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GENDER-RELATED FACTORS INFLUENCING WOMEN'S HEALTH SEEKING FOR TUBERCULOSIS CARE IN EBONYI STATE, NIGERIA

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Summary. This is a qualitative, descriptive study to explore gender-related factors that influence health seeking for tuberculosis (TB) care by women in Ebonyi State, Nigeria. In-depth interviews based on interview guides were conducted with participants selected through purposive sampling in communities in the state. The results show that gender relations prohibit women from seeking care for symptoms of TB and other diseases outside their community without their husbands' approval. Gender norms on intra-household resource ownership and control divest women of the power to allocate money for health care seeking. Yet, the same norms place the burden of spending on health care for minor illnesses on women, and such repeated, out-of-pocket expenditures on health care at the village level make it difficult for women to save money for use for health care seeking for major illnesses such as TB, which, even if subsidized, still involves hidden costs such as transport fare. The opening hours of TB clinics do not favour their use by most women as they are open when women are usually engaged in income-generating activities. Attending the clinics may therefore entail opportunity costs for many women. People with chronic, infectious diseases such as TB and HIV are generally stigmatized and avoided. Women suffer more stigma and discrimination than men. Stigma and discrimination make women reluctant to seek care for TB until the disease is advanced. Policies and programmes aimed at increasing women's access to TB services should not only take these gender norms that disempower women into explicit consideration but also include interventions to address them. The programmes should integrate flexible opening hours for TB treatment units, including introduction of evening consultation for women. Interventions should also integrate anti-stigma strategies led by the community members themselves.

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Introduction

Globally, tuberculosis continues to be a major public health issue (WHO, 2013a). In 2013, WHO reported that as many as 8.6 million people developed the disease, while 1.3 million people died from it. The burden of TB has significantly increased in the recent past largely due to the HIV pandemic, with 320,000 persons living with HIV dying from TB in 2012 alone (WHO, 2013a).

The developing countries bear the largest burden of the disease, with sub-Saharan Africa accounting for the greatest proportion of the TB burden. This is due mainly to a number of factors, most important of which are the very high prevalence of HIV in the region and pervasive poverty and ignorance. Nigeria is 13th among the 22 countries with the highest TB burden. These high-burden countries account for 80% of TB cases in the world (StopTB Partnership, no date). In 2012, Nigeria notified 97,858 cases (all forms of TB) to the WHO. Of these, 52,901 were smear-positive cases (WHO, 2013a). The results of the first Nigerian national prevalence survey conducted in 2012 suggested that the burden of disease caused by TB is high and 'there is considerable transmission of TB in the community'. This is indicated by the high prevalence of TB in the community found during the survey and the age group that is mainly affected. Specifically, a prevalence of 255 cases per 100,000 population aged 15 years and above was found in the survey, and this was about five times the number of cases found in the country in 2012 (reported to the National TB Programme) within the same age group, which was 55 cases per 100,000 population (WHO, 2013a, b).

Concerning gender and TB, as far back as 1990 Murray *et al.* reported that TB ranks third among the commonest causes of morbidity and death among 15- to 44-year-old women in developing countries. Tuberculosis is also the fifth highest cause of death among females aged 20–59 (ACTION, 2012) and is the leading cause of death among people with HIV/AIDS (WHO StopTB Partnership, 2009). Factors that predispose to TB include poverty, living in overcrowded conditions, poor ventilation, poor nutrition and cooking with charcoal and/or firewood (Fatiregun & Ejeckam, 2010). Although both women and men are found in these conditions, in developing countries women are disproportionately affected (Needham *et al.*, 2001). Indeed, despite women experiencing more of the predisposing factors than men, evidence has now shown that women encounter greater barriers to health seeking for TB (Fatiregun & Ejeckam, 2010).

The Nigerian National TB Programme was launched in 1991 and a decade later, in 2001, the WHO-recommended Directly Observed Treatment, Short Course (DOTS) strategy was adopted and used to implement TB prevention and control in some parts of Nigeria (Oluwadare & Ibirinde, 2010). Although the DOTS strategy emphasizes supervised ingestion of anti-TB drugs for diagnosed cases, the case finding relies on passive self-reporting to the health facility by individuals who develop symptoms (Luis *et al.*, 2011). Thus, the health-seeking behaviour of individuals within their households and communities is of paramount importance to TB diagnosis, as well as the starting, continuation and completion of their treatment, without default (Waisbord, no date). Indeed, as Waisbord noted, the components of the DOTS strategy are responses to behavioural challenges to health seeking for TB diagnosis and treatment (*ibid*).

One of the key findings of studies investigating health-seeking behaviour generally, and health-seeking behaviour for TB services in particular, is that the factors that impact

individual and group behaviour seem to be context-specific, relating to prevailing social, cultural, economic, geographic and political conditions (Qureshi *et al.*, 2008; Oluwadare & Ibirinde, 2010; Buregyeya *et al.*, 2011). Since the passive case-finding approach depends on a patient's willingness to seek care, awareness and knowledge of the disease and the diagnostic process are very important, as are positive attitudes towards receiving treatment and getting cured (Luis *et al.*, 2011).

Beyond the willingness to seek care, health seeking also requires the ability to negotiate the financial costs inherent in health seeking (Oluwadare & Ibirinde, 2010). Even in instances where diagnosis and treatment are free of charge, health seeking may still involve financial costs including transport costs. So many other factors may impact the health-seeking behaviour of individuals and groups, depending on the specific context (Qureshi *et al.*, 2008; Oluwadare & Ibirinde, 2010; Luis *et al*, 2011). In patriarchal societies in developing countries, gender norms may modulate and/or interact with other factors to hinder or enable women to seek care for TB promptly. In Nepal, Yamaski-Naagawa and his team (Yamaski-Naagawa *et al.*, 2001) reported that poor women were compelled to seek care at traditional healing places rather than go to modern health facilities that may not be close to them. Harmful gender norms that erode women's control over household resources and finance may result in their inability to seek care (Taylor *et al.*, 1996). Additionally, stigmatization and discrimination against persons who have TB and/or HIV may make women reluctant to seek a TB diagnosis (Mata, 1985).

The influence and interplay of the various factors that impact health seeking vary from location to location, depending on the specific social, cultural and economic contexts. In Ebonyi State, the factors that influence women's health seeking have not yet been systematically explored, and this research seeks to fill this gap, with a focus on gender issues.

Methods

Study setting and population

The study was conducted in Ebonyi State, southern Nigeria. Like other states in Nigeria, Ebonyi has three senatorial zones, with each zone composed of Local Government Areas (LGAs). This study was carried out in all three senatorial zones, starting, first, with the purposive selection of one LGA in each zone. Then two communities (one rural and the other sub-urban) were selected per LGA using a purposive sampling frame constructed to ensure inclusion of communities that have different economic and social development conditions. Fifty-six participants were selected (46 women and 10 men) through the use of a purposive sampling frame constructed to enable drawing of participants with various social and economic characteristics, namely, gender (males/females), age, residence (rural versus sub-urban), religious belief, educational status, primary occupation. Since the primary focus was on women and their access to TB services the majority of the participants were women (46 women). However, to get the perspectives of men on the various issues being explored, ten men were also selected.

Ebonyi is one of the least socioeconomically developed states in Nigeria. The situation is worse in the rural areas of the state. In these rural communities, the primary

occupation is subsistence farming, and in the absence of paved roads, harvests are often sold at give-away prices during the harvest season or rot in the barn, leaving households grappling with deprivation most of the year.

Anecdotal evidence shows that the people in these rural communities have large households (as a result of a high fertility rate among the women in the absence of literacy, health education, and awareness of and access to family planning). Many households reside in mud, thatched huts with only one small window or no window at all. Overcrowded, small, poorly ventilated huts provide a veritable conducive environment for the transmission of TB. Sources of water are the dirty rivers for those at the borders and for others it is local, shallow ponds that dry up in the dry season, slow-moving streams and temporary wells dug in the dry season. The ponds and slow-moving streams contribute to high morbidity in the area as vector-borne and water-borne diseases thrive and afflict the population. There is no electricity in many of these communities. Many of the project communities have wetlands, waterlogging of unpaved roads, muddy terrain and are very distant from the health facilities.

It is against these daunting social and economic environments that women negotiate health care seeking, mediated by existing gender norms, both at the intra-household and community levels.

Study instrument

The instrument for data collection was an in-depth interview guide. The guide consisted of five sections (A to E). Section A contained information on the socio-demographic characteristics of the participants. Section B focused on eliciting information on the knowledge of TB among the participants and the sources of such knowledge. Section C contained questions aimed at exploring gender and decision-making for health seeking within the household and in the community. This section thus sought to explore the social, economic and cultural norms that influence decision-making between the spouses at intra-household level, and at community level. Section D consisted of items used in the investigation of stigma and discrimination against persons with TB. Finally, Section E had items used for the exploration of issues pertaining to delivery of women-friendly services at TB clinics and how these would relate to access to such services by women.

Interview process

In-depth interviews were conducted using the interview guide. The purpose of the interview was explained to the participants and an oral consent obtained, after full explanation that they were at liberty to participate, decline to take part or withdraw from the interview at any time, without any consequences. Interviews were conducted in the native Igbo language and recorded. The participants were asked to freely respond to interview items/questions in the key sections of the interview guide. Each interview lasted about one and half hours. Ethical approval for this study was obtained from the authors' institute. This work was approved by the Institutional Review Board (Ethics) of the Ebonyi State TB and Leprosy Control Programme.

Data analysis

The interviews were recorded and transcribed each day after the data collection by native Igbo speakers, under the supervision of the lead investigator, who was also a native Igbo speaker and trained qualitative researcher. Individual transcripts were read through and over again, with key sociocultural and economic themes influencing women and health care access being identified. Narrative memos were written on the themes, followed by cross-case analysis.

Results

Fifty-six interviews were conducted with the participants (46 women and ten men) from the six communities. All the participants claimed Christianity as their religion. None of the participants had tertiary education. Eight participants had secondary school education, 25 had primary education, six dropped out of primary school while seventeen did not have any education at all. Thirty-nine of the participants had farming as their primary occupation, nine were civil servants (teachers and low cadre administrative staff in the local government) while eight were primarily petty traders. However, in addition to their primary occupations, many of the participants engaged in a variety of informal income-generating activities to complement, according to them, the small amount of cash earned from their primary occupation.

Knowledge of TB and sources of information on TB

All the participants had heard of TB, and most had heard of it in discussions within the community or within the household or extended family settings. Those who had heard of TB within the extended family setting were likely to have had a member of the extended family who suffered from TB, and it was from discussions of the disease condition of the person that they heard of TB. One woman stated that her own sister suffered from TB but the sister who had TB developed the disease while already married and living in her husband's house. A young man also indicated that his sister had TB but noted that she contracted the disease while living with her uncle in Lagos, a faraway mega city-state in Nigeria. She was brought back home to the village when she developed the disease.

All the participants stated that the name of the disease in the local dialect is *ukwaranta.* The participants described the manifestations of *ukwaranta* to include coughing that is prolonged and cannot be cured with medications bought from the patient medicine vendor, loss of weight, loss of appetite/emaciation and weakness.

There were divergent views on the causes of the disease. Four main causes were mentioned by different participants, namely, witchcraft, punishment for breaking a taboo, poisoning of food or drink by an enemy and a germ. Among the participants who stated that the disease was caused by a germ were those whose relations had had the disease, thus suggesting a link between health seeking for TB by an individual and knowledge of TB by the individual's relations. For example, in the words of a young male participant:

> I know what is TB. Here, we call it *ukwaranta*. My younger sister contracted the disease while living with our uncle in Lagos. She was brought back home for treatment, at Mile Four Hospital. She was treated and recovered fully. (EKC, male, 34 years, secondary education, artisan)

Indeed, as shown in the response above, perception of causation may link with perception of treatment. The participants who indicated that TB was caused by a germ also opined that the disease is treated in hospitals, and not by a native doctor. Most of such participants correctly mentioned hospitals in Ebonyi State where the disease can be treated.

However, among participants who thought the disease was caused by factors other than a germ, some still felt that persons with the disease can be treated in modern hospitals. Specifically, eighteen out of the nineteen participants who perceived TB to be transmitted through poisoning by an enemy indicated that TB patients can be treated by doctors in a hospital. On the other hand, participants who felt that TB was a result of witchcraft spell or punishment for breaking a taboo opined that the remedy for TB was exorcism, ritual sacrifice or prayers by prophets.

> It is only a prophet who can destroy the powers of the witch. So, such persons who have TB can only be cured through prayers by powerful prophets. (MOT, 41 years, female, no education, farmer)

Gender and decision-making for TB health seeking

Responses to the question 'Suppose you develop a cough, who decides whether you should go to the hospital for treatment or not?' revealed salient issues on how gender inequality in intra-household decision-making for health seeking can be powerful in its effect. Married female participants all answered that they either decided in consultation with their husbands or that their husbands made the decision for them. Female participants with secondary education seemed to make the decisions jointly with their husbands while female participants who had only primary school education or who were non-literate seemed to depend upon their husbands to make the decision for them. An uneducated woman in her fifties responded:

> My master [husband] loves me and will not want me to die. So, he decides whether to take me to hospital or not. It is men who make decisions in this community. But a man who lives harmoniously with his wife will certainly take her to hospital if she is coughing. (NEA, 50s, female, non-literate, farmer)

> In our culture, women obey their husbands and take orders from their husbands. In the same vein, it is not in the place of women to decide that they want to go to the hospital. If my wife starts coughing and we are worried that it is getting serious, as her husband I should understand that I should do something about it. It is with my money that she will be taken to the hospital. And so it is I that will take the decision about her going for treatment. (GTU, mid-50s, male, primary school drop-out, petty trader)

> My husband and I discuss many issues including sickness. So, if I have cough, we will also discuss my going for treatment in the hospital. (COO, 34 years, female, secondary school education, teacher)

Cursorily, unequal power relations between the husband and wife may seem to be insignificant in the case of women who were educated and who opined that they took a joint decision on health seeking. However, further probing does indicate that there is still unequal decision-making power between women who have secondary school education and their husbands. This inequality in gender relations is still a barrier to women who have secondary school education in their health seeking. For example, as regards whether they can take a decision alone and go to the hospital without prior permission from their husbands, all female participants indicated that it is impossible for a married woman to go to the hospital if they are feeling unwell without the permission of their husbands. Even women with secondary school education stated that they are unable to seek care for coughing unless they first obtain approval from their husbands to do so.

The following conversation between the interviewer and an educated female civil servant (NGH, 42 years, secondary education) working at a local government secretariat is illustrative:

> Interviewer: Can you take decision alone to go for treatment if you are coughing?
>
> NGH: No way. It's not done at all. I must consult my husband first. Going to the hospital without the approval of my husband is out of the question.
>
> Interviewer: What would happen if you did not take permission from your husband before going to hospital?
>
> NGH: That surely would not happen. No woman does it in our society. It is not part of our culture. That would imply the wife usurping the authority of the husband.
>
> Interviewer: But what if you are able to pay for the services in the hospital?
>
> NGH: It is not only about the ability of a woman to pay for health services. That is only a part of it. The ability of a woman to pay for hospital treatment does not mean that she can just get up and go to the hospital without her husband's permission.

Furthermore, women may not be able to seek care even if their own perception of care is different from that of the men (in the event the men do not believe in the efficacy of TB services). This is illustrated by the response of an elderly, female woman. In her words:

> Women should be submissive to their husbands. A woman who knows more than her husband portends danger to the community. If a man says the medicine is good, then it is good. If he says the medicine is not good, who is the wife to disagree. (MUA, elderly, female, non-literate, farmer)

Men who were interviewed were divided in their opinion on whether women should first obtain approval from their spouses. While some men said it is usual for women to get their husband's approval, others were of the opinion that it is not necessary as long as their wives inform them about their illness and intention to seek care. A male photographer opined that women should not necessarily seek opinion from their husbands but should inform their spouses as a mark of respect. He believed that every husband would want to see his wife healthy and so would support her seeking TB services. On the other hand, some male participants strongly argued that their wives should first obtain their permission before seeking care for a cough:

> I am the head of my household, and bear responsibility for any good or bad. So, why should my wife go to the hospital without my approval? (EHG, 34 years, secondary school education, mechanic/farmer)

Men who insist that their wives should get their approval for health seeking argue that they (the men) do not need to obtain permission from their wives before they go to hospital if they are coughing:

> Impossible, I am the head of the household. I don't need to obtain permission from my wife to go to the hospital. She does. ((EHG, 34 years, male, secondary school education, mechanic/farmer)

Economic empowerment and women's health seeking

Besides gender norms on women seeking approval from their husbands for health seeking, women also face economic constraints in their attempts at seeking health care. Many of the women interviewed were farmers primarily, with a few holding teaching or other jobs. The female farmers mostly engage in subsistence farming. Their households consume most of the produce with very little left to sell for cash. Thus, most of the rural women in the study communities are poor and vulnerable to shocks such as occurrence of severe illness in the household. Women find it difficult even to get money to pay for transport to health facilities. They therefore have to request money from their husbands to go for treatment. This increases their dependence on their husbands, and further weakens their ability to seek care for TB:

> I am a farmer and most women in this community are farmers. We merely produce what we and our households eat. Whatever is left is sold by women to get some money. You see, if I start coughing now, I will buy medicines from the chemist. But if that does not cure me, then I just do not have enough money to go to Abakaliki. (EDH, mid-forties, female, primary school education, farmer)

> There are very few women in my community who can afford the costs of transportation to the hospital and to pay the hospital fees. Maybe the traders! Even then, if they are not cautious taking money from their business to go for treatment will spoil [ruin] their business. Well, the female teachers in the secondary school in Onueke. (GUA, 29 years, female, secondary education, seamstress)

Gender norms on ownership and control of economic/financial resources further compound the vulnerable, dependence position of the women in the study location. Even when women succeed in obtaining cash from sales of their farm or off-farm products, the money, as other household assets and resources, is controlled by their husbands. Thus, women still need to abide by their husbands' wish on when, where and with what amount to seek care. This gender norm makes it a man's prerogative to allocate resources to needs, most frequently according to their perception of the severity of the illness or efficacy of the care to be sought:

> Women are free to sell their farm produce for cash. Some women are traders and make money from their business. But remember that it is usually their husbands who supported them financially to start the business in the first instance. So, no matter how you look at it, they should obey us on how to use the money. (HCE, mid-50s, male, primary education, farmer)

> I keep my money myself. I don't give it to my husband. I use it to buy some of the things we need in the home, the usual women's things. But when I happen to accumulate some savings, I cannot spend it without his approval. I also cannot use it to go to the hospital for cough treatment without his approval. If it is to buy cheap medicines from the medicine store here in the village I will do so without telling him, but to go to the hospital, yes, he must give his approval. (URU, 40 years, female, secondary education, trader)

Widows face even more difficult constraints. Those who were interviewed recounted how they have to negotiate the financing of health seeking with little or no support from their relations. Yet, their husbands' relations expect the widows to obtain permission before seeking care outside their community:

> They will not lift a finger to support me. Since their brother died I have had to carry the entire burden of looking after our six children alone. I try a little farming, and supplement whatever I can get from it with the small income I earn from paid labour on others' farms. Yet, my in-laws want to monitor whatever I do, including going for treatment. (UCG, 41 years, female, primary education, farmer)

> Women who lose their husbands suffer untold hardship in this community. Poverty is everywhere but ours is the worst. As a widow I have to pay my children's school fees, buy medicines from the chemist when they are ill, feed them and clothe them. I receive no assistance from my husband's family. You ask what I will do if I cough for two weeks or more. I will pray that the cough goes away. I will buy medicines from the chemist. . . . No, no, I can't go to the hospital. With which money? I have no money to go to the hospital. (OMM, 28 years, female, primary education, farmer)

> Yes, it is true that women whose husbands died suffer a lot. When I was growing up, extended family members helped each other, but all that has changed much. This is because of many reasons including increasing poverty, loss of kinship altruism, and maybe just sheer meanness. (TUN, mid-60s, male, non-literate, farmer)

> The community expects that a woman should abide by the norms of the extended family whether her husband is alive or dead. That is why it seems that women must take permission from them before leaving the community to go for treatment. (CEA, 32 years, male, secondary education, teacher)

Opportunity cost of care seeking for TB

For women whose primary occupation is farming, the opening hours of TB DOTS clinics may be inconvenient. Most of the female participants explained how they have to get up early to care for the children, including preparing the morning meal, before leaving for the farm as early as possible to enable them do some work before the sun becomes too harsh. They remain on the farm until late afternoon when they return to care for their household:

> I rise up every morning when the cock crows to prepare meals for my family. I have to do that quickly to be on my way to the farm because when I start working before the sunshine gets too hot I am able to keep working for a while. But if the sun gets hot before I start my farm work that day's work is ruined because I find it rather difficult to do any meaningful work. (DAE, 33 years, female, primary school, farmer)

I work almost every day except on market days on the farm and Sundays or if there are special occasions. I usually return in the late afternoon to cook for my husband and children. So, if I should go to the hospital in the morning hours as I am told that is when they open and return in the afternoon, that whole day is gone. (UHY, 41 years, female, primary school drop-out, farmer)

If they [hospitals] want to help us they should make their opening hours flexible so that we [women] can also go there in the evening hours, after the days' work. That will be more convenient for women. (AGN, 28 years, female, primary education, farmer)

Social stigma and discrimination

Social stigma against individuals who have chronic infectious diseases such as TB, leprosy and HIV is entrenched in the study population. Though males and females suffer discrimination, females are by far more discriminated against than their male counterparts. Discrimination may be subtle or overt depending on the disease. While TB patients experience stigma and discrimination, the experience of those living with HIV is more deplorable. The discrimination is even worse if the person is a woman. Incidentally, for epidemiological reasons, many individuals who have HIV develop TB with time. In Ebonyi State, as in many other sub-Saharan African regions, more women than men live with HIV, with many women therefore having HIV and TB dual disease.

Women with such cases may be driven away from their family compounds, and sometimes left in abandoned houses to die. Single women may find it very difficult to marry if they are known to have suffered from TB. Even if the TB has been cured, potential suitors and their families shun women with a history of TB. Therefore, fear of stigma may mean women do not seek treatment until the disease is advanced:

Women have been discriminated against truly more than men. It is difficult for me to say why. Let me give you an example: if a young man has TB and is cured, he will easily marry a woman. But if it is a single woman who suffers TB and is cured, no man will approach her for marriage unless he is from a distant community and has no knowledge of her disease. In fact, even if a young man wants to go ahead and marry a girl he knows has been cured of TB, his family will refuse. They may even blackmail him by threatening to ostracize him. (KRE, 45 years, male, primary education, carpenter)

I don't know anybody who has suffered the disease but I have heard community members describe the disease as terribly infectious. They say any individual who has the disease is usually isolated to prevent the disease from spreading to others. (IOA, 27 years, female, primary education, dressmaking apprentice)

They will chase me away if I develop the disease. That has been the practice since I was a young woman. There is this hospital in Abankeleke [Abakaliki] where the lucky ones were taken to by the church. The disease is bad. (LMA, female, 43 years, non-literate, farmer)

As I told you earlier, my sister had TB while she was in Lagos and our uncle sent her to the village. She was taken to the Mile Four Hospital [St Patrick's Hospital], Abakaliki, where she was cured. She is whole now. But she will be lucky if any man in this village will ever agree to marry her. She can only hope to marry an outsider. (EKC, male, 34 years, secondary education, artisan)

Discussion

Gender-sensitive research helps to illustrate how gender norms not only influence and shape vulnerability to TB and other major public health diseases but also access to diagnostic and treatment services for the diseases (Simwaka *et al.*, 2006). The findings from this research in Nigeria show how unequal gender relations within the household and at the community level may hinder women from seeking care for diagnosis and treatment for TB.

There is some evidence that lack of knowledge and awareness about TB may negatively influence health care seeking (Needham *et al.*, 2001). The findings of this research suggest that unequal power relations between married spouses may complicate women's seeking of care for TB in spite of their knowledge of the disease and where to seek care. Responses from female participants suggest that the knowledge and awareness of the husband about the disease determines whether there will be care seeking for the wife or not. In a study in Ekiti State, south-western Nigeria, 14% of the male participants perceived TB to be dangerous compared with 22% of the females (Oluwadare & Ibirinde, 2010). The current study did not focus on such a comparison, but the findings suggest that even if more women have correct knowledge than men in the study setting, they may still not seek care if their spouses disapprove of their care seeking for TB symptoms.

The responses of participants, both males and females, also suggest that though male spouses may not usually object to their wives' health seeking, the fact that women are dependent on their husbands' approval of their health seeking has very important implications for going for diagnosis and treatment of TB. First, such gender norms may prevent them (the women) from seeking care in the event they have a squabble with their husbands, since the men will probably disapprove of their care seeking. Second, if a male spouse lives an irresponsible life, such as excessive drinking of alcohol and/or family neglect, he may actually refuse to permit his wife to seek TB services. Third, the knowledge, awareness and perception of men concerning the efficacy of modern TB services may determine whether they will permit their wives to seek care.

Gender norms on health expenditure place more burden on women than men. As this study's findings show, in cases of slight symptoms such as mild fever, brief cough and malaise, households usually first seek care at the patent medicine vendor (PMV), popularly called the 'chemist'. It is women's duty to take children to the chemist and to purchase medicines for them. Most often, the money for the purchase of medicines is taken from her own earning from the sales of her products. Men's involvement in health expenditure comes in only when the health seeking entails going to major health care facilities. But the repeated, frequent 'minor' expenditures women make at the level of the PMV in the community leaves them unable to save any money. This study suggests that such out-of-pocket expenditure by poor women further worsens their deprivation and weakens their ability to seek care for TB in health care facilities. Widows face even more difficulties. Oshi (2009) also reported that similar difficulties were experienced by poor, rural women in Enugu State, a neighbouring Nigerian state.

The responses also suggest that when there is a need to seek care beyond the level of the PMV, it is the man who allocates the money irrespective of whether the money was earned by him or his wife. This implies that he takes the final decision on the amount

to be spent on the particular episode of health seeking. Taylor *et al.* (1996) also noted that men in rural south-west Uganda controlled the allocation of funds for health seeking. Women's lack of control of funds for health care seeking outside their communities may further aggravate the constraints they encounter in their seeking care for TB.

The responses obtained in this study imply that socio-cultural and economic factors ostensibly weaken women's decision-making power in matters of health care seeking. Unarguably, by undermining women's bargaining power in health seeking, unequal power relations between men and women are not only reproduced but also reinforced.

Conclusion

Programmes aimed at improving women's access to TB diagnostic and treatment services need to not only take these gender norms that disempower women into explicit consideration, but also include interventions to address them. Such interventions may include context-specific behavioural change messages that seek to portray the disadvantages of such norms, not only to women but to the entire household and society, and the training of community leaders and gatekeepers, community-based associations and similar traditional institutions on gender-sensitive norms and practices 'which truly meet the needs of women and uphold their rights' (Nudelman, 2013).

The findings from the study suggest that the opportunity costs of seeking care for women are considerable. Women who lack functional education end up as subsistence farmers, petty traders, artisans or low cadre civil servants. Combining labour-intensive jobs with taking care of the homes places a lot of burden on women. Yet, if women must seek care for TB, they may have to forego the day's work on the farm, off-farm or non-farm small businesses. Women's labour is often not easily replaceable making their absence from their jobs more complicated in terms of the losses in labour or sales they will incur. Also, because care seeking may involve repeated visits to hospital the opportunity costs may be quite burdensome to poor women, and may discourage them from going to hospital early. Programmes that aim to improve care seeking by women may consider introducing flexible opening hours for TB treatment units, including the introduction of evening consultation hours for women. Efforts to introduce such innovative approaches should include ways of addressing the challenge of the dearth of manpower in the Nigerian health system.

To address the issue of stigma, programmes that seek to improve women's health seeking for TB should integrate anti-stigma interventions led by the community members themselves. Awareness creation of early reporting for treatment and the curability of TB should be included. Women and men who have been cured of TB should participate in such programmes to serve as concrete evidence that cured TB patients will not infect others (GBCHealth, 2010)

The findings of this study indicate that persons suffering from chronic communicable diseases, especially TB and HIV, suffer discrimination, but that women are worse affected than men (see also Casali & Crapa, 2010). Women may be reluctant to go for diagnosis because of fear of stigma in the event they are diagnosed with TB. This is even more so given the association between TB and HIV.

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