

**Gender and Reproductive Health: Religious and Social Perspectives to Women's Health
Rights in Nigeria**

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Abstract

The paper assesses the religious and social perspectives to women's reproductive health rights in Nigeria. Reproductive health deals with the physical, mental and social well-being of individuals in all matters relating to their reproductive system. Reproductive health rights therefore, implies that individuals should be able to have a satisfying and safe sexual life, with the capability to reproduce and the freedom to decide if, when and how often to do so. However, these rights are oftentimes hindered by socio-cultural and religious barriers. The paper utilizes secondary sources to gather information on the socio-cultural and religious barriers to women's reproductive health rights in Nigeria. The sociological theories of gender roles serve as the theoretical underpinning of the paper. Findings reveal that socio-cultural and religious attitudes have affected women's reproductive health in Nigeria, thus resulting in high incidence of unwanted pregnancies, abortions, maternal mortality and sexually transmitted infections. The paper recommends value reorientation as a panacea for this ugly situation. This should be done through community self-assessment approach in which culturally and religiously oriented reproductive health programmes are designed to meet women's reproductive health needs.

Keywords: Gender, Reproductive Health, Health Rights, Women, Religion

Introduction

In recent times, the HIV/AIDS epidemic has been ravaging humanity, especially in the developing world. According to Joint United Nations Programme on HIV/AIDS (UNAIDS, 2013), about 35.3 million people were living with HIV infection globally in 2012, while 2.3 million new infections were also reported in the same year. Sub-Saharan Africa is however, disproportionately represented in this statistics as it was home to about 70% of all the new HIV infections in 2012. UNAIDS attributes the continuous high prevalence of HIV/AIDS in sub-Saharan Africa to the decrease in condom use, as well as an increase in sexual partners, as revealed by recent surveys conducted in several countries within the region (UNAIDS 2013). With regard to Nigeria, the Population

Reference Bureau Report (2013) shows that out of the 4.9% of the population of persons ages 15-49 that lived with HIV infections in 2013 globally, about 3.7 % of them lived in Nigeria. Also in 2011, about 3 million out of the 23.5 million people that lived with the virus lived in Nigeria (UNAIDS, 2012).

Similarly, the fertility rate in sub-Saharan Africa has been growing. Thus, while the world fertility rate stands at 2.5 children per woman that of Sub-Saharan Africa stands at 5.2 children per woman. And within the region, West Africa has the second largest average of 5.7 children per woman, which is next to the Middle Africa's 6.1 children per woman. For Nigeria, the fertility rate is equally high and stands at 6.0 children per woman (Population Reference Bureau, 2013). Correspondingly, there is a high maternal mortality rate both globally and in sub-Saharan Africa as well as in Nigeria. According to the World Health Organization, about 289,000 women died from largely preventable and treatable pregnancy and childbirth-related causes in 2013, globally. And sadly, about 99% of these deaths took place in developing countries, while more than half of them occurred in sub-Saharan Africa (WHO, 2014). Thus, while the maternal mortality ratio in developed countries was 16 per 100 000 live births in 2013, that of developing countries was 230 per 100 000 live births in the same year. In view of this, Sub-Saharan African women have a 1 in 160 lifetime risk of maternal death, as compared to a risk of 1 in 3,700 for women in developed regions (WHO, 2014). The Nigerian case is even worst as the maternal mortality ratio stands at about 500 per 100 000 live births, making Nigeria one of the countries with the highest rate of maternal mortality in the world. In fact, UNICEF (2009) State of The World Children Report acknowledges that one out of nine global maternal deaths occur in Nigeria as about 144 girls and women die every day from complications at childbirth (Daily Independent, 2009).

These growing incidents of reproductive health issues and challenges show the deficiency or failure of reproductive health programs to address the reproductive health needs of women and men in sub-Saharan Africa. This calls for more investigations to understand some of the structures and processes that shape sexual and reproductive health behavior of women and men in Africa. This paper is an attempt to do such, by focusing on how

gender, mediated by culture and religion shapes men and women's reproductive health behavior in Nigeria.

The paper is structured into six parts including this introduction. Part two assesses the relationship between gender and reproductive health, while part three discusses the theoretical framework of the paper. Part four looks at the socio-cultural and religious context of women's reproductive behaviour in Nigeria. Part five assesses the impact of socio-cultural and religious barriers to women's reproductive health, while part six concludes the paper with some recommendations.

Gender and Reproductive Health

Gender is the socially constructed meaning attached to being a male or female in the society. It leads to social exclusionary practices, which limit women's access to tangible and intangible societal resources needed to improve their socio-economic well being. However, this varies overtime and from society to society and is thus an outcome that is malleable to change. According to Shaw & Lee (2004), gender is the social definition of womanhood and manhood. It deals with the way society creates patterns and rewards our understandings of femininity and masculinity. In other words, gender relates to the way society organizes understandings of the sexual differences between being a male or female.

Reproductive health on the other hand, is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes and not merely the absence of disease or infirmity (International Conference on Population and Development (ICPD), 1994: 43). Similarly, Alubo (2000) defines reproductive health as the whole array of counsel, information and services required and necessary for safe and healthy sexual expression. But to Akhter (2009) reproductive health implies that people are able to have a satisfying and safe sexual life, with the capability to reproduce and the freedom to decide if, when and how often to do so. Akhter's definition of reproductive health is not as simple and straight forward in practice. This is because gender mediates on individuals' reproductive behavior, thus

affecting their ability to make choices, as well as to access reproductive health information and services. This has correspondingly resulted in differential health outcomes for men and women. However, women tend to be at a disadvantaged. Thus, while both men and women are faced with reproductive health challenges, women's reproductive health challenges are particularly made more complicated by their gender. Thus, women are faced with all kinds of reproductive health issues such as unwanted pregnancy, unsafe abortion, forced early marriage, early childbearing, save motherhood issues (breastfeeding, antenatal, postnatal), post abortion care, the spread of HIV/AIDS and other sexually transmissible infections (STIs), female genital mutilation and maternal mortality among others. The next section of the paper attempts a theoretical exposition of the impact of gender on reproductive behaviour and health.

Sociological Theories of Gender Roles

While sex that is being male or female is biologically determined, gender on the other hand is the social conception of the expectations and behavior considered appropriate for those identified as male and female. Hence, there are male's roles and female's roles. However, most cultures tend to assign higher values to males' roles, while females' roles are devalued (Giddens, 2001). This devaluation of the females' roles has correspondingly resulted in the marginalization of women in all spheres in the society. This is reflected in differential economic benefits, dependent relations and social inferiority.

Sociological attempt at explaining these role differentials is eclectic anchored on biology, culture and materialism. For Sociobiologists, the subordination of women in the society is justifiable, as this is physiologically determined. According to them, the biological predispositions of women to menstruate, gestate and lactate are major hindrances to their full and active participation in all spheres in the society. While they further argue that the 'human biogrammer' (the genetically based determinant of behaviour) of males predisposes them to be more dominant and aggressive (George, 1990). From this vein, masculinity is constructed as being intelligent, courageous, aggressive, sexually potent, ambitious, etc., while femininity means being soft, passive, emotional, nurturing, dependent, sensitive, fearful, etc. (Giddens, 2001; Shaw & Lee, 2004).

However, Ortner, a culturalist disagrees with the biological explanation of gender roles. Observing the universal secondary status of women, Ortner argues that although men and women are significantly different, it is however, culture and not nature that accentuates these differences. It is culture that assigns superiority/inferiority labels to the respective sexes and women and all they stand for are assigned the inferiority label (George 1990).

The socialist and radical feminists' conception of gender roles is different from that of Sociobiologists and culturalists. According to socialists and radical feminists, women's subjugation is a basic fact of every society, in all spheres of life and over all times. This oppression, they explain is tied to patriarchy, which they define as a system of male dominance over women in all spheres of life (Walby, 1990). However, socialist feminists emphasize a view of patriarchy that integrates male power within the social structures in the society. Thus, they situate male dominance within class, the state and ideology. They argue that an end to this dominance could only result from a transformation of these structures (Rowbotham, 1992). On the other hand, radical feminists' analysis puts greater emphasis on the biological, cultural and psychological determinants of women's oppression. According to them, the 'personal is political', thus domestic relations is a key factor in shaping gender roles. They therefore, examine how human reproduction is controlled and socialized through the institutions of marriage, compulsory heterosexuality and motherhood (Morgan 1975; Haralambos 1980; Giddens, 2001).

In the light of these arguments, it means that the erotic attractions, identity and practices involve in human sexuality are displayed and interpreted by individuals based on socially constructed sexual scripts (although sexual scripts are not static but dynamic and do vary across cultures and over time) (Shaw & Lee, 2004). However, by implication it means human sexuality is as much about society as it is about biological urges. Thus, when men and women enter into sexual relationships, men bring into the relationship, the power that they possess as the dominant gender in the society. This is demonstrated through sexual prowess and potency, while women as the subordinate gender strive to live up to the social expectation of being subservient. They therefore become passive, both sexually

and emotionally. This means that sexual intimacy although ‘personal’ is also ‘political’, since issues and problems involve in sexual relationships transcend personal boundaries to incorporate broader social, political and economic issues. Thus, sexual intimacies are enmeshed in unequal power relations and this in turn affects men and women’s reproductive health behaviour and rights. For example, the power enthroned upon men encourages them to engage in risky sexual behaviour, thus making them susceptible to reproductive health risks, while the powerlessness of women similarly exposes them to harmful sexual practices and reproductive health risks. Shaw & Lee (2004: 160) aptly describe this situation as preventing men and women ‘to love in healthy ways’.

The next section of the paper assesses the social and religious construction of sex and sexuality, which have correspondingly dictated men and women’s reproductive behaviour and rights in Nigeria.

Social and Religious Perspectives to Women and Men’s Reproductive Health Rights in Nigeria

In most societies, the moral imperatives of religion and cultural representations dictate the behaviours of men and women, as they ensure that what the society demands, permits and tabooed for each gender is well known and adhered to by most individuals (Davies, 1982). Similarly, in Nigeria, cultural norms and religious beliefs dictate men and women’s reproductive health behaviours. However, it is important to note that Nigeria as a geographical expression is quite diverse and complex. It comprises of diverse cultures and religions and these have given rise to a multiplicity of sexual behaviours and practices. This makes it a bit difficult to universalise reproductive health behaviour. Despite this diversity, some studies have demonstrated some commonalities in sexual behaviour and practices among the diverse cultures and religions (see Araoye & Fakeye, 1998; Asuquo, 1999; Adegbola & Babatola 1999; Alubo, 2000; Esiet, *et al*, 2001; Izugbara, 2001, 2004; Odimegwu, *et al*, 2008). Thus, it will not be totally misleading to discuss the social and religious perspectives to men and women’s sexual behaviour in Nigeria from a universalizing perspective.

Traditionally, sexual and reproductive health needs of men and women have been shrouded in mystery in most communities in Nigeria. This is because sex is often seen as a subject that should not be discussed in the open. Similarly, words commonly used to depict parts of the body, sexual desires and acts are often framed in ambiguous and indirect terms (Izugbara, 2005). This social conservatism about sex has made its discussion sensitive, inhibited, and often a taboo. Although the situation is changing in recent times as Esiet *et al* (2001) have acknowledged that sexuality is now a key issue that is commonly and publicly commented upon through a variety of discursive activities. However, the cultural quietude on sexual matters still impedes effective communication on it among the populace. This has invariably affected family communication on sex as well as formal reproductive health education. The resultant effect is of course the lack of adequate information and knowledge on how men and women should protect their reproductive and sexual health.

For women, the situation is further worsened by discriminatory cultural practices that work against them. According to Izugbara (2005:22) 'male socialization practices in many Nigerian cultures aim largely to train them to be domineering, ruthless and in control and to see themselves as naturally superior to women. On the other hand, female socialization often aims at making girls and women submissive, easily ruled or controlled and to see themselves as naturally inferiors to men'. This unequal ratings and power relation between men and women is often replicated in sexual relations. Therefore, women enter into sexual relationships as inferiors. Thus, they are not expected to enjoy sex in order not to become promiscuous. Their role in the sexual act is to gratify the sexual cravings of the men and in order to curb women's sexual desires, their genitalia is mutilated (FGM) in some communities and in others they are given out in early marriage. On the other hand, the men must demonstrate strength, a desire for sex and not allowing themselves to be dominated by women (Odimegwu, *et al*, 2008). Izugbara (2004) empirical study of local notions of sexuality and relationships among rural Nigerian adolescents supports these assertions. The study revealed that male dominance of the sexual scene and act; sexual aggression and indifference to the voices of women, were the cherished values among the boys studied.

It therefore follows that in male-dominated relationships, men may be less likely to accept a woman's request to use a condom or her desire to abstain from sexual engagement entirely (if she even dares), as culturally she has been conditioned to believe that it is her husband/boyfriend's right to control her body. Barnett (2009) study of adolescents in rural Edo State affirms this viewpoint as findings of the study reveal that boys were the decision-makers, very often in the context of condom use. Similarly, the study found that the conflation of masculinity with hetero-sex encourages men to seek out multiple partners both prior to and after marriage. In fact, boys who did not succumb to the social pressure of being sexually active were shamed and had their masculinity questioned for being 'shy and sexually inexperienced'. A fall out of this social power conferred to the men for sexual expression is the tendency for men to limit the use of sexual and reproductive health services, as they often perceived the use of such services and other positive-seeking behaviors as signifying a sign of weakness (Odimegwu, *et al*, 2008). This has adverse effect on women as it enables the spread of sexually transmitted diseases.

With regard to the use of contraceptives, there are similarly social stigmas associated with its use by unmarried persons, especially women. Since culturally, femaleness is defined in terms of shame, lack of interest in sexual matters and the 'other' to be conquered (Izugbara, 2005), women (especially unmarried) who dare to use contraceptives are seen as promiscuous and prostitutes. On the other hand, 'good women' are depicted as those who lack sexual desires (Izugbara, 2004). Therefore, to fulfill this cultural sexual script, women often do not want to be caught obtaining or possessing contraception, neither do they want to appear as not being naïve and inexperienced in sexual matters. Thus, many women do not negotiate contraceptive use with their partners in order to maintain these impressions of sexual innocence. Apart from these, there are also some other erroneous beliefs and myths about contraceptives, which have discouraged their usage among men and women. Some people believe that contraceptives have damaging side effects, such as sterility and cancer and are harmful to unmarried females.

Religious traditions also play a major role in dictating individuals' response to reproductive health information and services. Research by Pathfinder International on Reproductive Health and Family Planning in various parts of Africa including Nigeria has shown that untrained religious leaders have diverse and erroneous impressions about Reproductive Health and Family Planning (Burket, 2006). Their findings reveal that some religious traditions reject the use of reproductive health services such as contraception. This is because some religious sects are opposed to birth spacing and the limiting of family size. While others do accept it, they however allow such within the confines of marriage, since religious tenets prohibit premarital sex. From this premise, some religious leaders do not see the need to encourage unmarried adults to seek reproductive health information and services, since by their definition, such persons do not engage in sex. However, the reality is that not all unmarried adults and even young Christians/Muslims can or will abide strictly by the tenets of the faith.

Also most religious tenets prescribe that wives should be submissive to their husbands. Men have capitalized on this to subjugate women. Thus, women are not allowed to take reproductive health decisions without the permission of their husbands. Some men even believe it is their right to take all family planning decisions as women are not capable of learning about it on their own. Equally, some religious leaders and adherents believe that prayer is enough to protect them from contracting HIV/AIDS and other sexually transmitted infections. These attitudes often create barriers against the giving of adequate and comprehensive information and services to persons in need of reproductive health services by religious leaders and adherents. So what are the impacts of these beliefs and behaviours on women's reproductive health?

Impact of Social and Religious Conception of Reproductive Behaviour on Women's Reproductive Health and Rights in Nigeria

These social and religious obstacles have caused many men and women to embark on their sexual and reproductive lives with little or no knowledge and limited skills for discussing or negotiating sexual and reproductive health preferences and needs and

women have been worst for it. Findings by Sedgh *et al* (2009) show that although the use of modern contraceptives among sexually active female adolescents has increased in most parts of Nigeria, it is however, still extremely low with the national proportion of users doubling from 4% in 1990 to 8% in 2003. They similarly report that although early childbearing has declined, it still remains common as almost one in three women aged 20 - 24 had had a child by age 18 in 2003. USAID (2009) also buttresses this point. According to its report, 54% of young women in Nigeria give birth by age 20 and nearly one-third of sexually active women aged 15 - 24 had an unmet need for modern contraceptives in 2003 (Sedgh *et al*, 2009). Guttmacher Institute (2008) also reports that over 1.3 million unintended pregnancies occur annually in Nigeria and well over half (760,000) of these result in abortion. And unsafe abortion accounts for up to 40 percent of maternal deaths. On the other hand, 54,000 women die each year from pregnancy-related complications. The situation has not really changed as the Population Reference Bureau (2013) Fact Sheet shows that only 9% of married women ages 15-49 used modern contraception in Nigeria, while the maternal mortality ratio still stands at about 500 per 100 000 live births, about one of the highest in the world.

Equally, the National Agency for the Control of AIDS (NACA) reports that 60 percent of the about 3.5 million Nigerians living with HIV infection are women (Premium Times, 2013).

Conclusion

In recent years, sexual and reproductive health has become a front burner issue in Nigeria especially in response to the increasing rates of HIV infection and maternal deaths. The conservatism surrounding the discussion of sex is reducing. For example, sexuality education has been introduced into secondary school curriculum since 2002 (Esiet *et al*, 2001; Rosen *et al*, 2004). Similarly, the civil society has become more concerned about addressing sexual and reproductive health issues. Thus, many organizations are working to improve reproductive and sexual health through advocacy and prevention programming.

Despite these laudable efforts, the reproductive health status of many Nigerian, especially women still leaves much to be desired. This is because gender mediated by culture and religion still poses as a barrier to the effective implementation of reproductive health programs. Thus, there is a lack of knowledge, access and interest in reproductive health information and services. This has made Nigerian men and women victims of reproductive health issues. Women have been worst for it as the subordinate gender. Thus, they are exposed to sexually transmitted infections (STIs), unwanted pregnancies, unsafe abortions, genital mutilation, maternal deaths, etc. So how can this ugly trend be reversed?

The Way Forward

To reverse the tide of reproductive health issues in Nigeria, the role of culture and religion in mediating reproductive health behavior of individuals must be acknowledged and taken into consideration when designing and implementing reproductive health programs. In view of this, religious leaders must be sensitized to understand that individuals' reproductive health is a rights-based issue and so should be addressed from a 'rights' perspective, regardless of age, gender and marital status. Therefore, religious leaders should be sensitized to collaborate with relevant agencies in the implementation of reproductive health programs. The strong influence of religion in changing perception and behavior would be brought to bear when religious leaders buy into reproductive health programs and so educate their followers accordingly. Thus, Faith based advocacy, media campaigns and open dialogue can be arranged with religious leaders to address reproductive health issues of their members.

Similarly, there is a need for sensitization and cultural reorientation of the entire populace. Femininity should be accorded equal value as masculinity. This is because the optimum functioning of both genders is a requisite for a healthy and balanced society. Thus, socialization practices should not emphasize the superiority of one gender over the other. Custodians of tradition in the community (traditional rulers) should be used as the entry point for this. However, for immediate action that would make the implementation of reproductive health programs more effective, there should be community mobilization,

as community involvement in reproductive health programs has proven successful in some countries (Akhter, 2009). Based on the community self-assessment approach (Akhter, 2009), culturally and religiously oriented reproductive health programs should be designed and implemented. From this vein, the paper makes the following suggestions that would aid community mobilization and implementation of programs -

- Gather information on the live experiences of the reproductive health issues of community members.
- Use the information as the basis of advocacy for behavioural change so as to avoid also becoming victims.
- Collect information on men and women's reproductive concerns and needs from all strata of the community (boys, girls, single, married, adults, etc.).
- Set up local committees within the various communal associations (youth, women, men, trade, craft, etc.) that would serve as platforms for addressing these needs in collaboration with the relevant government agencies and civil society organizations.
- Recruit young peer educators to serve as ambassadors that carry reproductive health campaigns to their peers in schools and families.
- Make families (couples, parents and children) aware of the need to acquire reproductive health information and to discuss such among themselves.
- Tailor programs to focus on the direct participation of families (parents and adolescent children) in their design, implementation, management, and assessment.
- Create awareness on the cultural practices that endanger women's reproductive health (female genital mutilation, early marriage, unplanned pregnancies, etc) and discourage people from engaging in such practices, while perpetrators should be sanctioned.
- NGOs in collaboration with communal associations should sensitize community members on the dangers of discriminatory practices against women as an impediment to the general well-being of all in the community, thus encouraging a change in gender norms in order to create gender parity.

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