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Cultural and Religious Barriers to Women Accessing Healthcare in Jere, Borno State, Nigeria

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Abstract:
This research reports the results of a systematic sociological study of the cultural and religious barriers that hinder women's' accessibility to healthcare in Jere Local Government Area of Borno State, Nigeria, conducted in 2007. The women are mostly housewives, with minimal education and consequently low social status as such their inaccessibility to appropriate healthcare. Data gathering was via field survey, questionnaire administration and in-depth interviews. The quantitative and qualitative data were analysed by descriptive and inferential statistics of frequencies, tables, percentages, cross-tabulation and Chi-square using the Statistical Package for Social Sciences (SPSS) to establish the cultural and religious factors that influence women's access to healthcare in Jere and to test the relationship between variables. The findings indicate that, restriction of movement, male dominance and women's social status hinder access to healthcare. The Chi-square analysis shows that restriction of women has significant relationship with healthcare (P <0.05). The study recommends that women as a matter of necessity should be allowed to have a say in the affairs of the family especially as it relates to healthcare, have access to female doctors, and benefit from social health security in their own rights as individuals.

***Key words**: Women, healthcare, status, cultural, barriers, Jere, access, religious, Chi-square*

1. Introduction

Religious and cultural practices, such as purdah and polygyny, developed in patriarchal ways in most Islamic societies as argued by El Saadawi (1980) all make for gender inequality in favour of men. In Nigeria, the above factors and even more contribute to inequality in access to health services with its attendant problems of high morbidity and mortality. Moreover, tackling social inequalities and inequities in health has been identified as a major challenge in reforming the health system both in developed and developing countries. Problems related to inequalities are of particular importance in countries undergoing social, economic and political transition as is the case with Nigeria.

For a fuller understanding of the factors leading to inequalities in health, it is necessary to consider the cultural context of the country, in relation to health status of women; this has been lacking. Health inequalities become "unfair" when poor health is itself the consequence of an unjust distribution of the underlying social determinants of health. Women's economic situation, for example, a prerequisite for health, is generally less favourable than that of men in Nigeria.

Total health, having the highest possible standard of health and wellbeing, is as important and necessary for women as to any other segment of the population.

Religion is seen by feminists as a product of patriarchy as it serves basically the interest of men. Giddens (1997) in line with this argued that the Christian religion is a resolutely male affair in its symbolism as well as a hierarchy. Also, as argued by El Saadawi (1980) in the Hidden Face of Eve, religion plays an important role in creating and perpetuating oppression. She states the case of Arab girls who are often victims of sexual aggression by men, adding that just as religion has become patriarchal through the misinterpretation of religious beliefs by men, Islamic societies too have developed in patriarchal ways through the dominance of a male minority who owned herds of horses, camels and sheep. As a consequence, authority in Islam belongs to the man as the head of the family, to the supreme ruler or the Khalifa (political leader) or Imam (religious leader). El Saadawi noted that all the above are men and they distort the rules/laws in ways that are favourable to them. For instance although the Quran stipulates that both men and women could be stoned to death for adultery, this fate is very unlikely to befall men because they are permitted several wives (but women are not permitted several husbands) and men could divorce their wives instantaneously thus little need arrives for adultery. But most importantly, this puts women's health at risk. As argued by Miller and Rockwell (1988) polygyny gives men the licence to commit adultery while forbidding women from doing same.

According to Ajuwon and Shokunbi, (1996), under the Nigerian customary law, men are granted divorce if it is proven that their wives have had extra marital relationships. But women, especially those that are married under customary and Islamic laws in Nigeria, do not have the same opportunity (Ekundare, 1969). This is because these laws permit polygyny (Ajuwon and Shokunbi,

1996) and for Islamic law also divorce, (El Saadawi, 1980). This practice creates serious health risk for women who according to Miller and Rockwell (1988) easily contact STDS and HIV/AIDS from their unfaithful and multi-partner husbands.

Despite the above scenario, a woman who just contacted STD from an unfaithful husband cannot seek medical care without the permission of same, this is due to the low status and limited education of women that hinder them from taking part in decision making within the home even in matters affecting their health (Odebiyi, 1977). In fact husbands often times refuse to grant their wives such permission. It is of great importance too to note that a lot of women who are in polygynous marriages also lose out in accessing health facilities where health insurance is granted through the husband who has more than a wife but can only insure one. A good example is seen in the case of the National Health Insurance Scheme in Nigeria where allowance is made for husbands with more than a wife to pay a token so that such wives could be insured but such husbands most often do not pay. Also, at the instance of a divorce, a woman who had health insurance previously through her husband losses out totally from accessing the scheme.

Religious beliefs are known to influence access to health. Purdah, that is the seclusion of married women (Barkow, 1972; Smith, 1954; Schildkrout, 1978), is based on the premise that men provide for the material needs of women and children. Islamic ideology thus is seen to give religious sanction to the depended status of women and children while enhancing the political and social status attached to the economic roles of men. By defining dependency relationships in terms of kinship, this ideology enhances the importance of family and marriage but at the same time, religion has thus played a part in curtailing the economic roles of women in many parts of the Islamic world.

It has been observed that purdah makes it difficult for women to visit hospitals when they are sick and as argued by Ajuwon and Shokunbi (1996), purdah prevents women from enjoying medical facilities provided by the government for the generality of the people. It has been argued that purdah subjects women to the will of their husbands even in their health seeking behaviour as they must take permission from their husbands before they attend health centres. Oppressive religions are seen to draw inspiration and guidance from the values of patriarchy and class and female oppression can be seen as not being essentially due to religion but due to a patriarchal system that has long been dominant. Religion though has played its part as it has not failed to add a new load to the already heavy chains of women.

Women's status on the other hand is a composite indicator of the educational, cultural, economic, legal, and political position of women in a given society. While women's status generally underlies and shapes women's access to healthcare, there are specific ways in which it directly affects and delays decisions to seek care and thus access.

If poverty has a direct, dramatic, and measurable impact on women's health, the status of women is one factor that impacts more powerfully and pervasively on women's access to health. Though operating somewhat more subtly, its consequences are not so readily measured or acknowledged.

Status implies some judgements about relative value, worth or competence. It leads to conclusions about the right to participate on an equal basis, the right to share in decision-making, the right to do or not do the things that others do. Such judgments and conclusions have so intertwined with the determinants of woman's health and the struggle for an equitable development. As part of the status traditionally assigned to them, women, are expected to play certain roles, in most societies women are expected to juggle several roles at once, in reality women are the transmitters of cultural and religious traditions, although seldom are they the authority or official spokesmen in this realm.

For many women accessing the formal healthcare sector is impossible or extremely difficult because local social norms restrict women's mobility. Cultural factors often play a dominant role in healthcare seeking, be it place of delivery or otherwise (Kempe and Stougard, 1984).

The physical restrictions on women's movements, combined with limited access to financial resources within the house hold, severely constrain women's ability to seek healthcare for themselves and their children. Social mores regarding the seclusion of women in Northern India and of course in other societies result in a reluctance to have women or girls examined by an outsider such as a doctor particularly if such is a male (Jeffery, Jeffery and Lyon, 1989; Kempe and Stougard, 1984; Feldmeier et al, 1993). Furthermore, women's mobility is limited in certain areas as they need permission to travel. Often this permission must be granted by the spouse or the mother-in-law. In Ethiopia women tend to use those primary healthcare facilities within walking distance from their homes because of cultural restrictions placed on their travel outside the community (Kloos, et al, 1987). However for a woman with obstetric complications, access limited to nearby primary care centres is not of much help since these facilities are not equipped to deal with obstetric complications.

According to Dia, et al, (1989) in six Senegalese regions, only two per cent of the women interviewed in their study could themselves make the decision to seek medical care in the event of obstetric complications while for most women the decision would be made by the husband or another family member (96%). In some Asian countries, there are indications that it is the family, not the pregnant woman that makes decisions regarding appropriate behaviour during pregnancy and delivery.

In Benin, for instance the authorities exerted considerable pressure on women in their effort to persuade them to have institutional deliveries, yet women continued to insist on home delivery which provided them with an opportunity to demonstrate courage and bring honour to the family by their stoical demeanour during labour and childbirth (Sargent, 1985).

Women's access to health services is limited by constraints on their autonomy. Studies have shown that the decision to seek care in Nigeria, Tunisia, India, Ethiopia, and other countries belongs to a spouse or to senior members of the family thus women do not decide on their own to seek care (Kloos, et al, 1987; Dia, et al, 1989).

Vlassoff, (1994) writing on women's lower status in the family stated that where decisions regarding mobility and expenditures for health care are in the hands of men, it is not easy for women to access healthcare. Women are widely treated in an inferior way by healthcare providers making them reluctant to seek care. The status of girls and women in a given society and how they are

treated is a crucial determinant of their reproductive health. These inequalities therefore affect women's timely use of health services.

Kumar Dey, (1998) argued that greater emphasis be given to improve the status of women in the society in order to increase their capacity to control their lives, including their sexual and reproductive health.

As written by Diallo, (1985) of African women; they ought to be given pride of place for their reproductive, life-giving roles as well as for their productive roles (as farmer, health carers, housekeepers, educators as well as paid workers). However, women have only been revered and given nominal status in most societies for their reproductive functions to the neglect of their productive roles. But one would think that with the importance of both roles to society women should at least have at their disposal the resources, social support and decision making power needed to do both jobs well.

Diallo, (1985) presents a scenario where spiritually the African woman is a superior being mediating between God and men but in practice she uncomplainingly bears the weight of traditions which makes of her a sacrificial victim. Also, though many songs and sayings portray the woman as the one that gives birth to prophets, servants, great warriors and rich men, she herself may never be a prophet, a servant, a great warrior or a rich person. In these societies Diallo, (1985) argued, a woman can never act or state her opinions freely and the work she does, although a tremendous burden is never paid for. She is guaranteed no property rights whatsoever, neither in her home nor in the community, neither by law nor custom. Her social status is always inferior to the man's - girls are brought up strictly to play their allocated role in life - that of wife and mother.

In societies where large families are the norm, women gain higher status by having many children as they derive pride and prestige from their roles as mothers (Van de Walle and Quaidou, 1985); not forgetting too that repeated pregnancies and the responsibility of caring for large families especially in rural and impoverished households can put serious strains on mothers' health. The position of the Northern India women as indicated by the World Bank, (1990) is particularly poor as they lack the autonomy or capacity to make decisions both inside and outside their household concerning their own physical movements, ability to acquire, retain and dispose of earnings and property, to have some say in choosing a husband or using contraception. The unfavourable status of women in India affects the health status of women and their female children both directly and indirectly. The effects include a strong preference for sons, arranged marriages for very young girls, inequitable allocation of resources such as food, health care, education and income and discrimination against widows. Female infanticide and sex-selective abortion are the most extreme reflections of the low status of women and girls in Indian society (George, Abel and Miller, 1992).

In parts of Sierra Leone, the Bundo women's secret society exerts its influence on birth practices. Kargbo, (1984) reports that one of the main reasons women prefer to deliver at home is because the influential Bundo society favours deliveries that are accompanied by expetiatory ceremonies. In such situations, a woman's efforts to gain esteem and enhance her status have direct implications for the recognition of complications and delays in the decision to access care if they develop.

2. Methodology

This section deals with the study setting, the methods used in collecting and analysing data, as well as the logic for using these methods.

3. Study Setting

The study was conducted in Jere Local Government Area of Borno State, Nigeria. Jere is one out of the twenty seven (27) Local Government Area Councils of Borno State. (Federal Republic of Nigeria Official Gazette, 2007).

The creation of Jere Local Government Area, created out of Maiduguri Metropolitan Council in 1996, which consists of fourteen (14) wards, a total Population of 211204 out of which 102598 are women, bore out of the desire by the Federal Government to ensure an even spread of development oriented programmes throughout the federation. (Jere Local Government Council Dairy, 2006)

Covering a land mass of about 160 square kilometres, Jere is largely rural; this explains the prevalence of primary activities like cattle rearing, nomadic farming, fishing, and crop farming that includes such crops as millet, guinea corn, beans, onion, okra, as well as irrigation farming. Prominent ethnic groups here are Shuwa, Kanuri and sprinkles of Hausa and Fulani and other migrant ethnic peoples.

Despite the situation of the University of Maiduguri in Jere, an average Jere woman is illiterate and for economic activities engages in farming, cattle rearing, trading (in rice, cattle, sheep, camels and their bye products) and as well as plaits, sews and does Henna/Lele body decoration; all on petty basis.

A lot of religious and cultural festivals are celebrated in Jere. Predominant among them are the Sallah festivals (Eid-el-Kabir, Eid-el-Maulud, Eid-el-Fitr), turbanning/chieftaincy title taking ceremonies. These attract people from far and near as they converge to see the Durbar (horse riding) that usually goes along with the celebrations. Circumcision festivals, marriage and naming ceremonies and graduation from Quranic recitation schools are other ceremonies that are well celebrated. There is female Genital mutilation among the Shuwa Arabs of Jere, this is done between the ages of 3-6 years and is said to reduce sexual stimulation thus restricting girls from engaging in premarital sexual liaisons and also helps to keep them faithful to their husbands during marriage.

The marriage pattern among the Shuwa, Kanuri and Hausa/Fulani who are predominantly Muslims follows the Islamic tenet where a man is allowed to take up to four wives if he can indeed carter for them. However polygyny as argued by Miller and Rockwell (1988) exposes women to health risks. Also marriage age according to this researcher's informants is between the ages of 13 to l5 years for girls and from l8years for boys. This relatively young marriage age may as well have negative health implications for women. Drinking of Quranic slate writing is a cultural practice among Jere people of Islamic inclination. The drinking of the charcoal based ink used to inscribe relevant verses of the Quran is said to enhance pregnancy and it also helps in safe delivery.

Almost all the wards have one form of health facility or the other that provide services ranging from immunization, maternity to more complex health problems that are mostly handled by the University of Maiduguri Teaching Hospital (UMTH) located in Mairi ward.

4. Research Design

The study adopted the survey design. Both descriptive and analytical approaches were considered in the choice of the methods of collecting and analysing data; the qualitative and quantitative instruments were used in collecting data.

5. Study Population

The study population for the survey research consisted of middle aged women (age range 40-65), domiciled in Jere Local Government Area of Borno State. Women of different economic, educational, religious and marital status where involved in the study to bring to bear the fact that, though cultural and religious factors affect women's access to healthcare, they do so differently.

6. Sample and Sampling Techniques

The sample size for the study consisted of 360 women. To make for good representation of Jere Local Government Area, the multistage sampling technique was used in selecting respondents. First, the about hundred villages that make up the fourteen wards of Jere were clustered into twenty blocks of each five naturally occurring villages. Second, communities for the study were selected through balloting where one community was selected from each of the twenty blocks or zones. The third stage saw the random selection of ten villages from the selected communities.

Then systematic random technique was used in selecting households that were finally chosen for the study. From the selected households in each village 36 women aged 40-65 and above were randomly selected for the administration of the questionnaire.

The qualitative aspect of the study consisted of fifteen interviews; this incorporated the varying categories of women and by implication afforded the flexibility denied by the structured questionnaire.

7. Research Instruments

The study employed the use of both qualitative and quantitative methods of data collection. This involved the use of questionnaire and in-depth interview. These provided holistic, rich and complimentary data and insight on cultural and religious barriers as they bother on women's access to healthcare in the area of study.

8. Administration

The questionnaires were administered by the researcher with the aid of research assistants trained for the purpose of the study.

9. Methods of Data Analysis

Use was made of the Statistical Package for Social Sciences (SPSS) for the statistical analysis of data collected through questionnaires. Even though 360 questionnaires were administered 10 of them were invalidated for reasons of illegibility and incompleteness. Descriptive statistics of frequency tables and percentages were used to describe the responses on each of the variables in order to prepare the data for higher order analysis.

The inferential statistics of cross-tabulation and Chi-square were used for the bivariate analysis where relationships between variables were tested.

Information from the in-depth interviews were transcribed into written words and analysed using ethnographic summaries and content analysis whereby the central points made by interviewees are quoted and the points arising thereof discussed.

10. Ethical Consideration

The Principles of ethics involved in human research were strictly adhered to. Due to the nature of the study, which deals with the cultural and religious practices of the respondents involved it became apparently important to adhere to ethical standards. The researcher sought and obtained the approval of the religious leaders, village heads otherwise known as Lawan or BuIama, before data collection for the study began. The consent of the respondents were also sought and obtained.

11. Data Presentation and Discussion

Characteristics	Category	Frequency	Percentage
Age	40-44	160	45.7
	45-49	78	22.3
	50-54	84	24.0
	55-59	20	5.7
	60-above	8	2.3
	Total	**350**	**100.0**

	Category	Frequency	Percentage
Religious Affiliation	Christianity	47	13.4
	Islam	300	85.7
	Traditional Afr. Rel.	3	0.9
	Total	**350**	**100.0**
Ethnic Group	Shuwa	157	44.8
	Kanuri	85	24.3
	Hausa	66	18.9
	Others	42	12.0
	Total	**350**	**100.0**
Marital Status	Married	307	87.7
	Divorced	7	2.0
	Widowed	10	2.9
	Separated	26	7.4
	Total	**350**	**100.0**
Married Type	Monogamy	58	16.6
	Polygyny	252	72.0
	Non-Response	40	11.4
	Total	**350**	**100.0**
Form of Education	Formal	107	30.6
	Quranic	170	48.5
	Formal and Quranic	73	20.9
	Total	**350**	**100.0**
Level of Education	Basic Quranic	161	46
	Primary	71	20.3
	Secondary	96	27.4
	Tertiary	20	5.7
	Non-Response	2	0.6
	Total	**350**	**100.0**
Occupation	Farmer	42	12.0
	Trader	69	19.7
	Civil Servant	34	9.7
	House Wife	205	58.6
	Total	**350**	**100.0**

Table 1: Respondents' Biodata
Source: Field Survey 2007

Table 1 presents the age groupings, religious affiliations, educational backgrounds, marital status and the various divisions of labour the respondents are engaged in. These categories help the researcher to understand the type of responses elicited by the questions set for them to react to.

Factors	Agree		Disagree		Don't Know	
	Frequency	%	Frequency	%	Frequency	%
Cultural Practices	82	23.4	203	58.0	65	18.6
Restriction of movement	204	58.3	127	36.3	19	5.4
Male Dominance	190	54.3	104	29.7	56	16.0
Women's Social Status	167	47.1	22	6.3	161	46.0
Religious Practices	101	28.9	191	54.6	58	16.6

Table 2: Distribution Of Respondents According To The Barriers That Hinder Women's Access To Healthcare
Source: Field Survey 2007

In table 2 above, respondents were asked to indicate some of the barriers to women's access to healthcare in Jere. The data above shows that a good number of factors stand as barriers to women's access to healthcare, however restriction of movement proved the most dominant barrier as 58.3% of respondents answered in the affirmative followed closely by male dominance at 54.3% and women's social status at 47.1%. Interestingly, cultural and religious practices rank lowest at 23.45 and 28.9% respectively.
This is supported by the report of an interviewee, age category 55-59 thus:
''There are no cultural and religious practices that stop women from going to hospital in our community. In fact we have traditional ways of treating ailments, so is it possible to have such on ground and yet prevent people from utilising them?''

The above however, contradicts earlier works by Barkow (1972), Schildkrout (1978) and Kempe and Stougard (1984), who variously reported that cultural and religious factors often play dominant roles or rather influence access to healthcare be it place of delivery or otherwise. Interestingly too, literature shows that male dominance is rooted in the people's traditions and aggravated by the tenets of Christian and Islamic religions in Sub-Saharan Africa, and men being regarded as undisputed heads of households (Adewuyi, 1999). The inconsistency in the data is therefore, a pointer to the fact that the respondents might just have been proving protective of their various cultures and religions.

This shows that when the terms religion and culture were introduced as factors that affect women's access to healthcare, respondents' perception drastically changed as they tended to be protective of their religious and cultural beliefs.

To further make this evidently clear, an interviewee, age category 40-44 maintained that:

"Since it is men that marry women and not the other way round the wives are supposed to respect the opinion of their husbands. So their decisions determine what a woman will do both in the kitchen and at work. As such if your husband says you must not visit a physician for instance you must not go, after all, all religions and cultures assert that the man is the head of the family."

Indicatively, if the decision of the males in the home is more influential and is reinforced by religion and culture, it means that women's access to healthcare will be inhibited as husbands' restrictions of their wives' movement to healthcare facilities as well will be seen as a norm which the women have to adhere to.

In that light, respondents were asked to indicate who takes decisions concerning women's access to healthcare facilities and the data is presented on table 3 below:

Decisions	Husband	Self	Family
Final say on whether to consult a health practitioner/facility	279 (79.7%)	68 (19.4%)	3 (0.9%)
Final say on when to visit the health practitioner/facility	234 (66.9%)	112 (32.0%)	4 (1.1%)

Table 3: Distribution of Respondents According to who Decides on Issues Concerning Women's Access to Healthcare
Source: Field Survey 2007

In most parts of Nigeria, men constitute the dominant decision makers both in the private and public spheres and at that, even in matters that bother on the health of women. The data on table 3 indicates that husbands have the final say on whether their wives will consult health practitioners.

On when to visit the health practitioner/facility, husbands have 66.9%, wives represented by self 32.0% and family 1.1% decision making powers. In other words if the husband decides against the wife's visit to the practitioner, whether the facilities are available and the woman is aware access will still be poor. Indicatively too the women can only go to a facility at the time approved by her spouse. This is reported by Vlassoff (1994) as used in the literature as having consequences on accessibility.

The data above disputes Orubuloye and Caldwell (1975) who reported the emergence of significant changes in conjugal power relations, giving the impression therefore, that women's decision-making power is improving tremendously. The difference in the decision-making powers in their study may however be due to the aggressive activities of non-governmental organizations and increased women participation in education in Ado-Ekiti unlike in Jere where all these are still at the rudimentary level.

	Yes		No	
	Frequency	**%**	**Frequency**	**%**
Need to obtain permission before visiting health practitioner	305	87.1	45	12.9
Is permission always granted	58	166	248	70.9

Table 4: Distribution of Respondents on Permission Seeking from Husbands before Consultation
Source: Field Survey 2007

Table 4 shows the distribution of respondents by permission seeking from husbands before consultation. Here respondents were asked to indicate if they needed to obtain permission from their husbands before consulting health practitioners and if such permission was always granted. 87.1% of the respondents reported that they must obtain permission from their husbands before visiting a health practitioner. Asked if the permission was always granted, 70.9% of the respondents reported that permission was not always granted, with only 16.6% indicating that the permission was always given.

This implies therefore that, even though about 91.15 of the total respondents reported the awareness of healthcare facilities in their localities, access may be poor. Since in most parts of Nigeria and the northern parts particularly, a woman needs her husband's permission to actually access the available medical care even if she just contracted an STD from the unfaithful husband (Odebiyi 1977).

12. Test of Hypothesis

To establish the relationship between restriction of movement and access to healthcare, the below was hypothesized: Restriction of movement has no significant relationship to women's access to healthcare. The results thereof are presented thus:

		Access to Healthcare		
		Yes	**No**	
Movement	**Restricted**	72	132	204
	Not Restricted	57	70	127
	Undecided	17	12	19
	Total	**136**	**214**	**350**

Table 5: Distribution of Respondents by Restriction of Movement and Access to Healthcare
X^2= 3.063; df = 2; P <0.05. Source: Field Survey 2007

The Chi-square analysis on table 5 above indicates a significant relationship between restriction of women's movement and their access to healthcare ($p < 0.05$), that means that when women's movement is restricted, access to healthcare will be affected. This is indicated by a good number of the respondents who reported that their movements were restricted consequently upon which they do not have access to healthcare services even when in need. Interestingly too, a whopping sum of 70 respondents from the 127 who claimed that their movement was not restricted also reported not having access to health. The reason for this however may be a concern for further research. Based on the result therefore, the null hypothesis stated above was rejected since the results indicate a relationship between restriction of movement and access to healthcare.

13. Conclusion

Accessibility to healthcare services and facilities is the right of all humans but most importantly that of women since the continuity of any society, transformation of its culture and socialization of its young ones is dependent on the well-being and survival of women. So for women to survive and be healthy too, issues concerning their welfare ought to be taken seriously.

An understanding of the social, cultural, religious as well as educational barriers confronting women which prevents them accessing available healthcare services is highly needed and attempts towards eradication of these barriers is called for. Also evaluation for women's level of mobility and independence in deciding on their personal concerns is important as there is marked difference between women and men with respect to health issues. Lastly, it is necessary to mainstream a gender perspective in health studies and policies in such a way that the picture of women's health and healthcare position is made clearer.

14. Recommendations

Women as a matter of necessity should be allowed to have a say in the affairs of the family especially as it relates to health. Women should be key deciders in when they should consult healthcare services as their needs are not exactly the same as men's. The husband's decisions as to who the wife will consult may be detrimental as it hinders access.

Awareness campaign programmes such as visitation to groups and homes, market and social clubs sensitizing and updating people on health issues and the need for hospital visitation should be carried out so as to keep the people informed and so make for attitudinal change.

Health personnel and hospital management should seek innovative ways of promoting the coverage of healthcare. Adjustment in the timing of healthcare centres in Jere could make the services more easily accessible to women. Providing services in line with markets, mosques and church services as well as other community activities will go a long way. Special arrangements could be made for women who are not able to utilise normal services, this will serve especially for Muslim women in purdah who may not be able to go out in the daytime but may do so at night. Also, female doctors can be serviceable to women not allowed to consult male doctors so as to ease the need for access.

The law makers should promulgate laws that will ensure the importance of persons' access to social security (health insurance) benefits in their own rights as individual and not necessarily relying on husbands. This will make for a system in which people are treated equally. Moreover, in Jere where a man is entitled to four wives, each wife would by virtue of being a Nigerian citizen have health insurance, so the issue of which wife to enrol on the National Health Insurance Scheme will not hinder access in any way. Interesting too, in the case of divorce, break up or death, the wife will still have health insurance, thus aiding her accessibility to healthcare.

15. References

1. Adewuyi, A. (1999). Power and Privilege: The Male Issues in Fertility Transition in Nigeria, Sub-Saharan Africa. Proceedings of the Conference on African Population in the 21st Century. Volume 2, Durban, Union of African Population Studies.
2. Ajuwon, J.A. and Shokunbi, W. (1996). Women and the Risk of HIV Infection in Nigeria: Implications for Prevention and Control Programmes. In Oke, EA. and Owumi, B.E. (Eds.). (1996). Readings in Medical Sociology. Ibadan: RDMS. 85-103.
3. Barkow, J.H. (1972). Hausa Women and Islam. Canadian Journal of African Studies. 6(2): 317-328
4. Dia, A., et al. (1989). Maternal Mortality in Senegal: Contributing Factors in the Health System and the Community. Draft Report

5. Diallo, B. (1985). The Dream of Domination. World Health. April 1985. 26.
6. Ekundare, R.O. (1969). Marriage and Divorce under Yoruba Customary Law. Ife: University of Ife Press.
7. El Saadawi, N. (1980). The Hidden Face of Eve: Women in the Arab World. London: Zed Books
8. Federal Republic of Nigeria. (2007). Official Gazette. No. 24, Vol. 94, Lagos. 15th May, 2007. Lagos: The Federal Government Printer. B 175, B182, Bl83.
9. Feldmeier, H., et al. (1993). A Synoptic Inventory of Needs for Research on Women and Tropical Parasitic Diseases. Amsterdam: Acta Tropica. 55, No. 3. (Nov.) 139-169.
10. George, S., Abel, R. and D. Miles. (1992). Female Infanticide in Rural South India. Economic and Political Weekly. 27 (May 30): 429-431.
11. Giddens, A. (1997). Sociology. Third edition. Oxford: Polity Press.
12. Jeffery, P., Jeffery, R. and Lyon, A. (1989). Labour pains and labour power: women and childbearing in India. London: Zed Books.
13. Jere Local Government Council Dairy. (2006). Jere, Borno State.
14. Kargbo, T.K. (1984). Certain Practices Related to Delivery. Thaddeus, S. and D. Maine. (Eds.). (1990). Too Far To Walk: Maternal Mortality in Context. New York: Columbia University.
15. Kempe, A. and Stougard, F. (1984). The Quality of Maternal and Neonatal Health Services in Yemen: Seen through Women's Eyes. Stockholm: Rodda Barnen
16. Kloos, H., et al. (1987). Illness and Health Behaviour in Addis Ababa and Rural Central Ethiopia. Oxford: Social science and Medicine. 25 (9): 1003-1019.
17. Kumar, D.D. (1998). Factors Influencing Maternal Mortality in Bangladesh from a Gender Perspective. Project Work During the Course on Public Health in Dept. of Family Medicine, Umea University, Sweden
18. Miller and Rockwell (1988). AIDS in Africa. The Social and Policy Impact. Lewiston/Question: The Edwin Meller Press.
19. Odebiyi, A.I. (1977). The socio-cultural factors affecting health care delivery in Nigeria. Journal of Tropical Medicine and Hygiene. 1977 Nov; 80(11):249-54.
20. Orubuloye, I.O. and J.C. Caldwell. (1975). The Impact of Public health Services on Mortality: A Study of Mortality Differentials in a Rural Area of Nigeria. Population Studies. 29(2): 259-272.
21. Sargent, C. (1985). 1985. Obstetrical Choice Among Urban Women in Benin. Oxford: Social Science and Medicine. Vol. 20, No. 3: 287-292.
22. Schildkrout. (1978). Age and Gender in Hausa Society: Socio-Economic Roles of Children in Urban Kano. Lafontaine, L.S. (Ed.). Sex and Age as Principles of Social Differentiation. New York: Academic Press. 109-137.
23. Smith, M. (1954). Baba of Karo: A Woman of the Muslim Hausa. London: Faber and Faber.
24. Van de Walle, F. and N. Quiadou. (1985). Status and Fertility Among Urban Women in Burkina Faso. International Family Planning Perspective. 11(2): 60-64.
25. Vlassoff, C. (1994). Gender Inequalities in Health in the World; Uncharted Grounds. Oxford: Social Science and Medicine. 39: 1249-2259.
26. World Bank. (1990). Poverty World Development Report. New York: Oxford University Press