GENDER INEQUALITY, HIV/AIDS AND GENDER POLICIES IN JOS NORTH LOCAL GOVERNMENT AREA OF PLATEAU STATE, NIGERIA

BY

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A DISSERTATION SUBMITTED TO THE POSTGRADUATE SCHOOL AHMADU BELLO UNIVERSITY ZARIA IN FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF DOCTOR OF PHILOSOPHY IN DEPARTMENT OF POLITICAL SCIENCE AHMADU BELLO UNIVERSITY ZARIA, NIGEREIA.

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DECLARATION

I hereby declare that the work in this dissertation entitled "Gender Inequality, HIV/AIDS and Gender Policies in Jos North Local Government Area of Plateau State" has been conducted by me in the Department of Political Science under the supervision of Professor Ejembi Anefu Unobe, Dr. Yusufu A. Yakubu, and Dr Edgar Agubamah.

The information derived from the literature has been duly acknowledged in the text and references provided. No part of this dissertation has been previously presented for another degree or diploma at any other universities.

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Apine Margaret Date

CERTIFICATION

This dissertation entitled "Gender Inequality, HIV/AIDS And Gender Policies In Jos North Local Government Area Of Plateau State, Nigeria" by Apine Margaret meets the regulations governing the award of the degree of Doctor of Philosophy in the Department of Political Science, Ahmadu Bello University Zaria, and is approved for its contribution to knowledge and library presentation

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DEDICATION

This study is dedicated to the Almighty God, without whom, I wouldn't have been able to complete it.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
APIN:	AIDS Preventive Initiative in Nigeria
HEAP:	HIV/AIDS Emergency Action Plan
CBOs:	Community Based Organizations
CEDAW:	Convention on Elimination of all forms of Discrimination against Women
FMOH:	Federal Ministry of Health
FOMWAN:	Federation of Muslim Women's Association of Nigeria
HIV:	Human Immune - Deficiency Virus
HEAP:	HIV/AIDS Emergency Action Plan
PLWHA:	People Living With HIV/AIDS
NGOs:	Non Governmental Organizations
LACA:	Local Action Committee on AIDS
LGA:	Local Government Area
MAP:	Multi-Country AIDS Program
NACA:	National Agency for the Control of AIDS
PEPFAR:	President's Emergency Plan for AIDS Relief
PLACA:	Plateau State Aids Control Agency
STIs:	Sexually Transmitted Infections
UN:	United Nations
UNAIDS:	Joint United Nations Program on AIDS
UNICEF:	United Nations Children's Fund
UNDP:	United Nations Development Program
UNGASS:	United Nations General Assembly Special Session
UNIFEM:	United Nations Development Fund for Women
VCCT:	Voluntary Confidential Counselling and Testing
VVF:	Vesico Vaginal Fistula
WHO:	World Health Organization
NNRIMS:	Nigeria National Response Information Management System
NSF:	National Strategic Framework
OIs:	Opportunistic Infections
OVC:	Orphans and Vulnerable Children
PABA:	People Affected By HIV/AIDS

PHC: Primary Health Care

PHDP: Positive Health, Dignity and Prevention

PITC: Provider-Initiated Testing and Counselling

PMTCT: Prevention of Mother to Child Transmission of HIV

SACAs: State Action Committees on AIDS/State Agency for the Control of AIDS

SRH: Sexual and Reproductive Health

STIs: Sexually Transmitted Infections

TB: Tuberculosis

ABSTRACT

Thirty years into the HIV/AIDS epidemic, women still remain the largest at-risk group in Nigeria. Whereas the government has acknowledged the gender dimensions of HIV/AIDS and has developed and implemented gender-sensitive HIV/AIDS programmes, interventions, policies, and strategies, significant challenges remains. This study investigates practices that reinforce gender inequality in Jos North and their implications for policy. The approach in this study is not entirely new. We rely on gender and power theory to understand the phenomenon under investigation. A cross-sectional survey of three categories of sexually active respondents was conducted between September 2010 and February 2011. This was to ascertain the factors that limit their ability to protect themselves against HIV and their implications to policy. These categories of respondents include: 900 people from 30 different clusters, 200 PLWHIV in an NGO, 100 programme managers from NGOs and the State's AIDS Control Agency (PLACA). The instrument for data collection was the questionnaire and interview while descriptive results were obtained using the SPSS software. Of the 900 respondents in clusters, 60.7% indicated that religion was a barrier; while among the 200 PLWHIV, 28.7% stated that religion was a barrier against the effective utilization of available prevention methods. Furthermore, Of the 100 programme managers in the entire Local Government Area, 96% indicated that gender inequality impacts negatively on prevention programmes. While 60% of the 10 interviewees indicated that religious manipulation was at the root of female subjugation, the remaining 40% reported that policy makers were not committed to empowering women. The findings of the study suggest that religious manipulation is the major issue which reinforces gender inequality in the LGA, as religious leaders seems to manipulate the tenets of Islam and Christianity to enhance men's inherent desire to subjugate women; those who wield power in the private sphere use it to further their interest in the public sphere. This might explain why anti-stigma bill has been passed into law, while legislations that empower women are still pending in Plateau State. In order to adequately address this challenge, the AIDS Control Agency has to get the active involvement of faith leaders, since they wield a lot of influence on religious adherents and on policy in Nigeria.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND TO THE STUDY

Sub-Saharan Africa, of which Nigeria is a part, remains the most affected region in the global AIDS epidemic. Although just over 10% of the world's population live in this region, more than two out of three (68%) adults and nearly 90% of Children infected with HIV live here (SADC, 2008). More than three in four (76%) of global deaths due to an AIDS – related illnesses in 2007, occurred in Sub-Saharan Africa (SADC, p.2). It is estimated that a total of 22.5 million people were living with the virus in 2007 in Sub-Saharan Africa. This is stark evidence of the analytical poverty of the behavioural change hypothesis and the near absence of the use of condom as AIDS control strategy in the region. The region's epidemic varies significantly in scale with national adults (15 – 49 Years). The HIV prevalence in the region ranges from less than 2% in some countries of the Sahel to above 15% in most of Southern Africa.

However, adult HIV prevalence declined from 5.8% in 2001 to 5.0% in 2007. Unlike other regions, the majority of people living with HIV in Sub-Saharan African (61%) are women. Africa is the only continent where HIV prevalence is higher for women than for men; women account for the majority of adults (54%) living with HIV/AIDs (UNAIDS, 2003). Between 2001 and 2003, the number of adult women (13-49 years) living with AIDS rose by 5.3% while that of men rose by 5.0%. The ratio of women to men rose from 12:10 in 2001 to 13:10 in 2003 (UNAIDS 2003).

In an attempt to proffer solution to the AIDS crises in Africa, several suggestions have been put forward. One of such suggestions was that "the AIDS Crisis in Africa could be under control only if Africans restrained their sexual

cravings" (Poku, 2005). But can sexual cravings account for the fact that the prevalence of HIV in Botswana is over fifty times that of U.S.A, eight times that of France and 1000 times that of Cuba? The suggestion that those people who were marginalized, stigmatized and discriminated against before HIV/AIDS arrived – have later become over time, those at highest risk of HIV infection seems more plausible (Mann, 1990 p.15). It is therefore not surprising that women who have subordinate positions in Sub-Saharan Africa should be the most infected as mentioned earlier.

Many factors account for why vulnerability and risk differ for men and for women, and for men and women at different ages. Some are physiological, where women's risk of infection is higher; women are more vulnerable than men to contracting HIV. Research indicates that the risk of HIV infection is two to four times higher for women than men because of the large mucosal surface areas exposed to contact with infected fluids and semen as compared with vaginal secretions (Mutangadura, 2000; UNIADS 2002). Some other factors that have been found to increase women's biological vulnerability to HIV infection as compared to men include general poor health, and the greater likelihood that women will have other sexually transmitted infections (STIS). The most important and preventable biological risk factors associated with HIV infection are sexually transmitted infections especially the ulcerated STDs such as cancroids, syphilis and herpes. However, even the non-ulcerative STDs such as gonorrhoea, Chlamydia and trichomoniasis, have now been implicated in the risk of HIV acquisition.

Others are socio-cultural factors, reflecting different norms, roles and expectations, while others are economic, reflecting differences in command over asserts. Socially, women in Sub-Saharan Africa are dependent on marriage and relationships with men to gain access to decent levels of income. Most women are employed in traditionally female jobs in the informal sector, with large numbers of

women working as domestic help. Most of the formal sector posts open to the minority of women who have access to them are relatively low-paying in contrast to men's jobs: typists, clerks, secretaries, school teachers and nurses.

With the advent of HIV/AIDS, women are more likely than men to quit their jobs to care for sick relatives, thus reducing their income-earning capacity. Similarly, the increased participation of women into the labour market has also forced them to take additional income-generating activities while continuing with their domestic chores of which family care is a part. The tension brought about by these social and economic changes impact on all household members, but particularly on women. As a result, women are more likely to experience stress, role conflict, depression, fatigue, anger and other frustrations. Since women are typically the providers of care rather than its recipient, when resources are scarce, they postpone treatment for their own disorders to get care for their family. Cultural factors also affect women's likelihood of contracting HIV. Women do not often have the right to sexual and reproductive autonomy.

Historically, women in sub-Saharan countries are regarded as inferior to men; they are subject to guardianship through their entire life. Initially under their father's guardianship until they marry, and subsequently under their husband's in marriage; a wife is treated as her husband's child (MacDonald 1996; Schaper, 1970). The legacy of this cultural norm is important for understanding the contemporary position of women and its connection to the transmission and rapid spread of HIV/AIDs in sub-Saharan Africa. Men's role as the senior partner in marriage means that they are the ones who control sexual decision making and social norms tolerate them having multiple sexual partners. Men tend to think that it is acceptable to have extra-marital affairs, but they are not necessarily keen on using condoms and will use them only when they do not trust other party, for example for casual sex. These behaviours are

among the root causes of the growing AIDS epidemic and needs urgent attention. What is also apparent is that even though men generally assume knowledgeable, aggressive and directive role in sexual encounters with women, they lack the necessary information to make healthy and sensible choices. They prefer to consult traditional doctors or get treatment over the counter and thus some of them may not be getting adequate treatment for STDs.

Prevention programmes have traditionally neglected the role that hetero-sexual men have in the transmission of HIV. Even though men are the key stakeholders in policy decision, they knowingly or unknowingly have excluded men as a target group from prevention programmes. This is true more widely, also, for the whole health care delivery system. This perpetuates men's ignorance of HIV/AIDS and other health information. Studies on the use of health services have repeatedly shown that women use health services, thus gaining access to health information, while men remain uninformed on these matters. The exclusion of males has serious disadvantage for women because they cannot initiate HIV/AIDS prevention strategies without their spouses' or partners' approval. The knowledge gained by women can only be useful if they are empowered enough to prevent and avoid risky sexual behaviours to prevent HIV/AIDS.

Significantly, gender inequality contributes to greater vulnerability to HIV/AIDS of both women and men, with age being a major factor. As a result, young women represent the most vulnerable group. This is confirmed by research which points to the complex inter-linkages between poverty, inequality and, particularly, gender inequality and the AIDs epidemic (AFTPM, 2003). In a cultural environment in which multiple sexual partners is considered normal for men, the vulnerability and powerlessness of married women deserves particular attention, especially as studies in

Africa show that HIV infection levels are around 10 percent higher for married women than for sexually active unmarried girls.

For instance, some participants in a study in Botswana expressed the frustration of many women who want to use condoms but are not allowed to by their husbands. One of these stated that "When I showed my husband a condom and told him the doctor said we should use them, he was very upset and accused me of having sex with the doctor. I am still having itching down there, but he has refused to use condom with a woman he paid 'bogadi' (bride wealth) for" (cited in Phaladze et al,2006). As this and other studies point out, the single most important factor of vulnerability to HIV for women is being marriage which in turn has an impact on the effectiveness of the traditional "ABC" approach to HIV prevention.

There are three critical factors, all interconnected that place gender issues at the core of the HIV/AIDS pandemic in Africa, and which must be addressed systematically if the Multi – Country AIDS programme Operations are to achieve their objectives. The first factor is that risk and vulnerability to HIV/AIDS are substantially different for men and for women. The second is that the impact of HIV/AIDS differs markedly along gender lines reflecting differences in roles and responsibilities in household and market activities, and in access to, and control of, resources. The third is that tackling the AIDS pandemic is fundamentally about a radical change in gender relations in Sub-Saharan Africa. The combination of these factors can be termed the gender dynamics of HIV/AIDS.

It is in the light of this that we have adopted the theory of gender and power, to illuminate the direction of this study. Unlike the psychosocial theories which are essential gender blind,_the theory of gender and power is a social structural theory addressing the wider social and environmental issues such as distribution of power and authority, affective influence and gender-specific norms within heterosexual

relationships surrounding women (Connell 1987). Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices.

In the decade 1991-2001, Nigeria witnessed increase in its HIV prevalence level. The overall picture is that of significant increase within the period. The national HIV sero-prevalence level obtained through sentinel survey of antenatal care attendees increased from 1.8 percent in 1991 to 5.8 percent in 2001 and then declined to 5.0 percent in 2003 and further to 4.4 percent in 2005. This decline was followed by a recent rise to 4.6 percent in 2008 (NACA, 2010).

The National Agency for the Control of AIDS (NACA) estimated that there were about 2.95 million people living with HIV (PLHIV) in Nigeria in 2009, ranking the country third among countries with the highest burden of HIV infections in the world, next only to India and South Africa. Female constitute almost three-fifths (58.3%) of PLHIV in Nigeria: about 1.72 million women and girls are infected with HIV. With the highest HIV prevalence rate of 5.6% in the age group 25-29 years young people are disproportionately infected with HIV (NACA, 2010).

The leading route of HIV transmission in Nigeria is heterosexual intercourse, accounting for over 80 percent of the infections. Mother-to child transmission and transfusion of infected blood and blood products are generally estimated as ranking next as common routes of infection; arguably, each of these two is believed to account for almost ten percent of infections. However, other modes of transmission such as intravenous drug use and same-sex intercourse are slowly growing in importance.

Key drivers of the HIV epidemic in Nigeria include: low personal risk perception, multiple concurrent sexual partnerships, intense transactional and inter-generational sex, ineffective and inefficient services for sexually transmitted

infections (STIs). Inadequate access to and poor quality of healthcare service entrenched gender inequalities and inequities, chronic and debilitating poverty, and stubborn persistence of HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.

The HIV epidemiological picture shows considerable diversity across Nigeria's geographic landscape, both in terms of the level of infection and the trend. The 2008 national survey, for example, shows the HIV sero-prevalence levels ranging from 1.0 percent in Ekiti state (in South –West geo-political zone) to 10.6 percent in Benue State (North-Central geo-political zones). Seventeen States and the Federal Capital Territory (FCT) recorded Sero-prevalence of at least five percent. Sero-prevalence level was seven percent or higher in seven states and the FCT; four of these are in the South-South geo-political zone while none was in the South – West and the North East zone (NACA, 2010).

In Plateau, the HIV epidemiological situation is not different from the rest of the country. However, according to the national Sero-prevalence survey; the state was ranked as the 10th most infected area by HIV. Statistics from the national HIV/ Syphilis Sero- sentinel survey (HSS) shows that in 1991/ 92 periods, Plateau State had a prevalence of 6. 2%. This increased to 8.2% in 1993/94 cycles and to 11% in 1995/96 cycles. However, in 1999, the prevalence declined to 6.1 only to rise again to 8.5% in 2001. The survey conducted in 2003 by the national HSS showed another decrease to 6. 3%. While that of 2005 showed a prevalence of 4.9%. The most recent study carried out by Gomwalk et al (2008) found 4.88% prevalence of HIV in Plateau state. Housewives had a prevalence rate of 5.31%.

Jos North Local Government Council, as it is currently constituted, was carved out of old Jos Local Government Council during the 1991 local government creation, with Jos town as the council headquarters. It is made up of one district, Gwong which

includes the Jos town area and has a population of 437,217 persons based on the 2006 census (Official Gazette, 2009). The metropolitan nature of the council area provides it an added advantage, because of the availability of infrastructural facilities like good roads, pipe-borne water, and electricity and so on. The local government council is no doubt the melting pot of the state due to various economic, social and natural factors. Many people of varying cultures and social status come in and out of the state on daily basis. The interaction occurring due to the above has increased enormously the prevalence rate of HIV/AIDS.

According to the FMOH sentinel survey in 2005, Jos North and Shendam LGA had the highest rates of HIV prevalence of 16.07% and 12.20% respectively. This situation calls for an investigation into the factors that have rendered preventive programmes less effective, in view of the fact that the Plateau State Aids Control Agency was rated as one of the best in the management of responses to the epidemic at that level. It is therefore worth investigating how government both at the federal and the state levels have responded to this situation and the impact of gender on its strategies. It is however significant to note that sero-prevalence surveys carried out by the Federal Ministry of Health (FMOH) and the Plateau State AIDS Control Agency (PLACA) involved mostly pregnant women attending antenatal clinics or patients attending hospitals and clinics which makes such data unreliable. This calls for further research, which does not only compliment the works of scholars like Gomwalk et al(2008) but also seeks to investigate some major obstacles to the behavioural change model in the Local Government Area.

Like many other sub-Saharan countries, Nigeria has passed through several phases in her response to the epidemic. In 1997, the government of the Federal Republic of Nigeria, through the Federal Ministry of Health adopted the national

policy on HIV/AIDs and STI. This was designed to limit the spread of HIV/AIDS in the country.

However, this was at a time when the magnitude and wide spread nature and impact of the disease was not completely recognized. Excluded from this document quite comprehensively was the issue of gender. Not just because gender analysis was not integrated as part of the design, but for the fact that the impact of gender on the disease was grossly ignored. The result was that HIV continued to raise the number of AIDS-related deaths and its impact on the country worsened.

Consequently, the government developed a new approach to the epidemic ensuring that all sectors of the polity relevant to the control of the epidemic were involved in the planning, implementation and evaluation of the countries responses to the epidemic. Similarly, all sectors of the polity that were affected by the epidemic were to jointly develop plans and processes to mitigate its impact. This approach includes strategies to prevent further HIV/AIDS transmission, provide cure and support for the people living with HIV/AIDS in the country.

Specifically, in the area of prevention, the National HIV/AIDS Strategic Framework for action (2007-2009) provides a strong and comprehensive framework for prevention efforts including a balanced "ABC" approach. The question at this point is how balanced is the current "ABC" approach to HIV prevention? Will these action plans, policies and committees on HIV/AIDS be able to match up with the realities on ground? These and other issues will be properly analysed in the course of this research.

1.2 STATEMENT OF RESEARCH PROBLEM

Thirty years into the HIV/AIDS epidemic, women are still the largest at-risk group in Nigeria. Whereas the government has acknowledged the gender dimensions

of HIV/AIDS and has developed and implemented gender-sensitive HIV/AIDS programmes, interventions, policies, and strategies, significant challenges remain, giving rise to the need for further research. This need grew over the failure of researchers to demonstrate an understanding of the context and nature of gender relations, particularly the issue of power imbalance between the genders in the LGA. Public health discourse, as seen in scientific journals and forums, reflects definite progress in understanding the importance of both gender and sexuality, but because this increased understanding is fuelled in large part by the need to interpret the dynamics of the AIDS epidemic, the analysis of gender and sexuality is situated firmly within a framework of disease. Sexuality as seen through the public health prism, therefore, is still a potential determinant of ill health and little else. As a result, safer sex is the mainstream theme within this discourse, while sexual health, pleasure, and rights remain on the margin. This study seeks to review the existing realities of women's lives in Jos North LGA against the backdrop of what has been reported. It puts in proper perspectives, the challenges encountered by women in their efforts to protect themselves and the implication of these challenges to policy implementation. The study therefore unravels factors that reinforce gender inequality in the LGA, and has implications for policy and strategies aimed at addressing this challenge. We have addressed the following among other questions:

1. What factors are responsible for the persistent gender gap in HIV prevalence, in spite of the adoption of gender sensitive policies in Jos North LGA.?
2. Are there some gender specific issues that are yet to be unravelled in Jos North LGA and have implications for policy?
3. What factors are responsible for power-imbalance between the genders in Jos North LGA, which has implications for policies and strategies?

4. Are there gender differences in ricks perception as a result of this power imbalance?

5. Are policy makers committed to addressing this challenge?

1.3 OBJECTIVES OF THE STUDY

In the process of addressing these questions, we were able to achieve the objectives of this study, which includes the following:

1. To unravel the reasons behind the failure of these policies and strategies to adequately address the challenges of the persistent gender gap in HIV prevalence in spite of the adoption and implementation of gender sensitive policies.
2. To identify those gender specific issues that is peculiar to the LGA.
3. To identify those factors that are responsible for power-imbalance between the genders in Jos North LGA, which have implications for policies and strategies?
4. To investigate if there are genders differences in ricks perception as a result of this power imbalance?
5. To investigate if policy makers committed to addressing this challenge?

1.4 PROPOSITIONS

From the basic arguments of the study the following proposition are formulated.

1. The inability of stake holders to capture the reality on ground with regards to power-imbalance between the genders in the LGA is responsible for the persistent gender gap in HIV prevalence.
2. Those gender based power relations that shapes marital relations in Jos North L.G.A. are likely to impact negatively on HIV prevention programmes.
3. Differences in risk perception between the sexes are likely to impact negatively on HIV prevention strategies and programmes.

4. Knowledge about HIV and its prevention is a necessary but insufficient condition to reduce the spread of AIDs as the issue of power is central to HIV prevention..
5. The lack of commitment by government to adequately address gender inequality in the LGA is responsible for persistent gender gap in HIV prevalence.

1.4 SCOPE OF THE STUDY

In carrying out this research, we have deliberately avoided dwelling on identifying factors responsible for the disproportionate spread of HIV between men and women. This is due in part to the fact that the issue has been extensively dealt with in previous studies. Rather, we have focused on identifying factors that justify and reinforce gender inequality in the LGA, as this approach best unravels issues behind the persistent gender gap in HIV prevalence in Jos North L.G.A in spite of the adoption of gender sensitive strategies.

The research focuses greater attention on women since they are worst-hit by the AIDS epidemic, but takes into account the fact that opinion of men were needed for a balanced research. The scope of this study therefore incorporates opinions from the general public, experts in prevention programmes, to that of our targeted population (Women and people living with HIV). While other factors that have rendered the current policy on HIV prevention less effective have been examined, our main focus was on the complex inter linkages between poverty gender inequality and the material conditions for high risk behaviour. Although our scope covers the entire twelve wards in Jos North Local Government Area, for a purposive sampling, a total of 1212 respondents were randomly selected. The study covered a period of ten years that is, from 1990 to 2011 since the response to the epidemic in Nigeria begun in the 90s.

1.5 JUSTIFICATION FOR THE STUDY

In September 2000, the heads of a number of African countries declared HIV/AIDS a national disaster at the African summit on HIV/AIDS held at Addis Ababa Ethiopia. A declaration of a national disaster signifies recognition of the inability of systems of governance to respond to a challenge (ADF, 2000). Two decades of responding to the challenges of HIV has shown us the direct links between governance and HIV. It was partly good governance that halted or plateau the epidemic in Botswana, Uganda, Senegal, Brazil, Australia, USA and the countries of Europe. Access to treatment and access to prevention technologies were facilitated by these states in response to demands from citizens. Today in Africa, the gap between policy and implication can be seen in the poor quality of life of the people who are meant to benefit from HIV-related policies and resources allocation. A viable policy starts with a proper articulation of relevant ideas and issues identified as the causes of such a problem.

Gender issues are so complex that policy makers need to understand the dynamics of gender inequality and how this affects policies at every stage from its formulation to evaluation. This study shows that acknowledging differences between and among women and men is critical to understanding and responding to women's health needs, particularly, in terms of sexual health. All too often, health interventions result in the medical examination of women's bodies and a dismissal of the impact of a range of differences (religion, class, and ethnicity) on women's health and sexuality. In contrast, this study shows that a clearer understanding of different approaches can result in the practice of medicine as an instrument allied with women's empowerment and the realization of women's sexual rights.

Furthermore, we argue that it is not just enough to adopt recommendations from conventions and interventional agreements, but to fully understand societal

problems based on prior research finding. Thus, the justification of this study as it seek to contribute to a vast and still growing literature which views gender inequality as a formidable barrier to success in preventing the spread HIV/AIDs. In specific terms, the research becomes important in assessing through scientific procedures the effect of gender inequality on HIV prevention strategies that are designed in line with the provisions of national policy on AIDS. As a tool, it helps in identifying the lapses in previous studies particularly those gender specific issues that are peculiar to women within the local government area.

Finally, this intellectual activity contributes to an emerging literature which seeks to place the continent's struggle against HIV/AIDS, including responses to it, within the broader framework of its development challenges.

ORGANIZATION OF THE CHAPTERS

Chapter one: General introduction. This includes the background of the study, statement of research problem, the objectives of study, the scope, the basic assumptions and the justification of the study.

Chapter two: literature review and theoretical framework: This chapter examines the trends and perspectives on the causes of the African AIDS epidemic, the interlinkages between gender inequality, poverty and the material conditions for high risk behaviour. It review works on human rights and reproductive policies, on HIV prevention and how gender inequality impacts on prevention strategies adopted to combat the spread of the contingent as well as the theoretical framework of analysis.

Chapter three: Methodology: This chapter provides a detailed record of all activities that were involved in the collection of relevant data for the study. It entails a detailed collection of primary and documented data on gender and HIV/AIDS in

Nigeria and other Sub-Saharan countries. We relied heavily on primary data collected within 30 clusters in Jos North LGA, and on existing records and studies carried out in the entire Sub-Region because of the similarities in trends of the epidemic in the region.

Chapter Four: The origin of gender inequality in sub-Saharan Africa. In this chapter we explore the circumstances leading to the pervasive gender situation in Nigeria. Factors that have influenced inequality like religion, colonialism etc will be looked at. This chapter starts with some conceptual clarifications of the term gender and examines the evolution of gender, and gender relations in Africa, Nigeria and Plateau State. It seeks to determine if gender relations were egalitarian, and if yes, what factors are responsible for the present state of affairs. It begins by investigating gender relations in some preindustrial societies, particularly looking at gender division of labour and how these activities enhance individual's capacity to participate in decision making in these societies. The chapter further examines these issues in pre-colonial, colonial and post-colonial eras in Africa and Plateau State in Nigeria in order to determine those factors that govern gender relations in the area under survey.

Chapter Five: Politics, Gender and HIV/AIDS Policies in Nigeria

This chapter examines the issue of gender disparity in HIV prevalence inspite of the adoption of the National gender Policy in 2006 and the 2009 revised Policy on AIDS. . Furthermore it explores the politics involved in the adoption and implementation of gender sensitive HIV policies in Nigeria.

Chapter Six: Data Presentation on Gender Inequality, HIV/AIDS and Gender Policies in Jos North LGA.

This chapter presents and analyses primary data generated from the field and from published and unpublished relevant documents. Results and discussions are based on

the five propositions stated earlier in chapter one of this work and other information gathered during the cause of this study

Chapter Seven: Summary, conclusion and recommendation

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 INTRODUCTION

This chapter examines the trends and perspectives on the causes of the African AIDS epidemic, the interlink ages between gender inequality, poverty and the material conditions for high risk behaviour. We shall review works on human rights and reproductive policies, on HIV prevention and how gender inequality impacts on prevention strategies adopted to combat the spread of the contingent. A central issue in addressing the impact of gender inequality on HIV/AIDS prevention programmes is to understand the type of gender relations in the area under investigation. To achieve this, we need a theory that best explains how gender inequality impacts on HIV prevention strategies, thus the adoption of the gender and power theory. As women are not a homogenous group around the world, gender and power theory provides the analytical tool needed in identifying culturally gender specific norms in the Local Government area which limits women's ability to protect them against HIV.

2.2 REVIEW OF RELEVANT LITERATURE

2.2.1 Poverty and the AIDS Epidemic

Literature on the AIDS crisis in Africa provides several explanations on the causes and how its spread could be prevented. Western scientists assume that Africa's AIDS crisis is functionally related to its unusual high rate of sexual partners change and the nature of sexual politics more broadly.

Dr. Yuichi Shiokowa argues that "The AIDS crisis in Africa could be brought under control only if Africans restrain their sexual cravings" (cited in Poku, 2005:4). Though there is no empirical evidence to support this view, the central thrust of

prevention programmes over the past three decades has been dominated by the advocacy of behavioural modification and encouragement of condom use.

Oppositions to the above assertion have come from different dimensions, dividing researchers on the African AIDS crises into three broad categories. Those who believe that poverty is at the root of the African AIDS crises, those who view gender inequality as the major cause of the epidemic and those who see an inter-linkage between poverty, gender inequality and the AIDS epidemic.

Dixon (2005) posits that AIDS is a disease which thrives on poverty and spreads fast in the poorest nations with the least health or education infrastructure and scarce medical resources available to treat huge numbers of people or to prevent further spread. Halperin (2001) found out that poverty was at the root of the AIDS crises in Southern Africa. His work focused on the neglected factors behind the pandemic. Kempe (1999) in his book titled Aids and Development in Africa, demonstrated the human consequences of AIDS and the efforts being made by governments, individuals and non-governmental organizations to respond to the threats.

Jamie-Simmons et al (1996) pursues the theme further, noting that through a myriad of mechanisms, poverty creates an environment of risk. Certainly, the poor seem to represent a disproportionate number of people infected with HIV globally. The links between poverty and vulnerability to HIV is brought in to an even shaper focus by looking at the global distribution of infections. The glaring fact is that 95 percent of the global distribution of HIV infections and AIDS cases are located in the developing world. Here, as elsewhere, poverty is associated with weak endowment of human and financial resources, such as low levels of literacy and few marketable skills, general poor health status and low labour productivity. An aspect of this poor

health status is the existence of undiagnosed and untreated STDs – which is now recognized as a very significant co-factor in the transmission of HIV (WHO, 2000:2).

Barnett et al (2002) place the epidemic in a global viewpoint as they demonstrated the impact of HIV/AIDS on the marginalized agrarian populace. They assert that understanding and evaluating the broader and longer consequences of the pandemic in developing countries require the intervention of both national and international responses.

Akeroyd (1996) focuses on some gender and occupational aspects that impact the spread of AIDS in Eastern and Southern Africa, stating that there is an inter-linkage between poverty, gender inequality and the spread of AIDS in Africa. Toure et al (2005) and Sydney et al (2003) show how Africa's growth will be undermined even more than it is now by rising business costs, unstable governments, weakened security and social instability if the spread of AIDS is not stopped. The labour organization projects significant work force losses by 2020.in 36 African countries due to HIV/AIDS. It also says that without intervention, 14 of these countries will lose 10% to 30% of their workforce, and 4 countries will suffer losses of more than 30% (World Economic Forum, 2005).

Malcolm, et al (2005) demonstrate how caring for people with HIV/ AIDS has consumed as much as 60% of the time women and girls use to spend doing other household level work including gardening, which undermines the ability of poor household to grow food for consumption or sale. Research shows that poverty is interlinked with gender inequality and women control over their economic welfare (Business fights Aids, 2007). Economic disempowerment has also been linked to vulnerability to HIV infection. Poverty and economic dependence push women and girls into high-risk behaviour such as commercial sex work in exchange for money or resources. Poverty and HIV/ AIDS do not occur in a vacuum, but rather in a social

context (Ingalls et al, 1999). Lwihula (1992, as quoted in Ingalla, et al) linked the AIDS epidemic with the years of economic crises in the early 1980s that saw the scarcity of essential commodities. These economic hardships intensified poverty, destabilized families, and increased movement of people between countries. The situation widened the web of sex networking and in this way facilitated the early rapid spread of HIV. Understanding poverty within the context of HIV/AIDS is critical as it is viewed in this study as both a risk factor for, and consequence of, HIV infection. As a risk factor, poverty is associated with weak endowment of human and financial resources such as low level of literacy and few marketable skills, general poor health status and low labour productivity as stated earlier. The inability to attract endowment through engaging in income generating activities by adults is a consequence of HIV infection, mobility and mortality links poor households into even deeper poverty.

Poor households may find it even more difficult to exonerate themselves from dire poverty for many more years and generations to come. Poverty, as a consequence of HIV infection could see the poor adopting various mitigation strategies to cope with the disease that often exposes them to HIV infection. Cohen (1998) argues that it is not surprising that the poor adopt behaviour that exposes them to HIV infection. It is not simply that IEC activities are unlikely to reach the poor, but that such messages are often irrelevant and inoperable given the realities of their lives.

Whiteside (2002:320) is of the opinion that illness and poverty affect household resources and income. One sees rising costs of medical care/treatment, and an increased need for nutritious food. With the progression of illness, the demand for care also rises. Children are often withdrawn from school to care for sick adults, further compromising their basic right to education. The deprivation of education could place the household at further long-term risk for poverty, lack of skills and disempowerment. This results in a cycle of household impoverishment that may take

decades to reverse. Lack of /or limited education and skills also appear to influence vulnerability to HIV infection. A national household survey in South Africa has found that those with tertiary educational qualifications had lower rates of HIV infection than those with only school level qualification (Shisana and Simbayi, 2002). The assumption here is that people with the necessary educational qualifications, thus acquiring economic independence/freedom for survival do not engage in risky behaviour than those with limited education.

Cohen (1998) argues that HIV intensified poverty leads to its persistence and overtime generates a culture of poverty. When parents are sick and die from AIDS related complications, there is little or no transfer of skills and knowledge to the younger generation. The circle of poverty is likely to repeat itself and felt over generations. Loewenson and Chikubirike (2005) argue that persistent poverty leads to what is termed 'new variant famine" where chronic poverty and ill health are increased, reducing household mechanism and resources for coping with illness and mortality, and further undermining long term prospects for food security and household well-being. Barnett et al (2001) argue that interventions to mitigate the effect of the pandemic on the rising generations are needed. Nattrass (2004:28) uses the term 'sexual economy' to describe sexual activities that men and young women engage in, in exchange for money. The participation in the sexual economy activities as a result of poverty, places young woman in particular, at higher risk of HIV transmission and infection. Nattrass quotes Akeroyd (1997) who asserts that sexual culture places women in a vulnerable situation regarding HIV infection, and poverty exacerbates it by encouraging women to engage in sex as an economic strategy for survival.

Dixon-File and Mulanga (2004) agrees with this by stating that young women sell their bodies to help families, and men take advantage of the opportunity, or

express feelings of powerlessness and despair through sexual violence when they are not driven by a mistaken belief in the healing power of the virgin female body. While HIV/AIDS crosses all socio-economic groups, its economic impacts are greater on the poor, powerless and marginalized (Grant and Palmiere, 2003:213). From the time of diagnosis, poor households feel the economic impact of the disease, Wyss, Hutton and Diethor (2004) found in their study in Chad that the average cost of AIDS to patients and their families are very high. On average, a household spends US D 78.6 (R521.66) a month directly on AIDS treatment and care. Cross (2001) in her study on rural household in south Africa further asserts that the de facto per capita income may fall to as low as R50 per month. The household therefore spends considerable amount of money on consultation and treatment fees and transport. Households see a greater speeding on health care and associated costs (Save the Children, 2004; Wyss et al, 2004).

The chronically ill person is often unable to work leading to reduced income and out-put in agricultural production. Chronic illness coupled with the need to care for the ill by other household members takes valuable time away from productive activities leading to double loss of income thus exposing households to risks such as food insecurity and exposure to HIV transmission (save the Children, 2004). In addition, De Waal and Whiteside (2003) have found that diversion of labour coupled with the care of children orphaned as a result of the death of their parents to AIDS-related diseases further impoverishes the household.

HIV/AIDS strikes persons at the prime of their lives thus exerting a heavy toll on the economic well being of the household. The death of a productive member comes with a reduced or loss of income (Cross (2001; Save the Children,2004); absence of savings and other assets to cushion the impact of illness and death (Cohen, 2001). For households that are solely dependent on agriculture, the death of the

member means that the contributions to agricultural production and income from that person are permanently lost.

However, this may also be the case for people working in the industry. Grant and Palmiere (2003) found in their study in Bulawayo (Zimbabwe) that HIV/AIDS-affected households experience a 40% drop in house hold income. Although the households attempt to diversify, they are unable to add a lucrative income-generating project. Households may be forced to cut down on their livelihood strategies to counter the impacts of the loss and reduced household income. As it was found in Grant Palmere's (2003) study, households were forced to cut down on their livelihood to accommodate a lower average monthly income and an increase in the number of people living within the households. This, in effect, means that households sink deeper into poverty and likely chances to avert the economic impact are very low or non-existent for some very poor households. The HIV/AIDS epidemic undercuts the ability of the household to cope with shocks. Assets are likely to be liquidated to pay for the costs of care. Sickness and caring for the sick prevent people from migrating to find additional work (Wiggins, 2008). Both HIV and poverty exert tremendous pressure on the household's ability to provide for the basic needs like food.

Agricultural activities contribute to the welfare of households in two ways. Firstly, the production of food crops and ownership of livestock contribute to the food security, and secondly, they provide income (Samatebele, 2005). HIV/AIDS and poverty combined have a debilitating effect on agricultural sector of the poor countries and more on the households. A major impact on agriculture includes the depletion of human capital, diversion of resources from agriculture, and loss of farm and non-farm income, together with other forms of psychological impacts that affect productivity (Jooma, 2005). The decline in agricultural production is attributable to the effects of HIV/ AIDS. De Waal and Whiteside (2003) further assert that a

household with a chronically ill person sees an income reduction of between 30 & 35%. HIV/AIDS and poverty affect the food security of the household. HIV is often associated with morbidity leading to labour shortage and loss of income. Households affected by HIV/AIDS are vulnerable to increased risk of HIV infection and the resultant poverty. Niehof (2004) argues that households with vulnerable livelihood systems have neither assets nor capabilities to create or access them. The situation further impoverishes the household.

The cycle of poverty and AIDS entrenches the system of chronic impoverishment (Jooma, 2005). Families may not recover previous levels of social functioning, and may even resort to strategies that may imperil them further. These strategies may include engaging in commercial sex that puts women especially in danger of HIV infection. Food shortages in Southern Africa are an ongoing problem, and long-term projections suggest that regional food production per capital is likely to diminish in the future (Rose Grant et al. 2001). Food crisis is undoubtedly made worse and malignant by a full-fledged HIV/AIDS epidemic. The disease leads to competition within a household for its resources, money and productive capacity must compete between care-giving and health-care costs on the one hand, and agricultural inputs and labour on the other (Stewart, 2003).

Poor nutrition is often linked with adverse out comes in HIV/AIDS. Poor nutritional status is linked to vulnerability to progression from HIV infection to mortality (Bates et al 2004). However, a note of caution must be entered here because to acknowledge the synergistic relationship between poverty and vulnerability to HIV is not to concede that AIDS itself is a nutritionally based disease. Equally, it is important not to deny that HIV is sexually transmitted across Africa: or that gender inequality places women in a vulnerable position and poverty exacerbates it by pushing women into risky behaviour.

2.3 THE LINKAGES BETWEEN POVERTY, GENDER INEQUALITY AND THE AIDS EPIDEMIC.

Gender emerges as an overarching issue in the early 1990s, as it was becoming increasingly clear that heterosexually active women were at risk for HIV. Concern grew over the failure of researches to demonstrate an understanding of the context and nature of sexual interaction and relationships. Behavioural change models that focused on individual level variables began to be widely challenged for negating the complexity of agency and constraint that operate within gendered, radicalized, classed, sexualized context (Amaro et al. 2001; Lagan et al, 2002; Zieler & Trigger, 1997). Linked to this, is the patriarchal nature of African societies which continues to shape women's sexual behaviour, and in turn, accounts for the high prevalence of HIV/AIDS among women in sub-Saharan Africa. Of the several factors implicated in the unequal prevalence of the disease among women in Africa, economic dependency, feminization of poverty, unequal distribution of sexual power (sexual violence and coercion), limited educational opportunities and lack of political will continue to dominate the literature (Robinson, 2004; Dunkle, et al., 2003; Mill and Anarfi 2002). African societies are patriarchal with some ethnic traditions requiring pre-marital chastity, while others require women to prove premarital virility by having babies (Shopf 1991). Girls are therefore socialized from very young ages to play subordinate roles. Girls that are therefore socialized this way would then grow up as desirable women for marriage; they could be rewarded by their families for enhancing family honour and image.

African cultures also frown against the open discussion of sexual matters and desires. In Nigerian culture for instance, a great deal of pressure to remain quiet about sex is rooted in socio-cultural values, customs, expectations, beliefs, and ideas about what constitutes good and bad behaviour (Izugbara,2001c). Words commonly used to

depict sexual desires, parts of the body, sex, masturbation, and menstruation in many Nigerian cultures are often ambiguous and indirect, reflecting the cultural quietude expected on sexual matters.

This notwithstanding, sexuality remains a key issue commonly and publicly commented upon through a variety of discursive activities. Another factor that exacerbates women's vulnerability to HIV/AIDS in Nigeria is the issue of male-child preference. The preference for male children in Nigeria is considered one of the strongest in West Africa (Ibanga, 1994). Male children are less likely than female ones to suffer rejection, prejudice, discrimination, and abandonment. They are also more likely to be sent to school. Many girls in Nigeria are often left at home to do domestic work or engage in child labour as a way of life or as a means of supplementing family resources. Ejikeme (2002) found evidence that during emergencies and disasters, many Nigerian parents selectively attend to the male child. Nwosu (1972) reports that during the civil war in Nigeria, many parents fled with their sons, livestock, bicycles, clothing, and jewelleries, leaving their female children behind.

In short, male socialization practices in many Nigerian cultures aim largely to train them to be domineering, ruthless, and in control, and to see themselves as naturally superior to women. On the other hand, female socialization often aims at making girls and women submissive, easily ruled or controlled, and to see themselves as natural inferiors to men. The Social Science and Health Research Network (SSHRN, 1994; 2001) shows that the key lay terms around which the ideal man is constructed in Nigerian cultures are 'strong', 'hard', 'unyielding', 'vigorous', 'stout-hearted', 'resolute', 'aggressive', 'active', and 'tough'.

The good/ideal woman on the other hand is spoken of in terms of 'dutiful', 'submissive', 'quiet', 'fearful', 'humble', 'faithful', 'patient', and 'careful'

(Izugara,2006). These socialization experiences inscribe superiority into maleness and masculinity, and inferiority into femaleness and femininity. We see the agenda of cultural socialization to be that of locating men and women in specific places in (hetero) sexuality and endorsing the belief that the natural order of things is for men to control women. This narrative inherently privileges masculinity equating it with autonomy-the freedom to explore, experience, and experiment and femininity with danger, vulnerability, and weakness. Our cultures frame men as having a naturally stronger sexual drive and firmer control of their sexuality than women. We speak of women in terms of shame, lack of interest in sexual matters and as the 'other' to be conquered and demystified by the domineering active male.

Thus years of "hand-me-down" conditioning of women have accounted for gender inequality in the region. In the era of HIV/AIDS, this imbalance between the sexes carries a new sense of urgency. Women have become susceptible to the disease as a result of their limited power in sexual encounters. In one estimate, 6-11% of young women aged 15-24 years were HIV positive compared to 3-6% of their male counterparts (Tabi and Frimpong, 2003). Any intervention programme designed to reduce the high incidence of HIV/AIDS among women in the region must first address social, economic and cultural issues in addition to political will (Wodi, 2005). Several social, economic, cultural and political factors account for African women's dependence on men and their consequent vulnerability to HIV/AIDS.

In sub – Saharan Africa, the desire by men to have many children and women to validate their marriage have been implicated in the spread of this contagion (Mayo and Mbizvo, 2004). In these societies, marital fidelity is questionable since the relationships are usually not mutually monogamous. Mayo and Colleague reiterate the fact that "...in Zimbabwe, women may be under pressure from their spouses or sex partners not only to reproduce, but to also achieve a desired number of surviving

children" (Wodi, 2005). In their assessment of the quality of sexual partnership reporting in rural Tanzania, Nnko and Colleague noted that while 40% of married men reported having non-marital partners, only 3% of married women engaged in this habit (Nnko, at al, 2004), Married Nigerians are also known to maintain extramarital relations. In Asuquo (1999), 65% of married men ages 30-65 confirmed having extramarital sexual relations. Ten percent of women in the study reported similar behaviours.

Use of safe-sex methods in non-marital sexual relations is reportedly low in Nigeria. Abia (2001) holds that only 11% of young sexually-active Nigerians regularly use any form of safe sex skills. In Asuquo (1999), only about 40% of married people who reported involvement in extra marital sexual activity consistently used condoms. Scholars have associated the high incidence of HIV infection, unwanted pregnancy, and abortion in Nigeria to low contraceptive use and frequent involvement in risky sexual practices (Izugbara, 2003c; Araoye & Fakeye, 1998; Adegbola & Babatola, 1999). It is clear that even though marriage could protect spouses from sexually transmitted diseases, this can only be true if both spouses enjoy equal powers in their relationship. Compared to western countries, women in traditional African societies lack the power to deny sex to their spouses even when they can prove instances of marital infidelity in their relationship. In a study in Zimbabwe, it was noted that majority of the HIV-positive women were actually infected by their spouses (UNAIDs, 2003). Even more revealing in Sierra Leone, one half actually believed that their spouses had a right to beat them. They also admitted that it is the women's obligation to have sex with her spouse on demand even if she was not interested.

In their Millennium Development Goals, the United Nations has identified condom as well as education in combating the spread of HIV/AIDs (Robison, 2004).

Yet, several studies would suggest limited usage of this important weapon against HIV transmission in sub-Saharan Africa (Eaton, et al, 2002: Volk and Koopman, 2001, Adih and Alexander, 1999). These studies present socio –cultural, economic and religious barriers in the limited condom use in the region. For example, in their study of Health Information Sources for Kenyan Adolescents, Pratt Et al (2000) note that religion is the most frequently cited factor influencing teenage pregnancy and consequently sexually transmitted diseases (STDs) such as HIV/AIDS in that country.

Christianity is the dominant religion in Kenya with 30% of the population claiming to be catholic. The conservative protestant and catholic religion openly preach against the use of any barrier method. The result is that women members (particularly married females) as the most vulnerable population are denied opportunities for sex education including use of condom to prevent sexually transmitted diseases (Patt, et al.2000). On the other hand, several young people harbour a number of misconceptions and negative attitudes about how sexually transmitted diseases such as HIV are spread. In his survey of HIV/AIDS knowledge and attitudes among secondary school students in Nigeria, Wodi (2002) found that of 100 respondents, 60% admitted that none or few of their friends used condom in sexual encounters.

Lander, et al. (2002) also note similar limited condom use pattern among students in rural Zimbabwe. Akande (1994) reports a high incidence of risky sexual behaviour among students in Zimbabwe and Nigeria in spite of adequate knowledge levels. Nearly 30% of 1400 students surveyed admitted to never using condom. However, condom use increased significantly with free access to them.

However, in contrast to standard and ubiquitous messages on the use of condom for all sex occasions, a gender perspective argues that attempts to promote condom use need to consider the social and cultural realities in which sexual

interaction are embedded (Amaro, 1995, Cochrsnd may 1993, Curie 1988, Ehrhardid Exner, 1991, Earnhardt, Yingling zawadzth Martines-Remirez, 1992). Regardless of their desire to enhance their protection, many women report considerable difficulty negotiation condom use, especially when they are economically and socially dependent on male partners. Raising the issue of condom use can entail risk to the relationship in the form of relational conflict or dissolution of marriage, loss of economic or emotional security or abuse (Logan et al, 2002). It is particularly a problematic situation for women who are isolated emotionally or who are financially dependent (Campbell, 1995, Gupta Sweiss, 1993, 1995 Logan Slenkefeld, 2000, Sabo 1995). A history of abuse and violence is an even greater deterrent for a woman to insist on condom use with an unwilling partner. Researchers have found that women who experienced abuse, who fear a negative partner's reaction to safer sex or who perceive negative consequences to the relationship were significantly less likely to request condom use or to report condom protected intercourse (Amaro and Raji - 2000 Cabal Pulley Arts, 2002b, Gomez Van Boss Marine 1996, Oleary 2000, Wingood Diclement 1996).

Within committed relationship where desires for closeness and pleasure and traditional patterns of gendered behaviours become entrenched, initiating condom can be seen as interfering with trust intimacy and pleasure (Amaro 1995, Ehrhardt et al, 1992, Fulliove et al 1990). A substantial body of literature indicates that male condom are less likely to be used in committed relationship with main partners than with casual partners (Bowleg ,Bell grave & Reisen 2000 Declini et al,1998, Misovich, Fisher 1997, Richter Mukhtar Addy & Macera 1992; Hobfoll, Jackson, caving, Britten, & Shepherd, 1993, Lansky, Thomas,& Earp 1998). Once sex without condom has occurred, women find it difficult to introduce (or reintroduce) condoms into a relationship (Deren, Shedlin, & Be Ardsley, 1996).

Condom interrupts sex and can interfere with arousal and feeling of closeness and women and men who find intercourse less pleasurable with male condoms than without are less likely to report use (Ehrhardt et al, 2002b). Although the mass availability of oral contraception in the late 1960s contributed to increasing reproduction decision making-autonomy, it had the side effect of marginalizing the male condom as method for disease prophylaxis. Despite its high efficacy for preventing unwanted pregnancy, the male condom has become synonymous with infidelity, and casual sex. Raising the issue of condoms leads to potentially acknowledging the sexual double standard between women and men, while also raising the contentious domains of trust and fidelity. Even considering that one's steady partner might be unfaithful or disease infected is counter to the ideal of a committed, trusting relationship.

Sexual safety often becomes a secondary concern in relation to the desire for emotional and sexual intimacy (Logan et al 2002, Sobo, 1993). Cross cultural, women's gender roles frequently regard motherhood as a valued feminine ideal (Gupta, 2001). Because the male condom functions as a contraceptive as well as disease prophylactic, pregnancy intention can be a major barrier to consistent condom use, (Eze, Seroussi, & Roggers 1996, Hobfall et al, 1994). Men's intentions regarding pregnancy, with or without partner's concurrence, are also likely to affect condom use. Both factors combine to pose a significant, complex dilemma for women in risky relationship (Gupta, 2001).

2.4 HUMAN RIGHTS, REPRODUCTIVE HEALTH OF WOMEN, AND THE AIDS EPIDEMIC.

This section of the review of relevant literature offers an overview of how to apply human rights norms and standards to reproductive and sexual health and

sexuality. Arguing that the linkages between reproductive health and human rights are varied and complex, Cook (1995) offers a broad framework for advancing human rights protection for reproductive self-determination. Beginning with a brief overview of feminist methodologies, she examines how legal strategies and population policies have tended to ignore women's own perceptions of their needs. She then provides a detailed analysis of the application of human rights to reproductive self-determination, including rights relating to sexuality. She presents four categories of rights: rights relating to reproductive security and sexuality; rights relating to reproductive health; rights relating to reproductive equality; and rights relating to reproductive decision-making. In enumerating these rights, she also discusses how these rights are routinely violated. Finally, Cook also supplies an analysis of state accountability, noting how governments can be encouraged to fulfil their obligations to make reproductive self-determination a reality.

Correa and Petchesky (1994) define the terrain of reproductive and sexual rights in terms of power and resources, involving a core notion of "bodily integrity" or "control over one's body." In doing so, this essay has had significant influence on developing concepts of "sexual rights," particularly, in the context of global women's health and rights advocacy. Taking a critical view of "human rights," the authors propose a reconstruction of the rights discourse that specifies gender, class, cultural and other differences, while recognizing social needs or enabling conditions. While they purposefully explore the theoretical and historical foundations of "reproductive" and "sexual" rights, their emphasis is on policy implications of reproductive and sexual rights, concepts and advocacy. They are especially concerned with how to bridge the "individual-social" divide. In order to address this, they offer a set of ethical principles for reproductive and sexual rights: bodily integrity, personhood, equality, and diversity. This leads them to propose that governments and population

agencies must do more than avoid abuses. Rather, what is required is a reordering of priorities, including affirmative programmes to advance gender equality, promote women's empowerment, and redistribute resources in a fashion that promotes liberty and social justice.

Costa (2000) notes that acknowledging differences between and among women and men is critical to understanding and responding to women's health needs, particularly, in terms of sexual health. All too often, health interventions result in the medical examination of women's bodies and a dismissal of the impact of a range of differences (race, class, and ethnicity) on women's health and sexuality. In contrast, Costa proposes that a clearer understanding of different approaches can result in the practice of medicine as an instrument allied with women's empowerment and the realization of women's sexual rights. Dixon-Mueller (1994) emphasizes the interconnectedness of a comprehensive understanding of "the relationships between sexuality, gender-based power, and reproductive health". She critiques the methods of research and medical intervention as they are typically carried out around the world. She argues that because "gender power relations" are only infrequently taken into account when trying to understand human sexuality, service providers are not able to effectively help girls and women, and vulnerable boys and men avoid violence, disease, and/or pregnancy. The ignorance of researchers and health care providers means that certain relevant questions do not get asked. According to Dixon-Mueller, this means that certain behaviours will not be mentioned, as most people in the world are unlikely to discuss behaviours that could potentially be seen as deviant or immoral. She argues that sexuality "needs to be explored within a gender (and generational) framework by taking into account the ways in which structures and ideologies of gender organize experiences differently for adolescents and adult

women and men". Only then will limitations in sexual health care be understood and rectified.

Freedman (1994) sets out to expose some of the assumptions about human well-being that underlie traditional views of public health and human rights, while exploring the connections between them. In doing so, she seeks to offer some alternative directions for discussion, elaboration, and action. She takes the perspective that both public health and human rights discourses offer as yet unrealized transformational social justice potential. In particular, Freedman challenges the tendency to over-generalize in favour of approaches that empower individuals to make choices about their lives that can protect their health. For example, she reflects on the failure of HIV/AIDS prevention policies that primarily rely on individual behaviour change, exhorting people to "just say no" or to engage only in safer sex practices. She notes that women who are powerless and vulnerable may have little control over their sexual partners or their sexual lives more generally. In calling for approaches that empower women to exercise their sexual and reproductive rights, freedman locates herself within the reproductive health and reproductive rights movements. Contesting dualisms such as "negative" and "positive" rights, or "individual" and "community," Freedman sets out a perspective that emphasizes interconnections. She proposes that public health and human rights both offer useful and strategic tools for advancing the well-being of all people, centring on the ability of women to set the course of their own lives.

Fried and Landsbergis-Lewis locate the discourse of sexual rights within three overlapping social movements: women's human rights; women's health; and sexual orientation as a human rights issue. Arguing that notions of sexuality and sexual rights are rooted in gender norms, they contend that claims for sexual rights are both affirmative demands for women's right to fully exercise their citizenship and a

demand for protection against human rights violations. In order to make this argument they draw on two forms of information: personal stories from a series of tribunals and hearings coordinated by the Centre for Women's Global Leadership, where women "testified" about violations committed against them; and a detailed investigation of the emerging sexual rights discourse as articulated through the documents and debates at the International Conference on Population and Development (Cairo, 1994) and the UN Fourth World Conference on Women (Beijing, 1995). They conclude by describing the efforts of a number of women's and human rights organizations to highlight sexuality as a human rights concern. While the term "sexual rights" is increasingly being invoked, those engaged in debates about sexuality and human rights have noted a critical lack of clarity about what, precisely, the term implies.

Miller seeks to provide a human rights framework for understanding sexuality, and for delineating how sexual rights fit within international human rights norms and standards. Working from a rights-based analysis, Miller strives to critique and expand the boundaries of the human rights system. She confronts the issue of sexuality from two main human rights vantage points: the right to be *free from* (a *violations* approach) and the right *to do* something (a *promotions* approach). Miller also explores - and disentangles - the relationship between reproductive rights and sexual rights, noting that the two are often inappropriately conflated. In carefully reviewing the emerging global discourse of sexual rights, Miller argues that by conflating sexual rights with reproductive rights, individuals or groups of individuals engaged in non-procreative sex (heterosexual or not) can be disenfranchised. Miller wants to see a concept of sexual rights developed that rests on a rubric of rights which "will benefit all, liberate all, protect all" (p. 96). Inherent to this understanding are important tensions: at what point does one person's right to... violate another person's right to be free from...? How do rights and state regulation interact? Miller counsels readers to

tread these lines carefully and calls for "strategic cross-cultural and cross-sectoral coalitions, between groups and persons who act or speak in different ways or from different sexual identities" (p.96). Rajasingham takes up the apparent contradiction between the rise of women's (and feminist) organizing in postcolonial nations, and the persistence or re-emergence of women's cultural and sexual subordination. She argues that reproductive technologies and population policies both hinder and advance women's sexual autonomy. On the one hand, reproductive technologies enlarge women's choices. At the same time, they also give impersonal forces greater access to and control over women's bodies. In the context of nationalism and the organization of postcolonial states, women's sexuality has become increasingly scrutinized, while simultaneously women's citizenship remains insecure. The tenuous economic and political situation of many newly (or recently) independent nations has often resulted in greater regulation of women's sexuality, in the name of protecting culture and nation. She cites one example: the initial refusal of the Indian government to sign the Convention on the Elimination of All Forms of Discrimination against Women. In this case, the Indian government claimed that the Constitutional guarantees of personal law to minority communities conflicts with several articles of the Convention. However, rather than heeding to a call for dismantling such constitutional guarantees, Rajasingham advocates for reform toward greater gender equality within such minority communities

Tambiah (1995) examines the uses and limitations of current human rights instruments in relation to female sexuality, and provides recommendations for the development and realization of sexual rights for women. Focusing on the "battleground" of female sexual behaviour, Tambiah assesses the challenges faced by women and girls in realizing their sexual desire - both as individuals and as members of communities. While women often struggle to control their sexuality, Tambiah

explores how they are opposed by families and communities. Often the outcome is human rights violations against women. Compulsory heterosexuality is another form of familial and communal suppression of women's sexual autonomy. Tambiah contends that mandatory heterosexuality leads to abuses against lesbians as well as other women who refuse to act in accordance with heterosexual norms - such as forced marriage, forced psychiatric treatment, and social isolation, among others. Familial regulation of women's sexuality finds its counterpart in the state. The family, the community, and the state often collude in denying sexual rights to women. This denial of rights leads to abuse, for example, virginity testing in Turkey, where state doctors conduct tests on women at the request of parents or other community authorities, contravenes both the constitutional rights and human rights of Turkey's female citizens. Tambiah concludes with a series of recommendations that seek to affirm women's sexual rights as human rights, and to facilitate the incorporation of sexual rights advocacy into all human rights activism.

Izugbara(2006) asserts that official silence seems to surround the problem of sexual abuse of women in Nigeria. Although available data suggest that the sexual abuse of women is common in Nigeria, and are sometimes committed by state agents (army, police and ranking politicians), mum is often the word. The police do not always take reports of sexually abused women seriously on the excuse that they (the women) cause their own sexual harassment by exposing their bodies or that women lie a lot (Izugbara, 1997b). Sometimes, the false belief that men's sexual desire is naturally uncontrollable is used to excuse their sexual intimidation of women.

An estimated 54 million of Nigeria's 78 million women are based in rural areas and make a living from the land. The Nigeria Land Use Act of 1978 nationalised all land and vested authority in the State Governor who holds it in trust on behalf of all. In practice however, the way land is owned and accessed varies from place to place in

Nigeria and can be an amalgam of traditional Islamic Sharia and other local governance practices (Mabogunje, 2010).

In rural areas, women's rights of access are still regarded as secondary to those of men and many customs suggest that women's access to land is still mediated via patrilineal systems (Aluko and Amidu, 2006), in spite of the intentions of the 1978 Land Use Act. For women, use rights often follow marriage, inheritance or borrowing, while outright ownership can follow divorce only in the case of Muslim women in the North. The livelihood challenge is as much about access to land as it is about obtaining the means to use the land. In rural Nigeria land ownership is one of the key limiting factors of production (Peterman *et al.*, 2010). Land access is severely curtailed by the way land is inherited, owned and passed on by men to their male descendants in most patrilineal ethnic groups, especially in Southern Nigeria. Data from the NBS Core Welfare Indicators survey of 2006 show how the way land is controlled and accessed affects ownership patterns. As urbanisation increases, land tenure for women will become an increasingly important issue. This limitation has increased women dependence on men and their inability to make choices on issues that affect their health.

Similarly, Khaxas (2001) begins by noting the contradiction between the Namibian government's claim to respect the human rights of all women and the fact that lesbian women are told that they have no human rights at all. This essay tells the story of how Sister Namibia, a women's rights organization, coordinated a national and collaborative process of preparing a *Women's Manifesto*. At the outset of the process, one of the more contentious issues was whether to include language on sexual rights and the rights of lesbians. While the South West African People's Organization (SWAPO) Women's Council (a branch of the ruling party), among other groups, resisted including references to the rights of lesbians in the Manifesto, the

majority of other organizations, including grass-roots rural women's groups, welcomed the inclusion of these references. Through discussions and role-plays in regional workshops about the Manifesto, Sister Namibia found that the overwhelming majority of participants were enthusiastic about the use of human rights as a means of empowering all women, regardless of their sexual orientation. In fact, they were willing to boldly resist SWAPO's discriminatory position on this issue, and made supportive statements for inclusion, such as "Lesbian women are our mothers, sisters and daughters" (p. 64). Sister Namibia has continued to work consistently for the indivisibility of women's human rights in all their endeavours.

2.5. PROTECTION METHODS THAT GIVE WOMEN GREATER CONTROL.

Recognizing that women do not "use" male condoms, women's health advocates also called for the development of female controlled barrier methods and microbicides (Elias & Horse, 1994, stein, 1993, 1990). Following a vigorous campaign for the female condom, the U.S food and drug Administration approved it as a contraception method in 1993. The female condom although approved for one-time use, Buksin-ska et al, (2002) recently demonstrated that it can safely by reused after being washed and disinfected with bleach. The female condom has been demonstrated efficacious in preventing pregnancy (Fair, Gabelinick, Sturgeon, & Doflinger, 1994, and Trussell 1998) and has a high lifeline, of disease prevention efficacy (Drew, Blair, Mane, & Canant, 1990) super et al, 1993).

The potential of the female condom to reduce the risk of HIV transmission has been estimated to be greater than 90%, (Trussell, Surgery, & Diclemente 1994). Although evidence is not yet definitive, there is also a suggestion that offering the female condom as an additional option for couples may increase the total number of

protected occasions (Artz et al, 2000). It may enhance women's perception of empowerment within their relationships and their ability to raise issues of risk and protection with their male partners (Gollub, 2000).

Nevertheless, it is clear that the female condom does not eliminate the need for acceptance by the male partners.' cooperation in using the female condom is necessary even if method is female-initiated. Male partners have been reported to be positive about the method, when assessed either by the report (World Health Organization, Who, 1997) or directly from the male partners themselves, (Bounds, Guillebaud, & Newman, 1992). However, in some reports, Mathie, 1993 Farr et al; (1994), women who discontinued female condom use cited partner dislike as a major reason in part because the female condom requires some degree of negotiation with as partner, advocacy continues for the development of a vaginal microbicide, which theoretically, world after women a covert method of protection (The Rockefeller foundation, 2002). Research on a large scale continues, after the report that monoxyno 1-9 spermicidal does not protect against infection with HIV or other sexually transmitted infections (STI's) (Van Damme et al, 2002). Nevertheless, the most optimistic estimates suggest that it would be close to 2012 before the first generation microbicide is on market, (The Rockefeller Foundation, 2002). Thus, at present, microbicide remains but a hope, and although female condoms are now available, higher cost relative to male condom, the needs for partner negotiation and lack of marketing in the West contribute to its limited usage (Gollub, 2000; Kaler, 2002; Mantell et al, (2002). For the sexually active, safe sex remains focus on male condoms.

2.6 ADDRESSING GENDER AS AN INTEGRAL PART OF HIV INTERVENTIONS.

By the mid 1990s, gender sensitive programmes for women were emerging. These were reflected in initiatives that extended women's access to STI services within reproductive care settings. This was achieved through funding and by a substantial increase in the number of studies targeting women (Exner et at, 1997; Icteovics Yoshikawa, 1998: Longan et al, 2002; Wingood & Diclente, 1988). Although there have been no formal empirical evaluations of the efficacy of gender neutral verses gender sensitive interventions, reviewers of the literature have observed that interventions specifically directed towards women, tailored to the unique issues and circumstances of the target population, and focused on the relationship and negotiation skills necessary to enact condom use with a partner were generally the most efficacious (Exner et al, 2002; Wingood & Diclemente, 1998). The vast majority of these efforts have been directed toward the individual delivered one-on-on or in small groups.

One of the earliest examples of a gender sensitive intervention for women, Kelly and colleagues studied were the "high risk" Women (defined as those with multiple partners, or STI history) attending a comprehensive Community Health Clinic in Milwankee. Women were randomly assigned to either a 5- Session HIV prevention programme or a health education condition focusing on nutrition. The HIV intervention, grounded in cognitive behaviour principles, emphasized cognitions, risk reduction skills, and social support over the course of four -90-minutes workshops for groups of 8-10 women, plus a one month group follow-up all conducted in the clinic. Intervention activities included participant role-play of sexual negotiation scenarios, including how to initiate a discussion about HIV concerns with a partner and how to resist sexual pressure from a man. Another focus was helping women to identify, to

understand, and to manage their personal "triggers" for unsafe sex, such as drinking or drugs, loneliness, or involvement in a coercive or power-imbalanced sexual relationship. Group problem-solving strategies were used to help women brainstorm how to handle their high-risk situation, with women taking on roles that actively supported each other's concerns and efforts to change. For example, many women shared how they had dealt with sexual pressure and discussed benefits of change, such as protecting one's children or feeling in control of sexual decision making. At a 3-month follow-up, relative to control participants' intervention women were significantly more likely to report condom use, had a higher percent of condom-protected intercourse, and had significantly fewer occasions of unprotected intercourse (Kelly et al, 1994). This study illustrates critical elements characteristics of gender-sensitive interventions. Women were directly targeted; the intervention addressed critical partner negotiation/refusal skills while acknowledging the potential for abuse, and the negotiation scenarios and strategies themselves were derived from pre-trial focus groups, thus tailoring intervention content to circumstances pertinent to the women's lives.

2.7 MALE CIRCUMCISION AND HIV PREVENTION

Several types of research have documented that male circumcision significantly reduces the risk of HIV acquisition by men during penile-vaginal sex. A systematic review and Mata-analysis that focused on male circumcision and heterosexual transmission of HIV in Africa was published in 2000 (Weiss et al 2000). It included 19 cross-sectional studies, and 1 partner study. A substantial protective effect of male circumcision on risk for HIV infection was noted along with a reduced risk for genital ulcer disease. After adjustment for confounding factors in the population-based studies, the relative risk for HIV infection was 44% lower in

circumcised man. The strongest association was seen in men at high risk, such as patients with sexually transmitted disease (STD) clinics, for whom the adjusted relative risk was 71% lower for circumcised men. Another review that included stringent assessment of 10 potential confounding factors and was stratified by study type or study population was published in 2003 (Siegfried N, Muller M, Volmink J, et al, 2003). Most of the studies were from Africa. Of the 35 observational studies in the review, 16 in the general population had inconsistent results. The one large prospective cohort study in this group showed a significant protective effect. The odds of infection were 42% lower for circumcised men (Gray et al, 2000). The remaining 19 studies were conducted in populations at high risk.

These studies found a consistent, substantial protective effect, which increased with adjustment for confounding. Four of these were cohort studies; all demonstrated a protective effect, with two being statistically significant. Ecological studies also indicate a strong association between lack of male circumcision and HIV infection at the population level. Links between circumcision culture, religion, and risk behaviours may account for some of the differences in HIV infection/prevalence. In countries in Africa and Asia, the prevalence of male circumcision of less than 20% has HIV infection prevalence several times higher than those in countries where more than 80% of men are circumcised (Halperin, Bailey, 1999). Three randomized controlled clinical trials conducted in South Africa in 2005, Kenya and Uganda in 2006, found a reduction in male participant's risk for HIV infection from medical circumcision (Gray et al 2007).

Male circumcision has been associated with lower risk for HIV infection in international observational studies and in three randomized controlled clinical trials. It is possible, but not yet adequately assessed, that male circumcision could reduce male -to-female transmission. Individual men may wish to consider circumcision as an

additional HIV prevention measure, but they must recognize that circumcision does carry risk and cost that must be considered in addition to potential benefits. It has only proven effective in reducing the risk of infection through incentive vaginal sex. It confers only partial prevention and should be considered only in conjunction with other proven preventive measures.

SUMMARY

From our review of the arguments presented in the literature, it is evident that that there is a synergistic relationship between poverty and vulnerability to HIV. A substantial body of literature indicates the linkages between poverty, gender inequality and the material conditions for high-risk situations.

Poverty and economic dependency push women and girls into risky behaviours such as commercial sex work in exchange for money or resources. More current studies continue to associate intimate partner-violence and high levels of men control in a women's current relationship with HIV stereo positivity.

The authors warn that women with violence or controlling male partners remain at increased risk of HIV infection (Amaro and Raji - 2000 Cabal Pulley Arts, 2002b, Gomez Van Boss Marine 1996, Oleary 2000, Wingood Diclement 1996). They argue for social discourse and effective intervention strategies on the relationship between masculinity intimate partner violence, male dominance in relationships, and their implications for high HIV prevalence among women in Sub-Saharan Africa. These factors also account for women's inability to negotiate for safer sex or condom use. Negotiating for condom use, these authors warn, may entail risk to the relationship in the form of relational conflict or dissolution of marriages, loss of economic or emotional security, or even sexual violence.

Research has shown that female condom does not eliminate the need for acceptance by the male partner. Most investigators confirm that partner cooperation in

using the female condom is necessary even if method is female-initiated. Condom use on the hand has become synonymous with infidelity and casual sex. Raising the issue of condoms leads to potentially acknowledging the sexual double standard between women and men, while also raising the contentious domains of trust and fidelity. Male circumcision has been associated with a lower risk for HIV infection in international observational studies and in three randomized controlled clinical trials. It is possible, but not yet adequately assessed, that male circumcision could reduce male -to-female transmission of HIV. However, it provides only partial prevention. In Nigeria where most men are circumcised this might be a positive issue in prevention.

In spite of this vast and still growing literature on gender and HIV in sub Saharan Africa, there is still a yawning gap on the issue of power imbalance in relationships. In fact, one of the deficiencies of research to date is the small number of rigorous quantitative models that specify the link between gender-based power relations and sexual and reproductive health outcomes. Power itself is rarely measured; thus if a desirable outcome occurs, it is often not possible to attribute it to a change in power relations. Studies that link an intervention to changes in power and to a specific health outcome are greatly needed; thus the significance of this study.

Furthermore, much of what has played out in national and global responses to the HIV/AIDS pandemic is shaped by political factors. Yet, little analysis has been done to dissect political dynamics and motivations. Several research studies provide insights into some of the dimensions of the political realities that surround approaches to, funding for, and to engage communities in dealing with, HIV/AIDS. There is a growing body of evidence about the economic impacts-from household to national levels. There is far less analysis about how political decisions determine responses to HIV/AIDS or how the epidemic becomes a factor in decision making among political

actors. The epidemic is altering political systems-international and national-which determine approaches to controlling the epidemic and managing its impact.

An important starting point is to ask: why have analyses of political considerations been so limited in writings about HIV/AIDS? Where are the political scientists and political economists in the debates around HIV/AIDS?

The most obvious answer to the first question is that much of the response to HIV/AIDS has been shaped by a bio-medical and public health approach. It is not that these approaches were inappropriate, but they did not invite or welcome critical analysis that included consideration of power relations, inequalities between socioeconomic groups and nations, or of other systemic factors. The focus in much of what has occurred around HIV/AIDS has been on inter-personal dynamics, service delivery and already marginalized groups. Social changes that have magnified the spread and impacts of HIV/AIDS as well as the socioeconomic and political changes to control the epidemic are largely ignored.

In addition, issues related to sexuality and cultural change-with underlying racial assumptions-are highly sensitive. Interest and support for political analyses of these topics even in the context of a global crisis are not forthcoming. Many non-medical academics quickly learned that research on the politics of HIV/AIDS would not further their careers. Most donor agencies had little interest in funding research and analyses about the pandemic that linked HIV/AIDS to development issues such as poverty. Even as the global community moves to widen the availability of antiretroviral therapy, there is hardly any discussion about the reasons for the fragile state of national and local health systems that are meant to manage treatment, but which have been weakened for at least two decades by political choices.

2.8 THEORETICAL FRAMEWORK

Either implicitly or explicitly, nearly all prevention interventions are based on theory. Most rely on the assumption that giving correct information about transmission and prevention will lead to behavioural change. Yet, research has proven numerous times that education alone is not sufficient to induce behavioural change among individuals. Thus second generational interventions were developed based on individual psychosocial and cognitive approaches that educate individuals in practical skills to reduce their risk for HIV infection (Kalichman, 1997). More recently social researchers have come to realize that because complex health behaviours such as sex takes place in contexts, socio-cultural factors surrounding the individual must be considered in designing prevention interventions. Beyond the individual and his or her immediate social relationships also lie the larger issues of structural and environmental determinants that also play a significant role in sexual behaviour (Sweat, 1995).

These categories of theories include among others:

a) Theories that focus on individuals. As HIV transmission is propelled by behavioural factors, theories about how individuals change their behaviour have provided the foundation for most HIV prevention efforts worldwide. These theories have been generally created using cognitive-attitudinal and affective-motivational constructs (Kalichman, 1998). However, only one of the psychosocial models, the AIDS risks reduction model was developed specifically for AIDS. Psychosocial models of behavioural risk can be categorized into 3 major groups. Those predicting risk behaviour, those predicting behavioural change and those predicting maintenance of safe behaviour. Models of individual behavioural change generally focus on stages that individuals pass through while trying to change behaviour. Central to HIV preventions based on psychological behavioural theory is the practice of targeted risk

reduction skills. However these theories and models generally do not consider the interaction of social, cultural and environmental issues as independent individual factors.

b) **Social theories and models:** overemphasis on individual behavioural change with a focus on the cognition level has undermined the overall research capacity to understand the complexity of HIV transmission and control. Agleton (1996) points out that in many cases, motivations for sex are complicated, unclear, and may not be though through in advance. Societal norms, religious criteria and gender power relations infuse meaning into behaviour, enabling positive or negative changes. The main difference between individual and social models is that the latter aim at change at the community level.

c) Structural and environmental models:

Determinants of sexual behaviour can be seen as a function not only of individual and social, but of structural and environmental factors as well (Carael, 1997; Sweat, 1995; Tawill, 1995). These factors include civil and organizational elements as well as policy and economic issues. They are multidimensional with an emphasis on linking the individual to the surrounding larger environmental systems. Interventions using this approach thus target organizations, communities and policy.

As behavioural interventions are designed to reduce higher risk behaviour, perception of risk is a construct in most individual psychosocial behavioural models and some intervention use the constructs without applying any of the models in their entirety. Increasing perception of risk has been shown numerous times to increase HIV protective behaviour (Stevens 1998), yet, most behavioural model measure risk as individually determined which might not be relevant in many contexts. Not surprisingly, many women often perceive themselves at risk not because of their own

behaviour, but because of past or current, perceived or real behaviour of their sexual partners.

It is in the light of these factors that this study has adopted the theory of gender and power to illuminate the direction of this study. Unlike the psychosocial theories which are essentially gender blind, the theory of gender and power is a social structural theory addressing the wider social and environmental issues surrounding women, such as distribution of power and authority, affective influence and gender-specific norms within heterosexual relationships (Connel, 1987). Using this theory to guide intervention development with women in heterosexual relationships can help investigate how a woman's commitment to a relationship and lack of power can influence her risk reduction choices (DiClemente, 1995). A significant number of studies have shown that gender influences HIV risk behaviour (Auerback, 1994; Amaro, 1995). As Ulin (1992) notes, when referring specifically to women who are poor and dependent on their male sexual partners, reducing the risk of HIV transmission often means changing the balance of power in the relationship and this could mean failure in their role as women which are inextricably linked to their fertility. Many women are torn between the value of motherhood and the risk of HIV for either them or their children. The fear of their partners' violence has also been shown to predict whether women use condom (Gomez, 1993). In Uganda, stark gender differences were shown in perception of risk, women being more likely to perceive risk than men (Bunnel, 1996). The sexual double standard that sanctions many partners for men while restricting female sexuality has engendered confusing HIV prevention message such as reducing numbers of partners where this may not be protective. Data globally affirm that not only are many women monogamous already, but it is unsafe for them to assume they are safe in their monogamous situation (Heise, 1995). In high prevalence communities, rates of discordance among married couples

can be between 15% and 20 (Allen, 1992). Amaro notes that there is a growing body of knowledge that HIV among women has to be seen within the larger context. She suggests strategies such as participatory education that stresses longer term goals, assessing root causes of gender differences, including disempowerment and poverty (Amaro, 1995).

Wingood suggests a transition that will use gender-specific theories for research and programme development for women and HIV (Wingood, 1995). Studies in the USA and in Africa emphasize that self protection, especially for vulnerable women, may be affected by abusive partners, economic factors and norms within sexual relationships (Wingood, 1996; Bunnell, 1996; Van der Stricken, 1998). As Bunnell states, sharp differences in perceptions of risk between males and females in Uganda reflect underlying differences in societal power-the case in multiple settings around the world.

It is the contention of this researcher that to address women's needs in HIV prevention especially in Nigeria, the development of female-controlled methods needs greater emphasis as well as a wider approach to HIV preventions that consider the social position of women. Some conclusions regarding the theoretical framework, problems and arguments of this study are easily drawn from discussions in this chapter. These conclusions in many ways seem to illuminate the direction of the study. Firstly, the summary of the basic arguments arising from the problem of the study which can be summed up in the following phrases:

> "The sub-ordinate position of women in Nigeria creates an unfavourable environment for HIV prevention. As sexual double standard that sanctions many partners for men while restricting female sexuality has engendered confusing HIV prevention messages such as reducing number of partners where this may not be protective. This in turn has implications for policy and strategies to reduce the spread of AIDs".

Secondly, it is clear from the nature of the substance of the study that the theory of gender and power offers greater possibility for deeper appreciation and understanding of the impact of gender inequality on HIV prevention strategies. Moreover, this theory has been used for interventions and in assessing the issue of reduction of partners in Uganda. The theory of gender and power provided a model for the design of a successful gender appropriate social skills intervention for African-American women in San Francisco.

From existing literature on the subject matter most works point to the inter-linkages between poverty gender inequality and the material conditions for high risk behaviour. These studies show that gender inequality limits the ability of women to protect themselves against HIV in Sub-Saharan Africa and how this impacts negatively on prevention programmes. Some studies also demonstrated the links between bad governance and the Africa AIDS crises. These scholars argue that the inability of systems of governance to response to the plight of women is directly responsible disproportionate spread of the desire between sexes. They argue that though gender inequality is essentially a societal problem, nevertheless, issues of gender and HIV can best be tackled at the policy level of intervention, like community level intervention. The policy level focuses on changing social structures, social norms and cultural practices that surround individual risk behaviours in addition to changing policy. Policy level interventions are enabling approaches that attempt to remove structural barriers at a larger level. Many believe that AIDS interventions are moving from solely investigating individual approaches to multidimensional model of community investigations. However, the weakness of this position quickly arises when it comes to assessing effectiveness of these programmes. Some challenging issues such as measuring community level of changes using community as the level of analysis also arise. Additionally, identifying elements of

the intervention to measure, thus defining new community indicators and obtaining large sample size to dictated significance, add new challenges to community level evaluation. Consequently, the design to carry out research using this approach may be more complex than that of individual behavioural change models. On the other hand, recent works by indigenous scholars have contested the universality of Western construction of gender. Gandu (2010) posits that one flaw in the attempt to universalize Western thought system has been the persistent attempt, to categories women as homogenous, bio-anatomically determined group which is always powerless and victimised. The tendency in this thought process is that it distorts the fact that gender relations are social not biological. He further stated that Gender relations are also grounded in history and cultural relativity.(Gandu, 2010) It is therefore impossible to use the cultural traits of one given society as universal tool to interpret or explain others as this theory suggests. It is from this stand point that we adopt the gender and power theory while adjusting it to include constructs from other models particularly the AIDS risk reduction model and the policy level of intervention approach. Drawing on these, we modify them to suit the population in Jos North LGA. Investigating the wider social and environmental issue surrounding women in the locality such as distribution of power, affective influences and gender specific norms, and how these affects the ability of individual to protect themselves against HIV.

CHAPTER THREE

METHODOLOGY

3.1. INTRODUCTION

This research was designed to involve respondents from various shades of players and stake holders involved in the HIV response as well as individuals from the general public in Jos North Local Government Area. Before we proceed, it is worthy to state here that the claim that there is a causal connection between HIV/AIDS and gender equality is a deceptively simple one. The reality is much more complex. First, we need to understand that gender relations (or relations between women and men) in a society are also power relations in which women are subordinate and unequal to men. This means understanding both men's relative power and women's relative powerlessness. While this may take different forms in different national contexts, it applies to all. Second, when we talk about women's vulnerability to HIV/AIDS, it is not to deny male vulnerability; it is merely to understand how and why women are relatively more at risk. Thus, the guiding principle of the study was to ensure that there was a fair representation of all adults from all walks of life residing in the L.G.A. Data were collected from stake holders at the state and local government levels-particularly, from the twelve wards in Jos North L.G.A. Public opinion from the general public and that of people living with HIV/AIDS were collected in clusters within the LGA, and some organizations within Jos North. Others are the State AIDS Control Agency (PLACA), Local AIDS Control Agency (LACA) and selected ministries. The methodology for data collection is detailed in the sub-sections below.

3. 2 THE METHOD OF DATA COLLECTION

The research methodology adopts the use of both primary and secondary sources that is it employed field research as well as using library and archival materials.

Primary Sources: The primary sources involved the use of questionnaires and interviews in the twelve wards within Jos North Local Government Area of Plateau State. The purpose was to generate data and information from principal actors such as sexually active individuals from the general public, HIV/AIDS programme managers, people living with HIV/AIDS and other selected participants across all the three categories of respondents. The interview format employed was semi structured, to allow for flexibility in answering questions. To that effect, the interview and questionnaire instruments undertaken were along this format.

(a) The community level survey was carried out in thirty clusters within the LGA, where a sample of 900 respondents were randomly selected from the general public, to probe among other things their level of awareness, methods of HIV/AIDS prevention, risk perception and factors limiting their ability to use available HIV prevention methods. Similarly, it examined the gender gap in knowledge, prevention, risk perception and the gender gap with regards to factors that impede individual's ability to protect themselves successfully against HIV.

(b) Official level survey was used for HIV/AIDS programme managers, health workers and care givers to people living with HIV/AIDS in Jos North LGA. This was to ascertain the policy direction on ground, if people are utilizing available preventing methods, the effectiveness of programmes they have on ground, and if these issues need improvement.

(c)Questionnaires were administered to our third category of respondents- people living with HIV/AIDS to probe for loopholes in prevention programme since conventional wisdom has it that victim tell their stories better when they become actors. This will hopefully reveal some of the silent issues limiting the use of available prevention methods by women.

(d) In-depth interviews with key informants were conduced to compliment a-c above.

3.3 THE SURVEY SAMPLING PLAN.

The strength of surveys as a research tool lies in its ability to provide information about large categories of individuals. This has become established over the years as it is possible to sample people in such a way as to describe it accurately with a survey. For the purpose of this study, we relied on the probability sampling method in which each unit in the population has a known probability for selection. This probability needs not be equal for all the units in the population. The sample of the study is said to be representative of the population from which it has been selected where the generalization of the findings is made with reference to the population (Araoye, 2004:123).

The study-plan adopted the multistage sampling that is commonly associated with large scale surveys. It implies using selections based on stages, until the final units are arrived at. It also entails using a random sampling of the first stages, until the final stages are arrived at. Before moving ahead with the investigation, it is logical to show the geographical location of the country under investigation, that of the State, the Local Government Area, and socio-Economic profile.

Nigeria demographic and socio-Economic profile

Nigeria lies between latitudes $4^0$16' and $13^0$53' to the north of the equator and longitudes $2^0$40' and $14^0$41' to the east of the Greenwich Meridian. The country is located in the West African sub-region and is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and the republic of Benin in the west. To the south, Nigeria is bordered by approximately 800 kilometers of the Atlantic Ocean. The country is made up of 36 states and a Federal Capital Territory (FCT). The states are grouped into six geo-political zones: North-Central, North-East, North-West, South-East, South-South, and south-west. Nigeria has about 374 identifiable ethnic groups, with the Hausa, Igbo and Yoruba as the dominant tribes (NACA, 2012).

The total population of Nigeria as reported by the 2006 census was 140,003,542; males are more in number than females with a population of 71,709,859 and 68,293,683 respectively. This population size ranks Nigeria as the most populous country in Africa and one of the ten most populous nations worldwide. Nigeria has a young population structure, with almost half of the population being under the age 15 years. Young people, 15-24 years, constitute more than a quarter of the population. Based on the result of the 2006 National population and housing census, the National Population Commission specified the growth rate of the country as 3.18 per annum. At this rapid growth rate, Nigeria is expected to double her population in about 22 years. The most populous states in the country are Kano (10,863,275). The Lagos (9,013,534), while the least populous are Bayelsa (1,703,358) and Nassarawa (1,863,275). The growth rate for the states varies from 2.7% for Abia, Edo, and Taraba to 3.5 in Yobe state and 9.3 per annum in the Federal Capital Territory (Official Gazette, 2009).

With a land area of 923, 768 square kilometres Nigeria is the fourth largest country in Africa and the population density is approximately 152 persons per square kilometre currently. Wide variability is, however, encountered in terms of the spatial distribution of the population: Anambra, Akwa Ibom, Imo and Lagos are the most densely populated states while many of the states in the north have low population density. The population of Nigeria is predominantly rural, although rapid urban-rural migration is being continuously witnessed; at least three-fifth of the population is currently estimated to be rural dwellers. The most urbanized areas in the country are Anambra, Lagos, and Oyo while most of the states that are least urbanized are located in the northern part of the country.

The life expectancy rate in Nigeria, according to the 2009 World Population Data Sheet, is presently estimated at 47 years for males and 48 years for females.

Nigeria's total fertility rate, as reported by the 2008 Nigeria demographic and health survey, is 5.7 children per woman while the crude birth rate is 40.6 per 1,000 populations. Rural-urban variation exists in the fertility pattern with the total fertility rate being 6.3 for rural area and 4.7 for urban area. The infant mortality rate for the 2004-2008 periods, according to the 2008 NDHs, is 75 deaths per 1,000 live births while the under-five mortality rate is 157 deaths per 1,000 live births (NACA, 2010).

Most Nigerians are poor despite the status of the country as a crude oil producing country with high income. The gross domestic capital is US$1,166 and the annual GDP growth rate is 5.9 percent. According to the poverty profile published by the National Bureau of Statistics in 2004, 51.6 percent of Nigerians are living below the poverty line of US$ 1 purchasing power parity, while the poverty incidence is 53.8 percent based on the national poverty standard. The poverty incidence varies significantly in the country with the rural areas and northern part of the country disproportionately affected. There is marked economic inequality in Nigeria, with a national Gini co-efficient of 0.4884 in 2004. The gini coefficients for urban and urban areas were 0.5541 and 0.5187 respectively. These high figures of Gini coefficients at all levels are manifestation of poverty and inequality of distribution of income.

Plateau State of Nigeria covering an area of 26,890sq.kms is located in the middle belt zone. It lies between latitudes 8^0, 22 and 10^0 20'' North and longitudes 8^0, 32''and 10^0 38'' East. The state in bordered in the North West by Kaduna State, in the North East by Bauchi State, in the South West and West by Nasarawa State, while in the South East it is bordered by Taraba State (Placa, 2004).

Plateau enjoys a relatively temperate climate, with average temperatures of between 18.70c and21.70c with annual average rainfall of 131.750cm in the southern parts to 146cm on the plateau (Placa, 2004).

The state's topography is characterized with picturesque landscape and undulating high lands, thus providing a hydrographical head for many rivers, some of which are very fast flowing and have developed waterfalls such as ASSOP. Kurra Falls, in particular, is being used in generating electricity by NESCO (a private firm).

Plateau state, rightly described as a miniature Nigeria, harbours over 50 indigenous language groups as well as a sizeable number of all the other ethnic groups of Nigerians and foreign nationalities staying mainly in the urban area. The 2006 population census shows that the state has at that time 326531millon people (Official Gazette, 2009). A large proportion of the population is engaged in farming and mining activities. Due to its many natural endowments associated with favourable and conducive socio political policies of government, Plateau State offers limitless investment opportunities. Transportation and communication networks of the state offer an added impetus for attracting tourists and migrant farmers to the state. It is worthy to mention the state's many solid mineral resource endowments, especially tin, ore and bauxite, which for years have served the country's export mineral demands before petroleum was discovered.

Jos North Local Government Council, as it is currently constituted, was carved out of old Jos Local Government Council during the 1991 local government creation, with Jos town as the council headquarters. It is made up of one district, Gwong which includes the Jos town area and has a population of 437217 persons based on the 2006 census (Official Gazette, 2009). The metropolitan nature of the council area provides it an added advantage as there are infrastructural facilities like good roads, pipe born water, electricity supply etc. The local government council is no doubt the melting pot of the state due to various economic, social and natural factors. Many people of varying cultures and social status come in and out of the state on daily basis. The

interaction occurring due to the above, has increased enormously the prevalence rate of HIV/AIDS.

As mentioned earlier, the study-plan adopted the multistage sampling. It implies using selections based on stages, until the final units are arrived at. It also entails using a random sampling of the first stages, until the final stages are arrived at. The latter in this instance is either drawn from villages or wards. A list of smaller sampling units was generated from the first stage units till the final. In other words, the first stage units were undertaken in the L.G.A. It was further divided into twelve administrative wards which enabled us to use the random sampling of the second stage for villages, clusters, main roads and houses to get the household heads. The clusters that were selected, their locality names and the status of these settlements are shown bellow in table 3.1.

SELECTED CLUSTERS, AND THEIR CLUSTERS IDENTIFIED	**LOCALITY NAMES**	**LOCALITY STATUS**
PHC, Angwan Rogo	Angwa Rogo	Urban
NEPA District Office	Gangere	Urban
kabong market	Kabong	Urban
Rockland,SEC SCH	Laranto	Urban
Leatherworks village	Naraguta B	Rural
Filling Ball	Nasarawa	Urban
PHC, Rafin Pa'a	Rafin Pa'a	Rural
Low Cost Housing	Rantiya	Rural
PHC, Tudun Wada	Tudun Wada	Urban
LEA,Pry Sch,Tajir	Tajir	Rural
police Station, Jos-Jarawa	Jos-Jarawa	Urban
ECWA,Ang.Rukuba	Angwa Rukuba	Urban
PHC,Jenta Adamu	Jenta Adamu	Urban
COCIN,Jenta Mangoro	Jenta Mangoro	Urban
COCIN,Gamajigo	Gamajigo	Urban
LEA,Pry Sch,Mazah	Mazah	Rural
Police outpost,Babale	Babale	Rural
Baptist church,T.Rigiza	Targwam Rigiza	Rural
PHC, Lamingo	Lamingo	Urban

LEA,Pry sch,Gwash	Gwash	Rural
COCIN,Dung	Dung	Rural
Rockland, SEC SCH,Utan	Utan	Urban
COCIN, Katong,Rikos	Katong Rikos	Urban
GSS,Gwam Nabor	Gwam Nabor	Urban
Gidan Sarkin,H. Zangam	Harol Zagam	Urban
LEA, Sabon Liyi	Sabon Liyi	Urban
Unijos student vill. Rissau	Student Village	Urban
PHC, Yelwa	Yelwa	Rural
PHC,Kongo Russia	Kongo Russia	Urban
PHC,Apata	Apata	Urban

We are studying the impact of gender inequality on HIV prevention strategies since 1990; the work therefore covers a period of 10 years. It sets out to study how gender issues have impacted on government policies and programmes aimed at stopping or mitigating the spread of the contingent. The study investigates further, factors responsible for the persistent gender gap in HIV prevalence in spite of the adoption and implementation of gender sensitive programmes. However, in order to adequately measure the impact of gender inequality on these strategies, it is imperative to first analyse the main variables in this study. These include:

3.2.1 Gender Inequality

Gender inequality is viewed in this study as an unfair difference between the sexes in society, which limits a particular sex (women's) capacity to make effective choices on issues affecting their lives. Inequality between women and men manifest itself among other things, in unequal employment opportunity, unequal access to wealth, unfair division of labour in the household and generally unequal power relations. Here, we are concerned basically with those factors that impede women's ability to protect themselves successfully against HIV in the LGC.

The indicators and measurement indices include among others:

1. Those factors that limit an individual's ability to delay sexual activities measured as the ratio of male to female respondents (ages 15 and above), who are forced into early sexual activities due to economic, social, cultural factors or sexual violence.
2. Those factors that keep individuals in unsafe sexual relationships for economic or cultural reasons, pregnancy intentions, religious or other social factors.
3. Those reasons that were given by individuals, which limit their ability to reduce non-spousal and non-cohabiting sexual partners, measured as the percentage of male to female respondents, who said that they cannot reduce their non-spousal and non-cohabiting sexual partners due to existing social norms which encourage men to have multiple concurrent partners.
4. Factors that limit individuals self confidence and skills to negotiate their rights to safer sex, measured as the percentage of male to female respondents, who cannot initiate condom use due to either cultural or religious reasons.
5. Those factors that prevent individuals to have access to reproductive health services: measured as the percentage of respondents who said they do not have access to health facilities.
6. Those factors that prevent individuals from having adequate information on sexually risky behaviours, the risk it poses to them and the use of predominant prevention methods, measured as the percentage of respondents who are not knowledgeable about AIDS or its prevention methods as a result of their sex
7. Those factors that govern gender relations in the LGA, Measured as the percentage of individuals selecting those factors that can keep them in an unsafe relationship (see Appendix A).

3.2.2 Effectiveness of AIDs prevention methods:

Effectiveness is viewed in this study as all positive out-come of HIV/AIDS interventions to stop or mitigate the spread of HIV. The success of such programmes is partly attributable to the ability of millions of people to protect themselves successfully from HIV infection. The indicators of effectiveness in this regard include among others:

1. The number of individuals who can avoid risky relationships: measured as the percentage of female/male who is not hindered by cultural religious social economic or political factors to avoid risky relationships.
1. The number of individuals using condom, measured as the percentage of male/female respondents who are not hindered by social, cultural, religious or economic factors, but can use condoms.
2. The difference between girls and boys who can protect themselves against HIV, measured as the ratio of boys to girls who are knowledgeable enough about AIDS and can protect themselves against the disease.
3. The level of awareness among females and how they can protect themselves against AIDS.
4. The ratio of women to men who can initiate condom use.
5. The percentage of respondents saying they can avoid pre-marital sex, measured as the percentage of male to female respondents who are not hindered by social, cultural or economic factors, but can keep away from pre-marital and extra marital sex.
6. The number of females who have self confidence and skills to negotiate their rights to safer sex (for more details, see appendix A).

3.4 SAMPLE TECHNIQUES AND SAMPLE SIZE

This study generated data from social survey and existing records. Phase one of the survey took place in 30 clusters within the Local Government Area, while stages two and three were carried out in selected ministries, government agencies and some non-governmental organizations. In the clusters, respondents were sampled purposefully from all adults (15 years and above) residing in the locality. On this note, 900 respondents were selected using the procedure outlined above. These individuals are believed to be either sexually active, have been active or are knowledgeable about sexual and reproductive health issues. These respondents were asked of their level of awareness about AIDS, prevention methods and how they can or are able to protect themselves against the HIV virus. Furthermore, they were asked to identify factors that limit their ability to use available prevention methods. These respondents were wives, husbands, boys, girls, widows and widowers as well as divorcees. The entire survey was divided into three groups: the first survey was carried out in clusters as stated above.

Phase two: At this stage, questionnaires were administered to people living with HIV/AIDS. Our selection criteria were based on age, adult PLWHAS within the ages of 15 and above. We referred to these as our targeted respondents although there were younger PLHWAS, these were in position to tell us about the challenges they faced protecting themselves against HIV and if these challenges were gender related. They were also able to give us first hand information on the issues of stigmatization. Thus 200 PLWHAS were systematically selected and questionnaires administered to them.

Phase three: Selection And administration of questionnaires to HIV/AIDS programme managers and policy makers. One hundred respondents were selected from ministry of health, Plateau State AIDS Control Agency, Local AIDS Control Agency, 30 non-governmental organizations, 10 faith based organizations, Jos

University Teaching Hospital and the five voluntary testing and counselling centres in Jos North LGC and questionnaires administered to them. The selection criteria were based on the level of awareness of these respondents on policy issues.

Phase four: In-dept interview with key informants. To complement our findings in the quantitative studies ten key informants were selected. They were from the Federal Ministry of Health in Plateau State, the state AIDS Control Agency, State Ministry of Women Affairs, Faith Alive Foundation, State House of Assembly, VCCT centres, non-governmental organization and one respondent from the Local AIDS Control agency. This was to ensure that there was a fair representation of individuals from different walks of life involved in the fight against AIDS.

3.4 THE SURVEY AND DATA COLLECTION TECHNIQUES

The Field survey method for the dissertation was structured around the use of interview and questionnaire instrument. The questionnaire was mainly a combination of closed ended and open ended questions that were administered as a face to face strategy of investigation. This afforded the investigator the advantage of appreciating the study environment to ask questions where necessary and set the tone for the conduct of interviews with the informants.

3.4 (a) The Interview Method.

The interview was designed and conducted based on a developed checklist of issues in order to acquire responses relevant to the research questions and propositions of the study. The interview was based on the interactive face to face method. The interviews were structured and at the same time flexible which permitted dialogue. To ensure reliability and validity of our instrument and the type of response reserved, the follow-up strategy was adopted based on telephone interview to clear doubts and to further highlight issues where there were any doubts. The strategy was also adopted

where further clarifications were required on issues, which the questionnaires instruments failed to address. Overall ten (10) informants were interviewed. We targeted policy makers, caregivers, programme managers, leaders of people living with HIV/AIDS, religious leaders of community based organizations and associations.

3.4 (b) The Questionnaire Instrument.

The survey research and study design were undertaken as a multitier and multi staged approach. The questionnaires were applied as follows:

(1) The community questionnaires or the questionnaires for the general public are those that were administered to household heads within our sampled area.

(2) The official questionnaires were applied to HIV/AIDS programme managers and CEOs of NGOs.

(3) PLWHAS questions were applied to people living with HIV/AIDs in a nongovernmental organization that offers medical care and support to AIDS victims.

Initially, the questionnaire instruments were subjected to pilot testing for internal consistency. On this note, draft questionnaires were administered to 20 respondents from the general public: 1 to Faith Alive Foundation, 1 to OCEAN, a non- governmental organization in Jos North and 1 to the Plateau state AIDS Control Agency. Comments and observations were carefully examined and corrections made on the questionnaires. What was observed in most instances was the issue of language. However, those questionnaires that were to be administered to PLWHAS were critically scrutinized by the management of Faith Alive Foundation, making sure that the questions were moderate. In the first phase, nine hundred (900) copies of the community survey questionnaires were distributed and issued out by a

research assistant in the 30 clusters identified within the L.G.A. Out of these nine hundred copies, eight hundred and eighty seven copies were returned.

In the second phase, another set of two hundred (200) copies of questionnaires were distributed to PLWHAS in Faith Alive foundation. To ensure reliability and validity of the research, a copy was featured to the authorities to scrutinize before the actual administration of questionnaires to the respondents. A total of one hundred and eighty seven (187) copies were returned. In the third stage, questionnaires were distributed to AIDS policy makers and programme managers and PLACA and LACA officers in the state capital, which happens to be in Jos North L.G.A. One hundred (100) copies were distributed to this category of respondents. However, only Sixty-Three (63) copies were returned after exhausting the number of NGOs and Agency Ministry of Health in our list. The final stage of the survey was the in-depth information interview where we interviewed ten (10) key informants drawn from the three categories above. Research assistants were trained and employed to administer questionnaires in the clusters.

Table 3.5 below shows the dates of visits to the clusters, agency and some non-governmental organizations in the LGC.

S/No	Cluster/Organization	Date visited
1	All the cluster in the LGA	22nd or august 15th October 2010
2	Faith Alive foundation where questionnaires were administered to PLWHAS	15th January to 15th February 2011
3	HIVAIDs policy makers	12th November 15th of December2010
4	In-dept interview with key informant	5th November to - 14th February 2011

3.5 THE TECHNIQUES AND TOOLS OF DATA ANALYSIS AND INTERPRETATION.

The tool employed in the study in analyzing the data is a computer-aided analysis software and programme operating in the windows environment, that is, the current version of Statistical Package for Social Science for windows (SPSS.13 for windows, 2006). The software is used for general reporting and statistical analysis for categories. In other words, as a data analyzing software and programme, it is employed to generate and analyze descriptive statistics, frequencies, exploratory statistics, cross tabulations and ratios. Many of the procedures in SPSS environment produce results in the form of tables from data generated in the field of study. The portion of the SPSS offer special features designed to support a wide variety of customized reporting capacities especially in the form of a wide variety of customized tables. Descriptive statistics is one major tool of the SPSS to analyze data from the data editors and viewer of the SPSS environment. Descriptive statistics is attained through creating tables from the data editor and such tables are used to display and portray frequency tables, descriptive tables, cross-tabulations and ratios.

The frequency tables in SPSS are used to show percentages, central tendencies, (Medium and weighted mean), dispersions, (st. deviation, range, minimum and maximum) and distribution charts. Descriptive statistical table also shows mean, STD deviation, variations, minimum, maximum, range, S.E. mean, kurtosis, and skewers. Explore tables are also descriptive table, while ratio tables can also reveal central tendency, dispersion, and concentration index. Cross tabulations aid the display of asymptotic values, chi-square, and correlations nominal, external and internal scale. Most of the customized features of SPSS are particularly useful for survey analysis and marketing research. The frequency table so generated are more often than not used to summarise data generated and to show the number and percentages of people, characteristics, features, views, and other variables in each category. The data so captured in SPSS environment can also be used to create tables from which general reports are generated with graphs and charts. Some of the statistical producers can create high resolution charts that can be used to create graphs from the menu and many other types of charts like bar and pie chart (SPSS.14.2006).

This study relied heavily on the SPSS environment to present the data captured in the field survey. The data generated and captured from the field environment was transferred into frequency tables and cross tabulation. They are presented here and the succeeding chapters of this study as the result. The frequency procedure employed in this study generates frequency tables that display both the numbers and percentages of cases and values of variables. Frequency tables were used here to display graphic information in percentages of the numbers of cases and values in the variable. The frequency tables show the number and percentages of people in each category.

This study also adopts cross tabulations to examine and present the relationship between the various categories of respondents. The purpose of cross tabulations is to examine and present the relationship between two variables. Cross-tabulation tables also often referred to as contingency tables display the relationship between two or more categories of variables. The size of the tables is determined by the number of distinct values for each variable, with cell in the table representing a unique combination of values.

3.6 SECONDARY SOURCES OF DATA COLLECTION.

This section of the study entails a detailed collection of documented data on gender and HIV/AIDS in Nigeria and other Sub-Saharan countries. We relied heavily on existing records and studies carried out in the entire Sub-Region because of the similarities in trends of the epidemic in the region. Although existing policies and strategies for prevention might be similar, the factors responsible for the disproportionate spread of the disease differ slightly. Therefore, literature on differences in power relations between the sexes (largely grounded in cultural, social and economic inequalities) was reviewed in order to provide an objective explanation of the phenomenon under investigation. The information/data were obtained from existing records on:

-The epidemiological trends of the disease in books and records, and studies carried out by individuals, government, non-governmental organizations and international organizations.

-Policies and strategies that have been adopted by government to reduce the spread of the disease.

-Studies that have been conducted to understand why previous policies and strategies failed to address issues relating to the disproportionate spread of the disease between the sexes.

-The review and analysis of reports of national surveys and studies, programme

3.7 PROBLEMS/DIFFICULTIES OF THIS RESEARCH:

We faced three major problems in the course of carrying out the field work in this study. These are the attitudinal, bureaucratic and security problems of our respondents and research assistants. The attitudinal problems of our respondents had two dimensions, namely suspicion of research workers and expectation of some money from the field workers.

3.7.1 Suspicion of research workers

Majority of our respondents within the identified clusters were very suspicious of us (my research assistants and I), when we met them to administer questionnaires and to conduct interviews. The suspicions were higher in clusters that were affected by the recent Jos crisis. The respondents were particularly hostile to researchers who belonged to religions different from that of residents of such clusters. It was therefore difficult for this researcher to adequately supervise field assistants in some areas within the Local Government Council. Furthermore, some respondents refused to discuss issues of HIV/AIDS. Some illiterate women in particular claimed that we wanted to know their HIV status so as to discuss the issue with their spouses. It was difficult to get people who were illiterates to discuss freely on the issue of use of condom. Therefore, a great deal of time was spent trying to explain the purpose of the study to them. This affected our time frame and increased our financial expenses.

3.7.2 Bureaucratic Problems

Getting people living with HIV/AIDS to fill our questionnaire was quite tasking and time-consuming. First, some directors in the organization asked for a cover letter which was followed by the request for a sample proposal. After that, we were asked to produce a draft of the questionnaire. These were carefully vetted before I was allowed to administer questionnaires to our targeted population. This,

unfortunately, delayed the progress of the research and increased our financial expenses.

3.7.3 The security of the research assistants and this researcher:

As a result of the previous and recent Jos crises that was followed by the Christian/Muslim divide, this researcher could not directly supervise assistants in three wards within the LGA that were Muslim dominated. Thus, we had to go an extra mile to get an officer in the national population commission office in Plateau State to supervise the field assistants.

CHAPTER FOUR
GENDER RELATIONS IN PRE-NDUSTRIAL/INDUSTRIAL SOCIETIES.

4.1. INTRODUCTION

It should be noted that research into AIDS is overwhelming Western. The voice of African researchers who denounce the ethnocentrism of Western specialist discourse, battles to make it heard. It is from this stand point that the importance of inaugurating a history of AIDS is measured. In effect, AIDS lies within the scope of a social, political and cultural history, which precludes and includes it. In this context, we denounce a "decontextualised" reading of AIDS which limits itself to a description of the sexual practice of the potential carriers of the virus to the identification of other sources which favour the spread of the infection. The social contexts within which prevention and treatment policies are made are not static. They bear weight on history. AIDS developed in a territory which for generations has been marked by gender questions, political relations, class conflicts and racial tensions, which determine or, at the very least, explain the particular paths which the epidemic follows.

This chapter starts with some conceptual clarifications of the term gender and examines the evolution of gender, and gender relations in Africa, Nigeria and Plateau State. It seeks to determine if gender relations were egalitarian, and if yes, what factors are responsible for the present state of affairs. It begins by investigating gender relations in some preindustrial societies, particularly looking at gender division of labour and how these activities enhance individual's capacity to participate in decision making in these societies. The chapter further examines these issues in pre-colonial, colonial and post-colonial eras in Africa and Plateau State in Nigeria in order to determine those factors that govern gender relations in the area under survey.

4. 2. GENDER RELATIONS IN SOME PREINDUSTAL SOSIETIES

The term “sex” and “gender” are used interchangeably in everyday life, but in social sciences, they are frequently differentiated. The term sex is applied to differences between men and women that are based on biological differences such as anatomy, physiology, hormones and chromosomes, and in this respect, people are female or male. The term gender is applied to the cultural aspect of male or female roles, in other words the behaviour, personality and other social attributes that are expected of males and females, and these social attributes become the basis of masculine and feminine roles (Buswell, 1989:5).

According to Tong (1989) Pearson have argued that the distinctions between masculine and feminine traits are biological/natural rather than cultural/artificial. He stated that without rigid gender dimorphism, society would not function properly. Convinced that gender identifies and behaviours are not “an arbitrary imposition or an infinitely plastic base between the sexes”, Pearson confidently asserted that women’s sub-ordination to men is natural (Tong, 1989:97).

Gender could also be seen as the roles and behaviour which are designated to one gender or the other as well as one of the ways which the distribution power between the genders is expressed. Gender identities are largely culturally created and are subjected to shifts, changes and manipulations. They are ideal models for the genders, which actual individual may not live up to. Masculinity and femininity, whilst they change, remain in oppositional relation to each other; to be feminine is to be that which is not masculine. In addition to being oppositional, masculinity and femininity are intimately tied up with the subordination of women by men.

Those qualities which in a given situation are power enhancing are those which tend to be defined as masculine and associated with men. It is important to recognize that there may be multiple and competing notions of masculinity and

femininity at any given time and in any context. In conflict situations, gender identities become intensely politicized and the process of militarization can be traced in the reforming and restating of gender identities, through legal reforms and changes in employment patterns, propaganda and cultural discourse, education and the socialization of children. (Hooper, 1995:4; Zalewsk, 1995:341). The correct gender role in our society also suggests channelling sexuality into heterosexual behaviour and people who do not conform to this are sometimes labelled as deviants, because they infringe upon common expectations of these roles. Sexuality and the different capacities of men and women in the reproductive processes are particularly likely to be that of a given rational reason for gender division which underpins and explains the supremacy of men over women. It is the prized believed of enormous numbers of men and a useful excuse for resisting equality (Connell 1985:226).

Millet (1970), argues that sex is primarily political because the male-female relationship is the paradigm for all power relationships. Social caste supersedes all other forms of unegalitarianism, racial, political or economics, and unless the clinging to male supremacy as a birthright is finally forgone, all systems of oppression will continue to function simply by virtue of their logical and emotional mandate in the primary human situation. Because male control of the public and private world is what constitutes patriarchy, male control must be eliminated if women are to be liberated. This is no easy task. To eliminate male control, men and women have to eliminate gender specifically, sexual statuses, roles and temperaments-as they have been contacted under patriarchy.

Patriarchal ideology accordingly to Millet, exaggerates biological differences between men and women making certain that men always have the dominant or masculine roles and women have the subordinate or feminine ones. This ideology is particularly powerful because through conditioning, men usually secure the apparent

consent of the very women they oppress. They do this through institutions such as the academy, the church and the family; each justifies and reinforces women subordination to men with the result that most women internalize a sense of inferiority to men. Should a woman refuse to accept patriarchal ideology, and should she manifest her mistrust by casting off her femininity that is her submissiveness/subordination, men will use coercion to accomplish what conditioning has failed to achieve. Intimidation, observed Millett, is everywhere in patriarchy. The wise woman realizes that if she refuses to be submissive, she may be subjected to a variety of cruelties and barbarity (Millett 1970). For the purpose of this study, gender is conceptualized as the dichotomy between men and women, which are largely culturally created, and are subject to shifts, changes and manipulations.

Since Mead's work was published more research has been done on cross-cultural variations in gender. Rather than lending support to the notion of the universality of Western constructions of gender or gender inequality, these studies reveal a rich assortment of patterns of gender relations throughout the world. Every known society has a division of labour by sex (and by age) however, what is considered men's work or what is considered women's work varies dramatically from society to society. In some cultures, for instance, women build the houses; in others, this is men's work. In most societies, women usually do the cooking, but there are societies in which this is typically men's responsibility. For example among the Agta of the Philippines, women hunt deer and wild pigs with knives and bows and arrows (Estioko-griffin 1986). In most cases, though, women's hunting activities do not involve the use of spears, bows and arrows, or heavy clubs (Harris 1993). It has also been argued by some researchers that in virtually all societies men hold a monopoly on the use of physical violence (e.g. Harris,1993; Konner,1979). There is also considerable evidence that women may behave as aggressively as men, especially

when verbal abusiveness is employed as a measure of aggression (Bjoleqvist, 1994; Lepowskey, 1994). Of particular interest to this study are gender relations in contemporary foraging societies. Anthropologists maintain that these societies are probably most like the communities of our earliest human ancestors (O'kelly and Carney 1986). This is not to say that the present day foraging society is an exact replica of prehistoric social organization; these societies, like all others, have experienced numerous environmental and social changes throughout their histories, not the least of which came through contact with European and American colonizers during the past 600 years (Leacock, 1993; Bleier, 1984; Etienne and Leacock, 1980) but as the smallest (25 to 200 member) and least technologically developed of all human societies. Contemporary foraging peoples may offer us further clues as to how our early ancestors lived, while teaching us valuable insight about the diversity of social construction of gender.

Gender relations in contemporary foraging societies

The foraging society is referred to as the hunting-gathering society because its members meet their survival needs by hunting game and fish and by gathering vegetables and other types of food in their environment. Just who performs each task however, varies somewhat from society to society. The pattern most frequently observed is one in which men hunt large animals and go deep sea fishing if possible, while women take primary responsibilities for gathering and for hunting small animals as well as for food preparation, home building and child care (O'kelly and Carney 1986). In most societies, though, in spite of a clear of division labour by sex in principle, in practice, there is actually considerable overlap in what men and women do and are "cross over in role" as Gilmore (1990) refers to them without shame or anxiety for women or men.

O'Kelly and Carney (1986-12-21) have identified six different patterns of the gendered division of labour among hunting and gathering societies.

- Men hunt, women process the catch;
- Men hunt, women gather;
- Men hunt, men and women gather;
- Men hunt and fish, women hunt and gather;
- Men and women independently hunt, fish and gather;
- Men and women communally hunt and gather.

In the first type, which is common among Eskimo groups, meat and fish are dietary staples, and men are the chief food providers. This puts women at a disadvantage relative to men they are dependent on men for food as well as for goods obtained through trade with non-Eskimo. Consequently, men in these societies have more power and prestige than women, but this does not mean that women are powerless or that women's work is considered unimportant. Women may secure power and prestige as shamans, and elderly women may act as political and military advisors. Women are responsible for making the clothing and much of the equipment men need to hunt and fish (o'Kelly and Carney 1986). As a result, the skills women have are indispensable to survival as are those of men, and they are so perceived by men. The question of which is better (or more important) a good hunter or a good seamstress is meaningless in Eskimos. Both are indispensable (cited in Sacks 1979).

Despite the complementary roles of gendered behaviours in hunting gathering societies of these types, they are the least egalitarian of all hunter-gatherers; women who live in societies characterized by one of the five other previously listed patterns take a more direct and active role in food acquisition, which in turn affords them more equal access to their societies resources and rewards. Among the Kung bush-living

people of the Kalahari Desert for example, women provide from 60 to 80 percent of the society's food through their gathering activities. The Kung division of labour conforms to the second type on our list; but the game hunted by men is a much less dependable food source than the plant and small animal food obtained by women. Kung women are respected for their specialized knowledge of the bush; "successful gathering over the years requires the ability to discriminate among hundreds of edible and inedible species of plants at various stages in their cycles" (Drapper 1975:83). In addition, women return from their gathering expeditions armed not only with food for the community, but also with valuable information for hunters.

The Kung has a clear division of labour by sex, but it is not rigidly adhered to and men and women sometimes do one another's chores. This is especially true of men, who frequently do "women's work" without any shame or embarrassment. Child care is viewed as the responsibility of both parents and "as children grow up there are few experiences which set one sex apart from the other" (Draper,1975:89); in fact, Kung childrearing practices are very relaxed and non authoritarian, reflecting Kung social relations in general. Among the Kung, aggressive behaviour on the part of men or women is discouraged and the Kung rarely engages in organized conflict (Harris, 1993; Shostak, 1981; Draper, 19750). Harris (1993) notes that Kung boys are not taught to kill other people. Egalitarian gender relations like those of Kung are also characteristic of other types of hunting-gathering societies on our list. In these societies, one sex is not intrinsically valued over the other. Rather, an individual wins respect and influence with the community based on his or her contribution to the general well being of the group (Bleier, 1984).

In the Mbuti society, work is a collective enterprise, and few tasks are assigned exclusively. The Agta of the Philippines also have this type of division of labour as noted previously, Agta women and men hunts, using knives or bows and

arrows. They fish with spears while swimming under water, an activity that requires considerable skill and physical stamina. Although hunting and fishing supply most of the Agta's food, members of both sexes gather vegetable as well (Estioko–Griffin, 1986). As O'Kelly and Caney (1986:13) observe, "this cooperative interdependence is associated with highly egalitarian gender roles".

It should be noted that egalitarian gender relations are not limited to hunting and gathering societies, though they are more common in these types of societies than in orders. Leposwky (1990) reports on a horticultural society, the people of Vanatina a small island southeast of main land (Papua New Guinea) where the divisions of labour and other social relations are highly egalitarian. Both Vanatinai women and men plant, tend and harvest garden crops. Although hunting with spears is a male monopoly, women also hunt game by trapping. Women have primary responsibility for caring for children; members of both sexes learn and practice magic, participate in warfare, peacekeeping, and community decision making and undertake sailing expedition in search of ceremonial valuables. In short, Vanatinai society offers every group the opportunity of excelling in prestigious activities such as participation in traditional exchange or ritual functions essential to health and prosperity" (Lepowsky, 1990:178; see also Suilive 1993).

Several important points can be drawn from these cross cultural data. First, it should be clear to us that contemporary western constructions of gender are not universal. The research indicates that there is a wide range of gender relations across cultures and that in some societies gender relations are highly egalitarian. Furthermore, if contemporary societies do resemble the communities in which our earliest ancestors lived, they do not lend support to the reconstruction offered by man the hunter theory. Instead, they reinforce archaeological and primatological data that indicate that at least, some of our early ancestors may have lived in groups

characterized by cooperation and reciprocity and in which adults of both sexes actively contributed to group survival.

A second significant point that can be gained from these anthropological studies is that a gendered division of labour does not necessarily produce gender inequality. The key intervening variable appears to be value that the members of a society attach to a particular role or task. In our own society, the work women do is typically viewed as less important than the work men do. But in the societies discussed here, women are seen as "essential partners" in the economy and in decision-making even though women and men may be responsible for different tasks or have spheres of influence (Miller 1993; Gailey 1987; O'Kelly and Caney 1956). As Sacks (1979:92-93) observes, "many non-class societies have no problem in seeing differentiation without having to translate it into differential worth".

A third and final point concerns women's capacity to bear children. Some scholars maintain that women's reproductive role prevents them from fully participating in other activities such as food acquisition. However, the anthropological studies reviewed in this section suggest that women are not automatically excluded from certain activities because they can bear children nor are men automatically excluded from childrearing simply because they cannot bear children.

In pre industrial societies, like those we have discussed so far, childbearing and child rearing do not isolate mothers as they frequently do in societies like our own. "The tasks are absorbed by a broader range of people, and children are more incorporated into public activities…moreover, motherhood (either through childbirth, adoption, or fosterage) often conveys an increase in status, giving women a greater say in matters than when they were not fully adult" Gailey, (1987:456-46). It appears then, that non biological factors among them environmental, resources, size of the group, the economy, and of course, ideology-play a more significant part in

determining what the members of a society define as appropriate "men's work and women's works" than do biological factors. Contrary to Sigmund Freud's assertion, anatomy is not destiny. This point is made even clearer when we consider examples of multiple genders.

In contrast to Hobbessian analogy of man in the state of nature, we have discussed feminist's perspectives of the evolution of gender. Feminist social scientists have sought new evidence. These studies reveal that women, rather than being passive and dependent, are, instead, likely to have been active food providers as well as inventors and crafters of new materials technology. A presumption of gender inequality appears to be unfounded and misleading.

One question that remains unanswered is how did we get here from there? That is, if gender relation in some African societies were (and still are) highly egalitarian, what factors gave rise to the pervasive gender inequality characteristic of societies like our own? Any answer remains speculative, but scientists who have addressed this question have identified a number of related factors, including population growth, increased environment danger owing to ecological changes or warfare, the establishment of trade or exchange relation between societies, a change from a nomadic to a sedentary lifestyle and particularly colonialism. These therefore suggest that any analysis of the AIDS crisis in Africa must be placed in the context of the continent's past experience. The issue of the Aids crisis in sub-Saharan Africa and its disproportionate impact on women and girls require an approach that gives primacy to the issues of gender.

4.3. GENDER RELATIONS IN COLONIAL AND POST-COLONIAL AFRICA AND NIGERIA IN PARTICULAR.

Gender relations in Africa, and women's participation in decision-making in particular, vary from one community to another and it is not clear how much of this variation is associated with differences in the traditional political systems that prevail on the continent. Part of the variation seems to be related to whether or not women are engaged in the production of valued goods that would empower them economically and whether the community has a matrilineal or patrilineal social organization. In general, women who control wealth or who are engaged in the production of high-value products have greater access to decision-making power relative to women who do not have economic independence. In most cases, the position of women in matrilineal societies also seems to be better than those in patrilineal societies, although in some matrilineal societies such as the Berbers, Tuareg, and the Shaho of Eritrea, women neither participate in decision-making nor have inheritance rights.

Consensual systems in Africa are largely democratic in their dispensation. However, the decision-making process is rarely inclusive of all members of the community. Women and young adults, for example, though not formally prohibited by rule, are often presumed to be represented by their husbands and fathers, respectively, and are customarily excluded from participation in the decision-making assemblies. Although, in some cases, women played various key societal roles, the patrilineal systems are particularly weak in protecting gender equality in decision-making on issues of a public nature. Among the Ibo, for example, disputes that family heads fail to resolve are referred to the umuada (married daughters)(Uwazie,1994). Likewise, in the Eritrean village baito system, land is allocated to the household which is formed by marriage. In cases of divorce, the household's allotment, along with other property, are split equally between the former spouses (Mengisteab, 2003).

By contrast, we also find cases, such as among the Sonjo in Tanzania, the Gussi of Kenya and Uganda, and the Tiv of Nigeria, where women seem to have few rights as they are subordinated to their husbands who pay significant amounts in bride-wealth to marry them (Gray, 1960). As Kritz and Gurak (1989) note, acceptance of bride-wealth seems to transfer reproductive rights to the husband and his lineage. If divorce or separation occurs, the wife is often obliged to return the bride-wealth payment or leave her children with their father.

Similarly, opportunities for women to participate in decision-making in the chieftaincy systems are limited, although there are considerable differences between communities.

Women in the Nupe and Yoruba societies are generally considered to maintain an autonomous economic role as market traders organizing trade guilds, which protect their interests and allow them to play important roles in political activities (Lebeuf, 1963; Levine, 1970). Women in some Mende communities of Sierra Leone, where the Sande secret societies operate, are also said to be politically equal to men. In these communities, women's Sande societies and men's Poro associations are said to alternate political ritual control with women rising to become chiefs (Day, 1988). Kofyar women in the Jos Plateau of Nigeria are also said to exercise independent economic and social decisions with little subordination to men. However, they may be excluded from most symbolic performances of rituals (Netting, 1969).

The Berom woman in Plateau State, Nigeria also played a complementary role with men in the household/lineage based pre-colonial economy. But the right to take decisions on the allocation and use of land was vested on the heads of families, households, clans and lineages, who were all males. However, complementary gender relationships granted pre-colonial Berom women some measures of economic and social security within the household economy, which guaranteed them some basic

needs, such as food, shelter and ornaments. In spite of this, certain traditional practices like inheritance acted as fetters, which did not grant women appreciable autonomy and equality. Berom women served as an important and necessary labour in agricultural production. Both the official and unofficial marriages such as the Njem relationship was a very important source of labour especially in the absence of indentured and wage labour the mining industry and colonial agricultural policies had negative impact on women and agricultural development on the Plateau. The British agricultural policies resulted in the total neglect of subsistence agriculture and food crop production, which was left in the hands of peasant producers, who were mainly women. Women's role in the domestic economy and subsistence agriculture was indispensable to the colonial state because it helped to subsidise capitalist exploitation through the payment of low wages to colonial civil servants and labourers in the mines who were mostly men. Women did not play a major role in the mining sector not as carriers of sand, provision of social services such as cooking, selling of firewood, entertainment, etc. Alahera (2008) argues that colonial government was gender-biased and gender-blind in the economic policies, which were designed to make capitalist exploitation possible. Berom women experienced relative autonomy and self realization from modernization that came with colonialism, but lost their relative social and family security and complementarity of labour which they enjoyed in the pre-colonial society. Thus Berom women remained dehumanized and exploited under colonialism in which they bore the double burden of exploitation by colonialism and men. Thus the overall impact of colonialism on the Berom society was the breakdown of their traditional socio-economic and family structure leaving a fractured community in which women were left to bear the socio-economic burden of maintaining and subsidizing capital exploitation within and outside the family by their increased roles in subsistent agricultural production and their partial incorporation

into the colonial civil service and tin mining industry. This resulted in the creation of gender roles that were less complementary, more competitive and more exploitative of women (Alahera, 2008).

While their impact on the patrilineal and matrilineal social organizations is unclear, education and urbanization, along with active state involvement in supplanting traditional marriages with legal marriages, have led to some improvements in women's conditions.

Cameroon, for instance, has registered a notable decline in bride-wealth payments and widow-inheritance. It has also made progress in improving the inheritance rights of children and in raising the age of marriage by promoting mass education. However, less than 50 per cent of the African population lives in urban areas and only roughly the same ratio is literate. Thus, many of the mechanisms that subject women to oppression, including abduction, arranged marriages without the consent of the bride, and marriage at an early age, are still widely practised. A 2003 report by Ehiopia's National Committee on Traditional Practices, for example, indicates that marriages by abduction in the Southern Nations and Oromia regions of Ethiopia account for about 92 per cent and 80 per cent of all marriages, respectively (BBC, May 15, 2006). As stated above, the position of women in pre-colonial Nigeria is obviously different in the vast number of ethnic groups in Nigeria. A woman's position varied according to the (1) kinship structure of the group and (2) role of women within the economic structure of the society as noted above. Common factors among women of different ethnic groups however, include the domestically oriented jobs and the range of activities reserved for women. Women in pre-colonial societies held a complementary position to men although partrillineal and patriarchal kinship structures predominates Nigeria societies (Rojas 1994). The kinship groups expected women who married into a Yoruba or Igbo or the Anagutas patrilineage to give birth

to sons to ensure the future of the group. Usmanu (1990) reports that among the Anagutas of Plateau state, a woman who gives birth to a female child undergoes a purification to cleanse her from the pollution or ill-luck associated with female child. Furthermore, the position of a young wife improves as she grows older, bears children, and earns approval from its older members, she gains assistance from younger wives as she grows older thus allowing her to spend less time in the home and more time engaging in activities outside the household activities such as farming and craft making which allows her to provide the material resources needed in order to care for her family. However, the fact remains that the societies of pre-colonial Nigeria believed men were superior to women and to some extent in control of women.

According to Dennis, writer of women and states in Nigeria, "the religions of many Nigerian societies recognized the social importance of women by emphasizing the place of female gods of fertility and social peace, but women were also associated with witchcraft which appeared to symbolize the potential social danger of women exercising power uncontrolled by men. However, the British who usurped power in Nigeria only recognized the male Obi, male monarch to whom they even offered a monthly salary while completely ignoring the female Omu, female monarch (Tamale, 2000). This way, colonialism defined women as objects of men's rule. Colonial norms of gender discrimination play out very well in its emphasis on able-bodied men as the most important qualification needed to work as guides servants, tax collectors, cleaners, and stewards for the colonizers. By reproducing and reconstituting meanings of gender and culture, colonial state policies constructed natives in ways that invested control over everybody in the colonizer and those native men who have Europeanized. The colonial outlook of women as the 'unable other' casts femininity

as subordinate and inferior. The important role of men as rulers and their natural superiority emerged as the proper order of things.

Colonial schools

Colonial schools, informed by Victoria vision of the natural position of men and women in society were typical sites for the production and regulation of sexual identities. In these schools, most of which were single-sexed, socialization followed specific directions. Boys were taught civics, law, and politics to equip them for leadership and control. Education for women was geared towards sustaining their role as housewives, home keepers, and the inferior "other". They were taught domestic skills, nutrition, home economics and management. As in imperial Europe, not only were education opportunities disproportionately provided to Nigeria males, men's education was also accorded high priority than that of women, of course, men were women's natural superiors.

Male-privileging imageries of sexuality continue to live on actively in post-colonial official discourse and imageries of national identity, family, marriage and sexual conduct in Nigeria. Particular forms of sexual identity and family life have been discursively produced as the norm, and made to function as metanarratives for national identity.

Gender Issues in Post-Colonial Plateau State Nigeria

In contemporary Nigeria, one of the most important influences on gender relations and roles is religion. Here, it is important to emphasize the fact that Nigerians make less distinction between the spiritual and the secular than many other countries of the world, including Western Europe and the United States. Thus, it is not surprising that religion plays such an important part in shaping the roles and relationship between men and women. Within Nigeria, Islam is the religion that undoubtedly has the most impact on the lives of women in particular. Most women of

childbearing age have minimal presence in the public sphere outside of their homes. At local level, the most obvious consequence is that there are few public spaces where women of childbearing age are present. In cities like Katsina or Kano, only men, children including young girls and older women are seen throughout the city. Because of the women's public invisibility, the landscapes of cities are male dominated. Not all people in Northern Nigeria are Muslims. However, because of this, it is relatively easy to pick out Christians, non-Muslims, or non practising women in northern cities. Gender relations flowing from religions influence may also be evident in the material landscape. Christianity has also had a major impact on gender role. The belief that God destined man to be in charge and women to be governed by men is evident in many passages in Christian Holy Book. Christian identity thus consists in embodying patterns of control, domination, and submission that put men and women in an unequal relational status.

The Islamic discourse on sexuality is no more different from the Christian narrative. As Ikkaracan (2002) opines," For UN conferences on population and development, ICPD in Cairo, the 1995 Beijing conferences, the 1999 five-year review of ICPD (ICPD +5) and the 2000 five year review of the Beijing conference (Beijing + 5) witnessed the Catholic and Muslim religious right engaging in unprecedented cooperation to oppose and restrict women's right to control their bodies and sexuality".(cited in Izugbara, 2006)

As result of the above, the rise in sexuality and gender consciousness in post colonial Nigeria which followed the emergence of legal and constitute codes that supported freedom in the everyday lives of people have translated into little, at the level of praxis. National narratives are still awash with patriarchal themes that support the socialization of males and women in ways that promote the domination of the latter by the former. As proof of this, the gender empowerment measures introduced

in 1995 by the UNDP ranks Nigeria among the world's lowest. The report submits that the management of sexuality in Nigeria continues to recall powerful male privilege ideologies (IIkkaracan, 2002).

Pearce (2001) asserts that the contemporary Nigerian state celebrates men as aggressive and domineering and therefore denies women's right to naming and controlling their sexuality and body for their own joy. For instance, fearing that Nigerian men and husbands will express displeasure over the new freedom that modern contraceptives might bring for women, the Nigerian government was forced in 1988, to reconstruct the population policy in ways that supported the subordination of women and their body to male sexual needs and pleasure. The population policy document was therefore caused to read that the patriarchal family system in the country shall be recognized for the stability of the home (FMOH 1988:19). The penal code also endorses wife battering when it proclaims that wives may be corrected provided grievous harm is not inflicted (Section 55(1) (d) of the penal code. Cap. 89, Laws of the Federation of Nigeria (LFN), 1963, applicable in Northern Nigeria). Pearce (2001) adds that given the state's perspectives on marital and reproductive behaviour, the rights and freedom of husbands and women have thus been constructed as significantly different and unequal. Consequently, none of Nigeria's recent health programmes is a practical attempt to stop, levirate, seclusion, childhood marriage, female genital cutting and the corporal punishment of wives.

There is a bourgeoning body of empirical studies pointing to the role of patriarchal ideologies and views of sexual identities which encourage sexual risk taking and irresponsibility among men and prevent women from challenging men's sexual conduct and behaviour. Apart from Bauchi State, Nigeria, where government has taken concreted steps to empower women to challenge men's risky sexual behaviour, others are lagging behind (Wayap, 2009). This brutal and yet routine

socialization also explained why women conceal their sexual abuse, express shame about their bodies apologize for their bodies and lose touch with reality or what Walker (1992) calls “the secret of joy.” By depicting men’s control of women as natural, divine, cultural and normal, these discourses make it difficult to promote rights to choices, sexual freedom and positively healthy and respectful sexuality.

CHAPTER FIVE

POLITICS, GENDER AND HIV/AIDS POLICIES IN NIGERIA

5.1 INTRODUCTION

Most Governments in Africa have adopted constitutional provisions on human rights and gender equality. These constitutions guarantees equality before the law and non-discrimination based on sex. While some, mandate their respective states to embark upon affirmative action measures to remedy existing imbalances between men and women (UNIFEM, 2005) Nigeria falls within the second category, as reflected in the National Gender Policy and in the Revised Policy on AIDS in 2009. This chapter examines the issue of gender disparity in HIV prevalence inspite of the adoption of the National gender Policy in 2006 and the 2009 revised Policy on AIDS. . Furthermore it explores the politics involved in the adoption and implementation of gender sensitive HIV policies in Nigeria.

5.2 THE NATIONAL GENDER POLICY

Gender discrimination in Nigeria continues to be highly pervasive, manifesting in different dimensions and in different cultures in Nigeria. Women rank lower than men in all indices of development of the country, and records from the National Bureau of Statistics reveal that there are more poor women in the country than men, and women are more represented among the core poor. In the area of education, while giant strides are being made in bridging gender gap in enrolment ratio at primary school level, same cannot be said of higher levels of education where gender gaps are still highly prevalent. With a maternal mortality ratio of between 704 and 1000per 100,000live births, Nigeria continues to have one of the highest levels of maternal mortality in the world. While the disparity between men and women in HIV prevalence in past decades is another dimension of the problem. (NGP Strategic

Implementation Framework2008)

In a bid to pursue its international and local obligation of ensuring the realization of gender equality, the Nigerian government replaced its Women Policy with a Gender Policy in 2006. The policy seeks among other things to promote the evolvement of an enabling environment within all government ministries and agencies that have one role or the other to play in the successful implementation of the different aspects of the policy.

The document showed government commitment to building a nation devoid of gender discrimination, guaranteeing equal access to political, social and economic wealth creation opportunities for women and men; and developing a culture that places premium on the protection of all including children. It stated that in furtherance of this goal, government shall promote the full participation of women, men, girls and boys by involving both the public and private sectors as agents of development. The mission of the Federal Ministry of Women Affairs and Social Development is to serve as the national vehicle to bring about speedy and healthy development of Nigerian women and men in the mainstream of the national development processes and ensure the survival, protection, development and participation of all children in preparation for meaningful adult life. Nigeria as a member of the United Nations signed and ratified the various relevant international instruments, treaties and conventions without reservation. (NGP, 2006)

These instruments have always emphasized that member nations put in place all the necessary mechanisms needed to eliminate gender discriminations, ensure equality and human dignity to all, men and women. Yet there persists discrimination in national and state statues, customary and religious laws. We all know that in Nigeria, traditions, customs sexual stereotyping of social roles and cultural prejudice continue to militated against enjoyment of rights and full participation of women on

an equal basis with men in national development. The National Gender Policy, which supersedes and replaces the erstwhile National Policy on Women, would help to eliminate all such barriers.

The Policy is aligned with relevant regional and international protocols and instruments such as the Beijing Platform for Action (BPfA), New Partnership for African Development (NEPAD) AU Solemn Declaration for Gender Equality, African Protocol on People's Rights and the Rights of Women (APPRRW), the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), International Conference on Population Development Plan of Action (ICPD PoA), NEEDS/SEEDS, the Millennium Development Goals (MDGs), and a wide range of sectors. The Policy seeks to equip stakeholder with strategic skills for engineering the levels of social change required for achieving the desired empowerment of all citizens. For effective implementation of this policy a National Gender Strategic Framework (NGSF) was developed. The NGSF outlined explicit implementation, monitoring and evaluation guidelines for achieving measurable targets and enhancing accountability to gender equality and women's empowerment (NGP, 2006). **Former Minister for Women's Affairs and Social Development,** Mrs**. Inna Maryam Ciroma stated** that

"As a nation and a ministry, we are challenged by values and we will use global standards as instruments to formulate and assess our progress and achievements. These instruments are goals in themselves and tools for raising standards and informing the way policy and institutions work on the issues of gender equality, women's empowerment and child protection". (NGP, 2006)

Promoting gender equality is now globally accepted as a development strategy for reducing poverty levels among women and men, improving health and living standards and enhancing efficiency of public investments. The attainment of gender

equality is not only seen as an end in itself and human rights issue, but as a prerequisite for the achievement of sustainable development. In recognition of the extant National Women's Policy and other sect oral policies to respond to the challenges of gender inequalities and attendant low socio-economic indicators, a National Gender Policy was developed to replace the Women's Policy. An extensive research and consultative process informed the Gender Policy framework while the goal, objectives, strategies and targets were adopted by consensus at several national and zonal workshops convened for stakeholders and partners.

The goal of the National Gender Policy is to "build a just society devoid of discrimination, harness the full potentials of all social groups regardless of sex or circumstance, promote the enjoyment of fundamental human rights and protect the health, social, economic and political well being of all citizens in order to achieve equitable rapid economic growth; evolve an evidence based planning and governance system where human, social, financial and technological resources are efficiently and effectively deployed for sustainable development."(NGP, 2006)

Policies Objectives.

1. To establish the framework for gender-responsiveness in all public and private spheres and strengthen capacities of all stakeholders to deliver their component mandate of the gender policy and national gender strategic framework.
2. Develop and apply gender mainstreaming approaches, tools and instruments that are compatible with the macro-policy framework of the country at any point in time, towards national development.
3. Adopt gender mainstreaming as a core value and practice in social transformation, organisational cultures and in the general polity in Nigeria.

4. Incorporate the principles of CEDAW and other global and regional frameworks that support gender equality and women empowerment in the country's laws, legislative processes, judicial and administrative systems.
5. Achieve minimum threshold of representation for women in order to promote equal opportunity in all areas of political, social, economic life of the country for women, as well as for men.
6. Undertake women and men-specific projects as a means of developing the capabilities of both women and men, to enable them take advantage of economic and political opportunities towards the achievement of gender equality and women's empowerment.
7. Educate and sensitise all stakeholders on the centrality of gender equality and women's empowerment to the attainment of overall national development.

Some of the key principles upon which the policy is premised are:

a. Commitment to gender mainstreaming as a development approach and tools for achieving the economic reform agenda, evidence based planning, value re-orientation and social transformation.
b. Recognition of gender issues as central to and critical to the achievement of national development goals and objectives and a requirement for all policies to be reviewed to reflect gender implications and strategies as contained in the gender policy and implementation modalities specified in the National Gender Strategic Framework;
c. Realization that effective and results focused policy implementation demands a cooperative interaction of all stakeholders.
d. Promotion and protection of human rights, social justice and equity.

The Core strategies for achieving the objectives of the National Gender Policy include: Policy, partnership and programme reforms through mainstreaming of gender concerns at all levels;

 Gender education and capacity building to enhance necessary technical expertise and positive gender culture;

 Legislative reforms to guarantee gender justice and respect for human rights and

 Economic reforms for enhanced productivity and sustainable development, especially that which addresses the needs of women and children, and other vulnerable groups. (NGP, 2006)

However an anticipated major challenge to achieving the policy objectives is moving from the policy prescriptions to the actualisation of the policy goal and targets. For the conceptual framework to be functional, greater synergy is required among stakeholders. Furthermore, overarching institutional restructuring and increased professionalism is required in order to meet the demands of this policy document. The efficacy of the policy strategies is contingent on a functional gender management system while the following elements and actions are indispensable:

 Political Will

 Gender as a Core Value for Transforming the Nigerian Society

 Confronting Patriarchy

 Coordination, Networking, and Monitoring

 Resource Mobilization. (NGPSIFP,2008)

Despite a general commitment to the principle of non-discrimination as enshrined in Section 2 of the 1999 Constitution of the Federal Republic of Nigeria, Nigeria falls short of the desired result of giving males and females equal opportunities to advance socially, physically, educationally, politically and economically. Evidences abound that several negative aspects of gender relations,

such as gender-based division of labour, disparities between males and females access to power and resources, and By the Nigerian Constitution, civil and political rights (Chapter 4 of the 1999 Constitution) are actionable in a court of law whilst economic, social and cultural rights (Chapter 2 of the 1999 Constitution) are not. Section 43 permits both male and female Nigerians to own and acquire movable and immovable property. In spite of this, a large proportion of women in Nigeria are barred from owning land by customary laws of inheritance. (UNIFEM, 2006)

The under-representation of women in decision making bodies and policy formulation processes also has a significant impact on the core economic sectors including the health sector's responsiveness to gender equality considerations. With the exception of reproductive health policies, the vast majority of sectoral policies and service delivery systems frequently fail to adopt gender-sensitive approaches and address gender inequalities.

In the area of health care ensuring access to health facilities and affordable health services remains a major challenge for the country and women in particular. Doctor/patient ratios demonstrate that the health care system lacks the human resources necessary for responding to the health care needs of Nigerians (e.g. the doctor/patient ratio recorded at 1:70'000 in some instances). As a direct consequence, maternal and child mortality and morbidity rates remain alarmingly high with related implications for the overall health and well-being of Nigerian women and population growth rates (Adamu, 2008).

Prevalence levels of communicable diseases are also high, largely as a result of poor sanitation, low levels of awareness, and lack of access to potable water. HIV/AIDS prevalence rates amongst women are higher in part due to the fact that women are biologically more susceptible to contracting HIV than are men. Thus, the infection rate among females 20–24 years of age is 5.6%, as compared with the

overall infection rate of 5%, while 60% of new infections are among females 15-25 years of age.

Whereas the government has acknowledged the gender dimensions of HIV/AIDS and has developed and implemented gender-sensitive HIV/AIDS programmes, interventions, policies, and strategies (i.e. gender equality considerations are a central aspect of Nigeria's HIV/AIDS National Strategic Framework), significant challenges remain with respect to addressing practices that perpetuate gender inequalities, such as early marriage, transactional sex, lack of access to health information and services and women's role in shouldering the burden of care for persons living with and affected by HIV/AIDS (CIDA Nig. GSAA 2006).

As in most nations, Nigeria possesses a body of laws which regulate and govern various aspects of both public and private life. For instance, marriage is regulated by and can be contracted under the Common Law, Statutory Law, and Customary Law and Islamic (Shari'a) law. However, the manner in which such laws are interpreted and applied is often inconsistent and frequently varies based on subjective considerations, particularly in cases where women seek redress for violations committed by their spouses or when intestate inheritance issues arise. This is further complicated by unwritten family laws and traditions which discriminate against women, especially in cases related to divorce, child custody and inheritance of properties, although Islamic laws tend to be more accommodating of women's concerns in cases pertaining to family/marital break-up. Ensuring that laws and acts formulated to protect the rights and interests of women are enforced remains a major challenge for women's rights advocates and gender and development practitioners.(NGP, 2006)

Human rights violations are prevalent in Nigeria with women's rights being violated much more often than those of men, in both the public and private spheres.

To date, the National Human Rights Commission (NHRC), established in 1999, has not adequately fostered the capacity of key public institutions, officials and leaders to generate popular understanding and promote fundamental human rights and freedoms. The most pervasive and severe violations of women's rights are frequently those associated with the unwritten traditional norms and practices of Nigeria's numerous and diverse ethnic groups. The most common norms and practices concern widowhood rites, inheritance rights, the land tenure system, female genital mutilation/female genital circumcision (FGM/FGC) and early marriage. These practices have a devastating impact on the health and well-being of Nigerian women and girls and further undermine their progress and development. Gender-based violence has become a major issue in recent times. It reflects the extent to which women's human rights are threatened thereby leading to the voiceless ness of women in many issues concerning and affecting their lives. Violence against women, particularly domestic violence and rape, is widespread which has increased the vulnerability of women to HIV/AIDS.

In Nigeria, harmful traditional practices meant to control women's sexuality have led to great sufferings. Notable among them is the practice of female genital mutilation, which is a violation of basic rights and a major lifelong risk to women's health. Another major violence against women is the insalubrious attitude of wife-beating and women trafficking. The underlying force behind this behaviour is the wrong believe that women are inferior and are suppose to be treated as second class citizens in the society. In other to tap the potentials of women for development, gender sensitive policy that entrench equity between men and women is key. Equal relationships between men and women in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, requires mutual respect and willingness to accept responsibility for the consequences

of sexual behaviour, sensitivity and equity in gender relations enhance and promote respectful and harmonious partnerships between men and women The law on domestic violence is clearly inadequate, particularly regarding wife battery. Domestic violence is currently classified under common assault, which down plays the seriousness of this crime. According to section 55 of the penal code, wife beating is allowed as long as it does not amount to grievous hurt. As defined in section 241 of the penal code "grievous hurt" include emasculation, permanent loss of sight, ability to hear or speak facial disfigurement, deprivation of any member or joint, bone fracture or tooth dislocation (Imam, 2000). This means that a man who beats his wife short of inflicting the above injuries is acting within the law. How is the woman's fundamental right to dignity then protected under such circumstances? Section 353 of the criminal code makes an indecent assault on males punishable by 3 years imprisonment. A similar offence of indecent assault on females is treated as mere misdemeanour punishable by a maximum of 2 years imprisonment (section 360), clearly a discriminatory provision. The Nigerian Justice and Law Enforcement Administration is not gender friendly in the delivery of its mandate, often negating to adhere to the principle of upholding fundamental rights to freedom and good governance. Operational procedures and protocols within most law enforcement agencies are biased in favour of men. The most striking example is the Police Act which views and treats women as not on equal standing with men. Many of its provisions violate provisions of the CEDAW and the African Protocol on People's Rights and the Rights of Women (APPRRW). For instance, although women have the right to post bail for police detainees, in practice women are frequently denied this and other rights on insufficient grounds. Within respect to the police force, female police officers are not accorded the same degree of respect as their male counterparts. They are often treated as second-class officers, regardless of their rank, and are

seldom awarded strategic career postings, thus limiting their opportunities for professional advancement. With respect to recruitment and training, women are often prevented from participating in full drill training thereby limiting their capacity to effectively perform their duties. A wrong perception of the concept of gender by policy makers, charged with the responsibility for policy articulation and execution continues to challenge the attainment of gender equality and women's empowerment goals.

There is still evidence that gender education has not permeated all levels of the populace thus the impression that gender issues are exclusively about women still persists. Similarly the impression that gender issues negatively challenges accepted norms and values of marriage, family and religion is rife. Many stakeholders believe that gender concerns should be addressed only within the Ministry of Women's Affairs and Social Development. The long history of women empowerment in the country is not in tandem with the current situation analysis with respect to all the gender issues suffered by majority of women in Nigeria. All efforts through special legislation, state bye-laws and gender specific policies at all levels of government and by the civil society though note-worthy have failed to deliver dividends of development to women and men equitably. However the continued manifestations of the problems highlighted at the sectoral level demand for the adoption of a different and more pragmatic approach to the policy framework as compared to that of the National Policy on Women. (NGPSIF, 2008)

The overall goal is to build a just society devoid of discrimination, harness the full potentials of all social groups regardless of sex or circumstance, promote the enjoyment of fundamental human rights and protect the health, social, economic and political well being of all citizens in order to achieve equitable rapid economic growth; evolve an evidence based planning and governance system where human,

social, financial and technological resources are efficiently and effectively deployed for sustainable development.

5.3. NATIONAL POLICIES ON AIDS

Policy instruments are essential for guiding a country's response to the HIV/AIDS epidemic. They not only express the government's commitment and priorities, but they also set the framework for an effective and coordinated response to the epidemic. In Nigeria, these instruments include national policies, strategic plans, and technical guidelines. The first policy statement was developed in 1997 by the Federal Ministry of Health. This was at the advent of the epidemic. This policy statement was later revised in 2003 by the National Agency for the Control of AIDS in collaboration with other stakeholders with the sole aim of mitigating the impact of the HIV/AIDS. The policy focused on five thematic areas:

- Prevention of HIV/AIDS
- Law and ethics
- Care and support
- Communication
- Management and support of program (National policy on HIV/AIDS, 2003).

This policy entrenched the multi-sectoral approach and called for the establishment of a statutory body to coordinate and facilitate the national HIV/AIDS response. The policy's main objectives were to:

• Promote a national multisectoral and multidisciplinary response to the epidemic in addition to the establishment of an appropriate legal and institutional framework for its coordination;

• Identify sectoral roles and assign responsibilities for the implementation of programmes baseon sectors' comparative advantages and core competencies;

- Increase awareness and sensitisation among the general population about HIV/AIDS;
- Foster behaviour change as the main means of controlling the epidemic;
- Improve national understanding and acceptance of the principle that all persons must accept responsibility for prevention of HIV transmission and the provision of care and support for those infected and affected;
- Provide access to cost-effective care and support for those infected, including anti-retroviral drugs;
- Protect the rights of those infected and affected by HIV/AIDS as guaranteed under the constitution and laws of the Republic;
- Remove all possible barriers to HIV/AIDS prevention and control.
- Empower people infected and affected by HIV/AIDS through training, counselling, and education to cope with their circumstances.
- Develop standards and guidelines that lead to the institutionalisation of best practices to mitigate the impact of AIDS.
- Stimulate research, monitoring and evaluation of programs, relevant documentation of activities related to the epidemic and the dissemination of information generated to stakeholders and the general population.
- Ensure that prevention programmes are developed and targeted at vulnerable groups such as women and children, adolescents and young adults, sex workers, long distance commercial vehicle drivers, prison inmates, migrant labour etc.(National Policy on AIDS, 2003)

This policy was formally launched by the President of Nigeria on the 4th of August 2003.

One noticeable input of the policy formulation process was the wide stakeholder participation and the wide level of consultation. In spite of this many persons consider themselves distant from the policy making process. Many NGOs claim not to have been consulted during the process although they were represented through their umbrella group. The same has been stated by some religious organisations that were equally invited. This could mean that they do not consider their umbrella organisations as speaking for them or their umbrella organisations not giving enough feedback after returning from their assignments. This is of critical importance as the process was designed to ensure ownership by all. (Mafeni et al, 2003)

The policy tried to fill in gaps that had been identified in the 1997 'health sector' HIV/AIDS policy. The previous policy had made very little mention of care and support for persons living with HIV/AIDS, and even less on HIV/AIDS impact mitigation. However the 2003 policy document was for the most part, mute about the significance of gender in the epidemic. (NACA, 2010) Despite global consensus and compelling evidence showing disproportionate incidence and impact of HIV/AIDs on Nigeria women and young women in particular, the national response remained vague about the significance of mainstreaming gender into policy and its implementation. For instance the policy did not reflect gender as a major determinant of epidemiological trends. Moreover, the problem description completely ignored the multidimensional social and economic impact of HIV/AIDs on women as reproducers, care givers and pivotal contributors to community support systems which are often divested by the epidemic. Indeed the first reference to women cites "sex workers and their clients as a barrier to condom use". Furthermore, beside reference to mother as beneficiaries of PMCT, the policy makes only two significant references to women.

1) "Subjugation and subordination of women in the country, which limits their ability to decide when and how and with whom they have sex" (FMOH, 2003).
That "women shall be empowered through education and legislation to protect themselves from unsafe sex" was noted but not implemented.

However, the Implementation of the policy in the reversed national HIV/AIDs document in 2009 improved on the national responses to the gender dimension of HIV/AIDs. Overall the NSF 2005-9 mainstreams gender in the language, disease profile, trends problems and services delivery. Although the present policy on HIV has recognized and adopted a multi-sectoral and wholistic approach to HIV/AIDs prevention, women have been the main beneficiaries of primary health care (PHC) strategies. But despite this there are deficiencies' in the services in some critical areas such as, lack of and /or inadequate screening and treatment of reproductive tract infections. Women are the major consumers of health care compared to their male counterpart, whose use of health services is low. Yet women's subordinate status also frustrates health promotion and disease prevention strategies. (NACA. 2010)

The Policy Context in the revised 2009 policy document showed that it has been developed within the context and in agreement with selected key national and international framework that are germane to the national response to HIV/AIDS in Nigeria. They include the following:

· *The 1999 Constitution of the Federal Republic of Nigeria*, which affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and to freedom from discrimination. The constitution recognizes a three-tier level of governance.

· Complementary Government documents provide the framework for this policy, including the *NACA Act*, *Medium Term Strategy*, *National Economic Empowerment*

and Development Strategy (NEEDS) I and II, *National Gender Policy*, and the *Seven-Point Agenda* of the Federal Government of Nigeria.

· This Policy also responds to government ratification of and commitment to numerous international conventions including *Universal Declaration of Human Rights (1948*), the *Convention on Economic, Social and Cultural Rights* (1976), the *Convention on the Elimination of All Forms of Discrimination against Women* (1979), *Convention on the Rights of the Chil*d (1989), and the *African Charter on Human and People's Rights* (July, 2003).

· Specifically it is derived from agreed goals of international community to fight the epidemic and mitigate its impact which Nigeria ratified. These include:
Programme of Action of the International Conference on Population and Development ICPD (1994), *The Political Declaration and further action and initiatives to implement the Beijing Declaration and Platform for Action (2000), Political Declaration at the World Summit for Social Development* (1995), the United Nations Millennium Declaration (September, 2000) which target 2015 for reversal of epidemic trajectory. Others are the *Greater Involvement of People with AIDS* (GIPA) and M*eaningful Involvement of People with AIDS* (MIPA) Principles, *The Abuja Declaration and Framework for Action for the Fight Against HIV/AIDS, Tuberculosis and other related diseases in Africa* (April, 2001) and *The United Nations General Assembly Special Session on HIV/AIDS* (UNGASS) (June, 2001) at which countries committed to ensure an urgent, coordinated and sustained response to HIV/AIDS.

Other relevant international document include the New York Call to Commitment linking HIV/AIDS and sexual and reproductive health (SRH), and the

Glion call to action on family planning and HIV in women and children.(National Policy on AIDS,2009).

· The policy's goal and focus also derived from Nigeria's commitment to Universal Access to comprehensive HIV prevention, treatment, care and support as enunciated in the following: the 2005 Gleneagles G8 Universal Access Targets, the 2006 United Nations Political Declaration on HIV/AIDS, the African Union's Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS (2006), and the 2006 Brazzaville Commitment on scaling

up towards Universal Access to HIV and AIDS prevention, treatment, care and support services in Africa by 2010. (National Policy on AIDS 2009)

Guiding Principles

The document states that this policy shall be based on, and governed by the following principles:

· Strong political leadership and commitment to transparency and prudent management of financial and other resources at all levels for sustained response to HIV/AIDS.

· Multi-sectoral approach that is community-based, community-driven, gender responsive and forges broad partnerships, dialogue, consultations and effective coordination among stakeholders.

· Commitment to scale up prevention among the general population as well as among high risk and other groups vulnerable to HIV infection.

· Protection and promotion of the rights and access of PLHIV to comprehensive health care and other social services.

· Commitment to protecting rights of PLHIV, reduction of stigma anddiscrimination and ensuring greater involvement of PLHIV in national HIV/AIDS program at all levels.

· Commitment to promote and protect rights and reduce vulnerability of women, children, young people and marginalized groups to HIV infection.

· Promotion of comprehensive approach that strongly links HIV prevention, treatment, care and support and geared towards universal access.

· Strengthened linkages and forged synergies between HIV/AIDS programmes and poverty alleviation initiatives to break the vicious cycle of the disease and its relationship with economic disempowerment.

· Determination to address social, economic and cultural factors responsible for disproportional vulnerability of women and girls to HIV infection.

· Mainstreaming of gender into all policy-related and programming activities and related structures to ensure that all interventions and programmes are gender-sensitive and gender-responsive, appropriately meeting the separate as well as related needs of females and males.

· Promotion of consistent and effective partnerships and collaboration with development partners. (National Policy on AIDS 2009)

While the overall goal of the National Policy on HIV/AIDS is to provide a framework for advancing the national multi-sectoral response to the HIV/AIDS epidemic in Nigeria so as to achieve effective control by reducing the rate of new infections, providing equitable care and support for those infected and affected, and mitigating the impact of the infection, thereby enabling all people in Nigeria to be able to achieve socially and economically productive lives free of the disease and its effects(National Policy on AIDS 2009)

The following are some of the key considerations which inform the articulation of this Policy:

· HIV/AIDS epidemic in Nigeria threatens the well-being of many Nigerians, burdens families, impoverishes communities, weakens institutions and threatens the social and economic development of the country.

· As a public health issue, HIV/AIDS directly affects the health of millions of infected persons, contributes to maternal and under-five mortality rates and places unprecedented stress on already overburdened health care system.

· Prevention, treatment, care, support, and impact mitigation are mutually reinforcing elements of a comprehensive response to HIV/AIDS; advancing a public health-based response that integrates principles of these elements is critical for success of the national response.

· Significant sections of the population are most at risk of infection due to social, cultural and economic conditions which create and sustain vulnerability to HIV infection. The most vulnerable are women and girls, young people, the physically challenged people and mobile populations.

· HIV/AIDS-related stigma remains all pervasive and that people infected or affected by HIV/AIDS are discriminated against and denied access to compassion, care and support and social services.

· Culture, traditions and religion have a strong influence on behaviour, attitudes and practices of majority of Nigerians and traditional and faith based institutions as gate keepers of attitudes and behaviour and joint facilitators of social transformation are critical assets in the fight against the disease.

· Effective response to HIV/AIDS requires respect for, protection of and fulfilment of all human rights civil, political, economic, social, and cultural and upholding the fundamental freedoms of all people in accordance with the country's constitution and

existing international human rights principles, norms and standards. (National Policy on AIDS, 2009).

Based on the above, it is evident that the 2009 HIV/AIDS Policy is the most ambitious and comprehensive document so far that has attempted to address critical gender issues. The country is a signatory to many regional and international commitments and covenants on human rights. Yet, minimal progress, if any, has been made in addressing the human rights and legal issues surrounding HIV/AIDS. Despite compelling evidence that reducing stigma, promoting and protecting human rights, promoting greater involvement of PLHIV and gender mainstreaming strengthens HIV control,. Nigeria's achievement in this regard is slow and resistant. More than two decades after the identification of the first case in Nigeria, violation of human rights of persons infected and affected is still rampant and stigma remains pernicious and pervasive. This situation is compounded by attitude and practices which discriminate against widows and persons orphaned by AIDS. Furthermore, the approach of the national response appears to accentuate differential access to information, services and participation by marginalized segment of the population and those with high vulnerability such as women. This stems principally from the fact that, in Nigeria, official policy documents do not constitute law and cannot be enforced in courts of law. They are merely administrative tools and guidelines that provide direction for government action.

However, the policy documents can and may elaborate and specify the goals, values, and standards to which existing laws aspire and may be useful in interpreting the latter as well as guiding programmatic interventions by the government. The problem is that, at the moment, there are few HIV/AIDS specific laws that empower women to protect themselves against HIV.

As legal reforms have been notoriously slow in coming and without the

backing of the law, government policy documents can only be inspirational in wishing for an effective national HIV/AIDS response that respects the rights women. Currently, the 1999 Nigerian constitution and international treaties ratified by the country have provided the major sources of human rights for PLVIH and women in the country. However, as none of this treaties or the constitution specifically addresses the situation of PLHIV and PABA, the case of their applicability often has to be made through advocacy and lobbing. Thus, although PLHIV have human rights to be respected and protected, it is the tendency of the society to have pervasive prejudices and to overtly or covertly stigmatize and discriminate against PLHIV and PABA. A constitutional provision that does not speak HIV/AIDS contexts specifically does not do much to help the situation of the rights of PLHIV. And the protection of the rights of PLHIV and PABA are not on the priority radar screen of law enforcement agencies.

The NARHS (2007) found reluctance on the part of many Nigerians to relate with PLHIV who are not members of their families. Only 24 percent of respondent were willing to share meals infected persons and only 16% were willing to buy food from a shop keeper known to be HIV infected. Just about two-fifths were willing to work with an infected colleague, allow an infected student in school, and allow an infected female teacher in school.

The absence of explicit laws leaves PLHIV and women extremely vulnerable to the violation of their rights as available evidence demonstrate. The national HIV/AIDS response needs to do more to advance the intent and aims of a number of policies and guidelines in the context of the rights of PLHIV and women through intensive and consistent advocacy and lobbing.

CHAPTER SIX

DATA PRESENTATION ON GENDER INEQUALITY, HIV/AIDS AND GENDER POLICIES IN JOS NORTH LGA.

6.1: INTRODUCTION

This chapter presents and analyses primary data generated from the field and from published and unpublished relevant documents. Results and discussions are based on the five propositions stated earlier in chapter one of this work and other information gathered during the cause of this study.

The data were generated from both primary and secondary sources. Primary data were collected in 30 clusters within Jos North LGA (August–October, 2010); selected ministries, government agencies, hospitals, VCCT centres, non-governmental organizations in Jos North (November-December, 2010); Faith alive foundation (January-Febuary,2011) interview with key informants in the locality (Febuary-2011).

It is important to state that research assistants, mainly staff of the National Population Commission in Plateau State, who either volunteered or were recruited and trained by this researcher helped greatly in data collection. As stated in the methodology chapter of this study, we adopted an all inclusive approach in the field work: respondents from all walks of life residing in the LGA were randomly selected. Table 6.1 below presents the aggregate percentage of male and female respondents within the three age brackets.

TABLE 6.1: Shows the Age and sex of respondents in percentages

Age bracket	Age of respondent	Female	Male	Total
15-25	Count	146	187	333
	Age	43.8%	56.2%	100.0%
26-50	Count	207	234	441
	Age	46.9%	53.1%	100.0%
50 and above	Count	36	77	113
	Age	31.9%	68.1%	100.0%
Total	Count	389	498	887
	Age	43.9%	56.1%	100.0%
	% of Total	43.9%	56.1%	100.0%

Majority of the respondents within the age bracket of 15-26, were male. We had 21.1 % (187) male respondents as against a 16.5% (146) female, totalling 37.5% (333). Within the age bracket of 26-49, we had a large male population in which male surpasses female respondents. There were 26.4% (234) of male as against 23.3% (207) female respondents, giving a total of 49.7% (441). Among individuals of ages 50 and above, we had 4.1% (36) of female, as against 8.7% (77) male respondents totalling 12.8% (113) within this age bracket.

Although the male population was over represented in this study, this was partly due to the fact that some women refused to fill out questionnaires as stated earlier in the methodology chapter of this study. Nevertheless, this shortfall was later amended in the second phase of our field work with people living with AIDs.

6.2 PRESENTATION AND DISCUSSION OF DATA COLLECTED FROM THE GENERAL PUBLIC

Perhaps the first issues of concern to any HIV/AIDs programme manager is the level of awareness within the general public, and possibly how the spread of the disease could be prevented. How much knowledge has been disseminated to the public over the years that might be necessary to bring about behavioural change? Of

particular interest to this study is how the passage of time through the various phases of response to the epidemic resulted to either a gender gap or a closure of the gap in knowledge and attitude about HIV/AIDs and its prevention. Several studies have showed that adequate knowledge about the disease, how it is contracted and methods of prevention are prerequisites for any behavioural change, while theories which guided HIV interventions at the early stage of the epidemic, emphasized the dissemination of information a starting point for programmers and researchers alike. (Catania et al, 1990)

It was based on these that we set out to assess the level of HIV awareness in Jos North LGA where we enquired from respondents about the disease, their understanding of how it can be contracted and the predominant prevention methods. The relevant data generated by the inquiry are found in table 6.2 below. This table shows the percentage of men and women who are knowledgeable about HIV/AIDs, and some prevention methods; 96.9% of female and 96.0% of male respondents indicated they had adequate knowledge about HIV/AIDS and some prevention methods. This high level of awareness persisted even when control for age and marital status were introduced indicating that adequate information has been disseminated within the general public. Nevertheless women outnumbered men slightly which confirms the popular notion within the health sector that women are the main beneficiary of primary Health Care (PHC) in Nigeria compared to their male counterparts, but their subordinate positions frustrates HIV prevention efforts. Table 6.2 below presents details.

TABLE 6.2: Shows the Sex of respondent and their level of awareness about HIV/AIDS in percentages.

	Sex of respondent	Yes	No	Total
Female	Count	377	12	389
	Percentage of female	96.9%	3.1%	100.0%
Male	Count	478	20	498
	Percentage of male	96.0%	4.0%	100.0%
	Total	855	32	887

Further investigation on HIV prevention methods showed a gender gap in preference. We found out that more men than women opted for condom as a control strategy. Forty-Two per cent (42%) of the male respondents chose condom use as against a 24.4% of their female counterparts. Similar differences were exhibited on the issue of having one sexual partner as a prevention method where 36.6% of female respondents preferred having one sexual partner as against 30.9% of male respondents. Little change in distribution was shown on the issues of the avoidance of casual sex, where 5.2% female within the population preferred this option, with 8.5% of male respondents choosing same.

However, a gender gap in favour of women was exhibited with regard to the issue of abstinence as a control strategy, with 33.8% of women choosing this option as against a 17.9% of male respondents.

Table 6.3 bellow presents details.

Table 6.3: Shows the Sex of respondents and their preferred method of HIV prevention, in percentages.

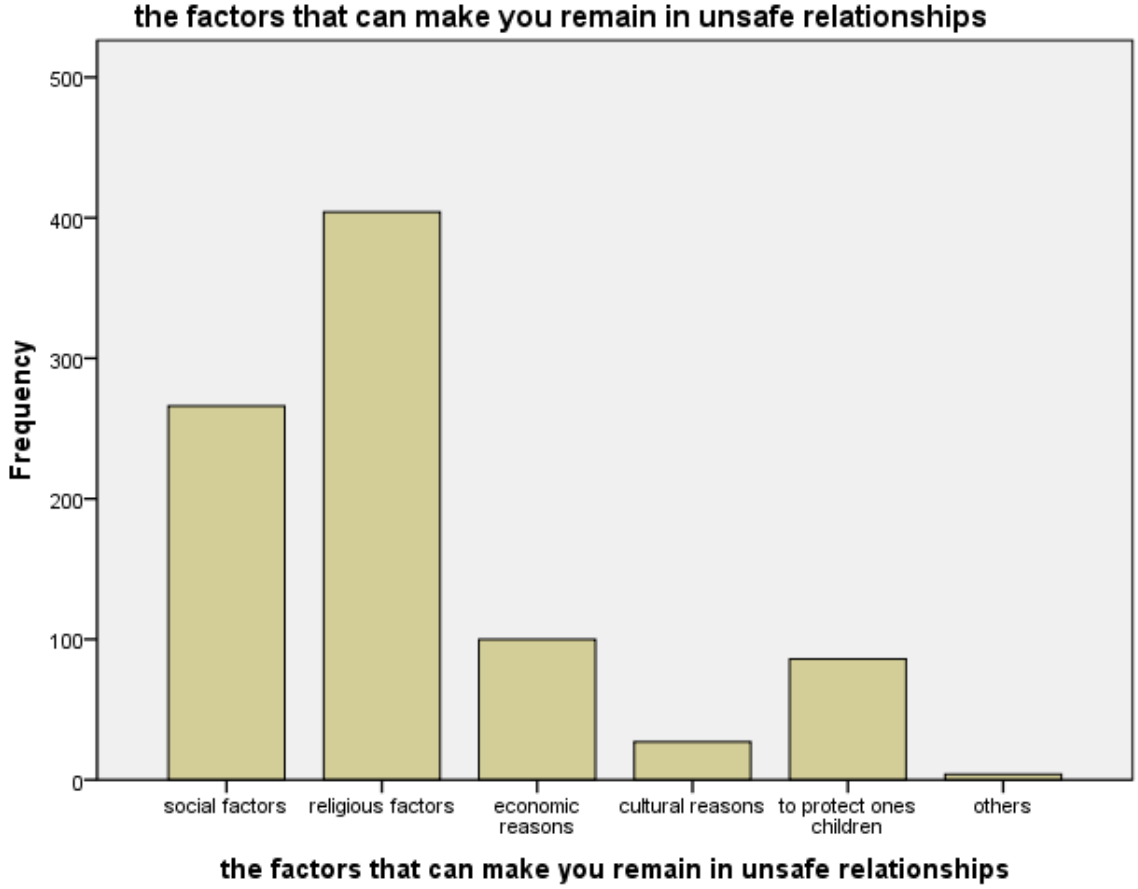
sex of respondent		use of condom	one sexual partner	avoid casual sex	Abstinence	Total
Female	Count	94	141	20	130	385
	Percentage of female	24.4%	36.6%	5.2%	33.8%	100.0%
Male	Count	210	152	42	88	492
	Percentage of male	42.7%	30.9%	8.5%	17.9%	100.0%
	Total	304	293	62	218	877

Further investigation to ascertain if respondents could avoid HIV risky behaviours found 99.2% of respondents saying they could keep away from these behaviours. In fact, only 7 respondents (0.78%) indicated that they can't keep away from these behaviours. A clearer picture emerged when probed for factors that could make them remain in an unsafe relationship with 47.8% of male respondents indicating that they could take such risk for religious reasons while, 42.7% of their female counterparts said they could do so for the same reason. Little change in distribution was found among those who chose economic factors. About 12.9% of male and 9.3% of female respondents said they could remain in an unsafe relationship for economic reasons. Nevertheless, women outnumbered men significantly on the issue of risking one's health, to protect one's children, and for cultural reasons as well. The gender gap on the protection of one's children stood at 14.7% as against a 5.8% in favour of women. A similar gender gap was found among those who opted for cultural factors in which the percentage of women (4.1) surpasses that of men (2.2 %.) However, the percentage of men surpasses that of female slightly where we found a 30.9% male, as against a 28.8% of female respondents on the issue of social factors. The general trend is for men and women to remain in unsafe relationships for religious reasons, while

the gender gap is more pronounced on the issue of risking one's health to protect their children than on any other factor.

Table 6.4 presents details of the Sex of respondents, and the factors that can make them remain in unsafe relationships in percentages.

		social factors	religious factors	economic reason	cultural reasons	To protect ones children	Others	Total
Female	Count	112	166	36	16	57	2	389
	Percentage of female	28.8%	42.7%	9.3%	4.1%	14.7%	.5%	100.0%
Male	Count	154	238	64	11	29	2	498
	Percentage of male	30.9%	47.8%	12.9%	2.2%	5.8%	.4%	100.0%
	Total	266	404	100	27	86	4	887



The preceding sub-section of data presentation has details of the level of HIV/AIDS awareness within the general public, the HIV prevention methods preferred by men and by women as well as factors that can keep individuals in unsafe relationships.

This section features those factors that limit the individual's ability to make effective choices on protecting their health. As in the previous section, respondents were asked if they could negotiate safer sex or condom use, and if the answer is no, they should select those reasons limiting their ability to do so. They were therefore asked to select among several options those factors impeding their ability to negotiate condom use. In order words, we investigated if respondents could convince partners to use condom or negotiate safer sex. The study found more men than women affirming to this, where 78.1% of our male respondents indicated they could negotiate safer sex or condom use as against a 68.0% of female in the research population. Only 21.9% of male indicated that they could not convince their partners to use condoms compared to the 32.0% their female counterparts.

Respondents who were not married exhibited the tendency to use condom, more than their married counterparts. A total of 77.4% of unmarried respondents said they could convince their partners to use condoms as against a 67.7% married individuals. These suggest that those who were not married were in a better position to make choices on issues affecting their health than married couples most especially women. It also complements the findings of several researchers in other sub Saharan countries which show that HIV infection levels are around 10% higher for married women than for sexually unmarried girls. Other studies reiterated that the most important factor of vulnerability to HIV for women is being married which in turn has implications on the effectiveness of the traditional (ABC) approach to HIV prevention.

Tables 6.5(A &B) below presents details.

Table 6,5: A: Shows sex of respondent who can convince partners to use Condom in percentages.

		Yes	No	Total
Female	Count	263	124	387
	Percentage of female	68.0%	32.0%	100.%
Male	Count	388	109	497
	Percentage of Male	78.1%	21.9%	100.%
	Total	651	233	884

6.5: B; Shows the marital status of those who can convince partners to use condom in percentages.

Marital status		Yes	No	Total
Single	Count	431	126	557
	Percentage of single	77.4%	22.6%	100.0%
Married	Count	214	102	316
	Percentage of married	67.7%	32.3%	100.0%
Divorced	Count	4	1	5
	Percentage of divorced	80.0%	20.0%	100.0%
Widowed	Count	2	4	6
	Percentage of windowed	33.3%	66.7%	100.0%
	Total	651	233	884

Further investigation to determine factors that shapes gender relations, which in turn limits their ability to negotiate safer sex reveals 51.9% of male and 60.0% of female respondents who said they cannot raise the issues of condom use or safer sex on religious grounds, while 20% of male respondents indicated they cannot raise the issue of safer sex or condom use for cultural reasons, as against a 4.4% of female respondents. Women surpass men on the issue of lack of power to initiate condom use where 31.1% of female respondents stated they lack the power to initiate condom use as against an 18.5% of their male counterparts. A gender gap in favour of men was exhibited with regard to peer influence with 20% of male respondents saying they cannot negotiate safer sex or use of condom as a result of peer influence as against a

4.4% of their female counterparts. Gender differences on issues limiting individuals ability to protect themselves against HIV was moderate, however the most outstanding gap was exhibited on the issue of power to negotiate condom use. A similar gap was found among those who chose peer influence where unmarried respondents outnumbered their married counterparts.

Table 6.7 (A&B) bellow presents details.

Table 6.7 A, Shows factors that limit respondent's ability to raise the issue of condom use in percentages.

		cultural factors	religious factor	peer influence	lack of power	Total
Female	Count	6	81	6	42	135
	Percentage of female	4.4%	60.0%	4.4%	31.1%	100.0%
Male	Count	13	70	27	25	135
	Percentage of male	9.6%	51.9%	20%	18.5%	100.0%
	Total	19	164	20	67	270

Table 6.7 B, Shows Marital status of respondents and factors that limit their ability to raise the issue of condom use in percentages.

		cultural factors	religious factor	peer influence	lack of power	Total
Single	Count	10	89	19	39	157
	Percentage of single	6.4%	56.7%	12.1%	24.8%	100.0%
Married	Count	9	73	1	25	108
	Percentage of married	8.3%	67.6%	.9%	23.1%	100.0%
Divorced	Count	0	1	0	0	1
	Percentage of divorce	.0%	100.0%	.0%	.0%	100.0%
Widowed	Count	0	1	0	3	4
	Percentage of windowed	.0%	25.0%	.0%	75.0%	100.0%
	Total	19	164	20	67	270

Probing for the impact of gender on HIV prevention, exhibited a gender gap on the issues raised. When asked if they (respondents) could say no to partners' sexual

advances, 73.1% (646) of our respondents said they can, as against a 26.4% (234) of those who indicated that they cannot refuse sex to their partners because of their gender. Among those who are constrained by virtue of their gender were mostly women; it was discovered that 62.8 % (147) were female, as against a 37.2% (87) of male respondents. Further investigation revealed that the percentage of married women surpasses that of the unmarried females where we found a 56.5% of married females, as against a 43.5% of their unmarried counterparts.

Table 6.8 bellow presents details.

Table 6.8: Shows respondents' position on sexual advances from partners in percentages.

		Frequency	Percent	Female	Male
Valid	0	5	.6	2	3
	Yes	648	73.1	35.5%	64.5%
	No	234	26.4	62.8%	37.2%
	Total	887	100.0		

On the issue of whether the gender of respondents affects their decision to use condom, found 399 respondents stating that it does, while 487respondents indicated that their gender those not affect their decision to use condom. The study showed that 85.6% of those who stated that their gender does not affect their decision to use condom were men; only 14.4% were female. Further break down of this information showed that 58% of these females were unmarried, while 41.4% were married women.

Table 6.8 bellow presents details.

Table 6.9: Shows the effect of respondents' sex on their decision to use condom in percentages.

		Frequency	Percent	Female	Male
Valid	0	1	.1	.1	.1
	Yes	399	45.0	55.3%	44.7%
	No	487	54.9	34.4%	65.6%
	Total	887	100.0		

From the data presented above, it is clear that our traditional sex-role orientations which suggest that women should be sexually passive and be less concerned about the sexual activities of their partners constitute a major obstacle to HIV prevention strategies. In this context, females, particularly, married women, have little or no power to avoid HIV risky behaviours.

Further investigation to determine how the gender of our respondents affects their ability to avoid HIV risky behaviours revealed that the gender of 394(44.4%) of respondents does not affect their decision to keep away from HIV risky behaviour as against a 493(55.6%) individuals in the study population. The gender gap among respondents who said their gender does not affect their decision to keep away from HIV risky behaviours stood at 72% as against a 28 % in favour of females. Most of the female respondents in this category were unmarried.

Table 6.10 bellow presents details.

Table 6.10: Shows the effect of respondents' sex on their ability to avoid HIV risky behavious in percentages.

		Frequency	Percent	Female	Male
Valid	Yes	394	44.4	72%	28%
	No	493	55.6	21.3%	78.7%
	Total	887	100		

The same patterns were maintained on issues of sexual and reproductive health, where male respondents surpass their female counterparts on the effect of gender on their ability to seek reproductive health advice. We had 226(71%) female and 92(29%) male respondents who said that their gender affects their decision to seek sexual and reproductive information. However, when control for marital status was introduced, it was discovered that 53.7% of married women said that their gender does not affect their decision to seek sexual and reproductive information as against a 46.2% of their single counterparts. The percentage of female respondents is higher than that of their male counterparts which confirms the notion that women of reproductive ages are the main beneficiaries of primary health care (PHC) in the country.

Table 6.10 below presents details.

Table 6.10: does your gender affect your decision to seek sexual and reproductive information

		Frequency	Percent	Female	Male
Valid	Yes	318	35.9	71%	29%
	No	569	64.1	21.3%	78.%
	Total	887	100.0		

Similar gender differences were exhibited on issues relating to one's economic status and their decision to keep away from HIV risky behaviours. 82% of male respondents stated that their economic status does not affect their decision to keep away from HIV risky behaviours as against 18% of the females. Only 42.6% of females in this category of respondents were married while 57.4% were unmarried.

However, the gender gap was very pronounced with the percentage of male respondents surpassing that of women.

Table 6.11 bellow presents details.

Table 6. 11: Shows the effect of respondents economic status on their decision to keep away from risky behaviours in percentages.

		Frequency	Percent	Female	Male
Valid	0	4	.5	.5	.5
	Yes	389	43.9	76%	24%
	No	494	55.7	18%	82%
	Total	887	100.0		

At this point, gender difference on issues that impede individual's decision to effectively utilize HIV prevention methods has been identified. Men continue to out-number women significantly on the ground that their gender empowers them to make decisions on issues that affect their health.

This sub-section on the other hand investigates the effect of the economic status of individuals on their ability to use condom. As with the previous sections, respondents were asked if their economic status affects their decision to use condom; 347(39.1%) of respondents said that their economic status does not have any effect on their decision to use condom as against 536(60.4%); 33% (173) of those who said their economic affects their decision to use condom were women, 67%(363) were men. Among this category of women, 106(61.5%) were single as against a 38.5% (67) married (including widows, divorcees and single girls).

Table 6.12 bellow presents details.

Table 6.12 Shows the effect of respondent's **economic status on their decision to use condom in percentages.**

		Frequency	Percent	Female	Male
Valid	0	4	.5	.5	.5
	Yes	347	39.1	62%	38%
	No	536	60.4	33%	67%
	Total	887	100.0		

6.3: PRESENTATION OF DATA COLLECTED FORM PEOPLE LIVING WITH HIV/AIDS

In order to complement our findings within the general public in Jos North LGA, another survey was conducted among people living with HIV/ AIDS in a non-governmental organization which provides free treatment, care and support to PLWHAS. This was to get first hand information on issues limiting individual's ability to use available prevention methods and the gender gap in access to care and support. As with the previous studies we started by investigating the level HIV awareness among PLWHAS before they contacted AIDS. It was discovered that 32.4% of male respondents heard of AIDS before they were infected as against 63.4% of their female counterparts.

Table 6.13 bellow present details of the level of awareness among PLWHAS in percentages

Gender: were you aware of methods of HIV transmission?										
			unprotected casual partners	use of contaminated blood or blood products	sharing of contaminated sharp objects	infection by unfaithful partner	sexual violence	all of the above	none of the above	total
	Male	Count	7	2	4	3	1	41	2	60
		% within gender	11.7%	3.3%	6.7%	5.0%	1.7%	68.3%	3.3%	100.0%
	Female	Count	8	2	5	7	14	77	6	119
		% within gender	6.7%	1.7%	4.2%	5.9%	11.8%	64.7%	5.0%	100.0%
		Total	15	4	9	10	15	118	8	179

Table 6.13 shows the level of awareness of PLHWAS of HIV prevention in Percentages.

Gender: have you had previous knowledge of prevention?					
			Yes	No	Total
Gender	Male	Count	52	11	63
		% within gender	82.5%	17.5%	100.0%
	Female	Count	102	17	119
		% within gender	85.7%	14.3%	100.0%
	Total		154	28	182

Further investigation on issues with regard to how they were infected found 21.0% of female respondents who indicated that they were infected by unfaithful partners, as against a 15.9% of their male counterparts. Similar gender gap was exhibited among those who stated that they were victims of rape. We found 11.8% of female respondents who said they were victims of rape as against a 4.8% of their male counterparts; 33.3% of male PLWHAS within our sampled population indicated that they contracted the virus through unprotected sexual relationship with casual partners as against a 22.7% of their female counterparts.

However, female respondents surpass their male counterparts on the issue of the use of contaminated blood and blood products; 23.5% of female respondents said that

they were infected with unscreened blood as against a 12.5% of their male counterparts. Similarly, 13.1% of female PLWHAS said that they contracted the virus through the sharing of contaminated objects as against 6.9% male respondents.

Table 6.14 bellow presents **mode of transmission or how PLHWAS were infected in percentages.**

Gender: what mode of transmission were you infected?									
Gender		unprotected casual partners	use of contaminated blood or blood products	sharing of contaminated sharp objects	infection by unfaithful partner	sexual violence	all of the above	none of the above	Total
Male	Count	21	9	11	10	3	9	0	63
	Expected Count	16.6	12.5	6.9	12.1	6.2	6.2	2.4	63.0
	% within gender	33.3%	14.3%	17.5%	15.9%	4.8%	14.3%	.0%	100.0%
Female	Count	27	27	9	25	15	9	7	119
	Expected Count	31.4	23.5	13.1	22.9	11.8	11.8	4.6	119.0
	% within gender	22.7%	22.7%	7.6%	21.0%	12.6%	7.6%	5.9%	100.0%
	Total	48	36	20	35	18	18	7	182

Further instigation into the prevention methods that these PLAWAS tried showed that 63.5% of female respondents relied on abstinence as their preferred method of protection as against 56.5% of their male counterparts. However, the percentage of male PLWHAS surpasses that of female on the issue of condom use where 32.3% of male respondents said they tried using condoms as against a 27.0% of their female counterparts; 11.9% of male respondents said they relied on mutual fidelity as against 9.6% of their female counterparts.

Table 6.15 bellow presents method of prevention tried by PLHWAS in percentages.

Gender: what method of prevention did you try?					
Gender		abstinence	mutual fidelity	**condom use**	Total
Male	Count	35	7	**20**	62
	%	56.5%	11.3%	**32.3%**	100.0%
Female	Count	73	11	**31**	115
	%	63.5%	9.6%	**27.0%**	100.0%
	Total	108	18	**51**	177

Further investigation to know if they were in the position to negotiate condom use revealed 90.0% of our male respondents stating that they were as against 69.9% of their female counterparts. Only 38.1% of our female respondents said that they were in a position to negotiate condom use; 61.9% of those who were in position to negotiate condom were not married suggesting that a substantial number of PLWHAS were infected by their spouse.

Tables 6.16a&b below present details.

6.16. A: Shows the position of PLHWAS to negotiate Condon use in percentages.

Gender		Yes	No	Total
Male	Count	54	6	60
	%	90.0%	10.0%	100.0%
Female	Count	73	45	118
	%	61.9%	38.1%	100.0%
	Total	127	51	178

6.16. B: Shows the marital status and position of PLHWAS to negotiate Condon use in percentages.

6.16 B: marital status: were you in a position to negotiate Condon use?				
		Yes	No	Total
Single	Count	45	20	65
	%	69.2%	30.8%	100.0%
Married	Count	62	23	85
	%	72.9%	27.1%	100.0%
Widow	Count	15	7	22
	%	68.2%	31.8%	100.0%
Widower	Count	5	1	6
	%	83.3%	16.7%	100.0%
	Total	127	51	178

To identify the challenges PLWHAS face protecting themselves against the virus before they were infected by HIV, we asked the respondents to select from several options those factors that limited their ability to protect themselves successfully against HIV. Figure 6.17 below is a graphical representation of these factors, while tables 6.17 A & B show the gender dimensions of the challenges and the effect of marital status on individuals' ability to protect their health.

Graph6.17 A: showing the challenges PLWHAS in our study population faced in protecting themselves against HIV.

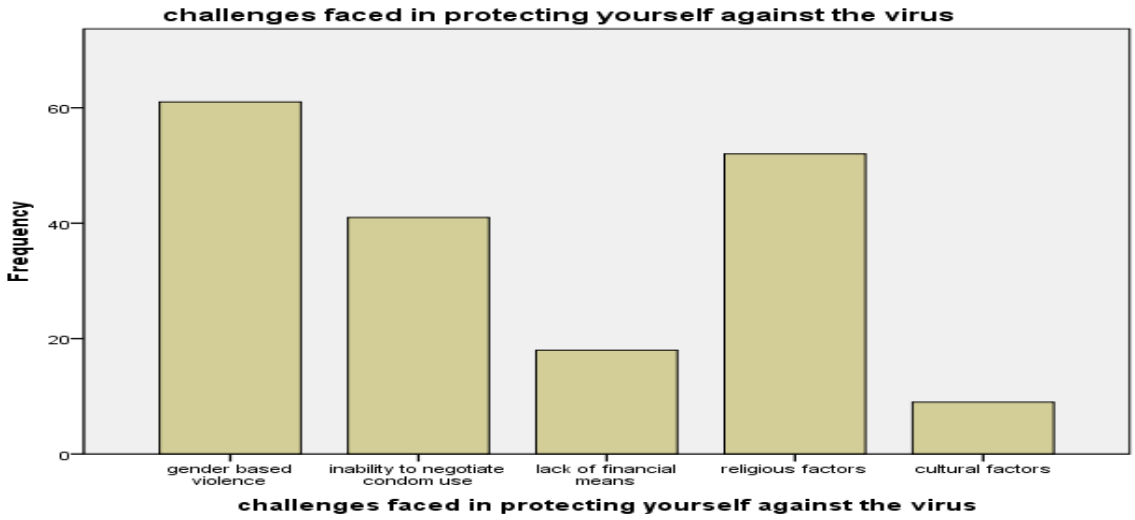


Table6.18 Showing the challenges faced by PLHWAS IN protecting themselves against the virus in percentages

challenges faced in protecting yourself against the virus		Gender based violence	Inability to negotiate condom use	Lack of financial means	Religious factors	Cultural factors	Total
Male	Count	16	6	8	25	8	63
	%	25.4%	9.5%	12.7%	39.7%	12.7%	100.0%
Female	Count	35	35	10	37	1	118
	%	29.6%	29.7%	8.5%	31.4%	.8%	100.0%
Total			51	41	18	62	181

From the various challenges presented above, it is evident that a significant number of our respondents suffered gender-based violence in the process of protecting themselves .As shown in figure 6.7A & table 6.7B, 25.4% of male and 38.1% of female said they couldn't use available prevention methods for fear of violence. There was a significant gender gap on the ability of respondents to negotiate condom use. We found 29.7% of our female respondents who said that they were unable to negotiate condom use against a 9.5% male PLWHAS.

However, the percentage of male respondents surpasses that of female on the issue of religion. We found 39.7% of our male respondents who said that religion was their major challenge as against a 31.4% of female PLWHAS suggesting that more women than men faced barriers that were linked to their gender, reflecting the power imbalance in our gender relations.

To further investigate those who suffered negative consequences as a result of their HIV status, we asked respondents to tell us the reactions of their partners or spouses. We found 41.2% of female respondents who said that their partners reacted violently as against a 34.0% of their male counterparts. Women were also more likely than their male counterparts to suffer one form of discrimination or the other. This study found 40.3% of female respondents saying that they suffered discrimination as against a 30.2% male PLWHAS. Women's unequal status within families and society means that they are often blamed for 'bringing HIV into the family'; while poverty and inequality means that they are unable to avoid the bad treatment that comes with this blame.

Table 6.18 bellow present **the level of discrimination face by PLHWAS because of their HIV status**

Gender: have you ever suffered discrimination because of your HIV status?				
		Yes	no	Total
Male	Count	19	44	63
	%	30.2%	69.8%	100.0%
Female	Count	48	71	119
	%	40.3%	59.7%	100.0%
	Total	67	115	182

6.4 PRESENTATION OF DATA COLLECTED FROM PROGRAMME MANAGERS

To examine the effectiveness of HIV prevention strategies that have been adopted to address the phenomenon under investigation, we asked programme managers to select from several options those strategies they have adopted in their various organizations. We found 40.5% of our respondents saying that they selected women and children as their targeted population. 22.8% were found saying they have youths as their targeted population and 29.2% were found saying that they have a combination of women, children and youths; 7.5% were found saying they have **uniform** men and women as their targeted group. Table 6.8 below presents details.

Investigating the effectiveness of these strategies they have adopted, we found 12.7% of our respondents who said it is less effective; 3.2% said that the strategy they have adopted is very effective while 84.1% said it needs improvement. Table 6.19 below presents details:

Table 6.19: Showing the responses or programme manages in the effectiveness of preventive strategies in percentages.

No of respondent	Very effective	Less effective	Needs improvement	Total
63	3.2%	12.7%	48.1%	100%

Further investigation into the ways that gender inequality manifests in the LGA, we asked respondents to select from several options the ways it manifests in Jos North. We found 9.5%(9) of our respondents who chose unequal access to resources between the genders; 15.9% (10) selected unequal employment opportunities between the genders; 20.6%(13) were found saying it manifests in unequal power relations; 11.1%(7) selected unequal educational opportunities, while 41.3%(26) chose all of the above. Table 6.10 below presents details.

Table 6.20: Showing the responses of programme managers on how gender inequality manifest in the LGA in percentages.

No of respondent	Unequal access to resources	Unequal employment opportunities	Unequal power relation	Unequal educational opportunities	All of the above	Total
63	9	10	13	7	26	63
100%	9.5%	15.9%	20.6%	11%	41.3%	

To probe for the impact of the above on prevention strategies, we asked respondents if these factors affect prevention programmes negatively or positively.Table6.11 below shows details:

Table 6.21: showing the opinion of programme managers on if mainstreaming gender into existing HIV strategies and programmes will improve their effectiveness in percentages.

No of respondent	Yes	No	Total
63	63	0	63
100%	10%	0%	100%

To find out the impact of the above on prevention efforts, we asked respondents to select from the two options. We found 96.8 % (61) of our respondents saying that it will affect prevention programmes negatively as against a 3.2 %(2) respondents. Table 6.22 below presents details.

Table 6.22: showing how gender inequality impact on HIV prevention programme in percentages.

No of respondent	Negative	Positive	Total
63	61	2	63
%	96.8%	3.2%	100%

When asked if prevention programmes would be more effective by mainstreaming gender into existing strategies, found that all 100 %(63) of the respondents said that gender sensitive programmes are likely to be more effective.

Overall, HIV/AIDS programme managers are of the opinion that the current policy and strategies to prevent the spread of AIDS will be more effective if gender issues are adequately addressed. A significant number of the respondents believe that the current policy and strategies need improvement. However, those at the helm of affairs

seem to display a lackadaisical attitude. Unlike the issue stigmatization and discrimination against those living with HIV/AIDS where laws have passed to prohibit any form of prejudice against them on the Plateau, there is a lot of uncertainty on the adoption of gender related issues by policy makers.

They have failed to explore ways of making relevant laws that empower women at the state level, while policy makers at the local government level are not involved with AIDS related issues as decisions are taken at the state level. Many countries have signed up the international human rights frameworks that oblige them to respect and protect the rights of all people regardless of HIV status and gender. However, HIV positive women, men and children are subjected to degrading and discriminatory treatment, causing blame, despair, isolation, shame and leading to little or restricted freedom of choice or movement in all areas of life. Moreover, gender inequalities in all areas of life increase the abuse of sexual and reproductive rights, as well as legal, economic and political rights for millions of women worldwide. Women's unequal social, economic, and legal status is increased by a positive HIV status, and vice versa.

Gender inequality and discrimination against women living with HIV hit personal relationships too. When HIV positive women face abuse from partners and other relatives, we are often even less able than other women to assert ourselves. For many of them, there may be no possibility of practicing safe sex - even if they are aware of the risks. This is especially true for young women who lack the protection of elders and the power and confidence to negotiate safer sex. The AIDS epidemic has affected us in a very devastating way. It has clearly revealed the imbalance of power between men and women. We cannot say that we have fared well in our efforts. This is because the epidemic continues to rage on. We need to utilize the knowledge,

diversity of experiences and expertise to support men and women to take up their responsibilities and acquire the power to protect them from HIV infection. For each new infection should concern us.

6.5: IN-DEPTH INTERVIEW WITH KEY INFORMANTS.

In the in-depth and key informant interviews, Mrs. Idoko of Halt AIDS, Mr. Bala Miltok of PLACA, Hajiya Miamunatu Abdul of FUMWAN, Pastor Benjamin of Faith Alive, Pastor Oluwatoyin of Messiah Foundation, Mrs. Annah of Almannah, Ms. Mary Wuyap of OCEAN, Mr. Tonny Izang of JDPC, Mr. Moses of LACA and Hajia Halima Hassan of academic planning division, University of Jos, are all in agreement on the connection between gender inequality and the disproportionate spread of HIV/AIDS in the LGA.

The interviewees pointed out some underlying risk behaviours among men and women and fundamental gender inequalities that put women in particular at high risk for HIV. Cultural norms, gender-based violence, sexual abuse, informal transaction and intergenerational sex, restriction on women mobility, access to education and economic opportunities were commonly reported to increase women's risk for HIV by limiting their ability to control their own sexuality and affecting their access to key information.

They maintained that cultural norms which relegate women to subordinate role within marriages make it difficult for them to negotiate their right to safe sex, refusal of sex or use of family planning. They further stated that cultural factors limit women's ability to effectively use condoms or other prevention methods. Mrs. Idoko of Halt AIDS stated that a lot of people do not like to go to shops to buy condoms for fear of being stigmatized; that this is particularly difficult for young girls and women as a whole. She maintained that access to sexual and reproductive education for young

girls is almost impossible since "good girls" are supposed to be sexually passive and ignorant about sex. Consequently, most women are not equip to use to use female condoms (Source: field survey, February, 2011).

The fact that Nigerian culture frowns at sexual matters and desire could be responsible for the above challenge. A great deal of pressure to remain quiet about sex in Nigerian culture is rooted in socio-cultural values, customs, expectations, believes and ideas about what constitutes good and bad behaviours. Words commonly used to depict sexual desires, parts of the body, sex, menstruation, in many Nigerian cultures are often ambiguous and indirect, reflecting the cultural quietude expected on sexual matters, which in turn has a negative effect on access to sexual and reproductive education. Consequently, unconventional behaviours such as rape, sexual harassment go unreported and the perpetuators go unpunished. Pastor Oluwatoyin of Messiah Foundation opines that in our churches, we do not want to talk about sex; the church shy's away from issues of sex education; nobody wants to be seen as a bad person. In mosques, nobody discusses sex; people shy away from the issue and women suffer most (Source: Field Survey, February, 2011).

Issues with regards to the vulnerability of women in the LGC was further reiterated by Mrs. Anna of Almanah (an NGO which gives care and support to widows, particularly those infected and or affected by AIDS) that our culture and tradition place women in a vulnerable position with regard to AIDS; church leaders do not explain clearly to her congregation the differences between the Biblical submission and traditional submission. She maintained that traditional submission is synonymous with female subjugation which entails forcing the individual into submission.

The woman is therefore required to do the following: work in her husband's farm without questioning how the proceeds from the farm is spent; she is required to have children until she exhausts her reproductive potentials; she is expected to welcome any number of wives her spouse might decide to marry; she is further required to be patient, fearful, careful and to receive corporal punishment from her spouse.

She stressed further that Biblical submission entails a willingness to yield or surrender to someone's spouse and not out of compulsion as it is commonly practised in our communities.

That there are laid down rules that govern gender relations in our religion, but in practices most couples allow cultural norms to determine the relationship between them. Traditionally, women in our rural areas marry at an early age, and male dominance within the relationship is accepted as normal. As our interviewee explains (when referring to rampant promiscuity of African married men), "most women in our villages are totally dependent on their husbands.....if your husband has decides to say this or do that, you will not say anything to stop him" (field work,2011).

A useful example of such dependence is evident through a woman's right to ownership of possessions within the marital home. These are always regarded as the property of the husband. This highlights an inequitable and frightening prospect for the many women who are widowed because of HIV/AIDS, since upon the death of a husband, many African cultures accept that the marital property and possessions belong to the deceased husband's family. Consequently, it is not unusual for widows and their children to become evicted at the hand of their husband's family. Based on this reality, it is clear that a culture, riddled with HIV/AIDS that empowers men in such a way, creates a scenario that exposes women to serious exploitation with devastating consequences. Faced with such desperation to secure the most basic of

needs, women in the LGA find themselves victims of male dominance. The respondent further stated that her attempt to develop programmes that will influence egalitarian power relations from the Christian perspective have often faced criticisms from church leaders. She maintained that these leaders often augured that gender relations are a component part of culture "which is seen as impermeable to-or inappropriate for external intervention (Source: Field Survey, February,2011).

The Muslim woman, like her Christian counterpart, suffers from religious manipulation which, in turn, affects their ability to protect themselves against HIV. As Hajia Maimunatu Abdul of FUMWAN opined, the sharia legal system has laid down rules which govern gender relations. A man is expected to love his wife and treat her with affection; stating further that Allah tells husbands to be patient with their wives (in surah 4.19), indicating a relationship of compassion, forbearing with faults and love as indicated in surah 30.21; not tyranny and dictatorship. She lamented that as a member of FOMWAN awareness committee, she has come to realize that a lot of Muslim women do not know their rights, and suffer because of their ignorance. She gave an example of women suffering from VVF, that it is not Islamic for their spouse to abandon them in their condition. She further stated that her religion does not approve use of condom; a woman, however, can still protect herself against HIV by reporting her spouse to a mallam (Islamic cleric), who will intervene in case of any extramarital affairs. She maintained that should the man refuse to heed to the cleric's advice, the woman can the take the issue to the sharia court where she will be granted an option to divorce.

This issue was supported by Mary Wuyap of OCEAN who stated that women have the right within the sharia legal system to protect themselves against HIV, if the government is willing to utilize such laws to the advantage of women. She cited an

example in Bauchi State where the State government has been able to empower women in the state to utilize the sharia legal system to protect themselves.

Hajia Halima Hassan and Mrs. Idoko of Halt AIDS stressed the issue further, with Mrs. Idoko stating that if given the right information, a Muslim woman is most likely to exercise her rights than her Christian counterparts. She cited some instances at Jigawa State where she worked, that all a Muslim woman needs is awareness provided it is in line with her religion for her to demand her rights. Hajia Hassan stated that the sharia legal has laid down rules which protect women within their matrimonial homes; that unfortunately some elements of our traditions have crept in and women suffer because of their ignorance (Source: Field Survey,2011).

Pastor Benjamin of Faith Alive on the other hand opines that the major factor responsible for the disproportionate spread of HIV between the genders has its root on the application or the practice of Christian teaching. He argued that most Christians are of either first or second generations, making it easy to carry on with some of our traditional practices that are contrary to Christian beliefs. He maintained that the underlying factor behind extramarital sexual relationship among some believers today could be traced to traditional norms that encouraged polygamous relationships in the past; that common practices of having inside and outside wives are some societal norms which assume that all men are polygamous, and this encourages men to have multiple partners to demonstrate their masculinity. He also said that it might surprise this researcher to know that this practice is common even among formal polygamous relationships.

Mr. Tonny Izang of JDPC supported this assertion, stating that Christian women would have been less vulnerable to HIV/AIDS if we lived the ideal Christian way of live with regard to gender relation rather than having this cultural mix. He

observed that the links between alcoholism and female vulnerability to the disease has been ignored in the past; however, there is enough evidence pointing to this fact. He stated further that women's limited economic options in the LGA and relative powerlessness have forced them in to brewing the local beer (burukutu) in order to cope with economic hardship, thereby exposing them to HIV risky behaviours. He also said that the proper use of condom in circumstances where individuals are drunk cannot be guaranteed which further exacerbates the AIDS crisis (Source: Field Survey, February, 2011).

From the policy dimension, the lack of legal framework for women's reproductive rights calls into question the relevance of government services to women. Nigerian government has been attending to women reproductive health through mere policy and directives, and the government does not confer enforceable rights on the citizens, neither do they impose any serious obligations on the government. Few of the numerous policies which Nigeria has embarked upon including the National Health Policy (1996) National Women Policy (2001) and the National HIV/AIDS Policy (2002) have ever translated to any serious, meaningful and concrete change in the health profile of the country. None confers on the individual a right that is actionable or the duty to hold government accountable for their performance in Nigeria. Another drawback to policy-making is that policy commonly lacks legal enforceability and may be replaced when government changes, creating the potential for instability in the manner in which reproductive health care services are provided. Mr Bala Miltok of PLACA noted that mainstreaming gender within HIV/AIDS programming is still a challenge in the state, since the State House of Assembly is yet to pass the Bill into Law. He however stated that women have been targeted in most interventions because of the disproportionate burden of the epidemic

on them. Mrs. Idoko supported this view while emphasizing that the issue of confidential testing of HIV is being looked into and there is the likelihood that spouses will be able to know the HIV status of their partners which in turn will protect a lot people particularly women (Source:Field Survey,2011).

6.6: RELATING RESEARCH ASSUPTIONS TO RESAERCH FINDINGS

The five propositions we set out to test in this work are:

1. That the effectiveness of the current policies on AIDS depends on the ability of stakeholders to capture the reality on ground with regard to gender and HIV/AIDS prevention.
2. That those factors those shape gender relations in Jos north LGC are likely to impact negatively on HIV/AIDS prevention strategies and programmes.
3. That the difference in risk perception between the sexes is likely to impact negatively on HIV/AIDS prevention strategies and programmes.
4. That knowledge about HIV/AIDS and available prevention strategies is a necessary but insufficient condition to reduce the spread of AIDS.
5. That the lack of commitment by government to adequately address gender inequality in the LGC is responsible for persistent gender gap in HIV prevalence.

To test these propositions we rely heavily on primary data generated in the Local Government Area. It is worthy to note that a total of 1212 respondents were selected among three categories, for both the quantitative and qualitative survey as stated in the methodology chapter of this study.

6.2 1 PROPOSITION ONE

This proposition states that the effectiveness of current policies on AIDS depends on the ability of stakeholders to capture the reality on ground with regard to the gender dimension of HIV/AIDS Jos North LGC.

In other to relate a research finding to this proposition, we administered questionnaires to three categories of respondents. At the first phase of the survey, questionnaires were administered to nine hundred individuals within thirty clusters in the LGC. We asked them to select from the options those factors that limit their ability to effectively utilize available HIV prevention methods. As presented earlier in this chapter, religion significantly outweighs other factors that reinforce gender inequality in the LGC, cutting across all age brackets and in the genders. This issue was noted among the second category of respondents (People Living With HIV/AIDS) and HIV/AIDS programme managers as well. The responses of our interviewees also captured this scenario when they stated that religious manipulation exacerbates women's vulnerability in the LGC. Unfortunately, this issue has not been captured in the current policy on AIDS, if one should go by those factors that have been identified and prioritized for HIV/AIDS interventions in the LGC and the country as a whole. This suggests that policy makers are yet to capture the reality on ground with regard to HIV/AIDS.

6.2.3 PROPOSITION TWO

In other to relate a research finding to this proposition states that those factors that shape gender relations in Jos North LGC are likely to impact negatively on HIV/AIDS prevention strategies and programmes. To test this proposition, we administered questionnaires and held interviews with three categories of respondents. In the quantitative survey, we asked respondents in thirty clusters as well as selected people living with HIV/AIDS to select from options those factors that can keep them in an unsafe relationship. The study found 42.7% (166) female and 47.8% (238) of male respondents saying they could maintain unsafe sexual relationship for religious

reasons. This position cuts across all the three age brackets and the two genders. This suggests that religion is one of the major factors that govern gender relations in Jos North LGC. But the gender dimension was captured only in our interview with key informants who stated that religion is one of the major factors that condition gender relations in Jos North LGC. They maintained that religious manipulation is the major factor that is responsible for generating unequal power relations within families and so increasing women's vulnerability to the disease. The study captures the fact that a wide range of power imbalances and inequality between men and women, rooted in religious values, particularly religious manipulations, have placed women in a position that makes it difficult for them to negotiate safer sexual practice with their partners.

So far, the picture that has emerged from testing our second proposition is that religious manipulation in the LGA is the major factor which conditions gender relations in the area under survey, which in turn impacts negatively on HIV prevention strategies.

6. 2. 4 THIRD PROPOSITION

This proposition attempts to show why women's risk perceptions might be different from that of men and how this impacts on their ability to avoid HIV risky behaviours. It says that differences in risk perception between the genders are likely to impact negatively on prevention programmes. To that effect, we administered questionnaires to selected individuals in the LGC. We asked if they could avoid HIV risky behaviours. Our findings were that most respondents said they could avoid these behaviours with an exception of seven individuals. Five men and two women

suggested that there is a gender gap in risk perception even though it might be difficult drawing conclusions with this small number of individuals.

6.2.5FOURTHPROPOSITION

Our fourth proposition states that knowledge about HIV/AIDS and available prevention strategies is a necessary but insufficient condition to reduce the spread of AIDS. To test this proposition we enquired from respondents about the disease, their understanding of how it can be contracted and the predominant prevention methods. Ninety-Six percent (96.9%) of female and 96.0% of male respondents said that they had adequate knowledge of the disease and some prevention methods. This high level of awareness persisted even when control for age and marital status were introduced, indicating that adequate knowledge has been disseminated within the general public. However, when asked if they could effectively utilize these prevention methods, more women than men said that they lack power to negotiate safer sex. Even among female PLAWHS that were informed about the diseases prior to their HIV status, they stated that they were powerless to negotiate safer sex. These findings validate our forth proposition.

6. 2. 6 FIFTH PROPOSITION

Our fifth proposition states that the lack of commitment by government to adequately address gender inequality in the LGC is responsible for persistent gender gap in HIV prevalence. To that effect, we ask programme managers if HIV prevention interventions will be more effective by mainstreaming gender into existing policy. We found all 100% (63) of the respondents saying that gender sensitive programmes are likely to be more effective. Our qualitative study shows the lack of commitment by policy makers when some interviewees stated that mainstreaming gender within HIV/AIDS programming is still a challenge in the state, since the state house of

Assembly is yet to pass the Bill into Law. Similarly, the existence of Laws which discriminates against women in Nigeria further validates our fifth proposition.

CHAPTER SEVEN

SUMMARY CONCLUSION AND RECOMMENDATIONS

7.1 SUMMARY

This Study captures the fact that a wide range of power imbalances and inequalities between men and women – rooted in religious values, (religious manipulations) and cultural norms, have placed many women in the position of being unable to negotiate safer sexual practices with their partners. Even among women and girls who are informed, unequal power reduces their ability to negotiate disease protection, to express their concerns about sexual fidelity, and to say no to sex. There are multiple constraints on a woman's ability to engage only in the sexual relationships and sexual practices she herself chooses and desires, and the autonomy women need in order to negotiate safer sex depends on the realization of women's right to equality in many different areas of life.

Although the list may be much longer, only three factors were outstanding among issues that impede women's ability to protect themselves against HIV. These are cultural, religious, and political factors. However due to religious manipulation, it has become difficult to differentiate between culture and religion, if one should go by the type of gender relations in the LGA. While Muslims' gender relations are governed by Islamic principles, the same situation obtains among the Christians. Gender stereotypes continued to be reinforced in Jos North LGA as series of the agents of socialization such as the family, schools, churches, mosques, and the media have become custodians as well as disseminators of gender roles, stereotypes, prejudices and discriminatory cultures. Girls and boys grow up in the LGA to accept male superiority over female and the patriarchal structure has become unquestionable phenomenon. Teachers, Religious Leaders, Parents, Police Officers and Artists in the

LGA, usually work to promote obnoxious customary beliefs and practices that violate the rights of women.

The findings of this study show that HIV/AIDS awareness and knowledge of prevention methods is wide spread in both sexes. However, this knowledge does not translate into effective utilization of prevention methods as more women than men reported having difficulties initiating condom use or to demand safer sex from partners. This challenge was exhibited by a significant number of women in this study, who indicated that they lacked power to negotiate safer sex with partners. Historically, women in the LGA are regarded as inferior to men; women are subject to guardianship through their entire life, initially under their father's guardianship until they marry, and subsequently under their husband's in marriage. A wife is treated as her husband's child. The legacy of this cultural norm is important for understanding the contemporary position of women and its connection to the transmission and rapid spread of HIV/AIDs in Jos North LGA. Men's role as the senior partner in marriage means that they are the ones who control sexual decision-making.

In Jos North LGA, gender inequality continues to be experienced by girls and women. This inequality, as an accepted cultural norm, effectively strips females of any rights to have any say in their own destiny. Arguably, this continuing, accepted oppression can be regarded as a form of secondary socialization, a consequence of which continuously lowers a woman's self esteem, reinforcing the norm that she is worthless. There are several ways in which this is achieved. This study revealed that religion is being manipulated to enhance men's inherent desire to subjugate women in which the practical application of Christianity is manipulated to privilege sexual self-donation by women as part of their Christian identity. Women are enjoined to submit to their husbands, conveniently leaving out the phrase that men should love their

wives as Christ loved the Church and gave His life for her. They are to be occupied, inhabited, and claimed by their men and must, first of all, make themselves available. This way, "Christianity" produces men as superior and women as inferior – an objects of rule by the superiors, i.e. men. Therefore, even if she is physically, mentally or sexually abused by her husband, it is tolerated since, as one interviewee straightforwardly concludes: "there is no choice."

The Muslim woman on the other hand is privileged to at least have the Shairia legal framework at her disposal. The framework spells out the rights and obligations of husbands and wives. In spite of this, most of these women are ignorant of their rights and suffer injustice. A respondent concludes that: "Given the right information, the Muslim woman is more likely than her Christian counterpart to demand her rights." However, the Sharia law discriminates against women in the interpretation of its provisions: women are easily established as culprits in cases of adultery, while the males who commit adultery with women can hardly be found guilty.

Traditional notions of masculinity also lead men to engage in risky sexual behaviours, e.g., multiple sexual partners, and to assume positions of power vis-à-vis women, including negotiating for sex. Women in Jos North LGA, are also products of this culture and may themselves have internalized ideas of manhood that make it appropriate for men to have many partners and to manage sexual relations while they accept their partner's dominance and remain faithful. This idea is common even among some Christians, in spite of the fact that the religion condemns premarital and extramarital sexual relationships. As this study reveals, there is a particular norm among the Beroms in which women encourage their husbands to maintain extramarital sexual relationships during lactating periods. This makes it impossible for women to protect themselves from HIV/AIDS even when they themselves are

faithful. It is clear that a culture, riddled with HIV/AIDS that empowers men in such a way, creates a scenario that exposes women to serious exploitation with devastating consequences.

Indeed, evidence reveals that men are yet to fully abide by the tenets of Christianity and Islam. Most men are yet to come to terms with the teachings of their religions as our qualitative survey reveals. Men seem to equate Biblical submission with female subjugation. Our findings also reveal that most Nigerians are either first or second generation Christians. They, therefore, have difficulties with the principle of having one sexual partner. As a result, most men tend to be legalistic Christians - a situation where a man will be married to one wife with several concubines and/ or sexual partners.

Women's social and economic vulnerability and gender inequality also lie at the root of their painful experiences in coping with the stigma associated with HIV infection. HIV positive women bear a double burden: they are infected and they are women. A substantial number of female PLWHAS indicated that they have been discriminated against and have faced some measure of violence from their partners as a result of their HIV status. A history of abuse and violence is an even greater deterrent for them to insist on using condom with an unwilling partner.

In the LGA, there is also a culture of silence surrounding sex which dictates that "good" women are expected to be ignorant about sex and passive in sexual interactions. This makes it difficult for unmarried women to seek reproductive health advice even when informed, thus limiting their capacity to be proactive in negotiating safer sex

This study further reveals that in very poor settings, simply urging men to use the condom raises the issue of sustainability. With the formula of one-condom-per-act

of intercourse, having an adequate supply of condoms has become a challenge. This study reveals that more women are likely to be infected by their spouses if programmes at the community level do not promote with equal vigour, other healthy options which reduce the spread of HIV such as mutual fidelity, reduction in number of partners, respect for women's rights and so on. This scenario was captured in our study when those involved in the care support of people living with HIV/AIDS expressed their fears of what will happen to poor PLWHAS if international donors withdraw their supply of free condoms. They maintained that the government will have to increase its commitments to this issue; otherwise, some women whose partners are HIV positive will be infected as well.

Power is fundamental to both sexuality and gender. The unequal power in gender relations that favours men in the LGA, translates into an unequal power in heterosexual interactions in which men are in control. Any attempt to address the disproportionate spread of HIV/AIDS will be of little effect, if this issue is not tackled. However, this study revealed that those who have attempted to develop programs that influence power relations in sexual relationships even from a religious perspective have frequently faced the criticism that gender relations are a component of "culture," which is seen as impermeable to, or inappropriate for, external intervention.

Existing legal frameworks are inadequate to deal with the reproductive rights and gender aspects of HIV/AIDS. Even where such laws exist, they are seldom enforced. For instance, the goal of the National Gender Policy is to "build a just society devoid of discrimination, harness the full potentials of all social groups regardless of sex or circumstance, promote the enjoyment of fundamental human rights, and protect the health, social, economic and political well being of all citizens

in order to achieve equitable rapid economic growth; evolve an evidence-based planning and governance system where human, social, financial and technological resources are efficiently and effectively deployed for sustainable development." The core strategies for achieving the objectives of the National Gender Policy makes reference to gender mainstreaming, gender justice and addressing the needs of women and children.

Nigeria, still falls short of the desired result of giving males and females equal opportunities and equal access to opportunities to advance socially, economically and politically. Evidence abounds of several forms of gender-based discrimination in gender relations in Nigeria. Gender-based division of labour, disparities between male and female access to power and resources, and gender bias in rights and entitlements remain pervasive in Nigeria.

Most governments in Africa have adopted constitutions that take on board gender equality. Selected countries with progress on constitutional provisions on human rights and gender equality include Benin (1990), Ghana (1992), Ethiopia (1994) and Malawi (2006) and Uganda (1995). These constitutions guarantee equality before the law and non-discrimination, while some also mandate their respective states to embark upon affirmative action measures to remedy existing imbalances which may be occurring between males and females in the social, economic, political and civil spheres of society. However, Nigeria being the giant of Africa, has failed woefully in this respect. Nigerian Government rectified Convention on Elimination of all forms of Discrimination against Women (CEDAW) in 1985 without reservation. Consequently, it is bound to fulfil its obligations. The situation of women's rights in Nigeria however signifies that government is not carrying out its obligation. The sorry

state of women's rights in Nigeria could be attributed to the non-domestication and non-implementation of this convention.

While Government has acknowledged the existence of discriminatory practices against women sustained by discriminatory legislations, policies and societal and cultural agents, it is silent in many respects on the measures it has taken to address these. Most of the socio-economic, legal and political frameworks needed for the protection of women's rights have not been effectively implemented. For instance, in 2007, the National Assembly rejected the Bill for the domestication of CEDAW which stands as the acid test for gender equality in Nigeria.

Evidence indeed attests to the fact that policy makers at the state level are not willing to empower women, since they have passed an anti-stigma Bill into law. The State Assembly refused to pass the Bill that will provide a legal framework to protect women's rights in the state.

The study further revealed weak political and financial commitment at state and LG levels as funding for HIV/AIDS in Nigeria is mainly from international donors. NGOs have no choice but to conform to donor-driven agenda which may not necessarily solve gender issues.

7.2 CONCLUSION

Most studies and programmes related to gender and HIV depict those factors responsible for the disproportionate spread of AIDS as purely socio-cultural, economic and health issues. What have been greatly underestimated in most instances are the issues that govern gender relations which in turn justify and reinforce female subordination and subjugation as the case may be.

This study reveals that the serious explanation for the low status of women in Jos North LGA has political undertone. Politics deals with power and its use. Those

who wield power use it to fulfil their interests. In a male-dominated society, power resides with men and too often, they promote policies which affect and reinforce the subordination of women. We ascribe the meekness of women in the LGA not merely to the practice of patriarchal Islam, but to the way the powers that be manipulate the tenets of Islam to enhance men's inherent desire to subjugate women. Christian women are similarly socialized like their Muslim counterparts. Christianity theoretically teaches equality for all its adherents. In reality, these teachings are differentially applied. Consequently, women are being manipulated out of their basic rights. Women are enjoined to be subject to their husbands through the much orchestrated tenets of the Holy Bible, particularly, the writings of St. Paul. Leaving out the phrase that men should love their wives as Christ loves the church was convenient for male adherents. Christian identity (in practice) thus consists in embodying patterns of control, domination and submission which put men and women into an unequal relational status. The Islamic discourses on sexuality are no more different from the Christian narratives. For instance, several conferences on population, ICPD in Cairo, the 1995 Beijing conference, the Beijing conference (+5), witnessed the Catholic and Muslim religious rights engaging in unprecedented cooperation to oppose and restrict women's rights to control their reproductive potentials.

Thus Nigerian women's struggle for individual freedom, particularly, reproductive rights is therefore curbed by cultural, political and religious narratives that construe such choices as ungodly. Although sexual reproductive rights of women are guaranteed in international conventions as well as in National Laws, such guarantees remain empty promises if they are neither recognised nor enforced in courts.

There are dearths of laws that unequivocally protect women's rights in Nigeria. The 1999 Federal Constitution of Nigeria has clauses that discriminate against women. In section 29 sub-section 4(b), 1999 Federal Constitution of Nigeria endorses child marriage when it proclaims that every woman who is married shall be regarded as an adult. The penal code endorses wife battery when it proclaims that wives may be corrected provided grievous harm is not inflected (section 55 sub-section 1(d) of the penal code, carp 89, (laws of the federal of Nigeria (LFN), 1963 applicable in Northern Nigeria). In the Criminal Code, the defilement of a boy is a crime punishable by seven years imprisonment, while defilement of a girl is only two years imprisonments (Nigerian criminal code 1948). All these suggest a deliberate attempt by those in power to maintain the current power structure. Thus, the adoption of a gender-sensitive approach to HIV prevention in Nigeria might just be a gimmick to show the world that the country is up to date with current strategies. After all, HIV/AIDS programmes in Nigeria are donor-initiated and donor-driven. In view of the foregoing, we wish to propose the following specific recommendations towards policy formulation and actions.

7.3 RECOMMENDATIONS

It is tempting to say, as many policy-makers have found it easy to do, that those factors responsible for the disproportionate vulnerability of women and girls, as described in this study, are difficult or impossible to address because so many of these have deep religious and cultural roots. But the problems persist in large part because the legal, policy, and program environment in Jos North allows them to persist. Changes in the law, more gender-sensitive policies, and more well-conceived programmes are necessary_if insufficient step toward eradicating this gender gap in

HIV prevalence. In our country, with some measure of democratic processes, changes in law and policy are likely to generate wider debates that may eventually influence cultural and social norms. We therefore recommend the following:

1. A strategic perspective is required to reduce women's vulnerability to HIV/AIDS. Such a perspective would be one which addresses environmental and structural factors which render women vulnerable to HIV/AIDS. Policies and programmes that will reduce women's vulnerability must boldly tackle the socio-cultural, socio-economic and religious factors which militate against women's empowerment.

2. One of the key strategies should be to work within the existing ideological frameworks of religious organizations to expand the frontiers of women's reproductive and sexual health and rights as well as their basic human rights rather than seeking to convert churches to a secular ideology.. After all, most churches and Mosques promote marital fidelity and pre-marital abstinence, which do not in any way increase the spread of AIDS. Bauchi State is one state that has taken bold steps aimed at empowering women to protect themselves against HIV/AIDS using the Sharia legal framework.

3. The government can start by repealing laws that discriminate against women. The following are some of the many different measures that might be taken to achieve compliance with the women Convention in relation to women's economic autonomy: ensuring equal access to education for girls and to adult literacy and vocational training for women; ensuring women rights to own property, including land and

access to financial credit on an equal basis with men; ensuring equality in employment.

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4. Based on the findings of this study, it is imperative that women and communities leaders participate in designing programmes and the content of preventive education. This is crucial for ensuring the respectability of information. Because sex and sexuality are conceptualized differently in different cultures, and because different cultures uphold different values relating to sexuality, the outside, expert-led approach to HIV/AIDS interventions at the global level, must give way to a more participatory and culture sensitive approach at the community level.

5. Due to the influence and power which men exert over women in relationships, and because men's sexual behaviours impact directly on women's exposure to the risk of infection, it ought to be clear that men should be at the centre stage of interventions against HIV/AIDS from a gender perspective..

6. It is worthy to note that whatever policies and programmes that are eventually designed to help reduce the vulnerability of women and girls to HIV/AIDS will not make much difference in their lives if not backed by adequate resources. Pressure must be put on governments at every level, particularly, the local Government, not only to design gender sensitive programmes and policies but also to make resources available for implementing them.

7. Finally, at the other end of the continuum-far away from programmes that foster damaging gender stereotypes - are programmes that seek to empower women. To

know how to empower women requires us to deconstruct the sources or components of power that are amenable to project or policy intervention. From the research we have conducted, we have identified four sources of power: information and education (*sacred narratives: Christian and Islamic discourses on women's rights*); access to economic resources; social capital; and the opportunity to have a voice in decision-making at all levels.

REFERENCES

Abia, F. P. (2002) 'Factors Influencing the Utilization of Orthodox Health Facilities in the Treatment of STDs among Youths in Ibiono Ibom, Akwa Ibom State, Nigeria'. B.Sc. Thesis, Dept of Sociology/Anthropology, Univ. of Uyo, Nigeria.

ADF,(2000) 'AIDS The Greatest Leadership Challenge' Online WWW.uneca.org/adf2000/daily-update/madia-kit

Adih.W.K, Alexander, C.S. (1999) "*Determinants of Condom use to Prevention HIV Infection Among youth in Ghana";* Journal of Adolescent Health, 24(1) 63-72

AFTPM (2002) 'Briefings Notes on Critical Gender Issues in sub-Saharan Africa. Last up-dated October 2005)

Aggleton P. (1996) "global priority for HIV/AIDs intervention research international journal STDs/AIDS.

Ajzen, I. and Fishbein, M. (1980) Understanding Attitudes and predicting Social behaviour. Englewood Cliffs, NJ: Prentice Hall.

Akande, A. (1994) "*AIDS related beliefs and behaviours of students: Evidence from two countries (Zimbabwe and Nigeria International"*. Journal of Adolescent youth, vol 4 (3-4). 285-303

Akerolyd, A; (1996) "*Some gender and occupational Aspects of HIV/AIDS in East and Southern Africa: change continuities and issues for further consideration at the end of the first Dacade";* Center for African studies Edoburgh University.

Alahira, A.H(2008) The Role Of Women In The Colonial Economy Of Northern Nigeria: A Case Of The Berom Of The Jos Plateau, 1900 – 1960.

Alice M. Miller, 2000. "Sexual but Not Reproductive: Exploring the Junctions and Disjunctions of Sexual and Reproductive Rights." *Health and Human Rights*, v. 4, no. 2: 68-109.

Allen S. et al (1992) confidential HIV testing and condom promotion in Africa impact on HIV andomoreal rates. JAMA 268.

Amaro H and Raj A. (2000) "*On the margin of power and women's HIV risk reeducation strategies";* Sex roles 42,723-749

Amaro H Raj.A and Reed E. (2001) Women's Sexual Health. The need for feminist analysis in public health. psychology of women quarterly, No. 25,324-334

Amaro H. (1995) "love sex and power: considering women's realities in HIV prevention American psychologist Jos (6).

Ana Maria Costa, 2000. "On Women's Right to Experience their Sexuality Free from Illness." *Women's Health Collection/5: Women, Sexualities, Rights*. Santiago, Chile: Latin American and Caribbean Women's Health Network.

Araoye M. O (2004) Research Methodology With Statistics For Health and Social Sciences. Nathadex, Publishers, Illorin.

Asuquo, A. (1999) 'Extramarital Sexual Behaviour in a Nigerian Urban Centre'.*Journal of Marriage and Family* 21 (3) 110-121.

Auerbach J. et al (1994) An integrated Approach .National academic press: constitution ave Nw.

Barnett; T. Whiteside A. and Desmond C. (2001) "*The social and Economic impact of HIV/AIDS in poor countries"*. A review of studies and lesson progress in development studies 1 (2) 151 – 170

Bates, 1 Fenton, C, Gruber J, Lattow, O.D, lara, A.M, Squire, S.B Theobald S, (2004) "*vulnerability to malaria tuberculosis and HIV/AIDS infection and disease"*. THE LANCET Infections Diseases

Becher, M.H, & josephs, J.G. (1988) "*AIDs and behavioural change to reduce risk";* A review. American journal of public health vol 78.

Bowleg L, Belgrave F.Z, & Zeisen, C.A (2000) "*Gender roles, power strategies and precautionary social self – efficacy implication for black and Latina women's HIV/AIDS protective behaviours"*; Sex roles 42,613-63

Brandt, A. M. (1988): "*AIDs in historical perspectives: Four lessons from the history of sexually transmitted disease"*. *American* Journal of Public Health, Vol. 78.

Bunnel R. (1996) promoting or paralyzing behavioural change: understanding gender and high levels of perceived risk of HIV infection in south western Uganda. Thesis Harvard school of public Health Boston, Massachusetts.

Business and HIV/AIDS in Africa regional snap shot. World economic forum (2008)

Business Fight AIDS (2007) "*Over view of the feminization of HIV/AIDS in sub – Saharan Africa"*.

Buswell, C. (1989) Women in Contemporary Society. London. Macmillan Education LTD

Cabral, R.J Pulley, L.V Artz, C.M; Brill, and Maraluso, M (1998). "*Women at risk of HIV/STD. The importance of male partners as barriers to condom use";* AIDS and behaviour, 2, 75 -85

Campbell, C. A. (1995). "*Male gender role & sexuality implications for women's AIDS risk and prevention";* social science and medicine 41 197 – 210

Catania J.A, Kegeles, S.m & Coates, T.J (1990) Towards an understanding of risk behaviour. An AIDs risk reduction model (ARRM); Health Quarterly, 17.

Cohen .D (2001) Poverty and HIV/AIDS in sub – Saharan Africa. Available on line: www. Undp-org/hiv/ publications/ issue/ English/issue 27e.htm.

Cohen. D. (1998) "*Poverty and HIV/AIDS in sub – Saharan Africa HIV and Development Programme"* issue paper no. 27.

Araoye M. O (2004) Research Methodology With Statistics For Health and Social

Sciences. Nathadex, Publishers, Illorin.

Cross C; (2001) "*Sinking deeper down HIV/AIDS as an economic shock to rural household society in transition";* Vol. 32(1)

Cynthia Rothschild with Scott Long, 2000. *Written Out: How Sexuality is Used to Attack Women's Organizing*. NEW

Darini Rajasingham, 1995. "On Mediating Multiple Identities: The Shifting Field of Women's Sexualities within the Community, State and Nation." pp. 233-248 in Margaret A. Schuler, ed., *From Basic Needs to Basic Rights: Women's Claim to Human Rights*. Washington, DC: Women, Law and Development International.

De Waal. A and Whiteside (2003) "*A new variant famine. AIDS and the food crisis in southern Africa"*. The lancent. Vol 363. (1)

Division of HIV/AIDS prevention (2003) "HIV and its transmission" Centers for Disease Control and Prevention. Retrieved on 2006 – 05-23.

Dixon-Fyle, Kand Mulangu, C (2004) "*Responding to HIV/AIDS in the world of work in Africa. The role of social protection"*. Working Paper 5. ILo programme on HIV/AIDS and the world of work. Geneva.

Drapper,P.(1975) Ikung Women:Contrast in Sexaul Egalitarianism in Foraging and Seduetary Contest. In Reiter,R.(1975) Towards an Anthropology of Women.New York Monthly Review Press.

Dunkle Kl Jewkes, R,Kbrown, HC, Gray, G.E Montyre, J.A and Harlow S. P. (2004). "*Transactional sex among women in Soweto, South Africa. Prevalence, risk factors and association with HIV infection"*; Social science and medicine, 30 (8) 1581 – 1592.

Eaton. L, Aishera. J. and Arab, L.E (2003) "*unsafe sexual behaviour in South African youth".* Social science and medicine; 56(1)149

Ehrhardt A.A, Exner, T.M, Hoffman, S, Silberman, I, yingling, S; Adams Kinner (2002b). "*HIV/STD risk and sexual strategies among women family planning Client in New York".* Project F 10. AIDS and Behaviour, 6, 1 -13.

Ehrhardt A.A, yinging, S. zawadzki, R, and Martinerz – Ramirrez, M. (1992) "*Prevention of heterosexual transmission of HIV Barriers for women";* Journal of psychology and human sexuality.

Ejikeme, G. G. (2003) *Socio-economic and cultural conditions of the girl child*, Jos, Decca Publications.

Elizabeth Khaxas, 2001. "Organizing for Sexual Rights: The Namibian Women's Manifesto." pp. 60-65 in Cynthia Meillón with Charlotte Bunch, eds., *Holding on to the Promise: Women's Human Rights and the Beijing + 5 Review*. New Brunswick, NJ: Center for Women's Global Leadership, Rutgers. See also, "Sexual Rights are Human Rights," statement by Elizabeth Khaxas at the Rally for Democracy and Human Rights, which took place in Windhoek, Namibia on 28 April 2001. Contact Sister Namibia at sister@iafrica.com.na.

Engelhard, P & Seek, M (1991) ' Sexual behaviour and cultural context' *Scandinavian Journal of Development Alternatives* x (1&2) 5-25

Estioko-Griffin, A. (1986) Doughters of The Forest. Natural History 5:37-42

Expert think tank meeting on HIV prevention in high-prevalence countries in southern Africa. External report. From SADC/ Botswana. Online http.//www.sadc.int/. Access 14th September 2009

Ezeh, A, Seroussi, M and Rogger, H (1996) "*Men's fetility, contraceptives use and reproductive preference";* DHS comparative studies No 18 Calvertion, MD: macro

Federal Ministry of Health (FMOH) (1998) *The National Population Policy,* Lagos, Government Printer.

Fullilove, M.T, Fullilove, R.F, Haynes, K and Cross, (1990) "*Black women and AIDS prevention; A view towards under standing the rules";* The journal of sex research, 27,47 -64.

Gandu, Y.K, (2010) Western Gender Paradigms and the Appropriation of African Women. Research Paper Presented at the Faculty of Humanities Seminar Series, Faculty of Humanities, Rhodes University, Grahamstown, South Africa.

Gemez, C A and Van Oss Marin, B. (1996) "*Gender Culture and Power. Barrier to HIV prevention, strategies for women";* The Journal of sex research.33, 335 – 362

Gomwalk et al, (2008) "*Seroepidemology of Human Immunodeficiency Virus (HIV) in Plateau State* Nigeria. Unpublished Work Submitted to Placa.

Grant, MR and Pulmiere, A.D (2003) *when Ten is luxury. The Economic impact of HIV/AIDS in Bulawayo Zimbabwe*. African studies.

Gray, Robert. "Sonjo Bride-Price and the Question of African "Wife Purchase"," *American Anthropologist*, New Series, 62, No. 1 (February 1960): 34-57.

Gupta, G.R (2001) "*Gender sexuality and HIV/AIDS. The what, the why and the how";* SIECUS Report, 201,6-1.

Gupta, G.R and Weiss, E. (1993) "*Women's lives and sex; Implications for HIV prevention";* Culture and medical psychiatry 17,399 – 912.

Halperin, D. (2001) *Poverty, the root cause of AIDS in South Africa;* South Africa AIDS Bulletin 10 vol2, page 12-14

Harne L and E. Miller eds. (1996) *All the Rage: Reasserting Radical Lesbian Feminism*. New York teachers press.

Harris 1995 "The AIDS Heresies" Retrieved 2 -9- 2008.

Harris, M.(1993) In Sex and Gender Hierarchies. Cambridge University Press

Heise L. Elias C. (1995) transforming Aids prevention to meet woman's needs a focus on developing countries soc. Sci Med 40 (7).

Hobfoll, et al. (1993). "*Safer sex knowledge, behaviour and attitudes of inner city women"*; Health psychology 12,481 – 488.

Ibanga, U. A. (1994) *Determinants of Fertility Behaviour in Selected States in Nigeria: A Report of the Cost of Children Project*. Ibadan. Population Research Fund, Management Unit, NISER.

Ilkkaracan, P. (2002) 'Women, Sexuality, and Social Change in the Middle East and the Maghreb' *Social Research* 8 (4) 101-132.

Ingalla, J, L Emmelin M.A.C Mutembe A.K, Comoro, C.J, Killewo, J.2.J. Kwesigaba, G, Sandstorm, A.I.M and Dahlgren, L. G. "*The social cultural contexts of HIV/AIDS transmission in the Kagera Region, Tanzania. Koninklijke";* Brill NV, Leiden. 377-402.

Izugbara, U. (2001c) 'Tasting the Forbidden Fruits: The Social Context of Debut Sexual Encounters Among Young Persons in a Rural Nigerian Community'. *The African Anthropologist* 8 (1) 96-107.

Izugbara, U. (2004c) 'Notions of Sex, Sexuality, and relationships among adolescent boys in rural southeastern Nigeria.' *Sex Education* 4 (1) 63-79.

Joint United Nations programme on HIV/AIDS (UNAIDS) (2003) Accelerating action against AIDS in African. Available online: www.unaids.org. Accessed April 2007.

Jooma B.M. (2005) "*Southern Africa assessment. Food security and HIV/AIDS";* African security Review 14 (1)

Kalichman S. (1997) Efficacy of behavioural skills enhancement HIV reduction interventions in community setting AIDs 11 (Suppl.A) S191-S199.

Kalichman S. (1998) preventing Aids: a source book for behavioural intervention Lawrence Eribanm Associate Inc publisher N.S.

Kalley L.O (2008) "*The first past modern pandemic. 25 years of HIV/AIDS";* International medicine 263 (3) 218-43.

Kempe R.H. (1999) *AIDS and Development in Africa*; Social science perspective. New York The Haworth press.

Koopman C Volk, J E. (2001) "*Factors associated with condom use in Kenya a test of the health belief model";* AIDS education and prevention.

Kritz, Mary M. and Douglas T. Gurak. "Women's Status, Education and Family Formation in sub-Saharan Africa," *International Family Planning Perspectives*, 15, No. 3
(September 1989): 100-105.

Ladner J. et al (2002) "*Teenage African women and HIV – infection"*. The lancet 2, (9348) 1889.

Logan T. H et al (2002) "*women, sex HIV: social and contextual factors, Meta: Analysis of published interventions and implications for practice and research"*; Psychological Bulletin 128,851.

Logan T.H ad Lenkefeild, C (2000) "*VIOLENCE and HIV risk behaviour among male and female crack users";* Journal of Drug issues 30,361 -282.

Lynn Freedman, 1994. "Reflections on Emerging Frameworks of Health and Human Rights." *Health and Human Rights*, v. 1, no. 4: 313-346.

Macera C.A (1992) "*Contraception and HIV prevention among women, in public health clinics"*; Health values. 16, 3-9.

Malcolm et al (2002) "*How household cope with the impact of HIV/AIDS Epidemic"*; Kaiser Family Foundation Trust for Health Systems Planning and Development.

Mane, P. and Aggleton, P. (2002). Cross national perspectives on gender and power in. R Parter, R. M. Barbosa and P Aggleton (eds) Framing the sexual subject. The politics of gender sexuality and power. (pp 104 -166) Berkeiey, CA. University of Califonia press.

MacDonald, D. S.(1996) 'Notes on the socio-economic and cultural factors influencing the transmission of AIDS in Botswana' Social Science Medcine42(9)

Mann (1999) Medicine and Public health Ethics and Rights. In Mann, S. Grusskin, M.A Grodin and G.J Annas (eds) Heath and Human Rights. A Reader. London Rutledge.

Mcormisk.J.B.(1996) *Level 4 Virus Hunters* of the CDC. Allanga Turner publishing Pg 188-90.

Mil, J. E, Anarfi J. K. (2002). "*HIV risk environment for Ghanaian women. Challenges to prevention"*; Social Science and medicine (54) 324 -337

Millet K. (1971) Sexual Politics. New York. Doubleday

Mead, M. (1935) *Sex and Temperament in Three primitive societies.* New York: Marrow William publishing.

Mengisteab, Kidane. "African Traditional Institutions of Governance: The Case of Eritrea's Village Baito," in Olufemi Vaughan, ed. *Indigenous Political Structures and Governance in Africa*. Ibadan: Sefer, 2003: 208 - 223.

Misovich S, Fisher J.D and Fisher W.A (1997) "*class relationships and elevated HIV risk behaviour Evidence and possible underlying psychological processes"*. Review of General psychology. 1, 72 – 107.

Mutangudara GB.(2000) Household Welfare Impact of Motility of Adult Female in Zimbabwe: Implications for Policy and programme Development: paper presented at the AIDS and Economic Symposium organized by IAEN network South Africa.

Nako Stes, Boerma J.I. Urassu M Mwaluko, G Zaba, B; (2004)Sexual female or Swaggering male.

National Action committee On AIDS (NACA; The National HIV/AIDS Behaviour Change communication, 5 year strategic Plan (2004-2008). Published by (NACA) Abuja

National Action committee On AIDS (NACA); The National HIV/AIDS Behaviour Change communication, 5 year strategic Plan (2004-2008). Published by (NACA) Abuja

National Agency for the Control AIDs: National HIV/AIDs prevention plan 2007-2009: Jodes press Ltd

National Agency for the Control AIDs: (2010) National HIV/AID Strategic Plan 2010-2015: Jodes press Ltd

National HIV/Syphilis serosentinal survey (HSS) 1991-2004 in plateau AIDS Control Agency (PLACA) Annual Report (2004/2005) Published by (PLACA) Jos National policy on HIV/AIDs 2003

Nattass, N.(2004) *The moral Economy of AIDS in South Africa United Kingdom*: Cambridge university press.

Netting, Robert McC. "Women's Weapons: The Politics of Domesticity among the Kofyar," *American Anthropologist*, New Series, 71, No. 6 (December 1969): 1037-1046.

Niehof. A.; (2005) "*The significance of Diversification for Rural Livelihood";* Food policy: 29; 321-338

O'Leary A (2000) women at risk for HIV from a primary partner: balancing risk and intimacy. Annual Review of sex Research, H, 191-234

O'Kelly and Canary(1986) Women and Men in Society(2ed)Belmont, CA, Wash worth Publishing Co.

Official Gazette of the Federal Republic of Nigeria No. 2, February 2009

Pearce, T. O. (2000) 'Women, the State, and Reproductive Health Issues in Nigeria' *Jenda* 1 (1) 1-21.

Plateau AIDS control Agency (PLACA) Annual Report (2004/2005). Jos shiginku publishing.

Plateau AIDS control Agency (PLACA) Annual Report (2004/2005). Jos shiginku publishing.

Plateau AIDS control Agency (PLACA) Up Date of Health facilities and institutions in plateau State (1999-2004). Jos Shigintku Publishing. Co

Phaladze, N. A, Tlou, S. (2006) Gender and HIV/AIDS in Botswana: Focus on inequality and discreminations. Gender and Development vol 14 no1

POKU N (2005) AIDs in Africa U.K. Cambridge Polity press

Pratt, CB et al (2000) Health- Information sources for Kenyan adolescents; implications for counting HIV/AIDS control and prevention in Sub-Shan ran Africa. The western journal of black studies. 24(3) 131-144

Rebecca J. Cook, 1995. "Human Rights and Reproductive Self-Determination." *The American University Law Review*, v. 44, no. 4: 975-1016.

Rienter S ,D.L et al. (1992) "*Contraception and HIV prevention among women in public Health clinics"*. Health values, 1b, 3-9. Rockefeller foundation, the (2002) Mobilization for microbicides the decisive decade New York. Author

Robinson J. (ed) (2004) "*Culture behaviour and HIV/AIDS"* International Nursing Review, 51 (1)5.

Rogers, R. W. (1983) *Cognitive Physiological Processes in attitude change: A theory of protection motivation;* In J. Cacippod R. Petty (eds), Social Psychology. New York: Guilford Press.

Ruth Dixon-Mueller, 1993. "The Sexuality Connection in Reproductive Health." *Studies in Family Planning*, v. 24: 269-282.

Sacks K.(1979) Sisters and Wives ; The Past and Future of Sexaulity Eqaulity. Westpont, C.T. Greenwood.

Shostak, M.(1986) The life and Works of an Ikung woman. NewYork Random House

Samatebele, H. (2005) Society Organization (CSO) Experience, monitoring of food security issues in Zambia. A paper presented at the southern African regional poverty Network (CSARPN)

San Francisco AIDS foundation (2006). How HIV Spread. Retrieved on 2006-05-23

Schneider et al (2004). National history and mortality in HIV positive individuals living in recourse poor settings. A literature review.

Sheopf B (1991) "*AIDS Action Research with women in Kinshasa, Zaire";* social science and medicine.

Sobo, E. (1993) Inner city women AIDS> the psychosocial benefits of unsate sex. In Ross. A. (ed) sexuality across the life course Chicago university of Chicago press.

Sobo, E. (1995) "*Finance romance, social support and condom use among impoverished inner city women"*; Human organization. 54, 115-128

Sônia Correa and Rosalind P. Petchesky, 1994. "Reproductive and Sexual Rights: A Feminist Perspective." pp. 107-123 in Gita Sen, Adrienne Germain, and Lincoln C. Chen, eds., *Population Policies Reconsidered: Health,*

Empowerment, and Rights. Boston: Harvard Center for Population and Development Studies; and New York: International Women's Health Coalition

Steedman C. (1986) land scope for a good women. A story of two lives. New Brunswick N. :J Rutgeer university press.

Stevens P. Hall, J (1998) participating action research for sustaining individual and community changed model of HIV prevention education AIDs education and prevention 10 (S).

Stewart J. (2003) Moving food: "*The world food programme's response to the southern African Security"* Review. 12 (1)

Susana T. Fried and Ilana Landsberg-Lewis, 2000. "Sexual Rights: From Concept to Strategy." pp. 91-122 in K. Askin and D. Koenig, eds, *Women's Human Rights Reference Guide*. New York: Transnational Press.

Sweat M. Division J. (reducing HIV incidence in developing countries with structural environmental interventions. AIDs.

Tabi M. M, and Frimpong. (2003) "*HIV infection of women in African countries, International council of nurses"*. International nursing review 50, 242-250.

Tawill O. Verster A Enabling approached for HIV/AIDs prevention can we modify the environment and minimize the risk AIDs.

Tong R.(1989) Feminist Thought. USA. Westview Press.

Toure, Aby, and Cynthia Case (2005) "*Press Release – AIDS flows, Debt Relief and Economic Growth on the rise in Africa, But threats to poverty Alleviation Remain"*. "World Bank Report" World Bank. Accessed 15th June, 2008

Ulinep (1992) African women and Aids negotiating behaviour change Soc. Sci Med 34 (1)

UNAIDS (2000) Stepping Back from the edge. The Pursuit of Antiretroviral Therapy in Botswana and South Africa online.www.unaids.org. Accessed 12th July, 2008

UNAIDS (2002) 'Reports on the Global HIV/AIDS Epidemic' Geneva UNAIDS.

Usmanu, M. (1999) *Anaguta Rites of Passage*, Jos Oden Press

Uwazie, Ernest E. "Modes of Indigenous Disputing and Legal Interactions among the Ibos of Eastern Nigeria," *Journal of Legal Pluralism*, No. 34, 1994: 87-103.

Weinstein N. D. (1984), "*why it won't happen to me: Perception of risk factor and susceptibility";* Health psychology, 3.

Whiteside A. (2002) "*Poverty and HIV/AIDS in Africa"*. Third world Quarterly 23(2) 313-332

Wiggins S. (2005) Southern African Food and Humanitarian. Crisis of 2000-2004. causes and consequences. Discussion paper, Agriculture Economic society Annual Conference. Nottingham.

Wingood and Diclemente (1997). "the role of gender relations in HIV prevention research for woman public Health 85 (4).

WYSS.K, Hutton and N Diekekehory, (2004) "*Cost attributable to AIDS at household level in Chad".* AIDS Cares 1617, 808-816

WHO World Health Report 1995

WHO, The World Health Report 1995

WHO, Weekly Epidemiological Record 71(26):215

Wuyap M(2009) An unpublished work submitted to the Plateau State Control Agency

Yasmin Tambiah, 1995. "Sexuality and Human Rights." pp. 369-390 in Margaret A. Schuler, ed., *From Basic Needs to Basic Rights: Women's Claim to Human Rights*. Washington, DC: Women, Law and Development International.

Yates J.F (1992) Risk-Taking behaviour, (Ed). Michigan University Press.

APPENDIX

QUESTIONNAIRE TO GENERATE DATA FOR DOCTORAL DEGREE DISSERTATION

Dear Respondents,

The researcher is a postgraduate student in the department of political science, Ahmadu Bello University, Zaria. She is conducting a research on "Gender Inequality and HIV/AIDS Policies in Nigeria: A case study of Jos North Local Government Area of Plateau State."

In this regard, she seeks your cooperation in obtaining necessary information relating to the problem. Your honest answer and information will be very useful in providing solutions for HIV prevention in the L.G.A and the country as a whole.

The information provided will be treated in strict confidence and use for the purpose of research. Thanks for anticipated cooperation.

Margaret Apine

Geographical Information:

State _____ CODE :_____

LGA:_____ CODE: _____

LOCALITY:_____ CODE: _____

STATUS (Urban1, Rural 2) _____

CLUSTER, NAME:_____

CODE:_____

SECTION 1: BIO- DATA OF THE RESPONDENTS

1. **Gender**: Female [ ] Male [ ]
2. **Age**: (as at lost birthday) 15-24 [ ] 26-49 [ ] 50 and above [ ]
3. **Religion**: No religion [ ] Christianity [ ] Islam [ ] Traditional Religion [ ]
4. **Marital Status: S**ingle [ ] married [ ] divorced [ ] widowed [ ]
5. **Level of Education: P**rimary [ ] secondary [ ] tertiary [ ]
6. **Occupation:** Civil/Public Servant [ ] Petty Trading/Business [ ] Artisan [ ] home maker/housewife [ ]

SECTION 2: KNOWLEDGE AND ATTITUDE ABOUT HIV/AIDS (TARGETED AT THE GENERAL PUBLIC)

(1) Have you ever heard of HIV? Yes ( ) No ( )

(2) Do you know how AIDS is contracted? Yes ( ) No ( )

(3) If yes (tick as appropriate).

Unprotected sex with a carrier [ ] Blood transfusion [ ]

Sharing of sharp objects that might be contaminated ( )

Mother to child transfusion [ ] All of the above [ ]

Non of the above ( )

(4) Are you aware of HIV prevention methods? Yes ( ) No ( )

(5) If yes (tick as appropriate) a) use of condom ( ) b) having one sexual partner ( ) c) avoid sex with casual partner(s) ( )

d) abstinence ( )

(6) Which of the above is readily available or would you prefer?

a) Use of condom ( ) b) having one sexual partner ( ) c) avoid sex with casual partner(s) ( ) d) abstinence ( )

SECTION 3: FACTORS THAT LIMIT INDIVIDUALS ABILITY TO PROTECT THEMSELVES AGAINST HIV IN JOS NORTH LGC

(1) Have you ever been exposed to the following behaviours?

a) unprotected sex with casual partners ( ) (b) sharing of sharp objects that might be contaminated ( ) (c) use of contaminated blood product ( ) (d) none of the above ( ) e) All of the above ( )

2) Can you keep away from these behaviours (a) Yes ( ) b) No ( )

3) If No, how do you protect your self against HIV? a) Use condom ( ) b) Do not use condom ( )

4) Can you convince your partner(s) to use condom?

a) Yes ( ) b) No ( )

5) If no what are the factors limiting your ability to raise the issue of condom use.

a) Cultural factors ( )

b) Religious factor ( )

c) Peer influence ( )

d) Lack of power to raise the issue of condom use ( )

(6) What are the factors that can make you remain in an unsafe relationship?

(a) Social factors ( )

(b) Religious factors ( )

(c) Economic reasons ( )

(d) Cultural reasons ( )

(e) To protect ones children ( )

(f) Others specify…….

SECTION 3: THE IMPACT OF GENDER INEQUALITY ON HIV PREVENTION STRATEGIES

1) Are you in a position to decide or convince your partner concerning the following:
   a) Safer sex ( )
   b) Use of condom ( )
   c) When to became sexually active
2) Do you have the choice to avoid sex when you want to?
   a) yes ( ) b) No ( )
3) Does your sex (man or woman) affect your decision to use condom? a) yes ( ) b) No ( )
4) Does it affects your decision to keep away from HIV risky behaviours? a) yes ( ) b) No ( )
5) Does it affects your decision to seek sexual and reproductive health information? a) yes ( ) b) No ( )
6) Does your economic status affect your decision to keep away from HIV risky behaviours? a) yes ( ) b) No ( )
7) Does it affect your decision to use condom? a) yes ( ) b) No ( )

SECTION 4: PEOPLE LIVING WITH HIV/AIDS

1) Were you aware of these methods of HIV transmission?
   a) Unprotected sex with a carrier? ( )
   b) Use of condom contaminated blood? ( )
   c) Sharing of sharp objects? ( )
   d) Victim of rape? ( )
   e) All of there above? ( )

f) Non of the above? ( )

2) Which of these applied to you? a)( ) b) ( ) c) ( ) d) ( )

3) Have you had previous knowledge of HIV prevention?
   a) yes ( ) b) No ( )

4) What are these prevention method?
   a) Abstinence
   b) Mutual fidelity
   c) Condom use

5) Which of these did you try? a) ( ) b) ( ) c) ( )

6) Did you have to choice to keep away from HIV risky behaviours? a) yes ( )
   b) No ( )

7) Were you in a position to negotiate anything (convince you partner(s) 1 mean?
   a) yes ( ) b) No ( )

8) If the answer to question 2 is yes then what challenges did you face protecting your self against the virus.

a. Gender based violence ( )
b) Inability to negotiate condom use ( )
c) Lack of financial means ( )
d) Religious reasons ( )
(e) Cultural factors ( )

9) How did you know that you were infected:
   a) You visited health clinic ( )
   b) Lost of a spouse or partners ( )
   c) Voluntary counseling/ testing ( )

10) When you discovered you were HIV positive, was spouse or partner informed? a) yes ( ) b) No ( )

11) If yes do your did he or she respond?
   a) Violently ( ) b) accepted it in good faith ( )
   c) Send you packing out of your home ( )

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Geographical Information:

State _____ CODE :_____

LGA:_____ CODE: _____

LOCALITY:_____ CODE: _____

STATUS (Urban1, Rural 2) _____

CLUSTER, NAME:_____ CODE:_____

SECTION 5: TARGETED AT POLICY MAKER AND HIV/AIDS PROGRAMME MANAGERS.

(1) What strategies have you adopted in controlling the spread of HIV in Jos worth?

a) Sex education to the general or specific targeted groups to delay sexual activities.
b) Mass Media enlightenment campaign to create awareness and knowledge about HIV to the general or specific groups.
c) Distribution of condoms to meet the needs of some targeted group(s)
d) Provide information that will build self-efficacy for partners reduction to targeted groups.
e) Use of multimedia to improve knowledge and provide skills on condom use or the demystification of condom.
f) Stigma reduction campaign
g) Mainstreaming gender into existing policies strategies
h) Promoting human right
i) All of the above

j) None of the above

(2) How effective are these in combating HIV in Jos North?

a) Very effective

b) Less effective

c) Needs improvement

3) If these strategies are not effective why?

a) Low risk perception

b) Gender factor

c) Cultural factors

d) High illiteracy level

e) Peer influence

f) High poverty level

g) All of the above

h) Non of the above

4) How does gender inequality manifest in the LGA?

a) unequal access to resources between the sexes.

b) Unequal employment opportunities

c) Unequal power relations between the sexes

d) Unequal educational opportunities

e) All of the above

f) Non of the above

5) How does these impact on HIV prevention strategies?

a) negatively ( ) b) positively ( )

(6) What factors limits sex education including knowledge about HIV prevention in Jos North LGC

a) Religious factor ( )

b) Gender factor ( )

c) cultural factor ( )

d) Illiteracy ( )

(7) What prejudices do you think people have about predominant HIV prevention methods in Jos North?

(a) Religious ( )

(b) Cultural ( )

(c) Social ( )

(8) Do you think HIV preventives strategies will become more effective by mainstreaming gender into existing programmes? (a) Yes (b) no

SECTION B: IN-DEPTH INTERVIEW (FOR KEY INFORMANTS)

1. What are the preventive strategies in Jos north LGA
2. How do people feel about these strategies
3. What are the causes of non acceptance of the strategies
4. How does gender inequality manifest itself in the LGA
5. What is the effect of gender inequality on these strategies
6. What prevention method have you adopted in the face of gender inequality in the State.
7. On the whole which strategies would you recommend to combat the spread of HIV in Jos North.
8. What are the factors that governs gender relations in LGA
9. Any comments on the issue?