INFLUENCE OF GENDER ROLES (FAMILY DECISION-MAKING PROCESSES) ON MEDICATION USE AMONG STROKE PATIENTS IN RURAL COMMUNITIES OF CROSS RIVER STATE, NIGERIA

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ABSTRACT
The focus of this paper is on the influence of gender roles such as family decision-making processes on medication use among stroke patients in rural communities of Cross River State, Nigeria, as a way of understanding the health-seeking behaviour of these patients in the study area. The Patriarchal and Marxist-Feminist Theories were adopted as framework. The study employed descriptive survey design which involved the use of both qualitative (IDI, FGDs, and life histories) and quantitative (questionnaire) methods of data collection. The sample size of 600 was selected, from which 200 respondents were sampled from each LGA. A multistage sampling technique was adopted to select 10 wards from each of the LGAs, 20 villages from each ward and 10 respondents who were stroke patients from each village and were administered with a semi-structured questionnaire. Thirty in-depth interviews were conducted with six key opinion leaders which included chiefs, elders and religious leaders, six care givers, six significant others, and 12 stroke patients. Eighteen Focus Group Discussions were conducted among six men, six women, two community leaders and four community members, while two life histories were carried out on stroke patients. Quantitative data were analysed using descriptive statistics, Chi-square and Multivariate logistic regression at p=0.05; while for the qualitative data, a manual content analysis was used to enhance the explanatory clarity of the findings. Results from the study revealed that family decision-making process was significantly associated with medication use for stroke cases. Most men made health-related decisions on stroke medications based on their positions as heads of the household and in most cases, provided funds for treatment. The respondents also noted that relying on men for health-related decisions sometimes led to unnecessary delays in presentation of cases. There is need for sustained enlightenment of the people, particularly men on the risk factors of stroke, access to treatment and medication use.
Keywords: *Cross River State, stroke patients, patriarchy, capitalism, Access to Medication.*

1. Introduction

Stroke is a significant medical, economic, and social problem, of which incidence is on the increase globally and regarded as the third leading cause of mortality and long-term disability in many societies (Ogun, 2010). It can also be referred to as cerebrovascular accident or brain attack; which is caused by an interruption in the flow of blood to parts of the brain due to occlusion or rupture of the blood vessel. When this interruption occurs in blood flow, it starves the brain of necessary nutrients and oxygen, which leads to injury to cells in the affected vascular region of the brain (Allen, 2013). Stroke was considered to be less prevalent among black Africans some decades ago, but recent findings depict an epidemic of stroke in developing countries due to some social and economic changes (Ogunrin, 2015).

Utilization is very critical to treatment and proper management of stroke because, if adequate use is applied and followed, it reduces disability and mortality arising from the disease. Therefore, and increased condition for a successful and long-term neurological response to treatment and cure produces positive results, while low utilization increases the chances of treatment failure and the development of the disease.

Recent studies in Sub-Saharan Africa indicate that stroke has become the leading cause of neurological admissions in many tertiary hospitals. These findings indicate that the disease has taken over from the central nervous system in this regard (Ashler, Megready, Droux, Nosten, 2011, Molua and

Akeniji, 2017). In 2009, stroke accounted for about 0.94-4% of admission in Nigerian hospitals and a mortality rate of 2.83-4%. Both episodes and genetic stroke has severally been reported from the second millennium BCE going forward in ancient Mesopotamia, and even Persia. The first scholar to describe the disease was Hippocrates (460-370 BCE), when he explained it as sudden paralysis that is often associated with ischemia. It was in his writing that apoplexy, a Greek word meaning "struck down with violence" first appeared. The word "stroke" was considered to have the same meaning with apoplectic seizure as far back as 1959, and is literally translated to mean the same thing with the Greek word. However, this term, "apoplectic stroke" is an outdated non-specific word for cerebrovascular accident which is associated with haemorrhagic stroke (Wikipedia, 2021).

The consequences of patriarchy in both the family and at the level of the communities; socioeconomic status of women in terms of education, income, and involvement in family decisions; the effect of stroke on the income of the family; the factors that influence use of health facilities and influence of cultural beliefs and practices on the value of health and health behaviours have not been adequately examined. The implication of this inadequate data on the health behaviour of the rural Cross River people on stroke is that attention to and knowledge of such a complex phenomenon is grossly undermined. Several studies by Menon S, Pandey D and Morgenstein, L. (2013) have demonstrated the effects of poor medication use, but only a few have attempted to examine the determinants.

Rural communities of Cross River State were selected for this study because; the demography of the people has received very little attention, more so, concerning the relationship that exist between gender issues and medication use for rural stroke patients at the level of the family. The state has majority of the population living in rural areas with farming as their major occupation, and classified in studies among areas of high prevalence of stroke cases.

2. Theoretical Framework

Two theoretical perspectives were triangulated for the explanation of gender roles influencing medication use among stroke patients in rural communities of Cross River State, Nigeria. These are the Patriarchal Theory and Marxist-Feminist Theory. Whereas the Patriarchal Theory emphasized the importance of both the individual and social organizations within society, and also present a general model of how society operates that have implications for medication use; the Marxist-Feminist theory presents the analyses of the way women are exploited through capitalism and the individual ownership of private property from the point of view of the participants.

Patriarchal Theory – Sylvia Walby

Patriarchy is a system of social structures and practices in which men dominate, oppress, and exploit women. Social stratification along gender lines, in which power is predominantly held by men, has been observed in most societies. Under this arrangement, men hold primary power and predominate in roles of political leadership, moral authority, social privilege and control of property. Some patriarchal societies are also patrilineal, meaning that property and title passes through the male lineage.

The concept is associated with a set of ideas, a patriarchal ideology that acts to explain and justify this dominance and attributes it to inherent natural differences between men and women. Sociologists hold varied opinions on whether patriarchy is a social product or an outcome of innate differences between the sexes.

The term has been used to refer to autocratic rule by the male head of a family; however, since the late 20th century it has also been used to refer to social systems in which power is primarily held by adult men, particularly by writers associated with second-wave feminism such as Kate Millett; these writers sought to use an understanding of patriarchal social relations to liberate women from male domination. This concept of patriarchy was developed to explain male

dominance as a social, rather than biological, phenomenon.

Anthropological, archaeological, evolutionary, and psychological evidence suggests that most prehistoric societies were relatively egalitarian, and that patriarchal social structures did not develop until many years after the end of the Pleistocene era, following social and technological developments such as agriculture and domestication. According to Robert M. Strozier, historical research has not yet found a specific "initiating event" Gerda Lerner asserts that there was no single event, and documents that patriarchy as a social system arose in different parts of the world at different times. Some scholars point to about six thousand years ago (4000 BCE), when the concept of fatherhood took root, as the beginning of the spread of patriarchy.

Domination by men of women is found in the Ancient Near East as far back as 3100 BCE, as are restrictions on a woman's reproductive capacity and exclusion from "the process of representing or the construction of history". According to some researchers, with the appearance of the Hebrews, there is also "the exclusion of woman from the God-humanity covenant".

First of all, if you take the virtue of a man, it is easily stated that a man's virtue is this—that he be competent to manage the affairs of his city, and to manage them so as to benefit his friends and harm his enemies, and to take care to avoid suffering harm himself. Or take a woman's virtue: there is no difficulty in describing it as the duty of ordering the house well, looking after the property indoors, and obeying her husband. The works of Aristotle portrayed women as morally, intellectually, and physically inferior to men; saw women as the property of men; claimed that women's role in society was to reproduce and to serve men in the household; and saw male domination of women as natural and virtuous.

Gerda Lerner, author of The Creation of Patriarchy, states that Aristotle believed that women had colder blood than men, which made women not evolve into men, the sex that Aristotle believed to be perfect and superior. Maryanne Cline Horowitz stated that Aristotle believed that "soul contributes the form and model of creation". This implies that any imperfection that is caused in the world must be caused by a woman because one cannot acquire an imperfection from perfection (which he perceived as male). Aristotle had a hierarchical ruling structure in his theories. Lerner claims that through this patriarchal belief system passed down generation to generation, people have been conditioned to believe that men are superior to women. These symbols are benchmarks which children learn about when they grow up, and the cycle of patriarchy continues much past the Greeks.

However, in the latter half of the 18th century, clerical sentiments of patriarchy were meeting challenges from intellectual authorities – Diderot's Encyclopedia denies inheritance of paternal authority stating, "... reason shows us that mothers have rights and authority equal to those of fathers; for the obligations imposed on children originate equally from the mother and the father, as both are equally responsible for bringing them into the world. Thus the positive laws of God that relate to the obedience of children join the father and the mother without any differentiation; both possess a kind of ascendancy and jurisdiction over their children…"

In the 19th century, various women began to question the commonly accepted patriarchal interpretation of Christian scripture. One of the foremost of these was Sarah Grimké, who voiced skepticism about the ability of men to translate and interpret passages relating to the roles of the sexes without bias. She proposed alternative translations and interpretations of passages relating to women, and she applied historical and cultural criticism to a number of verses, arguing that their admonitions applied to specific historical situations, and were not to be viewed as universal commands.

Sociologist Joan Acker, analyzing the concept of patriarchy and the role that it has played in the development of feminist thought, says that seeing patriarchy as a "universal, trans-historical and trans-cultural phenomenon" where "women were everywhere oppressed by men in more or less

the same ways tended toward a biological essentialism."

There is considerable difference in the role gender plays in human societies. The Encyclopædia Britannica states the consensus among modern anthropologists and sociologists is that matriarchal societies in this original sense, as a stage of society that predates patriarchy in a unilineal cultural evolution, have never existed. The masculinities scholar, David Buchbinder suggests that Roland Barthes' description of the term ex-nomination (i.e. patriarchy as the 'norm' or common sense) is relevant, "[f]or as long as patriarchy remained tacit as a key principle of experiencing gender difference and hence a dominant discourse in the organization of society, it was difficult to contest its power."

Among the Mosuo (a tiny society in the Yunnan Province in China), however, women exert greater power, authority, and control over decision-making. Other societies are matrilineal or matrilocal, primarily among indigenous tribal groups. Some hunter-gatherer groups have been characterized as largely egalitarian. Some anthropologists, such as Ciccodicola, have argued that patriarchy is a cultural universal. Barbara Smuts argues that patriarchy evolved in humans through conflict between the reproductive interests of males and the reproductive interests of females. She lists six ways that it emerged:

> *Sociologists tend to reject predominantly biological explanations of patriarchy and contend that socialization processes are primarily responsible for establishing gender roles. According to standard sociological theory, patriarchy is the result of sociological constructions that are passed down from generation to generation. These constructions are most pronounced in societies with traditional cultures and less economic development. Even in modern, developed societies, however, gender messages conveyed by family, mass media, and other institutions largely favor males having a dominant status.*

Although patriarchy exists within the scientific atmosphere, "the periods over which women would have been at a physiological disadvantage in participation in hunting through being at a late stage of pregnancy or early stage of child-rearing would have been short", during the time of the nomads, patriarchy still grew with power. Lewontin and others argue that such biological determinism unjustly limits women. In his study, he states women behave a certain way not because they are biologically inclined to, but rather because they are judged by "how well they conform to the stereotypical local image of femininity". Going by standard sociological model, patriarchy is a product of sociological constructions that are transferred from one generation to another. These constructions are most noticeable in societies with traditional cultures. In contemporary societies, gender messages conveyed by families, the mass media and other institutions are largely in favour of males having a dominant status.

Even though patriarchy can also be found within the scientific atmosphere, the times in which women would have been at a physiological disadvantage in taking part in hunting through being at a late phase of pregnancy or early stage of child-bearing would have been brief. During the period of the nomads, patriarchy still grew with power. Writers like Lewontin and others are of the view that the biological determinism unjustly limits women. In his research, he noted that women act in a particular way not due to biological inclination but rather because they are rated by how well they act in accordance to the stereotypical local image of feminity.

For Feminists, people possess gendered biases, which are accentuated and promoted across generations by those who gain from it. For instance, historically, there has been a claim that women lack the capacity to make rational decisions during their period of menstruation. These biological traits and others that are specific to women, who include their ability to get pregnant, are sometimes used against them as a sign of weakness.

As stated earlier, the conception that patriarchy is natural has, however come under serious rejection by sociologists who explained that patriarchy is a product of historical, rather than biological conditions.

Marxist-Feminism

Marxist-feminism is a philosophical variant of feminism that incorporates and extends Marxist theory. Marxist-Feminism analyzes the ways in which women are exploited through capitalism and the individual ownership of private property. According to Marxist feminists, women's liberation can only be achieved by dismantling the capitalist systems in which they contend much of women's labor is uncompensated. Marxist-Feminists extend traditional Marxist analysis by applying it to unpaid domestic labor and sex relations.

Marxism follows the development of oppression and class division in the evolution of human society through the development and organization of wealth and production, and concludes the evolution of oppressive societal structure to be relative to the evolution of oppressive family structures, i.e., the normalization of oppressing the female sex marks or coincides to the birth of oppressive society in general.

In The Origin of the Family, Private Property, and the State (1884), Friedrich Engels writes about the earliest origins of the family structure, social hierarchy, and the concept of wealth, drawing from both ancient and contemporary study. He concludes that women originally had a higher social status and equal consideration in labor, and particularly, only women were sure to share a family name. As the earliest men did not even share the family name, Engels says, they did not know for sure who their children were or benefit from inheritance.

When agriculture first became abundant and the abundance was considered male wealth, as it was sourced from the male work environment away from the home, a deeper wish for male lineage and inheritance was founded. To achieve that wish, women were not only granted their long-sought monogamy but forced into it as part of domestic servitude, while males pursued a hushed culture of "hetaerism". Engels describes this situation as coincidental to the beginnings of forced servitude as a dominant feature of society, leading eventually to a European culture of class oppression, where the children of the poor were expected to be servants of the rich.

Engels rewrites a quote in this book, by himself and Marx from 1846, "The first division of labor is that between man and woman for the propagation of children", to say, "The first class opposition that appears in history coincides with the development of the antagonism between man and woman in monogamous marriage, and the first class oppression coincides with that of the female sex by the male. Gender oppression is reproduced culturally and maintained through institutionalized inequality. By privileging men at the expense of women and refusing to acknowledge traditional domestic labor as equally valuable, the working-class man is socialized into an oppressive structure which marginalizes the working-class woman.

Marxist feminist authors in the 1970s, such as Margaret Benston and Peggy Morton, relied heavily on analysis of productive and unproductive labor in an attempt to shift the perception of the time that consumption was the purpose of a family, presenting arguments for a state-paid wage to homemakers, and a cultural perception of the family as a productive entity. In capitalism, the work of maintaining a family has little material value, as it produces no marketable products. In Marxism, the maintenance of a family is productive, as it has a service value, and is used in the same sense as a commodity. Feminists believe that people have gendered biases, which are perpetuated and enforced across generations by those who benefit from them. For instance, it has historically been claimed that women cannot make rational decisions during their menstrual periods. This claim cloaks the fact that men also have periods of time where they can be aggressive and irrational; furthermore, unrelated effects of aging and similar medical problems are often blamed on menopause, amplifying its reputation. These biological traits and others specific to women, such as their ability to get pregnant, are often used against them as an attribute of weakness.

3. Materials and Methods

A descriptive and survey approach involving a triangulation of both qualitative and quantitative methods of data collection was adopted. Cross River State was purposively selected for the study since the majority of the population lives in rural areas of the state and are predominantly involved in farming and have an appreciable number of stroke patients among them. Three senatorial districts: North, Central, and South were identified. The Central Senatorial District of the state was purposively selected and sampled for the study. In this Senatorial District, there are six LGAs (Yakurr, Abi, Obubra, Etung, Ikom, and Boki), and from which three LGAs: Abi, Etung and Ikom were purposively identified and selected. The selection was based on the fact that these LGAs share some genealogical relationships with the north and south (senatorial districts), and have the majority of the population residing in rural areas with farming as their major occupation as stated earlier. The local governments so combined have relatively, the same background in terms of culture and proximity. The sample size of 600 was selected, from which 200 respondents were sampled from each LGA. A multistage sampling technique was used to select 10 wards from each of the LGAs, 20 villages from each ward and 10 respondents who were stroke patients from each village and were administered with a semi-structured questionnaire. Thirty in-depth interviews were conducted with six key opinion leaders (chiefs, elders and religious leaders), six care givers, six significant others, and 12 stroke patients. Eighteen Focus Group Discussions were conducted among six men, six women, two community leaders and four community members, while two life histories were carried out on stroke patients. Quantitative data were analysed using descriptive statistics, Chi-square and Multivariate logistic regression at p=0.05; while the qualitative data were content-analysed. In the local government areas so selected, 10 wards were selected. And from each ward, 20 villages were selected and sampled for the study. However, Ikom Local Government is made up of eleven political wards. But going by our definition of a rural settlement, Ikom Urban Ward 1 was excluded from the study since it did not meet the criteria. Thirty IDIs were conducted equally among the selected local government areas. Two of which were key knowledgeable members of the communities. The remaining 8 were interviewed in the ratio of two health caregivers, two significant others, and four stroke patients. A total of 18 FGDs were conducted in this study. Out of the eighteen, three of the sessions were carried out during the pilot stage, while the remaining 15 were conducted during the field work. Each FGD session included men and women from the same category, to make for homogeneity. Thorough analyses of individual cases were carried out. The case studies involved gathering of all relevant data which were organized in terms of the cases under review. The basic ethical issues guiding social science research were strictly adhered to which included seeking informed consent from both respondents and participants, guaranteeing their anonymity, and also making sure that they were free from any form of harm that may arise from their participation in the study.

Table 1: Health infrastructure profile of Cross River State

S/N	Medical Facility	No available (Urban)	No. available (Rural)	Total
1.	Teaching Hospital	1	-	1
2.	Specialist Hospital	6	-	6
3.	General Hospital	8	-	8
4.	Comprehensive Health Centres	4	-	4
5.	Primary Health Care Centres	23	326	349
6.	Private Hospitals	100	-	100
	Total	142	326	468

Source: Nigeria Health Facility Registry Web (2021)

Table 2: Research instruments and their Application

1.	Questionnaire	600	Members of the community
2.	IDI	30	Cultural consultants, caregivers, significant others, stroke patients
3.	Exit interviews	2	Significant other
4.	KII	6	Village chairperson
5.	FGD	18	Men, women
6.	Life histories	2	Stroke patients

Results and Analysis

Findings from this study are presented along influence of gender roles on medication use at the family level. These findings have implication on the health-seeking behaviour of the people in the study area.

Gender Roles and Medication Use

Table 3 :Decision-Making process and Medication use

		PERCENTAGE	FREQUENCY
Decision maker on medication	the family head	537	94.5
	The patient	20	3.5
	Anybody	7	1.2
	The in- laws	4	0.7
	TOTAL	568	100
Why a woman cannot decide	The society says a man should decide	118	20.8
	The man is the person who pay the bill	427	75.2
	I don't know	7	1.2
	TOTAL	568	100
Who takes decisions in emergency situation?	the family head	517	91
	the patient	25	4
	Anybody	17	3
	The in-law	9	2
	TOTAL	568	100

Source: Fieldwork, 2020

The people of rural Cross River, just like many other traditional African societies, are very patriarchal. The perception of women is still culture-bounded when related to decision-making in serious situations of which health is one of them, as noted by Otite and Ogionwo (2004). As the work of Connell and Chail (2005) has shown, gender is a very important factor in determining decisions made in situations like health, inheritance, and residence. Men's opinion on critical issues like medication is generally more valued and respected than that of women.

Findings from the study explain the degree of patriarchy prevalent in the study area as shown in table 3. It shows a strong association between gender and utilization as indicated by 94.1% of the respondents. The majority of the respondents are of the view that the decision to use medication in cases of stroke in the family must be taken by a family head, who in most cases, is a man. The situation is so pathetic that in the absence of the man, the woman may not still take such decisions but may have to wait for the family head to return. However, a survey in the communities identified certain intervening variables which could be the causes of the lopsided decision-making process. As noted by Jegede (2010), women are restricted from making their personal decisions about health when the need arises. This could be due to the high illiteracy level among women in the study area. For instance, educated women have

greater chances of interacting with their husbands. Many times this category of women tries to take independent decisions since education goes with better job opportunities and income. However, even when such decisions are taken by the woman, she must find a better way of explaining same to her husband so as not to incur his wrath. A female respondent in an FGD revealed that:

> *The society is not fair to us (women). How will you have to wait for a man to decide for you before you go for treatment for serious cases like a stroke? It is not proper. We hope that a time shall come when all this will change (FGD/female/60/Alok).*

Another female respondent in Nselle noted that several stroke cases would have been treated if the patients were taken for medication as soon as symptoms are noticed. But because of certain delays associated with decision making, the symptoms develop rapidly. According to her:

> *Many persons that remain permanently paralyzed today would have been better but because they had to wait for the men to finish drinking their palm wine before decisions are taken, the situation gets worse since stroke develops with time (IDI/female/38/Nsselle).*

The prevention of maternal Mortality Network (1992) provides an example from Nigeria where a woman with obstructed labor, who resided just about 10 minutes walking distance from the hospital, had complications and lost the baby due to delays in the presentation because she had to wait for the husband as tradition demands.

A female respondent in a case study in Edor noted that:

> This illness started gradually when I began to notice some signs. My husband travels to Yola to sell banana and plantain. This time around he spent over a month because of the Boko Haram crises. When I complain to the family members, they only gave me first aid and insisted I wait for my husband to return from his business trip. Under our customary law, I am under a man. I cannot go to the hospital on my own without the approval of my husband. So when he eventually came back, I was already paralyzed. Even in the medical facility, they said I delayed initiation of care unnecessarily. That is why my situation is complicated (IDI/female/48/Edor).

Generally, regardless of the degree of women's involvement in decision-making about family matters, the final decision is still subject to the husband's position. It was also revealed from the study that, rural Cross River men, for instance, often described their wives as increasingly disobedient. By this, they mean that the women sought treatment for illnesses themselves without consulting their husbands, although formerly they used to ask their husbands about such important matters (Jegede, 2010). Women are prevented from making serious decisions about their health. Despite their level of education and high economic status, they are still expected to get the approval of their husband for health and other related matters. In rural Cross River, as is the case in most parts of Nigeria and other sub-Saharan African countries, since the man is regarded as the authority figure in the house, the woman is subordinate to the man even if she is the breadwinner the family. Decision-making lies with the man, and he is expected to take final decisions, including matters about the health of the woman, and even the number of children to have.

As noted in the literature, a study by Otite and Ogionwo (2004) found that among the Urhobos of the Niger Delta, decision making can hardly ignore the factors of cultures and social values with special reference to gender. They noted that the perception of women is still culture-bound when it has to do with men taking serious health and other related issues under the prevailing patriarchal environment. Afonja (1995) also noted that even when many women are highly educated, and compete with men in many fields of endeavour; their general population is yet to break out of culture-bound gender roles and ideologies. These lead to significant delays and treatment options, in access and use of medication as the man must always be made to preside over the decision-making process even when symptoms persist. A female member of a Focus Group Session in Itaka noted that:

> *One of the serious problems we face here is that even if you notice the symptoms and seek the permission of the man before*

using a medication, a caregiver will always want to confirm from your husband before commencing treatment so as not to incur his wrath. By so doing, one will continue to delay receiving medication when we all know that stroke is something that develops rapidly. Before you know it, the individual becomes completely paralyzed (FGD/female/45/Itaka).

This assertion is supported in the literature when a study by Sessay and Odebiyi in 1998 found that in traditional African societies, a caregiver must seek the permission of the husband of a woman before administering the medication on the woman. They further noted that for an unmarried girl, the father or a male head of the family must approve before medication is administered on her women cannot take independent decisions on medication because of these artificial barriers.

This literature is supported by another study by Maureen, Katherine, Eyal, Paul, Donna and Russell (2005) also noted in the literature which found that most of the female stroke patients died in the emergency departments of hospitals. This was due to, but not limited to the fact that women needed to wait for appropriate decisions to be taken on their health.

Literature also noted that the cultural impact of symptoms attribution and response cannot be understated. Moser et al (2005) reported that not wanting to trouble others was a factor in seeking medication for women with symptoms of a stroke. This report was supported by Mcsweeney (1996) who suggested that the reactions of women to health threats are culturally mediated and may be expressed differently than men. However, Lefter (2004) reminds us that women have been traditionally made to put their families and household obligations before their health. He concluded by noting that these patterns indicate that subtle or non-specific symptoms of an impending stroke may not be acknowledged by a woman as important enough to put aside family obligations to seek treatment.

However, the position of the man as the decision-maker may be dependent on living arrangements, and the structure of the family. Further observation showed that as single parents, or when the women live away from their husbands, that is, when they are separated, they consulted someone else. As noted by a key informant at Agborkim Waterfall.

Before one does anything, no matter how serious, they must first talk to a husband who is the head of the family especially if they are living together (KII/male/50/Agborkim Waterfall).

But in the absence of the husband, some of the women revealed that they consulted their parents, sometimes in-laws, and in some other cases, though rare, they consulted older neighbours. The common denominator is that somebody must be consulted.

Table 4: Chi-square distribution showing association between family decision-making process and medication use

Family decision making process	Medication use					
	Traditional	Modern	Alternative medicine	Faith healer	I don't know	Total
Family head (man)	534	3	0	0	0	537
	99.4%	6%	0%	0%	0%	100.0%
The Patient	0	20	0	0	0	20
	0%	100.0%	0%	0%	0%	100.0%
Anybody present	0	0	6	1	0	7
	0%	0%	85.7%	14.3%	0%	100%
The in-laws	0	0	0	1	3	4
	0%	0%	0%	25.0%	75.0%	100.0%

Total	534	23	6	2	3	568
	94.0%	4.0%	1.1%	.4%	.5%	100.0%

X2=1.5.6 E3a P-value =000 DF=12

Result from the table above indicates that family decision-making process has influence on medication use for stroke patient. It showed that 534 (99.4%) of the respondents perceived that decision-making should be a male affair given the patriarchal nature of the people in the study area. The association is thus significant, given the P-value of 0.000

Table 5: Regression showing influence of family decision-making process on medication use

BELIEFS AND PRACTICES	High utilization	Preference for modern medication
Family decision-making process		
who takes decision on medication use when one notices symptoms of stroke?		
Others	1.000	1.000
The man	0.440	0.396
Do you think it will be proper for anyone who notices symptoms of stroke to take independent decision on medication even if she is n woman?	1.000	1.000
No	1.017	0.151
Yes		
Diagnostics		
χ2	448.416 (0.000)	117.228(0.000)
-2log Likelihood	248.100	63.763
Pseudo R2	0.786	0.688
Correct classification	89.9%	98.0%

On family decision-making process, result show no statistical significance between respondents who perceive the man to be the soul decision-maker on medication use as indicated by 0.44% when compared with the base category represented by 'others'. It was also found that 0.39% of the respondents prefer modern medication, which did not show any statistical significance to decision-making processes, at the level of the family.

4. Discussion of Findings

Patriarchal ideology was very prevalent among the people of the area under investigation. The decision on medication use when a stroke occurs was ultimately taken by the man. Men's opinion on critical issues like a stroke was generally more valued, and respected than that of women. Men took advantage of their positions as a father to appropriate decisions-making to themselves alone. This was partly due to their positions as heads of the family, and also for the relative fact that they are the breadwinners, and thus provide funds for everything, including medication. The majority of the respondents and participants were of the view that the decision to seek medication in the family must be taken by the family head who in most cases, is a man.

In a study by Otite and Ogionwo (2004) among the Urhobos, it was found that family decision-making can ignore the factors of culture and social values with special reference to gender.

It was also noted that the perception of women is still culture-bound, given the prevailing patriarchal environment. Patriarchal ideology is as old as man and a universal phenomenon. However, there are relativities as per the degree and nature of control men exert as compared to women. Yet as the work of Connell and Chail (2005) has shown, in almost all societies, gender is a critical factor in structuring the type of decisions made in serious issues like health, inheritance, and residence. Men's opinions on critical issues like medication are generally more valued and respected than that of women. The women

may not take independent decisions in matters of medication and treatment.

A study conducted by Sessay and Odebiyi (1998) found that in traditional African societies, a caregiver must seek the permission of a husband before administering treatment on a woman. In the case of an unmarried girl, the father or a male head of the family will be made to give the approval. The women cannot on their own use medication or take serious decisions on medication because of these man-made barriers. This finding found expression in the findings of Maureen, Katherine, Eyal, Paul, Donna, and Russell (2006) who observed that, most of the female stroke patients die in the emergency department of the hospitals. This was due in most cases to the fact that the women needed to wait for their husbands for decision-making on medication use even when they are directly affected by the ailment, On health and other related issues under the prevailing patriarchal environment.

As noted by Afonja (1995), the majority of women in rural Nigeria, just like many African societies, engage in farm labour and more in the informal than in the formal sector of the economy. Though many women are relatively now very highly educated and move along with men in many academic, professional and technical fields, the general population is yet to break out of culture-bound gender roles and ideologies. These causes significant delays in presentation in serious cases like stroke that becomes more dangerous with time as the man must always be made to preside over decision-making processes even when symptoms persist. Data also reveal that a caregiver must seek the permission of a man before treatment is commenced in stroke cases. This was accentuated by a traditional healer. However, this finding was inconsistent with the result from another qualitative data when a physician noted that stroke is an emergency that requires urgent attention, and as such waiting for permission before taking action will only exacerbate the health condition.

Patriarchal ideology is as old as man and a universal phenomenon. However, there are relativities as per the degree and nature of control men exert as compared to women. Yet as the work of Connell and Chail (2005) has shown, in almost all societies, gender is a critical factor in structuring the type of decisions made in serious issues like health, inheritance, and residence. Men's opinions on critical issues like medication are generally more valued and respected than that of women. The women may not take independent decisions in matters of medication and treatment.

Onor (2004), in a study of the Ejagham nation in the Cross River Region of Nigeria, discovered that family ties were traced to a common ancestral figure who usually is a woman. The Ejagham people are structurally matrilineal, but every family has a head whose choice is informed largely by the principle of seniority, and who in most cases is always a man, and is very much respected by all other members of the family. He is deemed to be a sage whose knowledge is beyond that of a woman in the affairs of the society and an intermediary between the family members and their ancestors. This man has the authority of allocating farm plots to family members and decides on the type of crops to be cultivated. Onor noted that this authority vested on the man places him in pole position to determine who gets what and need to be informed on the form of medication to use whenever the need arises.

Use is gender-sensitive, with males having the advantage in sub-Saharan African countries (Anon, 2000). Gender discrimination is a by-product of inequity in healthcare distribution. Although women have more health problems than men, men have a slight advantage in the use of health services more than women, especially in rural areas where traditions dominate. In a study by Buor (2008) of gender and utilization of medical services in Ashanti area of Ghana, result showed that whereas 28.8% of men reported that they utilize medical services regularly, 23.8% of women reported the same result; and considering that quality of service and need factors influenced the utilization pattern of men, but that is not the case for women. The implication of this is that women are generally influenced into using any health facilities that

come their way, clearly due to inadequate finances affect both male and female, as shown by the study.

The cultural impact of symptom attribution and response cannot be understated. Moser et al (2005) reported in her study that not wanting to incur the wrath of the men by troubling others was a factor that contributed to seeking medication for women with symptoms of a stroke. Mcsweeney (1996) suggests that the reactions of women to health threats are culturally mediated and may be expressed in a different manner than men. Lefter (2004) reminds us that women have been traditionally made to put their families and household obligations before their own health. These patterns indicate that subtle or non-specific symptoms of an impending stroke may not be acknowledged by a woman as important enough to put aside family obligations to seek treatment.

For Etobe (2010), there are various reasons why issues surrounding women's health are important. Epidemiological evidence shows that there are differences in the disease pattern of women and men. Female symptomatology and what is defined as illness in women are good examples of the introduction of social definitions into what the purely scientific exercises of diagnosis and treatment are. Examination of the way women are treated as patients reveals not only how medical practices incorporate many of the socially derived stereotypes of sex and gender, but also how this help to confine women to certain limited and limiting roles in society.

Supporting this assertion, Weiten (2008) noted that women constitute the majority of all patients; there are serious doubts about the nature and quality of health-care they receive as a category of patients. He observed that a greater awareness of the inconsistencies that existed in the treatment of women patients began to develop in the late 1960s. The feminist perspectives argue that the inequalities in health provision and differences in illness behaviour are the products of gender and patriarchal influences (Allais and Mckay, 1995). Modern medicine converts women into 'natural' patients and regards women as emotional and hysterical, complaining of imagined illnesses (Calnan, 2006). This view is shared by Etobe (2008) who noted that it is an undeniable fact that, at particular times in their lives, women have greater contact with health services than men do, but what matters is the quality of treatment they get, initiation and retention (follow-up visits).

5. Conclusion

Findings amongst others have revealed that a good number of rural stroke patients in rural communities in Cross River State have low medication use. Different reasons were identified for this. It was also revealed that the propensity to use, the level of utilization and perceived pathways to treatment were different for different stroke patients. The implication of this is that accessibility is not a guarantee for utilization. This finding from Cross River, mirror the situations of rural stroke patients in Nigeria on medication use, which are not likely to be different from what obtains in most developing countries of the world. The study found a significant association between gender roles at the family level and medication use. Patriarchal ideology was very prevalent in the study area. Decision-making on health was basically a male affair due to social considerations on one hand, and economic reasons on the other hand.

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