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RESEARCH ARTICLE

GENDER: THE CROSS-CUTTING ISSUE IN MATERNAL MORTALITY

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ABSTRACT

High maternal mortality in African countries has often been linked to the practice of male dominance (patriarchy) or gender inequality. This study aimed to examine how gender inequality or patriarchy plays out in maternal mortality. A comprehensive literature search was conducted on Google Scholar database. Findings indicated that several cultural practices in African countries have had unfavorable effects on maternal health. Women were victims of injustice in cultural practices because of their relative lack of decision-making power which adversely affects maternal health seeking behaviors. Some women were denied adequate family planning use because of lack of decision-making power and non-approval of contraceptive use by some men. All these expose women to the risk of maternal mortality from high parity. Gender-based violence during pregnancy such as wife beating was also reported to be common because of the low status of women and inadequate legal protection. Also, the traditional views on the roles of women as primary caregivers limit their access to productive land assets and training as well as education. Thus, many women have little or no control over financial resources. This often limits women's possibility to seek maternal health care which in turn contributes to high maternal mortality. The maternal death rate remains high because the cross-cutting issue, gender, in maternal mortality has not yet been addressed. Gender is a cross-cutting issue in maternal mortality because it matters in all the three major non-biomedical (socio-cultural, economic, and political) factors that contribute to high maternal mortality.

INTRODUCTION

The high maternal death rate in African countries has often been attributed to the practice of male dominance (patriarchy) or gender inequality. According to Kinanee and Ezekiel-Hart (2009) patriarchy is defined "as the dominance of men over women, patriarchy describes a family structure or a society where the man is, as of right, the head of household and regarded by the women as the lord and master whose decision about any and all issues, including those of maternal health is final". It encourages men's access to resource control. Male dominance entails that women are to depend almost entirely on men in making every decision that affects the family including, but not limited to the number of babies to have, when to get pregnant, usage or non-usage of contraceptives, whether or not to go for antenatal care, to mention a few, even when they are directly affected by such decisions (Kinanee & Ezekiel-Hart 2009). Gender is the social construction of roles allocated to men and women (O' Brien & White 2003). These roles differ geographically and change over time (O' Brien & White 2003). The conventional system in many African countries lay out specific roles that both men and women are to perform in their families and communities.

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For instance, from childhood, boys are raised with the mentality that they were to be strong and hardworking, so as to be able to take care of their wives and families effectively. Girls, on the other hand, were to focus on the domestic activities. They were to be subservient so as to find good husbands. In reality, the success of future depends on the success of the male figure in the family. Consequently, some women are not able to think independently or develop skills such as resourcefulness. Thus affecting their ability to make effective decisions affecting them and the family in general (Kinanee & Ezekiel-Hart 2009).

METHODS

A comprehensive literature search was conducted on Google Scholar database. Organizations' websites such as those of the United Nations Population Fund and World Population Awareness were also utilized. Publications of interest were those published in English and with information on gender, maternal health, and mortality. To facilitate the search, the following keywords were used: gender, patriarchal practices, patriarchal, gender roles, gender inequality, maternal mortality, maternal health, Africa, Nigeria, and maternal death. Fifty-five papers were retrieved. After screening of abstracts and application of the inclusion and exclusion criteria, sixteen papers were included in the final review.

RESULTS

Several studies have shown that women do not decide on their own to seek maternal healthcare; the decision belongs to the husband or senior members of the family (Ebeigbe *et al*., 2005; Nwokocha, 2006; Osubor *et al*., 2006; Lanre-Abass, 2008; Tukur *et al*., 2010; Marchie and Anyanwu, 2009). In Okolocha *et al*.'s study (1998), participants in focus group emphasized the need to obtain permission from their husbands before seeking maternal health care. Turkur *et al*. (2010) stated that many women reported having waited for their husband to return before they could seek help, which contributed to the delay in maternal healthcare-seeking behavior. They also mentioned that this was an accepted fact of life in many Nigerian communities. Gender-based violence during pregnancy such as wife beating was also reported to be common because of the low status of women and inadequate legal protection (Andersson *et al*., 2011). Okolocha *et al*. (1998) also mentioned that women were denied adequate family planning use because of lack of decision-making power by women and non-approval of contraceptive use by some men. All these expose women to the risk of maternal mortality from high parity (Okolocha *et al*., 1998).

Furthermore, Lawoyin et.al. (2007) stated that some men reported in the interviews that, in many places, women are treated as 'baby factories,' an attitude related to one of the triple roles of women identified by Moser. Moser (1993) identifies the concept of a triple role for low-income women, which includes productive, reproductive and community roles while men only take part in two: productive and community work. Moser (1993) defines productive works as the production of goods and services usually paid or income generating. Therefore, men have more access to employment, finances, education, and other resources. Reproductive work is the care and maintenance of household and related tasks; usually time-consuming, unpaid and unrecognized (March *et al*., 2000). The demands of this unpaid care work have harmful effects on women's movement and thus limit the utilization of maternal healthcare services. In addition, the traditional views on the roles of women as primary caregivers, fulfilling reproductive and unpaid domestic functions constrain their access to productive land assets and training as well as education (Lawoyin *et al*., 2007). Thus, many women have little or no control over financial resources. This often limits women's possibility to seek maternal health care which in turn contributes to high maternal mortality (Lawoyin *et al*., 2007).

DISCUSSION

Maternal mortality rate remains high because the cross-cutting issue, gender/patriarchy, in maternal mortality has not yet been addressed. Gender is a cross-cutting issue in maternal mortality because it matters in all the three major non-biomedical (socio-cultural [Odekunle, 2016a], economic and political) factors that contribute to high maternal mortality as identified by Odekunle (2016b) in her book titled "Maternal mortality burden: the influence of socio-cultural, economic and political factors".

Socio-culturally: it has been shown that gender inequality is one of the societal institutions that contribute significantly to maternal mortality in many African countries. Several cultural practices in African nations have had unfavorable effects on maternal health. Kinanee & Ezekiel-Hart (2009) highlighted that women were victims of injustice in cultural practices because of their relative lack of decision-making power which adversely affects maternal health seeking behaviors. Women need to be empowered to control their health and fertility. Meaning that they have the ability to decide whether or not to seek maternal healthcare, the spacing/timing and the number of their children and they should be free to make these decisions without discrimination, coercion or violence (United Nations Population Fund, 2010). This is in light of the third International Conference on Population and Development (ICPD) in Cairo 1994 ICPD that framed Reproductive Health (RH) as a human right issue and provided a broad and holistic RH concept, included sexual health; linked to gender equality and empowerment. A number of maternal deaths could be evaded if women had access to effective and efficient family planning and, more importantly, if they felt empowered to firmly require its usage (World Population Awareness, 2011). It is estimated that up to 200,000 maternal deaths worldwide could be avoided each year if women who did not want children could use effective contraception and could choose to have their children with adequate spacing between births and had complete families of moderate size (Park, 2007).

Economically: in many African countries, the income disparity between men and women is wide (Kinanee & Ezekiel-Hart 2009). As mentioned earlier, the unequal access to employment, finances, education, and other resources serve to exacerbate poverty in women (Grown *et al*., 2006). Poverty in turns limits women's access to modern maternal healthcare services, hence increases their risk of maternal mortality. Mothers are intensely vulnerable to the effects of costs incurred during deliveries (Filippi *et al*., 2006). Globally, millions of women are constantly denied of basic health due to poverty and discrimination. Britain's removal of these financial obstacles is one of the main achievements of the National Health Service (NHS) regarding gender equality (Doyal, 2001).

Politically: gender inequality comes into play due to lack of political will and leadership for the firm integration of gender into maternal health policies to transform the traditional gender-biased attitudes in the society. Women's subordination has not to be challenged to transform gender roles and create more gender equal relationships and empower women and girls. The commonest condition that pregnant mother in developing countries face, according to the WHO, is no access to healthcare (Arthur, 2006). Maternal health can be seen as a case of human rights not being upheld (Arthur, 2006). Women are not sufficiently valued or respected; if they were, essential resources would be made available to ensure their welfare and guarantee their rights (Arthur, 2006). All these factors reflect a lack of commitment to maternal health by policy-makers (Arthur, 2006). Gender inequality/patriarchy has not been sufficiently addressed probably because is a difficult, fuzzy concepts, and political leaders/designers and implementers of programs are often men, who may have something to lose. Also, some of these issues may seem 'natural' to people rather than unhelpful cultural constructions. According to Ruxton (2004), the following problems may be encountered in the gender sensitive programmes: many men are resistant to changing ideas, beliefs and behaviors, difficulties in accepting new roles e.g. as carers, difficulties in sharing power with women, cultural or political support for existing unequal power structures, male hostility to gender equality programmes.

The decision-making powers of men transcend through various areas other than maternal health matters. Shown in their various roles as traditional, political and religious leaders, husbands, and fathers. So it is vital that the decision-making power of men is used to play an active role to ensure favorable maternal health outcomes (Kinanee & Ezekiel-Hart, 2009).

Conclusion

Gender is a cross-cutting issue in maternal mortality, thus, gender sensitive programs such as transformative interventions that transform gender roles and create more gender equitable relationships are of paramount importance in the reduction of maternal mortality. Emancipation of women from their subordination and attainment of equality and empowerment is essential to improve women's decision-making power. This can be achieved through education. However, empowerment and emancipation of women from their subordination may encounter strong resistance where it is not being accepted as a legitimate aim. Additionally, the involvement of men as partners in maternal health would go a long way in the maternal mortality reduction. The essence of this is to call on men to play more responsible roles in maternal health such as care for their pregnant wife and take part in the task of parenting. Men need to be educated to change their attitude to getting involved in reproductive work so that women will have more time to take part in productive work. Similarly, women too need to be educated and not see domestic chores as their main work but to get involved in income generating work that will give them access to financial resources. Furthermore, men can be involved in maternal health as agents of positive change where they as actors in promoting gender equality and maternal health. This reflects the intent of the Cairo ICPD. Poverty alleviation program to improve woman welfare is vital in the prevention of maternal mortality such as endowing the poor with greater assets, as in land for farming; and developing programs to provide the poor with greater access to loan.

REFERENCES

Andersson, N., Omer, K., Caldwell, D., Dambam, M.M., Maikudi, A.Y., Effiong, B., Ikpi, E., Udofia, E., Khan, A., Ansari, U., Ansari, N. 2011. Male responsibility and maternal morbidity: a cross-sectional study in two Nigerian States. BMC health services research. 11(2):1-11.

Arthur, J. 2006. Paternity, Patriarchy, and Reproductive Rights speech, December 2, "Remember Me" memorial, Vancouver BC.

Doyal, L. 2001 Sex, gender, and health: the need for a new approach. BMJ,vol. 323(7320),pp.1061-1063.

Ebeigbe, P.N. Enabudoso E. and Ande A. B. A. 2005. Ruptured uterus in a Nigerian community :A study of sociodemographic and obstetric risk factors, Acta Obstetrics and Gynecology Scandinavica.84(12), pp.1172-1174.

Filippi, V., Ronsmans, C., Campbell, O.M.R., Graham, W. J., Mill, A., Borghi, J., Koblinsky, M. and Osrin, D. 2006. Maternal health in poor countries: the broader context and a call for action,the Lancet 368:1535-41'

Grown, C., Braunstein, E., & Malhotra, A. 2006. Trading women's health and rights?: trade liberalization and reproductive health in developing economies. Zed Books.

Kinanee and Ezekiel-Hart 2009. Men as partners in maternal health: Implications for reproductive health counselling in Rivers State, Nigeria Journal of Psychology and Counseling Vol. 1(3), pp. 039-044.

Lanre-Abass B.A. 2008. Poverty and maternal mortality in Nigeria: towards a more viable ethics of modern medical practice, International Journal for Equity in Health.7,p.11.

Lawoyin, T.O., Lawoyin, O.O., Adewole, D.A. 2007. Men's perception of maternal mortality in Nigeria. J Public Health Policy.28[3], pp.299-318.

March C. Smyth I and Mukhopadhyay M. 2000. A Guide to Gender-Analysis Frameworks Oxfam, Oxford Chap3.

Marchie C.L. and Anyanwu F.C 2009. relative contributions of social cultural variable to maternal mortality in Edo South Senatorial District, Nigeria, African Journal Reproductive Health.13(4), pp.67-72.

Moser C. 1993. Exert from Gender, Planning and Development Theory: practice and training Routledge, London.

Nkwocha G.C. Anya S.E. and Anya A.E. 2006. obstetric mortality in a Nigerian General Hospital, Nigerian Journal of medicine.15(1), pp.75-76.

O' Brien O. and White A. 2003. Gender and Health: The case for Gender-Sensitive health policy and healthcare delivery in 1st UK gender and health summit London [online] available at: http://eresearch.qmu.ac.uk/2227/[Accessed February 28 2012].

Odekunle, F.F. 2016a. Maternal Mortality Burden: The Influence of socio-cultural factors. International Journal of Health Sciences and Research (IJHSR).;6(12):316-24.

Odekunle, F.F. 2016b. Maternal Mortality Burden: The Influence of socio-cultural, economic and political factors. LAMBERT Academic Publishing. Saarbrucken, Deutschland/Germany.

Okolocha C., Chiwuzie, Braimoh S., UnuigbeJ.andOlumeko P. 1998. socio-cultural factors in maternal morbidity and mortality: a study of a semi-urban community in southern Nigeria. J. Epidemiol. Community Health.52, pp.293-297.

Osubor K.M., Fatus, A.O. and Chiwuzie J.C. 2006. Maternal Health –seeking behaviour and Associated factors in a Rural Nigerian community, maternal and child Health Journal. 10[2], pp. 159-169.

Park, K. 2007. Text book of preventive and social medicine 19th Ed. Jabalpur,India: Banarsidas Bhariot.

Ruxton, S. (ed) 2004. Gender Equality and Men: Learning from Practice. Oxford, Oxfam.

Tukur, B.M., Bawa Umma, Odogwu K. Adaji S,Passano P and Suleiman I. 2010. praying for Divine intervention. The reality of the 'three delays' in Northern Nigeria, African Journal Reproductive Health.14(3), pp.113-119.

United Nations Population Fund. 2010. The right to contraceptive information and services for women and adolescents. Available At: https://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf [Accessed April 30 2012].

World Population Awareness. 2011 How to Attain Population Sustainability. Available At:http://www overpopulation.org/pop-sustainability.html? [Accessed April 30 2012].

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