THE IMPACT OF GENDER INEQUALITY ON THE INCIDENCE OF HIV/AIDS IN KADUNA STATE (1999-2015)

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A DISSERTAION SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY ZARIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DOCTOR OF PHILOSOPHY DEGREE IN POLITICAL SCIENCE

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SEPTERMBER, 2017

DECLARATION

I, Rahanatu Lawal, hereby solemnly declare that the whole of this research work submitted for the award of Doctor of Philosophy (Ph.D.) Degree in Political Science of Ahmadu Bello University, Zaria is the result of my research and has not been presented to any university for the award of a degree. All errors and omissions in this work are solely mine.

Rahanatu Lawal _____ _____

Signature Date

CERTIFICATION

This is to certify that the dissertation titled "The Impact Gender Inequality on the Incidence of HIV/AIDs in Kaduna State" A study of Kaduna State by Rahanatu Lawal to meet the regulations governing the award of Doctor of Philosophy (Ph.D.) Degree in political Science, Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

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DEDICATION

This work is dedicated to my late parents (May their gentle soul rest in peace Amin). Also to all vulnerable women living with HIV/AIDs in Nigeria

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LIST OF ABBREBIATIONS AND ACRONYMS

AD	After Death of Jesus Christ
AIDs	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinics
DFID	Department for International Development
FHI	Family Health International
FMOH	Federal Ministry of Health
GARPR	Global AIDS Response Progress Report
HEAP	National HIV and AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HPDP	HIV/AIDSs Programme Development Project
IBBSS	Integrated Biological and Behavioural Sentinel Survey
IDA	International Development Association (IDA)
IDU	Injecting Drug Users
IFAD	International Fund for Agricultural Development
IMF	International Monetary Fund
IPPF	Planned Parenthood Federation of Nigeria
KADSACA	Kaduna State Agency for Control of AIDs
KADSSP	Kaduna State Strategic Plan
KGH	Kafanchan General Hospital
LACA	Local Action Committee Action
MDGs	Millennium Development Goals
MSM	Men having Sex with Men
NACA	National Action Committee on AIDs
NASP	National AIDs Strategic Plan
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	Nigerian Adolescents Reproductive Health Survey
NBTS	National Blood Transfusion Service
NDHS	National Demographic Health Survey
NBS	National Bureau of Statistics
NEACA	National Expert Advisory Committee on AIDs
NGARPR	Nigeria Global AIDs Response Progressing Reporting
NGOs	Non-Governmental Organizations
NNRIMS	Nigeria National Response Information Management System
NPC	National Population Commission
NPHA	National Policy on HIV/AIDs
NPP	National Prevention Plan
NSF	National Strategic Framework
NSP	National Strategic Plan
NTBLTC	National Tuberculosis and Leprosy Training Centre
PLWH	People Living With HIV
PLWHAs	People Living With HIV and AIDs
PPP	Purchasing Power Parity
SACA	State Action Committee on AIDs
SPSS	Statistical Package for Social Sciences
SSP	State Strategic Plan
STDs	Sexually Transmitted Diseases

TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDs
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children Emergency Fund
WHO	World Health Organisation

ABSTRACT

This study examines the impact of gender inequality on incidence of HIV/AIDs infection on women within Kaduna state. HIV/AIDs has become a growing public health concern in the last three decades and has witnessed global commitments with much efforts to reduce the spread and eradicate the disease. Despite, various national, international and non-government interventions to resolve the stigma and spread of the disease, the HIV/AIDS disease escalating among those not earlier identified at obvious risk. Particularly, cohabited partners have high population among the newly affected group. The Objective of this study is to examine reasons for the high incidences of the spread of the disease on women and what impact gender inequality has on the incidence of the disease among women, as the disease continue to spread and become increasingly feminized. The Gender and power theory was used to explain and support why the problem persists and its likely consequences on women. The study used quantitative research which is descriptive techniques and qualitative analysis to give a representative reality in terms of numerical value used from the source for data collected, using both primary and secondary sources of information. The primary data were analysed using a combination of inferential and descriptive statistical techniques. Findings of this study identified gender inequality as a cause of high incidence of the epidemic among women within Kaduna State. Unequal gender relation accounts for reasons why majority 77-7% among those living with HIV/AIDs are women and 23% are men in the study areas in Kaduna State. The study supports the argument that gender inequality can be a major constraint to the effectiveness of anti HIV/AIDs policy measures. The existing inequality in gender is a hindrance to policies targeted at reducing the high prevalence of HIV/AIDs among newly effected population within Kaduna state. The study recommends that chances for policy success in reducing HIV/AIDs among individuals and groups can be effective by putting into considerations all kinds of problems peculiar to individuals or any groups of individuals in the society. Lastly, more attention should be given to preventives than curative measures.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The world's social and economic transformation brought about significant social and power status relations, an outlook to all social organizations in a characterised manner. The historical and contemporary categorization of social organizations either by race, ethnic group, or gender, creates hierarchy in social relations that lead to inequality. Joan (2006), argued that societal inequality originates from organizations. Gender like race can be categorise or use in aform of inequality, and could be anacceptednorms in societies. Gender is acknowledge in an institutionalized system of social practices that is deeply entwined with social hierarchy and leadership, and because gender is stereotype that contain status beliefs that associate greater status worthiness and competence between men and women. Its daily use has seem to favour one gender than the other. The belief shape their assertiveness, their ability to influence decisions that affect their lives(Cealia.2001).

However, the degree of categorization is transformingin contemporaryglobal social relations, particularly with rising identifies,but it is intensifying initsinability to reducinginequality in human relations (UN, 2012).The gender historical hierarchy for example, which gives men advantage and disadvantage women in responsibility allocation has not entirely been reversed. Accordingly,

women's statutory subordinate position to man in human relation has seen little transformation with negative implication for women's health among other challenges that women are confrontedwith.Theevidence is promotedwith the impact ofoutbreak of epidemic crisis in societies, where the vulnerable bear more pain than any other group.Women are mostly identified among the vulnerablegroup in most crisis situation. Women'svulnerabilityis among other reasonsacknowledged to be the result of unequal cultural treatment in human relations (Meer, 1998).

In the past, inequality has not been the central policy issue in many countries, but its continuous changing nature and the pressure it has on gender social relations as well as on countries policy influence have become a challenge for those who seek to understand the problem and those responsible to contest it. This is because most write ups on gender have made little or no impact when it comes to reducing and implementing existing problems in gender human relations. Thus, the notion of what constitutes gender difference and the social authority generated by such perceptions continue to inspire research and debate on gender relations. Even though, there are numerous critics on gender studies, for example, it has been argued that scholars on gender studies, emphasis on women's needs as important in resolving our organizational problems (Courpasson, 2013).Gender scholar's studies, unlike scholar's writings on economic inequality,for example, emphasize generally on the pressing societal inequality problems and their negative implications relate to health and wellbeing issues that affect gender (Wilkinson and Pickette,

2009). Studies on gender havebeen criticise to stress only on women discuss. Also, politically, writers on inequality in societal relations argue, that inequality could lead to breakdown of trust and increase of monitoring costs in society (Jayde and Bowles, 2006), and political system dysfunction (Stieglitz, 2012). The fact however, remains that inequality in society from whatever dimensionit is viewed, has negative implications for societies. It is equally true, that gender inequality has remain a contending issues with numerous research questions. For example, the recent gender inequality speculation on sexuality, masculinity, gender culture role relating to health issues maps for intellectual global debate, concerning gender inequality as entrenched social relations and realities of societies. The argument of this study therefore, is to attempt the complexity in gender relation, inequality and incidence of HIV/AIDS in Kaduna State. This is because the recent feminization of HIV/AIDS creates a worrisome scenario as more women are reportedlybecoming more infected by the epidemic than men globally (Kaduna State inclusive).Report of some locations in Kaduna State shows some sites as "hot spots" for PWLHAs, andthe state is said to have maintained the highest prevalence of the disease in the Northwest geopolitical zone (NACA 2013, UNAIDS 2015). The State has inconsistent report of people living with the disease in spite of efforts put in place through state agencies, policies and programmes by the national and international organisations. The prevalence in state has ranged from 0.9% prevalence in 1991, to 4.6 in 1993; to as high as 11.6% in 1999, and

has averaged 5.6% between the years 2001 to 2005 and rose to 7.0% in 2008 and 5.1% in 2010, with more women report on newly affected cases (FMOH, 2010).

The feminization of the disease and the concern for women's health inthe past three decades has attracted globalattention.Women's sexual and reproductive vulnerability due to women's perceived unequal gender relations to risk of Sexually Transmitted Diseases ((STDs), particularly HIV/AIDS and its related health problems has also seen a lot of commitments (Tallies, 2000; Schlep, 1991; Burnett et al, 2002; WHO, 2008 and UNAIDS, 2009; NACA, 2012). As theworld leaders' further emphasised on acknowledgment of women's predicaments on HIV/AIDS and its related problems. World leaders have come up with agreementstostreamlining equality in human relations in the Millennium Development Goal (MDGS) in the year 2000. MDGS set up eight target goals to help reduce inequality among humanity. Three out of the eight Millennium Development Goals were targeted towards women's health, as exemplified in goals 4, 5 and 6 (4: Reducing Child Mortality, 5: Improving Maternal Health and 6: Combating HIV/AIDS and other diseases) by the year 2015. Despite this commitment and many other policy incentives (strategy plans), the numbers of women in poverty, people living with HIV and dying of AIDS have not shown significant reduction (UNAID, 2013).

1.2 Statement of the Research Problem

It is globally acknowledged that HIV/AIDSprevalent has continued to spread and claim millions of lives. The incidence among the general public has remainedinconsistent as the disease became globallyfeminized. The incurable diseases among the general public andits incidences amongwomen, is what this study tries to assess in Kaduna State.

Since 2000, 38.1 million people globally have become infected with the disease with wide spared and its fundamental threat to social relations, which has called for concerns. An estimated 60% of infections are in west and Sub-Sahara Africa (UNAIDS, 2016), the Prevention Gap Reports, stated the disease has spared no region in the world, as also emphasised in the report by UNAIDS. Presently 36.9million people are living with the disease globally,with women accounting for 52% of all the People Living with HIV/AIDS (PLWHAs) globally, and approximately 57% of PLWHAs are in sub-Sahara Africa (UNAID, 2014). 17.1million do not know they have the virus and need to be reached out to, with HIV testing services and around 22million do not have access to HIV treatment (UNAID, 2015). Implying an increase in the number of theunaware people and contacting the disease across the general populations – resulting to easy spread of the disease among members of the society. For example, it was reported that an estimated 2.0 million individuals worldwide became newly infected with HIV in 2014alone.

Sub- Saharan Africa is the most affected region in the world, with 28.5 million people living with the disease in 2014, accounting for almost 70% of the global total of new infections. WHO estimated 34miillion people have died from AIDS related causes so far, including 1.2 million death in 2014. Nigeria is ranked second after South Africa with the number of People Living with HIV/AIDS (PLWHA) in Africa and ranked third in the world (UNAIDS, 2012). The disease in Nigeria is not homogenous across the geo political Zones and across States. Kaduna State has consistently maintained the highest HIV/AIDS prevalence of PLWHAsin the North West geo-political Zone, with some areas identified as 'hot spot' for PLWHAs. The Sere-prevalence Sentinel Survey (NACA, 2000) records are inconsistent in the State as since the early 1990s, the disease continued to rise.Between 1991 and 1999 the State had an exponential increase in the zero-prevalence rate of HIV in Kaduna State. The Sere-prevalence Report gave the percentage over the years as 0.9% for 1991 to a height of 11.6% in 1999. The prevalence reduced to 5.6% and then increased to 7.0% in 2008 and 5.1% in 2010 (KSGSHDP, in FMOH, 2010). Some areas in the State still maintain a high zero prevalence rate of over 17% in recent timesKADSACA, (2013).Even though some regions are more affected than others, new cases are continually reported (Greco, 2004; AIDS Alliance in Nigeria, 2003. UNAIDS, 2010).It is based on these issues that this study examines the impact of gender inequality on the incidence of HIV/AIDS among women in Kaduna State.

The study poses the following research questions:

1.3 Research Questions

1) What are the major causes of HIV/AIDS in Kaduna State?
2) Which of the gender group (male/female) is more vulnerable to HIV/AIDS infection in Kaduna State and why?
3) How has gender inequality impacted on the incidence of HIV/AIDS in Kaduna State?
4) To what extent has gender inequality exacerbated the incidence of HIV on women in Kaduna State?
5) Examine if any policy is in place to reduce the scourge on women with HIV/AIDS in the State.

1.4 Objectives of the Study

The following are the objectives of the study:

1) To examine the nature and major causes of women vulnerability to HIV/AIDS in Kaduna State;
2) to examine what account for gender differentials among PLWHIV in Kaduna State;
3) to examine gender HIV/AIDS awareness status and its implications on gender incidence of HIV/AIDS in Kaduna State;
4) to examine the effect of HIV/AIDSpolicy on people living with HIV/AIDS in Kaduna State;
5) Toexaminehow HIV/AIDS policy impact on men and women living with the disease in Kaduna State. .

1.5 Research Hypotheses

For the purpose of this study the followinghypothesis are raised:

1) The first hypothesis is about the susceptibilityto HIV infection amongst men and women

   H_o: Women are not likely to be prone to HIV/AIDS infection than men in Kaduna state.

H_1: Women are more prone to HIV/AIDS infection than men in Kaduna State.

2) The second hypothesis is about the effect of socio-economic status towards exposure of men and women to HIV.

H_o: Socio-economic status makes women more vulnerable to HIV than men in Kaduna State.

H_1: Socio-economic status does not make women more vulnerable to HIV/AIDS inclusive than men in Kaduna State.

3) The third hypothesis is about awareness to HIV/AIDS amongst gender.

H_o: Awarenessis a major determinant of women vulnerability then men to HIV/AIDS in Kaduna State.

H_1: Awareness status is not a major determinant of women's vulnerability than men to HIV/AIDS in Kaduna State.

4) The fourth hypothesis is about policies on HIV/AIDS as it relates to men and women.

H_o: HIV/AIDS Policies make women more vulnerability to HIV/AIDS than men in Kaduna state.

H_1: HIV/AIDS Policies does not make womenmore vulnerability to HIV/AIDS than men in Kaduna state.

1.6 Significance and Justification of the Study

The study examines effect of gender inequalities on the incidence of HIV/AIDS among women and menwithin Kaduna State. It shows inequality on awareness as a reason for incidence of HIV/AIDS among women and then men in Kaduna State.The study further shows the inability of policy measures takenby national, internationalorganizations and governmentsthrough its reports, policy strategies, plans and programmes on HIV/AIDShas not establish the impact of gender inequality on PLWHAs in Kaduna State.

The findings show an increase in thefeminization of the diseases in Kaduna, higher prevalence than the Official government reports by the State, and International Organization reports. The lack of development of preventive safe, effective, acceptable method women can use to prevent their exposure to acquisition of HIV needs to be addressed. While studies have identified women's vulnerability due to unequal cultural, biological nature, women's inability to influence policies among other problems. Identify legal means to reduce the disease on women has not given attention. For example, women deserve some legal agreed method of control, to the provided contraceptives. Thenegotiation forpartner's cooperation is not readily acceptable to the majority people living with the disease in the study area, as shown in this study, were 71.8% do not accept the use of condom, even when they are living with the disease.Also, there no identity interventions programmes that will help reduce stigma and discrimination in the studied area. These affect women than men in cultural term; the State effort in combating stigma has undermined HIV preventionefforts. Furthermore, there are no identified networks in process to change cultural laws, policies and structural arrangements that increase women's vulnerability to HIV infection.Examples can be seen inmultiple partners, cultural inheritance laws, property rights and access to socio economic benefits that push some women to sex slavery.

Unequal attention, is given seen in public attention through publicenlighten is more pronounced in men's protection through the

use of contraceptives and abstinences(NACA, 2010: WHO: 2008: UNAIDS,1998). Though, a major step taken to reduce the incidence of the disease through women is not directly to protect them from contact of the disease or prevent the disease on women, but to prevent womenoffspring's from contacting the disease from mothers. Themother to child prevention policy is a reference policy in place. It isan accepted policy that has attracted global attention on reducing the spread of the disease through mother to child prevention, the irony is many women give birth at home not in the hospitals or spend short time in hospital before delivery, which makes it difficult toinitialrecognition, and only treatment is given if detected at that point.

While sexual means is one of the highest means of transmission of the disease in recent time, studies have not shown attention is given in reducing the disease in this direction, i.e. reducing cultural influence on sexual relations. While cultural status is difficult to change, the recent global challenges of the world economic recession has ledto high unemployment, low and drop out in schools, close in opportunities gaps. These have impacted negatively on social relations, leading to high divorce rate that has worse consequences on people living with diseases, particularly PLWHIV and upsurge desperate tendencies that could lead to immoralbehaviours among young desperate women. This is because PLWHIV aside the stigmathey face in societies, the divorcedoccurrence among many spouse is high in the studied area and also the singles on treatment.

These are indicated ways of spread of the disease in the studied areas.Furthermore, the unawareness status among married relationships living with the disease, and theirinability to enforce the use of contraceptivesetc.) are reasons identified for onward spread of the disease among PLWHAs in the studied areas that policies are yet to be addressed.For, examples,heterogeneous nature ofcontact throughsexual relationship involving more than one sexualpartner, affect more women than men in the study areas because most respondents have mates with sexual partners in multiply of two to four.

The missing gap in this study demonstrates a need toeducate people, on reducing inequality in gender relation, byextension developing a safe legal effective and acceptable method, women can use to prevent contact to HIV. That is creating awareness and providing a legal agreed method of control for use of contraceptives than negotiatingpartner's cooperation.As well as identifying intervention programmes that will help reduce stigma and discrimination on PLWHIV.

The provided information will be useful in providing and enhancing policy choice for the targeted group. Programme could be drawn on inequality reducing strategies for the target group and could be a more effective way in coordinating and maintaining stability in gradual reduction of the incidence of prevalence of HIV/AIDS in Kaduna State and stimulate an extension framework to national effort to achieving the global goal of reducing and if possible eliminating the

epidemic. The information drawn could also help policy makers look into differences of all individuals in drawing policies that could help promote effective initiatives to advance the cause capabilities of the vulnerable groups and the infected individuals in Kaduna State.

Lastly, the number of women infected by HIV/AIDS has continued to rise within the studied area. This can be reduced through the efforts of analysis that impact genderinequality on the incidence of HIV.Reducing the disease among communities may be a mirage, as theburden on individual gender, families, communities as further exacerbated by poverty is shown in the study.

1.7 Scope and Limitations of the Study

The study is limited to Kaduna State between the periods 1999 to 2015. Two Senatorial zones out of the three senatorial zones of Kaduna State were used for the study. The Central Senatorial Zone and Southern Senatorial Zone have two hospitals selected, one from each zone was chosen for the study. Both Zones consist of eight Local Government Areas. In the Southern Zone, the local governments selected are Jaba, Jama'a, Kachia, Kagarko, Kaura, Kauru, Sanga, and ZangonKataf. In the Central Zone the Local Government Areas are BirninGwari, Chikun, Igabi, Kaduna North, Sabo Gari, Soba and Zaria. The reason for the selection of these locations is that the two Zones combined to have the highest percentage of people living with HIV/AIDS in the State.For example, Kafanchan in Jama'a local government area is identified as having the highest number of infected

people living with HIV/AIDS in the North West Geo Political zone (KADSACA, 2010). Also, because of stigmatization on PLWHAS prefer a general or teaching hospitals than HIV/AIDS services centres around their localities. Kafanchan general hospital in Jama'a Local government area is specifically chosen from the southern zone for study, this is because it is a semi urban location with diverse minority ethnics groups, with high percentage of people living with the disease in the State. Zaria is the second location chosen because it is also, a semi urban location and has hospitals with HIV/AIDScentres. Thus, information sought from groups attending the two hospitals assisted in identifying reasons for feminization of HIV/AIDSand how gender inequality surge women incidence of HIV/AIDS in Kaduna State.

1.8 Chapter Outline

Chapter one consists of the general introduction, statement of the research problem, research questions, objectives of research, and hypotheses of the study, justification of study, methodology, scope and limitation of study. In chapter two the study focuses on the literature review attempting arguments on gender inequality, power relations and vulnerability of people to HIV/AIDS in sub Saharan Africa, Nigeria and Kaduna State and linkages to women vulnerability to the high incidence of the disease on women. Chapter three consists of the methodology, the area of study, sources of data, sampling techniques and sample size, method of data collection, method of data analysis was discussed, Chapter four discusses the historical policy

over view of HIV/AIDSpolicy in Nigeria. Chapter five presents results and discussions while chapter six is summary, conclusion and recommendations for the study.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK.

Introduction: This chapter reviews related literature on gender inequality, and its implications on incidence of HIV/AIDS among women in Kaduna State.

2.1 Gender Inequalities and Impact of HIV/AIDS on Women

Gender inequality has a considerable impact on human development in relation to HIV/AIDS; it varies and pattern so as to ensure that HIV/AIDS – related problems play into creating social inequalities (Obaid, UNFPA. 2005).Considerable body of literature see gender equality, as giving equal opportunity to women and men of all ages' access to use of resources and services within families, communities and societies including deriving equal benefits from laws and policies. Also, processing equal decision making power either in family relationship or the society at large (Gouws, 2006.; Paula, 2005; Reskin, 1988).

However, gender equality can be measured by multiple quantified achievements based on the social responsibilities allocated to men or women, based on physical difference or sexual category (Gender). Thetransformation of the HIV/AIDS disease along groups, since its outbreak shows the disease has dynamic impact on the people, over time and across places. Also, study findingsshows,most human crisis can affect women, men, girls or boys or groups in different ways (Meer, 1989; Khan, 2002). The HIV/AIDS disease has impact on individual gender in different ways, and the consequences ofits

incidencesamong people, acrosssocieties is central to this study.Changing social and cultural structures in inequality can redefine gender status – in either positive or negative ways, and if for any reasoninterventions are not planned with genderdifference in mind, the need to those regarded as the vulnerable (in countries like Nigeria , women are categorize in this group), or under threat may be negatively affected. Thus, an opportunity to support positive change may not be achieved.For these reasons, gender equality is central to incidence of diseases and human developmentas the study explores views on gender inequality and the incidence of HIV/AIDS.

Parker et al (2014), argue that men and women are not dealt with the same wayhealth wise,in a patriarchy hierarchical system. For example, in a social organized system culture and religion plays a significant role in gender relations. Men have control on political and economic structures based on the organized gender relations; pointing out the numerous implications patriarchy hierarchy has on human relations and its consequences on women's mental health. Cecilia (2001), is of the view that the hegemony cultural belief has on gender and its impact, is what "social relation" is all about and are core to components,maintenances and change in the gender system; when gender bias is salient, its consequences cumulate over individual lives and result in substantially different outcomes for men and women.The acknowledgement that gender is an institutionalised system of social practice and is deeply entwined with social hierarchy in leadership is

because of genderstereotype. This iscomprehended in status beliefs whichassociate greater worthiness and competence with men and women relation, which result to inequality with different complications for gender.

Gender status is belief to shape man's and women's assertiveness, theirresponsiveness and evaluation of their performance, an ability attributed to gender on the basis of performance, influence they achieve and the likelihood that the emerge as leaders.

While gender status is seen to assert leadership responsibility to men, it did not explore implications of gender status on the health of individuals. The cultural acceptance of man's abilities toleadership and to having resources of paid responsibility outside home, gives him betteraccess to goods and services, including access to many women either in marriages or co-partners, socially acceptable in most societies for men.Women have less opportune as leaders, with less resources, because of their unpaid front roleresponsibilities and not accepted to have more than one man at a time, as apartner in most societies. By implication differences in responsibilities could make women victims to epidemic outbreak because they are in a less privilege position.From the HIV/AIDS perspectives it has been argued that multiple- partners allowed for menspread of HIV/AIDS disease in women (Hunter, 2005). Other issues such as culture and religious norms come to play in gender spread of HIV/AIDS in this regard.

Furthermore,the harmful traditional practices such as - female genital mutilation/cutting, forced marriage, financial dependence of women on men, wife inheritance are common to women than men. The women reproductive system and the legal cultural/religious nature of marriages of having multiple sex partners in our cultural society has negative implication for women when it comes to the spread of disease like HIV (Adeora, ed, 2014; Mujeres, 2001; Gomez, 2003; Higgins, 2010).

The natural reproductive system of women are identified as easy way ofspreadingviruses, this is because in womenHIV is spread in child birth, breast feeding which is peculiar to women and not men. The views above shows some reasons for the spread of the disease among women.Accordingly, the need to creating some policy or programmes to address and createopportunities to reduce some burden on women's inequality on gender could bring about equity andreduce inequality in gender relations, particularly when it comes to reducing the spread of disease.

Recent report on the effect of HIV/AIDS on women shows how health dimensions of gender inequality affect maternal mortality ratio and adolescent fertility rate in Africa. For example, the effect of HIV/AIDS on gender shows, young women between ages 15 – 25 are twice the number of men effected with and living with HIV/AIDS. Maternal orphans whose parents have died of HIV/AIDSare on the increase in Africa (UNAID, 2013: NACA 2013). As countries like

Nigeria are said to have increasing number of children born with HIV/AIDS.

Thus, natural nature of women's ability to give birth to children, breast-feed them and her societal gender responsibilities, cultural and religious wives inheritance, makes women more prone to HIV/AIDS than men.

2.2 Nature of Human Immunodeficiency Virus (HIV) andAcquired Immune Deficiency Syndrome (AIDS)

The Human Immunodeficiency Virus (HIV) or the type called retrovirus is a virus that affects cells of the human immune system and destroys or impairs the cells. HIV is found in the blood fluids of an infected person. According to Hutchinson (2001), HIV virus damage the host's immune system, resulting in AIDS, which is characterized by Immune Deficiency Syndrome, opportunistic infections and neoplasms that causes neurological problems. It is a complex retrovirus with a high mutation/transformation rate, the mutation rate allows the virus to evade host immune responses, and mutilate Infection, which results in the progressive deterioration of the immune system leading to immune deficiency. When a system is considered deficient, it can no longer fulfil its role of fighting off infections and diseases (NIH, 2015; UNAIDS, 2010).

Thus, an immune deficient person is more susceptible to wide range of infections, because the virus takes advantage of a weakened

immune system and makes the body weak, which results to Acquired Immune Deficiency Syndrome (AIDS).

AIDS is a group of sickness that comes after HIV has made the infected person weak. AIDS is characterized by progressive loss of the $CD4^+$ helper/inducer subset of T lymphocytes. The loss of T lymphocytes cells leads to severe destruction of Immune function that constitute diseases opportunist infections, neurological complications and the neoplasm's that seldom occur in persons with harmed immune functions and certain contact could result to infecting the unharmed person (Ho el at 1987; Fauci1988, 1993; Greene 1993; Levy 1993; Weiss 1993). This implies loosing and even killing cells that could allow the body to fight diseases, resulting to sickness and death in most infected persons (Allergy Infect. Dis 1995; Clavel et al 1986; Fisher et al 1988; price et al 1988). It has been emphasized that the precise mechanisms that result in destruction of the immune system are not completely understood. Many other researches by epidemiologist, virologist, and immunologistthrough collected data gatheredironically have not yielded the needed results on how to cure HIV/AIDS disease since its appearance over three decades ago. It has also being concluded that HIV infection is the central course of AIDS as was justified by these scientific groups (Ho et al 1987; Fauci 1988, 1993; Greene 1993; Levy 1993; Weiss 1993; Allery Infect Dis. 1995; Darby et al., 1995).

Achalu (2011), Acknowledges that, AID widespread has continued to be a major public health problem worldwide and

regarded as perhaps the most devastating health disaster in human history, the disease has no cure decayed into the break out of the disease worldwide. The worrisome issue is the nature of transmitting the disease from an effected person to uninfected person, which has led to the stigmatization of people living with the disease. This has resulted to silence among the newly infected persons, a situation of an onward spread of the disease in societies, among other problems it has on communities and the vulnerable group.

2.3 Overview of the Impact of HIV/AIDS in Sub-Sahara Africa

The Human Immunodeficiency virus (HIV) was identified in the United States in 1981 and the origin of the disease is a continue subject of academic debate (Hamilton, 1999). The disease caught the global attention when AIDS emerged as a major cause of death among Africans since the mid - 1990s and has continued to spread widely among millions of people in sub-Saharan Africa(Tarantula, 1996).

The 2013 report on global AIDS epidemic shows that globally, 35.5 million people are living with HIV/AIDS, with 2.3 million newly infected cases and about 1.6 million AIDS related death. Sub-Sahara Africa has the highest infection rate with 25 million people living with HIV/AIDS; the region has 1.6 million new infections cases and 1.2 million AIDS related death (UNAIDS, 2013). Sub - Saharan Africa is the worst affected region and has the highest burden of the disease (Lamptey, Johnson and Khan, 2006; UNAIDS, 2013; 2013 Report on Global AIDS Epidemic).

The HIV/AIDS virus is however not homogeneous with regions and within regions, with some countries badly affected than others. At the regional level, there are wide variations of infectious rate between different regions, states and the local settings. The African region is described as the most affected-centre of the global HIV/AIDS pandemic (Taylor et al., 2003; UNAIDS/UNICEF/WHO, 2000; Eaton, Flishera and Arob, 2002; Prat, et al; 2000). The worst affected States in the sub Saharan African Nations include South Africa, Botswana, Cote d'vioire, Ethiopia, Kenya, Mozambique, Namibia, Nigeria and Zambia (The United House, 2003; IBBSS, 2010).

Although, the obvious impact of the disease has been illness and death, the effect of the disease has certainly not been confined to the health sector alone but also households, schools, workplaces as well as country's economy. HIV/AIDS has a unique constrains on all sectors –for examples, on health workers and hospitals, as prevalence rises in countries; PLWHAs related cases occupy more beds in hospitals and require more health workers attention. A government-funded research in South Africa on the impact of the epidemic on the health sector suggested that, an average HIV positive patients stay in hospitals four times more than other patients IPSNA (2006). The toll of HIV/AIDS on household is severe, particularly on women, who in most societies are burden with caring for the ill in the family and home front runners in most African homes (Sesay andOdebiyi, 1998). The presence of HIVAIDS patient in a household not only causes psychological trauma and affect all in house activities – schooling,

income, comfort, among others, it can led to break up of the house hold entirely (Eric, 2013).

The burden of HIV/AIDS is high in the sub-Sahara Africa continent being the poorest and most impacted continent in the world. Empirical study shows poverty headcount ratio at $1.25 a day of percentage of population among regions of the world. Europe and central Asia had the lowest percentage of 0.5% of poverty headcount ratio at $ 1.25 a day as at 2011, followed by Middle East and North Africa with 1.7% while Sub Saharan Africa has a percentage of poverty headcount ratios of 46.8%, three times the world average that stood at 14.5%. It shows sub Saharan Africa has the highest poverty head count ratio in the world.

The high percentage headcount of poverty in sub-Sahara Africa is in confirmation that though poverty is not a key course of HIV but poverty consequences can influence the incidence of HIV/AIDS,sub-Sahara Africa havinghigh poverty headcount ratio, reflect reasons for her more burden cases of those living with the disease than any region in the world.

As argued, poverty is not the root cause of HIV/AIDS but the ingredients of poverty encourage the spread of the infection, this is because illiteracy and ignorance, high risk behaviour, labour migration, unemployment and economy dependence are consequences of poverty that have encouraged the spread of the disease in Nigeria (Epstein, 2002; Obi et al 2010). The prevailing factors affects women than men in most poor society were illiteracy, high risk behaviour,

unemployment among other factors, are common among women than men. Women often face the inability to access health care services and information because of their dependent nature and responsibilities vested on them as mother/wives and home front runners that limit their chances to concentrate in their daily endeavours and in some cases loss of income that increases their vulnerable situation. Furthermore, UNAIDS 2005 shows another significant factor of the disease that affect more women than men, according to the reportstigmatization is a key factor that affect more the vulnerable communities to HIV/AIDS. The UNAIDS argued that stigmatization can reinforce the existing exclusion of people who are less opportune and economically marginalized (UNAIDS, 2005). The implication of stigmatization among PLWHAs has led to silence and late reporting among the early carriers resulting to AIDS and subsequently death of the infected people. This situation could increase the loss of more numbers of labour work forces; increase the number of widows, widowers and orphans. An added responsibility to heads of households, who is force to immediately take over responsibilities unprepared for an increase in dependency at the family level and more dependents in an unorganized societies. Amoako (2008), summarizes the impact of the disease, that it further widened poverty and increases the unequal human relations.

Inequalities are acknowledged to exist in all human relations across nations in class/groups; ethnic or gender affiliation. However, the impact of HIV/AIDS disease has implications for all groups'

peculiarity differences. The epidemic unique challenges on economic, social relations as well as National development has forced Nations worldwide to make effort in combating the continuing spread of the disease, as shown by various studies reports on the disease over the years Plot, (2000); Butter, (2000); Eton, UNAIDS/UNICEF/WHO,(2002; 2002IBBSS (2007&2010), NACA (2012);KADSACA (2010), &GARPR (2012). Despite all efforts by world leaders, reducing the spread of the epidemic has shown little or no significant changes. A statistic figure shows an increase in the incidence of those infected with the disease in some places. Statistics in 2013, shows that 25.0 million people are estimated to be living with HIV/AIDS in sub-Sahara Africa alone; as against lower figure of 2011 that was estimated as 23.5 million people living with HIV in the region, the figure also shows an increase in 2009, when it was estimated that 22.5 million people living were living with HIV in 2009 UNAIDS (2012 & 2013).

2.4 Women's Cultural Role and HIV/AIDS in Africa

In the 1990s HIV/AIDS disease became generalized in Africa, as the level of zero prevalence became high among the general population. The disease since then continued to spread more rapidly among young female adults and those who had no obvious risk factors (Boue' A, et al 2001). Recent study findings show that globally 52% of all people living with HIV are women and live/residence in Africa and in this region women account for 57% of all people living with HIV,

whose age groups are between fifteen and forty-nine (Lamptey, Johnson and Khan, 2006; Achalu, 2011; UNAIDS, 2013).

The rapid spread of the disease among young women is said to be driven by harmful cultural gender norms and poverty. The epidemic imposes a particular burden on women and girls due to many cultural hurdles they have to overcome. For example, because of the long age continued stereotypes and contradictions inherent in African patriarchal social structures, the extent to which social structures are detrimental to women gains in status and prestige, constrain women in such ways that they lack access to means of production or control the production of their labour. Thus, women's relegate unequal responsibilities for household chaos and caregiving consent, results' to many women's inadequate training and education. Implying denial or inability of many women opportunity to attain other skills example education or any other skill development that could help improve their earning income toattain a better living condition.The consequence is disruption inwomen's lives ability to compete for good jobs or access to global market. Sanctioning many women to live in poor household and inability to think beyond daily survival.According to Amadu et al (1998), *"a disadvantage position many women find themselves in most cultural settings".*

Cultural role for gender relations in Africa shows the negative positions for women both in the rural and modern development perspectives. On one hand, it argues that Africa women are migrating

from rural areas where their autonomy is limited, while on the hand it isargued that foreign culture and modern development undermined women's status and autonomy in post-colonial African society (Kenneth, 1973; Boserup, 1970). Women and girls cultural role in most African societies is that of dependency on men, however, women heads of household and are not expected to have control over the family (Amadu and Odebiyi, 1998). Women are to access informations from men and in some cases have to get his permission to access social services (Davies, 1994), including health services. Furthermore, advancing women's dependence and inability to take decisions that affects their lives. The traditional and religious norms in line with cultural norms, accept women as a subordinate group in these societies.

At the state decision making level, women are equally poorly represented and the resultant effect of bad governance and corruption in many African States limit easy access to information and good health care facilities, that diminish easy access to essential HIV awareness programme and right to reproductive health services particularly for the vulnerable group in the society. The interpretation of gender role by culture, which is socially constructed and often designed by the leaders in communities, whose majority are men constitute has negative implication for women. The burden is much more when the man, as head of households, who is to shoulder the responsibility of providing for the family, is infected by any social crisis or epidemic. Women are expected to takeover in crisis situation

as heads of households - consciously or unconsciously embrace both gender roles, often at times, women neglect their means of livelihood and takeover completely house responsibilities (Narayan, 1999). Many African women often find themselves in this situation. These issues can further widen women's financial constrain in the eventualities of the man's death, due to unprotected legal women property right, of not having full right to her man's property. The implying enhancing girls and women's poverty and expose them to adultery, then to disease such as adultery, hence HIV/AIDS.

More so, the African cultural norms of accepting a man with more than a sexual partner and the lack of legal cultural protection for women from sexual harassment or rape, women's barriers to negotiate safe sex, economic dependency of women and girls on men put them at risk of HIV/AIDSdisease. It has also been argued that intense exposure of girls to child slavery or house helps, polygamy, forced marriages and wife inheritance enhances the spread of HIV/AIDS among female in Africa (Garennel et al., 2008; Mali, 1989; and Jewkes, et al., 2003).In reality, women and girls face a range of HIV related risk factors and vulnerabilities than men and boys do – many of which are embedded in the cultural relations and economic realities of structured culture societies.

In addition, young adult either living in the rural or urban areas today live in a multiple social centres that shape their attitudes and behaviours. Every person at early stage in life is faced with both risk and protective situations. Therefore, the early maturity age is a

transition that is marked by critical life events – puberty, sexuality initiations, marriage and childbearing (UN, 2002). These factors interconnect in shaping "youth culture" and the environmental social life that shapes their social behaviour and reproductive health within the confines of their families and within community they live. A considerable amount of literature has shown that in some African societies, women have limited chance to protection of their early lives decisions, culturally or politically. The hampered cultural right of women most times result in risk taking behaviours for most young adult women, who are sent for child slavery, hawking, and get married without their consent. In essence, young women push to risk-taking behaviour early in life is likely way to face negative social problems. The impact of inability of young women to handle stressful experience in life, could lead to destruction or anti-social behaviour and exposure to vulnerability (Barker and Fontes 1996), including vulnerability to diseases like HIV/AIDS. Lastly, to the deep troubling situation of the speeding spread of HIV/AIDS disease is, for every five persons placed on treatment, three out of five cases are young people (aged15 -24), accounting for 40 percent of new HIV infections worldwide(CDC, 2015; HSR, 2016).The implication is that more youth could be infected, who are the labour force for the future generation development, and the result could lead to underdevelopment.

The cultural role of gender has negative implication for the spread of HIV disease for women because of the disadvantaged positions for women, addressing issues of culture and its implication

on the spread of HIV/AIDS on women particularly could be a way to reducing the spread in our culture societies where the epidemic is spreading more widely.

2.5 The Impact of Gender Unequal Status and Power Relationsamong Women in Africa

Historically, women have been associated with inferiority in philosophical medicine, religious and culture/tradition beliefs. The philosophical schools such as stoicism and Platonism distrusted all that was corporal/physical; favouring instead the spiritual. From the religious point of view, in Christianity the Old Testament figured Eve in the form of earlier misogynist, who argued that Eve condemned humanity by corrupting Adam. Emphasizing, Eve's born out of Adam's rib that automatically shows her state of weakness as a weak sex as argued by critics from some Feminist groups The link between a woman's physical and obligation to man was made more noticeable in the responsibilities given to both sexes. This is obvious in both Public and private responsibilities as it affects human relations.

The medical view in the early writings of the first five centuries AD, shows women's inferiority to men as justified by them said physiological weakness. In agreement with the Aristotelian physiological tradition, which influenced early modern and even contemporary notion of sex and gender, women are the imperfect version of man. "She is matter whereas he is form". A Greek philosopher and medical doctor, Galen (AD129-200) said women

lacked self-restraint whereas men were characterized by self-control,the above views justified the earliest dominant view that women were physiologically, intellectually and spiritually inferior to men as argued by feminist critics (Grant and Newland,1991).

The traditional global view is not different from the traditional African perspective (Nigeria inclusive), where women do not have equal power relation in decision making as compared to men. Women are generally acknowledged to be unequal to men and do not have equal opportunities as compared to men politically, socially, economically or otherwise based on the obvious reasons mentioned above. However, they are said to have made a significant contribution to global development in the pre – colonial and complementary African societies (Mba, 1982). Women have exerted tremendous influence in the socio - political and economic spheres in their various communities in the past. Mba acknowledged that the prolong historical antecedence of gender inequality led to the early global feminist movements that incited the agitation for marketwomen's right on taxation in Nigeria and other various agitation on women's' right on suffrage among numerous calls. The precolonial Nigerian societies for example, studies have acknowledge the contributions of women's participation in the public decision-making in traditional settings and societal activities in decentralized societies. Their views were also considered with much significance in other areas of human relations, even though at some period it resulted into crisis as evidenced in the Aba women conflict in the 1922 Eastern part of Nigeria (Faseke, 2001;

Awe, 1992; Mba, 1982). One can conclude that the advent of colonialism also, contributed to exclusion of women from the public sphere practiced by the colonial government and alter women's roles in most African societies.

Under the colonial arrangement it was established that colonialism reinforced indigenous gender hierarchies negatively and thus pushed women to the background. As colonialism exploited Africa's gender, the social divisions of labour, shared negatively to the disadvantage of women and only further increased women's financially dependent on men and exclusion in public sphere,(see Mama, 1997; Amadiuwe, 1995).

Studies have shown that women's shared influence and power before colonization eroded and restructured the State (Wright, 1993; Tamale, 1999, Becker 2000). A recent gender analysis on the establishment of colonial rule in Nigeria outlined the process through which the colonial administration and subsequent administrations excluded female traditional rulers from the system's administration and perpetuate gender politics, which continued in the post-colonial era (Olasupo, 2005). The gradual disengagement of local women from local governance and de-radicalization of the women's movements since the colonial era as exhibited in pre-colonial societies are discussed by (Mama, 1996 and Okome, 2000) and consistent with Oyewumi conclusion that colonialism eroded the political position of African women.Pereira (2003) in agreement with the views, drew attention to the over laps in the laws guiding the domestic and public

arenas. She discusses how colonial and post-colonial laws interact to reinforce the denial of African women's citizenship, encouraged State control of women's rights and an unequal terrain in male and female contestations for political power.

In Nigeria, as in other many African countries, plural legal system that allow the co-existence of customary law, the Sharia and Statutory law, limits compliance and enforcement of law promoting gender equity (Afonja, 2001), the religious lawsfor example, use the holy books, that emphasis men's headship and women fellowship within the teachings of holy booksand legal institutions as instrument for implementation, in this light it is based on male interpretations who are more in the legal system institutions in most of these communities. These ideas reinforced Oyewumi's view (2003) that gender is concerned with the construction of socio-political categories of citizens. The corner stone of many Western political theory, is argued to be designed and in most times implemented by male. Women's contribution to the social and economic development of societies is high only in farm production for example, women contribute more by virtue of their dual contribution in terms of production and reproduction spheres. Nevertheless their participation is acknowledge in the informal sectorsand low in the formal sector, particularly where decisions regarding the state resources are taken, gender voice remains insignificant. The society is such that the power relation is one-sided, its structure is such a social relation which enable men dominate women (Aina, 1998, Stacey, 1993; Kramarae

1992; Lerner 1998). It is usually a system of social stratification and differences on the basis of gender, which put women at disadvantaged position. The unequal power relations justifies the marginalization of women in education, economic, labour market, politics and market (Salami, 2003). In effect, the exclusion of womenfrom the public decision making process has made them voiceless indecision-making and unable to critically address issues affecting them. Thus, making policies in women interest unattended to and difficult to achieve, with implication for issues transmissible and can easily be spread within communities. Making policy ineffective and spread of epidemic more among the vulnerable and marginalized groups in the society. In essence power relation need to equate opportunity for both gender, or led to unequal power relation and vulnerability of the disadvantaged groups to epidemic.

Study findings show the alternative model of development on feminized poverty and HIV/AIDS in Africa. In most countries of Africa, women constitute over 70% of the poor and 57% of HIV infected persons and not addressing issues affecting the vulnerable that could easily mean silence among the vulnerable ones and the continued spread of the disease, rendering policies on the scourge of HIV/AIDs ineffective. Thus, subdues women's choices and inevitablypermitting the exploitation of women sexuality. The IFAD Rural Poverty Report (2001) highlights that HIV/AIDS and poverty are closely intertwined in cause and effect. The report summarized that in developing counties (Africa inclusive), the histories of massive male migrate are ways in

which poverty forces families to send young village girls to cities to become sex workers, house helps or slaves to support families – this scenario also makes women vulnerable to HIV/AIDs disease.

Baylies andBujra, (2000) stress the linkage between HIV, poverty and conflict in Africa and affirmed that these issues are generating global concern. These are apparent in recent policies initiatives like - The global policy target of the Millennium Development Goals set in 2000, and other commitments made which date back to a United Nations fundamental principle in 1945 that agitate for gender equality 'equal right of men and women', CEDAW adopts in 1979 that came into force in 1981 and contemporary proposed 2030 sustainable development goals as a new date for global reduction of gender inequality and other socio – economic relations (UNESCO, 2015}. The argument of this study is evident that dealing with issues that affect women's right generally could help reduce women vulnerability and diseases such as HIV/AIDs.

2.6 Incidence of HIV/AIDS and Women in Nigeria

The initial recognition of HIV/AIDS in Nigeria over three decades ago (1985) identified some groups as most at risks, they include - drug users, sex workers, transport workers, members of the Police Force, and Nigeria Armed Forces among others (NACA, 2011). Over time, the HIV epidemic in Nigeria became generalized and affecting all segment of the population including people who were not earlier identified among those with obvious risk factors.In recent time young

women and girls are acknowledge to be more at risk of contact andspread of the disease then men and boys of their age, although most at risk population (prostitutes, drug user, and men having sex with men) still contribute significantly to the spread of the epidemic.

The recent analysis shows heterosexual sex particularly of the low risk type, make up the bulk of infections (about 80%), next to mother and child transmission with 10% – both are considered a risk factor for women than men (GARPR, 2012). The high percentages (90%) of the two identified ways of transmission have biological natural effect on women than men, which could easily put them at risk of the diseases (HIV/AIDS). There is a consensus among scientists that women'snatural reproductive system to childbirth can causevirus infection from mother to child such as HIV/AIDS virus. Also, the fact that man have control over sex relationships than women as demonstrated by the Nigeria custom, were custom does not allowed women discuss sex openly makes women silent when it comes to sex issues and exposing them to the risk of sexually transmitted virus of HIV/AIDS than men.

Nigeria has been a home of culture, rich in tradition, old age customs, values, norms, and strong relationships among family, kin and community members. The onset of HIV/AIDS in Nigeria has tested these cultural bonds and created enormous challenges for young women, their families and communities. Nigeria's cultural norms is also silent on the rising magnitude of domestic and sexual

violence against women, which Tenuche (2003), simply refer to as "the burden of marital vows" with its attendant negative implications for the reproductive capacity and a serious implication for women's health and spread of HIV/AIDS in the country. Similar studies on Nigeria have shown the existence of feminization of poverty, domestic violence against women and its implications on HIV/AIDS (Davies, 1994; Wallace, 1996; World Health Organization 1996; Moore, 1979; Therborn, 2004; Tenuche, 2011; NACA, 2011).

While it is true that heterosexual relation has implication on the spread of HIV for both gender, the gender norms and masculine nature of Nigeria societies allow men have more than one sexual partner, no legal control to divorce, remarriages and wife inheritance – all are factors that could increase women than men vulnerability to HIV/AIDS in Nigerian communities.

It has been argued by Epstein (2000) that spread of HIV in Nigeria is attributed to poverty, in his view the ingredient of poverty which encouraged the spread of the infection includes: financial dependence of women and their inability to negotiate safe sex, sexual harassment, unfair haring practice, illiteracy, ignorance and high rate of unemployment among women than men in Nigeria. These pressures on Nigerians particularly women could encouraged high risk behaviour, labour migration, alcohol abuse, desperation and gender violence, all identified factors responsible for the spread of HIV/AIDS among youth and the female gender.

The first two highest mode of infection by percentage in Nigeria shows heterosexual sex affects more the low risk group.That is, the cohabited and women most time have little control when it comes to issues relating to sexnegotiations in societies like Nigeria and they are likely to be victims to epidemics.

2.7 Gender Inequalities and Women Vulnerability to HIV/AIDS in Nigeria

Gender inequality is not a new phenomenon. Historians of the industrial revolution document the early recruitment of women (particularly young unmarried women) as highly flexible, inexpensive, and easily disciplined source of labour (Dublin 1979, Tilly and Scott 1978, Tsurumi 1990). Similarly, European colonial regimes relied in part upon the mobilization of colonized women (as well as men) to work for example, as domestic servants and concubines to colonial officials or as family workers on plantation estates in the colonial period (Stoler, 1985: 1991). Yet more than in any previous era today, the gendered and ethnically segmented labour pool upon which capitalist accumulation depends covers every corner of the globe. Gender Inequality, can be said tooperate simultaneously, but not identically in societies. As a symbol gender is dominant in meaning and signify a structured social relations. Gender inequalities has dynamics within a global labour force that is also segmented by class, ethnicity and race within nationality and region, among other factors. Clark, (1994) summarized the argument on gender inequality that in

any given place or time; gender is only one of “multiple, interlocking system of domination”. Highlighting the opportunities given to each gender and the differences, which differ from one society to other and in most society’s responsibilities given to majorities among the women make them powerless.

Research findings highlight the overlapping and multifaceted effect of gender and labour inequalities worldwide (Elson, 1995; Marchand andRunyan, 2000; Nash and Fernandez-kelly, 1983; Rothstein and Blim, 1992; Ward, 1990; among others) Other works have attempted to extend the analysis of gender and labour to global processes, its effect on transnational labour migration and domestic service (Anderson 2000, Constable 1997; Gamburd 2000; Hondagneu-Sotelo 1994; Parrenas2001).The variation in gender difference is seen in the micro-enterprise production and other forms of work in what is often called the informal sector (Beneria and Rooldan, 1987; Clark, 1994; Gill, 2000;Rahnan, 1999;Seligmann, 2001). The conclusion is that wages from informal sectors are usually low and cannot care for the needs of workers in these groups. Therefore, couldincrease their dependences in human relationships. The implication of dependency tendency of a particular gender in any given relationship, if not clearly definegives one gender advantage over the other, which result to adisadvantage positionfor the dependent and a vulnerable situation often to the individual, the family and the society at large.

The neo-liberal economic restructuring expandeddependency domination among regions, class and gender. By relying upon the

resilience of families to absorb social costs, for example, the Structural Adjustment Policy requires the roll back of the states and cut back or elimination of several formal social programmes and subsidies. This process has had a devastating effect on many communities (Nigeria inclusive) often with sharply gendered implications (Beneria and Feldman 1992, Bergeron 2001, Harrison 1997, Susser 1997). For example, the grip of economic conditions that have resulted from economic restructuring programmes, diminish the security of formal wage employment and increase dependence on informal means of income where majorities among the women work force, are positioned. With low wages from the informal sector and often highly unstable job, men are force out of formal jobs and mandatory cut out of their responsibilities to depend on women in the informal jobs. (Babb, 1989; Clark, 1994; Seligmann 2001). Low wages and unstable jobs would lead vulnerability and to risk taking behaviours' in other to meet basic needs. Often times, women out of desperateness could retort to exposure or even sex work or prostitution. Prostitution was initially identified as a common means to spreading HIV epidemic and still a high means of transmission, the recent identification of heterosexual sex as a faster means to spread, makes prostitution next to heterosexual spread of HIV/AIDs diseases to the general population in the recent period (Maher, 1997; Moon, 1997;Muecke, 1992; NACA, 2013). Even though, prostitution has long been identified as a central means of HIV transmission among the general public, policy on reducing the spread through this means

has not been given much emphasis. An advocacy on the use of condom is the only effort made to reduce the spread of HIV through prostitution and it was initiated to prevent men from contacting the disease this is because condom are given to the female prostitutes to use for their clients (SFH, 2010).Respondentsacknowledged that condoms are given to them and most of their men do not accept the use of condom.

Nigeria's initial HIV/AIDs response at the early stage of discovery reflected male preference and limited women's ego. For example, one of the early steps taken to preventing HIV, was the provision of the use of condom, as a shield to men from infection and thetesting of pregnant women to identify people living with NACA(2001). These steps of condoms distribution were for men's preventive purpose and women are left to risk, plead and negotiate the use of condom with men (respondents view, 2014). The process has yielded no result in the epidemic reduction, because heterosexual contact and prostitution are the central human contact of spread of the epidemic. As the number of women living with the epidemic continue to increase in percentage than men. This is because most men do not consent to the use of condom; women in most cases have limited power for such negotiations particularly among the sex workers who are financially dependent on the men by the nature of their profession. Even for the legally committed women, culture allows men have an edge over women when it comes to issues of sex in most

Nigeria societies; women generally have weak negotiating power when it comes to issues of contraceptives use, such as condom.

Furthermore, men's polygamous nature and cultural inability of women in marriages to discuss the pattern of sex or challenge men's infidelity rendered the policy initiative in the use of contraceptives ineffective, and incapable of reducing the spread of the epidemic among women and the general population. Wood (2005) summarized the gender issues and HIV/AIDS spread in Nigeria as shaped by sexual attitude based on gender and superiority.Men control the sexual relations based on societal hierarchy. One can argue that almost three decades into the widespread of the disease, there has been increase in policy and programme reviewed initiatives among African nations and donor from foreign countries, but the impact of policies (National HIV/AIDS strategy framework 2005-2009, national HIV/AIDS strategic plan 2010-2015, the global fund donations to PLWHAs on Nigeria's female gender is still a source of concern.

Nigerian stakeholders on the epidemic from public, private and civil society groups have acknowledged the rising prevalence of HIV/AIDS among women and the expansion of orphans and children from the AIDS epidemic (NSP 2010-2015, KSS). The many administrative policy document on HIV/AIDS do not constitute law and cannot be enforced by/in the court of law in Nigeria, the policy only constitute mere tools and guideline for government directions were there is need for actions (NACA, 2009; FMH, 2007). Health policies and programmes on women and HIV/AIDS focus on biological

aspects of diagnosis and treatment. The issues on mother child transmission, women's reproductive health information are considered their reproductive lives and not as factors affecting the spread of the disease thus exacerbating the epidemic in Nigeria (Nkoli, 2002).

2.8 Women's Vulnerability to HIV/AIDS in Kaduna State

Study reports by NACA, 2014 reported in NARHS, 2012 on Nigeria's' HIV/AIDS prevalence across the countries six geo political Zones shows that the highest concentration of the epidemic is in the North Central Zone with 7.5% prevalence and the lowest prevalence is in the North Western Zone at 2.1%. However, Kaduna State in the North West zone has sustained the highest HIV/AIDS prevalence in the zone, with a percentage higher than the national prevalence, as some location sites in the State is still having prevalence as high as 17% higher than the average prevalence of most sites in the North Central Zone.

The structure of Kaduna State population shows majority of the citizenry live in urban, and semi urban towns like Zaria, kafanchan, Kagoro, Makarfi and Zangonkataf. The State is a home to cultural and religious practices and has tasted the bond to most cultural and traditional norms of Nigeria.

The disease is generalized with cultural consequence, affecting all group of populations and sparing no geographical area in the Nigerian States. Heterosexual means of transmission is the fundamental means of spreading the epidemic in Nigeria and

culturally, sex continues to be defined primarily in terms of male desire with women being relative passive recipients of male passions (Seidel, 1993). In most marriages, women cannot assert their wish for safer sex, for their partner's infidelity or for no sex at all as defined by culture and religion, resulting to unhealthy sex risks and vulnerability to the risk of HIV/AIDS. Womenvulnerability is further reinforced by socio – economic constraints on women's inability to have a protective sex and insist on safe sex. For example, many women find the heterosexual relationship a difficult one to negotiate as strategy for their own safety. This is because most women are engaged legally in cultural/religious polygamous marriages; they find themselves either as inherited wife and cohabitated relationship. These situations women often find themselves could further increase the spread of the epidemic among women than men and the general population at large.

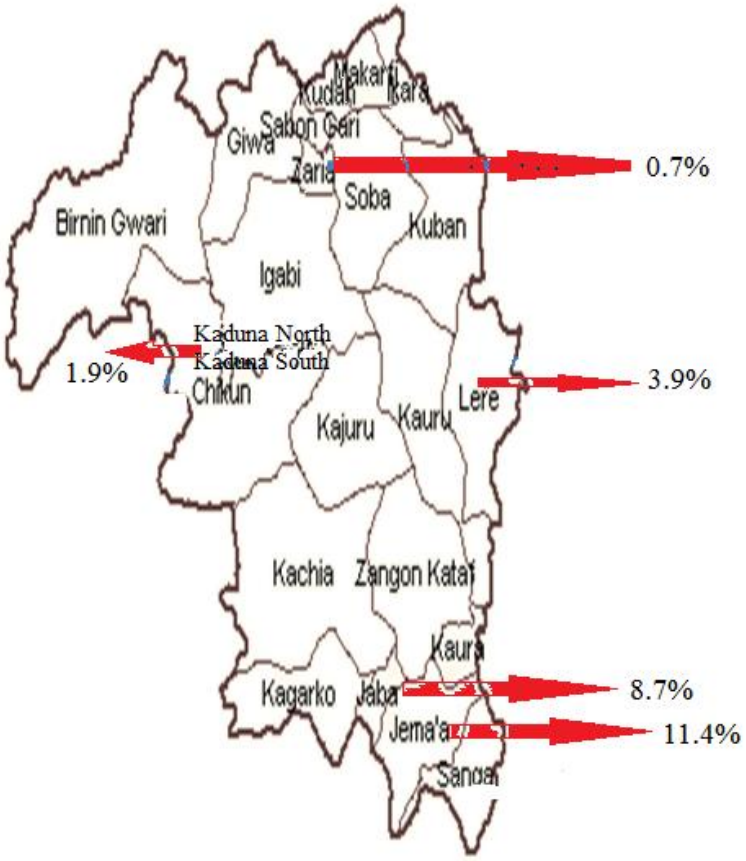
The nature and extent of inequality in the State is more evident in gender.Statistics indicate that women are more at the risk of social problems because of the systematic challenges they faced in education, healthcare, employment and the burden of care given responsibilities they have to shoulder. NBS (2004) study carried out in the State in the year 2004 shows that the adult's literacy based on gender is 73.9 percent for male and 50.5 percent for female; the illiteracy rate among women also reflected in their unemployment rate in the State as reported in the National Bureau of Statistics. The report shows that gender unemployment rate of women is twice that of men, with 36.2% for men and 18.7% for women unemployed in the

State. The implication is that an educated and employed person is better equipped, likely has a better-paid job to face challenges of life than an uneducated person. An uneducated and unemployed person has reduced chances of not contacting epidemics such as HIV/AIDS, particularly for the vulnerable girls who can easily give up their pride for money in a desperate situation. NACA in her 2013 report expressed concern over the rising number of people with the epidemic in Kaduna State).

A survey result of mode of transmission study conducted in 2011 suggested that the state has a generalized epidemic and that about half of the new infections (47.3%) occur amongst persons not engaging in high risk sex cohabiting or married sexual partners (GRAPP, 2012).

The variation of prevalence within the States shows that the Southern part of the State has 4 times higher prevalence than the Northern zone. Sites like Kafanchan, Saminaka and Kwoi having the highest prevalence and Zaria in the Northern area in the State has the lowest prevalence and Lere lower than any of the Southern State (KADSSP, 2011).

More so, Culture, poverty and conflict have played a significant



role in the spread of HIV/AIDS in the State; Kaduna State has witnessed many ethno religious conflict and political violence since the return of democratic era in 1999, which has led to increase in poverty and migration from one location to another. The increase in mobility of populations within the urban and rural areas, movement of workers from villages to cities, and consequent breakdown of traditional values, that could increase the spread of HIV among women and the population in general as show by studies of other conflict areas (UNAIDS, 1997, NACA, 2013). Poverty report of Nigeria shows the increase in relative poverty measurement from 54% in 2004

to 69% in 2010 with North West and North East badly affected with percentage level of 77.7% and 76.3% respectively. The incidence poverty has affected women folk more than any other social group in Nigeria, in most cases poverty courses increase in migration to look for work, living the women behind to take both the gender responsibilities of the families (UNAIDS, 2001). Also, in most transit period, polygamous tendencies of men's nature lead those to mutual relationships that could result to risky behaviour, as seen infect on most transporters and HIV/AIDS infection, the forces and the general population in transit (NACA, 2010). By implication man outside homes or in transit in search of daily responsibility traditionally assigned to him may have negative implication if promiscuous in behaviour that could make him and his partner vulnerable to diseases such as HIV/AIDS, in most cases; women bear the higher burden of these societal problems in most societies.

2.9 Theoretical Framework

The gender and power theory is a social structure theory that was developed by Robert Connell (1987) to explain the sexual difference on gender inequality and the power imbalance between men and women based on existing philosophical writing of sexual inequality, gender and power.

Although, views on gender perception are seen as being bias because of women's feminist view of the concepts, which focuses on women and women's rights. However, it is undeniable that much work on feminist theory is devoted to the task of critiquing women's

subordination, analysing the interactions between sexism and other forms of subordination of women such as - racism, heterosexist, class oppression, and envisioning the possibilities for both individuals and collective resistance to such subordination (Simone, 1953.; Bam, 1993.; Bernard, 1981; Brines, 2006.; Butler, 1990.; Chafed, 1990). Thus, the misconception that gender and gender talk only promotes women advocacy cannot be far from true. However, the power relations of gender, which are socially structured, based on responsibilities allocated to men and women and constructed by men, in most cases men as decision makers is trivial. This is because men make up the majority among the decision makers in most institutions in world societies.

Kintetsu (2006), as emphasized by UN Commission on the status of women which dates back to 1947 acknowledges women challenges and commitments made to salvage them, which has made little progress. The much gender theories and decades into gender talks and commitments, the theme on gender difference are still recurring and the vulnerabilities seems to worsen among women, especially with the new challenges of global socio economic crisis, conflicts/wars and diseases such as HIV/AIDS.

According to gender and power theory, there are three major social structures that characterize the gender relationships between men and women in most societies.

The concept of power imbalances in the subordination of women was first articulated in the early 20th century by

Chertoff Perkin Gilman (1911), that:

> All our human scheme of things rests on the same tacit assumptions: man being held the human type; women a sort of accompaniment and subordinate assistant, merely essential to making of people. She has always the place of a preposition in relation to man. She has always been considered above him or below him, before him, beside him a wholly relative existence

Gilman emphasized that in our different cultures, man defines woman not in relation to herself but in relation to him. This defines the whole relationship between man and woman in our pre-colonial societies where man is in all perspectives seen as either the head of the family, heads of most state institutions or in societies, showing the superiority of man over woman. This dates back to centuries in most societies of the world and has been maintained and most emphasized in the African culture.

Simone de Beauvoir (1949), also expounded upon gender and power imbalances. During the mid-1980s, Robert Connell an Australian Sociologist began examining the available theories on gender and power in search of an integrative theory that would reassemble the existing theories in the field of sexuality and gender.

The theory best explains this study because it assumes that an individual had total control over his or her behaviours, and contextual factors like power differentials and gender roles, can heighten or increase gender vulnerabilities to disease such as HIV/AIDS and particularly women's HIV risk when given little attention.

In 1987, Connell developed a collection of writings on the theories of sexual inequality and gender and power imbalances. According to Connell, three major structures characterize the gender relationships between men and women, which include - the sexual division of labour, the sexual division of power and the structure ofcachexia (effective attachments and social norms).

These three overlapping but distinct structures serve to explain the cultural bound gender roles assumed by men and women. Connell emphasized that none of the three structures is or can be independent of the other. He also noted that the three structures exist at two different levels, the societal and the institutional. The highest level in which the three social structures are embedded is the societal level.

These three structures are rooted in society through numerous abstract, historical and socio political forces that consistently segregate power and ascribe social norms on the basis of gender-determined roles. As society slowly changes, these structures remain largely intact at the societal level over a long period of time.

The fundamental structure of gender equality is sexual division of labour and power relations. At societal level; the sexual divisions of labour refer to the allocation of women and men to certain occupations. Many times, women are assigned different and unequal positions relative to men, as women are traditionally delegated to home front care takers, an unpaid responsibilities as “women’s work”. This assignment constrains women because of the nature and

organization of the society as what is known as women's work. This limits their economic potentials and confines their career paths.

At the institutional level, the sexual division of labour is maintained by social mechanisms such as the segregation of "unpaid" nurturing work" for women. These are mainly childcare, caring for the sick, elderly ones and housework. Because this work is on paid for or uncompensated in monetary terms, an economic imbalance occurs, in the sexual divisions of labour. These practices favours male in their educational attainment, support job status for male and the segregation of "income-generating work" for men, allowing men control of the family income. In situations where women participate in the paid labour force, their participation is often less than that of males and remains highly sex segregated even when both spend the same amount of time in paid works outside home. Lobber, (2010) argues that the amount of housework, childcare a wife does even when she works within the same organization as her husband is much more and often unrecognized as a contribution to development.

Belau (1977) andRetina et al (1988), argue that the concept of structural inequality is trivialized or true as evidenced inside an individual's belief, in the form of internalized norm and values. In most African societies, the role and duties signed to a boy or girl child are accepted as a way of life and to whom the signed role favours is never a question to be bothered with. Stevia, (2004) assert that:

> there are high unemployment levels among women compared to men, and even when women are employed, they are much more likely to work in low productive jobs

> with low income and status than men. While, women in the rural areas tend to be engaged as causal labourers' and in urban areas employed in the informal sectors mostly as support staff - in wealthy homes or in petty trade activities or business, the out and benefit does not generate an adequate income for their daily survival

An added social problem or responsibilities may only worsen their living condition. The implications are that women's defined role does not give her equal opportunity to negotiate opportunities as her male counterpart, a common condition is seen among many Nigerian women, particularly in rural and in most developing countries – is socio –cultural role of women. Women in traditional societies are encouraged to marry at a very low age with little or no educational skills. An uneducated person with no skill to self-development, left to survive in any condition she finds herself, is a vulnerable condition most women with illness find themselves.

Blau (2013), argues that structure is a force opposing individual motivation merely looking at structure as constraint; one concept of structure must be observable, external to the individual, and independents of individual motivation. By giving a clear decision between structure and action, with structure as constraint and action as choice, structure will be important. Constraint is an important function of structure, but focusing only on structure as constraint minimizes its importance. It is significant to note that women and men are forced/coerced into differential social roles; which also help shape their gendered paths. It is abnormal for example, for a woman to take a man role as head of the family in the then Africa societies

neither is accepted or common to see a man as a care taker of the children or cook for the family, these are considered woman's responsibility. This study argues, that the social role of gender is constructed by the society, also, emphasising on each gender to mainly adhere to than constructed role may result to unequal relations and vulnerability to certain groups who do not influence decisions in the community.

However, with dynamic changes globally and world economic recess on women are forced head households. A social structural analysis can help to understand how and why, actors choose one alternative over another. A structural theory of action according to Burt (1982), suggests that actors compare themselves and their options to those in structurally similar positions. This explains why actors are purposive, rationally seeking to maximize their self-perceived wellbeing under social structural constrains. As Burt argues, one can assume that actors choose the best alternatives without pre summing they have either enough information to do it well or the options available to make choices that effectively serve their own interest. While actions are a function of interests, the ability to choose is patterned by the social structure, i.e. the state structure are designed in such a way that role are signed to each gender group. For this reason we find women in the social structure less educated and mostly involve in the informal sectors as shown by study findings.

This study, share this presumption that in a structure of an unequal status, where there is limited choices surrounded by

numerous factors such as scarce resources; marginalization of some groups, among others sectorial difference may have serious influence in the pattern of choice particularly to the male/female gender in societies, that could enhance unequal social relations.

Lastly, whereas, "men's work' is often valued either directly through paid remuneration or indirectly through its high status, women's naturally signed work fails to be recognized as work and has less values.

The inequities resulting from social mechanisms that occur within sexual division of labour are manifested in the public health field as economic exposures and in the psychosocial domain as socioeconomic risk factors. According to the sexual division of labour, as the economic inequity between men and women increases and favour men, women will be more likely to experience segregation and to health hazards as attempted by this study on gender and HIV/AIDS.

The second fundamental structure of the theory is the sexual division of power. At the societal level, in-equalities in power between the sexes form the basis for the sexual division of power. Power has been conceptualized differently by several different disciplines. The social psychological literature define power as having the capacity to influence the action of others, conceptualizing powers in terms of power over others (Antonovsky; 1998). This ability can reside primarily at the interpersonal level and occasionally at the institutional level. The power literature defines power as having the

ability to act and to change in a define direction (Moserand Dracuped, 1995). Simply put the ability to make others do what they could not have done under normal circumstances.

Comment [SMU1]:

It is important to note that at the institution at level, the sexual division of power is maintained by social mechanisms, such as the abuse of authority and control in relationship. Women in power imbalanced relationships tend to depend on their male partner because men usually bring more financial asset (either money, status) to the relationship.

The relationship at both levels (societal and institutional) take place among groups and in organized communities and exiting in hierarchy to avoid riot as seen in the works of philosophers of the social contract theory of John Locke and others, emphasizing living together in communities entails having a ruler and the ruled, that must agree on terms of rule as it is in the agreement of the social contact.

Lorber (1994) further emphasized that, gender is an institution that "is embedded in all the social processes of everyday life and social organizations, and that gender difference is primarily a means to justify sexual stratification. Gender, she said is endemic (widespread) and unless we see difference we cannot justify equality". Lobber, provided much cross cultural literacy and scientific evidence to show that gender difference is socially constructed and yet is universally used to justify stratifications. She notes that: "the continuing purpose of gender as a modern social institution is to construct women as a

group to be subordinated to men as a group". This view is used to explain the chauvinistic nature of the relationship between man and woman in most modern societies that dates back to history. Example, can be seen in women leadership role that is globally and highly unpopular even in the developed world, we find a great deal of women marginalization in politics, education, leadership positions compared to men. In addition, this is socially constructed in which it is globally acknowledged and accepted as a way of life. In other words, gender inequality exists in all the process of human social relations and is socially constructed leading to the allocation of value through structure of power.

The theory of gender and power accepts the continuing process for the adjustment of conflicting group claims through an organized equal exercise of power. The concept of power is central to each of these theoretical tasks; (is) power is clearly a central concept for feminist theory as well. (ii) The difference in male/female gender roles which is related to the power differential between men and women, (iii) the structural and institutional power as resides in the form of access to education, economic and political resources and opportunities that exist and favour the male gender. Education for instance, provides people with the power to gather and process information, equipping them with more understanding the world they live, in most African countries the ratio of male/female differs with men more educated than women (show a clear disparity in access to education and its implication in understanding about the word we live). Secondly,

economic power provides people with financially support for themselves and their families; many studies have shown that men are more economically empowered than women. Thus, as the world acknowledged the unequal relationship between men and women, women activist and the United Nation have agitated for the need for women right and human right advocacy both national and international level.

The inequities resulting from social mechanisms that occur within the sexual division of power are manifested in the field of public health as physical impacts, while in the psychological domain as behavioural risk factors, according to the sexual division of power, as the power inequity that increases and favours men, while women experience unfavourable health outcomes.

The physical impact can be felt as institutional and interpersonal factors when men exert their power over women. These physical impacts can expose women to having a high-risk steady partner, a partner who disapproves of practicing safe sex and lack access to drug treatment or to HIV prevention education.

The behavioural risk factors can be define by attitudes of women prostitutes by profession, alcohol, poor condom use skills, low self-efficacy to avoid HIV. The limited perceived control in such relationship over lapping with the decision of power is the structure of social norms and effective attachments (Cathexis).

Cathexis is the social norms and effective attachment and is the last of the three structure of gender and power theory. This aspect of

the structure emphasized as effective and normative components of this structure. The structure is referred to as the structure of effective attachments and social norms. At the societal level, this structure dictates appropriate sexual behaviour for women and is characterized by the emotional and sexual attachments that women have with men. This structure constrains the expectations that society has about women with regard to their sexuality and as a consequence, shapes our perceptions of others and ourselves and limits our experience of reality. This structure also describes how women's sexuality is attached to other social concerns, such as those related to impunity and immorality.

At the institutional level, the structure of social norms and effective attachment is maintained by social mechanisms such as biases people have with regard to how women and men should express their sexuality. There biases produce cultural norms, the enforcement of strict gender roles, and stereo-typical beliefs such as believing that women should have sex entry for procreation, restraining women's sexuality (being monogamous as opposed to having multiple partners- an accepting norms for men but not women) etc.

The social impact can be defined as women who have older partners and are dependent on the patterns; family influence that is not supportive of HIV prevention, a mistrust of the medical system, conservative cultural and gender norms, and a religious affiliation that forbids the use of contraception. The personal risk factors are

defined as women having limited knowledge of HIV prevention, negative attitudes and beliefs about condoms, etc.

The structure of social norms and effective attachment also reflects in equalities of power, and the division of labour partly reflects patterns of social norms and effective attachments. Theoretically, all the three structures are distinct but interrelated.

Using the theory of gender and power to exploring the impact of high incidence of women with HIV/AIDS in Kaduna state is for these reasons. First, AIDS among the top ten cause of death among women and men between the ages 25 and 44 (WHO, 2015). Second, in Nigeria the number of women with HIV/AIDS has increased (Nigeria - UNAID, 2015).

Thirdly, globally, women account for 55% of the estimated 33.3 million adults infected with HIV and HIV/AIDS (affect twice the number of young women than men of same ages (UNAID, 2013). Fourthly, women infected with HIV are the major source of infection for infants, preventing the spread of HIV infection in women will reduce vertical transmission. Lastly, women in sub-Sahara African constitute the majority among the onward spread of HIV/AIDS as those in prostitutes still constitute a high percentage of those with the infection(UNAIDS 2014), therefore the need to develop intervention through employment will help reduce HIV/AIDS among women is central to reducing or eliminating the epidemic.

CHARPTER THREE

RESEACRH METHODOLOGY

3.1 Introduction

The section focuses on the approach used in obtaining data in an attempt to give results in answering the research problems and the objectives of the study. The study was carried out with an approved ethical clearance used to conductany research in state hospitals. The ethical approval clearance was gotten from three units to complete the study. The first and most important was obtained from the State Ministry of Health (SMH), a condition to have access to PLWHAs in state hospitals. It is only by an approved ethnical clearance that researchers are allowed access to PLWHAs any of the hospital in the state. The two other units where the ethical was requiredwere the two hospitals that the fieldwork was carried out. The process of seeking an ethical clearance was repeated at the two hospitals with an attached photocopy of SMH clearance.

The chapter will provide a detailed or step-by-step description of every procedure used in carrying out the study. The chapter entails description of the study area, the types and sources of data, techniques of data collection, population and sampling size and techniques of data analysis used in the study.

3.2 The Study Area

Kaduna State lies between Latitude 10^0, 2^0North and Longitude 7^0, 45^0 East with land mass of 45, 7112 567 square kilometres. It was

ranked 3rd position in Nigeria with estimated population of 6,066,562the population by gender showing male as 3,112, 028 and female as 2,954,534 estimated (2006 census). Kaduna State was originally part of the Northern Region in the three-region structure of 1954. In 1967, with the creation of twelve States, Kaduna State became part of North-Western States. By 1976, the government created nineteen States from the existing twelve, among them was Kaduna State. The State presently has 23 local government Areas namely; Birni-Giwari, Chikun, Giwa, Igabi, Ikara, Jaba, Jema'a, Kachia, Kaduna South, Kaduna North, Kagarko, Kajuru, Kaura, Kaura, Kubau,Kudan, Lere, Makarfi, SobonGari, Sanga, Soba, ZangonKataf and Zaria.

Kaduna State is mostly populated byHausa, Gbagyi, Adara, Gong, Atyap, Bajjuu, Ninkyob, Kurama, Koro, Kataf, Mada and Agworok ethnic communities, others includeIkulu people Moroa'a, AtukuGwandara Ham or Jaba.

The State has 3 emirates, with 32 chiefdoms and 345 districts. Kaduna State replicates Nigeria's multi – cultural, multi-ethnic and multi- religious diversities at State levels. The state who serves as a good representation of the economy of Nigeria at large, since it has experienced various government policy reforms on development. The collapse of industries within the State as well as widespread conflicts which were mostly rooted in poverty, religion/ethnic and inequality, in addition to massive rate of unemployment instanced by economic reforms embarked upon by government at all levels to tackle the

economic crisis are factors that have collectively heightened social tension. The implication of social tension in the society leads to mistrust, insecurity and conflicts with heavy migrations, unemployment, as many people could take to ill behaviours and desperateness resulting to drugs in take and exposed to epidemic such as HIV/AIDS in such societies.

Kaduna State has the highest HIV/AIDS prevalence in the North- West geo political zone, with 5.1 percent infected people living with HIV/AIDS in the state. The state has a total population of around 6 million people; confirming that the number of infected people living with HIV/AIDS in the Kaduna State is 300,000. That is (5.1%) of HIV/AIDS affected persons of estimated 6,000,000 people in Kaduna State.

The State population structure shows that majority of the citizenry live in urban, and semi urban towns like Zaria, Kafanchan, Zankwa, BrininGwari, Jama'a and ZangonKataf. Also, 22% of the State population are infant ages between 0-5 years, children aged 6-11 years - constitutes 18%. The age distribution of the State suggests that only 10% of male and 8% of female live up to their 44th birthdays and only 1% of the total population scales to 75 years. These figures suggest that women, infant and children are the most vulnerable group in the State (UNICEF, 2003; NPC, 2005).

3.3 Sources of Data

The study made use of both primary and secondary sources of data. The primary data was collected through survey and distribution of questionnaires. The questionnaires were distributed in two local governments, chosen from two of the three senatorial Zones in Kaduna State.

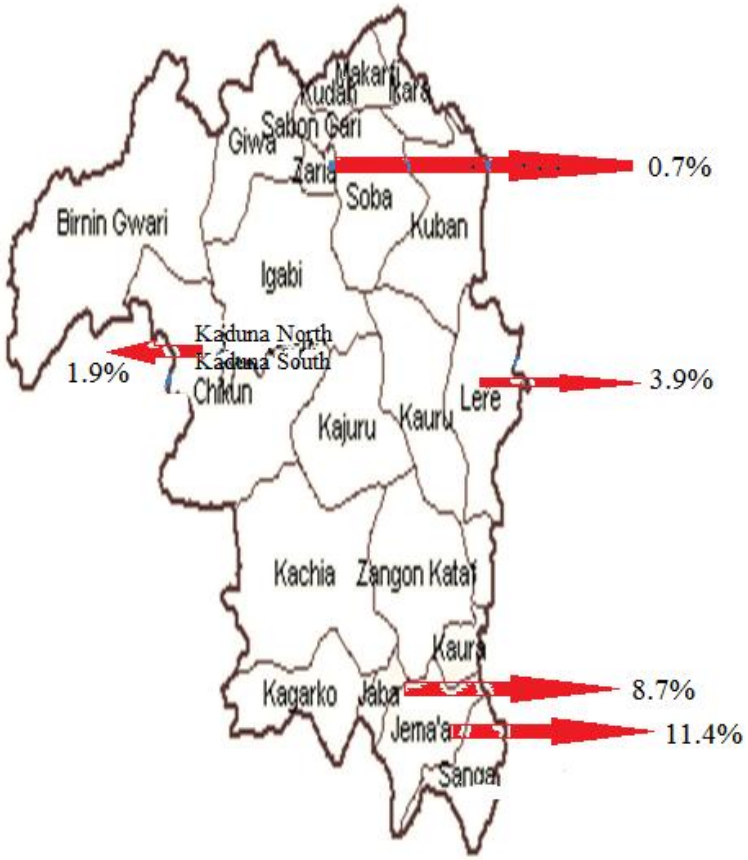
The secondary data were collected from books, journal, policy document from NACA, KADSACA, UNAIDS Reports, WHO reports and document and other related literature. The Internet was also used to source information on the subject matter.

3.4 Sample Size and Sampling Technique

The sampling technique is the simple random method. The researcher identified sites with population people living with HIV/AIDS and attending clinics in two specified hospitals in the identified locations.

The selected case study locations used for the survey, are two hospitals in two local governments in two of the three senatorial Zones in the State. The selection on accessibility to people living with HIV/AIDS was based on PLWHAS and attending clinics in hospitals at the period of survey. The two hospitals with HIV/AIDS unit for the survey are Kafanchan General Hospital (KGH), in Jama'a Local Government and National Tuberculosis and Leprosy Training Centre (NTBLTC) Saye Hospital, in Zaria Local Government respectively. The choice for the two Local Government areas is that Kafanchan in

Jama'a local government is located in the Southern part of the State and has the highest HIV/AIDSinfection rate (11.4%) and Zaria local government is located at the Northern part of the state and has the lowest prevalence of HIV/AIDS (about 0.7%) at the last national Prevalence survey in 2010 (KADSAC, 2010). The two hospitals chosen for the survey has a special unit for people living with HIV/AIDS and an identified number of affected people currently attending clinics in the chosen hospitals. The choice of the location is to enable easy access to those living with the disease and attending the hospitals' clinics. The two Local Government areas selected for survey have high population density, similar commercial centres and institutional centres. Kafanchan is a semi urbancentre that sees the influx of goods and services and a commercial town centres, while Zaria is an urban institutional town that also sees influx of people, goods and services. The map below shows HIV/AIDs prevalence across Kaduna state with identified site and percentage of PLWHAs across the State.



Map 1: HIV/AIDS Prevalence by Local Government in Kaduna State

The study and survey area identified have estimated figure of people living with HIV/AIDSpresently attending clinics in the two

hospitals identified for the survey. In order to get an accurate Sample size of the category of respondents, the actual number of people living with HIV/AIDS and attending each of the hospitals was collected from the hospitals records centres. The study applied the Yamane (1967: 886) Formula, to ascertain the number of questionnaires to be distributed in each of the selected location.

The Yamane formula was used to determine the sample size:

$$\boldsymbol{n = \frac{N}{1 + Ne^2}} \ldots\ldots\ldots\ldots\ldots\ldots\ldots\ldots (\mathbf{1})$$

Where n = Sample size

N = Total population

e = Level of significance

In order to get the sample size of both sites, the total number of PLWHIV/AIDS was collected from the identified hospitals, which are General Hospital Kafanchan(GHK) and National Tuberculosis and Leprosy Training Centre (NBTLC) at Saye in Zaria.

GHK has a total Population of about 10,000;NBTLC has a total Population of about 2,500. In Yamane formula N_1represent Total number of active HIV/AIDS clients at GHKKafanchan and N_2 for total number of active HIV/AIDS clients at NBTLC, Saye, in Zaria, Kaduna State. .

N_1 = Total number of active HIV/AIDS clients at General Hospital Kafanchan (GHK)

N_2 = Total number of active HIV/AIDS clients at NBTLC, Saye, Zaria.

$$n = \frac{N_1 + N_2}{1 + Ne^2} \quad (2)$$

GHK has a total of 10,000 active clients

NBTLC has a total active clients of 2500

$$n = \frac{10{,}000 + 2{,}500}{1 + 12500\,(0.05)^2} \quad (3)$$

$$n = \frac{12{,}500}{1 + 12500\,(0.0025)} \quad (4)$$

$$n = \frac{12{,}500}{1 + 31.25} \quad (5)$$

$$n = \frac{12{,}500}{32.25} \quad (6)$$

$$n = 387.596 \quad (7)$$

$$n \approx 400 \quad (8)$$

Kafanchan$= \frac{10{,}000}{12{,}500}\ x\ 400 = 320$ (9)

Zaria$= \frac{2{,}500}{12{,}500}\ x\ 400 = 80$ (10)

From the above calculation, KGH with a total population of about 10,000.00 HIV/AIDSpatientaccounts for 320 questionnaires, and NBTLC with a total population of about 2500 HIV/AIDSpatient accounts for 80 questionnaires, a total of 400 questionnaires will be distributed for the studies in the two locations identified.

The distribution of the questionnaires was done on the clinic days of patients of the various groups. The clinic days of patient at both hospitals were based on adult and children. We attended all clinics days at each of the hospital identified for the studies and

questionnaires were distributed based on willingness of patient PLWHAs on their clinics days.

3.5 Method of Data Collection

The major instrument used in the collection of data is the questionnaire. The questionnaire was structured to collect information on both gender status to identify reasons for high incidence of HIV/AIDS among women as a basis for analysing results and testing the preposition. It questionnaire was structured in numeric data (yes or no). The questionnaire were structured to provide demographic information about the respondents, awareness on government policy of people living with HIV/AIDS, accessibility to health services, effect of government support for those living with the epidemic and the affected aspiration in life.

3.6 Tools of Analysis

The study made use of both descriptive and quantitative mode of analysis. The quantitative data were collected through questionnaires and were subjected to simple statistical analysis and interpretations. A codebook was manually computed to organize the data collected and information transferred into a code sheet. It was then analysed with the aid of a statistical package for social sciences (SPSS version 15.0). The SPSS was used to generate table, frequencies and percentages and the data was subjected to a Chi-Square test. The Chi square statistic is used to test for relationship in the three of the four assumptions raised for the study. The data in frequency counts

are nominal (representative) by nature; hence the appropriate statistics to test for absence or presence of significant relationship is the chi square statistics of independence.

The development of a statistical test is to help determine whether or not two classification criteria, such as gender and job performance, and to ascertain the level of significances. The level of significant or insignificants of two cross tabulated questions answered by respondent are tested using the chi square statistics. The Chi square test was used to test whether two (2) or more variables are independent of each other in a sample population among people living with HIV/AIDS.

CHAPTER FOUR

OVERVIEW OF POLICY IMPACT ON PEOPLE LIVING HIV/AIDS

4.1 Nigeria's Health Policy on HIV/AIDS

The Nigeria government is responsible for forming policies to govern the country's HIV/AIDS programme and services.This is because government accorded to Fippo (1966) is solely responsible for policy making rules, regulations and procedures that govern the behaviour of anyorganised system. Sani (1999) is of the view that policy development is not only a technical issue but also about good governance, requiring the accommodation of varying interests with the significant issues. That is, practical issues requiring a guide should accommodate varying interest with the ultimate purpose of the common good.

The rational for Nigeria's policy on HIV/AIDS is to help confront the disease wide spread across the country, the Federal Ministry of Health is supposed to arrowhead the control of all levels of government (- Federal, State and Local Government) in the country. But because the country had a slow response, the fluctuating experience in the incidence of the disease and high record in the 1990s resulted to the presidentialresponse in 1999. Other intervention at national and international level and the multi-sector response came as a more effective approach, only first initiated byNACAin 2002.

The effort of government commitments is slow, given the fact that the

disease first appeared in 1986 and became widespread in the 1990s when the prevalence among the general population rose to its pick, only then did it attract government attention. The first action by all the stakeholders was to expand the response with the Lunch of Universal Assess to HIV/AIDS prevention, treatment, care and support. The response seems not effective because of the inconsistences in the report of incidence of the disease across the country. With several efforts, the government has identified some vulnerable group as target to reduce the spread of the disease and willing to take more action to promote the needs and rights of the vulnerable groups including women, young people and children of all age. This is because of the growing incidence among those not earlier identified as those at risk of the disease(married women and cohabited partners). Also, the contact nature and spread of the disease among a particular group, shows feminization of the disease and multiply sexas anessential way of spread among the general population. Women are vulnerable to sexual relations because of cultural defined role for women and policy documents relating to culture are not clearly defined and difficult to address.

The first attempt to develop a national frameworkplan for HIV/AIDS in Nigeria was an initial responds after the first reported case of the epidemic in 1986, with the establishment of a National Expert Advisory Committee on AIDS (NEACA). It was an advisory body to report directly to Ministry of Health all cases regarding the disease.

In 1988 the National AIDS and STI control programme was established in the Federal Ministry of Health that marked the beginning of more coordinated response. Both programme yielded little or no result. By 1999, when the epidemic became an epidemic, affecting the general population, the multi-sectorial response approach began with the National Action Committee on HIV/AIDS to coordinate multi-sectorial response and report to the established presidential committee on AIDS and later the committee was transformed into a full agency- the National Agency for the Control of AIDS (NACA) in 2000.It will be note that for over a decade there was noestablished policy document response to outbreak of the disease. The National Assembly Act was able to strengthen the coordinating role and the overall national response at all levels government (NACA, State Action Committee on AIDS, (SACA); and Local Action Committee Action, (LACA).

The NACA response to the disease was based on a national strategic work plan known as the HIV/AIDS Emergency Action Plan, it was to function for four years to be jointly executed by the government of Nigeria, bilateral donors and a World Bank credit. The HEAP documented over 200 activities to be carried out in four years. Designed to promote a multi –sectorial, participatory response to HIV/AIDS cure then prevention. In 2004 -2005 the HEAP period expired with little achievement as the disease became high among some major sectors of the society. A new frame work The National

Framework Strategic NFS was developed with wide participant of Civil society groups, privateorganizations etc. the NFS is designed with a life span of 5years to guide the National Response and all implementing and coordinating entries to contain the spreading of the growing disease (NACA, 2004) and expand its scope to encompass the general population. Nigeria National Response Information Management System (NNRIMS) for HIV/AIDS was also developed under the multi-sectorial response. Nigeria's response to the disease through these developments have allowed the country to operate under the framework of the "Three in One" principle, one coordination agency NACA, one strategic plan (NSF), and one monitoring and evaluation framework (NNRIMS) (NPHA, 2009). In spite of the policy and framework initiatives the disease in Kaduna is said to have taken hold and surpassed the 5% prevalence rate in many part of the country. The state retained its status in the geo political zone and can be said to be on point of neither controlling the disease nor even reversing its HIV rate.

4.2 Government and the Nigeria Health Sector

Nigerian governments at different points has made several efforts within their reach in the formulation of health policy, starting from her inception as a sovereign state. But these efforts have been anchored with a lot of criticism.According to Professor OlikoyeRansomi-Kuti, Nigeria's erstwhile health minister (1988), opines that:

> The National health policy is a vindication of the government readiness to establish a national health system, which will be wide in scope and provide comprehensive coverage with primary health care serving as the main thrust of the implementation strategy.

His view as a health minister shows government commitment to good governed on health issues and related matter, but the extent to which the comment is attain is a debate, as heath still remain an issues among other development issue in Nigeria still date.

Therefore, Oyetunde et al (2007), argues that the unsuccessful communication of policies from Federal to the State level or other lower levels including all agencies charged with implementing polices has shortcoming needing remedial actions. The certainty, is that despite the fact that several health policies have been instituted, its targeted result is still under noticed, which in effect results from poor implementation or not all encompassing. Our argument is not instituting or formulating policies (all policies including HIV/AIDs) in Nigeria but to what extent can these polices be implemented in order to achieve its targeted goals.

An over view of the country's policy shows that the first attempt, the country made in planning ahead for the development services was in the ten year development plan of 1946 – 1956. Other several policies initiatives' were between 1975 – 1985, then 1982 – 1992 and 1989 - 1999 that comprises for the third and fourth development plan. Most of this plans have remain a documented materials.

On the health sector a deliberate attempt to formulate National Health Policy of a wider scope or application was made in (1993), yet, health system and health of many people in Nigeria is still under terrible spells. Prior to 1999, the Nigeria government observed that, Nigerians health policies are characterized with deficiencies, which in effect has resulted in the ineffectiveness and inefficiency of the country's health care system. In this respect Mukhta (2001) observes that, the country's health care system (sector) has been bedevilled with many problems in the past and still entangled in many other ways.Revealing, despite the several policy formulated to control or solve many national health problems, health issues are still obvious with national problems.

Thus, achieving health care for all Nigerians are still on a modicum cycle, example is seen inthe rate of morbidity and mortality still high and most infectious disease control in the country has not been encouraging. Abdulwaheed (2008), opine that the poor public health situation in Nigeria demands an expedition action. According to him:

> it is a scandal that over five decade after independence, Nigeria still has records of epidemic of cholera, guinea worm and other disease that no longer exist in some African countries including those with less resources compared to Nigeria

In support of the view, Olusoji et al (2006) observe that the health care system is only one component of effective response to

health problems, yet Nigeria's health care system is weak, particularly the primary health care section. Based on the evidence of the poor health situation of Nigerians.The country was once ranked 187 out of 191 countries of the Member States of World Health Organization (WHO) in the overall health care system performance (WHO, 2000). DFID Nigeria, also confirms the poor health situation in the country as their report from the health system resources Centre stated below, that:

> Since the beginning of economic crisis in the 1980, the health sector has suffered dramatically, in as has all other public service activity. Development and recurrent expenditure has declined resulting in a scarcity of drugs and medical supplies and the deterioration of facilities David (2000)

Considering the government commitment and as has always been advocated in different literature, even with all the policies instituted, greater fear still persist, in the case of certain existing diseases, causing much harm to the health sector.With diseases such as HIV/AIDS whose cure has not been identified, our view or fear is that there is no existing structure to handle the spread of the disease, assures that much is still needed to control the spread of the disease in Nigeria particularly when it comes to issues of the vulnerable women inclusive.

4.3 Health Sector in Nigeria and Gender Perspective of HIV/AIDS

The nature and state of health sector in Nigeria has always been focusing on the need to provide a guide to achieving a

productive health to the people, and creating awareness among the people. Health policies are equally designed documents to help in the prevention strategies on the epidemics. Diseases like HIV/AIDS without cure and spreadingsignificantly among the general population across groups' could be difficult to control. The impact of an uncontrolled epidemic has implication for the vulnerable group in the society, who has no input in policy design or implementation. Thus, women as a vulnerablegroup who have had a long silence in partaking in policies development or design are vulnerable to police design (Health Policy inclusive). The appearance of HIV/AIDS and its impact on women are numerous because of the vulnerable nature of women (Ramjee G, 2013.)

The nature of contact, spread and home front cultural responsibility of women in Nigeria, has not been favourable to women (Michel Sidibe 2013). "This Epidemic Unfortunately remains a disease of women" UNAIDS). Nigeria is home to culture where relations are defined by gender, in most cases gender relations are at a disadvantage to women. Thus, the argument that an unhealthy population and inequality has a strong coloration - to the growing unhealthy population of women is logical. Wilkinson (2002), is of the view that states with unhealthy population creates inequality that result to poverty and increase in death role among the public. This is because an unhealthy population cannot be productive, could hinder development and encourage dependency. In most cases women who have health problems face these problems.

4.4 Nigeria's Health Policy and HIV/AIDS Prevention/Awareness

The World Health Organization (WHO) defines health as not merely the absence of disease, but the attainment of a state of physical, mental and social wellbeing. All states seek to attain for its citizen's wellbeing through various processes including having a guiding principle through policies. According to Oyetunde et al, (2007), policy is a more complex process through which a particular consideration comes to stating what matters and which voices count in policy deliberation in particular context. In this sense, the Federal Ministry of Health (FMOH) (1988), defines health policy as an expression of goals for the improvement of the health situation, the priorities among those goals and the main direction for the attainment of the stated goals.

Health policy is all about understanding what objectives is plan to be achieve, through stakeholders. This is to enable a trickledowneffect on problems are affect the people. Although, the definition given by (Modupe, 2006) is based on the fact that tries to depict the reason or the need for health policy and also at the same time gives insight on whose voice count in the policy deliberation. The voices count in the policy deliberation defines participatory policy development as a process that enables those experiencing the particular problem to input their views on what how the identify problems that affect them and what the need which the policies are designed to address. Affected groups views can be directly involved in designing policy or accessing the policy out come at each stage of

implementation and development. If policy design however, does not meet the general need, it may likely not be ineffective.

On the hand, Adesina (2005), in the analysis of public policy sees policy as a purpose course of action followed by an actor or set of actors in dealing with a problem. In this regard, all policies originate from demand or claim made upon public officials by other actors, private or official in the political system for action or inaction on some perceived problems. Thus, policy and health policy accepts that, no policy or decision is made without any drive attached to it,emphasizing this view,Modupe et al (2006),assert thatpolicies are not shaped simply on the basis of 'good' research or information, nor does it emerge simply from bargains among actors on a clearly defined option, rather is based on issues identified. The emphasis of any policy is geared towards achieving a particular aim or interest; in essence, it shapes the actors and non-actors direction in the pursuit of a particular goal.“According to Nasidi et al (2006),

> health policy is very important since it a guiding principle on how health care system and health of the people could be effectively and efficiently achieved. In the same vein Modupe et al (2006) argued that policies are erected through a process of problem identification, analysis and solution that involves a wide spectrum of stakeholders. It is on the basis of solving issues on health problems that health policies were initiated, which in the process involves range of classes

Theissue is that for whom or for whatever reasons policies are initiated and the objective lays in want it achieve, the need for people awareness on the issue is central, to achieving it policy goals.

The HIV/AIDS policy has been developed in the right direction to specifically address the issues revolving around the issues of PLWHAs in Nigeria. However, the process of selecting stakeholder and those voices that count in the policy deliberation, defines whether the policy out becomes a participatory policy development process or not. To enable those experiencing the particular problem be aware of what police is in place and the purpose to which the policies are designed to address, whobenefit should decide the legitimacy of the document. The uniqueness of the Nigeria Health policy on HIV/AIDS depends on its ability to address the problem it is designed to address.

4.5 The Impact of Nigeria's HIV/AIDS Policy

The formation of HIV/AIDS policy according to NACA (2004), is for the Nation to achieve an overall goal of the National HIV/AIDS policy to control the spread of the epidemic, toprovide equitable care and support for those infected by the disease and reduce its impacts. Thus, the need to accept that HIV/AIDS is not only a public health problem, but also a social and economic concern, that all Nigerians need to participate actively in reducing the spread of its predicaments to achieve a socially and economically productive life is a reality.

Policy instruments are basically to guide the country's response to HIV/AIDS epidemic. They not only express the government's commitment and priorities, but also set the framework for an effective and coordinating response to the disease. In Nigeria, these instruments include national policies, strategies and technical guidelines. The adopted 1997 policy on HIV/AIDS through the

Federal Ministry of Health, led to agency formation on HIV/AIDS including NACA at the Federal level and other agencies at the State and Local government levels to fight against the dynamic nature of the epidemic and control the spread of the disease and its related diseases like TB etc. came at a no better time. The NACA launched of the second policy in 2003, with the reason that the spread of the disease is not under control with the policy, shows weakness of the initial policy process. The revised national policy was both to acknowledge the importance of a multi-sector approach to the control of HIV/AIDS and emphasis the responsibility that all Nigerians must accept, care and support those infected and affected by the virus (NACA, 2005).

In a further affirmation, the importance of health policy, the approach adopted from policies of international agencies like, UNAIDS, WHO, UNICEF and NGOs nationally and internationally to support the prevention or control of the different diseases in the country was emphasised by the government. According toOsotimehin, former NACA chairman in his speech on the issues of HIV/AIDS (2003) observed that:

> HIV/AIDSpolicy represents Nigeria's commitment and her determination to stem the tide of this epidemic and mitigate its impact on her citizenry most reliantly acquired knowledge, skills and a clear understanding of the epidemic. It is also hoped that this policy will serve as the catalyst for a more rigorous organized means to reducing and eliminating the disease

The essence of reaffirmation of policies over a long period is to ascertain that the policies are ineffective and that road maps have not

been set to achieve the target goal, which is seen in the reverse policy of HIV/AIDS within a decade. The formed HIV/AIDS policy is to determine response towards eradication of the pandemic. And it is based on the outlined polices that individual, private partners or public partnership will step through in responses to the epidemic. It has similarly been stated in the Federal Ministry of Health report that the overall goal of the National Health Policy shall be to establish a comprehensive health care system. The argument is that the Nigeria health policy needs to include all stakeholders in policy formulation including those that policy is meant to affect. Only in this manner will target citizens get involved and be aware on the policy.

Lambo (2006) is of the view that, even though the Federal Ministry of Health in showcasing the health policy scope on an integrated and disease surveillance to response to policy on health, the disease surveillance should be a guide and provide the necessary environment for the planning, implementation, monitoring and evaluation of all integrated group affected by diseases and policies should response systematically to and by all tiers of government, including private sectors, non-governmental organizations and infected individuals.

Health policy (policies) is not only significant in defining issues but also must be determining factor to achieving effective and efficient objective of a particular problem. The Federal Ministry of Health (1988) observed that, the aim of Nigeria's National Health policy is to provide the government and the people of the country a formal framework for

appropriate national direction on health development. Therefore there is need for HIV/AIDS policy to respond to the needs of the targeted citizens in an effective way to help reduce the disease.

4.6 Nigeria Health Policy and Response to HIV/AIDS

The Nigeria government is responsible for the formulation of health policies or policy to govern the country's health programmes, services and issues, Modupe et al (2006), noted that though there has been support by different stakeholders. The involvement by international organisations such as the World Health Organization (WHO), international communities in the overall health care system performance is acknowledge by all its member states (Nigeria inclusive). With the appearance of the disease like HIV the health system challenges increased.

Nigeria's health agencies along other agencies such as National Agency for Food and Drug Administration and Control (NAFDAC), has been assisting in the control of drug, also the growing trend in the health sector according to a former minister of health Professor Aderiike Grange in a press briefing to celebrate the 51st National Council on health and disclose that:

> "though there were numerous police taking care of various aspect of health, the level of implementation of these policies has been cumulatively less than fifteen percent"

Rabiu (2007), there is the needs for a paradigm shift from policy development to policy implementation…"Insisting on Reform and Implementation, the Federal Ministry of Health must through the National Investment plan,ensure that health of Nigerians improve in such a manner that Nigerians can access health care services that is inclusive for all people. The fact that policy implementation clash with the cultural practices in most communities in Nigeria calls for concern and worst for situations for PLWHAS. Jegede (1998), noted that certain cultural practices is not adjustable andsustaining such practices withexisting policies is not achievable which affect people's decision on health issues.

Taking cognizance of the differences and existing widespread of diseases globally, HIV/AIDS has multiple impact on different group of people. The speedy spread and impact of the disease on women affect their economy, social well and makes the disease unbearable for those most affected. The complexity of HIV/AIDS epidemic according to Adeokunle (2006), is link with itsregulareffect on all cultures and stigma attach to it. The perceived nature that the disease is only contacted through sexual intercourse regards the disease a 'bad omen. The implication of stigmatization of the disease results to late reporting and onward spread of the disease, particularly those notinitial identified as at oblivious risk. In recent period its sporadic wide spread, most especially among the women, gave the global concern of the nature and spread of the epidemic. Thus, the need for policy to address spread is important.

Aeolian (2005), is of the view that unawarenessof the disease has creates challenges for people PLWHAS, as stigmatization still result to late reporting, which is still high among newly reported incidences.

Response to the HIV/AIDS are having serious implication on a global scale, as collective effort have been geared towards cure and control,then preventive control of the spread of the disease. This has led to increase in annual death rate of the diseaseand increase in the spread of the disease, this is evidence in the fact that billions of dollars are still needed to control the spread of the epidemicglobally (UNAID, 2015).

The feminization of women and children to thegrowing threat of the disease in Nigeria, provides the need for government policy to focus in this direction. This is because, the increase of the disease prevalence among women has resulted to rejections of them by friends and families, causing increase of widowed, manyamong them dismissal in places of work, and drop out of school girls as shown by the result of this study survey in 2015. The manifestation of rejection of PLWHAs impact is seen in the Armed forces HIV/AIDS control policy guidelines published in October 2003, which says inter- lia "all recruits, cadets and foreign student participants in military training institutions must provide as part of their medical examination HIV result and those found to be HIV positive shall be disqualified "Obom (2005). An indication of stigma and discrimination that affect people living with HIV/AIDS and results to spread of the disease.

Furthermore, the impact of this disease on women and children has results to drop in the life expectancy and high maternal mortality rate thataffect them more than men, which reduces the developmental process and on the other hand continued to inject poverty to family members and engulf societies to remain dependent. Though, the devastating impact of HIV/AIDS on women has made mother to child transmission an area of consideration for governments worldwide, the efforts has not reduce the spread among them.

Women need to be givenopportunity to share experience, form partnership in coordination, capacity building, awareness and knowledge about their environment. This will enable them be responsive actors in helping to find ways to reduce the spread of the disease. That is,stakeholders' contributions are significant to health policy formulation in accordance to Modupe et al (2006) view, who acknowledged that the contributions of all stakeholders will help to improve odds,identify weaknesses, rectify policies gaps and implement effective policy. In this respect, the former minister of health Professor Eyitayo (2006), acknowledge the contribution of different stakeholder in the development of National child health policy.

The HIV/AIDs policy design in Nigeria took a slow approach in the early appearance of the disease in 1986. The first attempt to tackle the disease was in 1999, when the first major step was taken on how to prevent the spread of the epidemic with emphasis on men prevention by distributing condomsto women and compulsory HIV test for all pregnant women attending antenatal clinics.While, emphasis was on

women to monitor those living with the disease, little effort was put in place to see how the spread of the disease can be reduce through them. The worrisome scenario today isheterosexual relations makes the highest means of spread of the disease, affecting more women than men and still has less policy attention. Modupe et al (2006) observed that, the period of the emergence of HIV/AIDS witnessed a predictably low response to the disease, partly because of the basic scepticism of some most stakeholders and partly because of the basic negligence in policy formulation. The view of this study is, government's design policies to solve citizens' problemsbut HIV/AIDS policy is far from meeting the requirement of targeting the need of the affected population. This is because policies are not designed along a process to meeting the needs of the most wanted and most citizens do not participate in all stages of policy making process thus, making policies ineffective andimplementationof such policies don't always address the problems it is designed to address.

CHAPTER FIVE

DATA PRESENTATION AND ANALYSIS

5.1 Results and Discussion

This chapter presents results and discussion, and itfocuses on gender relation and socio-economic status of respondents. The data used for the study were collected from survey conducted between 2014 and 2015 among 400 people living with HIV/AIDS in Kaduna State.The questionnaires were 400, however 309 were returned, representing 77.25% response rate. Thus, the analysis of data is generated from the field work based on the actualretrieved questionnaires.

The table below shows the sections used for the gender analysis of people liing with HIV/AIDs in Kaduna, the sections include gender status, head of household, Marital Status, employement status, awareness and educational level of the respondents was used in table 5.3. 1 and 5.3.2 in below

Table 5.3.1: Distribution of Respondent by Gender and Households

A Gender	Frequency	Percentage
Male	70	22.7
Female	237	76.7
No Response	2	6
Total	309	100.0
B HIV Status		
Positive	293	94.8
Negative	9	2.9
Others	3	1.0
No Response	4	1.3
Total	309	100.0
C Head of Household		
Male	95	30.7
Female	208	67.3
No Response	6	1.9
Total	309	100.0

The discussion is divided into sections. Sections one is on gender status and socio-economic characteristics of respondents, the second section discussed the accessibility to health facility; section three discussed the policy challenge of respondents and lastly, gender vulnerability and the incidence of HIV/AIDS in Kaduna state. The initial access to those living with the disease took a long protocol, as a result of caution taking for ethical protection of those living with the

diseases. This is because of the nature of acquiring and stigmatization attached to the disease. Also, even after having access to the ethical clearance, many among PLWHAs still feel unsecured as many collected the questionnaires and did not return. Many were emotional and not willing to answer some questions about their illness.For example, the question on the added responsibilities the disease has imposed on them. Many prefer to simply respond emotionally, by saying "God has destined them with the responsibilities or that they have faith in God". Many among the respondents have low educational qualification, are unemployed, psychologically disturbed and disguised to attend the HIV/AIDS clinics. Issues of unemployment, stigmatization, polices impact on people living with HIV/AIDS and inequality have a significant impact of estimated value on gender inequality and incidence of HIV/AIDS among women in Kaduna State. As shown by the finding of this study.

5.2 Socio – Economic Characteristics of Respondents

Key socio economic characteristics of the respondents such as gender status, employment, heads of house hold, age, marital status, level of education and job status were analysed using descriptive statistics. Other variables of analysis include accessibility to healthcare facilities, how they got infected and awareness of spouse status on the epidemic before, in and after marriage. How the respondent acquired the disease was asked to ascertain the nature

and course of the spread of the epidemic and how it has enhances women's vulnerability to the epidemic than men.

Further questions were asked on level of awareness on government policies, its impacts on respondents. And ways in which the policy has promoted the needs and rights of the vulnerable group including women, as emphasized in the government policy document of 2009. Lastly, respondents' views on power relations and other challenges of HIV/AIDS were also asked, for example the acceptance of use of contraceptives by partners among spouse, attainment on aspiration to get to their wishes in life and the challenges of going through trauma of living with the disease, discrimination, stigmatizations, financial constraints etc. are some of the challenging issues asked and analyses.

5.3 Background Characteristics of Respondents

The distribution of respondents HIV/AIDS status shows 94.8% were positive while 2.9% were negative. By gender 76.7% were female and 22.7% male. The respondents' show higher female respondents' percentage than male respondents.

The Heads of Household: The head of household result shows about 67.3% were female-head of households. This finding can be partly associated with the side effect of being a HIV/AIDS patient in most Nigerian societies. This is because female patient, are mostly rejected by husbands, (divorced) or widows (as a result of husband's death and stigmatized by family members and society, she is left with her grief

and care for the children, with little or no care from society (personal information of one respondents, 2014). The finding corresponds with the result of marital status of the respondents in table 5.1.3 where majority (65.7%) are either divorces or widows. The larger percentage of sexual active PLWHIV in the society has an implication of continues spread of the epidemic in the society, particularly with the stigmatization of the epidemic in table.

Table 5, 3.2: Distribution of Respondents by Marital Status, Present Job and Educational Status

Marital Status	Frequency	Percentage
Married	82	26.5
Divorce	100	32.4
Widowed	103	33.3
Single	24	7.8
Total	309	100.0
Present Job status		
Full employed	28	9.1
Partly employed	15	4.9
Trainee	15	4.9
Unemployed	117	37.9
Business	89	28.8
Farming	32	10.4
No Response	13	4.2
Total	309	100.0
Educational level		
No formal Education	23	7.4
Koranic Education	36	11.7
Primary Education	74	23.9
Secondary School/Grade II/Technical Education	114	36.9
Post-Secondary School Education	32	10.4
Post Graduate Degree	12	3.9
Others	2	.6
No Response	16	5.2

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Total	309	100.0

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The distribution by marital status showed 32.4% are divorced, 22.5% as married and 7.8% singled. The two survey result of heads of households and marital status shows the high rate of widowed and divorced women among PLWHAs in the studied area in Kaduna State and an added 8% singles living with HIV, implies a high percentage HIV sexual activity women unmarried in the state. The high percentage of female groups recorded respondents as either (divorced, widowed and singles) signals danger on the onward spread of the epidemic with majority of the respondents (63.3%) in their reproductive age (21-40years).

Job Status: the distribution of respondents' job status shows that only 9.1% are fully employed, 4.9% are partly employed and 4.9% as trainee, with the unemployed having the highest percentage of 37.9% among respondents. Other categories include a reasonable percentage of farmers of about10.4% while 28.8% are involved in business. The result of 37.9% of the unemployed respondents shows an extended burden on PLWHIV in Kaduna State, which could influence risk behaviours and spread of disease in the State.

The literacy level of respondents in table 5.3.1 above shows that 5.2% did not respond; 7.4% had no formal education; 11.7% had koranic education; 23.9% had primary certificate; secondary/grade11/technical education had 36.9% among respondents. The respondents' percentage of literacy level shows that

those with primary and secondary certificates have the highest level of respondents with about 60.8% responses of those living with HIV/AIDSin two accessed hospitals in Kaduna state. The least affected respondents are those with post graduate degree certificates with 14.9% among respondents. The low percentage of respondents with higher degree is an indication that majority among respondents may not have the chance of acquiring a high skill and qualities of getting better earning opportunity in a job competing environment, with the form of a boarder range of work jobs.

The result reflects respondents low level of skill job for most respondents who are (farmers, trainees, petty business entrepreneurs and a high 7.4% percentage of illiterates among total respondents) have the implications of unpaid and unsecured jobs that deny them access to bank loans as many among the respondents in this study acknowledged they have no access to loan and not entitled to prosperity owner ship. It is trivial a better educated person is healthier and has greater access to land, Job and financial resources to guide and fight against diseases such as HIV/AIDS. Majority among the unemployed and less privileged will seek attention of weak health centres and other systems that will limit effectiveness of government service delivery and difficulties in forging real community participation in governments programme for people living with HIV and even ownership of government programme for PLWHIV.

5.4 HIV/AIDS Policy Challenges of Respondents

Nigeria's policy documents on HIV/AIDS developed by government since itsappearance include - The National Strategic Framework developed in 1999 by NACA, The National HIV/AIDs Prevention Plan2007-2009, The National HIV/AIDs Prevention Plan 2010-2012, The National HIV/AIDs Prevention Plan 2014-2015, and the National Strategic Framework (NSF 1 and 11) developed` for 2005 -2009 and (NSF 11) developed for 2010 – 2015, along with some national strategic document, are to provide regulations and guiding principles on topics ranging from prevention of new infections, behavioural change, treatment, care and support for HIV/AIDS infected persons. As an advocacy and to provide legal document on issues that affect PLWHAs etc. The policies are to be implemented by all stake holders and at all levels of governments (Local, State and Federal). The result from the preceding NSF 1 and response analysis of proceeding 2005 -2009 with inputs from over 250 stakeholders from public, private and civil society sectors and development partners gave the guide for NSF1.

The response analysis of preceding National Strategy Framework 1 (NSF)acknowledged that approximately only one third of PLHIV get the required ARV drugs and are currently on treatment. It gave the gender dynamic in the profile of infections using women attending antenatal clinics and acknowledged the growing transmission of mother to child and burden of 2.2 million HIV orphans in the country (NSF II, 2015). This has made it necessary for

the reverse policy to critically hope to discourse the rising HIV prevalence among women, stigmatization of PLHIV, issues associated with increased access to treatment and care and the differences in communication and message on abstinence, condom use etc. for emphasis and consideration in NSF 11 for 2010 – 2015.The Nigeria government is also a signatory to international organizations and non-governmental actors working to reduce the epidemic globally, as the nation further seeks donor from international agencies to reducing the spread of the epidemic in Nigeria. The survey report on respondents' awareness on all government policies protecting those living with HIV/AIDS in work place or community show that 83.2% respondents are not aware of government policy protecting those with the illness in their community, the awareness of government policy for PLWHIV specified protection to help secure jobs for people living with HIV/AIDS.

Given the worrisome scenario the study survey report shows that 37.9% among the affected respondents in the area of study are unemployed, 28.8% of respondents are involved in private petty business, 10.4% are farmers and only 9.1% of the respondents are employed. However, 9.1% of PLWHIV accept accessing government policy for PLWHIV, awareness response reports shows that only 7.8% were aware of government policy protecting those with the illness while 83.2% of PLWHIV are not aware of government policy protecting those living with the epidemic by implication policy impact neglect or

does not address the issues of majority among the affected population living with the epidemic that may render policy ineffectiveness.

Table 5.4.1: Respondents' Awareness of Government Policy protecting those` with HIV/AIDS in the Workplace or Community

Awareness	Frequency	Percentage
Yes	24	7.8
No	257	83.2
No Response	28	1.9
Total	309	100.0

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Furthermore, the nature of the epidemic and stigmatization attach to HIV/AIDS do not allow easy access or outreach to those living with the epidemic as government policy on care and support for PLWHIV is not popular among PLWHIV. The care/support government programmes among those living with the epidemic shows about 89.6% have not benefited from government care and support policy while 10.4% responded acknowledged they have benefited from such government programme.

Table: 5.4.2:Respondents Benefit from Government Policy on Care/Support for People Living with HIV/AIDS

Policy Benefit	Frequency	Percentage
Yes	32	10.4
No	277	89.6

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Total	309	100.0

5.5 Gender Vulnerability and the Incidence of HIV/AIDS among Women in studied area in Kaduna State

In recent period, HIV/AIDS has become feminized.Various study findings show heterosexual mode of HIV/AIDS transmission is the major source of spreading the epidemic in Nigeria, affecting more female than male. This is in connection with gender cultural role, the polygamous nature of marriages and acknowledged means of spread controlling spread of the disease in Nigeria.

The study finding shows that major institution of contacting the disease is through marriage, about 90.9% of respondents' contacted the epidemic in their marriage while 9.1% contacted the disease through other means. The result of respondents complements the feminization of the disease in the study area.The gender status of respondents in the table above shows, majority infected with the diseasein Kaduna State are women. Also, many among respondents are widowed or devoiced and have been married two or more times (see frequency table above.This insinuates that majorities among those living with HIV/AIDS and attending clinics in the studied area are women, windowed or divorced which has implication for the control of the spread of the epidemic, who are not targeted as those to control the disease. This is because women have little control when it comes to sexual decision in marriages, the use of condoms was for men and women have little ability to enforce its use.

Table5.5, 1:If you are living with HIV/AIDS did you acquire the Illness in your Marriage

Acquired	Frequency	Percentage
Yes	281	90.9
No	28	9.1
Total	309	100.0

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In most Nigeria society, women have little authority over marriage affairs.This is because culturally, men marry women, and men head families and have responsibility to take over marriage affairs. The gender role of women could result to women's vulnerability to the epidemic and high chances of getting infected with the epidemic in the marriage. Also, most women do not have control to negotiate for safe sex particularly the use of contraceptive in marriage, the respondents' survey reports show that large percentage among men respondents did not accept the use of contraceptives with their spouse and women cannot enforce the use. Implying women forgoing the use of contraceptive and hindering a major protective way identified for prevention of the disease. The study survey result shows 71.8% of the respondents' do not accept the use of contraceptives from their spouses.

Table: 5.5.2.:Views of Respondents on Partner Acceptance to use condom or Contraceptives.

Acceptance	Frequency	Percentage
Yes	87	28.2
No	222	71.8
Total	309	100.0

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The implication is women could be vulnerable in marriage when it comes to negotiation of the use of contraceptives and the likelihood of their inability to enforce its use. This is because of their gender status intakingmarital decisions; most married women acknowledged they couldn't request their spouse use condom, even when they are aware they are unfaithful in their relationships (respondent view, 2015). A likely reason many among marriage are living with the disease among the sampled group. In ability to mutual decisions in marriages can also hinder government effort of the use of contraceptives as a means of reducing the spread of HIV/AIDS in Nigeria.

In most Nigerian cultures sexually related issues are not discussed before or even in marriages therefore, asking partners on HIV/AIDS status is hardly initiated by women on or before marriage.

The responses to awareness of HIV/AIDS status of spouse before marriage buttress the fact that many as high as 88.0% of respondents were not aware of their spouse HIV/AIDS status when they got married to them, only 12% were aware of the spouse HIV/AIDS status (see frequency table, variable 14b). With the larger percentage of divorcee, legal polygamous marriages, heterosexual relationships and gender disadvantage positions more women are likely to contact the diseases in marriages and further increasing the spread among women than men. Women dependence on men and cultural superiority of men over women enable men to have several multiple sexual partners in and outside marriage and given women's low chance to question men's infidelity.

Lastly, many among respondents 55.5% accepted their inability to achieve their aspiration in life because they are living with HIVin deplorable conditions(see Table 5.6 below), while 44.5% shows they are living their normal lives, particularly the widows and divorce and truly wish they were married (response from most respondents on the aspiration to hope or remarriage). Many acknowledged they could want to further education and remarry but living with the epidemic has limited their aspiration.

Table 5.5.3: Views of Respondents on Whether Illness Limit Aspiration in Life

Aspiration	Frequency	Percentage
Yes	170	55.0
No	139	45.0

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Total	309	100.0

5.6 Testing of Hypothesis

In order to test the research hypothesis, the study used chi-square test at 5% level of significance and n-1 degree of freedom.

Hypothesis 1

H_o:women are not likely to be more prone to HIV/AIDs infection than men in Kaduna State.
H_1:women are more prone to HIV/AIDS in Kaduna State

Table 5.6.1: Chi –Square Table of the relationship between gender of Respondent and HIV Status

		Var15. What is your HIV status?				
		No Response	Positive	Negative	Others	Total
Var1. Gender of Respondent:	No Response	0	2	0	0	2
	Male	2	65	3	0	70
	Female	2	226	6	3	237
Total		4	293	9	3	309

Calculated X^2 = 283.942 Alpha level = 0.05
Table value X^2 = 5.999 d.f = 2

The calculated chi square value of 283.942 at alpha level of 0.05 and 2 degree of freedom is less than the table of 12.592. Therefore, we reject the null hypothesis, which statesthat women are not more likely to be prone to HIV/AIDS infection than men in the study areas in Kaduna state and accept the alternate hypothesis which state thatwomen are more prone to HIV/AIDS in Kaduna State.

This finding is consistent with other finding, which shows that women are generally vulnerable to HIV/AIDS because of their reproductive

biological nature as stated in the world Health report.Also, in agreement with the opinion findings ofParker et al (2014), for example, who demonstrate the impact of patriarchal societies on women and the spread of diseases like HIV and Rachel & Rosert (2010), who describes how sleeping with multiple partners could result easily in the spread of HIV.

Hypothesis 2

H_oSocio –economic status does not make women more vulnerable to HIV than men in Kaduna State.
H_1Socio –economic status makes women more vulnerable to HIV inclusive than men in Kaduna State.

Table 5.6.2: Chi –Square Test of the relationship between presently employed by government and awareness of government policy for people living with HIV/AIDs (objective 2)

Presently Employed by government Yes	Awareness of government policy No	Total
Yes28 0 No 0 24	0 257	28 287
24	257	309

Calculated value X^2= 309.000 Alpha level =0.05 d.f =1
Table valueX^2 =3.841

The calculated chi square value of 38.568 at alpha level of 0.05 and 12 degree of freedom (df) in table 5.7.2 is greater than the table chi square tabulated value of 21.026. Thereforewe reject the nullhypothesis, which stateseconomic status does not make women more vulnerable to HIV than men in Kaduna State. Thus, women's

vulnerability is determined by their job status than men in Kaduna State and reject the alternatehypothesis which stateSocio –economic status makes women more vulnerable to STDs – HIV inclusive than men in Kaduna State. Thus, women's vulnerability is determined by their job status.

Hypothesis 3

H_O:Gender awareness status is not a major determinant of women's vulnerability to HIV/AIDs compare to men in Kaduna State.
H_1:Gender awareness status is a major determinant of women's vulnerability to HIV/AIDs compare to men Kaduna State.

Table 5.6.3:Chi–Square test of the relationship betweenawareness of spouse status and acquiring HIV/AIDs in Marriage (objective 3)

Acquired HIV/AIDs in your marriage	Awareness of your spouse status before marriage		Total
	Yes	No	
Yes	9	272	281
No	28	0	28
Total	37	272	309

Calculated X^2= 226.3 Alphalevel = 0.05
Table value X^2= 3.841 d.f 1

The calculated chi square value of 226.348 at alpha level of0.05 and 1 degree of freedom is greater than the table chi square value of 3.841. Therefore, we reject the null hypothesis which states that gender awareness status is not a major determinant of women vulnerability than men to HIV/AIDS in the study areas in Kaduna State; and accept the alternatehypothesis which states thatGender awarenessstatus is a major determinant of women's vulnerability than men to HIV/AIDs in Kaduna State.

The cross tabulation table is to determine awareness of spouse status of respondents living with HIV/AIDS and the chance that the disease has been acquired in the marriage. It is an attempt to know if awareness status before marriage could help inreducingthe spread of the disease in Kaduna state. Two questions put across to respondents were cross-tabulated using the frequency count of questions asked. The questions of variable 17b and 14b were cross tabulated and put to test. Questioned 17b asked (If you are living with HIV/AIDSdid you acquire the illness in your marriage?) cross-tabulated with the question in 14b that asked respondents (were you aware of your spouse HIV/AIDS status before marriage?),

Using the frequency count in the columns and rows as answers, of either (Yes and No of the questions variables). It shows that the frequency of those living with HIV/AIDS and were aware of their spouse status before marriage (that is the Cross tabulation of the first column of Yes and the row of Yes) to indicate their answers of been aware of their status before marriage shows frequency count of 9(3.2%) of total respondents.

While the frequent count of the cross tabulation of the first column and second row of (Yes and No), cross tabulated frequency count shows courts of those living with HIV/AIDS and were not aware of their spouse status before marriage frequent 272(96.8%) of the respondents. This indicate that the majority of the spouses were not aware of their spouse status of HIV before marriage.

The inferences drawn are:

1. Majority among respondents are ignorant of importance of HIV/AIDS testing before marriage.
2. Larger percentage among the respondents who were not aware of spouse HIV/AIDS status before marriage are female. Also, a high percentage of male respondents did not know the status of their spouse before marriage. The frequency figure is 237; 76.7% females and 70; 22.7% male, see frequency table page 1).
3. Unawareness of spouse HIV/AIDS status is a determinant factor of high incidence of HIV among women in Kaduna State.

Conclusion draw from inference are: Majority of marriages conducted among respondents did not go through HIV/AIDS testing concealing before marriage. Also, unawareness of spouse HIV/AIDS status before marriage is a determinant cause of spread HIV/AIDS in Kaduna State.

The study findings show there is high incidence of HIV/AIDS among women and cohabited partners that impact negatively on women. The high percentage of marriage respondents is not unconnected to culture and religious encouragements of marriages, acceptanceof polygamous marriages and the men having more than one sexual partner not been frown at or is general accepted as a way of life.

Hypothesis 4

H_o: Policies not targeting gender peculiarities does not make women more vulnerable to HIV/AIDs than men in Kaduna state.

H_1:HIV policies not targeting gender peculiarities will make women

more vulnerable to HIV/AIDs than men in Kaduna state.

Table 5.6.4:Chi–Square test of the relationship betweenPolicies Targetinggender peculiarities does not make women more vulnerable to HIV/AIDS than men in Kaduna State

8b. Are you presently employed by the government? * Var30. Are you aware of government policy protecting those with your illness in your workplace or community? Crosstabulation

			Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?			
			No Response	Yes	No	Total
Var8b. Are you presently employed by the government?	Yes	Count	28	0	0	28
		% within Var8b. Are you presently employed by the government?	100.0%	.0%	.0%	100.0%
	No	Count	0	24	257	281
		% within Var8b. Are you presently employed by the government?	.0%	8.5%	91.5%	100.0%
Total		Count	28	24	257	309
		% within Var8b. Are you presently employed by the government?	9.1%	7.8%	83.2%	100.0%

Calculated X^2= 309.000 Alpha level = 0.05
Table value X^2=5.991 d.f=2

The chi square value of 309.000 at alpha level of 0.05 and 2 degree of freedom (df) is greater than table chi square value of 5.991. Therefore, we reject the null hypothesis which state thatHIV Policies not targetinggender peculiarities does not make women morevulnerable to HIV/AIDs than men in Kaduna State; and accept the alternate which states that HIV Policies not targeting gender peculiarities will make women morevulnerable to HIV/AIDs than men in Kaduna state.

This is because majority among women living with HIV/AIDS are not aware of government policy for PLWHAs.In this study for example, the policy design is to protect those employed by government

and living with the disease.This study showsthat the policy is only protecting (9.1%) of people living with the disease in the study area and employed by government. This is because majority (86.2%) of therespondentswho areliving with the disease are not employed by government and therefore are not aware that the policy covered them policy.Also, the use of contraceptive is a waythe government intended to reduce the spread of the disease.Contraceptive use is not an easy way ofnegotiation for women living with HIV, and the popular contraceptive distribution by government are for women, this is evident in the response of PLWHAs in the studied areas. Most respondents indicatedtheir spouse do not accept the use of condom and they cannot enforce its use as evident in the survey field result.

The interpretation analysis of respondents who answered “Yes”; that is, they are living with epidemic and presently employed by government but did not respond to their awareness of government policy to protect those with the epidemic in their work place or community is 28(9.1%).

Respondents of the frequency count of those living with the disease and not employed by government but are aware of government policy protecting those with the disease in their work place or community frequent count was 24(8.5%). The responses of those not presently employed and are not aware of government policy protecting those with the epidemic amounts to 257 (83.2%).

The cross tabulation was on policy/programme openness and employment among PLWHAs in Kaduna state. Two corresponding

variables were analysed using questions (18b and 30) put across to correspondents. Question (18b) asked, “Are you presently employed by government”? (Employment is the independent variable) Cross-tabulated with question in variable (30) - are you aware of government policy protecting those with your illness in your work place or community? (Government policy protecting PLWHIAs is the independent Variable). The answers in frequency count to “Yes” and “No” in the column and row (see appendix 2).

Using the cross tabulation frequency count (Yes and No of the Response) the frequency count shows that those employed by government and living with HIV and did not respond to the question in the questionnaire are 28 in frequency count and they also did not responded to knowing about government policy protecting PLWHIV 0(0%) .

The statistics further show no frequency counts for those not presently employed by government and who did not respondent to awareness of government policy protecting PLWHAs.

Those not presently employed by government but aware of the policy protecting PLWHIV frequency counts was 24 (7.8%) of total response. The responses of those not presently employed by government and not aware of government policy protecting PLWHIV amount to 257(83.2%) in frequency count and percentage.

5.7 Discussion of Findings

This section provides the result of the measures adopted for the study.The results give an insight into female vulnerability to HIV/AIDSin Kaduna State This is to provide the social implication and policy guide for policy makers.

The analysis on inequality and high incidence of HIV/AIDS among women in the study area in Kaduna State is not unanticipated; this is because the vulnerability of group of people to natural disasters or manmade crises is evident in this study finding as others in Nigeria (Mba, 1982); Ibrahim& Salihu; Tenuche; NBS among others). The incidence of HIV/AIDS in the study areas in Kaduna State using variables - as gender of respondents, education level of respondents, heads of house hold, employment status, awareness and impact of government policy on people living with HIV/AIDS and method of acquiring the disease show that women on treatment areunderprivileged.

The variables were statistically tested using two statistical methods; charts or figures and frequency distribution. The method shows the result as it is through tables. The inferial statistical inference shows results drawn on conclusions. Through the inferial methods, the study used cross tabulation of variables by the use of- Chi square test for independence or dependence of the variables to draw conclusion on findings. That is, the result was drawn by using a cross tabulation of two variable questions from the questionnaires retrieve from respondents. Then the level of alpha p value determines

the significances or insignificants, by the standard given by the p value levels that range between (5% or .0005).If the p value of level significances are of the cross tabulated variable is above (5% or .0005),the assumption is reject and if the p value is below (5%) the significances of the two variables tested is valid and then it is accepted.

The reason for use of the above statistical methods of analysis is because our study data is in frequency counts and nominal by nature. Therefore, the appropriate statistics test for the absence or presence of significant relationship of frequency counts and nominal figures is the chi square statistics for independence.

The frequency description of respondent's shows that majority among the respondents receiving treatments were females.

Table 5.7.1: Frequency Distribution of Respondents According to Gender, Head of Household, Job, and Marital Status

Characteristics	Frequency	Percentage
Gender		
Male	70	22.7
Female	237	76.7
No Response	2	.6
Head of Household		
Male	95	30.7
Female	208	67.3
No Response	6	1.9
Present Job Status		
Fully employed	28	9.1
Partly employed	15	4.9
Trainee	15	4.9
Unemployed	117	37.9
Business	89	28.8
Farming	32	10.4
No Response	13	4.2
Marital Status		
Married	82	26.5
Divorce	100	32.4
Widowed	103	33.3

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The study survey shows that the incidence of HIV/AIDS respondents receiving treatment in Kaduna State have women percentage of (76.7%) and a lower percentage for 27.7% male living and receiving treatment in the State. Majority among female infected are divorced (32.4%), widowed (33.3%) and heads households (67.3%) see table 5.3.1above. The results shows respondents depend on government for drugs and face Stigmatization from societies. Thus, many among respondents are only forced to go to the clinics when their illness takes a critical dimension, resulting to late discovery among those living with the illness and death to AIDS, as majority seek drugs in secrecy and late clinics attendance for PLWHAs. The funding by government and withdrawal of funding from international agencies will only worsen the condition of those living with the epidemic and hinders the process of reducing the epidemic in the state and Nigeria at large.

The results establish high incidence of HIV/AIDS among women receiving treatment in Kaduna state. This is because many respondents have a low job status, low level of education, powerless in decisions making in marriages, unawareness of government policies for people living with the epidemic, culture and religion hindrance are at a disadvantaged situations for women. The study established the courses and extent of gender in balance between men and women living with HIV/AIDS in the State. Also, the cultural and environmental factors of respondents and their levels of exposure to income generating activities has an added contributing factors to

gender inequality in the study area. Lastly, high level of unawareness on government policy among the respondent shows the ineffectiveness of government policies towards targeting the right group for planning and effective implementation.

CHAPTER SIX

SUMMARY, CONCUSION AND RECOMMENDATIONS

6.1 Summary of Major Findings

The chapter presents the summary of key findings on this study, set out to determine the consequence of gender inequality on the incidence of HIV/AIDS in Kaduna State. The objectives are to examine the nature and major causes of women vulnerability to HIV/AIDS, what account for gender differentials among PLWHIV, gender HIV/AIDS awareness status and its implications on gender incidence of HIV/AIDS and the effect of HIV/AIDS policy on people living with highest incidences of the disease in Kaduna State.

The first chi–square test is a cross tabulation of hypothesis that is to determine gender ofthe most affected group, and those to belikely more prone to the HIV/AIDS disease in Kaduna State. Hypothesis three was tested on the awareness of spouse status before marriage. It is to determine if the claim that the disease is most contactedin marriages.

The result shows women are more prone to the disease than men in the study areas and that there is significant relationship that the disease was acquired most among the married group.

The inferences drawn from the two hypothesis 1 and 3 are:

6.1.1 Majority among respondents are ignorant of importance of HIV/AIDS testing before marriage.

6.1.2 Higher percentage among the respondents who were not aware of spouse HIV/AIDS status before marriage are female. Equally a high percentage among male respondents did not know the status of their spouse before marriage, the frequency figure shows 237; 76.7% females and 70; 22.7% male, were not aware of their spouse HIV status before marriage see frequency table appendix 2.

6.1.3 Lack of awareness of HIV/AIDSstatus of spouses is a determinant factor of high incidence of HIV among women in the study area in Kaduna State.

Deduction draw from the above inference are: Majority of marriages conducted among respondents did not go through HIV/AIDS testing concealing before marriage; also, unawareness of spouse HIV/AIDS status before marriage is a determinant cause of spread HIV/AIDS in the studied area.

The study findings show there is high incidence of HIV/AIDS among women and cohabited partners that impact negatively on women. This is as a result of cultural and religious polygamous marriages and the acceptance of men having more than one sexual partner not been frowned at or accepted as a way of life as shows by more of marriages and spouse in the frequency table.

Research findings in Nigeria shows the low risk heterosexuals group (married couples and cohabited partners) have the highest distribution of newly infected by mode of exposure (NARS,2007). The report is not different from the findings of this

study survey, which shows that there is high incidence among the married and widowed respondents accessing HIV/AIDS treatment in studied area.

This is because women do not have say culturally or religious when it comes health enquiring issues before their marriages, issues such as HIV/AIDS testing do not determine factors for marriages (personnel relieve by respondent during the field survey). Lastly, the state been a home to culture, women have little control on or before marriages culturally, because they are not custodian of their marriages.

Assumption 1 and 3 are validated by this result. Inferences drawn from the analysis are:

6.1.4 Majority among respondents receiving HIV treatment are not aware of government policy protecting PLWHAs and are not employed by government. Thus, efforts by government particularly in its revised 2003 National Policy on HIV/AIDS from that of 2009, shows a need by government to address the challenge of low effectiveness resulting from the use of single approach by all service providers. This is because the single intervention approach did not actualize the expected level of behavioural change required to avert new HIV infections.

6.1.5 With an objective policy rational goal "to reduce the spread of HIV/AIDS and mitigate its social and economic impact on all new affected PLWHIV" (NPHIV, 2009; Page 16, NPP, Report 2014-2015). More so, the Kaduna State Strategic Plan for 2010

– 2015 on “protecting the Rights of PLWHAs and empowering incentivesthrough governmentemployment to reduce their cultural, legal and socio–economic vulnerabilities to ensure their full participation in the national HIV/AIDS response and other development initiatives” may not be effective with the high rate of unemployment among the total respondents of 37.9%.

Secondly, the deduction drawn from the above inferences are: the policy emphasis on reducing HIV/AIDS in Kaduna State and the nation at large may be ineffective, if the policy is not gear towards addressing problems of creating employment for PLWHAs and policy to assist them through national health schemes. For example, the study shows that 28(9.1%) are employed by government and not aware of government policy protecting those with HIV. Also, 257(83.2%) who respondent to the same questions are not employed by government and are not aware of government policy protecting PLWHAs. Thus, all policy initiatives not responding to the needs of PLWHAs have little relevance to those living with HIV in Kaduna State. This may results tomuch effort by government on HIV/AIDS reduction with little result.

To further validate assumption 4, a further analysis was done to determine the frequency count and percentage of male/female respondents among people living with HIV/AIDS in Kaduna state. This is to ascertain the gender (male/female) with high incidence of PLWHIV in Kaduna state.

The study analysis on job status base of gender of respondents (female and male) was done by a cross tabulation of gender base on job status, educational qualification and acceptances of the use of contraceptives.

The study frequency count result for respondents who are fully employed by government is 28 (9.1%).The male percentage of the 28(9.1%) total of those fully employed by government amount to 15(21.4%) and the female frequency count was 13(5.5%) with an aggregate difference of 8% between the gender.

The result of the chi-square respondents for the unemployed shows that male unemployed frequency count and percentage is 22 (31.4%), while female count and percentage count amount to 95(40.1%).

The chi- square analysis reveals that job status is higher among males living with HIV in the state than female. An employed person has a higher income and has more productive effects not only on health but all investments in positive behaviour that generate benefit for human future.

Accordingly, government programme are mostly to addresses government institutions and agencies, thus, the unemployed and those not employed by government may not benefit from such government policies or programme addressing issues of PLWHAs. For example, government policy to protect stigmatization and protect employee's job for PLWHIV in their work place, is likely to be ineffective from the respondents response from our field survey report,

were over 70% of respondents in the area study are unemployed and living with the HIV in Kaduna State. It further shows the likely reason for high incidence among female, who are higher among our respondents of PLWHIV in the state.

To validate assumption 2, the study examined the impact of gender inequality on the incidence of HIV/HIDs in Kaduna State (1999-2014) in six chapters. Chapter one comprises the introduction, chapter two literature review, chapter three covers the general description of the methodology used to conduct the study, chapter four attempted the historical overview of Nigeria's Health policy on HIV/AIDS and it's challenges on Gender incidence of HIV/AIDS, chapter five is the analysis and discussions of the result of gender incidence of HIV/AIDS and six is the discuss of key finding, summary, conclusion and recommendations.

The key findings shows women are more prone to the disease in the study areas in Kaduna state: because majority of the respondents are ignorant of the importance of HIV testing before marriage. (76.7% female and 70.22% male, were not aware of their spouse HIV status when they got married.

There is little awareness of existing government policies among PLWH in the study area. The responses of those not presently employed that are not aware of government policy protecting those with the epidemic amounts to 257 (83.2%). Only 9.1% of PLWHAs are employed by government and are aware of the existence of government policy for PLWHAs, 28(9.1) are those employed by government among

respondents. Of this figures males constitute 15(2.1%) and females 13(5.5%). While male unemployed is 22(3.1%) female figure is 95(40.1%). Since the emphasis of government policy is insistence on protecting the jobs and stigmatization of PLWH, the policy did not target the most infected or vulnerable group, which is women.

6.2 Conclusion

There is no key legal attempt to reduce the major factors that influence women vulnerability to HIV that is the cultural influence on women vulnerability to the disease.

Reducing the spread of HIV through gender inequality is identified through such policies as contained in other considerations by Government Strategy Framework 2010-2025, but there is no established policy framework to reduce the effect

Ineffective preventive method and efforts on curative aspects currently in place have yielded little result as the disease continues to spread. Hence there is need for a new approach.

6.2 Recommendations

6.2.1 Governments attention on curative and imbalance preventive approach not targeting peculiarities of all individuals has rendered several government policies in effective, more over such policies are not lawcreating awareness about government policies for PLWHAs needs more coverage and the impact needs to be spread beyond government employee

6.2.2 Gender inequality is means of spreading HIV and thus needs to be addressed effectively by going beyond merely acknowledging it existence.

6.2.3 There is the need for the introduction and enforcement of legislation aimed at or targeting the peculiarities of individual such as the introduction and enforcement of legislations that will make HIV testing before marriage across the country compulsory.

6.2.4 Government's attention on curative and imbalance preventive approach not targeting peculiarities of all individuals has rendered several government policies in effective, more over such policies are not law.

6.2.5 creating awareness about government policies for PLWHAs needs more coverage and the impact needs to be spread beyond government employees

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APPENDIX I:

QUESTIONNAIRE FOR PEOPLE LIVING WITH HIV/AIDS

Section A: Demographic information of respondents

1. Gender of Respondent: a. Male ( ) b. Female ( )
2. Head of Household: a. Male ( ) b. Female ( )
3. Age ( )
4. Local Government Area:
5. Marital Status of Respondent: a. Married ( ) b. Divorced ( ) c. Widowed ( ) d. Single ( ) e. Others (specify)……
6. Number of Children:
7. Educational Level: a. No formal Education ( ) b. Koranic Education ( ) c. Primary Education ( ) d. Secondary School/GradeII/Technical ( ) e. Post-Secondary School ( ) f. Postgraduate Degree ( ) g. Others: specify ……

8a. Present Job Status: a. Fully Employed ( ) b. Partly Employed ( ) c. Trainee () d. Unemployed ( ) e. Others: specify……

8b. Are you presently employed by government? a. Yes ( ) b. No ( )

Section B: Access to Healthcare

9. Do you patronize health centre far from your environment?

a. Yes ( ) b. No ( )

10. Did you seek healthcare services long after your illness? .....

11. What type of health centre do you patronize most now? a. Modern healthcare ( ) b. Traditional Healthcare ( ) c. Faith-Healing ( ) d. Others: Specify.....

12a. which of the centre do you prefer? a. Modern ( ) b. Traditional ( ) c. Faith-Healing ( ) d. others: Specify .....

12b. Do you have access to regular check up in all your clinic days?

a. Yes ( ) b. No ( )

13. What is the distance to your healthcare source? a. 1-5 Km ( ) b. 6-10 Km ( ) c. 11-15Km ( ) d. 16 Km and above ( )

14a. Are you aware of the disease HIV/AIDS? a. Yes ( ) b. No ( )

14b. How did you know are positive? a. When my spouse was ill ( ) b. When I felt ill ( )

15. What is your HIV/AIDS status? a. Positive ( ) b. Negative ( )

16. If you are HIV/AIDS positive, for how long now? a. 2-5 years ( ) b. 6-10 years ( ) c. 11 years and above ( )

Section C: HIV/AIDS and Marital Status

17. If you are HIV positive or living with AIDS, how did you acquire the disease? a. In marriage ( ) b. Social outing ( ) c. Blood Transfusion ( )

d. Others: Specify.....

18. How many spouses/mates have your partner? a.1-2 ( ) b. 3-4 ( ) c. 5 and above ( )

19. How many marriages have you had in life? a. 1 ( ) b. 2 ( ) c. 3 ( ) d. Others: Specify .....

20. Did you start your clinic after you are confirmed HIV/AIDS positive? a. Yes ( ) b. No ( )

Section D: Policy Challenges on Gender and People Living with HIV/AIDS

21a. Have you lost any one to HIV/AIDS? a. Yes ( ) b. No ( )

21b. If yes, who? a. Husband ( ) b. Wife ( ) c. Relative ( ) d. Other: Specify.....
....

22. How has the lost affected you? a. Widow or widower ( ) b. Head of Household ( ) c. Lost source of income ( ) d. Single Mother ( ) e. Other: Specify.....
.....

23. Who is responsible for your everyday expenditure and care? a. Self ( ) b. Family ( ) c. Government ( ) d. Others: Specify .....

24. Are you aware of any government policy or programme on HIV/AIDS? a. Yes ( ) b. No ( )

25. Have you ever benefited from such government policy/programme on care and support for People Living with HIV/AIDS? a. Yes ( ) b. No ( )

26. If yes, mention two ways you have benefitted from the government policy/programme a.....

b.....

27. Are you aware of any non-governmental programme in your location, assisting those with your illness? a. Yes ( ) b. No ( )

28. Do you attend the care and support group meetings? a. Yes ( ) b. No ( )

29 Does anyone in your family or community know that you are living with HIV/AIDS? a. Yes ( ) b. No ( )

30. Are you aware of government policy of protecting those with your illness in your community? a. Yes ( ) b. No ( )

31. Have you ever been sexually harassed or had any violence sexual encounter? a. Yes ( ) b. No ( )

32. Do you discuss your relationship with your spouse? a. Yes ( ) b. No ( )

33. Is your relationship out of love? a. Yes ( ) b. No ( )

34. Does our partner accept the use of any contraceptive? a. Yes ( ) b.No ( )

35. How has your gender responsibilities affected your illness? a. More responsibilities ( ) b. No time to access healthcare services ( ) c. No chance to further education ( ) d. All of the above ( )

36. Say two ways your cultural norms has affect your illness:

a. .....

b.....

37. Give other two reasons on how cultural responsibilities has affected you and your illness: a.....

b.....

38a. Did you have a voluntary HIV/AIDS testing? a. Yes ( ) b. No ( )

38b. Did you attempt to know your partner's HIV/AIDS status before marriage? a. Yes ( ) b. No ( )

39. Who is presently your head of household? .....

40. Have your responsibilities increase since your illness? a. Yes ( ) b. No ( )

41. Do you think your financial dependence on your husband of relatives hinders your access to health services or hospital? a. Yes ( ) b. No ( )

42. How often do you do you access credit facilities or any government support in your community? a. Often ( ) b. Not at all ( ) c. Others: Specify.....

43. Does your illness limit your aspiration in life? a. Yes ( ) b. No ( )

44. If you are divorced or widowed, will you want to re-marry?

a. Yes ( ) b. No ( )

APPENDIX II

FREQUENCY DISTRIBUTION TABLE

Var1. Gender of Respondent:

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	2	.6	.6	.6
	Male	70	22.7	22.7	23.3
	Female	237	76.7	76.7	100.0
	Total	309	100.0	100.0	

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Var2. Head of Household:

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	6	1.9	1.9	1.9
	Male	95	30.7	30.7	32.7
	Female	208	67.3	67.3	100.0
	Total	309	100.0	100.0	

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Var3. Age Actual

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	00	8	2.6	2.6	2.6
	.00	1	.3	.3	2.9
	.00	1	.3	.3	3.2
	.00	1	.3	.3	3.6

Formatted Table

0.00	2	.6	.6	4.2
1.00	1	.3	.3	4.5
2.00	2	.6	.6	5.2
8.00	1	.3	.3	5.5
0.00	7	2.3	2.3	7.8
2.00	8	2.6	2.6	10.4
3.00	7	2.3	2.3	12.6
4.00	7	2.3	2.3	14.9
5.00	17	5.5	5.5	20.4
6.00	5	1.6	1.6	22.0
7.00	8	2.6	2.6	24.6
8.00	9	2.9	2.9	27.5
9.00	7	2.3	2.3	29.8
0.00	16	5.2	5.2	35.0
1.00	7	2.3	2.3	37.2
2.00	20	6.5	6.5	43.7
3.00	6	1.9	1.9	45.6
4.00	9	2.9	2.9	48.5
5.00	26	8.4	8.4	57.0
6.00	11	3.6	3.6	60.5

7.00	8	2.6	2.6	63.1
8.00	13	4.2	4.2	67.3
9.00	6	1.9	1.9	69.3
0.00	16	5.2	5.2	74.4
1.00	4	1.3	1.3	75.7
2.00	10	3.2	3.2	79.0
3.00	8	2.6	2.6	81.6
4.00	1	.3	.3	81.9
5.00	10	3.2	3.2	85.1
6.00	1	.3	.3	85.4
7.00	2	.6	.6	86.1
8.00	7	2.3	2.3	88.3
9.00	5	1.6	1.6	90.0
0.00	15	4.9	4.9	94.8
2.00	1	.3	.3	95.1
5.00	2	.6	.6	95.8
6.00	2	.6	.6	96.4
8.00	2	.6	.6	97.1
0.00	3	1.0	1.0	98.1
2.00	2	.6	.6	98.7

	4.00	1	.3	.3	99.0
	5.00	2	.6	.6	99.7
	5.00	1	.3	.3	100.0
	otal	309	100.0	100.0	

Var3b. Age Group

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	8	2.6	2.6	2.6
	<20	16	5.2	5.2	7.8
	21-30	85	27.5	27.5	35.3
	31-40	120	38.8	38.8	74.1
	41-50	64	20.7	20.7	94.8
	>51	16	5.2	5.2	100.0
	Total	309	100.0	100.0	

Var4. Local Government Area:

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	7	2.3	2.3	2.3
	Southern Kaduna	235	76.1	76.1	78.3
	Kaduna Central	1	.3	.3	78.6
	Northern Kaduna	66	21.4	21.4	100.0

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	Total	309	100.0	100.0	

Var5. Marital status of the respondent:

		Frequency	Percent	Valid Percent	Cumulative Percent
	Married	82	26.5	26.5	26.5
	Divorce	100	32.4	32.4	58.9
	Widowed	103	33.3	33.3	92.2
alid	Single	24	7.8	7.8	100.0
	Total	309	100.0	100.0	

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Var6. Number of Children - actual

		Frequency	Percent	Valid Percent	Cumulative Percent
	00	52	16.8	16.8	16.8
	.00	50	16.2	16.2	33.0
	.00	38	12.3	12.3	45.3
	.00	46	14.9	14.9	60.2
	.00	41	13.3	13.3	73.5
alid	.00	29	9.4	9.4	82.8
	.00	24	7.8	7.8	90.6
	.00	13	4.2	4.2	94.8
	.00	7	2.3	2.3	97.1
	.00	2	.6	.6	97.7
	0.00	3	1.0	1.0	98.7

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	1.00	3	1.0	1.0	99.7
	7.00	1	.3	.3	100.0
	otal	309	100.0	100.0	

Var6b. Number of Children – Group

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		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	52	16.8	16.8	16.8
	<2 children	85	27.5	27.5	44.3
	3-5 Children	119	38.5	38.5	82.8
	6-8 Children	43	13.9	13.9	96.8
	>8 Children	10	3.2	3.2	100.0
	Total	309	100.0	100.0	

Var7. Educational level:

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		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	16	5.2	5.2	5.2
	No formal Education	23	7.4	7.4	12.6
	Koranic Education	36	11.7	11.7	24.3

	Primary Education	74	23.9	23.9	48.2
	Secondary School/Grade II/Technical Education	114	36.9	36.9	85.1
	Post-Secondary School Education	32	10.4	10.4	95.5
	Post Graduate Degree	12	3.9	3.9	99.4
	Others	2	.6	.6	100.0
	Total	309	100.0	100.0	

Var8. Present Job status:

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		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Response	13	4.2	4.2	4.2
	Full employed	28	9.1	9.1	13.3
	Partly employed	15	4.9	4.9	18.1
	Trainee	15	4.9	4.9	23.0
	Unemployed	117	37.9	37.9	60.8
	Business	89	28.8	28.8	89.6
	Farming	32	10.4	10.4	100.0
	Total	309	100.0	100.0	

Var8b. Are you presently employed by the government?

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		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	28	9.1	9.1	9.1
Valid	No	281	90.9	90.9	100.0
	Total	309	100.0	100.0	

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Var9. Do you patronize health centre far from your environment?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	2	.6	.6	.6
	Yes	296	95.8	95.8	96.4
Valid	No	11	3.6	3.6	100.0
	Total	309	100.0	100.0	

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Var10. Did you seek health care services long after your illness?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	9	2.9	2.9	2.9
	Yes	281	90.9	90.9	93.9
Valid	No	19	6.1	6.1	100.0
	Total	309	100.0	100.0	

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Var11. What type of health care do you patronize most now?

	Frequency	Percent	Valid Percent	Cumulative Percent

	No Response	8	2.6	2.6	2.6
	Modern health care	292	94.5	94.5	97.1
	Traditional health care	4	1.3	1.3	98.4
alid	Faith-healing	1	.3	.3	98.7
	Others	4	1.3	1.3	100.0
	Total	309	100.0	100.0	

Var12. Why do you prefer (Modern health care or, Traditional health care or, Faith-healing or, Faith-healing) health care?

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		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	14	4.5	4.5	4.5
	It is cheaper	52	16.8	16.8	21.4
	It is nearest to you	61	19.7	19.7	41.1
alid	It gives you some privacy	32	10.4	10.4	51.5
	Drugs are available	135	43.7	43.7	95.1
	Others	15	4.9	4.9	100.0
	Total	309	100.0	100.0	

Var12b. Do you have access to regular check up in all you clinic days?

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		Frequency	Percent	Valid Percent	Cumulative Percent
	es	80	25.9	25.9	25.9
alid	o	229	74.1	74.1	100.0

	otal	309	100.0	100.0	

Var13. What is the distance to your health care source?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Response	33	10.7	10.7	10.7
	Less than 1km	45	14.6	14.6	25.2
	1 km – 2km	42	13.6	13.6	38.8
	3km - - 4km	90	29.1	29.1	68.0
	Over 4km	99	32.0	32.0	100.0
	Total	309	100.0	100.0	

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Var14. Are you aware of the disease HIV/AIDS?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Response	2	.6	.6	.6
	Yes	272	88.0	88.7	88.7
	No	35	11.3	11.3	100.0
	Total	309	100.0	100.0	

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Var14b Were you aware of your spouse HIV/AIDS status before marriage?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	es	37	12.0	12.0	12.0

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	o	27 2	8 8.0	88.0	100.0
	otal	30 9	1 00.0	100.0	

Var14c. How did you know you are positive?

		Fre quency	P ercent	Valid Percent	Cumul ative Percent
alid	When I felt ill	12 6	4 0.8	40.8	40.8
	When my spouse was ill	17 4	5 6.3	56.3	97.1
	When I was pregnant	9	2 .9	2.9	100.0
	Total	30 9	1 00.0	100.0	

Var15. What is your HIV status?

		Fre quency	P ercent	Valid Percent	Cumul ative Percent
alid	No Response	4	1 .3	1.3	1.3
	Positiv e	29 3	9 4.8	94.8	96.1
	Negati ve	9	2 .9	2.9	99.0
	Others	3	1 .0	1.0	100.0
	Total	30 9	1 00.0	100.0	

Var16. If your HIV/AIDS status is positive, for how long now?

Actual

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		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	00	8	2.6	2.6	2.6
	.00	34	11.0	11.0	13.6
	.00	40	12.9	12.9	26.5
	.00	42	13.6	13.6	40.1
	.00	36	11.7	11.7	51.8
	.00	37	12.0	12.0	63.8
	.00	31	10.0	10.0	73.8
	.00	31	10.0	10.0	83.8
	.00	14	4.5	4.5	88.3
	.00	10	3.2	3.2	91.6
	0.00	13	4.2	4.2	95.8
	1.00	2	.6	.6	96.4
	2.00	3	1.0	1.0	97.4
	3.00	1	.3	.3	97.7
	4.00	4	1.3	1.3	99.0
	5.00	1	.3	.3	99.4
	8.00	1	.3	.3	99.7
	0.00	1	.3	.3	100.0
	Total	309	100.0	100.0	

Var16b. If your HIV/AIDS status is positive, for how long now? Range

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	8	2.6	2.6	2.6
	<2 Children	76	24.6	24.6	27.2
	3-5 Children	115	37.2	37.2	64.4
	6-8 Children	76	24.6	24.6	89.0
	>8 Children	34	11.0	11.0	100.0
	Total	309	100.0	100.0	

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Var17. If you are HIV positive or living AIDS. How did you acquire the disease? Trough:

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	18	5.8	5.8	5.8
	Husband	224	72.5	72.5	78.3
	Wife	26	8.4	8.4	86.7
	Social outing	41	13.3	13.3	100.0
	Total	309	100.	100.0	

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Var17b. If you are living with HIV/AIDS did you acquire the illness in your marriage?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	281	90.9	90.9	90.9
	o	28	9.1	9.1	100.0

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	otal	309	100.0	100.0	

Var18. How many spouses/mates have your partner?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	57	18.4	18.4	18.4
	1-3	213	68.9	68.9	87.4
	4-6	22	7.1	7.1	94.5
	7 and Above	17	5.5	5.5	100.0
	Total	309	100.0	100.0	

Var18b Do you think culture and tradition enhance women vulnerability to HIV/AIAs?

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		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	220	71.2	71.2	71.2
	o	89	28.8	28.8	100.0
	otal	309	100.0	100.0	

Var19. How many marriages have you had in life?

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		Frequency	Percent	Valid Percent	Cumulative Percent
alid	1	33	10.7	10.7	10.7
	2	180	58.3	58.3	68.9
	3	83	26.9	26.9	95.8
	4 and Above	13	4.2	4.2	100.0
	Total	309	100.0	100.0	

Var19b. Did you start this clinic after you are confirmed HIV/AIDS positive?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	229	74.1	74.1	74.1
	o	80	25.9	25.9	100.0
	otal	309	100.0	100.0	

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Var20. Have you lost any one to HIV/AIDS?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	4	1.3	1.3	1.3
	Yes	161	52.1	52.1	53.4
	No	144	46.6	46.6	100.0
	Total	309	100.0	100.0	

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Var21. If yes that you have lost any one to HIV/AIDS then who?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	41	13.3	13.3	13.3
	Husband	101	32.7	32.7	46.0
	Wife	16	5.2	5.2	51.1
	Relations	40	12.9	12.9	64.1
	No Applicable	111	35.9	35.9	100.0
	Total	309	100.0	100.0	

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Var22. How has the lost affected you?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	123	39.8	39.8	39.8
	Widow or widower	35	11.3	11.3	51.1
	Head of household	84	27.2	27.2	78.3
	Lost source of income	18	5.8	5.8	84.1
	Single mother	16	5.2	5.2	89.3
	Not Applicable	33	10.7	10.7	100.0
	Total	309	100.0	100.0	

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Var23. Who is responsible for your everyday expenditure and care?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	11	3.6	3.6	3.6
	Self	227	73.5	73.5	77.0
	Family	66	21.4	21.4	98.4
	Government	5	1.6	1.6	100.0
	Total	309	100.0	100.0	

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Var24. Are you aware of any government policy of free drugs for people living HIV/AIDS?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	133	43.0	43.0	43.0
	Yes	142	46.0	46.0	89.0
	No	34	11.0	11.0	100.0
	Total	309	100.0	100.0	

Var25. Have you ever benefited from government policy on care/support for people living with HIV/AIDS?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	32	10.4	10.4	10.4
	o	277	89.6	89.6	100.0
	otal	309	100.0	100.0	

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Var26. If yes that you benefit from such government policy/programme on HIV/AIDS mention two ways you benefit from the policy/programme.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No Response	4	1.3	28.6	28.6
	9.00	10	3.2	71.4	100.0
	Total	14	4.5	100.0	
Missing	System	295	95.5		
	Total	309	100.0		

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Var27. Are you aware of any non-government programme in your locality assisting those with your illness?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	19	6.1	6.1	6.1
	No	290	93.9	93.9	93.9
	Total	309	100.0	100.0	100.0

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Var28. Do you attend the care/support group meetings?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	98	31.7	31.7	31.7
	No	211	68.3	68.3	68.3
	Total	309	100.0	100.0	100.0

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Var29. Does anybody in your family or community know your HIV/AIDS status?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	41	13.3	13.3	13.3
alid	No	268	86.7	86.7	86.7
	otal	309	100.0	100.0	100.0

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Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	28	9.1	9.1	9.1
	Yes	24	7.8	7.8	16.8
alid	No	257	83.2	83.2	100.0
	Total	309	100.0	100.0	

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Var31. If yes that that you have been sexually harassed or had any violence sexual encounter then from whom?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	33	10.7	10.7	10.7
	Husband	9	2.9	2.9	13.6
	Partner	5	1.6	1.6	15.2
alid	Others	7	2.3	2.3	17.5
	Not Applicable	255	82.5	82.5	100.0
	Total	309	100.0	100.0	

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Var32. Do you discuss your sexual relations with your spouse?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	36	11.7	11.7	11.7

alid	Yes	15	4.9	4.9	16.5
	No	33	10.7	10.7	27.2
	Not Applicable	225	72.8	72.8	100.0
	Total	309	100.0	100.0	

Var33. Is your relationship out of love?

		Frequency	Percent	Valid Percent	Cumulative Percent
	No Response	58	18.8	18.8	18.8
	Love	185	59.9	59.9	78.6
	Financial gains	39	12.6	12.6	91.3
alid	Forced marriage	13	4.2	4.2	95.5
	Others	14	4.5	4.5	100.0
	Total	309	100.0	100.0	

Var35. Does your partner accept the use of condom/contraceptives?

		Frequency	Percent	Valid Percent	Cumulative Percent
	Yes	87	28.2	28.2	28.2
alid	No	222	71.8	71.8	100.0
	otal	309	100.0	100.0	

Var36. How has your gender responsibility affected your illness?

		Frequency	Percent	Valid Percent	Cumulative Percent
	More responsibility	150	48.5	48.5	48.5
	Care Giving	102	33..0	33.0	81.6
alid	No Chance to further education	40	12..9	12.9	94.5
	No job and time for business	17	5..5	5.5	100.0
	Total	309	100.0	100.0	

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Var37. Say two ways your cultural norms affected your illness?

		Frequency	Percent
M issing	System	309	100.0

Var38. Give other two reasons on how cultural responsibilities have affected you and your illness?

		Frequency	Percent
M issing	System	309	100.0

Var38c Did you have a voluntary HIV/AIDS testing?

	equency	Percent	Valid Percent	Cumulative Percent
Valid	54	17.5	17.5	17.5
	255	82.5	82.5	100.0
	309	100.0	100.0	

Var38d Did you attempt to know your partner's HIV/AIDS status before marriage?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	234	75.7	75.7	75.7
	o	75	24.3	24.3	24.3

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	otal	309	100.0	100.0	100.0

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Var39. Who is presently your head of household?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	Self	265	85.8	85.8	85.8
	Husband	44	14.2	14.2	100.0
	Total	309	100.0	100.0	

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Var40. Who is responsible for the day to day care of the ill ones in your family?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	Father	41	13.3	13.3	13.3
	Mother	44	14.2	14.2	27.5
	Relatives	54	17.5	17.5	45.0
	Self	170	55.0	55.0	100.0
	Total	309	100.0	100.0	

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Var42. How often can you access credit facilities or any government support in your community?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	31	10.0	10.0	10.0
	Adequate	38	12.3	12.3	22.3
	Not at all	240	77.7	77.7	100.0
	Total	309	100.0	100.0	

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Var43. Does your illness limit your aspiration to be somewhere in life?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	es	170	55.0	55.0	55.0
	o	139	45.0	45.0	45.0

	otal	309	100.0	100.0

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Var44. If you are a divorced or widowed will you want to remarry?

		Frequency	Percent	Valid Percent	Cumulative Percent
	es	293	94.8	94.8	94.8
alid	o	16	5.2	5.2	100.0
	otal	309	100.0	100.0	

Table 13: Were you aware of your spouse HIV/AIDS status before marriage?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	37	12.0	12.0	12.0
No	272	88.0	88.0	88.0
otal	309	100.0	100.0	100.0

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Source: Field work report, 2014

Table 14: Does your partner accept the use of condom/contraceptives?

	Frequency	Percent	Valid Percent	Cumulative Percent
Yes	87	28.2	28.2	28.2
No	222	71.8	71.8	100.0
otal	309	100.0	100.0	

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Source: Field work report, 2014

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Table 16: If you are a male living with HIV are you married?

		Frequency	Percent	Valid Percent	Cumulative Percent
	es	281	90.9	90.9	90.9
alid	o	28	9.1	9.1	100.0
	otal	309	100.0	100.0	

Source: Field work report, 2014 .

Table 17: How many spouses/mates have your partner?

		Frequency	Percent	Valid Percent	Cumulative Percent
alid	No Response	57	18.4	18.4	18.4
	1-2	213	68.9	68.9	87.4
	3-4	22	7.1	7.1	94.5
	5 and above	17	5.5	5.5	100.0
	Total	309	100.0	100.0	

Source: Field work report, 2014 .

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APPENDIX III:

SPSS OUTPUT FOR CROSS TABULATION

ır17b. If you are living with HIV/AIDs did you acquire the illness in your marriage? * Var14 Were you aware of your spouse HIV/AIDs status before marriage? Crosstabulation

			Var14b Were you aware of your spouse HIV/AIDs status before marriage?		
			Yes	No	Total
Var17b. If you are living with HIV/AIDs did you acquire the illness in your marriage?	Yes	Count	9	272	281
		% within Var17b. If you are living with HIV/AIDs did you acquire the illness in your marriage?	3.2%	96.8%	100.0%
	No	Count	28	0	28
		% within Var17b. If you are living with HIV/AIDs did you acquire the illness in your marriage?	100.0%	.0%	100.0%
Total		Count	37	272	309
		% within Var17b. If you are living with HIV/AIDs did you acquire the illness in your marriage?	12.0%	88.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	226.348[b]	1	.000		
Continuity Correction[a]	217.258	1	.000		
Likelihood Ratio	146.792	1	.000		
Fisher's Exact Test				.000	.000
Linear-by-Linear Association	225.616	1	.000		
N of Valid Cases	309				

a. Computed only for a 2x2 table

b. 1 cells (25.0%) have expected count less than 5. The minimum expected count is 3. 35.

8b. Are you presently employed by the government? * Var30. Are you aware of government policy protecting those with your illness in your workplace or community? Crosstabulation

			Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?			
			No Response	Yes	No	Total
Var8b. Are you presently employed by the government?	Yes	Count	28	0	0	28
		% within Var8b. Are you presently employed by the government?	100.0%	.0%	.0%	100.0%
	No	Count	0	24	257	281
		% within Var8b. Are you presently employed by the government?	.0%	8.5%	91.5%	100.0%
Total		Count	28	24	257	309
		% within Var8b. Are you presently employed by the government?	9.1%	7.8%	83.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	309.000[a]	2	.000
Likelihood Ratio	187.846	2	.000
Linear-by-Linear Association	249.359	1	.000
N of Valid Cases	309		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.17.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.707	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

2b. Do you have access to regular check up in all you clinic days? * Var30. Are you aware of governm policy of protecting those with your illness in your workplace or community? Crosstabulation

			Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?			
			No Response	Yes	No	Total
Var12b. Do you have access to regular check up in all you clinic days?	Yes	Count	28	24	28	80
		% within Var12b. Do you have access to regular check up in all you clinic days?	35.0%	30.0%	35.0%	100.0%
	No	Count	0	0	229	229
		% within Var12b. Do you have access to regular check up in all you clinic days?	.0%	.0%	100.0%	100.0%
Total		Count	28	24	257	309
		% within Var12b. Do you have access to regular check up in all you clinic days?	9.1%	7.8%	83.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	178.968[a]	2	.000
Likelihood Ratio	176.459	2	.000
Linear-by-Linear Association	158.392	1	.000
N of Valid Cases	309		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.21.

**ɔ. Have you ever benefited from government policy on care/support for people living with HIV/AIDs? * V
ɔ you aware of government policy of protecting those with your illness in your workplace or communit
Crosstabulation**

			Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?			
			No Response	Yes	No	Total
Var25. Have you ever benefited from government policy on care/support for people living with HIV/AIDs?	Yes	Count	28	4	0	32
		% within Var25. Have you ever benefited from government policy on care/support for people living with HIV/AIDs?	87.5%	12.5%	.0%	100.0%
	No	Count	0	20	257	277
		% within Var25. Have you ever benefited from government policy on care/support for people living with HIV/AIDs?	.0%	7.2%	92.8%	100.0%
Total		Count	28	24	257	309
		% within Var25. Have you ever benefited from government policy on care/support for people living with HIV/AIDs?	9.1%	7.8%	83.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	273.094[a]	2	.000
Likelihood Ratio	184.065	2	.000
Linear-by-Linear Association	249.076	1	.000
N of Valid Cases	309		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.49.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.685	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

ır28. Do you attend the care/support group meetings? * Var30. Are you aware of government policy protecting those with your illness in your workplace or community? Crosstabulation

			Var30. Are you aw are of government policy of protecting those with your illness in your w orkplace or community?			
			No Response	Yes	No	Total
Var28. Do you attend the care/support group meetings?	Yes	Count	28	24	46	98
		% w ithin Var28. Do you attend the care/support group meetings?	28.6%	24.5%	46.9%	100.0%
	No	Count	0	0	211	211
		% w ithin Var28. Do you attend the care/support group meetings?	.0%	.0%	100.0%	100.0%
Total		Count	28	24	257	309
		% w ithin Var28. Do you attend the care/support group meetings?	9.1%	7.8%	83.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	134.612[a]	2	.000
Likelihood Ratio	144.561	2	.000
Linear-by-Linear Association	119.136	1	.000
N of Valid Cases	309		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.61.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.551	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

. How often can you access credit facilities or any government support in your community? * Var30. Are you a of government policy of protecting those with your illness in your workplace or community? Crosstabulation

			Var30. Are you aware of government policy of protecting those with your illness in your workplace or community?			
			No Response	Yes	No	Total
Var42. How often can you access credit facilities or any government support in your community?	No Response	Count	28	3	0	31
		% within Var42. How often can you access credit facilities or any government support in your community?	90.3%	9.7%	.0%	100.0%
	Adequate	Count	0	21	17	38
		% within Var42. How often can you access credit facilities or any government support in your community?	.0%	55.3%	44.7%	100.0%
	Not at all	Count	0	0	240	240
		% within Var42. How often can you access credit facilities or any government support in your community?	.0%	.0%	100.0%	100.0%
Total		Count	28	24	257	309
		% within Var42. How often can you access credit facilities or any government support in your community?	9.1%	7.8%	83.2%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	420.957[a]	4	.000
Likelihood Ratio	279.860	4	.000
Linear-by-Linear Association	263.656	1	.000
N of Valid Cases	309		

a. 4 cells (44.4%) have expected count less than 5. The minimum expected count is 2.41.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.759	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Var18. How many spouses/mates have your partner? * Var2. Head of Household: Crosstabulation

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var18. How many spouses/mates have your partner?	No Response	Count	1	17	39	57
		% within Var18. How many spouses/mates have your partner?	1.8%	29.8%	68.4%	100.0%
	1-3	Count	3	70	140	213
		% within Var18. How many spouses/mates have your partner?	1.4%	32.9%	65.7%	100.0%
	4-6	Count	2	1	19	22
		% within Var18. How many spouses/mates have your partner?	9.1%	4.5%	86.4%	100.0%
	7 and Above	Count	0	7	10	17
		% within Var18. How many spouses/mates have your partner?	.0%	41.2%	58.8%	100.0%
Total		Count	6	95	208	309
		% within Var18. How many spouses/mates have your partner?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	13.742[a]	6	.033
Likelihood Ratio	13.982	6	.030
Linear-by-Linear Association	.003	1	.956
N of Valid Cases	309		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is .33.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.206	.033
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

'23. Who is responsible for your everyday expenditure and care? * Var2. Head of Household: Crosstabulati

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var23. Who is responsible for your everyday expenditure and care?	No Response	Count	0	6	5	11
		% within Var23. Who is responsible for your everyday expenditure and care?	.0%	54.5%	45.5%	100.0%
	Self	Count	4	69	154	227
		% within Var23. Who is responsible for your everyday expenditure and care?	1.8%	30.4%	67.8%	100.0%
	Family	Count	2	18	46	66
		% within Var23. Who is responsible for your everyday expenditure and care?	3.0%	27.3%	69.7%	100.0%
	Government	Count	0	2	3	5
		% within Var23. Who is responsible for your everyday expenditure and care?	.0%	40.0%	60.0%	100.0%
Total		Count	6	95	208	309
		% within Var23. Who is responsible for your everyday expenditure and care?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	4.071[a]	6	.667
Likelihood Ratio	4.041	6	.671
Linear-by-Linear Association	.284	1	.594
N of Valid Cases	309		

a. 7 cells (58.3%) have expected count less than 5. The minimum expected count is .10.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.114	.667
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Var33. Is your relationship out of love? * Var2. Head of Household: Crosstabulation

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var33. Is your relationship out of love?	No Response	Count	1	18	39	58
		% within Var33. Is your relationship out of love?	1.7%	31.0%	67.2%	100.0%
	Love	Count	3	62	120	185
		% within Var33. Is your relationship out of love?	1.6%	33.5%	64.9%	100.0%
	Financial gains	Count	1	5	33	39
		% within Var33. Is your relationship out of love?	2.6%	12.8%	84.6%	100.0%
	Forced marriage	Count	1	2	10	13
		% within Var33. Is your relationship out of love?	7.7%	15.4%	76.9%	100.0%
	Others	Count	0	8	6	14
		% within Var33. Is your relationship out of love?	.0%	57.1%	42.9%	100.0%
Total		Count	6	95	208	309
		% within Var33. Is your relationship out of love?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	14.706[a]	8	.065
Likelihood Ratio	14.794	8	.063
Linear-by-Linear Association	.058	1	.810
N of Valid Cases	309		

a. 7 cells (46.7%) have expected count less than 5. The minimum expected count is .25.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.213	.065
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

35. Does your partner accept the use of condom/contraceptives? * Var2. Head of Household: Crosstabulat

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var35. Does your partner accept the use of condom/contraceptives?	Yes	Count	6	81	0	87
		% within Var35. Does your partner accept the use of condom/contraceptives?	6.9%	93.1%	.0%	100.0%
	No	Count	0	14	208	222
		% within Var35. Does your partner accept the use of condom/contraceptives?	.0%	6.3%	93.7%	100.0%
Total		Count	6	95	208	309
		% within Var35. Does your partner accept the use of condom/contraceptives?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	249.989[a]	2	.000
Likelihood Ratio	287.906	2	.000
Linear-by-Linear Association	237.704	1	.000
N of Valid Cases	309		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 1.69.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.669	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Var39. Who is presently your head of household? * Var2. Head of Household: Crosstabulation

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var39. Who is presently your head of household?	Self	Count	0	57	208	265
		% within Var39. Who is presently your head of household?	.0%	21.5%	78.5%	100.0%
	Husband	Count	6	38	0	44
		% within Var39. Who is presently your head of household?	13.6%	86.4%	.0%	100.0%
Total		Count	6	95	208	309
		% within Var39. Who is presently your head of household?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	122.296[a]	2	.000
Likelihood Ratio	125.067	2	.000
Linear-by-Linear Association	120.372	1	.000
N of Valid Cases	309		

a. 1 cells (16.7%) have expected count less than 5. The minimum expected count is .85.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.532	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

ar40. Who is responsible for the day to day care of the ill ones in your family? * Var2. Head of Household Crosstabulation

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var40. Who is responsible for the day to day care of the ill ones in your family?	Father	Count	0	14	27	41
		% within Var40. Who is responsible for the day to day care of the ill ones in your family?	.0%	34.1%	65.9%	100.0%
	Mother	Count	2	12	30	44
		% within Var40. Who is responsible for the day to day care of the ill ones in your family?	4.5%	27.3%	68.2%	100.0%
	Relatives	Count	1	12	41	54
		% within Var40. Who is responsible for the day to day care of the ill ones in your family?	1.9%	22.2%	75.9%	100.0%
	Self	Count	3	57	110	170
		% within Var40. Who is responsible for the day to day care of the ill ones in your family?	1.8%	33.5%	64.7%	100.0%
Total		Count	6	95	208	309
		% within Var40. Who is responsible for the day to day care of the ill ones in your family?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.178[a]	6	.521
Likelihood Ratio	5.655	6	.463
Linear-by-Linear Association	.143	1	.705
N of Valid Cases	309		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is .80.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.128	.521
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Var43. Does your illness limit your aspiration to be somewhere in life? * Var2. Head of Household: Crosstabulation

			Var2. Head of Household:			
			No Response	Male	Female	Total
Var43. Does your illness limit your aspiration to be somewhere in life?	Yes	Count	6	95	69	170
		% within Var43. Does your illness limit your aspiration to be somewhere in life?	3.5%	55.9%	40.6%	100.0%
	No	Count	0	0	139	139
		% within Var43. Does your illness limit your aspiration to be somewhere in life?	.0%	.0%	100.0%	100.0%
Total		Count	6	95	208	309
		% within Var43. Does your illness limit your aspiration to be somewhere in life?	1.9%	30.7%	67.3%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	122.682[a]	2	.000
Likelihood Ratio	160.924	2	.000
Linear-by-Linear Association	113.864	1	.000
N of Valid Cases	309		

a. 2 cells (33.3%) have expected count less than 5. The minimum expected count is 2.70.

Var1. Gender of Respondent: * Var5. Marital status of the respondent: Crosstabulation

			Var5. Marital status of the respondent:				
			Married	Divorce	Widowed	Single	Total
Var1. Gender of Respondent:	No Response	Count	1	1	0	0	2
		% within Var1. Gender of Respondent:	50.0%	50.0%	.0%	.0%	100.0%
	Male	Count	15	23	27	5	70
		% within Var1. Gender of Respondent:	21.4%	32.9%	38.6%	7.1%	100.0%
	Female	Count	66	76	76	19	237
		% within Var1. Gender of Respondent:	27.8%	32.1%	32.1%	8.0%	100.0%
Total		Count	82	100	103	24	309
		% within Var1. Gender of Respondent:	26.5%	32.4%	33.3%	7.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.027[a]	6	.805
Likelihood Ratio	3.756	6	.710
Linear-by-Linear Association	.232	1	.630
N of Valid Cases	309		

a. 4 cells (33.3%) have expected count less than 5. The minimum expected count is .16.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.098	.805
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Var1. Gender of Respondent: * Var8. Present Job status: Crosstabulation

			Var8. Present Job status:							
			No Response	Full employed	Partly employed	Trainee	Unemployed	Business	Farming	Total
Var1. Gender of Respondent:	No Response	Count	1	0	0	1	0	0	0	2
		% within Var1. Gender of Respondent:	50.0%	.0%	.0%	50.0%	.0%	.0%	.0%	100.0%
	Male	Count	4	15	3	2	22	17	7	70
		% within Var1. Gender of Respondent:	5.7%	21.4%	4.3%	2.9%	31.4%	24.3%	10.0%	100.0%
	Female	Count	8	13	12	12	95	72	25	237
		% within Var1. Gender of Respondent:	3.4%	5.5%	5.1%	5.1%	40.1%	30.4%	10.5%	100.0%
Total		Count	13	28	15	15	117	89	32	309
		% within Var1. Gender of Respondent:	4.2%	9.1%	4.9%	4.9%	37.9%	28.8%	10.4%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	38.568[a]	12	.000
Likelihood Ratio	25.404	12	.013
Linear-by-Linear Association	11.626	1	.001
N of Valid Cases	309		

a. 10 cells (47.6%) have expected count less than 5. The minimum expected count is .08.

Symmetric Measures

		Value	Approx. Sig.
Nominal by Nominal	Contingency Coefficient	.333	.000
N of Valid Cases		309	

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.