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Gender, Maternal Health and Development in Nigeria: A Literature Review

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Abstract

There has been high rate of maternal mortality in Nigeria, women dying every day in thousands and government policies on health have not been visible and where such policies come to stay they cater for the rich while the poor especially women in the rural areas do not benefit from them. The recent health insurance policy reveals that government health policies are made to soothe the elites. In a society where the child bearing power that readily resides in women is left to suffer set back then development of such society is at stake if not impossible. This paper assesses common challenges facing Nigerian women as regards gender inequality in the quest for health care delivery and development. The world Health Organization (2006) reports that Nigeria records the worst case of Obstetric Fistula affecting over 300,000 women annually with 576 of 100,000 maternal mortalities (Nigerian Urban and Reproductive Health Initiative, 2014) besides breast cancer incomplete abortion and still birth uterine fibroids has been on the increase killing women and rendering several ones infertile. This study also highlights Psycho-social theories in relation to gender.
Keywords: Development, Gender, Maternal Health.

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INTRODUCTION

Gender and Maternal health has been a serious concern for development in Nigeria the most populous black nation in the world with over 150 million populations. According to the Nigerian Demographic and Health Survey (NDHS, 2013, cited in The Nigerian Tribune, 26, September. 2014) about 23% of teenage girls between age 15 and 19 are already mothers or pregnant with their first child while half of the women between 25 and 49 were already married by age 18 and 61% were married at the age of 20. Also, the sexual and reproductive behavioural pattern of Nigerians shows that women and men tend to initiate sexual activity before marriage. These lifestyles coupled with high fertility and low contraception prevalence rate lead to unintended pregnancies, close birth spacing and high risk births (Clement, 2014). The World Health Organization (2006) revealed Nigeria as the country with the worst case of fistula globally with a record of 300,000 to 800, 000 cases annually. Mother and child wellbeing has been given very low concern and government policies do not readily provide adequate insurance for the common people especially the rural dwellers known for their agricultural support for the nation. The decrease in life expectancy is in large part reflective of the increased maternal and infant mortality. The continuous increase in maternal mortality in Nigeria has stimulated a re-examination of the issue in order to identify subtle, yet profound variables that may be responsible for this perennial problem, in order to attain development in health (Idowu, Osinaike and Ajayi , 2014).

Purpose of the study

The purpose of this study is to identify maternal health and gender challenges facing women and examine how such challenges affects development trends in Nigeria. The salience of this issue can be further seen from the numerous questions that past and present

research works raise such as; how high is maternal mortality and how can it be measured? In some cases, researchers attempt to investigate its biomedical causes. Other works on this subject matter have delved into its political dimensions and implications with a view on maternal health as a national priority. It is within this purview that, this paper attempts to assess the causes and socio-cultural determinants of poor maternal health while seeking plausible strategies or panacea towards improving maternal health as a national development priority. The finding in this research is expected to add value to knowledge both in the academic and health related fields.

Methodology

This study is a qualitative design which constructively reviewed empirical literature and related reports on gender, maternal health and development in Nigeria. The internet, Newspapers, and journals were critically assessed to help give this study a direction.

Gender Theories

Psychological Perspectives: Similarity or Difference? Within psychology, gender debates are more likely to address the question of whether the sexes are more similar or different. Sex differences have been an often-recurring theme in American psychology, which is generally characterized by essentialist explanations of gender and individualistic understandings of self (Bohan, 2002). For example, developmental psychologists have established predictable sequences of children's understanding of self, beginning with sex-related categorizations (i.e., male-female), moving to knowledge of sex-typed behaviors of self and others (i.e., masculine-feminine), and then to the presumed realization that sex is stable or constant (i.e., boys become men and girls become women) (Bigler, 1997; Signorella, Bigler, and Liben, 1993). In traditional studies of sex typing, many developmental and social psychologists have assumed that sex differences exist (e.g., Maccoby and Jacklin, 1974).

Feminist researchers increasingly argue that two categories are not adequate to describe variations in sex and gender experienced by individuals across their lives.

From a structural perspective, gender is the division of people into contrasting and complementary social categories, 'boys' and 'girls', 'men' and 'women'. In this structural conceptualization, gendering is the process and the gendered social order the product of social construction (Lorber, 1994).

Despite these cross-cutting statuses, the contemporary Western world is a much gendered world, consisting of only two legal categories – 'male' and 'female'. For individuals, gender is a major social status that is cross-cut by other major social statuses (racial ethnic, social class, religion, sexual orientation, etc.) and so gender is actually not a binary status, even though it is treated as such legally, socially and in most social science research (Lorber, 1996). On an individual basis, gender fragments; from a societal perspective, gender overrides these multiplicities and simply divides people into two categories.

The binary divisions of gender are deeply rooted in every aspect of social life and social organization in most societies. Although the binary principle of gender remains the same, its content and thrust change as other major aspects of the social order change. The gendered division of work has shifted with changing means of producing food and other goods, which in turn modifies patterns of child care and family structures.

Sociological Perspectives: Nature or Culture? Sociologists theorizing gender have suggested that culture and society are more powerful explanatory mechanisms than nature and biology (Shilling, 1993; Synnott, 1993). Many traditional sociologists, however, have subscribed implicitly to a model in which the binary categories of male-female and of normal-deviant are assumed to be natural dichotomies upon which most societies are based (Lorber, 1996). Many assumptions of gender socialization research (e.g., the categories of male vs. female and adult vs. child) or research on marriage and work (e.g., private vs. public domains) reflect the philosophical dualism that pervades mainstream sociology (Morgan, 1996). Feminist sociologists have critiqued such dualistic notions of socially constructed categories (Connell, 1999; Sprague and Kobrynowicz, 1999). In other words, the human species is generally classified into male and female.

Challenges to Maternal Health and Development in Nigeria

Nigeria has a public health care system that includes federal, state and community hospitals, clinics and health centers. Also a large component of health care is provided in private fee-for service centers usually with some beds, which are often referred to as clinics or hospitals. As such, no clear distinction really exists in the private sector between physician practices, clinics and hospitals (Henshaw, S. K., Singh, S., Oye-Adeniran, B.A., Adewole, LF. et al. (1998). This is perhaps one of the major reasons why there is a tremendous lapse in the progress towards improving maternal health care delivery systems in Nigeria. For instance, as at 1999 the national mortality rate was still at 704 per 100,000 live births, though with considerable regional variation (Shiffman, 2006:4).

On the other hand, the World Health Organization (WHO) described good health as an individual's state of complete physical, mental and social well-being, and not

merely the absence of diseases or disability. Good health is therefore an individual's priceless asset and it is a function of the environment, whereby in this context, this study is interested in the impact of its socio-cultural dimensions (Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005).

According to Shiftman and Okonofua (2006:1) the several studies that have attempted to determine maternal death rates in Nigeria uniformly show high national levels, large urban-rural disparities and wide variation across geographic regions. The leading biomedical causes of maternal mortality are the same as those in many developing countries: haemorrhaging, sepsis, unsafe abortion, anaemia, malaria, toxaemia, and cephalo-pelvic disproportion (NPLC, 2003).

Also, the quality of maternal health care facilities in Nigeria is poor. A 2003 study of 12 randomly-selected states revealed that only 18.5 percent of facilities overall and only 4.2 percent of public facilities met internationally accepted standards for essential obstetric care (Fatusi, 2003). As such, approximately two-thirds of all Nigerian women and three-quarters of rural Nigerian women deliver outside of health facilities and without medically skilled attendants present (National Planning Commission, 2004). Hence, it can be drawn that the dismal state of the health sector in the country contributes to these adverse maternal health outcomes.

This is corroborated by the recent spur in accumulation of credible evidence concerning the high level of maternal mortality and dismal state of maternal health facilities. In 2003 with support from the United Nations Population Fund, officials in the Federal Ministry of Health produced a study on the alarming state of obstetric care facilities across the country (Fatusi, 2003). However, the World Health Organization (WHO)'s ranking of Nigeria's health care system performance as one of the worst in the world in 2000 has served to awaken health and other political officials and was in Nigeria's health care system performance as one of the worst in the world in 2000 has served to awaken health and other political officials and was in part a spur for a major government health sector reform plan, now being supported by a US$127 million World Bank loan and African Development Bank and DFID assistance (WHO, 2005).

Furthermore, Shiffman (2006:9) noted that, the inclusion of maternal health in the Millennium Development Goals has contributed to prioritization of safe motherhood by the Nigerian state. In response to the international consensus, the government established a presidential commission on the achievement of the Millennium Development Goals and established an MDG office within the Ministry of the States. In 2005, supported by the World Health Organization the government adopted a road map to attain the maternal and child health MDGs. In addition, the health sector reform program noted above invokes the MDGs as a basis for a commitment to maternal mortality reduction in Nigeria (Idowu, Osinaike and Ajayi , 2014).

Hence, it can be seen that maternal health issues are germane to the attainment of sustainable development in Nigeria. Albeit, this paper seeks to reveal that beyond considerations for political factors and economic determinants, there is an increased need to investigate the effects of gender and socio-cultural underpinnings on maternal health care delivery systems in Nigeria.

Educational status

Findings from numerous studies like Kitts, and Roberts, (1996); Ogujuyigbe, and Liasu, (2007) on maternal health care and mortality conducted in developing countries over the last decade show a positive association between maternal education and maternal health care. The influence of education on health is assumed to derive from various dimensions of the educational experience. Schooling imparts literacy skills, which enable pupils to process a wide range of information and stimulate cognitive development. As Graczyk, (2007) situate it; lack of education can also affect health when it limits young women's knowledge about nutrition, birth spacing, and contraception. Before a woman decides to seek care, she must be able to recognize the signs and symptoms that indicate the need for care (AbouZahr 1994; Manderson 1994; in Kitts and Roberts, 1996). However, a lack of educational opportunities might lead to poor understanding of health-related matters; therefore, many women may not be familiar with different diseases and their presentation.

Table 1: Gender and education statistics; Series Name 2006 2007 2008 2009 2010

Nigerian Children out of school, primary, female 4,100,638…4,626,218 .. . male 3,237,267…. 4,023,402
Nigeria Literacy rate, adult female (% of females ages 15 and above)……………………………………..50 .. 50
Nigeria Literacy rate, adult male (% of males ages 15 and above)…………………………………………. 72 .. 72
Nigeria Literacy rate, youth female (% of females ages 15-24)……………………………………………. 65…..65
Nigeria Literacy rate, youth male (% of males ages 15-24)…………………………………………………. 78……78
Nigeria Primary completion rate, female (% of relevant age group)…………..75….. 74 .. …. (mean=74.5)
Nigeria Primary completion rate, male (% of relevant age group)…………………………. 96….. 84 90
Nigeria Primary education, pupils (% female)…………………………… ………… 45 46, 45 46 ….(mean= 45.5)
Nigeria Primary education, teachers (% female)………………………………………. 50 …..48 .. .. ….(mean=49)
Nigeria Ratio of female to male primary enrollment (%)…………………………85: 88, 85:88, …(mean=86:5)
Nigeria Ratio of female to male secondary enrollment (%)……………………………81…. 77 .. .. .. (mean=79)
Nigeria School enrolment, primary, female (% gross)………………………………92 87 82 84 .. (mean=86.25)
Nigeria School enrollment, primary, female (% net)…………………………………….62…. 58 .. .. ..(mean= 60)
Nigeria School enrollment, primary, male (% gross)……………………………… 10,899, 969…..(mean=599.5)
Nigeria School enrollment, primary, male (% net)……………………………………….70…… 64 .. .. (mean=67)
Nigeria School enrollment, secondary, female (% gross)…………………………. 30 …..27 .. .. .. (mean=28.5)
Nigeria School enrollment, secondary, female (% net)…. ……………………………………………….22 22
Nigeria School enrollment, secondary, male (% gross)……………………………37……. 34 .. .. .. (mean=35.5)
Nigeria School enrollment, secondary, male (% net)….. ……………………………………………….29 29
Nigeria Secondary education, pupils (% female)………………………………………. 44…… 43 .. .. .. (mean=43.5)
Nigeria Secondary education, teachers (% female)……………………………………. 38 ….34 .. …….(mean=36)

Source: British Council; Gender in Nigeria Report 2012

Culture

Culture influenced health behaviour in so many dimensions. For instance, culture influences the way illness is produced and acted upon in Nigeria (Dawitt, 1994 as cited by Kitts, and Roberts, 1996; Erinosho, 2005). Cultural factors include gender norms, child marriage and early pregnancy, nutritional taboos, particularly during pregnancy, certain birthing practices. The result for individual women and girls is mitigation of their health or their quality of life (Dawitt, 1994 as cited by Kitts, and Roberts, 1996). These factors condition women's reproductive intentions. That is, the number of children they want and how they want their births spaced. Women do not always get the support they need to fulfill their reproductive intentions. Therefore, cultural restrictions limit choice. Belief about appropriate behaviour can reduce access to health information and care and impair its quality (Idowu, Osinaike and Ajayi, 2014).

Belief System

It has been argued that perception of illness is affected or influenced by different belief system in societies (Jegede 1991; Kitts, and Roberts, 1996). Jegede (1991), noted that magic or religious belief system does influence how people perceive diseases. For this reason, quite a significant number of patients utilize the services of assorted traditional healers before seeking care from western style or modern health workers and facilities (Erinosho 1979; Igun 1988, as cited in Erinosho 2005). Today, there is a new dimension due to the influences of religion, such as Christianity and Islam. Most religious believers emphasize the healing power in their faith. Due to this fact, most pregnant women seek to patronize mission homes in other to be protected from evil during delivery. According to Dr. Isaac Owolabi, the Oyo state commissioner of health, no fewer than 36,000 expectant mothers die annually from avoidable complications before and after birth in the mission homes, mostly as a result of lack of qualified personnel (Idowu, Osinaike and Ajayi, 2014). In Nigeria, the Islamic religious practice severely restricts women's interaction with men and strangers.

Gender Role

As Diaz (1993), put it, sex discrimination affects women's lives, in one way or another in almost every

country, particularly in the deprived sectors of each society. However, its negative impact on women's health is greater in the developing world. Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005) made us to understand that, mother cannot just take health decision just because she has unified budget behind her husband over which she has some rights and which will meet the cost. This also connotes a cultural value of male dominant role in patriarchal societies (Jegede, 1998). This reduces the promptness with which medical assistance is obtained anytime an illness is suspected during pregnancy. Therefore, because of their heavy household duties, women cannot afford to be sick themselves. "It would be useful to discover how many ailments exist among women but never receive attention from the medical profession".

Age at Marriage

The concept of age indicates a structured nature of social relationship whereby interaction is hierarchical. By age it connotes the idea of superiority in terms of ability to think and make decision (Jegede, 1998). Child marriage is one of the cultural factors that work against women. When a mother is still young she always falls prey of every idea that has to do with child bearing and child care because they have no experience. Age also determines the readiness of the physiology of the mother. In Ufford and Menkiti (2001), many maternal deaths occur because of early childbearing, according to the 1999 Nigeria Demographic and Health Survey (DHS). Adolescents suffer disproportionately from complications related to childbearing because their bodies are not fully developed. High fertility means women are exposed more often to the risk of maternal death. In a country where only 15 percent of women use any form of contraception, the average Nigerian woman bears about six children during her lifetime (Ufford and Menkiti, 2001). Galadima, the regional manager of the Abuja-based Society for Family Health (SFH), in Abdul, Aziz, (2008) also affirmed that a woman should not start having children too early in life because if a woman's body is not ready to receive pregnancy, the likelihood of complications.

Economic status

A large number of studies have documented that a woman's position in the household largely determines her range of acceptable reproductive options (Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J. 2005). Women's status is a broad concept that encompasses multiple facets of women's lives. It has been defined as the degree of women's access to (and control over) material resources (including food, income, land and other forms of wealth) and to social resources (including knowledge, power and prestige) within the family, in the community and in society at large (Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005)). Financial barriers often prevent local people from being able to arrange transportation. In rural areas in Nigeria, vehicles are scarce and in poor condition. The cost of arranging emergency transportation can therefore be daunting (Izugbara and Ukwayi (2004). According to Jegede 1998, treatment of any disease depend on ability to pay, mothers who were dependent on their husbands were not able to respond immediately to any health related problems concerning their children and this also invariably concerning themselves. According to Lanre-Abass 2008 (cited in Idowu, Osinaike and Ajayi, 2014), user charges coming at a time of spreading deepening poverty have become a great barrier to access for many Nigerian women who are not educated, and hence economically disempowered. To Lanre-Abass, (Idowu, Osinaike and Ajayi, 2014,) getting money for treatment was the problem most commonly reported by Nigerian women of all backgrounds. There is a strong negative correlation between both levels of education and wealth quintile.

Gender differences in mortality

There is a mass of evidence that women live longer than men. This is true within all modern industrialized societies and there are now few societies in which men live longer than women (Doyal, 2000). At the beginning of the twentieth century, women lived on average two to three years more than men.

This difference is now approximately seven years (Lorber, 1997). Furthermore, there is a tendency for men to die earlier than women at every age. More male deaths occur in uterus and at birth than female deaths, and more male deaths occur at every age throughout life than female deaths (Doyal, 2000).

Gender differences in morbidity

Although women live longer than men in industrialized societies, evidence has accumulated over recent decades that women experience more illness throughout their lives than men. Indeed, there is a saying in epidemiology that ‘women get sicker but men die quicker’ (Lorber, 1997, p. 14). Women’s higher morbidity rates have been demonstrated in terms of them reporting more illness, having more days off work because of illness, taking more medication, and seeing doctors and other health care workers more often than men (Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005). Women also have higher rates of acute illnesses and most nonfatal chronic conditions (Okereke, H.C.,

Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005).

However, the broad statement that women experience more ill health than men overall has been questioned by some researchers, who argue that this may be an over generalization. Using two large datasets in the UK, (Doyal, 2000) have demonstrated that there are morbidity differences between men and women, but that these are not consistent and depend on the symptom, condition and stage of life. These authors reinforce previous findings which demonstrate that gender differences in health do occur, but vary by age, how a condition or symptom is measured, what is measured and also social context (Doyal, 2000). A number of studies have since demonstrated that gender differences in morbidity are more complex than previously thought (Doyal,2000).

Being female: what does it mean for health?

Various explanations have been put forward to explain women's excess morbidity.
These range from the biological (e.g. hormones, genetic differences) through to the social and cultural. Gender divisions in social, economic and cultural life have been linked to physical health and well-being, highlighting how gender inequalities affect women's health detrimentally (Doyal, 2000).

Furthermore, our social norms regarding who does what in terms of (unpaid) work inside the house as well as (paid and unpaid) work outside the house frequently mean that women shoulder heavy burdens of responsibility (Okereke, H.C., Kanu, N.C., Anyanwu, E.C., Ehiri, J. and Merrick, J (2005). Many women must combine employment with domestic work, pregnancy and child rearing (Doyal, 2000). Gender differences in occupations, incomes, work-hours and experience in the workplace often mean that women are disadvantaged compared to men (Doyal, 2000). Even though gender-equality laws have been passed in most developed countries, these have had little effect on women's status, quality of life and physical health. National surveys consistently show that women continue to be seriously disadvantaged compared to men. They have less money, less financial security, less desirable employment and less political and social power, and this has a detrimental effect on their physical health (Doyal, 2000).

Being male: what does it mean for health?

Previously, concern with gender was concern with women, and men's lives were not seen as gendered at all (Doyal, 2000). Indeed, two medical professionals have noted that when they asked men (both colleagues and patients) what masculinity meant for them, most men were astonished, some made jokes and no consistent answer was given (Good, 1987). There tends to be little reflection on how men are socialized and act in everyday life.

In very recent years, much greater research attention has been devoted to examining male gender, and as part of this, what maleness might mean for health.

While traditional masculinity might seem to provide privileged access to various resources and opportunities (e.g. education, employment, income, access to services), there are aspects of being male that are detrimental for health.
Among the predisposing factors in Andersen and Newman (1975) HBM is educational level, and occupation, which produced different propensity to use health care services. Schools are also important agents of socialization, with a crucial role in shaping attitudes, opinions and values. As stated by Holsinger (1973), exposure to new ideas and alternative lifestyles might lead to questioning of traditional norms and motivate greater willingness to adopt innovative behavioural models. Attitude creation and attitude change are not only linked to the explicit content of the school curriculum but also to the informal, implicit processes connected to the organization of instruction.

DISCUSSION

According to the health seeking behaviour model, the predisposing factors reflect the fact that there is uniqueness of predisposition to health care utilization within household, at the same time, the enabling factors reveal that even when there is predisposition to utilization of health service there must be means of achieving it. The perception of illness is influenced by different belief system in societies. There are many different beliefs as regard prenatal care. To understand how these beliefs, determine healthy choices among pregnant women, various questions was asked in relation to the belief system.

Mother and child health care has been a serious concern to individuals, groups and Nigeria as a nation. The survival of any nation is tied to its capability to maintain the growth and sustenance of human species capable of reproduction; this will of course give such a nation power in terms of population and wealth and therefore, nations which must develop have to provide adequate health care facilities for its regeneration (Idowu, Osinaike and Ajayi , 2014).
A study by Nigerian Urban Reproductive Health Initiative (NURHI, cited in The Nigerian Tribune, pg 6, Sept., 26, 2014) has indicated that Nigeria's maternal mortality ratio currently stands at 576 per 100,000 live births. This is in agreement with WHO reports titled "Trends in Maternal Mortality" in May, 2014, which stated that Nigeria lost about 40,000 women due to childbirth in 2013; a figure

which was second to India.

However, Nigeria remains one of the countries in the world with the poorest health policies and facilities. Maternal mortality and morbidity has been a serious concern in the health sector. There is much written on this issue from many vantage points, and women's reproductive rights have been a battle for social workers and the Nigerian Medical Association for quite a long time now. Ipas (2006) describes the battle over abortion as a "war on choice"; she believes that women's health around the world is in jeopardy as the right to choose is not available or is taken away. Ipas (2006), an international organization for women's reproductive health, estimates that 70,000 women die each year from unsafe abortions, almost half of those in Asia. In Nigeria, no accurate figure of abortion is reported owing to the psychological stigma attached to it and the law that bans it. Legalization of abortion in Nigeria is still open to debate in the national assembly. However, many unwanted pregnancies have either made many young girls single mothers or sent them to early graves from the consequences of incomplete and often times self-induced abortion.

Gender Inequalities and Women's Status

According to studies carried out on the health conditions of the elderly, differences in morbidity profile between age groups and sex exist. Women reported a higher prevalence of illness than men (Abdulraheem, 2007).

Inequalities, at least to some extent, are said to exist in all societies and social classes, but in developing countries and among the poor, inequalities are assumed to have a more negative impact on women's health. Throughout the life cycle, gender discrimination in child bearing, nutrition, health care seeking, education and general care make a woman highly vulnerable and disadvantaged (Hassan and Khanum, 2000). The subordinate status of women in developing countries has elicited diverse discussions. Some scholars argue that a woman suffering from an illness reports less frequently for health care seeking as compared to men (Ahmed, S.M., Adams, A.M., Chowdhury, M and Buiya, A. 2000). This trend is the effect of gender inequalities, especially in developing countries, for example, some studies show an increased number of male patients who attend medical services in areas where attendance rates are practically the same for both sexes (WHO, 2005; Nash, and Gilbert, 1992). Yet, other studies show that women are more frequent users of lieu services than men (Abdulraheem, 2007; Statistics Canada, 2001).

In general, however, gender inequality exists in access to health care and this is associated to findings

- availability of cash.
- On the other hand, there are other gender inequalities that negatively affect men's health care

that women have to overcome more obstacles to get health care. One such hindrance is cash money to which women have limited access compared to men, and which is needed for coping with health care costs. Decisions which economically affect the household lie with the breadwinner who is usually male, thereby making women dependent on men for accessing health care. The economic advantage of the men continues into old age, and elderly men are known to control funds of the household by virtue of their position as heads of their household.

Another dimension to this is the unequal treatment women receive from health personnel; health providers attend to men and boys better than women and girls (Nash, and Gilbert, 1992). The consequence of this sexism among physicians is that they tend to treat women's problems as less important, except reproductive health which has increasingly been gaining prominence. The implication of the disrespectful treatment and poor quality of information women receive is responsible for both the poor comprehension of actions to take (WHO, 2005) and lack of satisfaction among women who then increasingly abstain from health services (Vlassoff, 1994).

The obstacles which women face were grouped into four types (Nash and Gilbert, 1992), they are:

1. Institutional barriers: unequal treatment by health providers
2. Economic barriers: different access to resources example the National Health Insurance Scheme (NHIS) designed for the elites.
3. Cultural barriers: social status of women which situates them in socially inferior positions, male doctors who attend to women with sensitive health problems, etc.
4. Educational barriers: women having less access to education (an example is seen in literacy rates).

Based on empirical evidence of the increased risk factors in women compared to men for not receiving effective treatment for malaria. Tanner and Vlassoff (1998) proposed a detailed systematization as follows:

- Personal factors: knowledge and beliefs about illness, user/provider relationship " Social and reproductive activities: roles in health at household levels, decision-making at household and community level, use of services, quality of received health services, social stigma
- Economic/productive activities: division of labour, substitution of labour, exposure to infection, opportunity costs, economic policies in relation to accessibility of services/care,

seeking- behaviour. Some studies have pointed out that men not only have higher labour risks than women, but

also that certain risk behaviours are socially valued, denoting 'virility'

- (Doyal, 2000). Men are also said to attend to their health later than women so as not to show their weakness, or they do not comply with health advice that implies a change in habits because they will be considered 'feminine' (Doyal, 2000).

Table 2: Health and nutrition statistics (Country Name- Nigeria) Series Name 2006 2007 2008 2009 2010

Nigeria Mortality rate, female child (per 1,000 female children age one) ………… 57 93 .. … (mean=75)
Nigeria Mortality rate, male child (per 1,000 male children age one) .. ……………..57 91 .. ….. (mean=74)
Nigeria Life expectancy at birth, female (years) 50 51 51 52 ……………………………..…………..(mean=51)
Nigeria Life expectancy at birth, male (years) 49 49 50 50 ……………………………..……………(mean=49.5)
Nigeria Contraceptive prevalence (% of women ages 15-49) …………………… 15 15 .. .. ……(mean=15)
Nigeria Prevalence of overweight, female (% of children under 5) ……………. 13 11 .. …… …(mean=12)
Nigeria Prevalence of overweight, male (% of children under 5) 14 10 .. …………………(mean=12)

Source: British Council; Gender in Nigeria Report 2012

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RECOMMENDATION

Women need to be broadly educated about the importance of regular health care for them. The ripple effect of women's education on maternal health care highlights the need for programs that promote greater schooling for girl's population. Therefore, government must intensify effort to ensure the coming generations are well educated. Since reproductive health is a family health and social issue as well, it does not affect women alone. Therefore, informing men about reproductive health, and maternal health care can lead to more support for safe pregnancy. Men should be mandated to witness the process of child delivery while their wives go to labour room this probably will enhance social support for women and reduce the magnitude of gender bias.

* Addressing many commonly held attitudes and bahaviours, like gender roles, and other cultural beliefs that are inimical to health are cultural issues, which can be achieved through community -based program creating opportunity for easier communication, dealing with the dynamics of knowledge, power and decision making process in the family, must be part of the effort to ensuring good health during pregnancy.

* Finally, there is need to improve implementation of public health interventions in terms of both coverage and effectiveness, to provide prompt and adequate medical attention and referral when it is need. Also, service providers need constant training and support to provide sensitive care in the communities. Improvements are needed in the quality of care in the country, and particularly in reproductive health.

CONCLUSION

Gender and maternal health has been reported as common factors challenging women and development in Nigeria. On the whole, there is a connection to the fact that religious activity during pregnancy is used as a solace to antenatal care and to a large extent it does not have a negative effect on pregnancy. This is also related to Jegede (1998), who asserted that, whether Christianity or Islam, belief system is concerned with the cosmology, that is, the nature of the universe, the spirit that may control it, and so on. Due to this fact, most pregnancy women seek solution from the mission homes in other to be protected from evil during delivery.

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