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Research Paper

Women's Autonomy and Birth Spacing; Implications for Reproductive Health in Zaria Local Government Area of Kaduna State, Nigeria

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This study examined the impact of women's autonomy and birth spacing on reproductive health in Zaria Local Government Area of Kaduna State. The study examined the attitude of women to safer sex having in mind the risk of maternal mortality and morbidity. The data used for the study were collected through an interview schedule in which 250 female respondents were randomly interviewed from Zaria Local Government Area of Kaduna State. Using simple percentage and statistical methods it was observed that traditional method of birth delivery and skipping anti-natal services does no good for pregnant women and also their ability to decide on their own to take their children and themselves to the hospital for medical attention. All this reduce maternal, mortality and morbidity, hence having an influence on reproductive health. It is observed that 73.2% of respondents who are married and that 59.7% of them can take their children for medication on their own without the influence of their husbands. One interesting aspect of the study is the influencing of modernization such as the dissemination of information on the importance of birth-spacing on reproductive health in the radio and television. Despite the campaigns, 57.7% had pregnancy complications. This shows a bad situation that a lot has to be done on policy making to have its impact on the population.

Keywords: Women's autonomy, Maternal mortality, Decision-making, contraceptives, Reproductive health

INTRODUCTION

Most Nigerian societies are patriarchal, and the male or husband is the major decision maker, especially on issues relating to family matter (kritz and Gurak, 1991; Isiugo-Abanihe, 1994; Bankole, 1995; Feyisetan, 2000; Oyediran, 2002). In patriarchal societies normative principles, institutions and beliefs that differ across ethnic groups play prominent role in guiding and shaping family life. Within a patriarchal dominant structure, a woman has virtually no decision-making authority, and also receives the least with respect to resources allocation (Caldwell and Caldwell, 1987; Oyediran, 1998).

However, the Nigerian culture is heterogeneous, yet it is homogeneous in according low status to women and social norms convey little need for marital partners to communicate their desire to each other. As a result, decision-making on family related issues are prone to external influences (relative friends), whereas wives' preferences are probably shaped to a large extent, by familiar norms and pressures. Evidences from, which show that Nigerian couples, tend to come under pressure from husband's mother or other female relatives into starting or increasing their family (Kola and Ayodele, 2011). A lot of factors have come to bear on reproductive decision making in Nigeria. Besides the influence of extended family both men and women subscribe to the prevalence of gender ideology of male authority in matters of family size and composition. Evidence from World Health Organization shows that men's view are more influential than women's views in making family decisions: 88% and 78% of men and women surveyed confirmed this position (WHO, 1995:9).

In this study, the researcher seeks to understand how

birth-spacing as a dependent factor affects reproductive health of a woman. Consequently the level of autonomy in a patriarchal society spells-out the nature and pattern of birth-spacing. As it is acknowledged, that family planning, pre-natal health services and of course birth-spacing can improve the survival and quality of life for the mothers and children in several societies. What are questionable are the specific determining factors of the level of fertility to which any survival strategy is anchored. The level of fertility varies from one society to another not just for differentials associated with biological or social mechanism but also strongly as a result of social pressure affecting individual decision-making in human reproduction. Such decision-making at the family and individual levels influence why pressures may also take the form of prescription on who can have children, time limits of commitment and end of child bearing as well as desirable intervals between children, fertility levels therefore reflect the values of a society (Caldwell and Caldwell,1987). One such value that is of interest to this research is birth-spacing which also has implications on maternal health.

The high level of maternal mortality without any corresponding decrease shows the low value placed on the lives of women, it also serves as an evident to their limited voices in making decisions related to their reproductive health. The study therefore, focuses on the interplay between women's autonomy and birth-spacing as a panacea for mortality reduction in the study area (Zaria). The significance of the study is to be able to identify the major health benefits to both the mother and children associated with longer birth spacing. The risk of neonatal, infant, child, mortality is significantly greater when birth intervals are shorter than 36 months. Birth intervals of three or more years are associated with reduction in neonatal, infant, and child and under five mortality. These longer intervals are associated with improved childhood weight for age (Rutstein, 2000). The prenatal Information System Data Base of the Latin American Center for Human Development, which includes a very large number of women, found very short and very long birth intervals associated with increased risk of adverse maternal outcomes. Women conceiving 6 months after a previous birth or with an estimated birth interval of 14 months had a 2.5 increased risk of maternal death and risk of third trimester bleeding and premature rupture of membranes (compared to women with 2.5 to 3 years between births (Conde-Agudelo and Belizan, 2000). DHS pooled data from 17 countries indicated that the protective effect of breastfeeding is separate from and additive to the protective effect of three years birth intervals. Therefore the program supporting both interventions would have greater impact on reducing the risk of infant death. DHS data confirm that in many countries women desire considerably longer birth intervals than they achieve, reflecting a large unmet need for birth spacing. However, this desire is not necessarily reflected in family planning use. It also indicates that many women are unaware of the risk to state a preference for shorter intervals. The major aim of the study is to highlight the relationship between women's autonomy and birth spacing.

Hypothesis

(i) There is a positive relationship between spousal communication and birth spacing.
(ii) There is a negative relationship between birth spacing and reproductive challenges (ever had complications).

METHODOLOGY

Zaria is located in the northern part of Kaduna state with a latitudinal position of 11 North and 742 East. It is situated in the high plain of Hausa land that extends almost unbroken from Sokoto in the Northwest to Lake Chad in the Northeast. It is at the centre of Northern Nigeria. Zaria is made up of several local government areas, is bounded to the north by Sabon Gari local government area, to the south by Igabi local government area, to the east by Ikara local government area, and to the west by Giwa local government area. Zaria local government area has a population of about 10000018 people (NPC, 2003). It is ethically and religiously complex town with most Nigerian tribe living in it. Majority of the populations are Hausa, Yoruba and Ibo. The Muslims are in the majority with 5 percent Christians and 5 percent indigenous religious believers and Hausa speaking people are in the majority, English as the official language and Arabic as well. Zaria is divided into wards such as Tudun Wada, Gyellesu, Tudun Jukun , Wusasa, Limanci, Bakin Kasuwa, Kusfa, Babban Dodo, Magajiya, Kwarbai, Jushi, Kofar Doka, and Lemu wards to mention but a few. For the purpose of this study, Zaria was divided into local government area into four is along the two major roads that run down from Wusasa down to Dambo, up to soba local government area and the one from Kofar Gayan running down to Sabon Gari local government area. This action helps to balkanize the local government into four major parts, irrespective of wards, the two roads cross each other at Kofar Doka, as a semi urban settlement, apart from the major ethnic group, it consist of all known ethnic groups in the country with diverse socio cultural, economic, and political characteristics. It also house various educational institutions of learning such as the Congo Campus of Ahmadu Bello University Zaria, Federal College of Education, Kaduna, polytechnic, the famous Northern Nigerian printing press, A. B. U. teaching Hospital, Zarinject, Afcot, N. T. A. Zaria etc. This gives the town a high level of heterogeneous population and the existence of many service delivery companies and the concentration

of a large body of tertiary institutions. The uniqueness of this semi urban settlement makes it an appropriate choice for the research. The characteristic of her inhabitants and the long exposure to influence of western education foreign culture and modernization qualifies it a good place where institutional and attitudinal changes may be observed and measured.

Sampling design and selection procedure

Zaria is divided into wards, and each ward is further sub divided into enumeration areas by the National population commission NPC, (1991). The enumeration areas are curved along natural features such as streams and rivers and as well as manmade features such as corner buildings and roads or streets. Five enumeration areas were randomly selected from the list of enumeration areas as obtained from the local office of the national population commission in the local government area. The houses along the street in the enumeration areas selected were randomly selected at the interval of two houses. The National population commission house numbers were used to select the houses randomly and the household in the houses or buildings were interviewed or administered the questionnaire, to the female within the reproductive age of 15 to 45 years in that manner they were interviewed with the sole aim of covering a large number of the respondents. The data used for the study were collected through an interview schedule in which 250 women were selected through systematic random sampling.

Research instrument

The questionnaire for the study is specifically designed and prepared to elicit information relating to the objectives of the study. The questionnaire is divided into three sections, section A, which is made up of socio-demographic characteristics of the respondents, section B, has questions on decision making about reproductive health matters and section C is on birth spacing. The questionnaires were administered by trained and carefully selected research assistants. The questionnaire is processed by employing relevant computer program.

Method of data analysis

Returned questionnaires were subjected to thorough screening, checking for consistency and finally edited. The proceeded nature of the questionnaire facilitated easy entry of the data and statistical analysis. The data collected were subjected to basic demographic analytical analysis, a Pearson correlation co-efficient was used. Correlation analysis measures the degree of relationship between only one independent variable and the dependent variable and gives an indication as to how close they both come into forming a linear relationship. The explanatory variables that are used in the analysis are variables that have been identified as relevant from other studies. These are grouped as socio-demographic variables viz: educational attainment, age, occupation, religious affiliation, and some questions on reproductive decision making. Therefore since the dependent variable is a linear one, the Pearsonian correlation coefficient is used to test the hypothesis in this research. The population assumption identifying simple correlation analysis which state that the relation between the two variables is linear. Both variables are random variables, for each variable the conditional variances given different values of the variable are equal and for each variable the conditional distribution given different values of the other variables are all normal distribution. . Precisely, data from the field is edited and entered into the computer using EPI-INFO version 6.0. Analysis of the quantitative data is done by using SPSSPC + version 10.0.

$$\frac{\sum xy - nyx}{\sqrt{\left(\sum x^2 - nx^2\right)\left(\sum y^2 - ny^2\right)}}$$

RESULTS

The age distribution of the respondents as at the time of the survey is indicated in (Table 1). Age is a vital demographic parameter in describing, the characteristics of the population. A 10 years age grouping is used. The minimum age is 21 years. From (table 1), it is observed that the bulk of the population of the study area is relatively young. Seventy-eight percent of the respondents are in the group 21-49 years. It is of interest to know that the school proportion in this age group 41-50 and 51 and above are almost the male (74% and 3.4%) respectively. Above five categories of marital status were observed from the sample survey. These are married single, divorced, widow and others. It is observed that the overwhelming majority of the sample population (73.2%) is married as at the time of the survey. Singles constitute 15.4%, widows are just 6.0% respectively. This variable is meant to obtain data on the highest level of respondent. It is indicated that more than half of the population are in tertiary institution about 39.6% are in secondary school and 9.4% are in the primary school. That is to say that almost all the respondents claim to have knowledge of how to read and write. This might be due to the number of educational institution that are prevalent and as well the nature of Zaria as a Semi-Urban Local Government Area. A consideration of the economic activity of the respondent is also very important,

Table1. Socio-Demographic characteristics of the respondents.

Parameters	Frequency	Percentage
AGE		
21-30	67	45.0
31-49	50	33.6
41-50	11	7.4
51and above	5	3.4
Don't know	4	2.7
No response	12	8.1
Total	149	100.0
Marital status		
Single	23	15.4
Married	109	73.2
Divorced	9	6.0
Widow/Widower	4	2.7
Others	3	2.0
No response	1	.7
Total	149	100.0
Educational level		
Primary	14	9.4
Secondary	59	39.6
Tertiary	70	47.0
No response	6	4.0
Total	149	100.0
Occupation		
Student	34	22.8
Artisans	21	14.1
Civil servants	36	24.2
Unemployed	2	1.3
Business	30	20.1
Housewife	15	10.1
No response	11	7.4
Total	149	100.0
Ethnicity		
Yoruba	22	14.8
Igbo	16	10.7
Hausa	71	47.7
Fulani	12	8.1
Others	28	18.8
Total	149	100.0
Monthly income Naira		
10,000-20,000	44	29.5
21000-50000	38	25.5
51000-70000	2	1.3
71000 and above	1	.7
Don't know	5	3,4
No response	59	39.6
Total	149	100.0
Religion		
Christianity	56	37.6
Islam	86	57.7
Traditional religion		
No response	6	4.0
Total	149	100.0

Source; Author's field survey, 2011.

in determining sexual behavior/reproductive health. The 24.2% are civil servants; those that are engage in business are 20.1% of the respondents. While 22.8% are students as I have told you that Zaria is an institutional town/area; only 10.1% are house wives; and 1.3% is unemployed. Reported data on characteristics of the

Table 2 Reproductive decision making.

Questions	Frequency	percentage
Reject sex from their husband?		
Yes	103	69.1
No	29	19.5
No response	17	11.4
Total	149	100.0
Why reject sex from their husband?		
During menstruation	80	53.7
Tired/sick	27	18.1
Unhappy	12	8.1
No response	30	20.1
Total	149	100.0
Whether decide for child/children?		
Yes	89	69.7
No	19	12.8
No response	14	27.6
Total	149	100.0
Is birth spacing discussed on radio/TV?		
Yes	131	87.9
No	12	8.1
No response	6	4.0
Total	149	100.0
How often do you listen to birth spacing programme in a week?		
Once in a week	90	60.4
Twice in a week	24	16.1
Thrice in a week	14	9.4
Do not know	21	14.1
Total	149	100.0

Source; Author's Field Survey 2011.

respondents by their ethnic background reveals that the majority of the respondents are Hausa 47.7%. This is because the study area is basically an Hausa society. The Yoruba's are 14.8%, while the Igbos (Iyamirai) 10.7% and the Fulani's are 8.1% respectively. Others are 18.8%.

Income level of respondents is of great populace in this study. It will explain the financial reasons for women control on sexuality and their reproductive rights. The financial commitments of their husbands and the choice of health care services to be sought. The distribution of the respondents by level of income shows that 29.5 earn less than 10,000 which formed the highest proportion. This is closely followed by those earning between 20,000-50,000 which formed about 25.5% of the total respondents. And about 39.6% no response, 3.4% don't know while 7% between 11,000 and above respectively. The distribution of respondents according to their religious affiliation shows that the sample population consist of Muslims, Christian and Traditional religion. 51.7% are Muslims, the Christians are about 37.6% while the Muslims, the Christians are about 37.6% while the traditionalist are about 7% respectively. It is generally believe that reproductive health, fertility decisions-making and attitude differ according to marital status concerned especially on issues such as role sharing and decision-making. This May not likely hold among unmarried, separated or divorce women. For instance, it is a common practice among the Hausa's. For instance, it is a common practice in Hausa land that married women should be submissive to their husbands in fertility related matters and that they secure permission from their husbands before taking decision such as limiting fertility through the use of contraceptives or other means. There is a popular proverbial adage which says "mai- gida" which literally means the owner of the house or head of the wife who is in control of her sexuality and her entire life.

Table2 asked the question whether women can reject sex from their husband. It was revealed that men still have the power to determine when to have sexual intercourse 69.1% said yes they can while 10.5% said no and 11.4% no response. This was also supported by the focused group carried out. Excerpts from the focus group discussion are presented as follows:

A 36 years old married woman discussant expressed her concern on whether man can reject sexual intercourse from her woman have right to reject sex from their husband if the woman did not want to have it. We are not slaves or their rams that they can enter at will.

Table 3. Family planning.

Questions	Frequency	Percentage
Family planning improves woman's health and that of the child?		
Yes	126	84.6
No	1	.7
No response	22	14.8
Total	149	100.0
Have you ever heard of any other way or method that women can use to avoid pregnancy?		
Yes	75	50
No	68	45.6
No response	6	4.0
Total	149	100.0
Do you use any method to delay or avoid pregnancy?		
Yes	73	49.0
No	62	41.6
No response	14	9.4
Total	149	100.0
Do you discuss family planning with husband?		
Yes	130	87.2
No	15	10.1
No response	4	2.7
Total	149	100.0
Have you been using family planning?		
Yes	61	40.9
No	81	54.4
No response	7	4.7
Total	149	100.0
Which method of family planning?		
Contraceptives	47	31.5
Traditional methods	21	14.1
No response	81	44.4
Total	149	100.0

Another woman of about 50 years old believes that it is not the will of God for woman to reject sex or deny her husband sex. Our husbands are the owners of our body. Respondents were asked to indicate whether they had ever had a course to refuse sex with their husbands/partners, three-quarter reported that they had done so on at least one occasion or more. The circumstances reported include when the woman was menstruating 53.7%, tiredness/sick 18.1% unhappy 8.1%, other 6.0% and no responses 14.1%. From the above response none of the women mentioned that she has the right of choice not to have sex without any particular reason.

This position is supported by focus group discussions, for example; A 31 year old woman discussant. "If I reject sex from my husband, he will go and meet my senior. Since I am not the only wife. Even if am sick I will still allow him to have sex with me. It was observed from the focus group discussion that even when woman says no, polygamous married men turn to another wife or wives and those in the monogamous married turn to their girl friends, during the prescribed long period of post-partum sexual abstinence or when the woman is not inclined; This is on whether or not the woman can take the child/children for medical treatment without the consent of the husband. 59.7% agreed that they can take their children for medical treatment without the permission of their husband 12.8% said no while 7.4% said it depends. From (Table 2) we can see that there is an improvement in the level of women's autonomy. This can also attribute to the increase in mass conscioustised and education on the importance of reproductive health. Whether birth-spacing is being discussed in the radio/television and 87.9% said it is being discussed while 8.1% said no; while 4.0 said no response.

About 60.4% of the respondents said that they do listen to the programme once in a week, and 16.1% do listen twice in a week and 9.4% thrice in a week, and about 13.4% no response respectively. The question was asked; if/whether family planning improves the woman's health and that of the child/children in general. The response is those respondents that say yes they are 84.6% while those respondents that said no are just 7% which is an insignificant figure. It is glaring clear that the submission is that family planning improves the reproductive health/decision of the mother and the child. From the sampled respondents 50.3% said that they have heard ways or methods that women can use to avoid

Table 3 Contd.

Do you hear jungles or adverts on about family planning?		
Yes	123	62.6
No	12	8.1
No response	14	9.4
Total	149	100.0
Where do you think family planning should be heard on?		
Radio	73	49.0
Television	39	26.2
Newspaper	10	6.7
No response	27	18.1
Total	149	100.0
Which method of family planning do you use?		
Female sterilization	2	1.3
Pills	12	8.1
IUD	1	.7
Injectables	22	14.8
Implants	5	3.4
Condoms	36	24.2
Diaphram	1	.7
Periodic abstinence	11	7.4
Traditional methods	4	2.7
Non	10	6.7
No response	45	30.2
Total	149	100.0
Can you get yourself a condom?		
Yes	63	42.3
No	71	47.7
Others	15	10.1
Total	149	100.0

Source; Author's Field Survey, 2011.

pregnancy, while 45.6% said no. the percentage of the respondents that claim to have known how is more than that of those that claim to have the knowledge. The no response respondents' percentage is insignificant. This also shows that the level of knowledge is very high.

Table 3 presents data of respondents' level of awareness on family planning. 87.2% of the respondents said that they are aware of family planning, 10.1% claim not to have knowledge of it while 2.7% no response.

This table 3 shows their source of knowledge, 34.2% said they come to know of family planning through hospitals and 44.3% on Radio/Television programmes. And 8.1% claim to have knowledge of family planning in the school, while 8.7% no response. However, the question here is would the level of information, discrimination give them the desired autonomy to take a decision on their sex life? Here the question tries to see if despite the information dissemination rate, whether the respondents are using family planning. 40.9% said that they are using family planning while 54.4% said no. then what could have been the reason for not using family planning method despite the awareness level that is being passed on to them. Could it be because of tradition or their level of economic status? This asked the respondents which of the family planning method you are using, at the time of the interview 31.5% said that they are using contraceptives while 14.1% use the traditional methods. While 12.8% use other methods, 7% said do not know while 40.9% have no response. As we can see above, on one hand there is the need to increase effort on educating the respondents and on the other hand the women respondents really need the services of family planning, hence the adoption of traditional methods of family planning; another reason might be due to economic status. And 82.6% of the respondents say that, they hear jungles about family planning and 8.1% said no. the gap between those that hear and those that do not hear is very wide. Here, we can see that there is enough of enlightenment; on reproductive health services. And about 9.4% said no response which is also an indication that there might be factors such as cultural or tradition that prohibit them from such a discussion. Table 3 also shows that about (39.6%) said that they listen to radio and hear it from that source while about 34.2% hear it from the television always. Only 10.1% do listen twice and 1.3% thrice while you can now see that the once and always, the gap is not that very much which is an indication that there is much publicity about family planning to the populace. The views of the respondents were also sought out about the medium suitable for the

Table 4. Maternal health risk.

Questions	Frequency	Percentage
During pregnancy were you weighed?		
Yes	119	79.9
No	19	12.6
No response	11	7,4
Total	149	100.0
Where you told signs of pregnancy complications?		
Yes	106	71.1
No	25	16.8
No response	18	12.1
Total	149	100.0
Have you ever had pregnancy miscarriage, aborted or ended in stillbirth?		
Yes	86	57.7
No	52	34.9
No response	11	7.4
Total	149	100.0
Was your child ever delivered by caesarean complication?		
Yes	55	36.9
No	80	53.7
No response	14	9.4
Total	149	100.0
Have you ever had any pregnancy complication?		
Yes	79	53.0
No	61	40.9
No response	9	6.0
Total	149	100.0
Have you returned sexual relation since the birth of your child?		
Yes	112	75.2
No	19	12.8
No response	18	12.1
Total	149	100.0

dissemination of family planning programme. Table 3 also shows that not only having the knowledge, that is enough but whether they apply the knowledge practically. So, about 49.0% said that they use a method to delay or avoid pregnancy, while 41.6% of the respondents said they don't use any method. The percentage of those that used a method to stop pregnancy and that of those that don't among the sample respondent is not very wide, so we can see that there is an improvement in the use of the family planning method, which might be as a result of enlightenment campaign or education on the individual levels. However, this does not anymore the level of poverty/development (societal development) but on individual counts it adds quality to their life. Table 3 goes further to ask the question which type of family planning method they use. The table shows that 24.2% use condom and 14.8% use injectables. The use of condoms might be due to easy accessibility, cost less without much protocols while injectables which has less in percentage, compared to the use of condoms might be due to the belief or notion they have on injectables, such as, it might destroy their womb 26.2% is higher than those that are using condom and injectables, respectively, and it's that of the no response respondents. This attitude of no response might be due to the traditional and religious attitude.

About (42.3%) said they can go and get a condom for themselves while 47.7% said that they cannot. This attitude or behavior might be as a result of western education and urbanization. 79.9% of the respondents said that they were weighed and 12.8% said that they have been weighted while 7.4% no response. This shows that a large number of the respondents attend clinical or maternity clinic/hospitals for medical check-up; this is to ensure safe delivery and no or low rate of pregnancy complications. Secondly, 71.1% of the respondents claim that they are told signs of pregnancy while 16.8% of the respondents said they are not told the signs of pregnancy complication. There is a wide gap between those respondents that claim that they were told the signs of pregnancy complication from those that claim that they are not told. This shows that the society would have a better maternal population.

The study was able to deduced that (57.7%) of the respondents said that they have had pregnancy complication such as still birth abortion or miscarriage; while 34.9% said no. The number of pregnancy complication is very high.

Table 4. Maternal health contd.

For how many months after the birth of your last child did you abstain or not have sexual relations?		
1 – 5	86	57.7
6 – 10	4	2,7
11 – 12	1	.7
No response	58	38.9
Total	149	100.0
Did you get money for treatment always for you and your child/children?		
Yes	72	48.3
No	39	26.2
No response	38	25.5
Total	149	100.0

Source; Author's Field Survey, 2011.

The study shows that about (39.9%) of the respondents said that they have at one time or the other delivered their baby by caesarian complication while no response is about 7.4% which is very much insignificant. 53.0% of the sampled respondents said that they have had pregnancy complications while 40.9% said no and no response the figure is 6.0%.

75.2% of the respondents said they have resume/returned sexual relation since the birth of their child; while 12.8% said no. This is an indication that the sample population is very much sexually active. Only 12.1% said no response.

Data from the study shows that (57.7%) of the samples population said that they abstain from sexual activity only between 1-5 months, while only 2.7% abstained for between 6-10 months. But about 20.8% of the sampled population did not respond to the question while 18.1% said that they do not know and only 7% could stay for about 11-12 months without having sexual intercourse. 48.3% of the sampled respondents said that they get money for treatment always for herself and her children; while 26.2% said no, no response is 25.5%. No response and no are very close which is an indication that the society is a very conservative society (Table 4).

DISCUSSION

The results of the study show that there is significant relationship between spousal communication and birth spacing. The survey tells us that 87.2% from the studied respondents acknowledge discussing family planning with their husbands and that about 40.9% also claim they use family planning. This implied that there is good communication among couples that practice family planning and the likely practice of birth spacing. This study has shown that 87.9% of the respondents listen to birth spacing programme from radio and television. The hypothesis was subsequently tested using Pearson correlation coefficient model. From the study, it is observed that there is a change in women sexual control. Six of the respondents have had course to reject sexual intercourse from their husbands. Although, it was observed that 50% of those who have rejected sex do so during certain period in time, especially during menstruation breast feeding, pregnancy and during forbidden time. Only forty percent do it with the intention of protecting their body against unwanted pregnancy, sexual transmitted diseases, and with the sole aim of spacing birth; or birth intervals. Socio-economic characteristics of the respondents influence their reproductive rights (autonomy) such as sexual control and desired family size (reproductive decision making) from the survey it was discovered that women with higher education are likely to exercise their reproductive rights than their counterparts with lower or without education, at all. Income and occupation are important variables that can influence women's reproductive decision making. It was found from the study that those with higher income are likely to exercise their reproductive right within the marriage union than those who are full time housewives and with low income. This is also containing in one of the hypothesis that the socio-economic status of women may likely influence their sexual control (autonomy).

Reproductive decision making such as rejection of sex from their husbands and desired family size 69.3% said that they can reject sex and that also in terms of freedom of movement to attend to some medical treatment, 59.3% said that they can attend to medical or sought for medical treatment without the consent of their husband; this is a serious departure from the earlier policy of men's permission. This shows that women can take decision on their own. Despite spousal communication in which about 87.2% respondents claim to be doing, the knowledge of family planning also, which the women claim they are aware of. 82.6% is from jungles and adverts. The usage, is about 31.3% of contraceptives; the use of modern methods and about 14.0% use traditional methods, this shows that there exist a pre-modern methods and that some form of birth spacing use to take place. The women have the knowledge that family planning improves their health and that of their children

84.0% believes that it improves their health among the respondents sampled. But in terms of if the women can go and get for them contraceptives, 48.0% which is the highest percentage among the respondent's shows that women despite the knowledge they have, they can't go to get contraceptive for themselves, then there must be something amidst. This might be due to religious facts and other traditional practices. Another point from the data collected shows that the degree of autonomy is very high, this is indicated by their ability to go to the hospital and to get health care services without obtaining permission from their husbands. 48.7% collect or receive money from their husbands for medical treatment.

Conclusion

In Hausa society women are not seen to have no any influence on their husband, but in the area of reproduction/women's health in particular, men always give way to the women. The cultural factor that women cannot reject sex from their husbands and as well as spousal communication on their sexuality, is now gradually being eroded (being a thing of the past) by modernity and the influence of urbanization. The economic power of women in the urban area will determine the existence of women's reproductive rights within the conjugal union, in some quarters.

Recommendations

Empowerment of women is not simply an end-in-itself, but also a step towards eradicating poverty and stabilizing population growth. Reproductive health and rights is cornerstone of women's empowerment. Therefore, the following recommendations are put forward.

(i) Adequate knowledge of reproductive rights should be encouraged /given to the women.
(ii) Spousal communication should be encouraged among married people by government and non-governmental organizations to talk about their sexuality.
(iii) To increase the economic status of women by provision of loans, scholarship at all levels of education.

Author`s declaration

I declare that this study is an original research that was carried out by me and I agree to publish it in the journal.

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