

Religious and Gender Dimension of HIV/AIDS Risk among Women in Nigeria

Master's Thesis

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Cornelia Kammerer, Advisor

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by
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ABSTRACT

RELIGIOUS AND GENDER DIMENSIONS OF HIV/AIDS RISK AMONG WOMEN IN NIGERIA

A thesis presented to the Department of Global Studies

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Three million Nigerians are currently estimated to be living with HIV/AIDS, making it the third largest country with number of infected persons (USAID, 2010). Prevalence among young women ages 15 to 24 is nearly four times higher than the prevalence among young men, at 2.3% compared to 0.8% (USAID, 2010). This study sought to examine some of the social factors that predispose women in Nigeria to HIV/ AIDS, by focusing on both the religious and gender dimensions of HIV/AIDS risk. For the majority of Nigerians, religion is more than an organized system of beliefs. Nigerians, on average, attend a church, mosque or other religious service more often than most other nationalities (Oluduro, 2010). Therefore, any HIV/AIDS prevention program that does not recognize the effect of religion on Nigerians could fail.

Also, Gender inequality is marked in Nigeria: the nation is ranked 120th in the 2011 Global Gender Gap Report of the World Economic Forum. As shown below, gender

inequality relegates women to the background in terms of access to economic and social freedoms, and poses a major threat to public health issues such as the HIV/AIDS.

Christianity and Islam, the two major religions in Nigeria, have similar and different views on factors that predispose women to HIV/AIDS. This study compared and contrasted the effect of Christianity and Islam on HIV/AIDS risk among women across the regions. From the results below, the role of religion in HIV/AIDS prevention and risk is multifaceted. For example, direct effect of religious doctrines like abstinence could have a positive or negative effect on HIV/AIDS risks. While it is clear from the results below that factors like education, wealth/ income and healthcare access play an important role in the HIV/AIDS risks, it was also clear that gender inequality and religion influences these factors.

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INTRODUCTION

NIGERIA

Nigeria is located in West Africa with a population of more than 170 million people (Central Intelligence Agency, 2012). It is a diverse country with more than 374 ethnic groups, 500 indigenous languages, and various religions (National Population Commission (NPC) [Nigeria], 2009). The major ethnic groups are the Hausa-Fulanis in the north, the Yorubas in the south-west and the Igbos in the south-east. According to the Nigeria Demographic and Health Survey of 2008, the Hausa-Fulanis are the largest ethnic group, constituting 22% of Nigeria's population, followed by the Yorubas at 18% and the Igbos at 16%. The other smaller ethnic groups together constitute about 44% of Nigeria's population (National Population Commission (NPC) [Nigeria], 2009).

Nigeria, a former British colony, gained its independence in 1960 with the hopes and promises for the future. Over 50 years later, it has continued in its struggle to remain intact as religious and ethnic differences, coupled with corrupt leadership, have threatened to topple the existence of this nation. While the population has continued to grow – Nigeria is the 7th most populous nation, and the most populous black nation in the world – life expectancy at birth has continued to fall, and other health indicators like maternal mortality continue to worsen (Central Intelligence Agency, 2012). The nation continues to bears a heavy burden of infectious diseases such as malaria, tuberculosis and

HIV/AIDS, a burden that needs to be addressed for the Nigeria's advancement and development.

OVERVIEW OF THE TOPIC

Almost 3 million Nigerians are currently estimated to be living with HIV/AIDS, making it the country with the third largest number of infected persons worldwide (USAID, 2010). Although Nigeria has one of the lowest prevalence rates at 3.6% (USAID, 2010) in sub-Saharan Africa (SSA), it also has the second highest number of new infections reported each year (WHO/UNAIDS/UNICEF, 2011). This could only mean that Nigeria is lagging in its prevention campaign for reasons that are yet to be determined.

Women are disproportionately affected by the HIV/AIDS in Nigeria: prevalence among young women ages 15 to 24 is nearly four times higher than the prevalence among young men, at 2.3% compared to 0.8% (USAID, 2010). In general, women in many places are disproportionately affected in part for bio-physiological reasons, however the social dimensions of women's vulnerability to HIV/ AIDS varies across regions. This paper seeks to examine some of the social factors that predispose women in Nigeria to HIV/ AIDS. For example, gender inequality is marked in Nigeria: the nation is ranked 120th in the 2011 Global Gender Gap Report of the World Economic Forum. This is a sign that Nigerian women are fairing worse than they did in the 2006, when the nation was ranked 94th (World Economic Forum, 2011). When women are denied equal access to economic and social freedoms, they are forced to rely on others, especially their partners for sustenance. These partners are sometimes responsible for important decisions like whether to use a condom during sex or not. Most of the times, these women have no

choice but to ‘carry along’ with the wishes of their benefactors even if it meant exposing themselves to HIV/ AIDS.

Nigeria is one of the most religious countries in the world. For the majority of Nigerians, religion is more than an organized system of beliefs: it is a way of life. According to a survey carried out by the British Broadcasting Corporation (BBC) in 2004, Nigerians, on average, attends a church, mosque or other religious service more often than most other nationalities (Oluduro, 2010). This is why the role of religion in HIV/AIDS prevention is integral. No HIV/AIDS prevention program can be very effective unless it deals with the religious beliefs and practices of Nigerians.

Studies like that of Chinyere Okunna and Ileoma Dunu have blamed religion for its role in stalling the fight against HIV/AIDS infection in Nigeria. They have shown that “religion undermines the effectiveness of combating the pandemic by stakeholders, including the media” (Aguwa, 2010). However, in a study carried out by Seeman et al., some religious people exhibit positive health behaviors, such as abstinence from premarital sex (Seeman, 2003). These varying results have shown that the role of religion in HIV/AIDS prevention can be positive or negative (Aguwa, 2010; Essiet-Gibson, 2008; Seeman, 2003). The goal of this study is to analyze the positives and negatives of religion on HIV/AIDS prevention among women in Nigeria. However, the analysis would require looking at the two religions that are dominant in Nigeria, Christianity in the south and Islam in the north. Since both religions are fundamentally different, it is therefore important to analyze the effects of Christianity and Islam separately.

Some analyses have shown that HIV/AIDS rates among Christians in the south have remained significantly higher than among the Muslim populations in the north (Institute

for Global Engagement, 2006). Pearson's correlation analysis reported by Essiet-Gibson showed that Muslims were more likely to have lower HIV/AIDS risk behavior scores than Christians (Essiet-Gibson, 2008). What studies have failed to show in detail is how the roles of both religions differ or are similar in HIV/AIDS prevention among women. Of the few studies that have been done on the religious dimension of HIV/AIDS in Nigeria, many have focused solely on men. For example, A 2010 study showed the effect of alcohol and male circumcision on HIV/AIDS prevention in men in the Muslim north and compared it to men in the Christian south (Aguwa, 2010).

Other studies that focused on women looked at the religious dimension of HIV/AIDS in specific women e.g. pregnant women in particular cities and regions, women of certain ethnicities, etc (Essiet-Gibson, 2008). Essiet-Gibson came closest to analyzing the religious dimension of HIV/AIDS prevention among women in Nigeria, but with little emphasis on the role of gender inequality. This study focuses on both the religious and gender dimensions of HIV/AIDS prevention in Nigeria. Religion plays an important role in shaping the HIV/AIDS crisis in Nigeria, but this role extends beyond the underlying differences in beliefs and moral choices among Christians and Muslims.

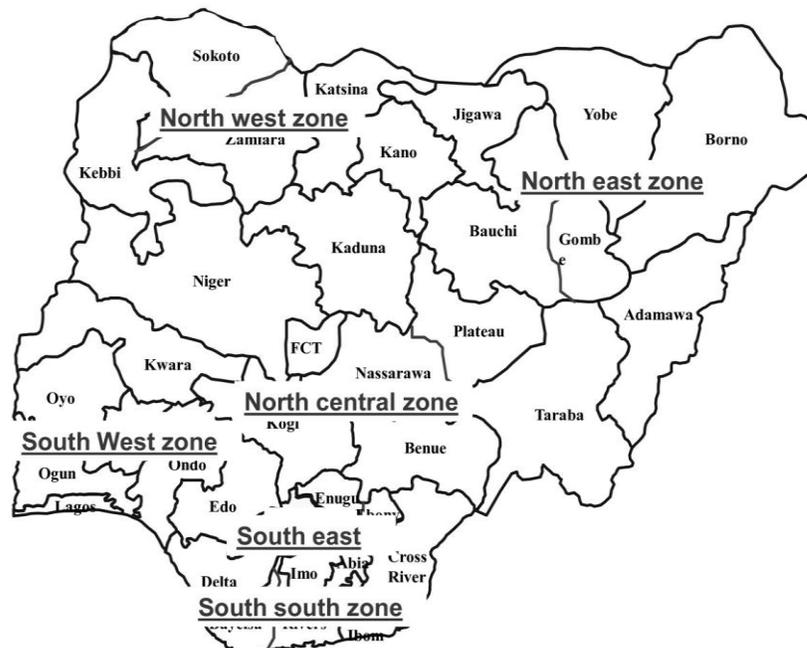
This study aims at answering how Christianity and Islam affects the prevention of HIV among women, but with emphasis on how religion contributes to the "other factors" that predisposes women to HIV/AIDS infection, e.g., access to education and wealth, the role of westernization/globalization, etc. This study will conclude by analyzing to see if gender inequality plays a greater role in HIV/AIDS infection risk than religion, or vice versa.

CHAPTER 1

RELIGIONS IN NIGERIA

Nigeria is divided along the lines of religion, with a north that is predominantly Muslim (95% Muslims and only 5% Christians), and a south that is predominantly Christian. The south is further divided into the south-west zone, the home of the Yoruba tribe, and the south-east zone, the home of the Igbos and the Ijaws. The south-west has a population that is 60% Christians, 30% Muslims and 10% followers of traditional religions. The Igbos in the south-east and the Ijaws in the south-south are 98% Christians, mostly Catholics. Only about 2% of the population in these regions practices indigenous religions. The middle belt region of Nigeria, sometimes referred to as the north-central zone is the home of minority ethnic groups whose members are mostly Christians and traditionalists with few Muslims (National Population Commission (NPC) [Nigeria], 2009) . Figure 1 below shows the 6 different zones in Nigeria.

Figure 1 showing the map of Nigeria, the Geopolitical zones & the 36 States
Source: Dineen *et al. BMC Ophthalmology* 2008 **8**:17 doi:10.1186/1471-
2415-8-17



Christianity and Islam, the most popular religions in Nigeria, are not native to the country, and yet their influences affect the core and the essence of the country, from economic development to health. The Nigeria National Population Commission survey of 2003 puts the total number of Christians in Nigeria at around 48.2% of the population (Nigeria National Population Commission and ORC Macro, 2004). The Muslim population is estimated to be around 50.4%, and only around 1.4% of the people practice the indigenous religions (Nigeria National Population Commission and ORC Macro, 2004). It is important to note that some Christians and Muslims continue to practice some aspects of the indigenous religions that are tied to their ancestry.

Nigeria has the largest total Christian population of any other country in Africa and one of the largest Muslim populations. Although 90% of Egyptians are Muslims, only 75 million Egyptians are Muslims compared to Nigeria's 85 million Muslims (Central Intelligence Agency, 2012). Also, 95% of Angolans are Christians, but only about 16 million are Christians compared to 82 million Nigerians who are Christians (U.S. Department of State, 2011).

Religion is defined as “an organized system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred and transcendent (God, higher power, or ultimate truth/reality) and to foster an understanding of one's relationship and responsibility to others living together in a community.” (Essiet-Gibson, 2008) For the majority of Nigerians, religion is more than an organized system of beliefs – it is a way of life. In a 2006 survey by the Pew Forum on Religion and Public Life, as shown in Table 1 below, 76% of Christians in Nigeria say that their religion is more important to them than their identity as Nigerians or members of an ethnic group. Among Muslims, the number

of people naming religion as the most important factor is even higher at 91% (Robert Ruby and Timothy Samuel Shah, 2007). The role of religion in the lives of Nigerians cannot be overlooked. Nigeria is one of the few countries in the world where almost everyone believes in God, irrespective of how they choose to worship their ‘him’. To ignore this is any capacity when making policies is to ignore the essence of what makes Nigerians who they are. This is the very reason why my paper is looking at the religious dimension of HIV/ AIDS risks and prevention in Nigeria

Table 1 on Religious Identity in Nigeria.

Importance of Country, Religion, Ethnicity in Your Life

% saying their nationality, religion, ethnic group or their continent is most important to them

	<u>Nationality</u>	<u>Religion</u>	<u>Ethnic Group</u>	<u>Continent</u>
	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Christians	9	76	6	8
Muslims	5	91	-	3

Source: Spirit and Power: A 10-Country Survey of Pentecostals, Pew Forum on Religion and Public Life, October 2006

HISTORY OF CHRISTIANITY AND ISLAM

Islam was introduced to northern Nigeria as early as the 11th century and became well established in the major regions of the north by the 16th century (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004). Islam also came to the south-west area of Nigeria during the time of Mansa Musa's Mali Empire. This is the reason the

Yorubas refer to Islam as "Esin-Mali," which means religion from Mali. Muslims in Nigerian are mostly Sunnis (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004). The Shia Muslims of Nigeria are primarily located in the Sokoto State in the north-west region (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004). Islam had already taken a deep root in northern Nigeria by the 20th century, so much that when the British colonial government established indirect rule in this region, it was based on the Islamic structure that was established by Shehu Usman dan Fodio (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004), the Fulani scholar who in 1804 launched a six year jihad, which lasted six years, to revive and purify Islam and to remove all innovations contrary to the Qur'an and Sharia law.

Nigerians first came in contact with Christianity in the fifteenth century through the Portuguese Catholic priest who accompanied Portuguese explorers in their bid to find a sea route to India (Samuel U. Eriwo, 1979). However, Christianity did not gain ground until the nineteenth century, when Roman Catholic missionaries returned (Serving in Mission-Evangelical Church of West Africa, 2010). The Catholic Church has grown ever since, and now claims approximately 19 million followers, mainly in the south-east (Serving in Mission-Evangelical Church of West Africa, 2010). In 1842, the first Protestant missionaries, Wesleyan Methodists, arrived in Nigeria and began work in the south-west among the Yorubas (Serving in Mission-Evangelical Church of West Africa, 2010). Other Protestant groups followed: the evangelical Anglican, United Free Church of Scotland, and the Southern Baptists (Serving in Mission-Evangelical Church of West Africa, 2010). Several other missions have since found their way into the country. According to the 2009 National Religious Survey, 15% of the Nigerians are Protestants,

13.7% of Nigerians are Catholics, and 19.6% are other Christians (Nigeria National Population Commission and ORC Macro, 2004). According to the 1963 census, conducted in the early years of independence, Muslims comprised 47% of the population while Christians comprised only 35% of the population. Today Christians account for almost 50% of the population, making Christianity the fastest growing religion in the country.

CHRISTIANITY AND ISLAM IN NIGERIA TODAY

Both Christianity and Islam have been experiencing a major transformation over the past three decades, as new religious movements have been supplanting the more established ones. (Pereira & Ibrahim, 2010) For example, the explosive growth in the country of Christianity, especially Pentecostalism, is a testament to the fact that the “center of gravity” in the Christian world has shifted towards Africa, and also Latin America (Philip Jenkins, 2008). The reason for this phenomenal growth has been attributed to the socio-political climate in the country (Donatus Pius Ukpong, 2006; Philip Jenkins, 2008). Nigerians have had to endure dictators who ruled with iron-clad hands and have forced the people into poverty. The Bible, especially the book of revelation vividly describes similar sufferings inflicted by the anti-Christ on the people. The book also promises hope and freedom from these suffering – the appealing message that Pentecostalism preaches (Philip Jenkins, 2008). Today Pentecostalism in Nigeria is a major movement, and Nigeria is estimated to have the world’s third largest population of Pentecostals (Donatus Pius Ukpong, 2006).

The rise of Pentecostalism is not the only movement attributed to the poor socio-economic infrastructures and poor governance in Nigeria. The rise of radical religious movements like Boko Haram is also believed to have been fueled by poverty and corrupt governance (J. Peter Pham, 2012). Boko Haram, currently “wreaking havoc” in the northern region of Nigeria and a source of concern for the Nigerian government and International bodies, first came to the attention of Nigerians when it launched attacks in December 2003 against police stations and government buildings in the towns of Geidam and Kanamma in Yobe state, north-east Nigeria (David Cook, 2011; J. Peter Pham, 2012). Boko Haram, literally translated as “western education is sacrilege,” is a group which strongly opposes western civilization and the legitimacy of secular Nigeria (David Cook, 2011; J. Peter Pham, 2012). The secular Nigerian state is described as “evil” and unworthy of allegiance, and therefore should be replaced by a “purified” Islamic regime (J. Peter Pham, 2012). This “purification mission” is a cause for significant concern for Nigerians, especially for non-Christians. Since late 2010, Boko Haram has been responsible for brutal attacks on public officials, government institutions, churches, ordinary men, women and children who do not buy into their ideology of a solely Islamic Nigeria. At least 550 people were murdered in 115 different attacks in 2011 alone (J. Peter Pham, 2012).

Even the introduction of Sharia law, the moral codes and religious law of Islam in the Muslim north is not sufficient for the groups in its “purification” bid. Almost all states in the Muslim north (as seen in figure 2 below) now uses the Sharia legal system and are looking to extend this system to southerners, a move that remains controversial and a source of conflict for the nation’s democratic project. The Christian south would not

accept being governed or even affected by Islamic law (Donatus Pius Ukpong, 2006).

While the adoption of Sharia law in most of northern states is believed to serve as a uniting factor among Muslims in Nigeria irrespective of sectarian differences, it has also been cited as the source of discontentment for the low-income, often rural, non-literate women, men and children in the Muslim north. These marginalized people are the ones who usually answer to charges in a Sharia court (Pereira & Ibrahim, 2010).

Figure 2: Highlighted Northern Regions Showing the States that have adopted Sharia Law in Nigeria.

Source: http://www.pbs.org/newshour/indepth_coverage/africa/nigeria/map_sharia.html



In Boko Haram’s view, some of the Muslim northern leaders are becoming too “western”, and Sharia law alone is not sufficient in its islamization bid. For this reason, the group is increasingly showing little regard for the traditional Muslim hierarchy that to it appears secular/ western. Recently, Boko Haram threatened the historic and prestigious

seat of the Sultan of Sokoto in an open letter to the Sultan, Muhammadu Sa'ad Abubakar III (J. Peter Pham, 2012).

STATE AND RELIGION

There is no denying the major transformations occurring among Christianity and Islam in Nigeria today. The majority of the conflicts in recent years have had religious undertone and have led to the loss of many lives. Regardless, it is not uncommon to find leaders who are constantly trying to incorporate their religion into governance. For example, former president Olusegun Obasanjo, a self-proclaimed born again Christian revivalist from the South, supported a growing numbers of Pentecostal government officials and doctrines while in power, although he is Baptist (Pereira & Ibrahim, 2010). “Pentecostal rituals were liberally infused into state functions during his tenure” (Pereira & Ibrahim, 2010). The president’s support of Pentecostalism had a major influence on the political climate and contributed immensely to the rise of the Christian religious right in society (Pereira & Ibrahim, 2010). Before President Obasanjo assumed office in 1999, there were four national mosques in the federal capital territory (FCT), and not a single church. President Obasanjo saw it as his calling to rectify what he perceived as a wrong by building a National Christian Center in the FCT, a development many Christians welcomed with joy and exultation (Codewit World News, 2005). President Obasanjo was not the only president who has used their religious influence in key governmental decisions. Former president Ibrahim Babangida, a Muslim from the North, upgraded Nigeria’s role in the Organization of the Islamic Conference from an observer status to full-fledged membership. After a tremendous outcry, especially by the Christian South, a

panel was instituted to evaluate Nigeria's status in the Islamic Conference (now called Organization of Islamic Cooperation). The panel made a recommendation for Nigeria's withdrawal from the body, but the recommendation was not carried out and Nigeria is still a member, to the chagrin of the Christian South. To allay the religiously- biased decisions a leader could make, the rule that most political parties now follow is to produce a running mate for a presidential candidate who is of a different religion and ethnicity. Therefore, it is becoming a norm for a presidential candidate who is a Muslim from the North to have a running mate who is a Christian from the South and vice versa. Even then, the presidential seat has to be rotated every second-term to favor the next candidate from the other religion.

While this un-official arrangement may sound absurd, it is not surprising that Nigerians would demand it as part of their own democratization. According to the Pew research studies of May 2006, followers of each religion, Islam and Christianity, feel a deep distrust towards followers of the other. According to this study, 62% of Christians said they do not trust people or have little trust for people from the other religion (Robert Ruby and Timothy Samuel Shah, 2007). A similar percentage of Muslims shares the these sentiments, as 61% said do not trust people from other religions or only trust them a little (Robert Ruby and Timothy Samuel Shah, 2007).

Whereas I recommend that religion be separate from the state, majority of Christians (72%) say the country's leaders should have strong Christian beliefs and a larger majority of Muslims (77%) say the leadership should have strong Islamic beliefs (Pew Research). The majority of the country's Muslims, 52%, also believe the government should take steps to make Nigeria an Islamic country. The percentage is lower among Christians who

believe that the government should make the country overtly Christian at 42% (Pew Research). It can be inferred from the lack of trust of the other religions that the reason members of a group would want a leader who shares similar beliefs with them is to be able to have support for their own “agenda,” whatever it may be, from selfish ambitions to incorporating their religion into national interest.

CHAPTER 2

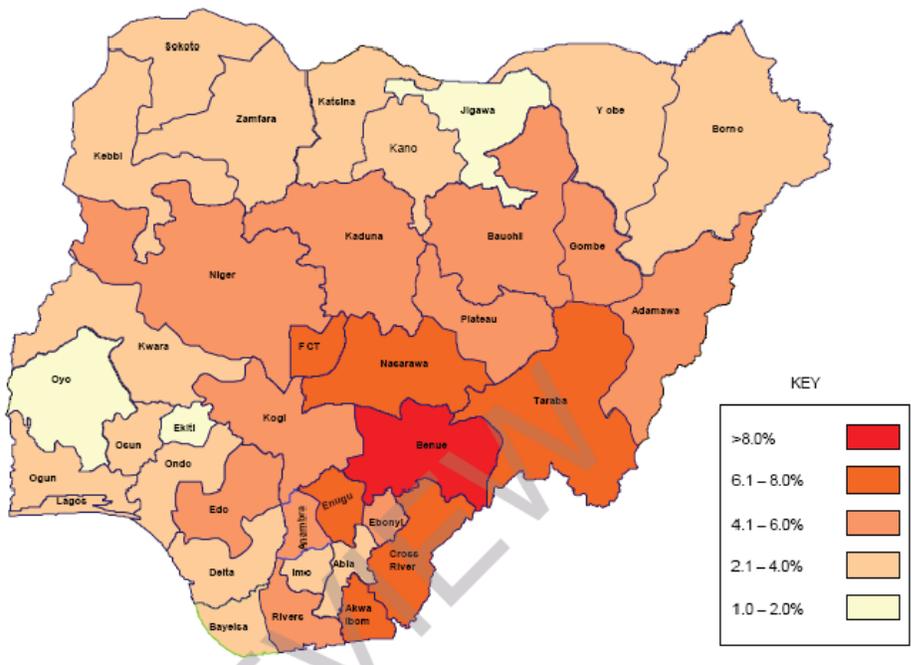
HIV/ AIDS IN NIGERIA

Studies have put the HIV prevalence among adults ages 15-49 at an estimated 3.1%, and approximately 2.6 million people in Nigeria are living with HIV/AIDS, the third largest estimate after South Africa and India (UNAIDS, 2007). In 2003, over 3.6 million Nigerians were estimated to be living with the HIV virus (UNAIDS, 2004). The number decreased to about 2.9 million in 2005 mainly due to expanded HIV surveillance into the rural areas (Kombe & Ubok-Udom, 2009). For example, increased awareness about important prevention strategies like condom use was employed. In 2003, 60% of urban women and 40% of rural women knew that using condoms can help to prevent HIV infection compared with 19% of urban and 11% of rural women in 1999 (Kombe & Ubok-Udom, 2009).

There is a wide variation in rates of HIV infection in the 36 states that make up the federal republic of Nigeria, with prevalence rates ranging from a low of around 1% in Ekiti state (south-west region) to as high as 10% in Benue state in middle belt region of Nigeria as shown in figure 3 below (USAID, 2010). According to a 2005 survey, 15 of the 36 states, including the Federal Capital Territory in Abuja, had prevalence rates greater than the national average of 4.4% (Essiet-Gibson, 2008). Figure 3 below shows that the prevalence rates are lower in north-east and north-west regions, where they are

mostly in the 2% - 6% range, while most of the south-east states and the central region have rates in the 4% - 8% range (Essiet-Gibson, 2008)

Figure 3 showing HIV/AIDS prevalence in Nigerian states
Source: (Essiet-Gibson, 2008)



HIV/AIDS AMONG WOMEN IN NIGERIA

The main mode of HIV transmission in Nigeria, like many other nations in the region, is through heterosexual intercourse (Essiet-Gibson, 2008; Mitsunaga TM, 2005). The percentage of women living with HIV/AIDS has steadily increased worldwide. In 1985, it was estimated that 35% of people living with HIV/AIDS were women, this increased to 41% in 1997 and to 61% in 2007 (Essiet-Gibson, 2008; UNAIDS, 2007). In

sub-Saharan Africa (SSA) alone, the proportion of women living with HIV/AIDS has increased gradually since 1985, from less than 50% to 59% in 2005 (Essiet-Gibson, 2008). The Joint United Nations Program on HIV/AIDS has estimated that three-quarters of all women living with HIV live in SSA region(WHO/UNAIDS/UNICEF, 2011) . Although Nigerian women are only about 50% of the population, they account for 58% of people living with HIV/AIDS in Nigeria (Essiet-Gibson, 2008; UNAIDS, 2004).

HIV/ AIDS PREVENTION IN NIGERIA

In addressing HIV/AIDS, Nigeria has made significant progress, but much remains to be done. To drive down infection rate nationwide, the federal government adopted a national multi-sectoral response leading to the formation of the Presidential Council on AIDS (PCA) and the National Action Committee on AIDS (NACA) in 2001. The state Action Committee on AIDS (SACA) and the local Government Action Committees on AIDS (LACA) coordinate the AIDS response at the state and local government levels, respectively (UNGASS, 2010)

In 2003, the proportion of women and men who had heard of HIV/AIDS rose from 86% to 97% (from 74% and 89% in 1999, respectively), with little variations across the geopolitical regions. Knowledge of HIV/AIDS does not show great variations by region, unlike the HIV/ AIDs prevalence rate. The significant rise in HIV/AIDS awareness can be credited to the aggressive campaign that began in the early 2000s about important prevention strategies like condom use (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004). Although knowledge of prevention practices, such as condom

use, are widespread in the general population, there is limited adoption of these practices due to the complexity of social and cultural factors – some of which are discussed in later chapters - that influence the sexual choices that people make (Essiet-Gibson, 2008; Mitsunaga TM, 2005; Smith, 2004). “This lack of adoption of preventive practices highlights the need for research that seeks better understanding of how specific factors influence the sexual choices that people make and how these influences can be harnessed in the context of designing interventions for the population.” (Essiet-Gibson, 2008)

Effort is ongoing to improve the availability of antiretroviral therapy (ART), prevention of mother-to-child transmission (PMTCT), and voluntary counseling and testing (VCT) services. ART uptake has expanded since the free antiretroviral drug (ARV) policy was introduced in 2006. In 2010 NACA launched a comprehensive National Strategic Framework that would span up to 5 years (Avert, 2011). This requires an estimated N756 billion (around USD 5 billion) to implement (Avert, 2011). The main aims included in this strategic framework are to reach 80% of sexually active adults and 80% of most at-risk populations with HIV counseling and testing by 2015, to ensure that 80% of eligible adults and 100% of eligible children are receiving ART by 2015 and to improve access to quality care and support services to at least 50% of people living with HIV by 2015 (Avert, 2011). As of March 2008, ART services were available at 251 centers (Kombe & Ubok-Udom, 2009). While there has been a cumulative increase in the number of individuals on ART from 50,581 in 2005 to about 269,859 in March 2008, VCT coverage is still low, as only 6 percent of women and 14 percent of men have undergone HIV testing and returned to receive their results (Kombe & Ubok-Udom, 2009). In the case of PMTCT, less than 25% of women who gave birth between 2001 and

2003 were *counseled* on HIV/AIDS during pregnancy (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004).

RELIGIOUS VIEWS OF HIV/AIDS

Eighty percent of HIV/AIDS transmission in Nigeria is through heterosexual intercourse. 10% of HIV/AIDS transmission is from mother-to-child, while homosexual sex and injecting drug use account for the other 10% (UNAIDS, 2004). Christianity and Islam have always pushed for abstinence among the unmarried, even before the advent of HIV/AIDS as evident in the scriptural verses: “let there be no sexual immorality, impurity, or greed among you. Such sins have no place among God's people” (Ephesians 5:3 – the bible) “and let those who cannot marry keep chaste, until Allah makes them free from want out of His grace” (verse 33 of chapter (24) surat-l-nur – the Qu’ran). However, with the advent of HIV/AIDS, both religions have advocated for abstinence even more. For example, the Catholic Church of Nigeria believes that the most “devastating cause of HIV/AIDS infection in Nigeria is a crisis of moral values and error in the understanding of human sexuality.” (D.N. Ucheaga, 2010). For Pentecostals, For Islam,

To ensure that those who have abstained from premarital sex do not marry an HIV/AIDS positive partner, most churches in Nigeria now require HIV/AIDS testing before a marriage ceremony can be conducted (PlusNews, 2008). While the Baptist church has been on the forefront of the “no test, no marriage” rule, the Catholics and the Pentecostals are also towing the line (PlusNews, 2008). According to Daniel Gbadero, the National Coordinator of the Baptist Awareness Against AIDS Program, "we ask

[couples to do an HIV test] about nine months or one year before the wedding to know the status of the person they want to marry.” (PlusNews, 2008) However, it is not as common for mosques to require HIV/AIDS test before marriage (PlusNews, 2008).

Bauchi, a state in the north-east region of the country has however put up a law requiring anyone who wants to get married in the state to undergo a mandatory HIV/AIDS test (Muhammed Abubakar, 2009). Bauchi State is one of the hardest hits in the north, with HIV/AIDS prevalence rate in the 4.1% - 6.0% range (see figure 2 above), and according to the commissioner of health, it is part of the government's efforts to control the spread of the disease in the state.

The “no test, no marriage” rule is being embraced more and more, however, it still remains controversial, as people fear the lack of confidentiality that would emanate from the process. Pastor Pat Maternilola of the Network of People Living with HIV/AIDS in Nigeria wants any form of testing which is not voluntary and confidential unacceptable. The Nigerian government also condemns this process citing its stance against the stigmatization of the disease. Most churches in Nigeria are however unyielding on this marriage ceremony requirement, as it is a significant part of their HIV/AIDS prevention campaign. Daniel Gbadero also noted that “If one of them is positive, we ask them if they still want to go ahead, and over 99 percent turn back. Whichever way you look at it, it prevents the spread of the virus.” (PlusNews, 2008)

Both Christianity and Islam believe that promiscuity is still largely responsible for the spread of HIV/AIDS (D.N. Ucheaga, 2010). It is not surprising that Christians and Muslims in Nigeria share similar view on this issue. Promiscuity is not only frowned upon by both religions, the underlying cultural traditions within Nigerian society also

frown against “promiscuity”. Before the introduction of Christianity and Islam, Nigerian cultural tradition has emphasized the importance of abstinence from sexual activities before marriage (Chinyere Stella Okunna and Ifeoma Vivian Dunu, 2006). However, what these religious organizations fail to understand is that Nigerian youths continue to engage in pre-marital sex, although the Christian youths do so more than the Muslim youths (Chinyere Stella Okunna and Ifeoma Vivian Dunu, 2006).

While the Christian and Muslim leaders and organizations discourage their followers from engaging in pre-marital and extra-marital sex, it would seem expected to find similar infection rates among both groups. However, this is not the case, as more states in the south-east and south-southern, predominantly Christian region reported more than 6% HIV/AIDS infection rate than those in the northern, predominantly Muslim region. None of the states in the predominantly Muslim region, with the exception of the middle belt states in the north central region which have very mixed religious beliefs, reported a rate of more than 6% (See figure 2 above).

While Christians and Muslims are aware that there are repercussions for adultery and fornication, Christians believe that they serve a merciful God who is quick to forgive their sins if they confess. However, especially with the advent of Sharia law, offenders caught in the act of fornication or adultery are punished. The harshest punishment for a Christian who is caught in the act of adultery and fornication would be the stigma, as God rather than the community is the punisher (Institute for Global Engagement, 2006).

However in recent times, there has been a significant shift in religion’s negative stance in the area of preventive measures that do not involve abstinence. Notable religious leaders have begun to speak out about HIV/AIDS (Chinyere Stella Okunna and Ifeoma

Vivian Dunu, 2006). It is evident that in spite of religious inclinations, Nigerian, especially the youths are still going to remain sexually active. Therefore, a prevention campaign rooted only in abstinence is not sufficient and not very effective to combat the spread of HIV/AIDS.

CHAPTER 3

GENDER INEQUALITY IN NIGERIA

According to the World Economic Forum which ranked Nigeria 120th in the global gender gap report, the index for ranking countries is based on a “framework for capturing the magnitude and scope of gender-based disparities and tracking their progress” (Institute for Global Engagement, 2006). The national gender index benchmark is based on economic, political, education and health criteria, criteria that are further discussed below.

Without looking into the religious dimensions of gender inequality in Nigeria, it is not hard to see how the federal government fosters inequality. For example, on 9 July 2008 at the National Assembly, a public hearing of the “Bill on Public Nudity, Sexual Intimidation and Other Related Matters” was held. The bill sought to promote the prohibition and punishment of public nudity, sexual intimidation and other related offenses in Nigeria (Pereira & Ibrahim, 2010). One would welcome this development, especially since it was spear-headed by a woman. Senator Ekaette sought to unite the discourse of morality with that of religion by citing the 1999 constitution of the federal republic of Nigeria as a “sovereign nation under God.” To garner support for her bill, Senator Ekaette sought to evoke the “religiousness” of Nigerians. She argued, “we are a people under the Almighty; we should therefore live under His laws, commandments,

injunctions and statues. We . . . are Christians, Muslims or traditionalists, all subject to the laws of the Almighty. All our religions forbid public lewdness, public nudity or public nakedness. All of us are on the side of the Almighty”(Pereira & Ibrahim, 2010)

While the bill appeared to be “gender neutral,” five out of the seven references to dressing are actually references to the dressing of a female person. According to the bill presented, “any state of indecent dressing which expose [sic]. . . any part of the body from two (2) inches below the shoulders downwards to the knee of a female person above the age of 14 years...” would be classified under nudity (Pereira & Ibrahim, 2010). As if this is not alarming enough, the ‘solution’ to the ‘problem’ of indecent dressing is to criminalize it, as the rising incidence of rape in Nigeria was attributed to ‘provocation’ or ‘indecent dressing’ by women (Pereira & Ibrahim, 2010). This is equivalent to absolving rapists (usually men) of any crime or responsibility by putting the blame on women’s “indecent dressing.” That an educated woman could spear-head such a campaign should not be entirely surprising in a culture that sees women as second rated.

While the world economic forum (WEF) may have considered bills like that of Senator Ekaette in its rankings, WEF does not capture, the disparities that exist among women even within the boundaries of the countries and, more specifically, the role of religion in gender inequality. Studying the rankings by WEF, I could not but notice that the countries that fared worse than Nigeria in the global gender rankings were predominantly Muslim nations. I sought to see whether this pattern would be present in Nigeria. Does the Muslim north fare worse than the Christian South in the issues of gender equality? To answer this important question, I looked at the religious dimensions of gender inequality.

RELIGIOUS DIMENSIONS OF GENDER INEQUALITY

The ground of “morality,” particularly the “immorality” of women’s sexuality, is common among Christians as well as Muslims in Nigeria. Niyi Olaniran, a Christian from the south, described in his pamphlet, “Evils in the Church,” the evil action of women. Mr. Olaniran draws his authority from the Bible to criticize the attire of a “harlot”: “And lo, a woman meets him, dressed as a harlot, wily of heart” (Proverbs 7:10, Revised Standard Version of the Bible) (Pereira & Ibrahim, 2010). While it is clear that is the men who cannot control themselves, the “evil” however rests on the women. This sentiment is also common in Islam. A writer for the Weekly Trust newspaper emphasizes that Muslim women are expected to cover themselves in the modest way so as not to call the attention of men on themselves: “truth be told, the moral corruption bedeviling the world today can be traced to immodest dress.” (Pereira & Ibrahim, 2010)

Growing up, I was taught at Sunday school the importance of dressing “appropriately” without tempting the men. I have heard relatives make excuses for men who assault women. To them, men cannot really control their sexual appetite; therefore, it is the responsibility of the woman to make it easier for them by appearing “decent” all the time. These relatives were quick to warn their daughters about the consequences of indecent dress, particularly sexual assault. No one admonished their sons to practice self-control and respect women’s bodies.

INEQUALITIES AND SOCIO-DETERMINANTS OF HEALTH: THE OTHER FACTORS

“The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.” (WHO Online) Social factors have been identified to be at the root of much of the inequalities in health. Examples of social factors or determinants of health include income and income distribution, the health system, education, unemployment and job security, environment and housing, gender, race. The United Nations is aware of the importance of social determinants of health to the degree that four out of the eight Millennium Development Goals (MDGs) directly address crucial social determinants like extreme poverty, and lack of access to education (WHO Online).

In Nigeria, the glaring disparities for the Christian women in the south and the Muslim women in the north are education, income and the health system. Since social determinants of health are mostly responsible for health inequalities, and health inequality is defined as “the unfair and avoidable differences in health status as seen within and between countries,” it is therefore paramount to address some of these inequalities (WHO Online).

Education

Research such as the (National Population Commission (NPC) [Nigeria], 2009) has consistently shown that educational attainment has a strong correlation on health

behaviors and attitudes, especially for women. The Nigerian National Policy on Education provides every child the right to tuition-free primary education. This has resulted in an increase in the school enrolment and in the number of educational institutions, particularly in the public sector. The 6-3-3-4 system introduced in 1981 provides six years of primary education, followed by three years of junior secondary education, and three years of senior secondary education. The last segment of the system is the four years of university or polytechnic education. To cater to the educational needs of the adults, the federal government launched the National Literacy Program for Adults (National Population Commission (NPC) [Nigeria], 2009).

According to data titled *Nigeria Demographic Health Survey of 2008* published by Nigerian Population Commission, 40 percent of females compared to 28 percent of males have never attended school. The proportion of women who have never attended any formal schooling ranges from 26 percent among the ages 10-14 to 78 percent among the ages 65 and above. For men, the proportion ranges from 20 percent of among the ages 10-14 to 62 percent of among the ages 65 and older (National Population Commission (NPC) [Nigeria], 2009). The north-west and north-east have the highest proportion of persons with no education. The south-south geopolitical zone has the lowest percentage of people who have never been to school, 15 percent among females and 8 percent among males. The south-west geopolitical zone has the highest proportion of females and males who completed more than a secondary education. As expected, educational attainment is positively related to household wealth income, and subsequently, health in these regions.

Research has shown that low levels of enrollment of female children leading to low educational achievement of Muslim women in the north has contributed towards the

maintenance of gender segregation that has contributed to the increased health risk for these women (Sohail Agha, 2008). It is, however, not clear how this form of gender inequality has contributed to the increase HIV/ AIDs for these women.

In the Christian south, secondary education was common by 1990, by which time about 50% of adolescents obtained secondary or higher education (Sohail Agha, 2008). By 2003, this level had increased to 75% (Sohail Agha, 2008). However, the level of secondary education was quite low among Muslim adolescents in the north as only 15% had obtained secondary or higher education by 1990 (Sohail Agha, 2008). Sadly, less than 25% of Muslim adolescents had obtained secondary or higher education by 2003.

While a lot of researches does not speak directly to the effect of education on HIV/ AIDs risk, there is research that speaks to the effect of education on sexual initiation. This research has found a difference among Muslims and Christians women (Sohail Agha, 2008). It is proven that secondary education had a powerful effect on the timing of sexual initiation of Muslim women, and delayed the time of first sex (Sohail Agha, 2008). From the above, Muslim adolescents with secondary or higher education were part of homes “where opportunities for the development of personal capacities were more highly valued and where there was less emphasis on early marriage.” (Sohail Agha, 2008) Many families in the Muslim north marry their daughters in the year following completion of primary school (Barker, 1992). It is important to note that secondary education did not differentiate Christian adolescents in terms of the timing of first sex (Sohail Agha, 2008), a clear indication that there are other factors influencing when women choose to have sex. While the act of sex in itself does not lead to HIV/ AIDs prevention – unprotected sex when one partner is HIV positive could. However, the level

of education, both prevention and old education a woman has could determine how well she is able to protect herself against HIV/ AIDs infection (Barker, 1992)

Reasons for the North/ South Education Gap

“Western education in the North has always been characterized by both differential access in relation to sex and class and limited access for women at all levels.” (Pittin, 1990) One of the reasons for the Muslim north’s disparity in women’s western education compared to what is observed in the Christian south is because access to western education was controlled by the ruling elites in the north. Girls chosen to participate in primary school in the early days of the newly independent Nigeria were largely supplied by the palace of the traditional leaders and the aristocracy (Pittin, 1990). Some girls were able to have access to western education because they were the daughters of former workers of the aristocracy and other people who have been associated with the aristocracy (Pittin, 1990). In-depth education was essentially restricted to women with political and scholastic aristocracies’ connections. Shehu Usman dan Fodio's daughters would be regarded as the exemplification of female Muslim scholars by the northerners, but even they were often left in certain levels of ignorance, something the Sultan himself recognized through his admonitions and recommendations for Muslim women’s education (Pittin, 1990).

Another reason for the poor access northern girls had to western education was the approach to women's education among Muslims. For example, the fathers and husbands were granted responsibilities either to train the women, send to them to Quranic school, or otherwise to arrange for their religious education (Pittin, 1990). Many, especially

among the scholarly and aristocratic families, believed that this approach led to the ideals of seclusion by separating men and women in public places. Furthermore, by permitting women to attend his lectures, Shehu Usman dan Fodio was condemned for permitting the mingling of both men and women and thereby leaving room for immorality (Pittin, 1990). His response was that the obligation to root out ignorance outweighs women's seclusion (Pittin, 1990)

Before independence, the women who had access to western education, evidence points out that the “British-designed education was intended to focus only on domestic subjects and literacy, and that girls were to be permitted to leave school at the customary age of marriage, with regard to the role of women in society” (Pittin, 1990).

Marriageable age in the north varied from 10 to 14, placing an early termination to the education of most girls.

In the Katsina (north-west region of Nigeria) formal education was introduced considerably later than for boys – 1929 for girls compared to 1912 for boys (Pittin, 1990) – with considerable caution exercised by the British (Pittin, 1990). This gender imbalance continued, because in the 1970s the Katsina Local Education Authority sought to maintain two-thirds to one-third ratio of boys to girls in primary schools. In 1972, 3,656 boys and 1,512 girls enrolled in the primary education system, but this changed for the worse (Pittin, 1990). By March 1988, primary school figures for Katsina Local Government schools showed that girls constituted only slightly more than one-quarter (26.5%) of the total enrollment (Pittin, 1990). “As education has expanded and become more valued, and as pressures on available resources increase, the government has ensured that progressively more boys than girls are educated, a situation which

guarantees an even greater marginalization of women students at higher levels.” (Pittin, 1990)

Even in recent times, access to Muslim education by women has been difficult, prompting many women to believe that the best way to an advance Muslim education is to marry a scholar and be careful not to argue with him too cleverly or lessons are over (Pittin, 1990). Whatever the case, the limited introduction of western education in the Muslim north resulted in a grave north-south educational imbalance (Pittin, 1990). To reduce this imbalance, many are suggesting that “the most effective strategy to increase funding for women’s education would be to stress the need for sex-segregated facilities - clinics, schools, and offices and thus the training of additional women, albeit in a limited number of areas.” (Pittin, 1990)

President Goodluck Jonathan, a Christian from the south, may be in agreement with the above idea. Recently, he approved the establishment of 400 Almajiri schools across the mostly in the Muslim north (Transformation week). Almajiri schools are based on Quran teachings and are mostly attended by boys. Many are criticizing the move by the president as it is seen as a way to further build the fundamentalism that have been tied to Boko Haram. Also, it is seen as a further way to encourage female seclusion as most Almajiri schools are for boys and the few for girls are usually separate from those for boys (creative associates website).

Health Care Access

Although the Hausas in the north are the largest ethnic group in Nigeria, they have fared the worst in the social determinants of health. The Hausas have the least access to

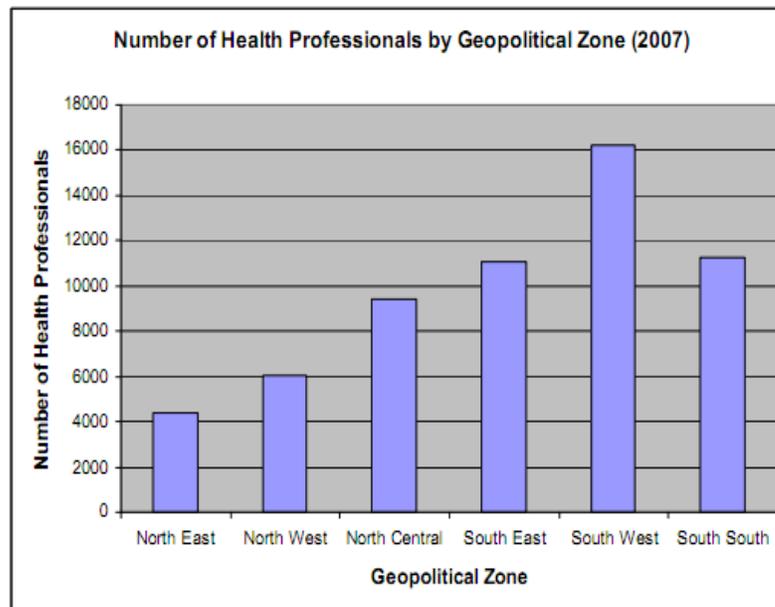
health care and health care services compared to other major ethnic groups in Nigeria (Kombe & Ubok-Udom, 2009). Nigeria has one of the largest supplies of human resources for health (HRH) in Africa, only comparable to Egypt and South Africa (Kombe & Ubok-Udom, 2009). Data provided by the Federal Ministry of Health (FMOH) of Nigeria indicated that there are about 39,210 doctors and 124,629 nurses registered in the country as of 2006, translating into 30 doctors and 100 nurses per 100,000 people (Kombe & Ubok-Udom, 2009). These figures are significantly higher than the sub-Saharan African average of 15 doctors and 72 nurses per 100,000 people (Kombe & Ubok-Udom, 2009). Despite the large supply of HRH, there are great disparities in access to health care across different population groups in Nigeria and the six geo-political zones in the country. The number of health workers, as reported by the FMOH in 2007 ranges from 4,414 in the north-east region to 16,249 in the south-west region. Health workers in these data are doctors, nurses and midwives, medical laboratory scientists and pharmacists. The tables below (2 & 3) demonstrate the disparities in the number of health workers available in the different regions. The north-west region has only 24 doctors per million populations, while the south-west region has 211.7 doctors per million populations (National Population Commission (NPC) [Nigeria] and ORC Macro, 2004). These data point to a very glaring disparity: that there are 782% more doctors in the south-west region than the north-west region. This should be concern to any government.

Table 2: Doctor Population Density in the Geo-Political Zones.
Source: Nigeria Health Svstems Assessment, 2008

Zones	Doctors/ Million pop
N/Central	101.0
N/East	35.5
N/West	24.0
S/East	142.7
S/South	89.2
S/West	211.7

Adapted from the NDHS Report (2003)

Table 3: Number of Health Professionals by Geo-Political Zones.
Source: Nigeria Health Systems Assessment, 2008



Although the federal government has tried to encourage the migration of health workers from the south to the north, the majority are unwilling to practice in the north due to the ethno-religious crisis that has continued to plague the development of the country. Most southerners do not feel safe in the north, as they become the target during conflicts/ crisis.

WEALTH/ INCOME/ LABOR FORCE

“Poverty is not just the lack of money or financial resources, but also a lack of assets and skills that may lead people into activities that may cause them to get infected with the disease.” (Okeke, 1997) Although Nigerian women have made considerable progress in the labor sector across geo-political zones over the past three decades, the gender gap when it comes to access to wealth is still significantly wide (Okeke, 1997). Statistics show that “women represent only 12.5% of full-time employees in the federal civil service, 33% of university teachers, 19.5% of legal practitioners, 17.3% of full-time medical practitioners and 4.3% of registered architects.” (Okeke, 1997).

When the first official census was conducted in 1963, only 12.8% of the adult female population in the North was included in the labor force, compared with 32.4% in the south-east region and 61% in the south-west region (Entwisle & Coles, 1990; Pittin, 1990) It is however suggested that the seclusion of women in the Muslim north contributed to the undervaluation of the labor force in the statistics (Entwisle & Coles, 1990; Pittin, 1990). Regardless, the northern women are not as well represented in the labor force as well as their compatriots from the south.

While a lot of factors have contributed to this huge disparity between the labor statistics of women in the north and south, the focus here will be to analyze the role religion has played in exacerbating this disparity. Although (Entwisle & Coles, 1990; Pittin, 1990) believes that seclusion contributed to the under-reporting of the labor statistics of Muslim women in the north, I also believe seclusion has a role to play in the hindrance of the women's access to work. For example, "a return to a more fundamental attitude towards Islam and an increased concern with Islamic scholarship seem to have encouraged the interpretation of Islamic ideology in a way that promoted the formal seclusion of women..." (Entwisle & Coles, 1990)

In the Muslim north, seclusion of women known as *purdah*, exists as an institution in which majority of married women can only leave the house only when necessary, for example to seek medical attention, to attend family functions such as marriages and funeral, and in rare cases to go to one's place of work (Entwisle & Coles, 1990). Permission to leave the house has to be sought by Muslim women in. Failure to do so could result in accusation of promiscuity (Entwisle & Coles, 1990). A lot of the women are fine with this arrangement, as it is seen "largely as a manifestation of social status and religious devotion. Many of the women believe that it is not their duty to work, as their husbands are obligated under Islam to provide for them and their children (Callaway, 1987; Entwisle & Coles, 1990) .

Research (Callaway, 1987; Entwisle & Coles, 1990) showed that a large proportion of married women in the Muslim north are in seclusion, and only a few are engaged in work outside their household. It is important to note that some of the women who are in seclusion do engage in sales and trading, and to some certain extent may contribute to

their up keep (Entwisle & Coles, 1990). Even in such situation, the form of employment is limited to food processing and animal husbandry and may not generate substantial income (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999).

When majority of women are not free to seek work, they are forced to rely on their partners for support. This is why compared to their male counterparts globally, women are the poorest with fewer access to resources like education, medicine, and other tools required to make them more socially and economically independent. For example, when women are denied the tools needed to stay economically independent, they are caught in a poverty trap that makes them vulnerable to partners who may have HIV/AIDS. This can also prevent them from negotiating for safer sex when they feel the need to.

Women are not well informed about issues when secluded, as they are prevented from continuing their education, especially when they have been married young. Even the few husbands who do allow their wives to continue with their education usually limit their wives' choice of work to those with minimal direct contact with the opposite sex, usually as school teachers, which means lesser salary than most jobs in Nigeria (Entwisle & Coles, 1990). It is believed that "these restrictions on women's activities are reflected in poorer demographic and health indicators than are found in other regions of Nigeria (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999)

"The other major ethnic groups - the Yorubas, Ibos, in Nigeria's Southern region, do not practice seclusion, and allow women to participate in the informal and formal economies." (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999) Yoruba women have worked traditionally as traders, and Igbo women as farmers (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999). Yoruba women are still known for their skillfulness

in trade, and are reputed to have a high degree of economic independence (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999). This does not come as a surprise to me as I grew up in a home where my mother, a university-educated high school teacher was better known for her entrepreneurial skills. She was not just a teacher; she was a fabric maker and trader, a caterer and also an event contractor. She became so successful with her various trades that she became the family's main bread winner for a while. While she is educated enough to make decisions that have helped her business succeed, she may not have been able to succeed that well if her husband, my father, restricted her, especially when her business required that she made out-of-state trips that sometimes lasted more than a week.

My mother had her own wealth that she controlled, and she was able to make economic decisions my father might have deemed unnecessary. For example, my sibling and I had access to better education and health care services because my mother's income was more than sufficient, especially when numerous business deals of my father were not successful. Our health and education did not depend on my father's wealth alone, and for this reason my sibling and I have enjoyed better health and access to quality education compared to most people in Nigeria.

My mother was not the only Yoruba women who sought access to wealth. There were a lot of women in the south-west region of Nigeria who earned extra income apart from their salaries or the income provided by their husbands. Many of these women picked up these trading skills from their mothers. My mother grew up in a polygamous home and her mother shared her husband with 3 other wives. This meant that the four wives, including my grandmother, shared whatever income my grandfather made. For these

women, this was not sufficient to sustain the needs of their children. Like my grandmother, many of these women had to find extra ways of earning more money. My grandmother sold fruits to travelers at bus stations, and enlisted the help of her children, including my mother, who as a result learned valuable trading skills she now uses in her own business. Yoruba women in the south are not secluded like their northern counterparts; they are free to seek other agreements of earning extra income even if these took them outside their locality. This kind of story is not uncommon across south-west Nigeria, and is just one of the reasons Yoruba women are more economically independent than other ethnic groups in Nigeria.

Traditionally, Igbo women in the south-east were farmers, and had less physical mobility and access to income than Yoruba women (Mary M. Kritz and Paulina Makinwa-Adebusoye, 1999). Igbo women had less control over income than the Yorubas because financial autonomy is based on men's control of the means of production, especially land on which women and their children depended for subsistence agriculture...with no direct access to the means of production, women's income was indirectly controlled by men, who allocated farming plots.” (Okeke, 1997) While Igbo women from the south-east region may not have been as successful as their other southern counterparts, the Yorubas, they are seeking higher levels of education more and more. This is helping to shift their employment focus away from farming to the jobs that are more autonomous but require higher level of education.

More and more northerners are beginning to call attention to this economic divide between northern and southern women. For example, feminist Muslim women are beginning to demand equal access to education and jobs (Abdullahi, 2011). Muslim men

are also not left out in the quest to bridge the economic divide between the Muslim women in the north and Christian women in the south. The Kano (north-west Nigeria) born governor of Nigeria's Central Bank (CBN), Mr. Sanusi Lamido told a gathering of local entrepreneurs in Kano that "inclusion of women, who account for the majority of the population of the entire region in economic activities, remains the shortest way out of the quagmire." (AbdulSalam Muhammad, 2012). The CBN governor expressed his opinion on this large economic divide by "blaming the region" for scheming women out of economic activities for selfish reasons, and suggesting that attitude toward northern women had to change for its people to make progress (AbdulSalam Muhammad, 2012). "Poverty reduction in the north would certainly remain an illusion so long we continue to deny women their rightful role in the economic processes by guaranteeing adequate empowerment like we have seen in our recent history" (AbdulSalam Muhammad, 2012). The CBN governor made these statements recently as part of a paper he delivered titled "Kick starting engine for job creation and economic growth". To wrap up his talk, the governor tasked northern governors to develop a centralized empowerment policy that would guarantee women equal access to economic opportunities. He believed that the inclusion of women would kick start the economy and kick out poverty from the region (AbdulSalam Muhammad, 2012)

HOUSEHOLD DECISION MAKING

The table below (Table 4.) shows the percentage distribution of wives responses to questions regarding who makes household decisions in Nigeria. According to these

women, important decisions pertaining to issues like health and education are made more by the men. The only decision that women made more than the men was how to spend their own income. For example, an issue as important as child education was decided 47.1% of the times solely by men compared to 0.7% of the times solely by women. This means that a man can decide to educate only the male children and ignore the female children, which is mostly the case when they are faced with such a choice. Also, the decision on whether to seek medical treatment for a child rests more on the men than the women: 54.3% on the men compared to 10.2% on the women. If women are empowered to earn their own income, they can supplement their husband's or have enough on their own to seek better education and health care for the children. The latter is feasible because according to the table below, women decide 68.4% of the time on how to spend their own income compared to men doing so 9.1% of the times.

Table 4: Wives Response on Household Decision Making in Nigeria
Source: Uchenna

Who makes the decision in your household on . . .	I do	We both do	Husband does	Other
1. How to spend husband's income	1.9	16.6	81.2	0.3
2. Whether to buy or sell land	1.6	33.4	61.0	4.0
3. What to purchase for household	17.1	19.1	63.7	0.1
4. Whether I (the wife) work for pay	17.2	28.7	52.9	1.2
5. How to spend wife's income	68.4	20.6	9.1	1.9
6. Whether to take a sick child for medical care	10.2	54.3	34.8	0.8
7. Whether to send children to school	0.8	50.2	48.1	0.8
8. How much education children should receive	0.7	49.8	47.1	2.5
9. Who takes responsibility for upkeep and rearing of children	21.0	47.8	30.7	0.5
10. How many children to have	2.3	48.1	35.0	14.6
11. Whether to use a method to avoid pregnancy	4.9	47.8	34.0	13.4
12. When sons should marry	1.0	39.0	30.8	29.3
13. When daughters should marry	3.0	40.8	27.4	28.8

*Each row sums to 100% (± 0.1).

THE ROLE OF GLOBALIZATION ON HIV/AIDS RISKS FOR WOMEN IN NIGERIA

Oftentimes parents in places like the United States blame the influence of the media on their children's lifestyle. What is not talked about as often is that parents in developing countries also blame western media for their children's lifestyle. After more than five years in the United States, I made a trip back home to visit family and friends. It was surreal to see my relatives who were catching up on the same television shows that are available in the United States. Satellite television gives them unrestricted access to stations like Music Television (MTV), Entertainment television (E!) and Black Entertainment Television (BET). The internet also provides an avenue for someone in Nigeria to watch the shows mothers are afraid would unduly influence their children's view on sexual initiation, exposure to drugs, etc.

Luckily, studies cited below have demonstrated the influence of western media on HIV/AIDS risk of adolescents in Nigeria (Sohail Agha, 2008). It is believed that exposure to western media provides an important framework for adolescent 'sexual socialization' (Sohail Agha, 2008). For example, "adolescents who are exposed to more sexual content in the media are more likely to report intentions to have sexual activity" (Sohail Agha, 2008). As early as 1992, Barker and Rich showed in their studies (Barker, 1992) that exposure to western models of behavior through the mass media has a significant influence on Nigerian adolescents. The hypothesis is that "as exposure to western values has increased, attitudes towards sexual behavior have become more liberal." In other words, westernization is associated with the loss of community control over young women's sexuality, hence, more liberal sexual attitudes and behaviors are now seen that

were not present decades before the “western media takeover”. (S. Agha, 2009) Agha was able to show in his study (S. Agha, 2009) that adolescent women who were exposed to mass media such as radio or television weekly were more likely to initiate sex at an earlier age.

Effects of Western Media on the Christian South and Muslim North

Although there are changes in attitudes towards sexual behavior in Nigeria, these changes have moved in opposite directions in the northern and southern regions (Agha). Westernization’ hypothesis described by Agha explains the behavior of adolescents in the Christian south. These adolescent in the Christian south appears to engage in higher levels of premarital sex than their Muslim counterparts thanks to the influence of liberal outlook towards sexual behavior (Agha) although this is mainly evident in urban areas of this region. This is comprehensible since adolescent females in this region have greater opportunities to interact with their male counterparts in schools and social gatherings. Also, the southern region is more urbanized than the northern region, and access to western media is greater as a result (S. Agha, 2009)

“By contrast, the context of sexual behavior in recent times has become more conservative in the predominantly Muslim north, which has experienced a growth in restrictive religious values.” (Sohail Agha, 2008) With the increasing Islamization trend, and the introduction of the Sharia law in the majority of the northern states, the region has been able to exercise stricter control over the sexual behavior of adolescent women. Such stricter control is achieved by increasing levels of early marriage, with more than 50% of Muslim female adolescents married by age 16 compared to (Sohail Agha, 2008).

Compared to the Christian south, it could be suggested from the above that being part of Muslim culture protects against the influence of more liberal social surroundings, especially in the timing of sexual initiation. The Muslim north and the behavioral codes prevalent in this region restrict indulgence in western forms of entertainment that are becoming paramount in the southern region. For example, nightclubs and movie theaters are rarely found in northern Nigeria, but are increasingly becoming a norm in the southern region, especially in Lagos, south-west Nigeria (Sohail Agha, 2008)

CHAPTER 4

DISCUSSION

The Role of Religion in HIV/AIDS Prevention

As evident from the above, religion plays an important role in HIV/AIDS risk and prevention, albeit both positive and negative. Both Islam and Christianity advocate abstinence as the best way to prevent HIV/AIDS infection. It is the only prevention method that is 100% safe. While I believe it is not wrong to advocate abstinence, it is however, wrong to advocate abstinence as the only preventive method. From the studies that have been described, the majority of the youths and women, especially Christians, in Nigeria do not practice abstinence, and denying them the necessary information needed for safe sex is a disservice to Nigeria's HIV/AIDS prevention campaign. For Christians, the punishment for committing fornication and adultery is from God, and not from a Sharia court of law. Christians are also of the opinion that they serve a merciful God who is able to forgive their sins of fornication and adultery if they ask for forgiveness..... Therefore, Christians are more likely to engage in extra-marital affairs or premarital sex when compared to their Muslim counterparts.

From the standpoint of abstinence as a prevention method, Muslims are better off adopting this method when compared to Christians because their religion beliefs and practices are geared to support this stance. For example, the fear of being punished for adultery and fornication under the Sharia law, the seclusion of opposite sex in the name

of religion and the enforcement of virginity and early marriage for young Muslim women could help reduce the chances of engaging in pre-marital and extra-marital sex. Also, young Muslim women in the north are married off early and before most of them can engage in premarital sex. Therefore, fidelity and abstinence, the safest ways of preventing HIV/AIDS is more feasible among Muslims than Christians.

The church believes that by requiring proof of HIV/AIDS test from couples before marriage is one of the ways it is helping to prevent HIV/AIDS transmission. This “preventive method” is however flawed, because couples who test negative to HIV/AIDS now could still have the virus. Also testing for HIV/AIDS right before the marriage may do little or nothing to prevent HIV/AIDS transmission between couples who have been engaging in unprotected sex.

The Role of Gender Inequality on HIV/AIDS Prevention

As is evident in the above, women have the least access to education and wealth in Nigeria. When women are denied these tools that are needed to stay economically independent, they are caught in a poverty trap that makes them vulnerable to partners who may have HIV/AIDS. This is because saying no to sex, or demanding safe-sex from a partner who is responsible for the woman’s sustenance is almost impossible. Also, to make ends meet, some women are forced to provide support for their children by engaging in prostitution thereby increasing their chances of HIV/AIDS infection.

Gender inequality in the form of access to education and wealth is more prominent in the Muslim north. Women in the Christian south are more educated and have access to

more wealth the women in the Muslim north. As is evident in the above, the more educated women are, the better health decisions they are going to make. Also, an educated woman will have access to better paying jobs than an uneducated woman. With better paying jobs comes access to better income. When women are empowered and they become financially independent, they can support their children without having to engage in risky behaviors such as prostitution. Most importantly, they can support themselves if they decide to leave their partners when they sense the risk of HIV/AIDS transmission. In addition, access to greater wealth would mean that wives do not have to tolerate abuse and violence from their partners. A recent study in South Africa reported that nearly one in seven cases of young women acquiring HIV could have been prevented if the women had not been subjected to intimate partner violence (AMFAR). Since domestic violence occurs equally in Nigeria, it is not wrong to believe this study would also apply to Nigerian women

Religious Influence on Gender Inequality & HIV/AIDS Prevention

Islam and Christianity see husbands as the lords of the wives. Therefore, wives are expected to be submissive to their husbands. This makes it more difficult for wives to negotiate for the use of condoms if they feel their husbands may be unfaithful. Rudolf Gaudio in his book chapter, "Introducing 'Yan Daudu'", in the northern part of Nigeria; "A man needs to control his wife...at the very least he must be able to feel as if he were in control. This notion of control, especially the controllability of a potential wife, lay

behind many young men's preferences for the type of woman they said they wanted to marry..." [Gaudio p.16]

Also, a woman's initiation of condom use is seen as a sign of insubordination, or more commonly, as a sign of her unfaithfulness; both common triggers of domestic violence. According to Go et al., "marital communication about fidelity, marital sex, and condoms are almost exclusively initiated and controlled by the husband. Because gender norms sanction male infidelity, women are expected to overlook their husbands' indiscretions and to care for them unconditionally." (p. 269)

While gender inequality is prominent in both Christianity and Islam, it is more evident in Islam and has led to the relegation of Muslim women to the background in terms of access to education and wealth – tools that are necessary to empower women to stay economically independent. Islam encourages seclusion of women and tends to discourage women from seeking employment. Islam preaches that husbands are responsible for providing for their families, and not the women's responsibilities. This is why women in the Muslim north of Nigeria have the lowest education and employment rate. For this reason, gender inequality in the Muslim north could lead to greater HIV/AIDS infection rate – especially for women who cannot protect themselves from their partners who may be HIV/AIDS positive.

The Role of the "Other Factors" in HIV/ AIDS Risks

Since Christian women are more economically independent than Muslim women, they are likely to get married at a later age. Getting married at a later age could mean longer

exposure to premarital sex. It is believed that the longer a woman is exposed to premarital sex, the higher her risk of contracting HIV/AIDS.

Also studies have shown that women who work outside of the community are more predisposed to HIV/AIDS. Since women in the Christian south engage in employment outside of the community, they are more likely to get infected with the HIV/AIDS virus.

Westernization, although generally a “good phenomenon”, is more paramount in the Christian south than the Muslim north. Access to western forms of entertainments and western mass media is more prevalent in the Christian south than the Muslim north. This has led to the infiltration of more liberal ideas into the southern region. Young women watch MTV and BET just like their counterparts in the west, and get their sexual liberal ideas from this media stations. This is why age of sexual initiation for young adolescents in the Christian south is lower than in the Muslim north. The longer a young adolescent is exposed to premarital sex, the higher her chances for contracting HIV/AIDS.

In terms of access to education, Christians in the south are more educated than the Muslims in the north. According to studies, they are more likely to make better health choices. Also, most young children and adolescents learn about HIV/AIDS at their schools. Because Christian women are likely to be better informed about HIV/AIDS than Muslim women, Muslim women are likely to get more infected than Christian women due to their limited knowledge of the disease. Also, because of the better access to healthcare services in the Christian south, women in this region are likely to be better informed about HIV/AIDS and have access to preventive methods than women in the Muslim north.

Religious Influences on the “Other Factors” that Pre-Disposes to HIV/ AIDS Risks

While it is clear that “other factors” like education, wealth/ income, healthcare access and westernization play an important role in the HIV/AIDS risks of women, it has been shown that religion influences these factors. For example, *purdah*, and Islamic doctrine of secluding women prevents Muslim women from having access to employment, especially outside of their community. The Islamic form of education that is taught to young pupils in the Almajiri school systems denounces western ideas like the use of condoms. Islamization in the Muslim north has continued to discourage medical practitioners and aid organizations from the northern region of the country. Muslim doctrines forbid liberal ideas that come with westernization, e.g., western forms of entertainments like bars, and clubs. By enforcing these doctrines, the socialization that would occur between the opposite sex are drastically cut down, reducing the risks of HIV/AIDS infection.

CONCLUSION

SUMMARY

Just as religion play a role in HIV/AIDS risk, it also influences other factors that affect HIV/AIDS prevention. It can therefore be concluded that the role of religion in HIV/AIDS prevention is multifaceted. For example, from figure 2 above, Muslim women in the north have a lower HIV/AIDS rate than their counterparts in the south, especially in the south-east zone of the country. However, because of the Muslim doctrine of *purdah*, they have the lowest education and employment rate. Also, gender inequality in the Muslim north occurs at a higher rate than in the Christian south. All of these should lead to greater HIV/AIDS infection rate. Yet, Muslim women in the north have lower infection rate for the same reason as *purdah*. With *purdah*, young girls especially are segregated from their male counterparts in public gatherings and most of the time, are not allowed access to leave their homes unless approved or supervised. These may be some of the factors contributing to the lower HIV/AIDS in this region.

In the same way, Christian women in the south are more educated and economically empowered than their Muslim counterparts in the north. They also enjoy greater autonomy than their northern counterparts, making it easier for them to leave their partners when there is a possibility of getting infected with HIV/AIDS. Yet, they have the highest HIV/AIDS rate than the Muslim women in the north. This could be because with

increased mobility and independence comes the choice of multiple partners. Having multiple partners increases the chance of HIV/AIDS infection.

The direct effect of religious doctrines and beliefs like abstinence could have a positive or negative effect on HIV/AIDS prevention. Among Christian women in the south, abstinence is more damaging than in the Muslim north (more negative for Christianity than Islam). This could be because the repercussions for premarital and extramarital sex for Christian women in the south are less severe than for women in the Muslim north (source). God is the judge of fornicators and adulterers in the Christian south, while the harsh punishments of Sharia law await an offender in the Muslim north.

The new wave of Christianity in Nigeria namely Pentecostalism, and the new wave of Islam in Nigeria namely radicalization of Islam e.g. Boko Haram have some effects on healthcare. The effect in the Christian south is mixed, and the effect in the Muslim north is *negative*. For example, medical practitioners and aid agencies are fleeing the north thanks to the incessant havoc the radicalized Boko Haram sect is wreaking. When there are not enough healthcare practitioners, hospitals and community centers in the Muslim north, there would be no where for women in the Muslim north to seek out HIV/AIDS prevention methods. Pentecostalism in the Christian south is beginning to gain attention for its HIV/AIDS initiatives, but where abstinence is advocated as the only preventive method, the gains made are easily vanished (*Positive and Negative*).

Religious influence on gender inequality among women in the Christian south is less negative (more *positive* for Christianity than Islam) compared to the Muslim north. Women in the Muslim north are usually secluded and have restricted access to wealth and education that can empower them to become economically independent. Women who are

economically independent are less likely to engage in risky behaviors like prostitution. Most importantly, economically independent women are able to leave a partner who they deem unfaithful and pose a high risk of HIV/AIDS infection. Many women cannot leave their partners even when they sense danger because they cannot survive without the financial and material support from these partners.

Christianity in the south supports education through the building of mission schools where western form of education and Christian values are taught. Just like the Almajiri schools in the north, pupils are taught values based on the bible, such as abstinence. When this is taught solely, it could be detrimental to the pupils who are unaware of how to protect themselves from HIV/AIDS during sexual intercourse. On a positive note, these pupils are getting the education needed to make them marketable on the job market. A steady income could go a long way to provide financial stability to these women thereby leading them to become economically independent. Since Muslim women in the north are also discouraged from seeking employment, especially outside of their community, “forcing” them to rely solely on their partners for economic support. The influence of Islam on the economic empowerment of women in the north is therefore *negative* to this effect. However, this could also have a *positive* effect on HIV/AIDS prevention since studies have shown that women who seek employment outside of their community are more likely to get infected with HIV/AIDS.

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