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Gender inequality in reproductive health services and sustainable development in Nigeria: A theoretical analysis

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If policies for the promotion of gender equality are to be realizable their goals must include equitable distribution of health related resources in line with MDG goals 3 and 5 which focus on promoting gender equality, empowerment of women and family planning. This requires careful identification of the similarities and differences in the use of family planning as a component of reproductive health. It also necessitates an analysis of the gendered obstacles that currently prevent men and women from participating or using family planning. Reasons for inequalities in the use of family planning include patriarchal culture, religious beliefs and sex preference manifested in discrimination against female children in health and general care. This paper examines gender inequality in family planning practice and sustainable development in Nigeria, using Patriarchal theory as the framework. The paper strongly argued that socio-cultural factors as well as gender roles influence the use of family planning and affect health and sustainable development in Nigeria. It outlines some measures for change which include policies to ensure universal access to reproductive health care, to reduce gender inequalities in access to resources and to relax the constraints of rigidly defined gender roles. The paper recommends that strategies to improve true sustainable development will depend on the empowerment of women in Nigerian through education and access to socio economic opportunities. The paper further recommends policy initiatives to include men in family planning programmes in Nigeria to engender equity in health and sustainable development.

Key words: Gender equity, family planning, patriarchy, sustainable development.

INTRODUCTION

Over the past few decades, global research has shown that gender inequalities can give rise to health inequities between men and women and between boys and girls. In developing countries of the world, differentials in morbidity and mortality between men and women arising

from sex and gender have been established across diseases and health conditions (Jamison, 2006). The differences in morbidity arise largely from pregnancy, complications from child birth such as severe bleeding, and abortion which are results of challenges in

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reproductive health services utilization. Again, the mortality rate amongst child bearing women is often high in developing nations. For example, the maternal mortality ratio of 630 deaths per 100,000 births in Nigeria is among the 10 highest of such rates in the world (WHO et al., 2012). Scholars are in agreement that there are some inevitable differences in the reproductive health needs and status of men and women in these nations. Unfortunately, many health systems and interventions have failed to respond to these different needs, typically disadvantaging women over men (Jamison, 2006). Indeed, research shows that all aspects of the reproductive health of men and women – including family planning are influenced by gender inequality. In many communities, women tend to have less access to the resources that could help them overcome existing vulnerabilities. These gender differences appear to be greater where women have relatively lower socio-economic status than that of men (WHO, 2011, Nelson, 2011). Gender inequality intersects with other social determinants of health, such as race, ethnicity and socio-economic status, to produce health disparities between men and women that are similar to social divisions within society (WHO, 2008). In other words, gender is an important factor in the promotion of health equity. The point being made here is that gender determines production and social relations as most productive resources are controlled by men and this in turn affects health disparities between men and women (Ezeah, 2004). These health disparities tend to reflect the underlying distribution of roles and power between men and women in society, resulting in constraints on the ability of men and women to influence their own health outcomes, and thus are considered unfair and unjust. Therefore, promoting gender equality has become a global concern, prompting the emergence of a globally accepted strategy referred to as ‘gender mainstreaming’, which acts as a means to achieving gender equality (WHO, 2008). Gender mainstreaming considers the concerns and experiences of men and women as an integral dimension of all phases of programme and policy development. In the context of health, gender mainstreaming can be summarized as reducing inequities in health status and access to health care between men and women. Both men and women must have the same chances and opportunities from health policies and programmes. This is referred to as gender equality, and acts as a prerequisite for health equity (WHO, 2009), and aims to ensure equal conditions for both men and women to realize their full rights and potentials to be healthy, contribute to their community health development, and be able to benefit from the results. Sexual and reproductive health and rights are fundamental human rights and ethical imperatives that lie at the core of advancing women’s empowerment and gender equality; and investing in them is central to achieving broader social, economic and sustainable development goals.

Specifically in this paper family planning as a component of reproductive health is used to demonstrate the linkages between gender inequality in health among men and women and sustainable development in Nigeria. Family planning has been identified by the World Health Organization (WHO) as one of the six essential health *interventions* needed to achieve safe motherhood and by United Nations Children Emergency Fund (UNICEF) as one of seven strategies for child survival (Hyeladi et al., 2014). In Sub-Sahara African as a whole only 27 % of married women are using contraceptives (UNDESA, 2004). Male involvement in family planning makes up a relatively small subset of the above prevalence rates although data for men are not available in literature (WHO, 2013). In other words throughout the ages, the use of family planning between men and women has never been close to equality. Even in the most advanced countries, gender equality in family planning use has however remained a top priority issue (Cleland et al., 2006). In Africa, there are many obstacles that impede people from using contraceptives ranging from cultural, social factors and structural factors like less access, availability and affordability of contraceptives.

In Nigeria, it can be observed that men are not included in family planning programmes (Ijadunola et al., 2010). This is probably because the family unit in Nigeria is; essentially patriarchal and patrilineal, with all the important decisions taken by the male head while the woman’s fundamental social role is to bear and raise children and engage in productive tasks within the household. The patriarchal nature of the society, traditional beliefs, religious barriers and a general lack of male involvement have weakened family planning interventions in Nigeria. Inequality results from the denial of family planning services as culture requires that married women must obtain their husbands’ consent among other restrictions. Again, women are usually socially and economically dependent on their husbands (Ijadunola et al., 2010). This may have contributed to Nigeria becoming a country in Africa with the fastest population growth averaging 5.2 births per woman and with attendant high maternal and child mortality. Furthermore, rapid population growth makes it difficult for the Nigerian economy to create enough jobs particularly for women and youths to lift large numbers of people out of poverty, maintain healthy living conditions and protect the environment (Ityai, 2000, World Population Data Sheet, 2013). This underscores the need to step up family planning practices in Nigeria which is presently affected by gender imbalance as a result of non involvement of men. Unfortunately, gender inequality in reproductive health (family planning) and sustainable development in Nigeria has not received adequate treatment in literature. Thus, the focus of this paper on gender inequality in family planning aimed at theoretically analyzing the nexus between gender equality and reproductive health equity in Nigeria to redress the population challenges in the

country. The point is that high fertility and low family planning practices occasioned by gender inequity strongly affect sustainable socioeconomic development in Nigeria (NDHS, 2008). According to NDHS (2008), the contraceptive prevalence rate for Nigeria was 14.62% for any method and 9.7% for modern methods in 2008. This scenario is largely due to a culture that is highly supportive of large family size, misconceptions about family planning methods, and male child preference. Other major factors include inadequate access to family planning services, poor quality of services and inadequate demand creation efforts (UNFPA, 2012). Igbudu et al. (2007) observed that the desire by most individuals and couples for a large family size is as a result of the positive value which the Nigeria society attaches to marriage, family life and procreation. It is a deep-seated traditional value which is supported by the dominant religious beliefs of Christianity, Islam and Traditional religions to the extent that all the religions abhor barrenness.

We therefore argue in this paper that gender inequality in family planning practice in Nigeria has far reaching consequences on the reproductive health of women and sustainable development in the country which must be critically analyzed and understood. This will help to deal with the population challenges in Nigeria. Family planning practice should be particularly beneficial to developing nations like Nigeria that are trying to achieve demographic transition from high to low fertility. This is because fertility level is a critical index used in measuring socioeconomic development and underdevelopment between nations. This paper is therefore a theoretical analysis of gender inequality in family planning practices and sustainable development in Nigeria.

CONCEPTUAL ISSUES

The following concepts are clarified for proper elucidation in this paper.

Gender

According to Ezumah (2003), gender refers to characteristics that are socially constructed for women and men such as roles, attitudes, behavior, and values. Most people are born with a defined sex, but they learn respective appropriate norms and behaviors from their societies, including proper interactions with individuals of the same or opposite sex, within households, workplaces and their communities (Ezumah, 2003). Gender characteristics are assigned to men and women during their childhood and are expected to be followed; and they vary across cultures and over time; they thus are amenable to change.

For Ezumah (2003), gender consists of two categories, feminine and masculine. Masculine, the male gender is perceived to be tough and strong, while the feminine or

female gender is soft and weak (Oakley, 1980; Oyewumi, 2002; Germov, 2010 cited in Ngum, 2012). Gender can be best described as both a psychological and cultural term, widely used to rationalize the subordination of women globally (Oakley, 2005 cited in Ngum, 2012). Gender is not biological nor genetic; rather gender and the roles one plays within their families and society are assigned to them, and are shaped by the societal beliefs in which the person is born into or lives in (Oakley, 1980 cited in Ngum, 2012).

Gender equity

According to Ngum (2012), gender equity is the process of being fair to both women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity can be understood as the means, where equality is the end. Equity leads to equality.

Gender Mainstreaming:

Gender roles

Gender roles are those behaviours and activities that men and women are to play or do within their families, relationships and communities because of their gender (Shearer et al., 2005; O'Sullivan et al., 2006; Boileau et al., 2008; Dlamini et al., 2009 cited in Ngum, 2012). Men and women bring different values and expectations into the relationship, shaped and influenced by different roles assigned to these individuals at birth. These roles affect women and men differently and at varying levels, with women often disproportionately affected. These levels include the relationship level and the actual sexual enactment level (Shearer et al., 2005 cited in Ngum, 2012).

Gender-based roles are the roles men and women are to play within their families and subsequent relationships because of them being of male or female sexual category (Maticka-Tyndale et al., 2005 cited in Ngum, 2012). For example, some gender-based roles assigned to women include doing the housework, cooking, cleaning, fetching water, sewing, doing needlework and caring for the children. Conversely, gender roles assigned to men include men doing paid work out of home, splitting wood, dress up in suits and ties, attend and preside over special traditional ceremonies, dressing up in suits and ties, requesting or asking the woman's hand in marriage. Some cultures and religious organizations expect women to wear veils and dress conservatively (Boileau et al., 2008 cited in Ngum, 2012).

In some societies, gender-based roles extend beyond what women can do and wear to what they can eat, where they can go, and with whom they can interact. Such gender roles imposed on women may inhibit or

deprive women of their freedom and liberty, foster poor self-esteem, lower levels of achievements, and may result in poor health outcomes (WHO, 2007). In more traditional societies where gender roles are re-enforced through cultural practices, the level of school attainment and completion, positions held by women in political office and decision making within organisations are considerably lower compared to societies where roles are shared (Boileau et al., 2008 cited in Ngum, 2012). When women have low or poor participatory rates this affects their health and that of their families negatively. For teenage girls and women this could mean low self-esteem, or engaging in transactional sex for livelihood (Wamoyi et al., 2011 cited in Ngum, 2012). The consequences are poor health decision making, poor outcomes for the girl and her family (Westercamp et al., 2010 cited in Ngum, 2012).

Gender-based roles do change as the society develops and this affects women's attitudes towards traditional gender roles (Boileau et al., 2008 cited in Ngum, 2012). An example of a gender role that has evolved and changed significantly is women gaining paid work outside of their homes (Ngum, 2012). This means that women get up in the morning, dress up for work outside of the home; their husbands, or another paid individual or institution take the responsibility to care for the children, clean the house, do the ironing, and cook the food for the family (Ngum, 2012).

Are behaviors that are expected from men and women. Gender roles are learned and vary across cultures and over time; they are thus amenable to change.

Health

In the preamble of the WHO (1948, p. 100), health is defined as a state of complete physical, social and mental wellbeing of an individual and not merely the absence of disease or infirmity. Health is not just about one's physical health but includes the social, emotional and physical health. The social and cultural context in which, including their identities and the constraints they afford affect their health. Further, the environment from where the persons come from, their health beliefs and socio-economic status all affect their health directly and indirectly. Public health and population health is concerned with understanding health and disease occurrence in the community, and improving health and wellbeing (Ewles, 2005; Baum, 2008; Greiner and Edelman, 2010 cited in Ngum, 2012). Health gains are achieved through prioritizing health approaches and addressing the inequalities in health status that exist between social groups (Lin et al., 2007 cited in Ngum Chi, 2012).

A recent World Health Organization (WHO) report on 'Trends in maternal mortality: 1990-2013' classifies

Nigeria as of the 10 countries of the world that contribute about 60 per cent of the world's maternal mortality burden. Though Nigeria currently has a maternal mortality ratio of 560 per 100,000 live births, the ratio improved slightly moving from 630 per 100,000 recorded in 2010 (World Population Data Sheet. (2013).

Health experts explain that 1 in 4 maternal deaths are caused by preexisting medical conditions such as diabetes, HIV, Malaria, and Obesity. These health conditions are usually aggravated by pregnancy. Other identified causes of maternal deaths include severe bleeding, pregnancy induced high blood pressure, infections, and abortion complications (Ezeah, 2004).

Reproductive health

Reproductive health is defined as a state of physical, mental, and social well-being in all matters relating to the reproductive system, at all stages of life. Good reproductive health implies that people are able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when, and how often to do so. Men and women should be informed about and have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and the right to appropriate health-care services that enable women to safely go through pregnancy and childbirth.

Sustainable development

According to the classical definition given by Brundtland Report (1987), the term sustainable development is usually understood as "intergenerational" equity which would be impossible to achieve in the absence of present-day social equity, if the economic activities of some groups of people continue to jeopardize the well-being of people belonging to other groups or living in other parts of the world. In other words the concept of sustainable development as defined by the Brundtland Report (1987) is the development that meets the needs of the present without compromising the ability of the future generations to meet their own needs of development (WCED, 1987). This suggests that the principal goal of sustainable development is meeting present human needs in such a way that will not jeopardize the potentials of posterity to meet their needs. Viewed from a holistic perspective, Wiedenhoef (1981) and Padisson (2001) noted that sustainable development entails the attainment of equilibrium among three contending sub-systems—economic, social-cultural and environment

According to the more operational (practice-oriented) definition used by the World Bank, sustainable development is "a process of managing a portfolio of assets to preserve and enhance the opportunities people face". The assets that this definition refers to include not just

traditionally accounted physical capital, but also natural and human capital. To be sustainable, development must provide for all these assets to grow over time—or at least not to decrease.

Sustainable development includes economic, environmental, and social sustainability, which can be achieved by rationally managing physical, natural, and human capital. Thus, sustainable development could probably be otherwise called “equitable and balanced,” meaning that, in order for development to continue indefinitely, it should balance the interests of different groups of people, within the same generation and among generations, and do so simultaneously in three major interrelated areas—economic, social, and environmental. Therefore, sustainable development is about equity, equality of opportunities for well-being, as well as about comprehensiveness of objectives. Obviously, balancing so many diverse objectives of development (economic objective: growth efficiency and stability; social objective: full employment, equity, security, education, health, participation and cultural identity; environmental objective: healthy environment for human, rational use of renewable natural resources and conservation of nonrenewable natural resources) is an important criteria for any nation on the road to sustainable development. Thus, to ensure that future generations inherit the necessary conditions to provide for their own welfare, our present day values must be educated enough to reflect their interests as well

More recently, the United Nations has popularized the multi-dimension term called sustainable development. This is defined as development that not only generates economic growth but distributes its benefits equitably; that regenerates the environment rather than destroys it; that empowers people rather than marginalizing them. It gives priority to the poor, enlarging their choices and opportunities, and provides for their participation in decision affecting them. Sustainable human development is pro-poor, pro-nature, pro-jobs and pro-women (Padişon, 2001). It stresses growth, but growth with employment, growth with environmental friendliness, growth with empowerment and growth with equity.

Theoretical Framework

This study is anchored on patriarchal theory.

Sir Henry Maine is the chief advocate of the patriarchal theory. He defines it as theory of the origin of society in separate families, held together by the authority and protection of the eldest male descendant (Retrieved from <http://oll.libertyfund.org/titles/2001>).

A patriarchal family is one in which descent is traced through males. Father or patriarch occupies a dominant position in the family. Patriarchy is the prime obstacle to women’s advancement and development. Despite differences in levels of domination the broad principles remain the same, i.e. men are in control. The nature of this control may differ. So it is necessary to understand

the system, which keeps women dominated and subordinate, and to unravel its workings in order to work for women’s development in a systematic way (Retrieved from <http://oll.libertyfund.org/titles/2001>).

In the modern world where women go ahead by their merit, patriarchy there creates obstacles for women to go forward in society. Patriarchal society gives absolute priority to men and to some extent limits women’s human rights also. Patriarchal theory provides a framework for this study. This is because patriarchal institutions and social relations are responsible for the inferior or secondary status of women in relation to reproductive health of women.

On the other hand, the word ‘patriarchy’ literally means the rule of the father or the ‘*patriarch*’, and originally it was used to describe a specific type of ‘male-dominated family’ (Sultana, 2011). In contemporary times it is used more generally “to refer to male domination, to the power relationships by which men dominate women, and to characterize a system whereby women are kept subordinate in a number of ways” (Bhasin, 2006:3).

Different scholars have also defined the concept of patriarchy in different ways. Mitchell, a feminist psychologist, uses the word patriarchy “to refer to kinship systems in which men exchange women” (Mitchell, 1971:24 cited in Sultana, 2011). Walby defines “patriarchy as a system of social structures and practices in which men dominate, oppress and exploit women” (Walby, 1990:20 cited in Sultana, 2011). She explains patriarchy as a system because this helps us to reject the notion of biological determinism (which says that men and women are naturally different because of their biology or bodies and, are, therefore assigned different roles) or “the notion that every individual man is always in a dominant position and every woman in a subordinate one” (Walby, 1990:20 cited in Sultana, 2011).

Patriarchy, in its wider definition, means the manifestation and institutionalization of male dominance over women and children in the family and the extension of male dominance over women in society in general. It implies that “men hold power in all the important institutions of society” and that “women are deprived of access to such power”. However, it does not imply that “women are either totally powerless or totally deprived of rights, influence, and resources” (Lerner, 1989:239 cited in Sultana, 2011).

Thus, patriarchy describes the institutionalized system of male dominance. So we can usefully define patriarchy as a set of social relations between men and women, which have a material base, and which, though hierarchical, establish or create independence and solidarity among men that enable them to dominate women (Jagger and Rosenberg, 1984 cited in Sultana, 2011). The patriarchal system is characterized by power, dominance, hierarchy, and competition. Thus, patriarchy is a system of social structures and practices, in which men dominate, oppress and exploit women (Sultana, 2011).

GENDER EQUALITY IN FAMILY PLANNING PARTICIPATION AND SUSTAINABLE DEVELOPMENT IN NIGERIA

The high rate of population growth in Nigeria is driven by high fertility rates. Researchers have suggested various reasons to explain why, despite the high fertility rates, acceptance and utilization of modern family planning methods remain low (Isiugo-Abanihe, 1994; Ijadunola et al., 2010). Family planning has beneficial effects in terms of sustainable socio-economic development and protection of the environment. Through family planning, individuals can obtain greater prosperity and security for the family because they can have a better chance of receiving an education and devoting more time in earning an income (Bayray, 2012).

Thus, the importance of family planning can be realized through active involvement of both sexes. This is because reproductive health requires active involvement of the entire family and society at large (Berhane, 2006). Furthermore, the 1995 World Women conference in Beijing reinforced the shared responsibility between men and women in reproductive health matters to improve women's health. This underscores the importance of male participation in family planning. Participation of men in family planning is not limited to the use of family planning methods, but also includes the supportive attitude that men have towards their wives in using family planning and motivation in sharing responsibility in reproductive health matters.

However, achieving the objective of men's participation in family planning is faced by many obstacles in Nigeria. In the traditional Igbo socio-cultural setting for example, family planning as a programme of reproductive health was not accepted as people believed that children were gifts from God. Even in the contemporary Nigerian society, most family planning programmes are exclusively female based (Isiugo-Abanihe, 1994; Ozumba, 2010). Women are usually the target groups while men are removed from family planning. The participation of men in family planning is constrained by cultural norms, tradition, values and religious beliefs.

A man that participates in roles socially defined for women is regarded as weak or lazy (Nwoko and Oguttu, 2010). Men are also recognized to be responsible for the large portion of the ill reproductive health suffered by their wives (Isiugo-Abanihe, 1994). Also, traditional social norms often require men to maintain the honor and position of their extended family, village, religious group or social organization. Therefore, men feel responsible for the behavior of their wives, and think that they have no right to make decisions for themselves (Tuloro and Deressa, 2006). Moreover, certain cultural practices like the preference of male children over their female counterparts influence a man to have as many children as possible especially when it comes to getting a male child. Some men fear that family planning may make their wives have sex with other men if they are no longer

at the risk of pregnancy. Some others think that large family size reflects their masculinity or their wives faithfulness in serving them (Bayray, 2012). This culture is deeply rooted and seems unchangeable. These ideas remain part of the social structure and hinder men from participating in family planning. Again, some religious organizations see family planning as evil (Bayray, 2012). The participation of men in family planning is crucial for successful family planning programmes and empowerment of women in Nigeria. When men participate in reproductive health services, as equal and responsible partners, there will be increased outcome in reproductive health indicators, safer sexual behaviours, use of reproductive health services, and a reduction in reproductive mortality and morbidity (Bayray, 2012).

The inequality between men and women in family planning participation in Nigeria tends to undermine the quality of life of women and sustainable development in the country. The fundamental cause is patriarchal culture which gives rise to the unequal access to socio-cultural resources between men and women in the country. As a result of patriarchy, certain rules and practices of society have kept women in a subservient role and the institutions of society, run by men, have continued this practice over time. Women are overburdened and subordinated by gender roles. It is strongly argued that women have a right to enjoy quality reproductive health status which they are bound to lose when there is inequality in the participation of men in family planning. The non participation in family planning by men has continued to pose tremendous challenges on their reproductive health and well-being. Consequently, women are thus debilitated by the effects of reproductive ill health, disempowerment and crushing poverty which adversely militate against sustainable development in Nigeria.

Conclusion

There are obvious nexus between gender inequity in reproductive health and sustainable development in Nigeria. Gender differences in access to and control over key material and social resources result not only in inequalities of health and wellbeing, but also inequalities in power, knowledge, making independent decisions relating to sexual and reproductive decisions and to act on them in health seeking behaviour (Oakley, 1998). According to Walby (1997), gender norms and values and the resulting behaviours are affecting reproductive health in a negative way. The fundamental cause is patriarchy and the unequal distribution of socio economic resources between men and women in Nigeria. Compared to men, women tend to have fewer resources to cope with health related issues which in turn affect their wellbeing and sustainable development in Nigeria. Women are unfairly discriminated and subordinated on the basics of their sex. Much of this discrimination is based on custom of the society and is the product of

gender roles. Since, the 1994 International Conference on Population and Development (ICPD), and the 1995 World Conference on Women, interest in men's participation in reproductive health has increased (Oyediran et al., 2002). In spite of this, the belief that family planning is largely a woman's business, with the man playing a peripheral role has continued to persist (Ijadunola et al., 2010). The inequality in reproductive health services between men and women engenders reproductive ill health, well-being of women and sustainable development in Nigeria

RECOMMENDATIONS

To promote gender equality in reproductive health in Nigeria, the following specific recommendations are put forward in this paper:

1. Free and compulsory education for the girl child must be sustained in Nigeria. This will help eliminate female illiteracy because good quality education is the bedrock of progress, enabling ideas and livelihoods to flourish. Sustainable development cannot be achieved when young girls' opportunities are stripped from them by not allowing them to go to school and close gender gaps.
2. Family planning service providers in Nigeria need to create adequate awareness through meetings, seminars and workshops with married couples, opinion and religious leaders to signify the importance of male participation in family planning.
3. Family planning services providers in Nigeria should develop a definite and detail work plan on the processes of male participation in family planning.
4. The government should develop policies that will reduce the disproportionate and increasing burden on women who have multiple roles including the child bearing roles within the family by providing them with adequate support and programmes in health and social services and encourage men to share equally in child care and household work.
5. The government should encourage women have universal access to quality, comprehensive and integrated information on reproductive health rights and services.
6. Education is important in equipping men with adequate knowledge regarding family planning, reduce the culture and tradition of patriarchy and also enhance the status of women in Nigeria.

There is need to include men in family planning programmes for this purposes, the following measures are recommended:

1. Family planning service providers in Nigeria need to create adequate awareness through meetings, seminars and workshops with married couples, opinion and religious leaders to signify the importance of male participation in family planning.

2. Family planning services providers in Nigeria should develop a definite and detail work plan on the processes of male participation in family planning.
3. Government should properly equip family planning centers in Nigeria with material for use by men
4. Family planning service providers in Nigeria should act as both motivators of men and their confidant to enhance their participation in family planning.
5. Family planning service providers in Nigeria should provide precise information to men on the various family planning methods and how they help to prevent child birth.

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