KNOWLEDGE, ATTITUDE, AND PRACTICE OF WOMEN TOWARDS SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KADUNA STATE, NIGERIA

BY

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NOVEMBER, 2016

DECLARATION

I declare that this dissertation entitled: "Knowledge, Attitude, and Practice of Women towards Sexual and Reproductive Health Rights in Kaduna State, Nigeria", was written by me in the Department of Physical and Health Education. The information derived from the literature has been duly acknowledged in the text and a list of references provided. No part of this dissertation was previously presented for another degree or diploma at this or any other institution.

_____ _____

Zainab Mohammed HUSSEIN **Date**

CERTIFICATION

The dissertation entitled, "KNOWLEDGE, ATTITUDE, AND PRACTICE OF WOMEN TOWARDS SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KADUNA STATE, NIGERIA", by Zainab Mohammed HUSSEIN meets the regulations governing the award of the degree of Master in Health Education of the Ahmadu Bello University and is approved for its contribution to knowledge and literary presentation..

Prof. M.A. Suleiman **Chairman, Supervisory Committee**	**Signature**	**Date**
Dr. Umar Musa **Member, Supervisory**	**Signature**	**Date**
Prof. M. A. Suleiman **Head of Department,** **Physical and Health Education**	**Signature**	**Date**
Prof. K. Bala **Dean, School of Postgraduate Studies**	**Signature**	**Date**

DEDICATION

This dissertation is dedicated to Almighty Allah (S.W.T) for seeing me through this programme.

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ABSTRACT

The purpose of this study was to assess the knowledge, attitude, and practice of women towards sexual and reproductive health rights in Kaduna state. To achieve this purpose, stratified proportional sampling procedure was used to draw the sample from Kaduna state; it was divided into three (3) senatorial zones, where two (2) Local Government Areas were selected from each zone making six (6) Local Government Areas selected. Thus, a total of 377 women were used for the study. Data collected were analysed using descriptive statistics of frequency counts, percentages, mean and standard deviation to answer research questions on knowledge, attitude, and practice of women towards sexual and reproductive health rights in Kaduna state. Multiple regression analysis was used to test the major hypothesis, one sample t-test was used to test hypotheses 1-3 and ANOVA was used to test hypotheses 4-6; the influence of knowledge and attitude on practice of women towards sexual and reproductive health rights, the significant difference in knowledge, attitude, and practice of women towards sexual and reproductive health rights, and the significant effect of marital status, educational level, and occupation on knowledge, attitude, and practice of women towards sexual and reproductive health rights in Kaduna state respectively. The findings of the study revealed: Knowledge and attitude significantly influence the practice of women towards sexual and reproductive health rights in Kaduna state, Nigeria. There is no significant difference in knowledge, attitude, and practice of sexual and reproductive health rights in Kaduna state. Marital status, educational level, and occupation have significant effect on knowledge, attitude, and practice of women towards sexual and reproductive health rights. Based on the findings of the study, the following recommendations were made; enlightenment campaigns, advocacy and community mobilization programs should be embarked on to improve knowledge, impact positive attitude towards sexual and reproductive health rights, hence enable good practice of sexual and reproductive health rights in Kaduna state, Nigeria.

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LIST OF ABBREVIATION

AIDS	-	Acquired Immune Deficiency Syndrome
CDC	-	Center for Diseases and Control
CEDAW	-	Convention on the elimination f all discrimination Against Women
CRLP	-	Centre for Reproductive law and Policy
DAWN	-	Development alternatives with Women for a New Era
FGM	-	Female Genital Mutilation
HIV	-	Human Immuno-deficiency virus
ILGA	-	International Plan+ned Parenthood Federation
MDGs	-	Millennium Development Goals
NDHS	-	Nigeria Demographic Health Survey
NGO	-	Non Governmental Organization
NMCP	-	National Malaria Control Program
NMSP	-	National Malaria Strategic Plan
NPC	-	National Population commission
SRHR	-	Sexual and Reproductive health and Rights
STIs	-	Sexually Transmitted Infections
U of T	-	University of Toronto

UDHR	-	Universal Declaration of Human Rights
UN	-	United Nation
UNDP	-	United Nations Development Programme
UNESCO	-	United Nations Educational, Scientific and Cultural Organization
UNFPA	-	United Nation Population Funds
UNICEF	-	United Nations children's Fund
VCT	-	voluntary Testing and Counselling
WAS	-	World Association for Sexual Health
WHO	-	World Health Organization

OPERATIONAL DEFINITION OF TERMS

Sexual health: Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexual rights: One's ability to take control over and make decisions concerning one's own sexuality. The person should be able to make those decisions free of discrimination, coercion, and violence.

Reproductive health: Reproductive health is a state of physical, mental and social well-being in relation to reproduction; couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of reproductive health.

Reproductive rights: Reproductive rights is the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion, and violence.

Women: Women referred to are females of reproductive age in Kaduna state.

Knowledge: To be well informed about sexual and reproductive health rights.

Attitude: Way of thinking with regard to sexual and reproductive health rights.

Practice: The use of or working with sexual and reproductive health rights by the women.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Sexual and Reproductive Health and Rights (*SRHR*) are human rights applied to sexuality and reproduction. They form a combination of four fields that in some contexts are more or less distinct from each other, but less so or not at all in other contexts. These four fields are sexual health, sexual rights, reproductive health and reproductive rights. These four fields are treated as separate but inherently intertwined (Adebayo, Fahmeir, Seiler, & Heumann, 2011). Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence (Speizer, Magnani, & Colvin, 2003).

Reproductive health, or sexual health, addresses the reproductive processes, functions and systems at all stages of life (Issues for Framework Health Service Providers, 2008). Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Women International Network in 2009 implied that men and women ought to be informed of and to have access to safe, effective, affordable and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and childbirth that could provide couples with the best chance of having a healthy infant. On the other hand individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, education level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income individuals lack the resources for appropriate health

services and the knowledge to know what is appropriate for maintaining reproductive health (Neumayer & Thomas 2007).

Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence (Baptiste, Kapungu, Khare, Lewis, & Barlow-Mosha, 2010). Sexual Rights unlike the other three aspects of SRHR, includes and focus on sexual pleasure and emotional sexual expression. One platform for this struggle is the World Association of Sexual Health (WAS) Declaration of Sexual Rights. The Platform for Action from the 1995 Beijing Conference on Women established that human rights include the right of women freely and without coercion, violence or discrimination, to have control over and make decisions concerning their own sexuality, including their own sexual and reproductive health (Baptiste, Kapungu, Khare, Lewis, & Barlow-Mosha, 2010).

The current population of Nigeria is 188,789,677 as of Monday, November 21, 2016, based on the latest United Nations estimates. Out of this number, women constitute 94,017,259 (Worldometers, 2016). In a country with such number of women, it is expected that the government of that country ought to pay particular attention to issues affecting the women folks. One of such issues is the right to choose provisions contained in the Convention on the Elimination of all Discrimination against Women (CEDAW) (Olatokun, 2014). Sadly, this Convention is yet to be domesticated and implemented in Nigeria, revealing that, Nigerian women are likely to be denied of three things which basically can be guaranteed by the right to choose as contained within CEDAW. Firstly, Nigerian women will be denied of the right to decide what to do with their bodies, in that, they will be denied of the right to choose and determine the timing of their pregnancies. Secondly, Nigerian women are likely to be denied

of the right to health, in that, failure to be able to determine the right timing of pregnancies is injurious to both mother and the unborn child. Lastly, the Nigerian women are robbed of the opportunity of being self-determined in that, women in Nigeria will not have the opportunity to decide for themselves on issues of maternity. Aside these, the right to choose provision contained in CEDAW is capable of reducing the economic hardship presently faced in Nigeria to the barest minimum (Olatokun, 2014).

In the pre-independence era when formal education was first introduced in Northern Nigeria, the government through the Native Authority which transformed to Local Government Authority had to force parents to send the girl-child to enrol in formal schools. The Native Authority fully funded the education of these girls who were conscripted to various schools often located outside their province. However, the socio-cultural and religious practices that evolved later in Northern states, particularly the North East and North West changed with the highest number of girl-child not enrolled in school and those who drop out to get married. The majority of these girls never return to school to complete their education, learn a trade, or acquire vocational skills that would economically empower and make them self-reliant (Bala, 2003).

Every society and culture has some basic norms and beliefs that guide the people. In Nigeria for instance, specifically the Northern Nigeria (Hausa - Fulani dominated) allowed early marriage of the girl-child. Erulkar and Bello (2007) argued that the reason for acceptance of early marriages among Northern region is to preserve the value of virginity, fears about pre-marital sexual activity, to reduce promiscuity of the girl-child, and other socio-cultural and religious norms. However, due to the ignorance and selfish nature, more often than not they forget the effect it has on the girl- child as well as their community development. It is worrisome that the girl- child has no power to resist the offer. The effect of early marriage on the girl-child that affects her wellbeing and that of the society include education, lack of economic empowerment and lack of knowledge on reproductive health services which will

enable them take informed decisions, enhance their ability to leverage resources and participate in community decision making (Isiugo-Abanihe, 2005). These translate into development of negative attitude towards sexual and reproductive health and the sexual and reproductive rights of the girl-child in later life which prompted the researcher to conduct the research on the knowledge, attitude, and practice of women about sexual and reproductive health rights in Kaduna state.

1.2 Statement of Problem

Violations of women's sexual and reproductive health rights are often deeply engrained in societal values pertaining to women's sexuality. Patriarchal concepts of women's roles within the family mean that women are often valued based on their ability to reproduce. Early marriage and pregnancy, or repeated pregnancies spaced too closely together, often as the result of efforts to produce male offspring because of the preference for sons, has a devastating impact on women's health with sometimes fatal consequences. Women are also often blamed for infertility, suffering ostracism and being subjected to various human rights violations as a result.

Women seemly lack awareness and knowledge of their sexual and reproductive health rights which is one of the causes of problems and complications (female genital mutilation, lack of sexual pleasure and satisfaction, uterine rupture, infertility, and so on) women face when it comes to sexual and reproductive health and in turn the development of negative attitude. In Nigeria, women may shy away from exercising their rights due to cultural, religious, and moral values because it is frowned upon in the society. Young women of reproductive age who are married are prevented from accessing sexual and reproductive health care which they rightfully deserve because they are expected to give birth to as many children as possible without family planning. Whereas single women of reproductive age who are sexually active

also shy away because they fear how the society will treat them and the shame they will have to feel while tending to their sexual and reproductive health, thereby leading them to practice unsafe sex because room was never created to have positive attitude. This would result in unwanted pregnancies, which if they try to abort may result into serious complications such as sepsis, uterine rupture, etc. The researcher observed that a lot of women present at health facilities with complications resulting from sexual and reproductive health problems. Therefore, the present study aims at assessing the knowledge, attitude, and practice of women towards sexual and reproductive health rights.

1.3 Purpose of the Study

The purpose of the study is to assess the knowledge, attitude, and practice towards sexual and reproductive health rights among women in Kaduna State. Specifically, the study is to:

1. assess the knowledge of women on sexual and reproductive health rights.
2. assess the attitude of women towards sexual and reproductive health rights.
3. investigate the practice of sexual and reproductive health rights among women in Kaduna state.
4. examine the effect of marital status on the knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.
5. examine the effect of educational level on the knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.
6. examine the effect of occupation on the knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.

1.4 Research Questions

The research questions were designed to specifically assess the knowledge, attitude, and practice of women towards sexual and reproductive health rights, thus:

1. Do women have knowledge on sexual and reproductive health rights in Kaduna state?
2. What is the attitude of the women towards sexual and reproductive health rights in Kaduna state?
3. Do women practice sexual and reproductive health rights in Kaduna state?
4. Does marital status have effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state?
5. Does level of education have effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state?
6. Does occupation have effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state?

1.5 Significance of the Study

The findings from this study will uplift the standard of Health education on sexual and reproductive health rights in the following ways:

i. The study would add to the existing body of knowledge in Health Education, especially with regards to the knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna State by making it available on the internet and in libraries for use. This would acquaint health educators with information and knowledge to use while carrying out their roles.

ii. This study would provide health workers with information and knowledge of sexual and reproductive health rights as they are the ones that the women

come across first when they have complications resulting from sexual and reproductive health problems, hence they can refer them appropriately thereby treating the underlying cause of that problem.

iii. This study would make the government aware of the existence of sexual and reproductive health problems and help the government in legislations and policy making that will ensure the implementation of the laws of sexual and reproductive health rights already in the Nigerian constitution.

iv. The study would make women aware of the existence of sexual and reproductive health rights. It will enlighten them by giving them in-depth knowledge on sexual and reproductive health rights. It will change the attitude of women positively towards sexual and reproductive health rights. The study will also enlighten women on safe practice on sexual and reproductive health rights via the use of health talks, mass media, social media, discussions, lectures, and conferences at health facilities and Non-Governmental Organisations (NGOs) to disseminate information to women in Kaduna state.

1.6 Basic Assumptions

The following basic assumptions were made for the study:

1. Women would have knowledge of sexual and reproductive health rights in Kaduna state.
2. The attitude of women towards sexual and reproductive health rights would change after having been exposed to enlightenment campaign programs on sexual and reproductive health rights in Kaduna state.
3. The women would practice sexual and reproductive health rights in Kaduna state after the enlightenment campaign program on sexual and reproductive health rights has impacted on them positively.

1.7 Hypotheses

The following hypotheses were tested for the purpose of this study:

Major hypotheses

Knowledge and attitude would not significantly influence the practice of women towards sexual and reproductive health rights of women in Kaduna State, Nigeria.

Sub hypotheses

1. There is no significant difference in knowledge of sexual and reproductive health rights among women in Kaduna State.
2. There is no significant difference in attitude towards sexual and reproductive health rights among women in Kaduna State.
3. There is no significant difference in practice of sexual and reproductive health rights among women in Kaduna State.
4. Marital status will not have significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.
5. Educational level will not have significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.
6. Occupation will not have significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.

1.8 Delimitations of the Study

This study was delimited to:

1. Women of reproductive age (15 - 49 years) in Kaduna State, Nigeria.
2. The variables tested were knowledge, attitude and practice.
3. Questionnaire was used for data collection.

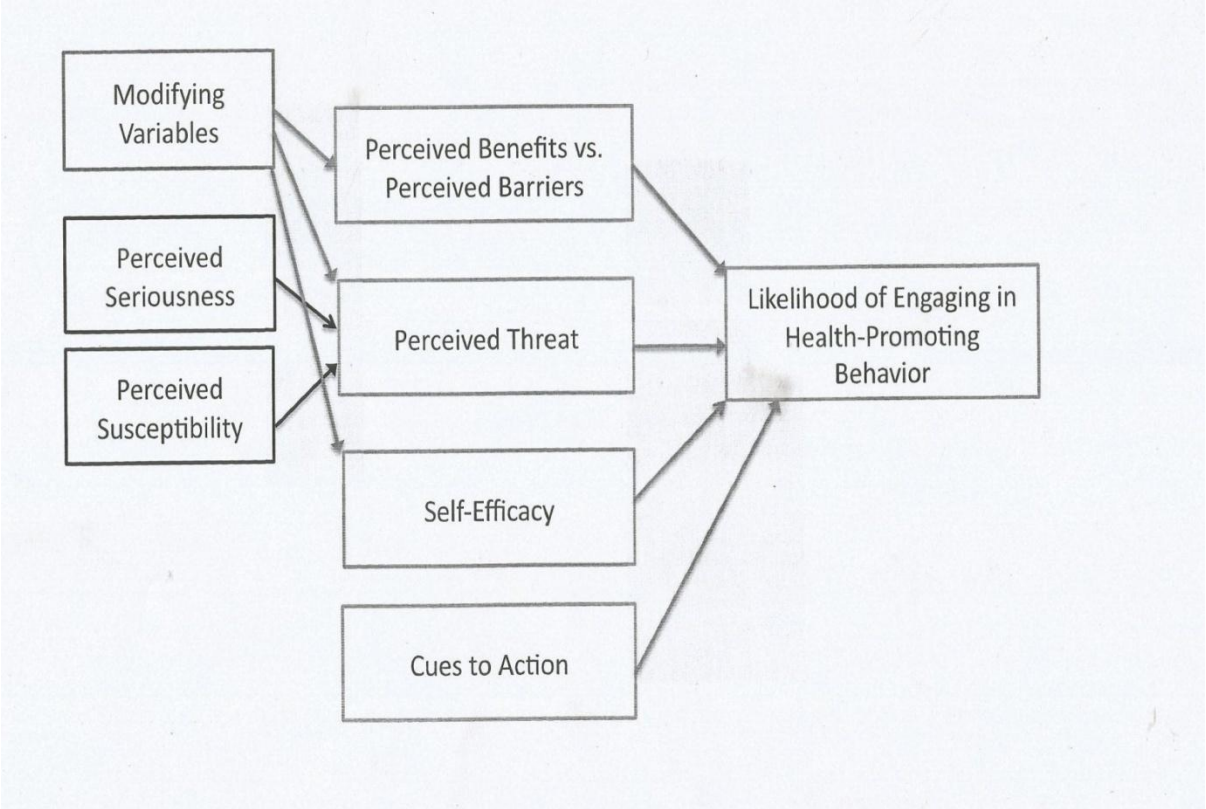
CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

In order to have a clearer picture, the researcher has surveyed some of the existing literature in order to gather relevant information from the findings of similar studies pertaining to the knowledge, attitude, and practice of women about sexual and reproductive health rights. The review is arranged in line with the study major variables which are knowledge, attitude, and practice. The headings featured in the review are:

2.1 Theoretical Framework



2.1.1 Health Belief Model

The **health belief model** (**HBM**) is a psychological health behavior change model developed to explain and predict health-related behaviors, particularly, in regard to the uptake of health services. The health belief model was developed in the 1950s by social psychologists at the U.S. Public Health Service and remains one of the best known and most widely used theories in health behavior research. The health belief model suggests that people's beliefs about health problems, perceived benefits of action and barriers to action and self-efficacy explain engagement (or lack of engagement) in health-promoting behavior. A stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior. (Carpenter, 2010).

One of the first theories of health behavior, the health belief model was developed in the 1950s by social psychologists Irwin M. Rosenstock, Godfrey M. Hochbaum, S. Stephen

Kegeles, and Howard Leventhal at the U.S. Public Health Service to better understand the widespread failure of screening programs for tuberculosis. The health belief model has been applied to predict a wide variety of health-related behaviors such as being screened for the early detection of asymptomatic diseases and receiving immunizations. More recently, the model has been applied to understand patients' responses to symptoms of disease, compliance with medical regimens, lifestyle behaviors (sexual risk behaviors), and behaviors related to chronic illnesses, which may require long-term behavior maintenance in addition to initial behavior change. Amendments to the model were made as late as 1988 to incorporate emerging evidence within the field of psychology about the role of self-efficacy in decision-making and behavior (Glanz & Bishop, 2010).

Perceived severity refers to the subjective assessment of the severity of a health problem and its potential consequences. The health belief model proposes that individuals who perceive a given health problem as serious are more likely to engage in behaviors to prevent the health problem from occurring (or reduce its severity). Perceived seriousness encompasses beliefs about the disease itself (whether it is life-threatening or may cause disability or pain) as well as broader impacts of the disease on functioning in work and social roles (Glanz, 2008). For instance, an individual may perceive that influenza is not medically serious, but if he or she perceives that there would be serious financial consequences as a result of being absent from work for several days, then he or she may perceive influenza to be a particularly serious condition.

Perceived susceptibility refers to subjective assessment of risk of developing a health problem (Glanz, 2008). The health belief model predicts that individuals who perceive that they are susceptible to a particular health problem will engage in behaviors to reduce their risk of developing the health problem. Individuals with low perceived susceptibility may deny that they are at risk for contracting a particular illness. Others may acknowledge the

possibility that they could develop the illness, but believe it is unlikely. Individuals who believe they are at low risk of developing an illness are more likely to engage in unhealthy, or risky, behaviors. Individuals who perceive a high risk that they will be personally affected by a particular health problem are more likely to engage in behaviors to decrease their risk of developing the condition.

The combination of perceived severity and perceived susceptibility is referred to as perceived threat. Perceived severity and perceived susceptibility to a given health condition depend on knowledge about the condition. The health belief model predicts that higher perceived threat leads to higher likelihood of engagement in health-promoting behaviors.

Health-related behaviors are also influenced by the perceived benefits of taking action. (Glanz, 2008). Perceived benefits refer to an individual's assessment of the value or efficacy of engaging in a health-promoting behavior to decrease risk of disease. If an individual believes that a particular action will reduce susceptibility to a health problem or decrease its seriousness, then he or she is likely to engage in that behavior regardless of objective facts regarding the effectiveness of the action. For example, individuals who believe that wearing sunscreen prevents skin cancer are more likely to wear sunscreen than individuals who believe that wearing sunscreen will not prevent the occurrence of skin cancer.

Health-related behaviors are also a function of perceived barriers to taking action. Perceived barriers refer to an individual's assessment of the obstacles to behavior change. Even if an individual perceives a health condition as threatening and believes that a particular action will effectively reduce the threat, barriers may prevent engagement in the health-promoting behavior. In other words, the perceived benefits must outweigh the perceived barriers in order for behavior change to occur (Glanz, 2008). Perceived barriers to taking action include the perceived inconvenience, expense, danger (side effects of a medical procedure) and

discomfort (pain, emotional upset) involved in engaging in the behavior. For instance, lack of access to affordable health care and the perception that a flu vaccine shot will cause significant pain may act as barriers to receiving the flu vaccine.

Individual characteristics, including demographic, psychosocial, and structural variables, can affect perceptions (perceived seriousness, susceptibility, benefits, and barriers) of health-related behaviors. Demographic variables include age, sex, race, ethnicity, and education, among others. Psychosocial variables include personality, social class, and peer and reference group pressure, among others. Structural variables include knowledge about a given disease and prior contact with the disease, among other factors. The health belief model suggests that modifying variables affect health-related behaviors indirectly by affecting perceived seriousness, susceptibility, benefits, and barriers **(**Glanz, (2008).

The health belief model posits that a cue, or trigger, is necessary for prompting engagement in health-promoting behaviors. Cues to action can be internal or external. Physiological cues (pain, symptoms) are an example of internal cues to action. External cues include events or information from close others, the media, or health care providers promoting engagement in health-related behaviors (Carpenter, 2010). Examples of cues to action include a reminder postcard from a dentist, the illness of a friend or family member, and product health warning labels. The intensity of cues needed to prompt action varies between individuals by perceived susceptibility, seriousness, benefits, and barriers. For example, individuals who believe they are at high risk for a serious illness and who have an established relationship with a primary care doctor may be easily persuaded to get screened for the illness after seeing a public service announcement, whereas individuals who believe they are at low risk for the same illness and also do not have reliable access to health care may require more intense external cues in order to get screened.

Self-efficacy was added to the four components of the health belief model (i.e., perceived susceptibility, seriousness, benefits, and barriers) in 1988. Self-efficacy refers to an individual's perception of his or her competence to successfully perform a behavior. Self-efficacy was added to the health belief model in an attempt to better explain individual differences in health behaviors. The model was originally developed in order to explain engagement in one-time health-related behaviors such as being screened for cancer or receiving an immunization. Eventually, the health belief model was applied to more substantial, long-term behavior change such as diet modification, exercise, and smoking. Developers of the model recognized that confidence in one's ability to effect change in outcomes (i.e., self-efficacy) was a key component of health behavior change. (Carpenter, 2010).

The health belief model has gained substantial empirical support since its development in the 1950s. It remains one of the most widely used and well-tested models for explaining and predicting health-related behavior. A 1984 review of 18 prospective and 28 retrospective studies suggests that the evidence for each component of the health belief model is strong. The review reports that empirical support for the health belief model is particularly notable given the diverse populations, health conditions, and health-related behaviors examined and the various study designs and assessment strategies used to evaluate the model. A more recent meta-analysis found strong support for perceived benefits and perceived barriers predicting health-related behaviors, but weak evidence for the predictive power of perceived seriousness and perceived susceptibility. The authors of the meta-analysis suggest that examination of potential moderated and mediated relationships between components of the model is warranted (Carpenter, 2010).

The health belief model has been used to develop effective interventions to change health-related behaviors by targeting various aspects of the model's key constructs. Interventions

based on the health belief model may aim to increase perceived susceptibility to and perceived seriousness of a health condition by providing education about prevalence and incidence of disease, individualized estimates of risk, and information about the consequences of disease (medical, financial, and social consequences). Interventions may also aim to alter the cost-benefit analysis of engaging in a health-promoting behavior (increasing perceived benefits and decreasing perceived barriers) by providing information about the efficacy of various behaviors to reduce risk of disease, identifying common perceived barriers, providing incentives to engage in health-promoting behaviors, and engaging social support or other resources to encourage health-promoting behaviors. Furthermore, interventions based on the health belief model may provide cues to action to remind and encourage individuals to engage in health-promoting behaviors. Interventions may also aim to boost self-efficacy by providing training in specific health-promoting behaviors, particularly for complex lifestyle changes (changing diet or physical activity, adhering to a complicated medication regimen). Interventions can be aimed at the individual level (working one-on-one with individuals to increase engagement in health-related behaviors) or the societal level (through legislation, changes to the physical environment).

The health belief model attempts to predict health-related behaviors by accounting for individual differences in beliefs and attitudes. However, it does not account for other factors that influence health behaviors. For instance, habitual health-related behaviors (smoking, seatbelt buckling) may become relatively independent of conscious health-related decision making processes. Additionally, individuals engage in some health-related behaviors for reasons unrelated to health (exercising for aesthetic reasons). Environmental factors outside an individual's control may prevent engagement in desired behaviors. For example, an individual living in a dangerous neighborhood may be unable to go for a jog outdoors due to safety concerns. Furthermore, the health belief model does not consider the impact of

emotions on health-related behavior. Evidence suggests that fear may be a key factor in predicting health-related behavior (Glanz, 2008).

2.1.2 Application to the Study

From the review of the Health Belief Model (HBM), the researcher deducted that in order for women's behavior to change, people must feel personally vulnerable to health threats related to sexual and reproductive challenges such as lack of sexual pleasure, lack of sexual satisfaction, rape, violence, sexual harassment, female genital mutilation, uterine rupture due to grand multiparity (having many children), and so on. Therefore, a person must be competent (have self-efficacy); be knowledgeable about sexual and reproductive health rights in order to exhibit positive attitude and behavior towards sexual and reproductive health rights that enables good practice of sexual and reproductive health rights.

2.2 Conceptual Framework

2.2.1 Sexual and Reproductive Health and Rights

Sexual and reproductive health and rights or *SRHR* is the concept of human rights applied to sexuality and reproduction. It is a combination of four fields that in some contexts are more or less distinct from each other, but less so or not at all in other contexts. These four fields are sexual health, sexual rights, reproductive health and reproductive rights. In the concept of SRHR, these four fields are treated as separate but inherently intertwined. Distinctions between these four fields are not always made. Sexual health and reproductive health are sometimes treated as synonymous to each other, as are sexual rights and reproductive rights. In some cases, sexual rights are included in the term sexual health, or vice versa. Not only do different nongovernmental organizations and governments use different terminologies, but different terminologies are often used within the same organization. Notable global NGOs that fight for sexual and reproductive health and rights include International Planned

Parenthood Federation IPPF), International Lesbian and Gay Alliance (ILGA), World Association for Sexual Health - formerly known as World Association for Sexology (WAS), and International HIV/AIDS Alliance among many others.

2.2.2 Sexual Health:

The WHO defines Sexual Health as: "Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence."

2.2.3 Sexual Rights:

Unlike the other three aspects of SRHR, the struggles for sexual rights include and focus on sexual pleasure and emotional sexual expression. One platform for this struggle is the WAS Declaration of Sexual Rights. The Platform for Action from the 1995 Beijing Conference on Women established that human rights include the right of women freely and without coercion, violence or discrimination, to have control over and make decisions concerning their own sexuality, including their own sexual and reproductive health. This has been interpreted by many countries as the applicable definition of women's sexual rights. The UN Commission on Human Rights has established that if women had more power, their ability to protect themselves against violence would be strengthened. At the 14th World Congress of Sexology (Hong Kong, 1999), the WAS adopted the Universal Declaration of Sexual Rights, which includes 11 sexual rights:

1. The right to sexual freedom.
2. The right to sexual autonomy, sexual integrity, and safety of the sexual body.
3. The right to sexual privacy.
4. The right to sexual equity.
5. The right to sexual pleasure.

6. The right to emotional sexual expression.
7. The right to sexually associate freely.
8. The right to make free and responsible reproductive choices.
9. The right to sexual information based on scientific inquiry.
10. The right to comprehensive sexuality education.
11. The right to sexual health care.

This Declaration gave an influence on The Yogyakarta Principles, especially on the idea of each person's integrity, right to issues of sexuality, including sexual and reproductive health.

2.2.4 Reproductive Health:

Within the framework of the World Health Organisation (WHO) definition of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity; reproductive health, or sexual health, addresses the reproductive processes, functions, and system at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. One interpretation of this implies that men and women ought to be informed of and to have access to safe, effective, affordable, and acceptable methods of birth control; also access to appropriate health care services of sexual, reproductive medicine and implementation of health education programs to stress the importance of women to go safely through pregnancy and child birth could provide couples with the best chance of having a healthy infant.

On the other hand, individuals do face inequalities in reproductive health services. Inequalities vary based on socioeconomic status, educational level, age, ethnicity, religion, and resources available in their environment. It is possible for example, that low income

individuals lack the resources for appropriate health services and the knowledge to know what is appropriate for maintaining reproductive health.

2.2.5 Reproductive Rights: are legal rights and freedoms relating to reproduction and reproductive health. The World Health Organisation defines reproductive rights as follows: "Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right to make decisions concerning reproduction free of discrimination, coercion, and violence." (Adamchak, Bond, MacLaren, Magnani, Nelson, & Seltzer, 2000).

Reproductive rights may include some or all of the following: the right to legal or safe abortion; the right to birth control; freedom from coerced sterilization, abortion, and contraception; the right to access good-quality reproductive healthcare; and the right to education and access in order to make free and informed reproductive choices. Reproductive rights may also include the right to receive education on sexually transmitted infections and other aspects of sexuality, and protection from gender-based practices such as female genital mutilation (FGM).

Reproductive rights began to develop as a subset of human rights at the United Nation's 1968 International Conference on Human Rights. The resulting non-binding Proclamation of Tehran was the first international document to recognize one of these rights when it stated that: "Parents have a basic human right to determine freely and responsibly the number and spacing of their children." States though, have been slow in incorporating these rights in internationally legally binding instruments. Thus, while some of these rights have already been recognized in hard law, that is, in legally binding international human rights

instruments, others have been mentioned only in non-binding recommendations and, therefore, have at best the status of soft law in international law, while a further group is yet to be accepted by the international community and therefore remains at the level of advocacy. Issues related to reproductive rights are some of the most vigorously contested rights' issues worldwide, regardless of the population's socioeconomic level, religion or culture.

2.3 Human Rights & Sexual and Reproductive Health Rights

Since most existing legally binding international human rights instruments do not explicitly mention sexual and reproductive rights, a broad coalition of NGOs, civil servants, and experts working in international organizations have been promoting a reinterpretation of those instruments to link the realization of the already internationally recognized human rights with the realization of reproductive rights. An example of this linkage is provided by the 1994 Cairo Programme of Action: "Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant United Nations consensus documents.

These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes the right of all to make decisions concerning reproduction free of discrimination, coercion and violence as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community."

Similarly, Amnesty International has argued that the realization of reproductive rights is linked with the realization of a series of recognized human rights, including the right to health, the right to freedom from discrimination, the right to privacy, and the right not to be

subjected to torture or ill-treatment. However, not all states have accepted the inclusion of reproductive rights in the body of internationally recognized human rights.

At the Cairo Conference, several states made formal reservations either to the concept of reproductive rights or to its specific content. Ecuador, for instance, stated that: "With regard to the Programme of Action of the Cairo International Conference on Population and Development and in accordance with the provisions of the Constitution and laws of Ecuador and the norms of international law, the delegation of Ecuador reaffirms, inter alia, the following principles embodied in its Constitution: the inviolability of life, the protection of children from the moment of conception, freedom of conscience and religion, the protection of the family as the fundamental unit of society, responsible paternity, the right of parents to bring up their children and the formulation of population and development plans by the Government in accordance with the principles of respect for sovereignty.

Accordingly, the delegation of Ecuador enters a reservation with respect to all terms such as "regulation of fertility", "interruption of pregnancy", "reproductive health", "reproductive rights" and "unwanted children", which in one way or another, within the context of the Programme of Action, could involve abortion." Similar reservations were made by Argentina, Dominican Republic, El Salvador, Honduras, Malta, Nicaragua, Paraguay, Peru and the Holy Islamic Countries, such as Brunei, Djibouti, Iran, Jordan, Kuwait, Libya, Syria, United Arab Emirates, and Yemen made broad reservations against any element of the programme that could be interpreted as contrary to the Sharia. Guatemala even questioned whether the conference could legally proclaim new human rights.

2.4 Women's Rights & Sexual and Reproductive Health Rights

The United Nations Population Fund (UNFPA) and the World Health Organization (WHO) advocate for reproductive rights with a primary emphasis on women's rights. In this respect the UN and WHO focus on a range of issues from access to family planning services, sex

education, and the reduction of obstetric fistula, to the relationship between reproductive health and economic status. The reproductive rights of women are advanced in the context of the right to freedom from discrimination and the social and economic status of women.

The group Development Alternatives with Women for a New Era (DAWN) explained the link in the following statement: “Control over reproduction is a basic need and a basic right for all women. Linked as it is to women's health and social status, as well as the powerful social structures of religion, state control and administrative inertia, and private profit, it is from the perspective of poor women that this right can best be understood and affirmed. Women know that childbearing is a social, not a purely personal, phenomenon; nor do we deny that world population trends are likely to exert considerable pressure on resources and institutions by the end of this century. But our bodies have become a pawn in the struggles among states, religions, male heads of households, and private corporations.

Programs that do not take the interests of women into account are unlikely to succeed…” Attempts have been made to analyse the socioeconomic conditions that affect the realization of a woman's reproductive rights. The term reproductive justice has been used to describe these broader social and economic issues. Proponents of reproductive justice argue that while the right to legalized abortion and contraception applies to everyone, these choices are only meaningful to those with resources, and that there is a growing gap between access and affordability.

2.4.1 Abortion

Lara Knudsen, (2006) a pro-choice activist, has suggested that *"twenty percent of all pregnancies worldwide end in abortion and nearly half of those abortions are unsafe and often illegal.* “According to the WHO, 2004, more than 45 million (legal and illegal) abortions take place annually. At the same time, approximately 66,500 women die from the

complications of unsafe abortion every year. An article from the World Health Organization calls safe, legal abortion a "fundamental right of women, irrespective of where they live" and unsafe abortion a "silent pandemic". The article states "ending the silent pandemic of unsafe abortion is an urgent public-health and human-rights imperative." (Greer, 2006).

It also states "access to safe abortion improves women's health, and vice versa, as documented in Romania during the regime of President Nicolae Ceauș escu" and "legalisation of abortion on request is a necessary but insufficient step toward improving women's health" citing that in some countries, such as India where abortion has been legal for decades, access to competent care remains restricted because of other barriers. WHO's Global Strategy on Reproductive Health, adopted by the World Health Assembly in May 2004, noted: "As a preventable cause of maternal mortality and morbidity, unsafe abortion must be dealt with as part of the MDG on improving maternal health and other international development goals and targets." The WHO's Development and Research Training in Human Reproduction (HRP), whose research concerns people's sexual and reproductive health and lives, has an overall strategy to combat unsafe abortion that comprises four inter-related activities:

i. to collate, synthesize and generate scientifically sound evidence on unsafe abortion prevalence and practices;
ii. to develop improved technologies and implement interventions to make abortion safer;
iii. to translate evidence into norms, tools and guidelines
iv. and to assist in the development of programmes and policies that reduce unsafe abortion and improve access to safe abortion and high quality post abortion care.

When negotiating the Cairo Programme of Action at the 1994 International Conference on Population and Development (ICPD), the issue was so contentious that delegates eventually decided to omit any recommendation to legalize abortion, instead advising governments to provide proper post-abortion care and to invest in programs that will decrease the number of unwanted pregnancies. On April 18, 2008 the Parliamentary Assembly of the Council of Europe, a group comprising members from 47 European countries, adopted a resolution calling for the decriminalization of abortion within reasonable gestational limits and guaranteed access to safe abortion procedures. The nonbinding resolution was passed on April 16 by a vote of 102 to 69. (Bernstein & Hansen, 2006).

During and after the ICPD, some interested parties attempted to interpret the term 'reproductive health' in the sense that it implies abortion as a means of family planning or, indeed, a right to abortion. These interpretations, however, do not reflect the consensus reached at the Conference. For the European Union, where legislation on abortion is certainly less restrictive than elsewhere, the Council Presidency has clearly stated that the Council's commitment to promote 'reproductive health' did not include the promotion of abortion. Likewise, the European Commission, in response to a question from a Member of the European Parliament, clarified:

> *"The term 'reproductive health' was defined by the United Nations (UN) in 1994 at the Cairo International Conference on Population and Development. All Member States of the Union endorsed the Programme of Action adopted at Cairo. The Union has never adopted an alternative definition of 'reproductive health' to that given in the Programme of Action, which makes no reference to abortion."* (The Alan Guttmacher Institute, 2004).

With regard to the US, it should be noted that, only a few days prior to the Cairo Conference, the head of the US delegation, Vice President Al Gore, had stated for the record: *"Let us get a false issue off the table: the US does not seek to establish a new international right to abortion, and we do not believe that abortion should be encouraged as a method of family planning."* Some years later, the position of the US Administration in this debate was reconfirmed by US Ambassador to the UN, Ellen Sauerbrey, when she stated at a meeting of the UN Commission on the Status of Women that: *"nongovernmental organizations are attempting to assert that Beijing in some way creates or contributes to the creation of an internationally recognized fundamental right to abortion"*. She added: *"There is no fundamental right to abortion. And yet it keeps coming up largely driven by NGOs trying to hijack the term and trying to make it into a definition"*. Collaborative research from the Institute of Development Studies states that "access to safe abortion is a matter of human rights, democracy and public health, and the denial of such access is a major cause of death and impairment, with significant costs to [international] development". (Bernstein, 2005).

The research highlights the inequities of access to safe abortion both globally and nationally and emphasises the importance of global and national movements for reform to address this. The shift by campaigners of reproductive rights from an issue-based agenda (the right to abortion), to safe, legal abortion not only as a human right, but bound up with democratic and citizenship rights, has been an important way of reframing the abortion debate and reproductive justice agenda. Meanwhile, however the European Court of Human Rights settled the question through a landmark judgment (case of *A. B. and C. v. Ireland*), in which it is stated that the European Convention on Human Rights does not contain a right to abortion. (Bernstein, 2005). Compulsory or forced sterilizations and abortions may also occur in the context of population control policies. From the 1970s to 1980s, tension grew between

women's health activists who advance women's reproductive rights as part of a human rights-based approach on the one hand, and population control advocates on the other.

At the 1984 UN World Population Conference in Mexico City population control policies came under attack from women's health advocates who argued that the policies' narrow focus led to coercion and decreased quality of care, and that these policies ignored the varied social and cultural contexts in which family planning was provided in developing countries (Bernstein, 2005). In the 1980s the HIV/AIDS epidemic forced a broader discussion of sex into the public discourse in many countries, leading to more emphasis on reproductive health issues beyond reducing fertility. The growing opposition to the narrow population control focus led to a significant departure in the early 1990s from past population control policies. In the United States, abortion opponents have begun to foment conspiracy theories about reproductive rights advocates, accusing them of advancing a racist agenda of eugenics, and of trying to reduce the African American birth rate in the U.S. (Bernstein, 2005).

2.5 History of Sexual and Reproductive Health Right in Other Countries

2.5.1 Proclamation of Teheran:

In 1945, the United Nations Charter included the obligation "to promote universal respect for, and observance of human rights and fundamental freedoms for all without discrimination as to race, sex, language, or religion". However, the Charter did not define these rights. Three years later, the UN adopted the Universal Declaration of Human Rights (UDHR), the first international legal document to delineate human rights; the UDHR does not mention reproductive rights. Reproductive rights began to appear as a subset of human rights in the 1968 Proclamation of Teheran, which states: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children". This right was affirmed by the UN General Assembly in the 1974 Declaration on Social Progress and Development

which states "The family as a basic unit of society and the natural environment for the growth and well-being of all its members, particularly children and youth, should be assisted and protected so that it may fully assume its responsibilities within the community. Parents have the exclusive right to determine freely and responsibly the number and spacing of their children." The 1975 UN International Women's Year Conference echoed the Proclamation of Teheran.

2.5.2 Cairo Programme of Action:

The twenty-year "Cairo Programme of Action" was adopted in 1994 at the International Conference on Population and Development (ICPD) in Cairo. The non-binding Programme of Action asserted that governments have a responsibility to meet individuals' reproductive needs, rather than demographic targets. It recommended that family planning services be provided in the context of other reproductive health services, including services for healthy and safe childbirth, care for sexually transmitted infections, and post-abortion care. The ICPD also addressed issues such as violence against women, sex trafficking, and adolescent health. The Cairo Program is the first international policy document to define reproductive health, stating: **"**Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes." Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed (about) and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Unlike

previous population conferences, a wide range of interests from grassroots to government level were represented in Cairo. 179 nations attended the ICPD and overall eleven thousand representatives from governments, NGOs, international agencies and citizen activists participated. The ICPD did not address the far-reaching implications of the HIV/AIDS epidemic. In 1999, recommendations at the ICPD+5 were expanded to include commitment to AIDS education, research, and prevention of mother-to-child transmission, as well as to the development of vaccines.

The Cairo Programme of Action was adopted by 184 UN member states. Nevertheless, many Latin American and Islamic states made formal reservations to the programme, in particular, to its concept of reproductive rights and sexual freedom, to its treatment of abortion, and to its potential incompatibility with Islamic law.

2.5.3 Beijing Platform:

The 1995 Fourth World Conference on Women in Beijing, in its non-binding Declaration and Platform for Action, supported the Cairo Programme's definition of reproductive health, but established a broader context of reproductive rights: **"**The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences. The Beijing Platform demarcated twelve interrelated critical areas of the human rights of women that require advocacy. The Platform framed women's reproductive rights as "indivisible, universal and inalienable human rights." (United Nations,1995).

2.5.4 The Yogyakarta Principles:

The Yogyakarta Principles on the application of international human rights law in relation to sexual orientation and gender identity, proposed by a group of experts in November 2006 but not yet incorporated by states in international law, declares in its Preamble that "the international community has recognized the rights of persons to decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free from coercion, discrimination, and violence." In relation to reproductive health, Principle 9 on "The Right to Treatment with Humanity while in Detention" requires that "States shall provide adequate access to medical care and counselling appropriate to the needs of those in custody, recognizing any particular needs of persons on the basis of their sexual orientation and gender identity, including with regard to reproductive health, access to HIV/AIDS information and therapy and access to hormonal or other therapy as well as to gender-reassignment treatments where desired." Nonetheless, African, Caribbean and Islamic Countries, as well as the Russian Federation, have objected to the use of these principles as Human Rights standards. (United Nations, 2006).

2.6 Sexual and Reproductive Rights and Health and Universal Health Coverage

One issue that has received much attention as discussions around the post-2015 development framework have accelerated is universal health coverage. Universal health coverage is commonly defined as "a system in which everyone in a society can get the health care services they need without incurring financial hardship." Universal health insurance is a critical factor in achieving universal health coverage, because of the role it can play in providing financial protection against catastrophic health costs. The right to health and uptake of health care are other essential elements, of achieving universal coverage, but generally receive less attention than the financing aspects. The design of health insurance schemes can have major implications for women and girls and can either facilitate or impede access to sexual and reproductive health services. Considerations of who is covered; what services are

covered; the extent of financial protection; and confidentiality and privacy in the provision, documentation and billing of services, all need to be taken into account to ensure that the financial barriers faced by women and adolescents are addressed.

Certain types of insurance programs are more likely to reach women, particularly poor and marginalized women, than others. Compulsory social insurance schemes that are linked to formal employment may exclude from coverage large proportions of women globally who work in the informal sector, or do not participate in waged employment. Community-based health insurance schemes, often seen as a stepping stone for the poor and those employed in the informal sector to universal health coverage, might still exclude poor women or women who have limited control over or access to cash, despite the low premiums. Indeed, there is increasing evidence that community-based health insurance schemes may be regressive for poor households, especially if premiums are not assessed on the basis of ability to pay; something which in practice has proven difficult to implement. Health services that are essential for women, including family planning counseling and contraceptives; prenatal, delivery, postnatal and emergency obstetric care; safe abortions; STI diagnosis and treatment; prevention, diagnosis and treatment of reproductive tract cancers; and other sexual reproductive health services, are often only partially covered by insurance schemes, or may be excluded from coverage altogether. A survey of 152 Essential Services Packages in the 1990s, which define services that are eligible for no-cost or low-cost coverage, found that only 20 included coverage for *all* of the following basic reproductive health services: family planning, antenatal care, delivery by trained attendants, post-partum care, and emergency obstetric care. (Habbema & Hayes, 2005).

In countries with parallel insurance schemes covering different segments of the population, differences in the services covered may result in inequities in access to sexual and reproductive health care. For example, Thailand's Universal Coverage program, which covers more than 45 million, covers a comprehensive set of sexual and reproductive health

services, increasing access for millions who were previously uninsured. However, parallel insurance schemes, which cover more than 10 million private sector employees, does not cover family planning, menopause services, or diagnosis and treatment reproductive tract infections, including HIV, and provides only partial coverage of reproductive tract cancers. On the other hand, social protection health insurance schemes that target poor and marginalized women with no-fee services or conditional cash transfers that simultaneously incentivize health-seeking behavior and address the costs associated with care may facilitate access to services for poor women. In both cases, women who are above the poverty line but still face financial constraints, adolescent girls, and older women may still fall through the cracks due to a number of reasons including lack of autonomy and decision-making power, or lack of information. There is a long-established consensus recognizing the importance of addressing sexual and reproductive health and rights. Twenty years ago at the International Conference on Population and Development in Cairo, governments recognized the central role of sexual and reproductive health and rights for both guaranteeing women's equality and empowerment and development. The current Millennium Development Goals recognize the importance of reproductive health for development: target 5(b) under the goal to improve maternal health aims to achieve universal access to reproductive health by 2015. The UN Secretary-General's Every Woman, Every Child initiative has further galvanized momentum toward achieving MDG (Rosa, 2016).

More recently at the Rio+20 conference on sustainable development, governments called for the "full and effective implementation of the Beijing Platform for Action and the Program of Action of the International Conference on Population and Development, and the outcomes of their review conferences, including the commitments leading to sexual and reproductive health and the promotion and protection of all human rights in this context" and "emphasize[d] the need for the provision of universal access to reproductive health, including

family planning and sexual health, and the integration of reproductive health in national strategies and programs."

Despite the international consensus, progress in addressing sexual and reproductive health and rights and achieving international targets on these issues has been mixed. While there has been a substantial decline in maternal deaths over the past twenty years of about 50% since 1990, only 9 of 74 low and middle income countries that were recently reviewed by the Countdown to 2015 initiative are on track to meet MDG 5.2 Universal access to reproductive health services, including family planning, skilled antenatal, delivery, postnatal and emergency obstetric care, sexuality and reproductive health information and education, safe abortion services, and diagnosis and treatment of reproductive tract infections and cancers, among other services, continues to be a distant goal (Rosa, 2016).

In many places, what is and is not covered by health insurance programs may be deeply political. In most countries, safe abortion services are rarely covered by public insurance programs, despite the fact that they are legal on at least one or more grounds. In the United States, for example, federal law prohibits coverage of abortion services for women with Medicaid, except in the cases of rape, incest, or where the pregnancy threatens the health or life of the pregnant woman. Coverage of contraceptives and sexual health services for adolescents may be likewise constrained due to political sensitivities. The level of financial protection offered by insurance schemes also varies. There is substantial evidence that women consistently experience a higher burden of out-of-pocket costs for health care services than men who have similar levels of insurance coverage, largely due to non-coverage or limits on coverage for sexual and reproductive health services. In Thailand, although comprehensive maternity care is a part of the universal coverage benefit package, only the first two pregnancies and deliveries are covered, meaning that women shoulder an additional financial burden if they have more than two children. Even nominal co-pays as a requirement for accessing care, common in many insurance programs, may also pose a significant barrier

if women do not have access to or control over cash. Concerns about the confidentiality and privacy of insurance users may also impede access to services for those with insurance. For example, in the United States adolescent girls and boys and young women and men who are enrolled as dependents under their parents' health insurance policies often forgo using their insurance coverage to access and pay for sexual and reproductive health services, for fear that their parents will see explanation of benefits or billing statements from their insurance companies that disclose that they sought such care. To illustrate the resulting gap: 90% of insured women over 30 who obtained contraceptive services in 2002 used their insurance to cover their care; but only 68% of insured adolescent girls and 76% of insured young women (age 20-24) did. Instead, many young women and men seek care from publicly funded or subsidized services or pay directly for the services out of pocket. Women covered as dependents under their husbands' insurance policies, may likewise be hesitant to seek much-needed care if they do not want their husbands to know, such as contraceptives or treatment for violence (Rosa, 2016).

2.7 Sexuality & Sexual Rights

Traditionally, SRH programmes have problematized sex, seeing it as something that needs to be controlled in order to avoid negative consequences such as STIs, HIV and unwanted pregnancy. Positive aspects of sex and sexuality, such as pleasure and fulfilment, have been ignored. This has partly resulted from the public health perspective, but also from discomfort in seeing sex for procreation not reproduction. The concept of sexual rights brings together both aspects of sexuality, including both protection against negative aspects such as disease and discrimination, and promotion of positive aspects. It also recognizes multiple sexualities, encouraging a move away from rigid, western categorizations such as MSM (men who have sex with men) and transgender, which are seen by some to promote heterosexuality as the unchallenged norm against which 'sexual minorities' are compared (Baudh, 2006).

There are potential public health benefits of addressing sexual rights in SRH programmes. For example, it has been argued that sexuality education can make people more comfortable with their bodies, and so more able to communicate wishes to others including safer sex, and to resist coercion (Ingram, 2005). However, most SRH services and policies do not adequately address sexual rights. People with sexual identities different from the perceived 'norm' may be denied access to health services, and health education, and services continue to focus on negative consequences of sexuality mentioned above. Promotion of sexual rights faces fierce opposition, in particular from religious fundamentalist groups, many of which only consider certain forms of sexuality to be acceptable – usually heterosexual and within marriage. On the other hand, there are examples of religion engaging positively, such as the 'Coalition for Sexual and Bodily Rights in Muslim Societies', which brings together organizations in the Middle East & South East Asia. Some SRH programmes have started to address sexuality, for example in relation to safer sex. Sexuality has been used to promote use of condoms in some settings (Phipott, Knerr, & Maher, 2006).

2.8 Knowledge of Sexual and Reproductive Rights and Health

Young women of reproductive age who are married are prevented from accessing sexual and reproductive health which they rightfully deserve because they are expected to give birth to as many children as possible without family planning. Whereas single women of reproductive age who are sexually active also shy away because they fear how the society will treat them and the shame they will have to feel while tending to their sexual and reproductive health, thereby leading them to practice unsafe sex which would result in unwanted pregnancies that if they try to abort may result into serious complications. The cultural beliefs, religious beliefs, and moral values of the society frown upon it in order to curb and prevent promiscuity in the society and also emphasize on procreation which is believed to be the purpose of life. (Bessinger, Katende, & Gupta, 2003).

Sexuality is an integral part of the personality of every human being. Its full development depends upon the satisfaction of basic human needs such as the desire for contact, intimacy, emotional expression, pleasure, tenderness and love. Sexuality is constructed through the interaction between the individual and social structures. Full development of sexuality is essential for individual, interpersonal, and societal wellbeing. Sexual rights are universal human rights based on the inherent freedom, dignity, and equality of all human beings. Since health is a fundamental human right, so must sexual health be a basic human right. In order to assure that human beings and societies develop healthy sexuality, the sexual rights must be recognized, promoted, respected, and defended by all societies through all means. (Bessinger, Katende, & Gupta, 2003).

Sexual health is the result of an environment that recognizes respects and exercises these sexual rights. Sexual and reproductive health services desperately needed by women and girls are often not available because they are not seen as a priority by governments. Even where governments have developed programmes and allocated resources to reproductive health, the impact has often been limited because they have not addressed the structural barriers that prevent women getting access to these services. In other words, positive initiatives have been undermined by the continued failure by governments to address underlying discrimination and inequality. (Bessinger, Katende, & Gupta, 2003).

Sexual and Reproductive Health and Rights (SRHR) encompass the right of all individuals to make decisions concerning their sexual activity and reproduction free from discrimination, coercion, and violence. Specifically, access to SRHR ensures individuals are able to choose whether, when, and with whom to engage in sexual activity; to choose whether and when to have children; and to access the information and means to do so (Bessinger, Katende, & Gupta, 2003).

2.9 Empirical Studies

Ahuja and Tiwari (2005) found in their study that in the school-going women, friends followed by the mothers were the major source of information regarding reproductive and sexual health rights and matters, whereas in the non-school-going women, it was mainly mothers followed by older sisters or sisters-in-law. Khan et al., (2005) provided an analysis of exposure to various mass media regarding sexual and reproductive health rights and issues. The findings showed little difference between the male and female students, except in the case of newspapers. More males (74%) than females (57%) read them daily. A comparison between types of schools (government and private), revealed a significant difference in the choice of media. Students in private schools depended more on print media, whereas the public school students favoured the radio. T.V. was used equally by both groups. Television, books, and magazines were the main sources of contraceptive information. Friends were another important source. Bahulekar and Garg (2007) have stated that seven percent students in their study had received information through health personnel. Awasthi and Pande (2008) revealed that the primary sources of knowledge about sex were friends, television, magazines and books, and siblings. The immediate initiation of reproductive health counselling programs is recommended. It was found by Sachdev (2008) that basic knowledge regarding sexual anatomy and function was inadequate among both males and females, and this knowledge was obtained primarily from friends and books and rarely from parents.

Bhatia and Swami (2010) expressed concern about the low levels of knowledge in the rural women regarding fertility control and rights particularly, because three fourths of the India's country's populations stay in villages. The crucial role that schools, parents, peers, and social organizations can play in strengthening reproductive health programs was discussed. Thakor and Kumar (2010) in their study stated that doctors and teachers were preferred as the source for imparting sex education; doctors still remained the first choice for imparting sex education. Acharya and Dasgupta (2005) adopted a right based approach; the study explores

widely the needs of women in general and those of sexuality in particular. An in-depth analysis of contemporary and relevant policies has been undertaken in context of women. A small field study of Jaunsari tribes of Uttranchal has been incorporated to demonstrate the key issues. In-depth interview, FGDs with unmarried females and males in age group 15-19 were conducted. The results reflected that there is absence of a source to satisfy the queries on health and sexual matters, including HIV/AIDS, contraceptives and menstruation related problems. Young adults site that they know about HIV/AIDS but are not clear as to the causes etc. Pointed out that advertisements in Doordarshan and radio do not clearly explain the causes and how and why does it happens, all information they get are from peers and video films that they watch in village. It was reported by the respondents that in a village, Kalsi Johdi – A young PHC worker usually available and helped them and answered their queries and women usually get information from mother, elder sisters and sister-in-law.

Prasad (2006) reported that the perception on sexual matters among rural men represents that more than one-fifth of males (22%) were inclined to read sex related issues published in periodicals than half of the females (50%) who used to read a little. Half of the males (50%) had read letters to editor on sex issues. Two-fifth of men (40%) opined that sex related articles were useful to unmarried men. They believed that articles published in magazines were useful and should be made available to unmarried men. Forty eight percent acquired knowledge on sex indirectly through observation, whereas Thirty nine percent assimilated sex knowledge directly through discussion with peers or relatives.

CHAPTER THREE

METHODOLOGY

3.1 INTRODUCTION

This study investigated knowledge, attitude, and practice towards sexual and reproductive health rights among women in Kaduna State. This chapter was discussed under the following: Research design, Population of the study, Sample and sampling technique, Instrument for data collection, Validity of the instrument, Data collection procedure, Data analysis.

3.2 RESEARCH DESIGN

In this study, the researcher adopted Ex-Post-facto design. The study was on existing identified phenomenon, so the design was said to be appropriate. According to Kerlinger (2000), the Ex-Post-Facto design is a design in which the investigation of the variable is done retrospectively whether they have occurred in natural cause of event. Ofo (1994) also supported that the causal-comparative or Ex-Post-Facto research attempts to determine the cause-and-effect relationships by examining conditions and tracing back the information and available data for probable causal factors.

3.3 POPULATION OF STUDY

The population of the study was made up of women of reproductive age in Kaduna State which is 1,562,634 (22%) of the total population (7,102,880) of Kaduna state (National Bureau of Statistics, 2012).

3.4 SAMPLE AND SAMPLING TECHNIQUE

For the purpose of this study, a sample size of 384 women was used for the study. This is in accordance with Krejcie and Morgan's (1970) table which was used to determine the sample size.

$n = z^2 * p\ (1-p)/r^2$.

Where the z value is taken as 1.96; p, proportion of positive attitudes, was assumed to be 50%; and r, the margin of error of estimation, was assumed to be 5% or 0.05.

n=1.96*0.5(1-0.5)/0.05

n=0.9604/0.0025=384.

This provided a sample size of 384.

A stratified proportional sampling procedure in which samples were drawn from each ward in proportion to the number of women of reproductive age at the time of the study was used. Kaduna state consists of three (3) senatorial zones, namely Kaduna central, Kaduna north, and Kaduna south senatorial zones. Two (2) Local Government Areas were selected from each zone, and one ward was selected from each Local Government Area, hence six (6) wards were selected by simple random sampling. The wards include Hunkuyi, Giwa, Ikara, Kawo, Kachia, and Kafanchan. In the second stage, 384 questionnaire were distributed across the six (6) selected wards using proportionate sampling technique with the following formula;

X=a/b *n

Where X= number of samples from a particular area

A= total population of selected area

B= total population of all selected area (223,471)

n= sample size

Hunkuyi = 19,541/223471* 384 = 34

Ikara = 42,970/223,471*384 = 74

Giwa = 31,527/223,471*384 = 54

Kawo = 89,238/223,471*384 = 153

Kachia = 26,676/223,471*384 = 46

Kafanchan = 323,225/1,767,441*384 = 70

Proportion of the population for questionnaire distribution

SN	WARD	POPULATION	SAMPLE PROPORTION
1	HUNKUYI	19,541	34
2	IKARA	42,970	74
3	GIWA	31,527	54
4	KAWO	89,238	153
5	KACHIA	26,676	46
6	KAFANCHAN	13,519	23
	TOTAL	223,471	384

Systematic random sampling was used to select houses for the study and every fifth house in the ward was selected, that is, 5^{th}, 10^{th}, 15^{th} and so on. In each house one woman of reproductive age was selected using simple random sampling if there was more than one woman in the household.

3.5 INSTRUMENT FOR DATA COLLECTION

The instrument for data collection for this study was a researcher developed questionnaire on knowledge, attitude, and practice toward sexual and reproductive health rights of women in Kaduna State (KAPSRHRWKS). The questionnaire was divided into sections A, B, C, and D. Section A, on demographic characteristics consisting of five (5) items; Section B, on knowledge of sexual and reproductive health rights consisting of twenty four (24) items; and Section C, on attitude towards sexual and reproductive health rights consisting of twenty one (21) items; and Section D, on practice of sexual and reproductive health rights consisting of eleven (11) items. A modified Four Point Likert scale was used to agree with statements formulated to responses which are Strongly Agree (SA), Agree (A), Disagree (D) and Strongly Disagree (SD). The responses for items in section C were rated as follows:

Degree of response		**Points**
Strongly Agree	(SA)	4
Agree	(A)	3
Disagree	(D)	2
Strongly Disagree	(SD)	1

3.6 VALIDITY OF THE INSTRUMENT

The instrument was designed by the researcher in accordance with the research questions under the guidance of her supervisors and clean copies were produced. The clean copies were given to five (5) jurors whom are experts in the field of Physical and Health Education, Nursing Sciences, Guidance and Counselling for vetting. All the corrections and observations

made were incorporated in the final copy of the questionnaire and approval was given by the supervisors before using it for collecting data for the study.

3.7 PROCEDURE FOR DATA COLLECTION

The researcher obtained a letter of introduction from the Head, Department of Physical and Health Education, Ahmadu Bello University, Zaria, Kaduna State introducing the researcher and also stating the purpose and benefits of the research. In conducting this study, six (6) research assistants; one from each Local Government Area were involved to assist and accompany the researcher in obtaining data for the study. These six (6) research assistants were trained by the researcher on how to administer the questionnaire to respondents in their homes, how to fill the questionnaire on the spot of administration, and interpretation to respondents by research assistants if there is need. 384 questionnaires were administered and 377 were retrieved; 7 respondents did not return their questionnaire.

3.8 PROCEDURE FOR DATA ANALYSIS

The following statistical tools were used to test the hypotheses for this study:

1. Descriptive statistics of frequency counts, percentages, mean, and standard deviation were used to organize and access the demographic information of the respondents, and answer the research questions on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state. A constant mean of 2.5 was used to ascertain the agreement or non-agreement of respondents on the questions.

2. Multiple Regression analysis was used to test the major hypothesis at 0.05 alpha level.

3. One sampled t-test was used to test hypotheses 1-3 while ANOVA was used to test hypotheses 4-6 advanced at 0.05 alpha level.

CHAPTER FOUR

RESULTS AND DISCUSSIONS

4.1 Introduction

A total of 384 questionnaires were administered to women across the selected local government areas of Kaduna state. Of the total administered, 377 were found to be successfully filled with the required information, amounting to 98.2% response rate of the total administered. This chapter presents the statistical analyses of the data on the expressed knowledge, attitude, and practice of sexual and reproductive health rights among the women involved in the study.

4.2 Demographic characteristics of the respondents

The personal data selected along the expressed opinions of the respondents were age, ethnicity, marital status, education and occupation. These variable were considered to be directly associated with the knowledge, attitude, and practice of sexual and reproductive health rights among women in the state. Each of the variables is classified in frequencies and percentages in Table 4.1.

Table 4.1: Classifications of the respondents' demographic characteristics.

Variables	Variable options	Frequency	Percent
Age	15 – 24years	51	13.5
	25 – 34 years	183	48.5
	35 – 44 years	87	23.1
	45years and above	56	14.9
	Total	377	100.0
Ethnicity	Hausa	138	36.7
	Yoruba	86	22.8
	Igbo	68	18.0
	Others	85	22.5
	Total	377	100.0
Marital status	Single	76	20.2
	Married	265	70.3
	Divorced/Separated/widowed	36	9.5
	Total	377	100.0
Education	No formal education	75	19.9
	Primary school/Adult literacy	57	15.1
	Secondary School	70	18.6
	OND	35	9.3
	HND	30	8.0
	First Degree	78	20.6
	Higher Degree	32	8.5
	Total	377	100.0
Occupation	House Wife	77	20.4
	Civil Servant	130	34.5
	Business	73	19.4
	Teaching	35	9.3
	Others	62	16.4
	Total	377	100.0

The distribution in the table revealed that 51(13.5%) of the women were within the age range of 15 to 24years. Those between 25 and 34years were 183(48.5%), 87(23.1%) were between 35 and 44years and 56(149%) were above 45years. This would imply that most of the women were within reproductive age bracket and would therefore be able to provide the required information on the knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state.

As indicated in the table, dominant ethnic group among the respondents was Hausa with 138(36.7%) and was followed by those of Yoruba 86(22.8%), minority groups like Bajju, Jaba, Idoma, Tiv among others (85(22.5%) and Igbo with 68 (18.0%). This would imply that women of various ethnic groups in the state were represented in the study.

For their marital statuses, women who were single among the respondents were 76(20.2%). Those who were married constituted the bulk of the respondents with 265(70.3%) while those who were divorced, separated or widowed were added together and amounted to 36(9.5%) of the total respondents. The inclusion of this variable is vital for its association with the topic of investigation in the study.

The educational statuses of the women as indicated in the table revealed that 75(19.9%) have no formal education. Those with primary school or adult literacy were 57(15.1%) while those with secondary school education were 70(18.6%). Women who had OND or its equivalent NCE were 35(9.3%), those with HND 30(8.0%), First degree 78(20.6%) and those with higher degree were 32(8.5%). The distribution implies that the respondents have the broad spectrum of education statuses prevailing among women in the state. It would therefore be expected that education could play a role in the knowledge, attitude, and practice of sexual and reproductive health rights among the women involved in the study.

By occupational distribution, only 77(20.4%) were house wives. This could account for the level of education expressed above. Those who were civil servants were 130(34.5%) while those involved in business and teaching were 73(19.4%) and 35(9.3%) respectively. Only 62(16.4%) of the respondents were involved in other occupations like artisans that were not classified in the table. This would imply that the respondents comes from all the different occupational backgrounds in the state.

4.3 Assessment of knowledge, attitude, and practice of sexual and reproductive health rights among the women

The major objective of this study is to asse**ss** the knowledge, attitude and practice of sexual and reproductive health rights among women in Kaduna state. These were stated as specific objectives and research question 1 to 3 respectively. For the assessment, each of the variables (knowledge, attitude and practice) was assessed independently with mean scores computed on a four point scale. Decision on each of the item is based on a midpoint average of 2.5. Mean score of 2.5 and above would imply positive or agreement with the suggested notion of the item while mean level lower than 2.5 would indicate negative or disagreement. Table 4.2 shows expressed knowledge of the women on the sexual and reproductive health rights in means and standard deviations.

Table 4.2: Mean scores of the women on knowledge on the sexual and reproductive health rights

Sn	Knowledge of sexual and reproductive health rights	Mean	Std. Dev.
1	Sexual and reproductive health rights are in the Nigeria constitution.	1.95	0.881
2	Nigeria women have sexual and reproductive health rights.	2.06	0.850
3	Schools are a source of knowledge for sexual and reproductive health rights.	2.09	0.860
4	Hospitals are a source of knowledge for sexual and reproductive health rights.	2.11	0.822
5	Primary Health Care Centres are a source of knowledge for sexual and reproductive health rights.	2.13	0.903
6	Social media is a source of knowledge for sexual and reproductive health rights.	2.05	0.865
7	Mass media is a source of knowledge for sexual and reproductive health rights.	2.20	0.913
8	The right to sexual freedom is a sexual and reproductive health rights	2.14	0.853
9	The right to sexual and reproductive health rights.	2.18	0.867
10	The right to sexual is a sexual and reproductive health rights.	2.19	0.905
11	The right to safety of the sexual body is a sexual and reproductive health rights.	2.17	0.898
12	The right to sexual privacy is a sexual and reproductive health rights.	2.14	0.929
13	The right sexual equity is asexual and reproductive health rights.	2.16	0.835
14	The right to sexual pleasure is a sexual and reproductive health rights.	2.26	1.011
15	The right to emotional sexual expression is asexual and reproductive health rights.	2.18	0.963
16	The right to sexually associate freely with my partner is a sexual and reproductive health rights.	2.01	0.992
17	The right to make free and responsible reproductive choices is a sexual and reproductive health rights.	1.86	0.914
18	The right to sexual information is a sexual and reproductive health rights.	2.04	0.967
19	The right to comprehensive sexuality education is a sexual and reproductive health right.	1.93	0.898
20	The right to sexual health care is a sexual and reproductive health rights.	2.00	0.940
21	The right to sexual cohabitation with my partner is a sexual and reproductive health rights.	1.95	0.886
22	The right to have any number of sexual partners as desired is a sexual and reproductive health rights.	1.91	0.890
23	The right to terminate an unwanted pregnancy is a sexual and reproductive health rights.	1.96	0.894
24	The right to reproductive health care is a sexual and reproductive health rights.	1.89	0.887
Aggregate mean		2.06	0.267

The aggregate mean score for the table is 2.06 with a standard deviation of 0.267.The score is lower than the midpoint average of 2.5 which means that the women did not agree with suggested knowledge or do not have the knowledge solicited. From the scores, there is no major indication that the women have the knowledge of sexual and reproductive health rights in the state. This lack of knowledge cuts across all the items in the table. It could therefore be concluded that the women did not have adequate knowledge of sexual and reproductive health rights in the state. Table 4.3 shows the mean scores of the women' attitude towards sexual and reproductive health rights in Kaduna state.

Table 4.3: Mean scores of the women on attitude towards sexual and reproductive health rights

Sn	Attitude towards sexual and reproductive health rights	Mean	Std. Dev.
1	Sexual and reproductive health right should be taught to young adolescents in school.	2.99	0.844
2	Health institutions should advocate sexual and reproductive health rights.	2.62	0.918
3	Outreach programmes should be set up to educate men and women of all ages about sexual and reproductive health rights.	2.33	0.975
4	All communities should advocate sexual and reproductive health rights to young adults.	2.37	0.981
5	Women should have the right to sexual freedom.	2.49	0.957
6	Women should have the right to sexual autonomy.	2.45	1.033
7	Women should have the right to sexual integrity.	2.47	0.992
8	Women should have the right to safety of the sexual body.	2.54	1.018
9	Women should have the right to sexual privacy.	2.44	0.979
10	Women should have the right to sexual equity.	2.30	0.947
11	Women should have the right to sexual pleasure.	2.39	0.931
12	Women should have right to emotional sexual expression.	2.14	0.859
13	Women should have the right to sexually associate freely with their partners.	2.00	0.872
14	Women should have the right to make free and responsible reproductive choices.	2.04	0.835
15	Women should have the right to sexual information.	2.07	0.829
16	Women should have the right to comprehensive sexuality education.	2.13	0.886
17	Women should have the right to sexual health care.	2.07	0.850
18	Women should have the right to sexual cohabitation.	2.08	0.844
19	Women should have the right to have any number of sexual partners desired.	2.03	0.793
20	Women should have the right to terminate an unwanted pregnancy.	1.97	0.803
21	Women should have the right to reproductive health care.	2.11	0.822
Aggregate mean		2.29	0.289

The aggregate mean score on attitude for the table is 2.29 with a standard deviation of 0.289. This mean score is short of the midpoint average of 2.5 for agreement or positive attitude toward sexual and reproductive health rights solicited for. It could therefore be concluded that the women have no positive attitude towards sexual and reproductive health rights in the state. Table 4.4 shows the mean level along with respective standard deviations on practices of sexual and reproductive health rights by the women.

Table 4.4: Mean scores of the women on practices of sexual and reproductive health rights

Sn	Practice of sexual and reproductive health rights	Mean	Std. Dev.
1	I am not comfortable when sexual and reproductive health rights are taught to young women.	2.18	0.816
2	It is difficult for me to talk about sexual and reproductive health rights.	1.93	0.804
3	I have cause to demand for my sexual and reproductive health rights	2.03	0.793
4	My partner has had sex with me against my will.	1.95	0.806
5	I prefer to speak to health personnel about sexual and reproductive health problems and rights.	2.00	0.807
6	I confronted my partner to discuss his violation of my sexual and reproductive health rights.	1.97	0.790
7	I prefer to discuss sexual and reproductive health rights with my parents.	2.05	0.848
8	I prefer to discuss sexual and reproductive health rights with my friends.	1.89	0.805
9	I involved the police while exercising my sexual and reproductive health rights.	2.09	0.863
10	I involved the judiciary while exercising my sexual and reproductive health rights.	2.06	0.923
11	I involved the clergy while exercising my sexual and reproductive health rights.	2.55	1.018
Aggregate mean		2.06	0.320

From the aggregate mean score of 2.06 with a standard deviation of 0.320 for the table, there is no major indication that the women have adequate practices of sexual and reproductive health rights in the state. The mean score (2.06) for the table is lower than the midpoint average of 2.5, that would imply adequate practice of sexual and reproductive health rights by

women in the state. It could therefore be asserted that the women in the state have no adequate practice of sexual and reproductive health rights.

4.4 Effects of women's demographic factors on their knowledge, attitude and practice of sexual and reproductive health rights in Kaduna state

Among the specific objective of the study is the examination of the effect of selected demographic variables of the women on their knowledge, attitude and practice of sexual and reproductive health rights in the state. These were investigated with the fourth, fifth and sixth research questions of the study. Variables whose effects were investigated include women's marital status, educational level and occupation. Table 4.5 shows the mean scores and standard deviations by the women of different marital statuses on the knowledge, attitude and practice of sexual and reproductive health rights.

Table 4.5: Mean scores of women with different marital statuses on knowledge attitude and practice of sexual and reproductive health rights in Kaduna state

		Knowledge		Attitude		Practice	
Marital status	N	Mean	Std. Dev	Mean	Std. Dev	Mean	Std. Dev
Single	76	2.01	0.222	2.29	0.243	2.03	0.341
Married	265	2.09	0.275	2.29	0.310	2.09	0.306
Divorced/separated/widow	36	1.99	0.267	2.26	0.215	1.95	0.357
Total	377	2.06	0.267	2.29	0.289	2.06	0.320

The mean scores on knowledge, attitude and practice of sexual and reproductive health rights by women of the different marital statuses in the table did not reveal that the status could play a significant role in the investigated variables. For knowledge, the married, single and others did not have what could be regarded as positive knowledge as indicated by the mean scores since none was able to score up to the midpoint average of 2.5. This was the case for attitude and practice in the table. By implication, the marital statuses of the women did not play a

major role in their knowledge, attitude and practice of sexual and reproductive health rights in the state. But there were some variability in the mean scores on the knowledge, attitude and practice of sexual and reproductive health rights by groups of women in the different marital statuses. The significance of the variability was subjected to test in the related hypothesis. Table 4.6 shows the mean scores of the respondents with the different marital statuses on attitude towards sexual and reproductive health rights.

Table 4.6: Mean scores of women with different educational levels on knowledge, attitude and practice of sexual and reproductive health rights in Kaduna state

Highest educational qualification	N	Knowledge		Attitude		Practice	
		Mean	Std. Dev	Mean	Std. Dev	Mean	Std. Dev
No formal education	75	2.03	0.216	2.27	0.247	2.03	0.334
Primary school/Adult literacy	57	2.06	0.282	2.30	0.276	2.09	0.307
Secondary School	70	2.15	0.287	2.29	0.308	2.18	0.290
OND	35	2.12	0.264	2.37	0.323	2.02	0.269
HND	30	1.91	0.235	2.28	0.327	1.96	0.306
First Degree	78	2.04	0.265	2.28	0.300	2.03	0.345
Higher Degree	32	2.12	0.270	2.23	0.260	2.04	0.322
Total	377	2.06	0.267	2.29	0.289	2.06	0.320

The table shows that education did not really influence knowledge, attitude and practice of sexual and reproductive health rights of women in Kaduna state. In the table, none of the women of different educational status was found to have positive knowledge, attitude and practice of sexual and reproductive health rights. The mean scores for all the categories of different educational statuses were lower than the midpoint average of 2.5. But there were major variability in the mean scores which will be subject to test of significance in the related

hypothesis. Table 4.7 shows the mean scores of the women with different occupational groupings on knowledge, attitude and practice of sexual and reproductive health rights in Kaduna state.

Table 4.7: Mean scores of women with different occupations on knowledge, attitude and practice of sexual and reproductive health rights in Kaduna state

		Knowledge		Attitude		Practice	
Occupation	N	Mean	Std. Dev	Mean	Std. Dev	Mean	Std. Dev
House Wife	77	2.01	0.221	2.29	0.241	2.03	0.339
Civil Servant	130	2.03	0.264	2.26	0.282	2.04	0.325
Business	73	2.13	0.299	2.30	0.304	2.17	0.292
Teaching	35	2.12	0.264	2.37	0.323	2.02	0.269
Others	62	2.09	0.271	2.28	0.319	2.05	0.326
Total	377	2.06	0.267	2.29	0.289	2.06	0.320

The table revealed that occupations of the women play no major role in the knowledge, attitude and practice of sexual and reproductive health rights in Kaduna state. Their mean score from the house wife to those of civil service orientations did not reach the midpoint average of 2.5 used for agreement in the table. This means that occupation could not be regarded as a major factor of knowledge, attitude and practice of sexual and reproductive health rights by women in Kaduna state. The observed variability in the mean scores is tested in the related hypothesis.

4.5 Testing of null hypotheses

One major null hypothesis along with six null sub-hypotheses were tested in the study. The tests were conducted at the 0.05 probability level of significance. The hypotheses were tested as follows:

Major Hypothesis: Knowledge and Attitude will not be significantly influence practice of women towards sexual and reproductive health rights in Kaduna state, Nigeria.

To assess the impact of knowledge and Attitude of the women as significant predictors of practice of sexual and reproductive health rights in the state, the variables were subjected to a multiple regression model along with the practice as the dependent variable Table 4.8 shows the summary of the regression estimates for determining the functional relationship between the women's Knowledge and Attitude and practice of sexual and reproductive health rights.

Table 4.8: Regression estimates of Knowledge and Attitude of the women and their practice of sexual and reproductive health rights in Kaduna state

Variables	Unstandardized Coefficients		Standardized Coefficients		
	B	Std. Error	Beta	T	Sig.
(Constant)	0.559	0.141		3.967	0.000
Knowledge	0.509	0.056	0.425	9.141	0.000
Attitude	0.198	0.051	0.178	3.841	0.000

Dependent Variable: Practice

The result, as indicated in the model showed that attitude and knowledge are significant predictors of the women's practice of sexual and reproductive health rights in Kaduna state. The observed F-value for the model was 63.550 obtained at the 2, 374 degree of freedom. The probability level of significance for the model is 0.000 ($P < 0.05$). The observed coefficient of determination (R^2) for the model is 25.4% which clearly indicated that the knowledge and attitude of the women accounted for 25.4% of the variance estimate on practice of sexual and reproductive health rights by women in Kaduna state. The functional relationship for the knowledge and attitude as predictors of practice of sexual and

reproductive health rights the model could be estimated as Practices = 0.559 + 0.509 knowledge + 0.198 attitude. At the level of the individual variables as predictors, knowledge and attitude of the women were found to be significant predictors of their practice of sexual and reproductive health rights in Kaduna state ($P < 0.05$).The null hypothesis that Knowledge and Attitude will not be significant predictors of practice of sexual and reproductive health rights among women in Kaduna State is therefore rejected.

Sub-Hypothesis I: Women have no significant knowledge of sexual and reproductive health rights in Kaduna state.

The respondents score on knowledge of sexual and reproductive health rights assessed in Table 4.2 was tested here with the one sample t-test was used because of the need to test the observed mean score with a fixed constant of 2.5 which will indicated whether the knowledge is significantly adequate or not. The result of the test is summarized in Table 4.9.

Table 4.9: One sample t-test on knowledge of sexual and reproductive health rights

Variables	N	Mean	Std. Deviation	Std. Error	t-value	DF	P-value	Remarks
Knowledge	377	2.06	.267	.014	31.696	376	.000	Sig.
Fixed mean	377	2.50	0.00	0.00				

The test revealed that respondents' knowledge of sexual and reproductive health rights in Kaduna state is significantly low ($P < 0.05$). The observed mean score (2.06) is lower than the fixed score (2.50). This is indicated by an observed t-value of 31.696 and the observed level of significance is 0.000. This means that the null hypothesis could be rejected. The implication here is that the knowledge is significantly low.

Sub-hypothesis II: Women have positive significant attitude towards sexual and reproductive health rights in Kaduna State.

The respondents score on attitude towards sexual and reproductive health rights assessed in Table 4.3 was tested here with one sample t-test was used because of the need to test the observed mean score with a fixed constant of 2.5 which will indicate whether the attitude is significantly adequate or not. The result of the test is summarized in Table 4.10.

Table 4.10: One sample t-test on attitude towards sexual and reproductive health rights

Variables	N	Mean	Std. Dev.	Std. Error	t-value	DF	P-value	Remarks
Attitude	377	2.29	.289	.015	14.278	376	.000	Sig.
Fixed mean	377	2.50	0.00	0.00				

The test revealed that respondents' attitude towards sexual and reproductive health rights in the state is significantly low ($P < 0.05$). The observed mean score (2.29) is lower than the fixed score (2.50). This is indicated by an observed t-value of 14.278 and the observed level of significance is 0.000. This means that the null hypothesis could be rejected. The implication here is that the observed attitude is significantly low.

Sub-hypothesis III: Women do not have adequate practice of sexual and reproductive health rights in Kaduna State.

The respondents score on practices of sexual and reproductive health rights assessed in Table 4.4 was tested here with one sample t-test was used because of the need to test the observed mean score with a fixed constant of 2.5 which will indicate whether the practices is significantly adequate or not. The result of the test is summarized in Table 4.11.

Table 4.11: One sample t-test on attitude towards sexual and reproductive health rights

Variables	N	Mean	Std. Deviation	Std. Error	t-value	DF	P-value	Remarks
Practice	377	2.06	.320	.016	26.527	376	.000	Sig.
Fixed mean	377	2.50	0.00	0.00				

The test revealed that respondents' attitude towards sexual and reproductive health rights in Kaduna state is significantly low ($P < 0.05$). The observed mean score (2.06) is lower than the fixed score (2.50). This is indicated by an observed t-value of 26.637 and the observed level of significance is 0.000. This means that the null hypothesis could be rejected. The implication here is that the observed level of practices of sexual and reproductive health rights is significantly low.

Sub-hypothesis IV: Marital status of women will not have significant effect on knowledge, attitude and practice of sexual and reproductive health rights among women in Kaduna State.

The mean scores of the respondents in Tables 4.2, 4.3 and 4.4 were used here as dependent variables to determine the effect of the women's marital status on the expressed knowledge, attitude and practices of sexual and reproductive health rights. The one way analysis of variance (ANOVA) was used for the test because of the multiple levels of the independent variable. Table 4.12 presents a summary of the ANOVA model.

Table 4.12: Analysis of variance on knowledge, attitude and practice of sexual and reproductive health rights among women of different marital status

Variables	Source	Sum of Squares	DF	Mean Square	F	Sig.
Knowledge	Between Groups	.526	2	.263	3.755	.024
	Within Groups	26.215	374	.070		
	Total	26.742	376			
Attitude	Between Groups	.025	2	.013	.150	.861
	Within Groups	31.341	374	.084		
	Total	31.366	376			
Practice	Between Groups	.651	2	.325	3.217	.041
	Within Groups	37.831	374	.101		
	Total	38.482	376			

The observed F-values for knowledge as indicated in the table is 3.755 the test is higher than the critical value of 3.00 at the same degree of freedom of 2, 374. The observed level of significance is 0.024 ($P < 0.05$). This is a clear indication that the women differ significantly by their marital status in their knowledge of sexual and reproductive health rights. But for their attitude, no significant difference was observed ($P > 0.05$). In practices of sexual and reproductive health rights, there was significant difference between the different marital status ($P < 0.05$). This would mean that the null hypothesis could be rejected on the basis of knowledge and practices of sexual and reproductive health rights. But on the basis of attitude towards sexual and reproductive health rights, there is no evidence to reject the null hypothesis. The mean scores for the different marital status of the women on the three variables were presented in Table 4.5. For the determination of the marital status category

that was significantly different from the others in their knowledge and practices of the sexual and reproductive health rights, a post hoc test was performed on the mean scores using the Scheffe procedure. The result is summarized in Tables 4.13 and 4.14 respectively.

Table 4.13: Scheffe result on knowledge sexual and reproductive health rights by marital statuses of the respondents

(I) Marital status	(J) Marital status	Mean Difference (I-J)	Std. Error	Sig.
Single	Married	-.07388(*)	.03445	.050
	Divorced/separated/widowed	.02175	.05357	.921
Married	Single	.07388(*)	.03445	.050
	Divorced/separated/widowed	.09562	.04703	.128
Divorced/separated	Single	-.02175	.05357	.921
/widowed	Married	-.09562	.04703	.128

* The mean difference is significant at the .05 level.

The result revealed that the observed difference in knowledge of sexual and reproductive health rights was between women who were single and those who were married. Between the single and divorced/separated/widowed women, no significant difference was observed and the married women were not significantly different from those who were divorced, separated or widowed in their knowledge of the sexual and reproductive health rights in Kaduna state. Table 4.14 shows the result of the Scheffe procedure on the level of practices of sexual and reproductive health rights.

Table 4.14: Scheffe result on practices of sexual and reproductive health rights by marital statuses of the respondents

(I) Marital status	(J) Marital status	Mean Difference (I-J)	Std. Error	Sig.
Single	Married	-.05569	.04138	.405
	Divorced/separated/widowed	.07656	.06435	.493
Married	Single	.05569	.04138	.405
	Divorced/separated/widowed	.13225(*)	.05649	.046
Divorced/separated/widowed	Single	-.07656	.06435	.493
	Married	-.13225(*)	.05649	.046

* The mean difference is significant at the .05 level.

The result revealed that the observed difference in practices of sexual and reproductive health rights was between married women and those who were divorced from their spouses, separated or widowed. Between the single and married women, no significant difference was observed and between the single and those who were divorced, separated or widowed no significant difference was observed.

Sub-hypothesis V: Educational level of women will not have significant effect on knowledge, attitude and practice of sexual and reproductive health rights among women in Kaduna State.

The mean scores of the respondents in Tables 4.2, 4.3 and 4.4 were used here as dependent variables to determine the effect of the women's educational levels on the expressed knowledge, attitude and practices of sexual and reproductive health rights. The one way

analysis of variance (ANOVA) was used for the test because of the multiple levels of the independent variable. Table 4.15 presents a summary of the ANOVA model.

Table 4.15: Analysis of variance on knowledge, attitude and practice of sexual and reproductive health rights among women of different educational levels

Variables	Source	Sum of Squares	DF	Mean Square	F	Sig.
Knowledge	Between Groups	1.532	6	.255	3.747	.001
	Within Groups	25.210	370	.068		
	Total	26.742	376			
Attitude	Between Groups	.360	6	.060	.716	.637
	Within Groups	31.006	370	.084		
	Total	31.366	376			
Practice	Between Groups	1.579	6	.263	2.639	.016
	Within Groups	36.902	370	.100		
	Total	38.482	376			

The observed F-values for knowledge as indicated in the table is 3.747 the test is higher than the critical value of 2.10 at the same degree of freedom of 6, 370. The observed level of significance is 0.001 ($P < 0.05$). This is a clear indication that the women differ significantly by their educational levels in their knowledge of sexual and reproductive health rights. But for their attitude, no significant difference was observed ($P > 0.05$). In practices of sexual and reproductive health rights, there was significant difference between the different marital statuses, the F-value was 2.639 and the observed p-value is 0.016 ($P < 0.05$). This would mean that the null hypothesis could be rejected on the basis of knowledge and practices of sexual and reproductive health rights. But on the basis of attitude towards sexual and reproductive health rights, there is no evidence to reject the null hypothesis. The mean scores

for the different marital statuses of the women on the three variables were presented in Table 4.6. For the determination of the educational levels that was significantly different from the others in their knowledge and practices of the sexual and reproductive health rights, a post hoc test was performed on the mean scores using the Scheffe procedure. The result is summarized in Tables 4.16 and 4.17 respectively.

Table 4.16: Scheffe result on knowledge sexual and reproductive health rights by educational levels of the respondents

(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.
No formal	Primary school/Adult literacy	-.02295	.04587	1.000
education	Secondary School	-.11190	.04338	.216
	OND	-.08571	.05343	1.000
	HND	.12639	.05639	.537
	First Degree	-.00780	.04221	1.000
	Higher Degree	-.08906	.05512	1.000
Primary	No formal education	.02295	.04587	1.000
school/Adult	Secondary School	-.08895	.04657	1.000
literacy	OND	-.06276	.05605	1.000
	HND	.14934	.05888	.244
	First Degree	.01515	.04548	1.000
	Higher Degree	-.06611	.05766	1.000
Secondary School	No formal education	.11190	.04338	.216
	Primary school/Adult literacy	.08895	.04657	1.000
	OND	.02619	.05404	1.000
	HND	.23829(*)	.05696	.001
	First Degree	.10411	.04298	.334
	Higher Degree	.02284	.05570	1.000
OND	No formal education	.08571	.05343	1.000

	Primary school/Adult literacy	.06276	.05605	1.000
	Secondary School	-.02619	.05404	1.000
	HND	.21210(*)	.06495	.025
	First Degree	.07792	.05311	1.000
	Higher Degree	-.00335	.06384	1.000
HND	No formal education	-.12639	.05639	.537
	Primary school/Adult literacy	-.14934	.05888	.244
	Secondary School	-.23829(*)	.05696	.001
	OND	-.21210(*)	.06495	.025
	First Degree	-.13419	.05608	.361
	Higher Degree	-.21545(*)	.06634	.027
First Degree	No formal education	.00780	.04221	1.000
	Primary school/Adult literacy	-.01515	.04548	1.000
	Secondary School	-.10411	.04298	.334
	OND	-.07792	.05311	1.000
	HND	.13419	.05608	.361
	Higher Degree	-.08126	.05480	1.000
Higher Degree	No formal education	.08906	.05512	1.000
	Primary school/Adult literacy	.06611	.05766	1.000
	Secondary School	-.02284	.05570	1.000
	OND	.00335	.06384	1.000
	HND	.21545(*)	.06634	.027
	First Degree	.08126	.05480	1.000

* The mean difference is significant at the .05 level.

The result showed that respondents with HND were generally low in the knowledge and were significantly different from those with higher degrees along with those with secondary and those with OND certificates. Between the educational levels of the remaining categories, no

significant difference was observed. Table 4.17 shows the result of the Scheffe procedure on the mean level of practices of sexual and reproductive health rights by educational levels of the respondents.

Table 4.17: Scheffe result on practices of sexual and reproductive health rights by educational levels of the respondents

(I) Education	(J) Education	Mean Difference (I-J)	Std. Error	Sig.
No formal education	Primary school/Adult literacy	-.05219	.05549	1.000
	Secondary School	-.14918	.05248	.099
	OND	.01316	.06465	1.000
	HND	.07636	.06822	1.000
	First Degree	.00014	.05107	1.000
	Higher Degree	-.00867	.06668	1.000
Primary school/Adult literacy	No formal education	.05219	.05549	1.000
	Secondary School	-.09699	.05634	1.000
	OND	.06535	.06782	1.000
	HND	.12855	.07123	1.000
	First Degree	.05232	.05503	1.000
	Higher Degree	.04351	.06976	1.000
Secondary School	No formal education	.14918	.05248	.099
	Primary school/Adult literacy	.09699	.05634	1.000
	OND	.16234	.06538	.283
	HND	.22554(*)	.06892	.024
	First Degree	.14932	.05199	.091
	Higher Degree	.14050	.06739	.793
OND	No formal education	-.01316	.06465	1.000
	Primary school/Adult literacy	-.06535	.06782	1.000

	Secondary School	-.16234	.06538	.283
	HND	.06320	.07858	1.000
	First Degree	-.01302	.06425	1.000
	Higher Degree	-.02183	.07724	1.000
HND	No formal education	-.07636	.06822	1.000
	Primary school/Adult literacy	-.12855	.07123	1.000
	Secondary School	-.22554(*)	.06892	.024
	OND	-.06320	.07858	1.000
	First Degree	-.07622	.06785	1.000
	Higher Degree	-.08504	.08026	1.000
First Degree	No formal education	-.00014	.05107	1.000
	Primary school/Adult literacy	-.05232	.05503	1.000
	Secondary School	-.14932	.05199	.091
	OND	.01302	.06425	1.000
	HND	.07622	.06785	1.000
	Higher Degree	-.00881	.06630	1.000
Higher Degree	No formal education	.00867	.06668	1.000
	Primary school/Adult literacy	-.04351	.06976	1.000
	Secondary School	-.14050	.06739	.793
	OND	.02183	.07724	1.000
	HND	.08504	.08026	1.000
	First Degree	.00881	.06630	1.000

* The mean difference is significant at the .05 level.

The result showed that respondents with HND were significantly lower in their practices than those with secondary school certificates. Between the educational levels of the remaining categories, no significant was observed.

Sub-hypothesis VI: Occupation of women will not have significant effect on knowledge, attitude and practice of sexual and reproductive health rights among women in Kaduna State.

The mean scores of the respondents in Tables 4.2, 4.3 and 4.4 were used here as dependent variables to determine the effect of the women's different occupations on the expressed knowledge, attitude and practices of sexual and reproductive health rights. The one way analysis of variance (ANOVA) was used for the test because of the multiple levels of the independent variable. Table 4.18 presents a summary of the ANOVA model.

Table 4.18: Analysis of variance on knowledge, attitude and practice of sexual and reproductive health rights among women of different occupations

Variables	Source	Sum of Squares	DF	Mean Square	F	Sig.
Knowledge	Between Groups	.737	4	.184	2.635	.034
	Within Groups	26.005	372	.070		
	Total	26.742	376			
Attitude	Between Groups	.295	4	.074	.883	.474
	Within Groups	31.071	372	.084		
	Total	31.366	376			
Practice	Between Groups	1.047	4	.262	2.602	.036
	Within Groups	37.435	372	.101		
	Total	38.482	376			

The observed F-values for knowledge as indicated in the table is 2.635 the test is higher than the critical value of 2.37 at the same degree of freedom of 4, 372. The observed level of significance is 0.034 ($P < 0.05$). This is a clear indication that the women of different occupations differ significantly in their knowledge of sexual and reproductive health rights.

But for their attitude, no significant difference was observed ($P > 0.05$). In practices of sexual and reproductive health rights, there was significant difference between women of different occupations, the F-value was 2.602 and the observed p-value is 0.036 ($P < 0.05$). This would mean that the null hypothesis could be rejected on the basis of knowledge and practices of sexual and reproductive health rights. But on the basis of attitude towards sexual and reproductive health rights, there is no evidence to reject the null hypothesis. The mean scores for the different marital statuses of the women on the three variables were presented in Table 4.6. For the determination of the occupations that was significantly different from the others in their knowledge and practices of the sexual and reproductive health rights, a post hoc test was performed on the mean scores using the Scheffe procedure. The result is summarized in Tables 4.19 and 4.20 respectively.

Table 4.19: Scheffe result on knowledge sexual and reproductive health rights by occupations of the respondents

(I) occupation	(J) occupation	Mean Difference (I-J)	Std. Error	Sig.
House Wife	Civil Servant	-.01840	.03802	.994
	Business	-.11039(*)	.04319	.051
	Teaching	-.10444	.05390	.442
	Others	-.07679	.04512	.576
Civil Servant	House Wife	.01840	.03802	.994
	Business	-.09199	.03867	.228
	Teaching	-.08603	.05035	.572
	Others	-.05839	.04081	.727
Business	House Wife	.11039(*)	.04319	.051
	Civil Servant	.09199	.03867	.228
	Teaching	.00595	.05436	1.000
	Others	.03360	.04566	.969
Teaching	House Wife	.10444	.05390	.442
	Civil Servant	.08603	.05035	.572
	Business	-.00595	.05436	1.000
	Others	.02765	.05590	.993
Others	House Wife	.07679	.04512	.576
	Civil Servant	.05839	.04081	.727
	Business	-.03360	.04566	.969
	Teaching	-.02765	.05590	.993

* The mean difference is significant at the .05 level.

The only significant difference observed in the knowledge of sexual and reproductive health rights was between women who were business oriented and those who were housewives.

Between the housewives and women of other occupations; no significant difference was observed and between the business women and those of other occupations, no significant difference was observed in their levels of knowledge. Table 4.20 shows the summary of the Scheffe procedure on the mean levels of practices of the sexual and reproductive health rights by women of the different occupations.

Table 4.20: Scheffe result on practices of sexual and reproductive health rights by occupations of the respondents

(I) occupation	(J) occupation	Mean Difference (I-J)	Std. Error	Sig.
House Wife	Civil Servant	-.00986	.04562	1.000
	Business	-.13867(*)	.05182	.053
	Teaching	.00992	.06467	1.000
	Others	-.01769	.05413	.999
Civil Servant	House Wife	.00986	.04562	1.000
	Business	-.12881	.04640	.105
	Teaching	.01978	.06041	.999
	Others	-.00783	.04896	1.000
Business	House Wife	.13867(*)	.05182	.053
	Civil Servant	.12881	.04640	.105
	Teaching	.14859	.06522	.270
	Others	.12098	.05479	.302
Teaching	House Wife	-.00992	.06467	1.000
	Civil Servant	-.01978	.06041	.999
	Business	-.14859	.06522	.270
	Others	-.02761	.06707	.997
Others	House Wife	.01769	.05413	.999
	Civil Servant	.00783	.04896	1.000
	Business	-.12098	.05479	.302
	Teaching	.02761	.06707	.997

* The mean difference is significant at the .05 level.

The only significant difference observed in the level of practices of sexual and reproductive health rights was between women who were business oriented and those who were housewives. Between the housewives and women of other occupations no significant difference was observed and between the business women and those of other occupations, no significant difference was observed in their levels of practices. Table 4.20 shows the

summary of the Scheffe procedure on the mean levels of practices of the sexual and reproductive health rights by women of the different occupations.

4.6 Discussion

This study investigated knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna state. One major null hypothesis and six sub-hypotheses were tested in line with the major objective and specific objectives and research questions of the study. In the analysis of the data relating to the major hypothesis, it was found that the women did not have adequate knowledge about sexual and reproductive health rights in the state. The attitude they expressed was found to be inadequate and their practices of sexual and reproductive health rights was found to be extremely low. In the test of the major hypothesis, the knowledge and attitude of the women were found to be significant predictors of their practices of sexual and reproductive health rights. The null hypothesis was therefore rejected. This finding agrees with the findings of Hossain (2006) who reported that knowledge and attitude have significant impact on practices of sexual and reproductive health rights**.**

In the test of sub-hypothesis I, it was found that the women were significantly deficient of the required knowledge of sexual and reproductive health rights. The null hypothesis was therefore rejected. The finding is consistent with Sawyer (2012) who reported in their findings that it is not only that women lack adequate information and suffer from the taboo surrounding women reproductive health right issues, but the low social status and the lack of rights of women also seriously hamper them in making decisions to protect themselves from sexual and reproductive health problems and unwanted pregnancies.

Sub-hypothesis II tested the significance of the attitude of the women towards sexual and reproductive health rights in the state. The result revealed that the attitude was significantly inadequate. The null hypothesis was therefore rejected. The finding agrees with Khima

(2007) who reported that sexual and reproductive rights and health for the women of Asia sometimes appears to be a distant vision.

The practice of sexual and reproductive health rights by the women was tested in sub-hypothesis III. The result revealed that the women's level of such practices was significantly low. The null hypothesis was therefore rejected. The finding agrees with Marjorie, Fran, Denise, Mauzy M, Sarah, (2006) who reported that youth are unable to deal with such violations because of barriers like shame, guilt, embarrassment, not wanting friends and family to know; confidentiality; and fear of not being believed and partly because of their inadequate knowledge and experience on sexuality issues including legal instruments that may accord them an opportunity to claim and protect sexuality-related rights.

In sub-hypothesis IV, the effect of marital statuses of the women on their knowledge, attitude, and practice of sexual and reproductive health rights was tested. The results revealed that marital status of women have significant effect on their knowledge and practices of sexual and reproductive health rights in Kaduna state. But no significant difference was observed in the attitudes of the women towards sexual and reproductive health rights.

The test of sub-hypothesis V focused on the effects of women's educational levels on the knowledge, attitude and practices of sexual and reproductive health rights in Kaduna state. The result of the test revealed that the women differed significantly by their level of education on the knowledge and practices of sexual and reproductive health rights.

Sub-hypothesis VI tested the effect of difference of occupations of women on their knowledge, attitude and practices of sexual and reproductive health rights in Kaduna state. The result of the test revealed that women differed significantly by their occupation in their knowledge, attitude and practices of sexual and reproductive health rights in Kaduna state.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

This study assessed knowledge, attitude, and practice towards sexual and reproductive health rights among women in Kaduna State. To achieve this purpose, six (6) research questions were formulated; a major hypothesis and six (6) null hypotheses were tested. Causal comparative (Ex-Post-facto) design was adopted for this study. The population of the study was made up 377 women of reproductive age in Kaduna State. Data were collected using a self-developed 4 point modified Likert-scale questionnaire (see Appendix A). For the purpose of analysis, data collected from the three hundred and seventy seven (377) respondents were analysed using frequency counts, percentages to describe the demographic characteristics of the respondents. The research questions were addressed with and mean and standard deviations. The hypotheses were tested with multiple regression, one sample t-test and one way analysis of variance along with a post hoc test conducted with the Scheffe procedure. The major and six null sub-hypotheses were tested at 0.05 level of significance.

5.2 Conclusion

Based on the findings of the study, the following conclusions were drawn:

1. Knowledge and attitude significantly influence the practice of women towards sexual and reproductive health rights in Kaduna state, Nigeria.
2. There is no significant knowledge of sexual and reproductive health rights among women in Kaduna State, Nigeria.
3. There is no significant attitude towards sexual and reproductive health rights among women in Kaduna State, Nigeria.
4. There is no significant practice of sexual and reproductive health rights among women in Kaduna State, Nigeria.

5. Marital status of women has significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna State, Nigeria.
6. Educational level of women has significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna State, Nigeria.
7. Occupation has significant effect on knowledge, attitude, and practice of sexual and reproductive health rights among women in Kaduna State, Nigeria.

5.3 Recommendations

1. Enlightenment campaigns, advocacy and community mobilization programs should be embarked on to improve knowledge, impact positive attitude, and enable good practice of sexual and reproductive health rights among women in Kaduna state, Nigeria.
2. There should be collaborative efforts of both the health and education sectors to provide comprehensive sexual and reproductive health education as this would change attitude towards sexual and reproductive health rights positively thereby improving health outcomes in the future.
3. Sexual and reproductive health rights should be included in the curricula of marriage counselling programs of all religions to ensure that all women practice sexual and reproductive health rights.

5.4 Limitations of the Study

1. Financial constraints due to the unanticipated ever worsening of the Nigerian economy at the time of the study, the budget was more than over stretched and supplemented.

2. Women were reluctant to divulge actual information sexual and reproductive health rights due to shyness with regard to the nature of the topic; the researcher had to further counsel and emphasize on confidentiality of information given.

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DEPARTMENT OF PHYSICAL AND HEALTH EDUCATION

FACULTY OF EDUCATION

AHMADU BELLO UNIVERSITY, ZARIA

QUESTIONNAIRE ON: KNOWLEDGE, ATTITUDE, AND PRACTICE OF WOMEN TOWARDS SEXUAL AND REPRODUCTIVE HEALTH RIGHTS IN KADUNA STATE.

Dear Respondent,

I am a student of the above-mentioned Department carrying out a project work on Sexual and Reproductive Health Rights of Women in Kaduna State.

Kindly fill this questionnaire and the information provided will be treated as confidential.

Instruction: Tick (✓) as appropriate

SECTION A: PERSONAL DATA

1. Age (in years): (a) 15-24 [ ] (b) 25-34 [ ] (c) 35-44 [ ] (d) 45 and above [ ]

2. Ethnicity: (a) Hausa [ ] (b) Yoruba [ ] (c) Igbo [ ] (d) Others (specify):_____

3. Marital status: (a) Single[ ] (b) Married[ ] (c) Divorced [ ] (d) Widowed [ ]

4. Highest educational qualification:

   (a) No formal education [ ] (b) Primary school/Adult literacy certificate [ ] (c) Secondary school [ ] (d) OND [ ] (e) HND [ ] (f) First degree [ ] (g) Higher degree [ ]

5. Occupation: (a) House wife [ ] (b) Civil servant [ ] (c) Business [ ]
   (d) Teaching [ ] (e)Others (specify):_____

SECTION B: KNOWLEDGE OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD).

S/N	**I know that:**	SA	A	D	SD
1.	Sexual and reproductive health rights are in the Nigerian constitution				
2.	Nigerian women have sexual and reproductive health rights				
3.	Schools are a source of knowledge for sexual and reproductive health rights				
4.	Hospitals are a source of knowledge for sexual and reproductive health rights				
5.	Primary Health Care Centres are a source of knowledge for sexual and reproductive health rights				
6.	Social media is a source of knowledge for sexual and reproductive health rights				
7.	Mass media is a source of knowledge for sexual and reproductive health rights				
8.	The right to sexual freedom is a sexual and reproductive health right				
9.	The right to sexual autonomy is a sexual and reproductive health right				
10.	The right to sexual integrity is a sexual and reproductive health right				
11.	The right to safety of the sexual body is a sexual and reproductive health right				
12.	The right to sexual privacy is a sexual and reproductive health right				
13.	The right sexual equity is a sexual and reproductive health right				

14.	The right to sexual pleasure is a sexual and reproductive health right				
15.	The right to emotional sexual expression is a sexual and reproductive health right				
16.	The right to sexually associate freely with my partner is a sexual and reproductive health right				
17.	The right to make free and responsible reproductive choices is a sexual and reproductive health right				
18.	The right to sexual information is a sexual and reproductive health right				
19.	The right to comprehensive sexuality education is a sexual and reproductive health right				
20.	The right to sexual health care is a sexual and reproductive health right				
21.	The right to sexual cohabitation with my partner is a sexual and reproductive health right				
22	The right to have any number of sexual partners as desired is a sexual and reproductive health right				
23.	The right to terminate an unwanted pregnancy is a sexual and reproductive health right				
24.	The right to reproductive health care is a sexual and reproductive health right				

SECTION C: ATTITUDE TOWARDS SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD).

S/N	**I feel that:**	SA	A	D	SD
1.	Sexual and reproductive health rights should be taught to young adolescents in school				
2.	Health institutions should advocate sexual and reproductive health rights				
3.	Outreach programmes should be set up to educate men and women of all ages about sexual and reproductive health rights				
4.	All communities should advocate sexual and reproductive health rights to young adults				
5.	Women should have the right to sexual freedom				
6.	Women should have the right to sexual autonomy				
7.	Women should have the right to sexual integrity				
8.	Women should have the right to safety of the sexual body				
9.	Women should have the right to sexual privacy				
10.	Women should have the right to sexual equity				
11.	Women should have the right to sexual pleasure				
12.	Women should have the right to emotional sexual expression				
13.	Women should have the right to sexually associate freely with their partners				
14.	Women should have the right to make free and responsible reproductive choices				
15.	Women should have the right to sexual information				
16.	Women should have the right to comprehensive sexuality education				
17.	Women should have the right to sexual health care				
18.	Women should have the right to sexual cohabitation				
19.	Women should have the right to have any number of sexual partners as desired				
20.	Women should have the right to terminate an unwanted pregnancy				
21.	Women should have the right to reproductive health care				

SECTION D: PRACTICE OF SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

Key: Strongly Agree (SA), Agree (A), Disagree (D), Strongly Disagree (SD).

S/N		SA	A	D	SD
1.	I am not comfortable when sexual and reproductive health rights are taught to young women				
2.	It is difficult for me to talk about sexual and reproductive health rights				
3.	I have had cause to demand for my sexual and reproductive health rights				
4.	My partner has had sex with me against my will				
5.	I prefer to speak to health personnel about sexual and reproductive health problems and rights				
6.	I confronted my partner to discuss his violation of my sexual and reproductive health rights				
7.	I prefer to discuss sexual and reproductive health rights with my parents				
8.	I prefer to discuss sexual and reproductive health rights with my friends				
9.	I involved the police while exercising my sexual and reproductive health rights				
10.	I involved the judiciary while exercising my sexual and reproductive health rights				
11.	I involved the clergy while exercising my sexual and reproductive health rights				