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Reproductive Health Freedom and Domestic Violence in A Patriarchal Society: Some Findings in Akwa Ibom State, Nigeria

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Abstract: There is paucity of freedom in the area of reproductive health in patriachal communities which leads to domestic violence. This study looked at the socio-cutural factors and other perculiarities of reproductive health freedom and domestic violence in Ibibioland, South-South Nigeria. With feminism as the theoretical drift, the study utilized interviews and other qualitative methods to elicit data from participants recruited through a multi-staged sampling technique. Simple percentage was the instrument for presentation of socio-demographic statistics of study participants. Emerging data from the largely qualitative work shows that issues of reproductive health freedom and domestic violence mainly border on social power relations against the female gender and cultural worldviews. Since the situation is culturally constructed, the study argues that legal framing and international declarations should be domesticated with vigour. This should be with a view to criminalizing counters to such laws and declartions.

Keywords: A Patriarchal Society, Domestic Violence, Reproductive Health Freedom.

1. Introduction

Reproductive health is an important aspect of society's a health system in terms of individuals' ability to have a satisfying and safe sex life, the overall capability to reproduce as well as the freedom of decisions and choices on when and how to do so. Freedom is central to reproductive health, and varies amongst countries around the world. The totality of the right of couples to freely and responsibly decide on the number, spacing and timing of their children and to have information and means to do so is universally acknowledged as a fundamental human right, and domesticated in some countries' national laws. Many scholars and reports (including Cook and Fathalla 1996, Freedman and Isaac, 1993, UN 1995) specifically added several elements to reproductive rights including the right to legal and safe abortion, birth control, right to education about sexually transmitted diseases, freedom from coerced sterilization and contraception; the right to good quality reproductive health care; the right to information as a basis for making informed choices, among others.

The United Nation's international conference on human rights in 1968 (held in Teheran, Iran) pioneered an effort at recognizing reproductive rights as an aspect of human right: 'parents have a basic human right to determine freely and responsibly the number and the spacing of their children' (Freedman and Isaacs 1993). The Tehran proclamation was consolidated in Cairo, Egypt in 1994 tagged 'Cairo Programme of Action' at the

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international conference on Population and Development (ICPD). Paragraph 72 specifically covered a broad range of issues including family planning services, violence against women, sex trafficking, adolescent health etc., as follows:

> "Reproductive health is a state of complete physical, mental and social wellbeing 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 are able to 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 be informed [about] and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (Cook and Fathalla 1996).

Subsequent international interest and support for reproductive health included the Beijing Conference (the Fourth World Conference on Women held in 1995) and the Yogyakarta principles in 2006. While the Beijing Conference came out in full support of the Cairo declaration, it went further to broaden the scope of reproductive rights in its declaration in paragraph 96 (Cook and Fathalla 1996):

> "The human rights of women include their right to have control over and decide freely and responsibly on matters related to sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences".

Despite this important framework, the country's progress in mainstreaming reproductive health rights in national health policies and legislations remain slow and complicated by factors relating to socio-economic, religion and culture. Acknowledgement is given to the little progress located in wider campaigns on social rights, which have formed the framework for articulating safe and effective contraception, motherhood, universal basic education, gender equality, water, sanitation and hygiene, etc. The patriarchal family arrangements in most countries imply that reproductive freedom and choices are highly limited. Studies have noted several aspects of patriarchal influences on women's reproductive behaviours on issues of sexuality, contraception, timing and the number of children, as well as other choices (Dixon-Mueller 1993, Mason 1987). Women have no autonomy and control over these issues due to cultural limitations as well as poor socio-economic background. Within this context, reproductive freedom mirrors an important aspect of how power relationship is gendered.

This paper interrogates the narratives on attitudes and cultural norms that shape women's decisions on reproductive health and domestic violence in Akwa Ibom State. Issues examined here include sexual freedom, family planning preferences, and decisions regarding the number of children, among others. This study attempts a replication of extant findings which situate domestic violence as a serious crime (Brown & Umoh, 2009; and Brown, 2009) is organized into sections. Immediately following introduction is a discussion on the Ibibio and reproductive health matters. Section three discusses the research process. The fourth section focuses on research findings, which is immediately followed by a discussion and concluding remarks.

Theoretically, this work is predicated on the feminist theory which basically seeks changes on behalf of women by focusing on promoting the meeting of the desires, values, and priorities of the feminine gender (Alsop, Fitzsimons, & Lennon, 2002; Edstro & Greig, 2002; Consalvo, 2003; Connell & Messerschmidt, 2005; and Higgens, Hirsch, & Trussell, 2008). Driven by the need to understand the nature of gender inequality, this work acknowledges the patriarchal nature of the study area and posits the needs to rescript the balance for the betterment of women.

2. Method

This study was a multi-sited survey conducted in the headquarters of the three senatorial districts (Uyo, Eket and Ikot Ekpene) of Akwa Ibom State. These Local Government Areas were purposively selected because of the likelihood of having good representation of indigenes of other local government areas within the senatorial districts. Different techniques of qualitative data collection and analyses were employed in the study.

2.1 Study participants and data collection

Study participants were women of reproductive age (18years and above) who were conveniently recruited for the study. The major instruments of data collection were in-depth interview (IDI), Key informant investigation (KII) and community conversation organized among community influencers in the study locale. A total of four (4) community conversations (CV) were conducted. Three of the community conversations were exclusively for women (one in each of the senatorial district), while the participants of the remaining one were both male and female drawn from the three senatorial districts (2 participants from each senatorial district). Each community conversation group in Ikot Ekpene had 8 discussants, Eket had 8 discussants and Uyo was purposively allotted 11, due to its cosmopolitan status as Akwa Ibom State Capital City. Hence, a total of 27 discussants participated in the community conversation.

Questions captured major interest which revolved around sexual freedom, sexuality, decisions on contraception practices, number of children and intervals of births. Twenty-one women and six men were interviewed, at random, over a period of one year. The interviewees came from different ethnic backgrounds in Ibibio land including Oron, Annang and Ibibio. A single interview could last between 40 and 60 minutes. Two volunteer student field assistants were trained on the modalities for such interview and other data collection processes. The student field assistants were used for typing field notes, and manual coding for purposes of identifying and highlighting themes, which were later cross-checked collectively. One another's field notes from individual interviews were reviewed and discussions of interpretations were made collaboratively. Secondary sources of information came from academic articles and newspaper reports.

For ethical reasons, the sample size for this study comprises those who had expressed oral consents to participate in the study and were available for data collection exercise. All study participants had met the inclusive criteria of being adult of reproductive age. Participants were given honorarium and light refreshments as incentives. This kind of research depends on trust, the researchers had the advantage of being culture bearers with long-term relationship with the study participants, and there was no difficulty in securing the confidence of prospective participants. While women were considered of higher importance, the researchers considered it expedient to attempt achieving some degree of gender representation by incorporating the views of some men. Ethically, the respondents were guaranteed high levels of anonymity, confidentiality, transparency and liberty to withdraw participation at any time. Despite these limitations, this study offers important basis for further research in this field.

2.2 Analysis

Data analysis involved thematic organization and analyses of the transcribed responses from interviews and community conversations. Adopting a qualitative inductive approach, specific attention was paid to competing narratives exploring experiences on issues bothering on freedom to decide when and where to have sex, the number of children as well as issues related to sex education, abortion, safe sex practices and contraception are mostly in the control of their spouses as sanctioned by tradition, religion and customs.

For purpose of familiarization, the data was read, and re-read to look for patterns and important issues. Related codes were manually identified, and categorized. The categories were collapsed to form initial themes, which were further refined to make meaningful interpretations of the data.

3. Result and Dicussion

This research was conducted to determine the level of students' abilities to solve mathematical problems based on the Polya solving steps. The indicators discussed in this study were students' ability to understand problems,

students' ability to plan problem-solving, students' ability to solve problems, and students' ability to reassess answers and draw conclusions. Assessment of the ability to math problems in terms of learning

3.1 Result

This section presents socio-demographic characteristics of study participants.

Table 1- Percentage distribution of participants by education level.

Educational qualification	Participants by gender				Total	%
	Women	%	Men	%		
No formal education	13	48.2%	0	0%	13	48.2%
Primary level	4	14.8%	3	11%	7	25%
Post-primary level	4	14.8%	1	3.7%	5	18.5%
Higher level qualification	0	0%	2	7.4%	2	7.4%

Gender, age, occupation, income and education were important socio-economic variables considered to be of greater relevance to reproductive health practices in any society. The interview was deliberately targeted mostly at women, hence their high numerical representation (77.8%) over male participants (22.7%). A gendered society in African context concentrates more power of decisions and control in men in relation to women. Consequently, women are more likely to be poorly represented in every facet of social and economic lives. For instance, the educational characteristics of the participants placed women at a very disadvantaged level, with the greater percentage (48.2%) not having formal education, while none of the female participants had acquired higher level of education (Table 1 above)

Table 2: Percentage distribution of participants by occupation.

Occupation	Participants by gender				Total	%
	Women	%	Men	%		
Private business	10	37%	2	7.4%	12	48.2%
Civil service	7	25%	4	14.8%	11	25%
Student	3	11%	0	1%	3	18.5%
Unemployed	1	3%	0	0.7%	1	7.4%

Two categories of occupation were dominant among the participants namely private businesses (44.4%) and Civil service (39.8%). Students constituted 12%, while only one participant (3.7%) said she was unemployed. By gender categories, women were equally poorly represented, perhaps in line with the cultural norms of patriarchy, that tend to place women at the background. The analysis shows 10 female participants (37%) indicated private business, while 7 female participants (25%) indicated they were Civil servants. Three female participants said they were higher educational level students, while one woman said she had no job. Private business engagements for women could translate to anything including 'no clear employment.
According to a study participant:

> Some of these women depend on men…nothing to do, but would not tell you they do not have anything doing, this trend has affected to have a say or argue with their husbands on any issue affecting them.

A further confirmation emerged when one of the female participants who mentioned 'private business' was asked to be specific. It was found out she was engaged in subsistent farming and few other informal trading to support the family. Occupational engagement depends on the location of residence. Women in the rural areas are more likely to be involved in subsistent farming activities that those resident in cities. Of the six men interviewed, four were civil servants while two were into private businesses. In terms of age categories, most of the respondents fell in the age range of 18-30 years (37%) and only one respondent was above 50 years (Table 2)

Table 3: Percentage distribution of participants by age.

Age Range (in years)	Respondents by gender				Total	%
	Women	%	Men	%		
18-30	9	33.3%	1	3.7%	10	37%
31-40	6	22.2%	3	11%	9	33.3%
41-50	6	22.2%	1	3.7%	7	25%
51 and above	0	0%	1	3.7%	1	3.7%

Household size of respondents' families ranged between 3 and could be as high as 8 members (specifically the number of children per family). Three broad reproductive issues were considered including child preferences, family planning and sex education. They are all discussed below:

3.1.1 Child preferences

Twenty-three respondents (85.2%) clearly expressed their preference for male children over the female child. Three respondents (11%) did not indicate any specific preference, while only one respondent (3.7%) mentioned a female child. A further analysis into the statistics indicate that all the female respondents (77.8%) indicated high preference for the male child over the female. A female participant during IDI aged (30) said:

> my first child should be a boy…in short I should have male children than females, but that is what the society wants…you secure your marital future by having a male child…my husband wants that…that is what I come to see.

Another female participant aged (46) added thus during Cv:

> If you don't have a male child in the family, your husband can send you out one day and re-marry…in fact the more male children you have the more you are valued in your matrimonial home.

Spousal and extended family pressure was popularly cited as the reason, but also friends and neighborhood, An elderly IDI participant aged (75) confessed:

> hmmm! No one would regard you in the society if you are a mother of females…you are only regarded and feared if you have many male children…', argued one female respondent who should be in her early 40s. she went on to add as follows: '…here, if you don't have male children, you are likely to be exposed to all forms of ridicules and gossips…any person can walk and insult you scot free…or what of if me or my husband dies, who would inherit the property and who would reproduce the father's name in the family?.

The male respondents all had similar feelings. A close investigation showed the participant who preferred a female child claimed he has 4 children (two males and two females), but his opinion on this was interesting:

> I am not too bothered if God gives me a female child…I like female children but you know we need the male children most to carry on the family name and heritage

Relatively few respondents (11%) were not categorical on their child preferences. However, further discussions indicated their views were not significantly different from the prevailing attitudes of male preference over female children. It was also interesting to note that the respondents' attitudes and preferences were clearly independent of their socio-economic background namely, level of education and exposure. The two male participants with higher qualifications did not deviate in their attitudes and opinions on this topic, as one of them in his early 40s noted:

> my brother, you can't help…this is what the society enforces in our mind…at least you have to have a male child in the family no matter what…it is part of your dignity as a man and a husband…'.

Having a male child in the family is a necessity quite in line with the expectation and norms of the society for reasons of heritage, relevance, continuity and family security. Women have no choice of their own, neither do they have any excuse; the husband, the family and the larger society enforce this practice in every matrimonial homes. The pressure to have a male child from the society is at the root of all forms of reproductive behaviours and practices of most spouses. They resort to churches, faith, spiritual homes, traditional health practitioners and all forms of unorthodox practices to secure their marriage and family with male children. Popular views during FGD is summarized in this opinion by a male participant:

> It is so serious that families can go extra length…can do anything in the hands of prophets, pastors, sorcerers…just to have a male child…those who have money can secretly take the option of buying a male child…

In all cases, the woman is always at the receiving end of accusations of 'curse' 'witchcraft', 'defective womb', and many others, all of which could eventually lead to a divorce. It is a common saying in Ibibio land that the pride of every woman in her matrimonial home is to have children, not only having children, but having male children. Men have options of re-marriage or extra-marital sexual relationship for the sake of having a male child in the home.

3.1.2 Family planning

Family planning here covers the comprehensive approach to the practice of controlling the number of children and the intervals between their births. Family planning is central to reproductive health, and the freedom of choices and decisions in this regard is shaped by the prevailing tradition, religion, customs, attitudes, beliefs and norms of the society. Although family planning practices vary from contexts to contexts depending on awareness level, discussions here were narrowed to the use of contraception, abortion and child spacing practices. All the female participants held religious and customary views on these issues:

> Abortion? No! it is against the will of God…if it happens now, I have no option with me…God will take care…'

Another female participant aged (34) added:

> It would depend on my husband…if he agrees and provide money…I could try, but whatever consequences he would bear…I cannot do it on my own…'.

But one female participant aged (45) argued as follows:

> *'many factors could force one to commit abortion either secretly or with the consent of the husband…if you do not want more children or if the family* economy *does not support, one can secretly do it without the knowledge of the husband…but sometimes the husband may pretend not to know…'*.

Only one male respondent was relatively open in his views of family planning during our discussions as follows*: 'there is no point bringing a child into the world to suffer…I take step to prevent this, and I have to explain to my wife the need…times are hard, so I have to be careful…'*Similar views were held about child spacing. The idea that children are gift from God was the most frequently use phrase to justify inability to regulate and control child spacing either through contraception or abortion. As one female respondent aged(40) narrated:

> I had my second child almost one year after my first child…when we discovered the pregnancy while still nursing my first child, we could not do anything about it…how do we start, what of if I die in the course of abortion…we decided to keep it…it was real trouble but thank God they are now grown up…come to think of it, if I had aborted the pregnancy, I wouldn't be a proud owner of my second child (a male) (now about 12 years old)…'.

Traditional, religious and moral burdens; a lack of decision autonomy on the part of the woman and the general, traditional attitudes and the absence of appropriate health care infrastructures shape child spacing attitudes and practices of spouses. As children are seen as gift from God, decisions on unwanted, accidental or unplanned pregnancies are often taken with due regard to the moral, religious and traditional considerations: *'it impinges on the consciences of those concerned, and also the fear of losing any possible opportunity of having a child in the nearest future…'*, argued one male informant. The belief that children are special gifts from God implies considerations for such practices as abortion and contraception will be met with negative spiritual repercussions. Traditionally, women have no control of their bodies and reproductive behaviours. Usually in the exceptional cases of the option of abortion or contraception, the overall consent must be secured from the husband to protect the marriage: *'yes, it can lead to divorce if the man has not consented to such practice…your husband would see your action as affront on his position and authority…*' noted one female respondent.

Contraception was also discussed, and the consensus was that women have less power over such practices: *'you can do that without the knowledge of your husband…all depends on the pressure on you as a woman…*' stated one female respondent in her early 40s.
Another woman aged (30) said:

> My husband would not want to hear the idea of using condom…he knows he would not be the one to bear the consequences [as in unplanned pregnancy] when it comes…'.

Contraception is one important approach to family planning and reproductive controls. However, women in Ibibio land are presumed not the real owners of their bodies-they are traditionally the properties of their husbands, the family and the community. Invariably, it is the man that controls the reproductive behaviours and choices of his spouse. Women, however devise strategies of coping and controlling their reproductive systems. Friends' network, peer advice and professional assistance are platforms for coping and engagement*: "…we depend on patent medicine dealers and other informal itinerant practitioners as well as network of friends for solutions, counselling and services…",* observed one female respondent in her late 40s. Women draw on these resources to help themselves without the knowledge of their husbands. Several traditional methods were suggested including 'enema with some herbal mixtures', amulets and other traditional contraceptive remedies. Others depend on patent medicine dealers or informal itinerant services. Instances of cooperation with the husbands were equally discussed: *'yes, most husbands understand and can finance such services without direct involvement…times are hard, some husbands do cooperate…*' observed a female respondent in her early 30s. The problem arises when the husband is not cooperating, as any instance of unilateral action by the wife could challenge the stability of such marriage.

Newly wedded couples face difficult challenges on two fronts. While the woman would be aiming to secure the marriage through early procreation, this idea would depend on the cooperation and understanding of the husband. In some cases, the man may be keener on having children than the woman. Under this circumstance, family planning decisions remain a highly sensitive issue: *'the woman would have to be careful as any mistake may endanger her chances of having children in the future as well as the prospect of her marriage…'* argued one male informant. The spiritual belief of the divine origin of children imposes hard choice on the family especially the woman on such issues as abortion, contraception and child spacing. The number of children and the intervals of births do not really matter given the general belief in the generosity of the Creator to provide for their wellbeing. Going contrary to this belief is generally believed could lead to some spiritual punishment including barrenness of the womb.

3.1.3 Sex education

Sex education was another interesting element considered in the fieldwork interview. Sex education cross-cuts every aspect of reproductive health, including: contraception, safe sex, abortion, child spacing and sexuality, among several others. However the question of the right and freedom to discuss and seek appropriate sexual and *reproductive behaviours depend on complex cultural, religious and social factors: 'people are just morally not disposed to discuss such matters except in the secret…the society sees you as a spoilt [morally depraved] child…*' noted one male respondent aged 37. Freedom to participate in sex education is more discriminatory in age: *'girl teenagers rarely cross such boundaries…parents would be concerned that they could barrier their prospects and chances of marriage…'* argued a male respondent. Married women are relatively free to participate in sex education mostly in the secret among their peers and friends.

The outcome of the field interviews demonstrates that the degree of tolerance for participation in sex education is highly gendered particularly against women of different age brackets. Information on reproductive health education is generally secretly guarded against children. At adolescence, sensitivities to reproductive health education and information are moderately high against the girl child. Girls and boys are exposed to limited information on sex education in Senior Secondary school, mostly in Biology and related disciplinary classes, fully complemented secretly through the agencies of peer groups and friends. Such freedom may be relatively possible at adult and under marital relationship in specific contexts through friends' network, professional services and spousal communications: '*yes, at that level a woman may have access to seek and to participate in discussing these things in her interest or when she has a problem or to improve sexual and reproductive wellbeing of the family…but you do not do it open less you are labelled as bad [depraved]…*' argued a woman respondent in her late 40s. The respondent went on to further state as follows: *'the important issue is don't be open about it, and in some cases, don't allow your husband to see you…'*. The power to exercise freedom of access to sex and reproductive education belongs to the husband (who is traditionally vested with the overall power of discipline including determining the marriage, scolding, beating and other physical and psychological deprivations) at first instance and the society (the power of shaming, discrimination and stigmatization).

3.2 Discussion

There is a difference between formal and cultural understandings of reproductive freedom as applicable in Ibibio land. Several issues could be inferred as central to this argument including the notion of the body, the concept of marriage and sex, attitudes around family planning, abortion, sex preferences and the number of children and interval of birth. For instance, the idea that the husband and the community own the woman's body deeply contrasts with the formal notion of the body as a biological/physical entity. Logically, the body (as an important reproductive element of the woman) more or less represents a site of contestation between authorities attempting to inscribe formal notion of reproductive right and the cultural version. For instance, an act of sexual violence committed by the husband against his wife does not qualify as crime (by legal understanding), so also is a case of rape especially against a woman, whose sexual behaviour or orientation is culturally unacceptable.

Two fundamental issues have underpinned the findings of this study, and this mostly border on social power relations and cultural worldviews. Ibibio land is structured on a patriarchal system, with much power (physical, economic, social and cultural) concentrated in males at inter-personal relationship, family, associational and society levels. The power of decisions at the domestic and society levels are highly gendered, so also are the power of discipline and control. The society expects women to subject themselves to their husband, and it would amount to a sign of insubordination if the contrary happens: *'every husband expects submission from his wife…and acting contrary is a sign of impudent…'* argued one female informant. 'Submission' involves everything that belongs to the woman including the body. As one female respondent in her early 40s noted: *'you see, I don't own anything in my husband house…everything is owned by my husband…if I have a salary alert now, I would show my husband and he is the one to decide how the money should be spent…'*. Spousal relationship at family formation mirrors how the larger society is constituted. Men occupy the decision ladder and hold the power of discipline, which keep being reproduced across generations.

Such gendered constitution of family and society translates to less power for the women in relation to their spouses.

Cultural worldviews of the Ibibios equally reinforce power inequalities among men and women. Attitudes, beliefs, traditional customs and religious values reflect gender biases, mostly to the detriment of women. Culturally and religiously, women are locked in unequal relationship with men: '*even the Bible supports this…in 1 Peter 3…'* noted a female respondent in her early 40s. The Ibibio traditional religion holds on to a similar belief. Historically, the practice of marrying many wives in Ibibio land was symbolically one aspect of expressing the superiority and power of men over women. In this context, women are expected to be less visible in the public but more active at the domestic arena.

Tradition, religion and customs shape dominant gender-based attitudes and practices of women subordination. This extends to reproductive health matters. Questions on who owns and control the body have already been explored in different contexts. In south eastern Nigeria Izugbara and Undie (2008) had discussed that the right of woman in some communities is culturally segmented into reproductive right (sexual, reproductive organs and the children born within) believed to be owned by her entire matrimonial community, while the right to her head (life) belongs to her own community of origin. In a related case in Western Brazil, Conklin (2001) argued that people see the body (in Wari community) as a place where personality, community and individuality reside, which constitute the basis for inclusion/exclusion practices involving enemies and loved ones. Traditionally, women do not own and control their bodies in Ibibio land, which forms the entry point for understanding how reproductive health issues are managed. Marriage exists mostly to satisfy the man's desires, needs as well as meeting the expectations of the larger society. In this case, the fertility desires of the husband, family and the entire community override individual freedom and right to sexual health and reproductive freedom. Decisions on appropriate sex behaviours, family planning needs, sex preferences, maternal health and sex education are usually determined by the husband and, by extension, the extended family/the larger society. Funding for family planning needs, maternal healthcare and several other reproductive health issues must be authorized by the husband, while the wife remains a passive recipient. The pressure to have a male child in the family leaves the wife with no choice but to experiment with many children till the desired preference is reached. Such pressure equally carries the prospect of exposing the woman to risky unorthodox options to secure the satisfaction of the husband and the stability of the marriage. Women were noted to be at the receiving end of husband-induced violence at any attempt to resist the sexual urge of the husband. ''*The society frowns at such behaviour…whatever happens to you in the heat of your spouse's anger will be seen as the consequences of your stubbornness, no one cares…''* argued a female informant.

4 Conclusion

The study has found out that the notion of the body as the entire property of the community is the first entry point for understanding reproductive freedom of women in Ibibio land. Reproductive freedom is understood not within the context of the body as a physical/biological entity owned and controlled by an individual. It revolves around the discourse and conceptualization of the body as culturally embedded and the locus of the construction of sociality (Kaplan-Myrth 2000). Universally, issues around reproductive rights, including sexual freedom, take the individualist's view of the body as the biological/physical entity, which underpin current universal norms and legal framework as well as the basis for campaigns against sexual violence and rape. Other elements of reproductive freedom including the universally articulated rights (World Association of Sexual Health) around sexual autonomy, integrity and safety; sexual privacy and free and responsible reproductive choices, follow a similar gender-based cultural worldviews. But enforcing these rights and related ones in sub-Saharan Africa is often resisted by entrenched socio-cultural beliefs, attitudes and values.

Recommendations

Since the notions and discourses of reproductive health and freedom in Ibibio land is a cultural construction, this paper argues that legal framing and international declarations should proceed with nuanced understanding of local cultural knowledge and discourses underpinning these issues.

Massive and compulsory education of the girl child is advocated in this study as key to capacity building, self-determination and acquisition of other social resources to frustrate unnecessary suppression and oppression from the opposite sex in the patriarchal setting.

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