure), only five were found to have a positive significant correlation with the dependent variable. Two factors (age; and whether respondents' parents discuss relationships and sexuality issues with them while they were growing up) significantly correlated positively with the dependent variable at 0.05 level (2-tailed). Three factors (occupation, level of income, and level of education) significantly correlated positively with the dependent variable at 0.01 level (2-tailed). Ethnic group and religious affiliations were found to be negatively correlated with the dependent variable. In Table 3, we present detailed bivariate analyses of these five factors by whether women can reject sexual intercourse from husbands. The analysis aforementioned shows that the occupational status of a woman tends to influence her ability to reject sex. About 64.0% of women in professional jobs said they could say no, followed by those in clerical jobs (60.0%), trading (43.5%) and housewife (41.9%) in that order. The assumption is that those who have good jobs tend to be financially empowered to challenge their husbands since they depend lesser on them economically. The analysis also reveals that a woman's educational background influences her ability to reject sex from her husband. We find from the table that 68.5% of women with post-secondary education said they could say no to sex from their husbands as compared to the 50.0% with secondary education who said no and the 28.6% with a primary education. One explanation for this is that the more educated women are, the more the probability that they will be engaged in well paying jobs (clerical; professional). And with such jobs come some degree of financial independence which tends to give them a voice in decisions that are taken in the home (including sexuality decisions).

Furthermore, the analysis reveals that the level of income affects women's ability to reject sex. The more women earn, the more they tend to have the ability to say no to sex from their husbands. For example, while only 35.7% of women who earn less than N10,000 monthly believe that a woman can say no to sex from her husband, 66.7 and 81.8% of those who earned between N31,000 to N40,000, and N41,000 and above respectively believed a woman can reject sex from her husband. One explanation for this is that women who earn sizeable income tend to depend less on their husband financially and also contribute to the upkeep of the home. The implication is that the husband is forced to show some respect to the woman and her wishes in the home. One housewife for example said she cannot refuse sex from her husband because in her words: "He will be angry with me; He might not even drop money for food". The analysis also shows that 70.4% of women whom their parents discussed relationships and sexuality issues within their growing up years believe a woman can reject sex from her husband as compared to the 57.3% who believe a woman can reject sex from her husbands but never discussed such issues with their parents in their growing up years. One probable explanation for this trend is that those with whom their parents discussed relationships and sexuality issues with may have been better

Table 3. Factors that affect the control of women over their sexuality.

Criteria for evaluation	Yes	No	Total
Can a woman reject sex from her husband?			
Characteristics			
Age			
15 – 25	5 (55.6)	4 (44.4)	9
26 – 35	28 (71.8)	11 (28.2)	39
36 – 45	39 (58.2)	28 (41.8)	67
46 and above	24 (55.8)	19 (44.2)	43
Occupation			
Housewife	13 (41.9)	18 (48.1)	31
Trading	10 (43.5)	13 (56.5)	23
Clerical	9 (60.0)	6 (40.0)	15
Professional	64 (71.9)	25 (28.1)	89
Level of education			
Primary	4 (28.6)	10 (71.4)	14
Secondary	15 (50.0)	15 (50.0)	30
Post-secondary	74 (68.5)	34 (31.5)	108
Level of income			
Less than 10,000	5 (35.7)	9 (64.3)	14
11,000 – 20,000	11 (61.1)	7 (38.9)	18
21,000 – 30,000	18 (60.0)	12 (40.0)	30
31,000 – 40,000	24 (66.7)	12 (33.3)	36
41,000 and above	27 (81.8)	6 (18.2)	33
Did your parents discuss relationships and sexuality with you while you were growing up?			
Yes	38 (70.4)	16 (29.6)	54
No	43 (57.3)	32 (42.7)	75

informed about husband-wife relationship and better equipped for that life.

Finally, the analysis shows that the age of women tend to affect their ability to reject sex. Older women tend to have a relatively higher ability to reject sex from their husbands than young women.

Knowledge and attitude of Nigerian women about sexually transmitted diseases (STDs) and preventive controls

Analysis shows that most of the respondents have good knowledge of STDs, particularly HIV/AIDS. Most of them also claim that the knowledge came from watching TV. Almost all the respondents said they have heard about condom but only one-third of them claimed to have demanded the use of condom from their husbands. Those who said they have never demanded the use of condom from their husbands said they did not like it. Others said they did not use condom because they love their husband and that they believe he is faithful to them. There was however some who said their husband will not agree to use it. A particular respondent said: 'My husband will never accept it'. Some of the respondents' refusal to use condom seemed to be based on a wrong perception. One particular respondent said that she does not use condom: 'Because I was told it is dangerous' (Table 4).

Empowering women to exercise control over their sexuality

Most of the respondents said that women can be empowered to control their sexuality if they are educated. Education is seen as important because it is believed that an educated person would be gainfully employed. Others stated specifically that women could be empowered to control their sexuality if they have jobs that they do. One housewife stated that women will be empowered: 'if they have market they are selling'. What these imply is that most of the respondents believe that financial or economic independence is important if a woman is to have some form of control over her sexuality in sexual relations with her spouse. Some other respondents said that the awareness of the spread of STDs could also make women exercise control over their sexuality. This may be the reason why some of the respondents believed that sex education was necessary if women are to exercise control over their sexuality. When asked what could be done to make husbands respect the sexual wishes of their wives, most of the women said that men should be given proper education on why they should respect the sexual desires of their wives. Others said that mutual understanding between husband and wives would suffice. However, some respondents reiterated the need for women to be economically independent. A particular respondent put it this way: 'Women should have good work or business that will bring them money and their husbands will respect them.'

DISCUSSION

This study is the first to be conducted in Edo state in South-south Nigeria. Orubuloye et al. (1993) and

Table 4. Women's knowledge and attitude towards STDS and preventive controls.

Knowledge and attitude about STDs and preventive controls	Number	Valid percent
Ever heard of STDs?		
No	4	2.3
Yes	164	95.3
No response	4	2.3
STDs heard about		
HIV/AIDS	163	94.8
Gonorrhoea	146	84.9
Herpes	57	33.1
Syphilis	121	70.3
Source of information		
Radio	142	82.6
TV	156	90.7
Newspapers	113	65.7
Posters	94	54.7
Ever discussed HIV/AIDS with anyone?		
Yes	108	63.5
No	22	12.9
No response	40	23.5
Mode of HIV transmission		
Sexual intercourse	161	93.6
Unsterilised needles	140	81.4
Blood transfusion	142	88.4
Sharing plates	4	2.3
Ever contacted STDs?		
Yes	19	11.2
No	142	83.5
No response	9	4.3
Ever heard of condom?		
Yes	155	91.2
No	1	0.6
No response	14	8.2
Ever demanded the use of condom from your husband?		
Yes	51	30.0
No	92	54.1
No response	27	15.9

Ogunjuyigbe and Adeyemi (2005) have looked at similar studies using women in Ado- Ekiti and Lagos State respectively in western Nigeria. Our findings to a good extent confirm the findings of these similar studies. We found that most Edo women have a considerable level of control over their sexuality in their homes. They have a considerable level of ability to refuse sex from their husbands. This finding appears to be in consonance with Orubuloye et al. (1993) findings on Yoruba women's ability to control their sexuality in sexual relations as well as Ogunjuyigbe and Adeyemi (2005) findings on women in Lagos state. On conditions under which women can refuse sex from their husbands, our findings are similar to those of Ogunjuyigbe and Adeyemi (2005). Conditions of

illness, menstruation, tiredness, when not in the mood were given amongst others as reasons why women can refuse sex from their husbands. However, there were women who said they cannot refuse sex from their husband for fear of been beaten up or been ill treated. This finding corroborates several other findings where violence against women or fear of violence stifles their courage to exercise control over their sexuality in sexual relations with their husbands or partners (Hannan, 2003; UNIFEM, 2001; Heise et al., 1999). The study showed very importantly that women with improved socio-economic status tend to exhibit greater control over their sexuality than their counterpart with lesser status. Women with higher education and income tend to exhibit greater control over their sexuality than women with lesser education and poor income. The level of education and income appears to be the major factors militating against Edo women's ability to exercise control over their sexuality in their sexual relations in the home. This finding is also similar to that of Ogunjuyigbe and Adeyemi (2005). Apart from age and occupational background that were found to also affect women's ability to exercise control over the sexuality, the study showed that women with whom their parents discuss relationships and sexuality issues with in their growing up years reported a greater ability to refuse sex from their husbands than their counterparts that did not have those kinds of discussions with their parents. This finding appears to be unique to this study as there has not been a report of such factor influencing women's ability to reject sex from their husbands in previous studies. We did not find it necessary to categorize the data by local government since ethnicity was not found to be a determinant of women's ability to exercise control over their sexuality.

A great majority of the respondents to this study demonstrated good knowledge of STDs and its mode of transmission. A great majority of them also have heard about condom but not very many fancy using it. This finding is consistent with several other findings that have shown a low prevalence of condom use amongst women (Ezeh and Mboup, 1997; Pattalo et al., 1994). Apart from some of the women who said they did not like to use condom, some have the erroneous belief that it is dangerous while others said that their husband will not agree to use condom with them. This calls for a proper education of both women and men on the use of condom. Finally, the study shows that to empower women, we must look at their economic status. Economic independence was identified by many or the respondents as way they can be given a voice in their homes, particularly with respect to sexuality issues. Education is important if women are to be economically empowered. A well educated woman is likely to be employed in a well paying job and thus be economically empowered. Most men would tend to show respect to their wives if they perceive them as partners with them in the home rather than one who had to share a substantial part of his earning with him. The findings of this study is consistent with several others (Gupta, 2000; Hannan, 2003) that have identified economic empowerment as a major strategy for empowering women to exercise control over their sexuality in sexual relations with their husbands or male partners.

Conclusions

The HIV/AIDS epidemic is becoming increasingly feminized globally. More than four-fifths of new infections in women result from sex with their husbands or primary partners (UNFPA, 2005). In Nigeria, heterosexual plays a major role in HIV infection accounting for about 80% of all infections (Pennington, 2005). Since heterosexual sex is the major way through which HIV/AIDS is contracted, control of women over their sexuality, particularly in the conjugal union, and generally in their sexual relations, will have implications for the control and spread of HIV/AIDS. This study has looked at the control of Nigerian women over their sexuality in an era of HIV/AIDS using Edo women as a case study. Edo women, like their counterpart in Lagos and Ado-Ekiti, tend have a considerable degree of control over their sexuality in sexual relations with their husbands. While most Edo women tend to be able to refuse sex from their husbands, they do so under conditions that appear to be common to all women, such as during menstruation or when ill. The degree to which Edo women can exercise control over their sexuality tend to increase especially with their age, level of education, income and whether their parents had discussed relationships and sexuality issues with them prior to marriage. Also, most Edo women have good knowledge of sexually transmitted diseases (STDs) and the use of condom, but not very many of them use condom. This is particularly disturbing because as Caldwell et al. (1997) observed, Nigerian women's vulnerability to HIV and other sexually transmitted infections can be traced to the behaviour of their male partners. Most Edo women believe that economic empowerment is the solution to the problem of inequality in sexual relations with their husbands. Since 80.0% of HIV/AIDS transmission in Nigeria is through heterosexual sex, women's ability to control this aspect of their lives would have implications for the spread and control of HIV/AIDS.

Economic empowerment is what women need to give them the leverage required to decide what they want to do with their sexuality.

REFERENCES

Baylies C (2000). "Perspective on Gender and AIDS in Africa" in: Baylies, C., Bujara, J. and the Gender and AIDS Group (2000), AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia, London and New York: Routledge.

Bridge (2002). Gender and HIV/AIDS, Overview Report. Sussex: Institute for Development Studies (Prepared by Vicci Tallis).
Caldwell JC, Orubuloye IO, Caldwell P (1997). "Perceived Male Sexual Behaviour in South-West Nigeria." Social Sci. Med., 44(8): 1195-1207.
Dorsett G (2003). "Some Considerations on Sexuality and Gender in the context of AIDS." Reprod. Health Matt., 11(22): 21-29.
Ezeh A, Mboup G (1997). "Estimates and Explanations of Gender Differentiation in contraceptive Prevention Rates." Stud. Fam. Plann. 28(2): 104-121.
Federal Ministry of Health Nigeria (2004). "2003 National HIV Seroprevalence Sentinel Survey: Technical Report." Abuja: Federal Ministry of Health.
Gupta GR (2000). "Gender, Sexuality, and HIV/AIDS: The What, the Why, and the How", Plenary Address, XIIIth International AIDS Conference, Durban, South Africa, July 12, 2000. www.icrw.org.
Gupta GR (2000). "Approaches for Empowering Women in the HIV/AIDS Pandemic: A Gender Perspective." Expert Group Meeting on "The HIV/AIDS and its Gender Implications", November 2000, Windhoek, Namibia, pp. 13-17.
Hannan C (2003). "Workshop on HIV/AIDS and Adult Mortality in Developing Countries, Population Division, Department of Economics and Social Affairs, United Nations Secretariat, New York, pp. 8-13.
Heise L, Ellsberg M, Gottemoeller M (1999). "Ending Violence Against Women; Population Report Series L, Baltimore: Johns Hopkins University School of Public Health, Population Information Program, p. 11.
International Labour Organization (2001). "An ILO Code of Practice on HIV/AIDS and the World of Work." Geneva: International Labour Office.
Ivancevich JM, Glueck WG (1989). Foundations of Personnel/ Human Resource Management, 4th edition, Illinois: Richard D. Irwin Inc.
NIAID (2004). "HIV Infection in Women, National". National Institute of Allergy and Infectious Diseases, National Institute of Health and Human Services, www.niaid.nih.gov/factsheets/womwnhiv.htm.
Ogunjuyigbe PO, Adeyemi EO (2005). "Women's Sexual Control within Conjugal Union: Implications for HIV/AIDS Infection and Control in a Metropolitan City." Demogr. Res., www.demographic – resaerch.org/Volumes/. 12: 2.
Orubuloye IO, Caldwell JC, Caldwell P (1993). "African Women's Control over their Sexuality in an era of AIDS." Soc. Sci. Med., 37: 859-872.
Otive-Igbuzor EJ (2003). 'HIV/AIDS in Nigeria: Rethinking Women's Vulnerabilities Beyond the Biomedical Paradigm. Nig. J. Health Biomed. Sci., 2(1): 1-6.
Otive-Igbuzor EJ (2006). "Sexuality, Violence and HIV/AIDS in Nigeria." http://www.gamji.com/article6000/NEWS6820.htm.
Pattalo AL, Malonza M, Kimani G.G (1994). "Survey of Knowledge Behaviour and Attitudes Relating to HIV Infections and AIDS among Kenyan Secondary School Students." AIDSCARE, 6(2): 173-181.
Pennington J (2005). "HIV and AIDS in Nigeria." www.avert.org.
Population Council (2004). "Child Marriage Briefing Nigeria." September, www.phishare.org.documents/PopCouncil/2478.
United Nations Joint Programme on HIV/AIDS (UNAIDS) (2001). "AIDS Epidemic Update." www.nblca.org/UN_EPIupdate.
United Nations Joint Programme on HIV/AIDS (UNAIDS) (2005). "Basic Facts about the AIDS Epidemic and its Impact. Questions and Answers." UNAIDS, www.unaids.org.
United Nations Population Fund (UNFPA) (2005). "State of World Population: The Promise of Equality: Gender Equity, Reproductive Health and the MDGs. www.unfpa.org.
UN Division for the Advancement of Women (2000). "The HIV/AIDS Pandemic and its Gender Implications. Report of the Expert Group Meeting 13-17 November, 2000, Windshock, Namibia.
United Nations Development Fund for Women (UNIFEM) (2001). "Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic." United Nations Development Fund for Women, New York.
Weiss E, Gupta RG (1998). "Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention, Washington D.C: International Centre for Research on Women.