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ANALYSIS ON THE INFLUENCES OF THE INDICATORS OF WOMEN'S EMPOWERMENT ON THEIR REPRODUCTIVE HEALTH PRACTICES: A STUDY FROM THE 2008 NIGERIA DEMOGRAPHIC HEALTH SURVEY (NDHS).

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Abstract:- A large body of research has attempted to explore the relationships between women's empowerment and their reproductive health practices in some developing countries. The objective of this study is to investigate whether women's empowerment in Nigeria has relation with their reproductive health outcomes. The study uses the Nigerian Demographic Health Survey (NDHS 2008). Three dimensions of empowerment were considered in the study; these include household decision making and attitudes to wife beating and attitude to refusal of sexual intercourse. We determine if the dimensions of women's empowerment considered have any effect on women's reproductive health outcomes in Nigeria. The study reveals that women's empowerment has a direct and significant influence on their reproductive health practices in Nigeria. The study clearly reveals that lack of women's participation in their household decisions compromise women's reproductive health in Nigeria.

Keywords: Reproductive Health; Influence; women's empowerment; institutional delivery; analysis.

INTRODUCTION:

Being a woman has implications for health. (Fathalla, 1997) classified the health needs of women into four categories; First, health needs related to the sexual and reproductive function, second, women have an elaborate reproductive system that is vulnerable to dysfunction or disease, even before it is put to function or after it has been put out of function, third, women are subject to the same diseases of other body systems that can affect men. The disease patterns often differ from those of men because of genetic constitution, hormonal environment or gender-evolved lifestyle behaviour. Diseases of other body systems or their treatments may interact with conditions of the reproductive system or function, and fourthly, because women are women, they are subject to social diseases which impact on their physical, mental or social health. The reproductive system in function, dysfunction and disease plays a central role in women's health, Corroon .M. et al. (2014).

The concept of reproductive health has recently emerged in response to the fragmentation of the existing services and their orientation. The broader concept of "reproductive health" offers a comprehensive and integrated approach to the health needs related to reproduction. It puts women at the centre of the process, as subjects and not objects, as ends and not means. It recognizes respects and responds to the need of the woman behind the mother.

Nigeria being the most populous city in Africa characterised by low use of family planning (FP) and high fertility leading to eventually high maternal mortality and morbidity, Corroon et al (2014). In as much as women's empowerment is viewed as an important factor in the development of any nation in which Nigeria is one, few studies were carried out on the association between women's empowerment and the reproductive health practices specifically, family planning (FP) and maternal health behaviours of women particularly in the study population.

Defining women's empowerment has spanned a wide range of concepts. Kabeer (2001) defines women's empowerment as "the expansion in people's ability to make strategic life choices in a context where this ability was previously denied to them." Most of the existing studies which examine women's empowerment and reproductive health outcomes have been from Asia, where definitions and measures of empowerment have been fully explored. Several studies examining women's empowerment and maternal health in Asia defined empowerment as combined measures of bargaining power, spousal awareness of gender equity and greater decision- making power and found that more empowered women were more likely to make use of maternal health care services than the less empowered women, Corroon et al (2014).

The International Conference on Population and Development (ICPD) Programme of Action defines reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health, therefore, implies that people can have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so.

In the Constitution of the World Health Organization, health is defined as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. This definition, idealistic as it may look, is nowhere as relevant and applicable as in the area of reproductive health. A woman in the distress of carrying an unwanted pregnancy cannot be considered healthy simply because her blood pressure is not elevated, and the foetus is showing a normal biophysical profile. In the context of this positive definition, reproductive health is a condition in which the reproductive process is accomplished in a state of complete physical, mental and social well-being and is not merely the absence of disease or disorders of the reproductive process.

REVIEW OF LITERATURES

A large body of research has attempted to explore the relationship between women's empowerment and their reproductive health practices in the developing countries, but the evidence is still inconclusive due to numerous challenges faced in this area of study. Despite the consistent findings from researchers that show broad Socio- economic and demographic characteristics such as education and economic status have a significant impact on reproductive health services uptake, the relationship between women's decision-making power and their use of reproductive health services is unclear. For example in Nepal, Matsumura and Gubhaju (2001) report that the decision-making power has a mixed impact on maternal health services utilization. Survey data from Pakistan also show a weak or no relationship between women's reproductive health services uptake and measures of their autonomy (Sathar and Kazi 1997; Fikree, Khan, et al. 2001; Mumtaz and Salway 2005).

Reproductive health implies that, apart from the absence of disease or infirmity, people can reproduce, to regulate their fertility and to practice and enjoy sexual relationships. It further implies that reproduction is carried to a successful outcome through infant and child survival, growth and healthy development. It finally implies that women can go safely through pregnancy and childbirth, that fertility regulation is achieved without health hazards and that people are safe in having sex. (Fathalla, 1988).

However, few numbers of studies from sub-Saharan Africa were identified so far that builds on their studies based on the empowerment measures developed in Asia. Ahmed et al. (2010) carried out a Meta-analysis study of 31 countries in sub-Saharan Africa and defined women's empowerment as women's ability to make a decision related to her personal health choices, ability to make household purchases, visit family/relatives and decide on other key activities. Their study reveals

that higher level of women's empowerment was associated with modern contraceptive use, attending four or more antenatal visit and having a skilled attendant at birth. Similarly, a study based on the Demographic Health survey data (DHS) from eight countries in sub-Saharan Africa examined measures of women's status including household and financial decision-making and their attitudes towards gender equity in relation to maternal and child health outcome and found out that gender-related factors have an effect on the women's health outcomes. In another multi-country analysis of DHS data of four African countries which defined empowerment to included economic independence, household decision-making, control over marriage, fertility, health care seeking behaviour, negotiation of sexual activity and perceptions of domestic violence. The results obtained from this study reveals a positive association between women's empowerment and family planning method use in all the countries considered.

Only few studies have examined women's empowerment in relation to their reproductive health outcomes in Nigeria. Kitz and Makinwa (2001) conducted a study in five states of Nigeria in which they examined the association between gender empowerment and reproductive behaviours. They measured women's empowerment at the household and interpersonal levels and included decision-making roles, findings from their study reveals that empowered women were more likely to use family planning method. Similarly, in another study using eight states of Nigeria which examined the impact of women's income generation on household decision-making, it revealed that women living in poor household were less likely to have a say in household decision-making compared to women living in wealthy households.

REPRODUCTIVE HEALTH IN NIGERIA

Although much effort has been placed on increasing reproductive health in Nigeria, the uptake of services is still far from optimal, even in settings where services are more and easily accessible. The infant and maternal mortality rates in Nigeria is still very high (Rizvi and Nishtar 2008). Several factors are thought to contribute to the high level of maternal mortality in Pakistan. Women in Pakistan marry at a relatively young age, and they tend to have their first child very soon after marriage. Low contraceptive use also contributes to high rates of induced abortion (Rana 1992). A shortage of skilled health professionals, particularly female skilled health professionals (Ashraf 1996) and low rates of tetanus toxoid (TT) vaccination are also some contributing factors to the high maternal mortality rate in Pakistan (Rizvi and Nishtar 2008).

According to Fathalla (1996), the reproductive health is an integrated package, as such for women to be healthy, they must have a complete package. That is to say women cannot be healthy if they have one element and miss another. Moreover, the various elements of reproductive health are strongly inter-related. Improvements of one element can result in potential improvements in other elements. Similarly, lack of improvement in one element can hinder progress in other elements.

OBJECTIVE OF THE STUDY:

The objective of this study is to examine whether women's empowerment in Nigeria is associated with their reproductive health outcomes of the women. In addition to this, we also examined whether the empowerment dimensions have a different effect on reproductive health in the.

METHODOLOGY

This study uses the Nigeria Demographic, and Health Survey (NDHS) conducted in 2008. The NDHS is a nationally representative survey which was conducted by the Nigerian National Population Commission (NPC) in collaboration with ICF Macro, USAID, PEPFAR and UNPA. A sample of about 34,070 household was used, 33,385 women of aged 15 – 49; 15, 486 are men of age 15 – 59 and 28,647 are children. A sample of 23,954 currently married women of reproductive age 15 – 49 was used for this study.

For the purpose of the study, the sample used varies slightly by the dependent variable of interest. For analysis on family planning, only currently married women who are not pregnant as at the time of the survey were considered in both populations. For the analysis on reproductive health

outcomes, the sample size is limited to currently married women who have had at least one live birth in the past three years.

Dependent and Independent Variables used.

The dependent variables used for the analysis in this study are; family planning/contraceptive method (modern or other methods), presence of a skilled attendant at the time of delivery in the last three years (skilled or non-skilled attendant) and place of delivery (institutional or non-institutional) at last birth in the last three years. Each of these dependent variables was dichotomized for the purpose of analysis in the following manner: For the use of modern family planning/contraceptive method, code one is given for women who said they used modern FP/contraceptive method and 0 if they used traditional or no any method of FP/contraceptive. For the presence of skilled attendant at time of delivery, women who responded that they were assisted at the time of their last delivery by either a doctor/clinical officer, nurse/ midwife or other health workers were considered to have had an assisted delivery by a skilled attendant and are coded 1 and all other women's responses are coded 0. Finally, for institutional delivery, all delivery made in the past three years at the time of the survey reported having taken place in a health facility are considered institutional birth and are given code1 while all delivery done outside any health facility is termed as non-institutional births are coded 0.

A number of measures were used in this study to capture the various dimensions of women's empowerment. Three independent variables were used in the study, viz: Decision making ability, women's attitude to wife beating by their husbands/spouse, and their attitude to refusing sexual intercourse. Five questions on women's decision making ability were asked to know who have a greater say in various aspects of household decision making (ie on use of contraceptive, health-care, major household purchases, purchases for daily household use and visit to family/relatives), the choice options given for each of the five questions are: the husband/spouse, the respondent, both husband and respondent, respondent and someone else, and others. Women who responded having a say in decision-making either alone or jointly with husband or someone were coded 1, and all other responses coded 0.

Similarly, five questions were asked based on the women's attitudes toward domestic violence that is whether a husband is justified in beating/hitting his wife under certain conditions such as if she goes out without husband's permission, if she argues with him, if she neglect the children, if she refuses to have sex with husband, and if she does not cook properly. For each of the items, women who responded 'no' that the husband is not justified is given code 0 and women who responded yes that the husband is justified to beat his wife/don't know where coded 1.

Finally, on the third indicator 'attitudes of women towards refusing sexual intercourse with husband', questions on the respondent's opinion as to whether a woman is justified in refusing to have sexual relation with her husband in the following situations: If she knows that the husband has sexually transmitted disease (STD), If she knows that the husband has intercourse with other women, If she is tired/not in the mood. For each of these questions, a response that says yes a woman is justified to refuse sex is coded 1, and that who says a woman is not justified to refuse sex with husband is coded 0.

In order to identify the relationship between the measures of women's empowerment, exploratory factor analyses were carried out on the 13 items measuring women's empowerment (i.e. five decision-making variables, five variables on attitude towards domestic violence, as well as three variables on attitude to refusing sexual intercourse). Factor analysis is a data reduction technique that allows us to examine the linear relationships between a large numbers of variables so as to identify a smaller number of factors which can be used to represent the multiple variables. The identified factors are called latent variables, and it is labelled based on the variables that contribute the most.

RESULTS AND DISCUSSION

Table 1 show the percentage distribution of socio-economic and demographic characteristics of the sample of currently married women who are of reproductive age 15 – 49 years in Nigeria. Majority of the women as shown in the sampled analysis from the populations are young

(less than 35years) married women, with age at first birth below 35 years and have between 3 - 5 children. More than 50% of the women considered in Nigeria lives in rural areas, and more than half of the sampled women have no education (51.3%), and only 27.4% of them have secondary or higher education. The result in Table 1 also reveals that about 49.1 percent of sample women in Nigeria were from poor wealth status and 32.1% were from rich status. The result on work status of women reveals that higher percentage of women (65.5%) in Nigeria reported that they were working in the last 12 months.

Table 1

Percentage distribution of socio and demographic characteristics of currently married women age (15 - 49) in Nigeria

Percentage distribution of socio and demographic characteristics of currently married women age (15 - 49) in Nigeria			
Characteristics		**Frequency**	**Percentage**
Age of respondent	15 - 34 years	15121	63.1
	35 - 49 years	8833	36.9
Age at first marriage	15 - 34 years	17173	71.7
	35 - 49 years	107	0.4
Age at first birth	15 - 34 years	19500	81.4
	35 - 49 years	96	0.4
Parity	0 - 2 children	5112	21.3
	3 - 5 children	11915	49.7
	more than 5 children	6927	28.9
Residence	Urban	6586	27.5
	Rural	17368	72.5
Educational status	No education	12288	51.3
	Primary	5110	21.3
	Secondary/Higher	6556	27.4
Wealth status	Poor	11754	49.1
	Middle	4506	18.8
	Rich	7694	32.1
Work status	Not working	8256	34.5
	Working	15647	65.3

Table 2 presents the distribution of women's empowerment indicators for all the three variables used in order to measure women's empowerment. The table reveals that in Nigeria, women's participation in household decision-making was highest (53.8%) for visit to family/relatives, followed by decision on making small HH purchases (47.8%) while the least percentage is recorded for contraceptive use (11.4%). The table also shows for variables under domestic violence against women (i.e wife beating); a large percentage of women from the study population strongly disagree ("say no") on the issue of wife beating by husband for any of the reasons stated. Similar results can be observed in the justification of women towards refusing sexual intercourse with their husbands based on the three reasons given, where greater proportion of women say 'yes' it is justified for a woman to refuse sex if the husband is having STD or if he goes out with other women or she is not in the mood, and only few them says 'no'.

Table 2
Women's empowerment indicators by percentage responses of currently married women in Nigeria (N=23,954)

Characteristics	Percentage responses	
Women's participation in household decision-making	**No**	**Yes**
Contraceptive use	88.6	11.4
Own Health care	57.8	42.2
Making large HH purchases	62.8	37.2
Making small HH purchases	52.2	47.8
Visit to family/relatives	46.2	53.8
Justification for wife beating (Attitudes towards Domestic Violence)		
If she goes out without permission	62.7	37.3
If she neglect the house/children	65.8	34.2
If she argues with him	69	31
If she refuse to have sexual relation with him	68.8	31.2
If she does not cook properly	81.2	18.8
Justification to refusing sexual intercourse		
If husband has sexually transmitted disease (STD)	17.8	82.2
If husband has other women	38.9	61.1
If she is not in the mood	38.9	61.1

Table 3A gives the distribution of Decision-making variables by socio-economic and demographic characteristics of women according to their level of participation in household decisions in Nigeria.

Table 3A
Distribution of Decision-making variables by Demographic characteristics of women in Nigeria.

Background characteristics of women	Final say on contraceptive use	Final say on health care	Final say on large HH purchases	Final say on daily HH purchases	Final say on visit to family/relative
Respondent Age					
15 - 34 years	10.2	39	34.4	44.3	50.8
35 - 49 years	13.4	47.6	42	53.7	58.9
Age at first marriage					
15 - 34 years	13.8	47.4	41.9	53.8	58.9
35 - 49 years	5.6	68.2	62.6	74.8	74.8
Age at first birth					
15 - 34 years	12.9	43.8	38.6	49.7	55.5
35 - 49 years	9.4	52.1	46.9	63.5	64.6
Parity					
0 - 2 children	8.5	41.1	36	45.8	51.9
3 - 5 children	14	44.5	37.9	49.8	56
Above 5 children	12.7	42.3	37.8	48.6	54.5
Educational status					
No education	2.9	27.3	24.1	30.5	39.8
Primary	14.1	52	46.4	60.7	63.9
Secondary/Higher	25.1	62.3	54.4	70.1	72.1
Residence					
Urban	20.9	52.1	44.1	57.1	61.6
Rural	7.8	38.4	34.6	44.2	50.8
Wealth status					
Poor	3.6	30.7	27.7	35	43
Middle	9.5	44.8	40.9	51.8	57.9
Rich	24.4	58.1	49.4	64.9	67.9
Work status					
Not working	5.9	29.2	26.4	31.9	39.4
Working	14.3	49	42.9	56.2	61.5

Table 3B gives the percentage responses (i.e those women that responded 'no' to wife beating) of women's attitudes towards domestic violence in the study population.

Table 3B
Distribution of Women's Attitude to Domestic Violence (justification to wife beating) by socio-economic and demographic characteristics.

Background characteristics of women	If she goes out without permission	If she neglect the children	If she argues with husband	If she refuse sexual relation with him	If she does not cook properly
Respondent Age					
15 - 34 years	61.3	65.2	68.5	67.3	80.6
35 - 49 years	65	66.7	70	71.4	82.2
Age at first marriage					
15 - 34 years	65.5	67.7	71.1	72.2	82.8
35 - 49 years	72.9	72.9	76.6	79.4	85
Age at first birth					
15 - 34 years	63.2	66	69.7	69.7	81.7
35 - 49 years	70.8	76	82.3	82.3	90.6
Parity					
0 - 2 children	64.3	67.9	70.6	70.7	81.9
3 - 5 children	64.8	67.1	71.6	70.4	82.5
Above 5 children	61.1	63.9	67.3	67.1	80.4
Educational status					
No education	56.8	62.7	63.8	60.1	78
Primary	60.5	61.5	66.5	70.2	78.8
Secondary/Higher	75.4	74.8	80.7	84	89.1
Residence					
Urban	72.6	72.7	77.3	78	86.8
Rural	58.9	63.2	65.9	65.3	79.1
Wealth status					
Poor	56.9	62	63.7	60.9	77.2
Middle	57.5	61.6	66.5	66.5	78.9
Rich	74.6	74	78.6	82.3	88.6
Work status					
Not working	61.3	66.3	68.6	66.7	78.9
Working	63.4	65.5	69.3	69.9	82.4

Table 3C present the percentage distributions of women who supports women's refusing sexual intercourse based on stated reasons by their socio-economic and background characteristics.

Table 3C
Distribution of women's Attitude to justification to refusal of sexual intercourse by socio and Demographic characteristics.

Background characteristics of women	If husband have sexually transmitted disease (STD)	If she knows that husband have other women	If she is tired or not in the mood
Respondent Age			
15 - 34 years	81.7	61.3	59.6
35 - 49 years	83.2	60.8	63.7
Age at first marriage			
15 - 34 years	82.8	62.1	65.4
35 - 49 years	82.2	57.9	61.7
Age at first birth			
15 - 34 years	83	61.7	62.6
35 - 49 years	83.3	64.6	69.8
Parity			
0 - 2 children	81.2	61	60.9
3 - 5 children	82.5	61.1	63
Above 5 children	82.9	61.2	60.8
Educational status			
No education	79.3	58.2	49.9
Primary	84.6	62.2	68.5
Secondary/Higher	86	65.6	76.5
Residence			
Urban	84.8	63.7	68.4
Rural	81.3	60.1	58.4
Wealth status			
Poor	79.3	58.1	51.4
Middle	82.8	62.9	64.1
Rich	86.4	64.6	74.2
Work status			
Not working	79.5	57.6	52.7
Working	83.8	62.9	65.6

Table 4 present each of the reproductive health outcomes by women's empowerment indicators considered for all currently married women of ages 15 – 49 years in Nigeria. The percentage of currently married women in Nigeria who participate in HH decision making and are using modern contraceptive method is only 13.8%, those who have had institutional delivery during their last birth before the time of the survey are 82.8%, and those who were assisted by a skilled attendant during their last birth are 50.6%. The table further reveals that only 9.9% of women who does not justified wife beating make use of modern contraceptive method, 78.1% of them had an institutional delivery and 40.4% were assisted by skilled attendant at the time of their most recent delivery. From the table, it can be observed that only 9.5% of women who justified to refusal of sexual intercourse used modern method of contraception, 77.3% had institutional delivery and 40.3% of them were assisted by skilled attendant at the time of their most recent births.

Table 4
Reproductive Health Outcome by the selected indicators of Women's Empowerment in Nigeria.

Indicators	Use of modern method of contraceptive(N=23954)		Institutional place of delivery(N=23954)		Assistance by a skilled attendant at time of delivery(N=16922)	
Participation in HH decision making	Percent	Frequency	Percent	Frequency	Percent	Frequency
No	3.5	415	68.7	8210	22.4	1939
Yes	13.8	1655	82.8	9937	50.6	4172
Justified Wife beating						
No	9.9	1661	78.1	13078	40.4	4700
Yes	5.7	409	70.3	5069	26.6	1411
Justification to Refuse sexual intercourse						
No	6.6	457	72.1	5005	25.8	1263
Yes	9.5	1613	77.3	13142	40.3	4848

Table 5 presents results from logistic regression with modern method of family planning/contraceptive use, assistance by a skilled attendant during last delivery and institutional place of delivery as the dependent variable, while the three indicators of women's empowerment as independent variables (decision-making, wife beating and women's attitudes to refusing sexual intercourse). From the table, it can be observed that women who were not pregnant at the time of survey and who participate in household decision-making were more likely to used modern method of contraception/FP than those using other methods of FP with Odds ratio (CI) = 1.829*(1.769 - 1.892). However, women's participation in household decision making have a significant relationship with getting skilled assistance during delivery in Nigeria with the odd ratio (CI) =1.421*(1.394 - 1.448). The table also reveals that women who participate in household decision making in the population are likely to give birth in a health facility than women who do not participate. Table 5 further reveals that women who agree with the notion of wife beating by their husbands were less likely to use modern method of contraception, assisted by a skilled attendant during delivery and have an institutional delivery at their most recent birth than the women who do not justify wife beating. This is revealed by the low values of odds ratio and 95% confidence interval values (below 1) recorded. Looking at the odds ratios (CI) for women's attitude to refusing sexual intercourse, this indicates that currently married women who support women's attitudes to refusing sex were more likely to use a modern method of family planning, assisted by skilled attendant during their most recent birth and have institutional delivery in Nigeria.

Table 5
Logistic regression with odds ratio and Confidence Interval for reproductive health outcomes for Nigeria

Independent Variables	Modern method of contraceptive use(N=23954)	Assistance by a skilled attendant at time of delivery(N=16922)	Institutional place of delivery(N=23954)
Participation in HH Decision-making:	**Odds ratio (CI)**	**Odds ratio (CI)**	**Odds ratio (CI)**
No(REF)			
Yes	1.829*(1.769 - 1.892)	1.421*(1.394 - 1.448)	1.258*(1.258 - 1.280)
Justified wife beating:			
No(REF)			
Yes	0.9173*(0.892 - 0.944)	0.867*(0.850 - 0.883)	0.918*(0.904 - 0.933)
Justification to refuse sexual intercourse:			
No(REF)			
Yes	1.046*(0.997 - 1.098)	1.272*(1.230 - 1.316)	1.082*(1.051-1.114)

CONCLUSION

In conclusion to this study of the influences of women's empowerment indicators on reproductive health outcomes of a sample of currently married women in Nigeria reveals that women's empowerment indicators considered in the study has a direct and significant influence on women's reproductive health practices. The study clearly shows that there is a significant relationship between women's participation in household decision making and their reproductive health practices in Nigeria.

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