

Women's Role in Household **Decision- Making:**

A Case Study
in Nigeria



**International
Center for
Research on
Women**

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Decision-Making:
A Case Study in Nigeria**

by

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We hope this research provides useful tools and insights for those who work to improve women's lives and the lives of their families. We see both the methodology and application of this research as an initial contribution to analyzing the gender dynamics of household decisions and would welcome comments and suggestions on all aspects of the research analysis.

INTRODUCTION

Many advocates of women in development and development practitioners call for women's empowerment as a means of raising women's social and economic status and improving their health and welfare and that of their families. However, there is general disagreement on the definition of "empowerment" as well as the appropriate mechanisms by which to support and operationalize improvements in women's social and economic status. One means of empowering women is through supporting their role as decision-makers at the household level. While women play an active role in household decision-making, the arenas in which they exercise power over decisions and their ability to control the allocation and distribution of household resources is highly circumscribed. How much control women are able to exert over household decisions is critical to understanding intrahousehold dynamics and the availability and use of household resources.

In order to explore how women might be additionally supported in their productive and reproductive roles in Nigeria, ICRW was contracted by the United States Agency for International Development (USAID) office in Lagos through AIDSCAP/Family Health International to document and analyze the role of women in household decision-making with a particular emphasis on health care decision-making. Households are an aggregate of individuals of all ages, each of whom has preferences and needs, some of whom contribute time and income, and others of whom depend on these resources and inputs for their existence. Households can be viewed as a microcosm of society, they are a collection of people who are joined together or who have come together to increase their chance of survival.

Every hour of every day, decisions must be made by individuals or households about the use of household resources. These decisions are the product of a complex process of preference negotiations over which individuals exert leverage. There are multiple spheres of decision-making in which some or all members of the household participate. Decisions may be made autonomously or collectively, harmoniously or competitively, depending on how much the decisions impact upon each of the household members.

Women participate in many of the spheres of household decision-making, however, the degree to which they participate and the extent to which they are able to influence the decision-making process remain under-explored. If household decision-making can be documented, perhaps ways can be found to support women in this process, to enable them to better achieve their preferences and to participate more actively and more equally in fundamental decisions that affect their health and welfare and that of their children.

Nigeria is one of the most densely populated countries in sub-Saharan Africa. It is a richly diverse country peopled by members of many different ethnic groups and religions, both sedentary and migratory. The geography is vastly different, from the northern desert to the central plateaus and the coastal plains. The farming systems, rural and urban lifestyles, and economic activities reflect this cultural and geographic diversity. Nigeria has tremendous heterogeneity, a useful characteristic for small samples and pilot investigations such as this study, which uses household survey data from three different states in Nigeria -- Ondo, Abia, and Kebbi. The data are used to compare and contrast household decision-making within and between the different groups and regions to gain a greater insight into the process of decision-making and the position of women in societies in Nigeria, and may have relevance for other parts of West Africa.

Objectives

The research was designed to explore women's role in household decision-making, and to identify correlates of women's participation in the decision-making process. Policy and programmatic recommendations for interventions to improve women's role in decision-making within the household were developed.

The study investigated different spheres of household activity both daily decisions about tasks like food preparation, housecleaning, and childcare, and less frequent decisions about the use of household resources such as whether to buy a productive asset (a plough or a bullock, for example), whether to educate children or purchase health care.

The research questions for this study were whether women can and do participate in household decision-making and whether factors can be identified that are associated with the extent to which women exert influence. The study also explored the hypothesis that where women are able to influence the decision-making process, they are able to achieve welfare improvements for themselves and for their children. This was particularly important as the underlying objective of this study was to develop programmatic recommendations for interventions to improve women's role in decision-making within the household, with the intention of improving the health and welfare of the women themselves, and of members of their families. The structure of the questionnaires and the quantification of the extent of leverage exerted by the different individuals provide information that may be used to develop new programs and interventions to modify existing activities supported by USAID in Nigeria.

METHODOLOGY

Spheres of Decision-Making

The study explored three spheres of household decision-making, examining in each the extent to which women can identify, articulate, and negotiate their preferences. The following spheres were considered:

Education

Parents usually want their children to be educated, and providing schooling is generally considered a household responsibility. However, all too often families are confronted with financial constraints and competing demands for their children's time and earning power. It may be that there are different aspirations for girls and boys and different risks or costs associated with their education. In many cultures once a girl begins to menstruate she is considered a woman and is subject to a range of conditions on her mobility and freedoms that reflect the concerns for her safety and virginity. Such attitudes and mores may significantly influence decisions to educate girls, or to allow them to travel to schools at some distance from the family house or compound. This study examines the extent to which women participate in decisions about the education of their children. How much education can their children receive (given the constraints households face), where do they receive it (in secular or religious schools, for example), and who pays for it? The analysis also sought to investigate any systematic differences between education and enrollment decisions for sons and daughters.

Reproductive and Child Health

This study also explores a range of health care issues—from whether women are involved in decisions about their children's health, including breastfeeding decisions, to decisions about their own general and reproductive health, including the use of family planning. Households face many constraints to obtaining and maintaining good health status. There are monetary and opportunity costs to using services. Clinics or other service delivery points may be inaccessible in terms of location or hours of operation. People may lack information about the full range of health care and family planning services. How do such constraints affect women's participation in health care decision-making and the choices that they make for themselves and their families?

Household Economy

This study also examines how much cash is contributed by women and how they earn this income, who else contributes income, whether women have any say in who works outside the home (particularly children). This is a crucial sphere because the extent to which women are involved in decisions about how to spend their households' financial resources is determined by how much they contribute to the household economy and underlies the other spheres. Schooling decisions are, in part, financial ones, as are health care choices. This sphere is complicated because there is significant variation among households in how much cash women contribute to their household's financial resources.

Research Teams

During July 1995, ICRW staff traveled throughout Nigeria to identify Nigerian counterparts with whom to collaborate. The project design called for research teams that included principal investigators, who were responsible for the technical aspects of the research, and representatives of non-governmental organizations (NGOs), who helped to define the cultural context, could provide access to the communities, and could implement the study recommendations. The following teams were identified in three states, as shown in table 1. ICRW sponsored a proposal development workshop with these teams in October 1995 and signed subagreements with them in February 1996.

Table 1 Research Teams

State	Principal Investigator	NGO Partner
Kebbi	Dr Dora Shehu Department of Geography <i>Usman Danfodiyo University</i>	Mrs Ada M S Kaoje <i>Federation of Muslim Women's Associations in Nigeria (FOMWAN)</i>
Ondo	Mrs Olutoyia Sadiq <i>Centre for Population and Health Research (CEPHER)</i>	Mrs Oluwatosin Banke <i>Country Women Association of Nigeria (COWAN)</i>
Abia	Dr Ephraim N Madu <i>COTA KONSULT</i>	Mrs NIK. Ndukwe <i>Nigerian Association of Women in Nursing (NAWIN)</i>

Sample Selection

A random sample of 50 households was chosen from the urban and rural sites in Ondo and Abia states, and smaller samples were chosen in Kebbi state because the population there is much more disperse (table 2). Each of these households was surveyed to gather data on household demographic and socioeconomic characteristics, and to provide the sampling frame for a subset of women of reproductive age (15-49) in all households. Then, a smaller subset of primary respondents was selected at random from those women and interviewed to gather information about each woman's role in household decision-making and to nominate all significant others whose opinions carried weight and influenced the outcome of certain decisions across a range of different spheres of decision-making. In this way a web of decision-makers was interviewed to capture information about their preferences and concerns.

Table 2 Sample Sizes

State	Households	Subset of Primary Respondents	Subset of Significant Others
Ondo			
- rural	50	20	20
- urban	50	20	25
Abia			
- rural	50	20	20
- urban	51	21	20
Kebbi			
- rural	20	9	9
- urban	42	12	12
Total	263	102	106

Quantitative and Qualitative Data Collection

This study attempted to detect and describe the complexity of household decision-making, involving a network of actors who feel more or less strongly about particular spheres, and who have more or less influence or ability to act on their preferences. For the purposes of the study, “decision-making” was operationalized by comparing preferences and outcomes. It is often difficult for respondents to accurately answer questions about how decisions are made. It may be more tangible for them to report their preferences and the outcomes of decisions among the primary respondents and significant others with roles in decision-making.

The primary respondent was a woman of reproductive age, who was asked to nominate all those members of the household (“significant others”) who participate in decision-making across the different spheres. Since the nature of the decision-making process and the significant others involved are expected to differ depending on the decision sphere, primary respondents were asked to nominate significant others separately for each sphere. For particular decisions in each of the spheres, she was also asked about her preferences in reference to the decisions, the outcomes of those decisions, and how she would rank the importance of each member of the household in determining those outcomes. The data were collected using a three-part questionnaire and focus group discussions.

Part 1 Household Survey

A household survey was administered to generate information on the following attributes, as well as to identify women and households for more in-depth study:

- a) household demographics (family size and structure, the age, gender, and educational level of each household member, household religion, ethnicity, language or dialect, and others), and
- b) occupation and income of individual household members and household income proxies (house type, size and location, the building materials used, number of rooms, latrine, water, and domestic energy source)

Part 2 Primary Respondent Questionnaire

This questionnaire was administered to women of reproductive age who were the primary respondents. Data were collected on the following characteristics:

- a) demographic information on the primary respondent,
- b) detailed information on each of the spheres of decision-making,
- c) significant others with whom the woman consults concerning each of the different spheres of decision-making,
- d) possible correlates of influence or leverage: education level, employment status and income, community association, hierarchy within the household, marriage, and
- e) outcomes such as children's immunization histories, contraceptive and health histories for the primary respondent and her children, and children's school enrollment patterns.

Part 3 Significant Others Questionnaire

Researchers contacted as many of the significant others nominated by the primary respondent as possible. These included husbands, mothers-in-law, friends, other relatives, and others. Their questionnaire was essentially the same as that of the primary respondents.

Part 4 Focus Groups Discussions

Building on preliminary analyses of the questionnaires, the research teams also held focus group discussions with purposively chosen members of the community who represent groups of significant others and primary respondents. These groups explored certain aspects of the research findings to examine the dynamics of communication in the household and to generate culturally appropriate program recommendations. In the focus groups, household economy decisions, the incentives to conceal income and economic contributions to the household, and conflict resolution within the household and through non-household intermediaries were explored.

Analysis

The qualitative and quantitative data were utilized to rank preferences, reported participation in decision making, and perceived influence, as well as to document preferences and outcomes, across the different spheres of decision-making. Data also were used to map the network of significant others for each primary respondent and to compare the primary respondents' networks to those of the significant others, and this is described in the individual reports from the three states (CEPHER 1997, Madu and Ndukwe 1997, Shehu and Kaoje 1997).

The information about preferences and outcomes was then used to develop an index of leverage over decision-making to examine the relative importance of each primary respondent and her significant others in decisions concerning each sphere. The index was intended to capture information about the extent to which women were able to articulate, negotiate, and achieve their preferences in three critical realms of decision-making: education, health care, and household economy. The index of leverage over decision-making was calculated within each of three spheres simply by dividing the number of subspheres in which the primary respondent was able to actualize her preferences on at least one occasion by the total number of subspheres. She was considered to actualize her preference if the outcome in one aspect of the sphere or subsphere was the same as her preference on at least one occasion. Each index of leverage ranges between 0 and 1 -- at 0 the individual does not achieve her stated or expressed preferences even once, and at 1 she achieves all of them at least once (whether her preferences coincide with those of the significant others or not). By counting her preference as actualized if it was only actualized on one occasion (instead of on all occasions), the index assesses a woman's potential to exert leverage over decisions in the sphere, but not the prevalence of her leverage. Potential for leverage was chosen because it was of interest in this study, and also because it would not have been feasible to determine preferences and outcomes of all household decisions.

A variety of non-parametric techniques were used to quantify relationships, assess association, and reflect the co-movement of variables without imposing assumptions about causality and reciprocity. Because of the small size of the sub-samples and the type of relationships investigated, Chi-square, Cramer's V, Fishers Exact Test, and measures of central tendency and deviation were used (Bernard 1994, Siegal and Castellan 1988). Correlates of decision-making, using univariate and bivariate techniques, were analyzed to address the following kinds of questions: Do educated women have more leverage over household decisions, or do older women or women in monogamous households? Where possible, expressed preferences were compared to observed or reported outcomes. In the case of breastfeeding, for example, it might be that a woman prefers to breastfeed for a short time and the family believes that she should breastfeed for a longer time. If the outcome -- length of breastfeeding for previous children -- was closer to her stated preference in that time period, then it is assumed she was able to exert greater leverage over the decision in this sphere.

Methodological and Analytical Limitations

Despite the richness of the data, and the creativity of this new approach, there were certain limitations to the study, especially in the amount and specificity of data that could be collected, and these should be kept in mind.

Norm-Convergence The analysis of preferences and outcomes allowed important information about influence over decision-making to be collected. It is important to bear in mind, however, that all preferences are mediated through norms, be they societal, familial, or individual. It may be that the primary respondent expressed a preference that is entirely coincident with the societal norm, and that she appeared to have exerted her preferences in determining the outcome, when in fact she was merely responding to socialized expectations about her actions and preferences. In this case, preferences that truly reflect her desires cannot be distinguished from those that are the result of social conditioning.

Hysteresis Another complication that arose from the analysis of preferences and outcomes is that preferences are not stable over time and reporting may be "contaminated" by current preferences or perceptions. It may be that preferences the primary respondent held at a previous point in time which have contributed to past decisions are not the same as those she expresses at the moment of the survey, and similarly with her characteristics. An example of this might be age and household hierarchy. Age undoubtedly confers influence over decision-making. As a primary respondent ages, she may move up the household hierarchy, therefore, her current age and status may not be relevant to her previous influence over decisions that occurred in the past. This problem is particularly acute in assessing the factors that conditioned the primary respondents' own education outcomes. The characteristics of each primary respondent at the time of interview are not those that she held at the time decisions were being taken about investments in her education. For this reason, the primary respondents' own education decisions are excluded from the calculations of indices of leverage for education.

Self-Reporting The data were gathered from the individuals, requiring them to self-report their involvement in decision-making and to give opinions about their relative importance in those decisions. Much of these data are not verifiable. However, some of these data could have been verified, particularly on immunization compliance, contraceptive methods used, and years of education completed. Since having respondents produce certificates, prescriptions, and school reports would have been too invasive and time-intensive, it was not done, and self-reporting error may have occurred.

Recall Errors: Many types of data can be influenced by recall error, especially when they refer to the complex and iterative procedures of household decision-making. Leaving aside the question of when and how leverage is exerted over decisions and whether this is correctly recalled, other data such as age at marriage may also be subject to considerable recall error.

Specificity Some of the decisions are particularly complex and much information is required to correctly specify the outcome. For instance, the length of breastfeeding is only one feature of her breastfeeding pattern -- other aspects are daily feeding frequency, exclusivity vs mixed feeding with other foods or formula -- and by itself does not specify much about that pattern. Different degrees of leverage might be found for these different features of the breastfeeding pattern.

Supply-Side and Economic Constraints It is not enough to look at women's participation in and influence over the decision-making process, which in many cases may not translate into the final outcome, as there are many other factors that limit an individual's achievement of preferences. Women may participate in decision-making, but their preferences may hold little weight, or may not have been fully articulated in that process. There may be external factors that intervene to prevent the outcome from being realized or achieved. It could be that a sudden death in the family diverted household resources away from investing in the education of a child or the purchase of an asset and, therefore, prevented the primary respondent from achieving her preference to educate her child or to invest in an asset. It could be that there are no health care services available to treat a particular ailment and, therefore, the decision to seek treatment is artificially limited.

FINDINGS

In this section of the report, the states in which the three studies were conducted, and the sample characteristics from each are described. Then the main findings are set out in three parts -- preferences and outcomes, indices of leverage, and roles of significant others. Within each of these three parts, findings are further divided into spheres of decision-making -- education, reproductive and child health, community associations, and household economy. Because of a special interest in the health aspects of this study, data were collected on a greater variety of aspects of reproductive and child health than of the other decision-making spheres, and so this subsection was further divided. Due to sensitivity among respondents to discuss either preferences, outcomes, or roles of significant others within certain of the spheres, different information was collected within some of the subsections. Consequently, indices of leverage, the calculation of which required data on both preferences and outcomes, could not be formed for variables in all of the subsections. A more detailed description of these findings by state can be found in the individual reports (CEPHER 1997, Madu and Ndukwe 1997, Shehu and Kaoje 1997).

Description of the Sites

Ondo state is located in the southwestern region of Nigeria. Ondo is primarily Yoruba, although some other ethnic groups have migrated to the area or live within the state boundaries. Ado-Ekiti, the District headquarters (now the Ekiti state capital), was estimated to have a population of about 150,000 people in 1991, which may have increased by as much as an additional 70,000-100,000 people since this date. Ago-Aduloju, the rural location, has a population of about 1,200 people and was founded by an Ado-Ekiti farmer and warrior who fought to defend the town during the inter-ethnic wars of the 19th century. The village has a major rural weekly market that serves Ado-Ekiti and the neighboring towns and villages in the area, as such, its population fluctuates, and it is rapidly becoming a local center of commerce and trading (CEPHER 1997). Two locations were sampled in Ondo state in a district formerly known as the Ado-Ekiti local government district (Ekiti State since October 1, 1996). Urban Ado-Ekiti and rural Ago-Aduloju were selected for this study because they were thought to represent urban and rural areas in Ondo, and because the NGO partner, COWAN, had an existing relationship with the communities in each location.

Abia state is located in the southeast region of Nigeria. There are approximately 2.3 million inhabitants of which 1,108,357 are male and 1,189,621 are female. With the recent creation of Ebonyi state, however, the population will change as some parts of Abia (Afikpo South and North, Onicha and Ohazara local governments) will form part of this new state. Abia is inhabited by the Ibos, and Igbo is spoken throughout the state. Subsistence agriculture is the primary occupation in Abia, engaging approximately 70 percent of the population. Rural women are actively involved in agriculture and are essential to the subsistence economy. Two sites were chosen in Abia: urban Umuahia and rural Uzuakoli. Umuahia is the capital city of Abia state and is made up of four major areas: Ugwunchara, Bende¹, Umuahia-Aba², and

¹ Bende Road Settlement

² Umuahia-Aba Road Settlement

Umokpara Uzuakoli is a rural community in the Bende local government district of Abia state and is predominantly agricultural (Madu and Ndukwe 1997)

Kebbi is one of the five states in the northwest of Nigeria. It is comparatively small with a total population of 2,060,000, which is growing at approximately three percent annually. The majority of the population lives in rural areas with only 30 percent inhabiting urban areas. The rural areas are typified by small and somewhat dispersed settlements. The people in Kebbi are mainly Hausa and Fulani, although other ethnic groups are found in Birnin Kebbi town. The principal economic activities are subsistence farming and livestock production. Women's economic activities are usually confined to the household where they may engage in artisan crafts, petty trading, and food processing. Two local government areas were selected for this study to represent urban and rural sites in Kebbi state. Birnin Kebbi was chosen as the urban site, it is the state capital and has been an administrative center since colonial times. Prior to 1991, it was a major local government center that fell under the boundaries of the neighboring Sokoto state. Gwadangari and Dalijan were chosen as the rural sites.

Sample Characteristics. Ondo, Abia, and Kebbi

The sample characteristics are shown in table 3. The average age of women who were the primary respondents was 31 years, they had an average of 5 children, and 64 percent were in monogamous marriages. Participants were generally Christian in Ondo and Abia states in southern Nigeria, and Muslim in Kebbi state in the north.

Table 3 Characteristics of Primary Respondents

State	Mean Age	Marriage Status (percentage)			Dominant Religion	Average Number of Children	Household Status (Percentage)		Modal Level of Secular Education
		Monogamy	Polygyny	Not Married ^a			Nuclear	Multiple ^b	
Ondo - rural - urban	34 31	48 66	52 34	0 0	Christian Christian	6 4	68 90	32 10	None Secondary
Abia - rural - urban	34 28	85 76	0 0	15 24	Christian Christian	4 3	90 88	10 12	Secondary Secondary
Kebbi - rural - urban	28 26	22 58	78 42	0 0	Islam Islam	4 4	33 58	67 42	None None
Total Sample	31	64	28	8	Christian	5	76	21	Primary

^a Women “not married” are either single, widowed, or divorced.

^b Multiple households are defined as those with at least one other distinct sub-family, comprising a couple in union with children. Generally, multiple households are defined using information about whether or not this family generates income and undertakes separate expenditures. Since the income and expenditure data were difficult to capture for all household members, and given the existence of a complex system of transfers and receipts in many households, this definition was simplified.

Preferences and Outcomes

For the purposes of the study, “decision-making” was operationalized by comparing preferences and outcomes. It is difficult for respondents to accurately answer questions about how decisions are made, but more tangible for them to report their preferences and outcomes of decisions. Described below, therefore, to the extent possible, are the preferences and outcomes of the primary respondents concerning their children’s education, their own reproductive health and health of their children, and their contributions to the household economy. In the next section, indices of leverage over decision-making were calculated based on preference and outcome data.

Education

Regarding the level of education their children should achieve, primary respondents (and significant others as well) tended to state the preference that their children achieve secular tertiary (post-secondary) education (85 to 100 percent). The proportion did not differ greatly between the urban and rural areas. Notably, there was no evidence of gender bias in stated preferences for length of schooling for their children in Ondo or Abia states (85 to 100 percent for both sons and daughters). Gender bias was, however, pronounced in Kebbi state. Ninety percent of primary respondents in rural and urban areas of Kebbi state reported preferring that their sons achieve tertiary level

education, whereas dramatically fewer preferred this for their daughters (10 percent in urban areas and 0 percent in rural) There was a strong preference among Kebbi women, however, to educate their daughters through secondary school (70 percent in urban and 44 percent in rural areas)

In addition, in Kebbi the majority of primary respondents reported that they would prefer their children to attend both secular and religious schools (89 to 100 percent for sons and 67 percent for daughters) This was similar for urban and rural areas A proportion of primary respondents from rural (17 percent) and urban (33 percent) areas would prefer that their daughters attend only religious schools In Koranic education, boys and girls are taught separately Literacy for girls may be actively discouraged -- they may be taught to recite from the Koran, but not read.

Regarding the outcomes of level of education achieved by the children, it should be noted that most children of primary respondents in the sample were currently attending primary and secondary school, if at all This means that the outcome -- whether or not the child achieves a tertiary education -- could not be determined. Instead, a preference was counted as having been achieved if the child was still attending school, whether that was primary or secondary school, and this was considered a proxy of the eventual tertiary education outcome Consequently, achievement of tertiary education may be overestimated.

In a majority of cases, the primary respondents had their education preferences for their children achieved (table 4) They were, however, considerably less likely to have their preferences achieved for their daughters than their sons, except in rural Kebbi where this was reversed and the achievement of preferences was higher for daughters than sons The result in rural Kebbi reflected that preferences for girls were so much lower than in the other sites and, therefore, easier to achieve

Table 4 Percentage of Primary Respondents Achieving Education Preferences for their Children

Ondo	Sons	Urban	Rural
		100	100
	Daughters	89	76
Abia	Sons	87	94
	Daughters	56	83
Kebbi	Sons	67	57
	Daughters	43	75

Reproductive and Child Health

Health care preferences and outcomes were divided into a number of different decisions that defined various types of health-seeking behavior for the primary respondent and her children. Preventive as well as curative health care decisions were considered, including immunization, general treatment, and reproductive decisions about breastfeeding, birth-spacing, contraception, and sexual negotiation. Of note across many health care decisions in all three states is that rural women were more likely than urban ones to report involvement in decision-making and more likely to rank their weight in decision-making as being equal to or greater than that of the significant others.

Immunization Approximately 98 percent of children in all three sites were immunized, which may imply that at least this proportion preferred their children to be immunized.

Type and source of health care Questions were asked about what types of treatment would be sought for different sicknesses and according to different degrees of illness severity. In all areas, a variety of health services were sought for primary respondents and their children. In urban areas, the majority of primary respondents reported seeking treatment from private clinics and public hospitals, whereas in rural areas the range of services sought was much wider, including traditional healing, spiritual guidance, and naturopathic medicine. The nature and severity of the illness guided, in large part, the choice of type of health care, and when each was used. Roughly 75 percent of urban primary respondents used a clinic or a hospital most frequently, as did 55 to 65 percent of rural primary respondents. In the rural areas, 10 percent in Ondo also regularly sought spiritual guidance and naturopathic services for many illnesses, and 20 percent in Abia and Kebbi. Traditional care was sought for a variety of ailments including epilepsy, convulsions, fits and seizures, and a number of conditions related to pregnancy and childbirth. Often these traditional health care services were considered to be complimentary to other modern medical services and may have been sought simultaneously. Notably, Kebbi women were particularly reluctant to seek care for reproductive tract infections and sexually transmitted diseases at hospitals or clinics, seeking out traditional healers, naturopaths, or spiritual counselors instead.

Circumstances preventing achievement of health care preferences Many primary respondents stated that there were circumstances in which they were unable to achieve their health care treatment preferences for themselves (32 to 40 percent in urban and rural Ondo, respectively, 63 percent in Abia, and 25 to 43 percent in urban and rural Kebbi, respectively). A common reason stated was they might not think themselves sick enough to merit visiting a hospital or clinic (100 percent in urban Ondo, 25 percent in rural Ondo, and 100 percent in rural Kebbi). Another common reason was that household financial constraints would limit their access to health care services (50 percent in rural Ondo, 41 percent in both Abia sites, and 25 percent in urban Kebbi), and an additional proportion said it was their own financial constraints that limited access (12 percent in rural Ondo, 10 percent in urban Abia, and 50 percent in urban Kebbi). In urban Kebbi, 25 percent also felt that they would be unable to access health services if there was no one to look after their children.

In data from Abia, approximately 63 percent of primary respondents from urban and rural Abia stated that a lack of household resources would prevent a child from receiving health care. Another 10 percent in both urban and rural areas stated that a lack of personal income or cash resources would prevent a child from receiving treatment.

The focus group discussions corroborated information from the household survey, underscoring that financial constraints and the severity of illness are most likely to limit whether a primary respondent received treatment

“It depends on the nature of the illness. If it is an ordinary headache or fever she will not wait for her husband. But if it is a serious illness requiring going to the hospital she must tell her husband.” Young woman, Abia state

“A woman can take decisions concerning her children’s health when the husband is not at home. When the husband is at home, treatment will be sought on the husband’s decision. Women can take decision[s] on where to go for treatment, but the husband has to make the money available for treatment.” Older rural women, Ondo state

Breastfeeding The primary respondents demonstrated considerable autonomy over breastfeeding decisions in all three states. This is important both for their children’s health and nutritional status, and because lactational amenorrhea was the predominant birth-spacing method. The majority of primary respondents (53 to 74 percent) expressed a preference to breastfeed for 13 to 24 months, though in Abia more preferred a shorter lactation of seven to 12 months (67 percent). Stated preferences between urban and rural groups were similar except that in Ondo more rural respondents (100 percent) said they would prefer breastfeeding 13 to 24 months than did urban respondents (47 to 61 percent). Stated preferences among the three states were also somewhat similar, although in Kebbi state the proportion preferring 13 to 24 months was higher (91 to 100 percent)

Correlation coefficients for breastfeeding preferences and outcomes revealed that primary respondents exerted considerable control over the length of breastfeeding (Table 5). In all cases, the correlations between the expressed preferences of primary respondents and the reported outcomes were positive

Table 5 Correlation Between Breastfeeding Preferences and Outcomes

State	Boys	Girls
Ondo	0.77	0.75
Abia	0.56	0.48
Kebbi	0.43	0.49
Total	0.74	0.71

Birth-spacing A range of decisions that would impact on individual fertility were explored. Many of the respondents were reluctant to express an opinion or reveal a preference about birth-spacing in Kebbi and Abia, although they were forthcoming in Ondo. In Kebbi, it was necessary to modify the survey, so that few direct questions were included about such decisions, although the enumerators pursued structured questions if the respondent seemed comfortable

A primary respondent's preferred birth-spacing between children was compared with the actual gap achieved between her last two children, to the month. Despite the large element of chance in the exact month of any contraception and, therefore, birth, most respondents achieved their birth-spacing preferences (table 6). In Abia, respondents were also asked about achieving their preferences within a year, and then the proportions were even higher (76 percent in urban and 67 percent in rural areas). The mean stated preferred spacing between children was 21 months, and the mean outcome was 21 months in Abia and about 24 months in Kebbi.

Table 6 Percentage of Primary Respondents Achieving their Birth-Spacing Preferences

State	Urban	Rural
Ondo	70	55
Abia	43	50
Kebbi	50	44
Total	55	51

Achieving birth-spacing preferences to this high degree seems due in large part to long amenorrhea from breastfeeding. Also contributing could be natural family planning, abstinence, abortion, and less sexual activity of a primary respondent in a polygamous household, but the degree to which these contributed to birth-spacing could not be determined in this study. It should be noted that household size can be "regulated" through adoption and fostering arrangements for children, which are common in the North and used less frequently elsewhere in Nigeria, usually to relieve household economic constraints, but this was not investigated in the study.

Characteristics of the primary respondents who achieved their birth-spacing preferences were investigated. Income contributed to the household by the primary respondent, having a bank account, high level of education of the respondent (Kebbi only), and use of family planning methods were all significantly associated with achieving birth-spacing preference, although the specific factors varied by state. In urban areas in Ondo, whether the primary respondent was contributing more than 30 percent of the weekly household expenditures and whether she ranked her own weight in the decision to earn as being important were the significant factors in whether her birth-spacing preferences were achieved ($p < 0.04$ for >30 percent of expenditures). In Abia, it was whether she was a member of a group or community association (Cramer's $V=0.53$, $p=0.1$). And in Kebbi, it was whether the primary respondent had been enrolled in secular education (Cramer's $V=0.46$, and Fisher's one-sided exact test, $p=0.06$).

Contraceptive methods contributed to birth-spacing among those who used contraceptives, but primary respondents did not widely use them (table 7), despite high awareness levels in all areas. The low utilization may be a function of undersupply and lack of access, or of divergent preferences about contraceptive use between the primary respondent and significant others.

Table 7 Percentage of Primary Respondents Using Contraceptive Methods

State	Urban	Rural
Ondo	20	10
Abia	24	25
Kebbi	25	22
Total	23	18

Characteristics of the primary respondents who used family planning methods were similar to those of respondents who achieved their birth-spacing preferences, as expected. In Abia, the primary respondent was more likely to use a family planning methods if she contributed in excess of 800 Naira (US \$10) to household expenditures in the previous week ($p < 0.03$), and if she had a bank account (Cramer's $V = 0.38$, $p < 0.02$). This same variable was also associated with whether the primary respondent had discussed child spacing with her partner. In Kebbi, a respondent was more likely to use a family planning method if she contributed income to the household (Cramers $V = 0.69$), and if she contributed in excess of 200 Naira (US \$2.50) per week to household expenditures (Fishers one-sided Exact Test, $p = 0.023$).

For the entire sample of primary respondents, there is a positive relationship between whether the primary respondents are aware of family planning methods and whether they contribute to weekly household expenditures. This held in both urban and rural samples. It is interesting to note that in Abia the relationship between earnings and awareness of family planning is more marked than in Ondo and Kebbi. Abia is the state where the primary respondents' contributions to household maintenance and expenditures were the highest (see under Preferences and Outcomes, Household Economy).

Sexual negotiation Women's perceived sexual autonomy and ability to negotiate their stated sexual preferences with their partner were explored. Due to the sensitivity of questions about sex, only a limited number of questions were asked, and these are interpreted as proxies for the outcome of women refusing sex. Women were asked "Do you think a woman has the right to refuse sex?" and under what circumstances. Following this were questions about conditions under which condoms might be used.

When asked about the right to refuse sexual intercourse, most primary respondents reported that women could refuse, with some variation between urban and rural areas and among the three states. In Ondo, 70 percent of urban and 85 percent of rural primary respondents reported they thought a woman has the right to refuse sexual intercourse with her partner. In Abia, these percentages are 62 percent for urban and 79 percent for rural primary respondents. Only 58 percent of urban and 75 percent of rural primary respondents thought a woman has a right to refuse to engage in sexual intercourse in Kebbi. It is interesting that, in all cases, more rural than urban women reported they can refuse sexual intercourse.

Circumstances under which a woman was thought to have the right to refuse sex, as reported in Kebbi, in order of importance were 1) illness (of the primary respondent), 2) if one or other of the couple has a sexually transmitted disease, 3) if the woman is in the later stages of pregnancy, and 4) excessive menstrual cramps or bleeding. The desire not to have a child was not mentioned by the respondents as a reason women could refuse sex.

The perceived right to refuse sexual intercourse was associated with whether or not a primary respondent earned income (Fisher's exact test, $p=0.06$), and whether the respondent was a member of a work-related group, but this was only of borderline significance ($p=0.1$). Whether or not the primary respondent was educated or not was also related to the perceived right to refuse sex, but this was only statistically significant in urban Ondo ($p=0.05$). In addition, in Kebbi, if age of marriage was less than 14, primary respondents were more likely to perceive the right to refuse sex ($p=0.004$). The reason for this was not clear, perhaps these women were older and more likely to perceive and articulate their rights.

Given the concern about contracting a sexually transmitted disease, the study explored attitudes toward and the use of condoms. In Ondo and Abia, many primary respondents reported that it would be possible to ask a partner to use a condom if they believed he had a sexually transmitted disease (40 percent of urban Ondo, 55 percent in rural Ondo, 65 percent in both urban and rural Abia, 25 percent in urban Kebbi, and 11 percent in rural Kebbi). In at least the rural areas, condom use according to this perceived right may be highly theoretical, since fewer primary respondents have ever seen a condom (40 percent in Ondo, 45 percent in Abia, and none in Kebbi) than perceived the right. In the urban areas of Ondo and Abia, a greater proportion have seen a condom (70 percent in Ondo, and 87 percent in Abia), but none have in Kebbi. Actual reported use of condoms was much lower (10 to 20 percent).

The possible problems in using a condom were also explored. Reasons cited in the states were demonstrating a lack of love and trust in the relationship, creating the suspicion that the woman has a sexually transmitted disease, the moral and social unacceptability of their use (Kebbi only), the fear that the woman's partner might become angry or violent, and sex may become less pleasurable. A great many (70 percent in Abia) claimed that a condom might remain inside the vagina, or cause the woman harm, a perception which would also discourage condom use.

Household Economy

Concerning the extent to which primary respondents contributed to the household economy, it is clear that the vast majority of primary respondents generated income (tables 8 and 9). Of note is that the size of the contributions to household expenditures were much higher in Abia than in Ondo or Kebbi (table 8), but the proportion of women generating income was somewhat lower (table 9). In Abia, urban primary respondents generated an average of 47 percent of the total household family income whereas rural primary respondents generated 24 percent. These figures may be subject to significant measurement error as the reported expenditures were nearly always in excess of the income generated, but such error is assumed to occur consistently across the three states. The higher expenditure of primary respondents in Abia may also indicate that women actively borrow and save, both in the informal and formal sectors and, therefore, have additional reserves available to finance weekly expenditures. This is borne out by the data on savings and borrowing: 29 percent of urban

and 40 percent of rural primary respondents hold a bank account, as opposed to only five percent in urban Kebbi

Table 8 Economic Contributions by Women to the Weekly Household Budget, in Naira (80 naira = US\$1)

State	Weighted Average of Total Contributions Per Week	Average Food Contributions Per Week	Average Health Care Contributions Per Week	Average Education Contributions Per Week	Average Clothing Contributions Per week
Ondo					
- urban	342 00	183 93	25 38	70 00	49 23
- rural	527.25	131 92	167 33	46 43	286 25
Abia					
- urban	1506 62	520 79	167 33	414 58	637 50
- rural	3079 75	602 63	268 33	1215 29	727 50
Kebbi					
- urban	277 08	39 83	88 75	33 33	99 33
- rural	115 89	31 33	31 67	13 33	4 11
Total					
- urban	788 75	287 73	97 63	169 86	210 06
- rural	1493 53	327 98	168 75	535 75	320 41

Table 9 Percentage of Primary Respondents Generating Income

State	Urban	Rural
Ondo	75	75
Abia	76	55
Kebbi	80	88
Total	76	69

It is also clear, at least in Ondo and Abia, that an additional set of primary respondents generated surplus either from subsistence production or from processing foods. Stocks and services were occasionally traded to raise money when the households were cash-constrained and were subsequently contributed to the household. Many of the primary respondents were also involved in informal savings and credit associations which allowed them to contribute resources to household maintenance. In addition, some of the primary respondents were able to borrow money from relatives and friends to purchase essential items, such as food, education, and health care. Thus, the proportion of women contributing to household expenditures in Ondo and Abia (about 80 percent, table 10) are even greater than those generating income at any one time (table 9)

Table 10 Percentage of Primary Respondents Contributing to Weekly Household Expenditures

State	Urban	Rural
Ondo	93	93
Abia	76	80
Kebbi	67	56
Total	79	79

In Kebbi, however, the proportions contributing to household expenditure were lower than those generating income (tables 10 and 9, respectively) This may represent a failure of the study to capture the level of contributions to the household economy by primary respondents in the North A general reluctance by primary respondents to admit their cash earnings may have biased the estimates of the contributions downwards This supposition is reinforced by some of the focus group discussion, which revealed that women are not supposed to contribute income to the household economy as this undermines the importance of the male income earner However, the marked deviation between this viewpoint and the reported size of contributions reported by the primary respondents (table 7) would indicate that these norms may be shifting (Shehu and Kaoje 1997) Kebbi was, however, similar to Ondo and Abia in the proportions of primary respondents who reported holding savings (50 percent in urban Kebbi, 56 percent in rural Kebbi, 67 percent in urban Ondo, and 45 percent in rural Ondo) While the form of these savings was not specified in any of the sites, it is assumed that the majority are not in the formal banking sector and are either held as assets, investments, or cash holdings within the household or with relatives

Many women in the sample did not pool their income with other members of the household, and this likely gave them relative autonomy over how it was spent This was particularly true in Abia where fully 76 percent of urban and 65 percent of rural primary respondents did not pool income, and true to some extent in Ondo and Kebbi (55 percent in urban Ondo, 50 percent in rural Ondo, eight percent in urban Kebbi, and 33 percent in rural Kebbi)

Membership in a community association was significantly related to the index of leverage regarding the household economy described below in a number of sites Although membership was also associated with the other indices in these same sites, the overlap of influences between membership and household economy seemed the greatest Membership in a group or community association was investigated to learn about women's decision-making beyond the household. Information was collected on whether the primary respondent was a member of a group or community association, what type of association, and who was important in deciding or approving her membership Many women preferred to be a member of a group or community association and, therefore, participate actively in the decision to join The proportion actively involved in this decision varied by state (35 percent in urban Ondo, 50 percent in rural Ondo, 90 percent in urban Abia, 75 percent in rural Abia, 50 percent in urban Kebbi, and 80 percent in rural Kebbi)

Actual membership in a group or community association was generally high, and varied across states (table 11) Membership was highest in Abia in both urban and rural areas In both Ondo and Abia, the proportion of primary respondents who were members of a group was similar for both urban and rural areas In Kebbi, membership was lowest for urban women (only 17 percent)

Table 11 Percentage of Primary Respondents who Were Members of a Group or Community Association

State	Urban	Rural
Ondo	50	50
Abia	81	80
Kebbi	17	56
Total	55	65

The majority of primary respondents who were members of a group or community association in urban and rural Ondo were members of professional, religious or women's associations. In Abia, the majority of urban and rural women were members of religious organizations, however, the range of group association was wider in rural than urban areas. In Kebbi, those few urban women who were members of a group were exclusively in religious organizations, whereas the rural primary respondents were dispersed among religious organizations, farming associations, and women's groups.

Indices of Leverage over Decision-making

Data on preferences and outcomes were used to develop an index of leverage in three spheres-- education, health care, and household economy -- to examine the primary respondent's potential to exert leverage over decision-making in that sphere. Also, factors influencing the index are described. It is the potential to have leverage that was assessed, and not the extent of her leverage, because a woman was considered to achieve her preference if, on at least one occasion, the outcome in one aspect of the sphere was the same as her preference, instead of on all occasions.

Education

The index of leverage over decision-making in the education sphere was calculated using three matched preference and outcome variables: whether the primary respondent expressed a preference to educate daughters and sons, compared to whether she achieved her stated preference for her children's education, and also to whether the children were receiving their education in the school she preferred. In this study, it should be noted that a predominant preference was for tertiary education, yet most children of primary respondents were of primary- or secondary-school age. Since a preference was counted as having been achieved if the child was still attending school at any level, the education outcome may overestimate the degree to which preferences are achieved in the future, which in turn may overestimate the index of the primary respondent's leverage over decision-making regarding her children's education.

Primary respondents demonstrated a high degree of leverage over decisions to educate their children (0.74 to 0.95, table 12), indicating that 74 to 95 percent of women had the potential to leverage decisions about their children's education. There was more variation in the indices between the urban and rural sites than among the states themselves. The indices were highest in Ondo, and higher for urban than rural respondents. In Abia, slightly more rural women are achieving their education preferences than are urban women. This reflects both the age of their children (who are in general younger) and the fact that children often take longer to complete primary and secondary education in rural areas because of their productive responsibilities. In Kebbi, the index was similar for urban and rural areas, and includes preferences having been achieved if children, mostly girls, are only receiving a Koranic education. The index was high in Kebbi despite some respondents' reported dissatisfaction with the type of school--many prefer that their children receive both secular and Koranic education, but some of the girls were attending only Koranic.

Table 12 Index of Leverage over Children's Education Decisions

State	Urban	Rural
Ondo	0.95	0.88
Abia	0.74	0.87
Kebbi	0.84	0.84
Total	0.84	0.87

Reproductive and Child Health

The health index was calculated using three matched preference and outcome variables whether the primary respondent expressed a preference to immunize her children compared with whether they were actually immunized, the preference for the length of breastfeeding compared with the actual length of breastfeeding, to the month, and her birth-spacing preference compared with the number of months between the births of her last two children

Primary respondents demonstrated a somewhat high degree of leverage over decisions to seek health care for themselves and their children (0.53 to 0.74, Table 13), indicating that 53 to 74 percent of women had the potential to leverage health care decisions, though the leverage was not as high as for decisions of the children's education. In Ondo and Kebbi, there was little difference in indices between urban and rural sites. In Abia, however, significantly more rural women had the potential to leverage these health-related decisions than did urban women, largely because women in urban Abia achieved fewer of their breastfeeding and birth-spacing preferences.

Table 13 Index of Leverage over Health Decisions

State	Urban	Rural
Ondo	0.73	0.71
Abia	0.53	0.74
Kebbi	0.66	0.69
Total	0.63	0.72

Household Economy

The index for leverage over household economy decisions was calculated with three matched preference and outcome variables concerning whether the primary respondent (and/or her children) generated income whether she was working, whether she believed that single women and married women should work, and whether her children were working.

Primary respondents demonstrated a high degree of leverage over decisions about whether she and her children should generate income (0.73 to 0.94, table 14), indicating that 73 to 94 percent of women had the potential to leverage decisions about their children's education. In Kebbi, the indices were higher for rural than urban respondents because more rural women expressed a preference to generate income and achieved this preference than did urban women. In Abia, the index was slightly higher among urban respondents, despite the fact that more rural

women generated income and that their net contribution to household expenditures (54 percent) was higher than among urban women (39 percent of expenditures) This is because many rural women in Abia reported a preference to not be working, but continue to work because their contributions are vital to household maintenance

Table 14 Index of Leverage over Household Economy

State	Urban	Rural
Ondo	0.73	0.83
Abia	0.83	0.82
Kebbi	0.89	0.94
Total	0.81	0.85

Factors Influencing the Indices

Decisions within each sphere can be influenced by characteristics that contribute to leverage in other spheres In this study, the strongest such influence was that if the primary respondent contributed to household expenditures, the education and health indices were higher (table 15) These indices also rose with the size of her contribution to the household (The index of household economy was included for the sake of completeness, it was also higher if the primary respondent contributed to the household, but this relationship is tautological) The strong relationship between income and the indices is confirmed by similar relationships between income and many of the health variables shown in Appendix I ³

Table 15 Whether Primary Respondents Contributed to the Household Economy and the Indices of Leverage

	Education Index	Health Index	Household Economy Index
Contributed to the household	0.86	0.68	0.91
Did not contribute	0.78	0.65	0.73
Mean	0.85	0.68	0.83

A surprising finding was that the indices of leverage over decision-making concerning her children's education, health, and the household economy were higher if the primary respondent did not attend secondary school, and if she could not read (table 16) And in Appendix I, three education variables -- whether she attended secondary school, whether she attended primary school, and whether or not she was literate -- were not significantly related to the health variables More data analysis is needed to clarify this, but development specialists cannot lose sight of the fact that educating girls is a powerful development intervention The study may be suggesting that issues such as income generation may complement education ⁴

³ Appendix I gives the results of a univariate logit analysis of the primary respondents' ability to achieve reproductive health preferences Note that a fuller analysis of the relative influence of education and income variables would require interactive and multivariate specifications of the determinants of the ability to achieve preferences

⁴ The relative importance of income variables in determining leverage over household decisions does not imply that education has little or no impact in increasing women's autonomy or equal participation in decision-making Rather, this result is a feature of the lack of variation in education within the sample It may be assumed that a larger sample in a

Table 16 Whether Primary Respondent Attended Secondary School or Was Literate and the Indices of Leverage

	Education Index	Health Index	Household Economy Index
Attended Secondary School	0.78	0.65	0.80
Did not Attend	0.93	0.71	0.85
Reads	0.86	0.69	0.75
Could not read	0.99	0.75	0.83
Mean	0.85	0.68	0.83

The indices also varied with whether or not respondents were members of a community association, at least in urban Ondo, and rural and urban Kebbi, where membership was relatively low (table 17). If women in these three sites were members, their indices over decision-making in the education, health and household economy were higher than for women who were not members of any association. In Abia where membership in a community association is quite common, on the other hand, women who were not members had higher indices of leverage over decision-making in the education, health, and household economy spheres. There were only a few women in Abia who were not members of community associations, and they could be a self-selected set for whom, for example, support is derived from kinship relations or friendships. The results in Appendix I confirm the positive relationship between membership of primary respondents in a group or community association and the health outcomes. This was true regardless of the type of group, but it was strong for membership in a work group in particular, suggesting that part of the potential influence of group membership was through the economic leverage a woman gained.

Table 17 Whether Group Association is Related to Education, Health, and Household Economy Indices of Leverage

State	Urban	Rural
Ondo	✓	x
Abia	x	x
Kebbi	✓	✓

The Role of Significant Others

Both the qualitative and quantitative instruments were designed to explore the role that significant others play in influencing household decisions. The assumption is that a variety of actors are involved in household decisions across different spheres of decision-making. Who is considered to be important, or whose opinions matter, and how much influence each exerts over a decision may greatly affect an outcome. The role that significant others play and their leverage over an outcome provide important insights into the complex process of preference negotiation within households. Understanding these roles also yields information about how to support

more heterogeneously educated group of women would better demonstrate the importance of education in raising awareness and supporting more effective preference articulation and negotiation.

women in household decision-making. It may be that a primary respondent expresses a preference to immunize her children, but a significant other expresses a stronger preference against immunization, or that the primary respondent perceives the significant other will not support her preference. In either case, the outcome may be that the primary respondent does not immunize her children. In this way, a household member who most influences a particular decision can be identified, and perhaps targeted with information to convince him or her otherwise.

The distribution of significant others chosen by the primary respondents in all three states is shown in table 18. Each percentage indicates the number of times a significant other of that category was chosen divided by the total number of significant others chosen by all primary respondents in that state. While this provides an aggregate picture of the significant others considered by the primary respondents to be relevant to the decision-making process, it is important to recognize that the significant others may vary according to the decision being taken. Across different decisions and within different spheres of decision-making, the number and type of significant others may vary, as might their influence in decision-making and in the outcome.

Table 18 Percentage of Significant Others Nominated by Primary Respondents

State	Husband	Mother	Mother in Law	Father	Father in Law	Sister	Brother	Sister in Law	Brother in Law	Son	Daughter	Co-wife	Friend/ Neighbor
Kebbi rural urban	26 50	10	16 10		10	6		6		3	3	30 10	7 10
Ondo rural urban	54 78				3	3			4	3 13		7	29 4
Abia - rural urban	38 59	9 10		3	3 3	3 3			6 3	18	18		3 7
Total	38	6	8	2	3	2	2	4	4	7	9	9	7

Education

The significant other reported to be prominent in education decisions for the children in all three states was the husband. Husbands were cited as being very important in determining which children attend school, and the number of years they attend. Others who were reported to be significant in education decisions were fathers and fathers-in-law (Ondo and Kebbi), and brothers or brothers-in-law in the absence of the husband (Kebbi), and mothers, mothers-in-law, and sisters (Abia). In Ondo and Kebbi, men were dominant. The focus group discussions in Ondo indicated overwhelmingly that while the woman may suggest that a child be enrolled, the final decision is left to the husband or father (CEPHER 1997).

Only in Abia did primary respondents rate themselves as having leverage over decisions of education for their children. Within Abia, this leverage varied greatly by urban vs rural, and according to whether the child was female or male. The primary respondents' leverage was greatest in the rural area for the schooling of their daughters -- fully 55 percent rank their own opinion as very important, and another 30 percent as quite important, alongside their husbands'

60 percent as very important. Rural women consistently ranked themselves and their partners as being equally important in the decision-making process. For sons in rural and urban Abia and for daughters in the urban area, a smaller proportion of women, about 20 percent, reported their opinion on education as very important, alongside 43 to 57 percent of their husbands.

The reason more women in rural Abia participated in decision-making about their children's education may be that they generated the highest average contributions to the household compared to the five other sites (table 8). Rural Abia women cultivate land, grow sugar cane, process palm oil, and sell farm produce. In fact, total household incomes in rural Abia were lower than in the other two states, but women's income and expenditures were higher and, therefore, the proportion of income contributed by women was much higher. This may give women greater leverage in the decision-making regarding their children's education.

Primary respondents and their husbands (or significant other male) divided education costs roughly along gender lines, as reported in Abia and Kebbi. The school fees, which form the majority of the costs, were paid by the husband (and also uniforms in Kebbi), while notebooks, pencils, and food for daily participation in school (and also uniforms in Abia) were paid by the primary respondents. While the overall contribution to education by women was smaller than that of the men, it forms an indivisible part of the decision to educate a child and, as such, probably conferred leverage upon them over the decision to invest in education.

The following quotes from older male significant others from the focus group discussions in Abia support the importance of women's role in the decisions about education due to their economic contributions:

"The husband and wife should jointly decide. They should discuss it."

"It is important that they [the women] participate because some women make money."

Even in Ondo, where women thought their opinions on education decisions were less important, the focus group discussants thought financial contributions were crucial:

"A woman who wants her child to go to a particular school not approved by the husband must be able to meet the cost." Older woman, Ondo state

Reproductive and Child Health

Data on the role of significant others are reported for a number of health topics: the decision to seek treatment for the primary respondent and for children, breastfeeding, and birth-spacing.

Decision to seek treatment for the primary respondent Most women reported that they were involved in the decision to seek treatment for their own illness or condition, and considered their own opinion very important in deciding whether they seek and obtain health care. Following primary respondents, husbands were most often reported as the main significant other in this decision. Others reported were co-wives (in Kebbi), mothers, mothers-in-law, and

fathers-in-law The proportions reporting these sentiments varied slightly by state and by urban or rural location In Ondo, almost 84 percent of urban and 100 percent of rural primary respondents considered their own opinion as being very important in determining whether they sought and obtained the health care they needed In Abia, the proportions were lower In urban Abia, only 57 percent considered their own opinion very important in decisions to seek treatment for themselves, but 70 percent considered their husbands' opinions very important in the decision In rural Abia, the proportion was not as low, with 80 percent considering their own opinion very important, and 70 percent considering their husbands' opinion as very important In Kebbi, 75 percent of primary respondents in the urban sample and 78 percent of the rural sample considered their own opinion very important in this decision

The focus group discussions yielded interesting information about the role of the primary respondents in health care decision-making

“Women do not have the right to take decision[s] on health if the husband is absent ” Older male significant other, Ondo state

“It is the duty of the man to take decisions on treatment He must involve his wife ” Young women, Abia state

“If the man has no money, the woman may insist on what she wants But ordinarily it is for the man to decide Older male significant other, Abia state

Decision to seek treatment for children Most women also reported that they were involved in all decisions about seeking health care for their children, as with health care for themselves, and ranked their own opinion as very important in deciding on that care In addition to primary respondents, they ranked husbands and other male significant others as having much influence, followed by brothers, co-wives, neighbors, brothers-in-law (in Kebbi only), and sisters and daughters (Ondo only) In Kebbi, the decision-maker varied with the age of the child, with women deciding exclusively for children under about three years old, except when the cost of the child's treatment was more than the women could afford, and husbands and some other male significant others thereafter The proportions of primary respondents and significant others reported to have decision-making influence varied by state and by urban/rural location In Ondo, 95 percent of both urban and rural women reported that they were involved in all decisions about their children's health care, and 60 percent of urban and 85 percent of rural women ranked their influence to be jointly as important as that of significant others In Abia, the proportions were less In urban Abia, 52 percent of primary respondents reported their own opinion to be important, while 76 reported their husbands' opinions to be very important In rural Abia, the proportions were not as low, with 85 percent reporting their own opinion to be very important, and 70 percent reporting their husbands' opinions as very important In Kebbi, 100 percent of urban and 78 percent of rural primary respondents reported they were involved in the decision for the child's health care, and 92 percent of urban and 66 percent of rural respondents ranked their opinion as being of greater or equal importance than significant others

Breastfeeding For the decision about how long to breastfeed, a majority of primary respondents ranked their own preferences as the most important Following themselves, husbands were considered very important, and mothers, mothers-in-law, and sisters were

featured less frequently, though in Kebbi the significant others were always ranked as very important. In Ondo, 65 percent of urban and 60 percent of rural women were involved in the decision about how long to breastfeed. In urban Abia, 57 percent ranked their own opinion as being very important, and 52 percent ranked their husbands' this way, while in rural Abia, the proportion for women was higher, with 85 percent ranking their own opinion as being very important, and only 20 percent ranking their husbands' opinions this way. In Kebbi, 58 percent of women in urban areas and 55 percent in rural ones reported that they were actively involved in the decision about how long to breastfeed.

Birth-spacing The preferences of primary respondents tended to be similar to that of significant others, in both urban and rural areas. For example, in Abia, 55 percent of significant others in urban and 58 percent in rural Abia achieved their preferences. High proportions of women reported that the decision about whether to have another child, and when to have it, was made jointly with their husbands (90 in urban Ondo, 50 in rural Ondo, but only 33 percent made these decision jointly with their husbands in rural Abia). In Kebbi, 67 percent either made decisions jointly with their husbands, or by themselves.

Household Economy

In urban Kebbi, all women participated in the decision to earn a wage and all ranked their influence in the decision as being significant. Other family members involved in the decision-making process were husbands, fathers-in-law, and mothers. In this area, 63 percent of the sample who earned income did so through petty trading activities. The remaining 37 percent were equally divided between artisan and food processing activities, while one of the primary respondents was a civil servant. In rural Kebbi, women were also involved in the decision to earn a wage and all ranked themselves either exclusively very important in decision-making or equally as important as the significant other involved in the decision. Those significant others listed most frequently, in order of importance, were husbands, mothers, sisters, and co-wives. In these areas, the entire rural Kebbi sample who earned income were petty traders selling soaps and pomades, cooked food, snacks, and soft drinks.

Whether the primary respondent earned income and under what conditions were aspects of her income generation that often required negotiation with significant others. As people in the focus group discussions said:

“Women need a husband’s consent to do jobs of their choice. If a husband disagrees, then the wife has to send his friends to him to appeal on her behalf. If he refuses, the women then assumes that God has not chosen a career for her.” Older rural woman, Ondo state

“I think it is not proper for a woman to contemplate working without the consent of the husband. The liberation of women has not gotten to this matter, at least in this part of the world.” Young rural husband, Abia state

“No, a woman should not decide for herself. If you want to work you must tell your husband. This is so because you are doing work for him.” Older urban woman, Abia state

It is interesting to note the level of involvement of the primary respondents from different areas in decisions for children to earn money and the degree of control which they subsequently exercise over the earnings generated by their offspring. In Ondo and Abia the primary respondents are more equally involved with significant others in decisions for their children to earn. In Kebbi, the primary respondents were differentially involved in the decision for children to earn. If the child was a girl, they appeared to participate more fully in the decision about whether the girl should earn and subsequently whether the earnings were considered a net contribution to the household budget of the primary respondent. All the girls who were earning income in Kebbi were able to do so largely because they worked directly with their mothers and contributed labor to the products finished or generated from within the household. The income that they earned in this fashion was then considered a net contribution to the household, but largely controlled by the primary respondents. If the child was a boy, however, the primary respondent did not participate as much in the decision about whether he worked.

Data was also examined regarding the influence of significant others over group membership. The significant others nominated most frequently as being critical to the decision about group membership across all three states were husbands, mothers-in-law, fathers-in-law, and co-wives (in Kebbi). Approximately 72 percent of all significant others cited were male. According to almost all significant others and primary respondents, the most acceptable group for married and single women of all age groups to join were religious ones.

The focus group discussions supported the view that the most acceptable form of association for both single and married women was a church group or religious organization, and that the husband, partner, or principal male significant other should sanction all forms of membership.

“My wife cannot tell me she is joining a political party or any association. But if it is a church association, she can join without telling me.” Young male significant other, Abia state

“There is no way a woman will join an association without telling her husband. It should not be heard at all.” Young husband, Abia state

Further Analysis

While the discussion of household decision-making and the methodological refinements presented here are rich, there is much of the analysis that can be extended. The methodology elaborated here, and the study findings highlight several potential avenues for further research and analysis.

- The comparison of preferences and outcomes between primary respondents and significant others could be enriched by weighting the definition of leverage exerted over the decision-making process. A primary respondent who achieves her preferences in a setting where the significant others express divergent preferences might be considered to have exerted greater leverage and influence over the decision-making process than a primary respondent who

achieves her preferences where those preferences are in harmony with those of the significant others

- Some of the central questions about the role of significant others in household decision-making can be answered by mapping the constellations of preferences and outcomes and using non-parametric techniques to describe clustering and dispersion. Much information exists on the preferences of the significant others that could be usefully integrated into the analysis to provide a more sophisticated pictorial analysis of leverage.
- The analysis of the determinants of preference achievement and leverage was univariate and bivariate only. A multivariate analysis will allow for a more complex understanding of the relative importance of different factors and characteristics, although it would be limited by the small sample sizes in this study.
- A number of the findings that informed the policy and program recommendations were identified from the focus group discussions. Many of the recommendations about the determinants of leverage, such as mobility enhancing economic power, the importance of the stability of income earnings and the deleterious role played by intermediaries who capture a portion of the income generated by female artisans, deserve additional exploration and integration with the survey findings.

RECOMMENDATIONS

This study revealed that women whose preferences were achieved were better able to articulate and negotiate them, and typically enjoyed greater economic power, considerable mobility, better access to information, enhanced social support from membership in groups or community associations, and independent social and economic activities outside the household. In those households where preferences differed among themselves and significant others, women whose preferences were achieved were better able to communicate effectively.

In this section, programmatic recommendations are made to encourage and support women's leverage over household decision-making in Nigeria, based on the quantitative and qualitative research results presented. Although circumstances for women in the three study sites differed between urban and rural areas, between geographical and agronomic settings, and among ethnicities, religions, and classes, there were broad commonalities that suggest useful intervention points at which to raise the status of women in their households and communities, increase their leverage over decisions, and ultimately improve the welfare of themselves and their families. The recommendations are not exhaustive, but rather highlight actions that could build on key findings from this research.

Supporting Women's Economic Roles

Women with greater economic power were better able to negotiate and achieve their preferences. Where women earned money and where these earnings were stable, continuous, and accrued to discrete and autonomous activities, these women were better able to retain their earnings and exercise dominion over their expenditure. On the other hand, women who performed multiple tasks that were linked to the economic activities of other individuals, and whose earnings were discontinuous and erratic, were more likely to surrender their earnings to significant others in a household and were less likely to leverage household expenditure decisions. Thus, a woman's leverage within household decision-making was a function of whether she made economic contributions to the household, and also of the stability of the contribution, and the visibility of her income-generating role.

Key to the achievement of an enhanced economic role is the issue of mobility. Where their mobility was relatively high, women were better able to achieve their preferences in a variety of decision-making spheres, such as those who worked outside the home or who were active members of groups and work-related associations. Mobility restrictions may be sociocultural (prohibiting the free movement of women of reproductive age), economic (rooted in the inability of women to use or co-opt household funds to access a particular service), or psychosocial (deriving from intergenerational inertia emphasizing the security of the known local environment and stressing the insecurity of the unknown distant environment). Whatever the origin of the restrictions, they undermine women's leverage and autonomy in the household. Limited mobility prevented women from realizing a range of activities critical to their well-being, from accessing health care services to maintaining ties with significant others, to taking advantage of educational and economic

opportunities. In many cultures, mobility is a principal determinant of whether a woman is able to access formal saving and borrowing facilities and to trade and sell products.

One example of an implication of women's restricted mobility is that they use intermediaries to sell products they make. Many women in the three study sites prepared foods and spices, made soaps, sold oils and pomades, and undertook craftwork or artisanry. They performed multiple, predominantly home-based activities to generate income that was critical to weekly household expenditures, though perhaps erratic and intermittent. Despite the importance of the income, some women did not identify themselves as income earners, were not cognizant of their full economic contribution made in a week or month, did not appear to "value" these activities, and in turn attained little leverage over education, health, and household economy decisions. This was especially true for women who performed economic activities that require highly specialized markets at some distance from their homes, such as a craft or handiwork, and relied on several intermediaries to sell their products. Women for whom sociocultural taboos restricted their mobility were often forced to rely on intermediaries to market their produce, whether these intermediaries were contracted or members of the family. They had the lowest indices of leverage. One interpretation of this may be that as the number of intermediaries increased the profit diminished and a woman's leverage decreased. On the other hand, when women were engaged directly in the production and marketing of their products, they were better able to retain income and exert influence over household expenditure decisions, even if they were based at home.

In addition to affecting their economic power, women's restricted mobility also limits their ability to access services. One arena where such mobility constraints are crucial to decision-making is that of health. For instance, women who required treatment in hospitals or clinics far from home were more reluctant to seek treatment for themselves, preferring to use local services. Women's lack of mobility appeared to be a prime factor in determining whether they would discuss their own health problem in the household, though the specific social or cultural constraints were not clear. Other determinants of mobility and access may be social or psychological. The finding that many women prefer to seek spiritual guidance or naturopathic services to treat reproductive tract infections and sexually transmitted diseases would indicate that these services are comparatively more accessible than those provided by clinics, private doctors or hospitals. Determining whether this comparative accessibility is a function of the cost of these services, the privacy offered, or the counseling provided would yield information on how modern medical services could be modified to be more fully utilized.

Recommended Actions

Where possible, interventions should encourage

Specialization Specialized training will enable women to concentrate their energies on a small number of production activities. Vocational training will enable them to refine existing production processes and capture more value added. It will also focus attention on the value of their activities and increase awareness of the economic role that these women play in the community and the household. Training should address basic accounting, inventory management, and business development plans where appropriate.

Where sociocultural restrictions limit women's mobility, trainers should be women, the training should occur in the household or among small groups of women, and the focus should be on refining, coordinating, and channeling existing activities. The Country Women Association of Nigeria (COWAN) could be drawn upon to adapt and replicate many of their training activities, and to providing training and technical assistance inputs for grass-roots trainers in other regions.

Financial services Many women belong to informal lending associations, which perform critical functions, enabling individuals and households to borrow money and cushion against temporary shortfalls in income. These associations could be built upon to extend credit to micro-enterprises or to channel savings to formal sector banking.

Establishing a women's banking facility that could lend explicitly to women and operate through these associations would reduce the physical, economic and psychological costs of saving and borrowing in the formal sector. The women's banking facility could be highly decentralized and mobile, operating through existing NGOs such as the Federation of Muslim Women's Associations in Nigeria (FOMWAN) or COWAN.⁵ Representatives of the facility could meet with local informal lending groups to receive and document their contributions and to disburse loans. Small finances already exist as seed moneys from these groups, and savings could be readily encouraged. In addition, these informal lending groups could also be used to generate business plans that could petition the women's banking facility for flexible loans whose terms and conditions would vary depending on the gestation period of the business investment plan.

Marketing associations Many women are unable to market their products directly, often because of cultural restrictions, and must rely on intermediaries and on local sales persons. The mechanisms that these women use dilute their ownership of the moneys generated and consequently undermine their bargaining power in the market place and the home. This is particularly acute in northern Nigeria. Marketing associations could be crafted from existing social and religious groups, or added on to their existing activities. FOMWAN could be used to define a culturally appropriate mechanism that would collect produce from the individual's home and sell it in the market-place or distribute it beyond the boundaries of the village or town.

⁵ The institutions through which micro-lending could be channeled to end-users should already be engaged in micro-lending activities. It is important not to require NGOs with non-financial mandates and objectives to act as a conduit for micro-lending, as this often introduces competing objectives which are incompatible with their existing activities and forms of service delivery. The amount of lending disbursed in this way should be carefully adjusted to the size of the NGO in question, as it is critical not to overburden existing institutions (Buvimic 1996, Buvimic and Paolisso 1996).

Decentralizing service provision Another way to reduce the distance between a service and the household is by further decentralizing components of service provision by promoting mobile clinics and flexible community-based training and educational opportunities. This has been particularly successful in the community based distribution approaches incorporated into many family planning programs throughout the developing world. While this can in many circumstances increase the cost of service delivery, the cost increment can be minimized if the services providers work with or are supported by NGOs in their service delivery areas. Indeed, NGOs such as NAWIN and FOMWAN have been most effective in bringing low cost services to women in rural and urban areas. The highly decentralized organizational units, with small groups dispersed across a range of rural and urban areas, enables many women to participate in meetings and be drawn into activities.

Where services (such as micro-finance, general health information and preliminary diagnostics, contraceptive services, literacy, numeracy, and skills training) can be decentralized, existing NGOs could also be used to disseminate information, undertake training, and provide a forum for exchange. This not only ensures that vital services reach women at the grass roots level, but also provides a support mechanism, whereby women gain household leverage and widen their knowledge base through group association.

In order to do this successfully, the service provider will need to identify appropriate messengers or representatives whose ability to enter households and meet with women is already accepted. The messengers may bring critical information about an existing service or perform a diagnostic to channel components of a service to these women at a later date. Many services that are not readily decentralizable may have segments of that service that can indeed be performed off-site. Ensuring that the initial contact with an institution or service takes place in the home of the recipient or beneficiary may reduce the social and cultural barriers that prevent women from accessing such services, though this may reinforce women's lack of mobility in the short term (Schuler, Hashemi and Jenkins 1995).

Refining existing services Further research should be undertaken to identify those characteristics that make certain services more accessible to women, for example, the treatment of reproductive tract infections and sexually transmitted diseases. This research could be highly focused and qualitative, undertaken by community groups and NGOs active in the areas. The research should explore cultural norms and attitudes toward all types of services available, generating information on the costs of the different services, the counseling services provided, the privacy afforded, the class and gender of the service-providers, the overall time costs invested in receiving the service, and the perceived stigma associated with the use of each service. In this way, services that are comparatively inaccessible to women may be modified to replicate those characteristics and features of successful services offered by other informal and semi-formal health care providers.

Fostering Communication with Significant Others

Women who were better able to communicate their needs to significant others were better able to negotiate and achieve their preferences. In those households where the significant others expressed highly divergent preferences from those of the primary respondent, the primary respondent was consistently less able to achieve her preferences and generally demonstrated lower indices of leverage over education, health care, and household economy decisions. This was critical in determining the length of time a child was breast-fed, the amount and type of education for girls (particularly in the north), whether a woman held a job or not, and often what type of health care service she sought. Inability to communicate entrenches all parties in existing prejudices about the other individuals' motivations and needs, depresses information exchange, and impedes conflict resolution. The survey data and information generated in the focus group discussions revealed that both men and women appeared to believe and perpetuate misinformation about each others' motivations, social and economic constraints, and needs. In households where there was a greater degree of communication, there was a greater transparency of motive, negotiation was more explicit, and women were often better able to exert influence over the process.

One communication breakdown of particular note is that women in all three states seldom knew their husbands earnings and were unaware of the total household resources⁶. Men in many of these households felt that it was crucial to withhold such information, because women were "poor money managers," indicating that women would use whatever means available to extract that income to make unnecessary expenditures or to fund consumption expenditures that would not generate future income. The women believed that men withheld this information to conceal support to other households and other women.

Recommended Actions

Interventions that bring women and significant others, particularly husbands, together within the confines of what is considered culturally appropriate, and encourage the joint resolution of shared problems and objectives may facilitate communication and better enable women to negotiate and achieve their preferences.

Channel health and nutritional information to significant others Significant others should be targeted simultaneously with information about breastfeeding, dietary and nutritional information about weaning foods, feeding practices, sexually transmitted diseases and reproductive tract infections in women, and health care and educational services for women and girls. The information should be carefully tailored to challenge many of the existing assumptions and attitudes that limit the options available for women or that stress women's conformability to expectations about their reproductive roles that undermine their own health or deleteriously affect that of their children.

⁶ Only 28 percent of all urban and 5 percent of all rural primary respondents stated that they knew how much their husband earns.

Create positive images of women's work. Another activity that can effectively channel information to women and significant others simultaneously could be an information exchange to increase the visibility and acceptability of women's contributions to households. Such a campaign could promote an exchange of experience about working women's contributions to the household, with men and women discussing changing values about women's work, and the importance of both partners' contributions in maintaining households and supporting children. This could be promoted effectively using local radio and organizing community discussion fora, or by holding a poster campaign in schools and colleges. Any intervention should be carefully pilot-tested and undertaken on a gradual and incremental basis at a measured pace. In particular, all messages, promotional posters and scripts should be pilot-tested prior to their release.

Joint activities and problem-solving Another way of increasing communication and fostering transparency between men and women is by creating the opportunity for them to engage in solution generating activities that are designed to achieve a common objective. Bringing men and women together to solve a community need might be particularly useful. Where appropriate, it might also be useful to break existing patterns in the division of labor that define certain activities as being exclusively male or female. Coordinating community activities to repair, maintain or build low cost public infrastructure may provide a useful channel for fostering communication. Mapping routes and laying pipes for irrigation or public water supply, improving the drainage of roads, building schools, repairing public structures, parks, etc. Small infrastructure development projects may be used to achieve many objectives that benefit women. Not least because women often depend disproportionately on the benefits of public infrastructure, but also because in the absence of such infrastructure, women often perform tasks to compensate for the underprovision of such public goods -- as they affect activities that link intimately to the reproductive sector. This is particularly apparent in the case of water and energy resources, and the provision of schools and nurseries. The beneficiaries should be actively drawn into the process of identifying a public need, seeking or obtaining funds and materials (either from existing programs or through a small fund set up along the lines of social action funds),⁷ contributing labor, distributing the resources, planning and undertaking the project.

⁷ The small social action funds could be set up as part of a larger democracy and governance initiative, to empower communities through public infrastructure activities. This could be couched in terms of achieving broad democracy and governance objectives, breaking dependence on social and governmental institutions, coalescing community action, and supporting the development of alternative decision-making structures at the grass-roots level.

Community theater. Theater can be an effective tool to challenge existing prejudices. Theater can be used to demonstrate conflict resolution techniques, to highlight effective communication and negotiation strategies, and to promote dialogue on intra-household communication. Targeting adolescents and young couples, both as an audience and as actors and participants in community theater, may prove most rewarding. Centering theater on conflict resolution over household resources to improve educational opportunities or health care decisions for children may provide an acceptable entree into the topic of conflict resolution and negotiation techniques for both men and women. In order to draw men and women together to successfully resolve conflict, areas of intersection will need to be identified, where the preferences and concerns of men and women and the objectives coincide.⁸ The survey data and focus groups discussions revealed that a point of mutuality between men and women in many households was the education and health of offspring. Men and women both expressed concern for their children's education and health and demonstrated clear incentives to expend household resources on improving child welfare.

⁸ The survey data could be used to identify different scenarios of household conflict, pertinent to each region, where the conflict was resolved successfully and unsuccessfully. These examples could then be discussed by the community groups in a participatory fashion. The theater can then be used to promote discussion on effective communication strategies between men and women and between women and significant others to overcome conflict.

APPENDIX 1 Factors Associated with Reproductive Health Variables Odds Ratios (s e)

Variable	Can Refuse Intercourse	Can Refuse Intercourse if Risks Disease	Can Refuse Intercourse if Risks Pregnancy	Ever Discussed Decision to have A Child	Achieved Birth-Spacing Preferences	Knowledge of Family Planning Methods
married after the age of 15	0.427 (0.343)	3.558** (2.293)	0.121 (0.220)	2.827 # (1.736)	0.959 (0.571)	4.318 * (2.829)
urban resident	2.359 # (1.105)	1.134 (0.593)	2.800 * (1.186)	1.473 (0.620)	0.862 (0.342)	1.169 (0.642)
polygamous household	2.251 (1.249)	0.468 (0.260)	0.798 (0.369)	0.571 (0.261)	1.333 (0.598)	1.169 (0.734)
member of a group	1.769 (0.797)	2.167 (1.141)	2.880 * (1.261)	1.370 (0.577)	0.345 ** (0.146)	1.144 (0.630)
member of a work group	2.600 (2.077)	3.5 (3.745)	4.000 * (2.505)	1.561 (1.001)	0.388 # (0.228)	1.282 (1.043)
earns money	0.355 # (0.213)	0.811 (0.506)	0.774 (0.354)	1.181 (0.570)	0.588 (0.272)	2.372 (1.343)
contributes earnings to household	1.007 (0.561)	1.756 (1.071)	2.039 (1.125)	2.571 # (1.419)	1.242 (0.641)	5.25 ** (3.257)
contributes more than 200 Naira	1.490 (0.669)	3.162 * (1.806)	1.970 # (0.819)	3.147 ** (1.372)	0.854 (0.339)	5.24 ** (3.551)
contributes more than 500 Naira	1.413 (0.685)	2.019 (1.234)	2.063 # (0.900)	2.841 * (1.358)	0.912 (0.381)	4.308 # (3.397)
contributes more than 30%	0.820 (0.366)	1.820 (0.968)	1.969 # (0.818)	2.806 ** (1.211)	0.486 # (0.196)	2.663 # (1.550)
contributes more than 50 %	1.067 (0.480)	1.814 (0.992)	2.267 ** (0.953)	3.24 ** (1.443)	0.688 (0.275)	2.860 # (1.766)
secondary education	1.023 (0.473)	0.700 (0.395)	0.665 (0.285)	0.791 (0.341)	0.771 (0.317)	0.862 (0.476)
primary education	0.857 (0.396)	1.053 (0.578)	0.929 (0.394)	1.016 (0.436)	1.087 (0.444)	1.286 (0.710)
literate	0.699 (0.428)	0.539 (0.335)	0.236 * (0.167)	0.593 (0.346)	1.286 (0.710)	0.549 (0.363)

The odds ratios were generated using univariate logit regressions on discrete 0,1 variables to assess the impact of each variable on the probability of being able to achieve or articulate each of the dependent variables

** indicates statistical significance at 1 % level

* indicates statistical significance at 5 % level

indicates statistical significance at 10 % level

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