Gender Inequality on Women's Access to Health in Developed and Developing Countries with Reference to Nigeria

Usman Sambo, Hadiza Mali Bukar & Halima Ali Buratai

Department of Public Administration,
Yobe State University
Corresponding author: ussambo2@gmail.com

Abstract

The research is a comparative study of Gender Inequality on Women's Access to Health in developed and developing countries. The researcher indicated his interest on the topic because of the vital role women play in the overall development of the society in the world. The researcher employed the use of secondary data in his data collection technique in order to carry out this work. In the process of the work, the researcher mentioned indicators and measures of inequality generally in the developed and the developing countries. These measures are: Poverty, Health, Access to Resources, Education, Globalization, Governance, Conflict and Emergencies and Human Right. The above were discussed in order to assess the Human Development Index (HDI), the Gender Empowerment Measures (GEM) and the Gender Development Index (GDI) of developed and developing countries. Attention was then focused on the factors of inequality in the access to health services which is the main concern of the paper. These factors that were discussed in the comparative analysis were; Maternal Mortality, Life Expectancy, HIV/AIDS, Nutritional Status and Anaemia. The research work reveals that the disparity in maternal mortality ratios between the developed and the developing countries is greater than any other indicator. It is therefore suggested among others that global health service emergency should be declared by the WHO and compel both developed and developing countries to respond not only by initiating policies that take into consideration the Health of women as the vital partners of sustainable development but by acting on the policies.
Keywords: Comparative, Developed, Developing, Gender, Health, Inequality.

Introduction

The issue of Gender Equality has over the years been a topical issue worldwide and most especially in developing countries. The issue has been generating a lot of controversies and has become a source of concern for Governments worldwide (Ojanuga & Gilbert, 1992). There is the growing demand for information on gender equality which serves as an important tool for development. This is because of the following reasons according to DFID (2008) report several issues some of which are: Raising awareness among policy makers of the need for the engendering of development; Proving a foundation for the formulation of gender sensitive policies and programmes; Assessing the monitoring and evaluation of policies for their gendered effect and measure process towards addressing gender inequality and Challenging unhelpful stereotypes in societies that misrepresent women's contribution to social and economic life.

In view of the above, the UNDP report (1997) was quick to state that 'If development is not engendered, it is endangered'. The above was further supported by the Beijing Platform for Action (1995) which highlighted the different needs of women and men, girls and boys. These

are affected by policies in different ways and hence experience development differently but all have the right to share in the benefits of development. If sustainable development is to be achieved, an engendered approach to development policy and practice is essential.

The shift from a focus on women in isolation, to a focus on gender, ensures a more comprehensive view of the co-operation and conflict between women and men. Of key concern are inequalities in the division of responsibilities, and access to and control over resources. Gender relations within the household are as important mediator of women's life outcomes, as are gender relations within other institutions such as the community, market, and the state. In addition, other aspects of social differentiation which cross-cut gender - such as class, caste, age, race, and ethnicity – cannot be ignored (Obadina, 2023). The research intends to comparatively look into these gender inequality issues with particular reference to unequal access to health by women in some developed and developing countries in order to find out where and what the problems are and proffer some solutions. Recent reports by UNIEF, UNDP and WHO in 2018 revealed a disturbing figure of the level of gender inequality across the globe and particularly in Sub-Saharan Africa where its prevalence is higher (Odeyemi & Nixon, 2013). This study examined these trends relying on reports, statistics and data from the above-mentioned agencies to make the case for the danger of gender inequality in the 21st century.

Table 1: Gender disparity: comparisons of GEM, GDI and HDI ranks, with GDP

Country	GEM rank	GDI rank	HDI rank	Real GDP per capita (PPP$)[2] 1992
Developed/ing country comparisons:				
Trinidad and Tobago	17	27	32	9,760
UK	20	12	14	17,160
Mexico	31	41	38	7,300
Japan	34	11	6	20,520
Botswana	39	54	59	5,120
France	40	5	2	19,510

Africa:				
Mozambique	43	85	91	380
Zambia	71	77	83	1,230
Mali	83	86	92	550
Asia:				
Bangladesh	76	80	84	1,230
India	86	75	80	1,230
Pakistan	92	76	81	2,890

Source: Adapted from UNDP, 1995: 41, Table 2.9

We shall now concentrate on women's inequality in access to health which is our main concern in this paper. The current rend of global gender inequality indicates that men are better off in the higher performing countries than in countries with lower living standard. This work carefully selected five top performers, middle performers and lower performers with gender differences as indicated in the table below.

Table 2: Comparative Level of Gender Inequality in Some Selected Countries Based on Performance

S/ No.	**Country**	**Gender Development Index**	**Human Development Index (Women)**	**Human Development Index (Men)**	**The Difference in favour of Gender**
Top 5 in the World					
1.	Qatar	1.031	0.870	0.843	0.027 (women)
2.	Latvia	1.030	0.858	0.834	0.024 (women)
3.	Lithuania	1.026	0.868	0.846	0.022 (women)
4.	Mongolia	1.023	0.750	0.733	0.027 (women)
5.	Belarus	1.020	0.814	0.799	0.015 (women)
Middle Top 5 in the World					
1.	Chile	0.961	0.823	0.856	0.033 (men)
2.	Kyrgyzstan	0.960	0.654	0.681	0.028 (men)
3.	Malta	0.960	0.858	0.893	0.035 (men)
4.	Tonga	0.960	0.707	0.736	0.029 (men)
5.	United Kingdom	0.960	0.903	0.941	0.038 (men)
Lower Performers in the World					
1.	Central African R.	0.780	0.319	0.409	0.090 (men)
2.	Chad	0.775	0.350	0.425	0.075 (men)
3.	Pakistan	0.750	0.465	0.620	0.155 (men)
4.	Afghanistan	0.625	0.364	0.583	0.219 (men)
5.	Yemen	0.425	0.223	0.524	0.301 (men)

Source: UNDP 2019.

The above table indicate a pattern of gender inequality in some selected countries. The table disclosed that although, women recorded an impressive higher living standard in the top performers, in most of the average and bottom countries, the gap of inequality is higher in favour of men against women including the developed countries like United Kingdom.

Methodology

This work used secondary sources of data for data collection. Various sources including books, journals, internet sources, reports from local and international agencies and organisations and other related documents were used as sources of data for the research. The data collected were discussed and interpreted using content analysis where some charts, maps, tables and other data were comparatively analysed and interpreted to support the arguments of the paper on the subject of discussion.

Discussions and Findings

In this section, data collected were discussed and analysed accordingly based on the subject matter of study. The work here concentrates on women's inequality in access to health which is our main concern in this paper.

According to WHO report (1998), the gaps between the health status of rich and poor are at least as wide as they were half a century ago, and are becoming wider still. Policies to improve the health status of the poor have been an important focus of development policy over the past 25 years in all the regions of the world.

Gender gaps are also persistent in health status, in access to health services, and in health outcomes. This signals that gender inequality, as well as poverty, needs to be addressed in health sector reform. For instance, according to the World Bank report (1994), in 1990, over one third (36 percent) of 'healthy life' lost by adult women (15-44) was caused by reproductive health problems, especially maternity-related causes and sexually transmitted diseases (STDs), compared to only 12 percent for men. An additional five percent of 'healthy life' lost by women was estimated to be due to gender violence and rape (Vlassoff, 1994).

The above is undoubtedly a worrisome situation which must be addressed if countries of the world are to achieve sustainable development. To find out the problem, I therefore intend to compare the following health indicators in developed and developing countries in the analysis of unequal access to health by women. These indicators are:

1. Maternal mortality 2. Life expectancy 3. HIV/AIDS 4. Nutritional status 5. Anaemia.

Maternal Mortality

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. From 2000 to 2017, the global maternal mortality ratio declined by 38 per cent – from 342 deaths to 211 deaths per 100,000 live births, according to UN inter-agency estimates. This translates into an average annual rate of reduction of 2.9 per cent. While substantive, this is less than half the 6.4 per cent annual rate needed to achieve the Sustainable Development global goal of 70 maternal deaths per 100,000 live births (UNICEF, 2018).

There has been significant progress since 2000. Between 2000 and 2017, South Asia achieved the greatest overall percentage reduction in MMR, with a reduction of 59 per cent (from 395 to 163 maternal deaths per 100,000 live births). Sub-Saharan Africa achieved a substantial reduction of 39 per cent of maternal mortality during this period (UNICEF, 2018).

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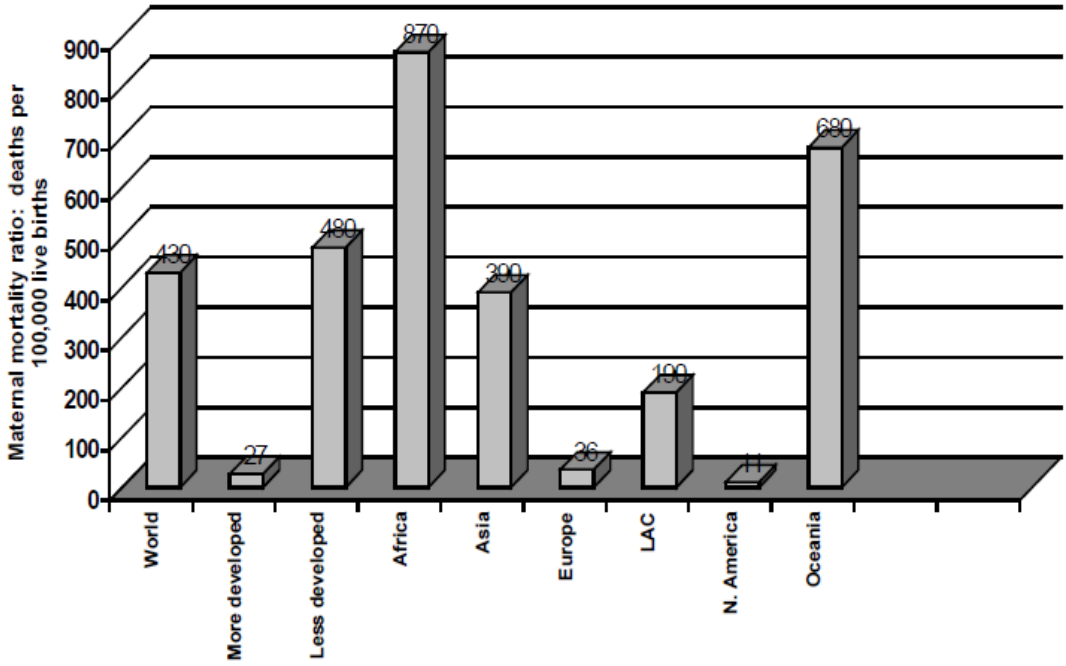
According to WHO report (1995), the disparity between developed and developing countries in maternal mortality ratios is greater than for any other indicator. Every year, around 200 million women become pregnant, of these:

Figure 1: Maternal mortality ratio (MMR) by region, 1990



Source: adapted from WHO/UNICEF, 1996: 3

Table 3: Maternal Mortality Comparisons Among Some Selected Developing Countries in 1997

Table 2: GDP: maternal mortality comparisons

	GDP (1994) (1987 $)	*MMR (1990)*
Mozambique	132	1,500
Malawi	133	560
Indonesia	522	650
Sri Lanka	676	140

Source: adapted from UNDP, 1997: 166-7; 174-5

Recent data after several years from the above study still indicate that maternal mortality rate is higher in developing countries even though it is generally declining in the globe as shown by the map below.

gure 2: Showing A Comparative Incidence of Maternal Mortality Rate Across Regions in the World.

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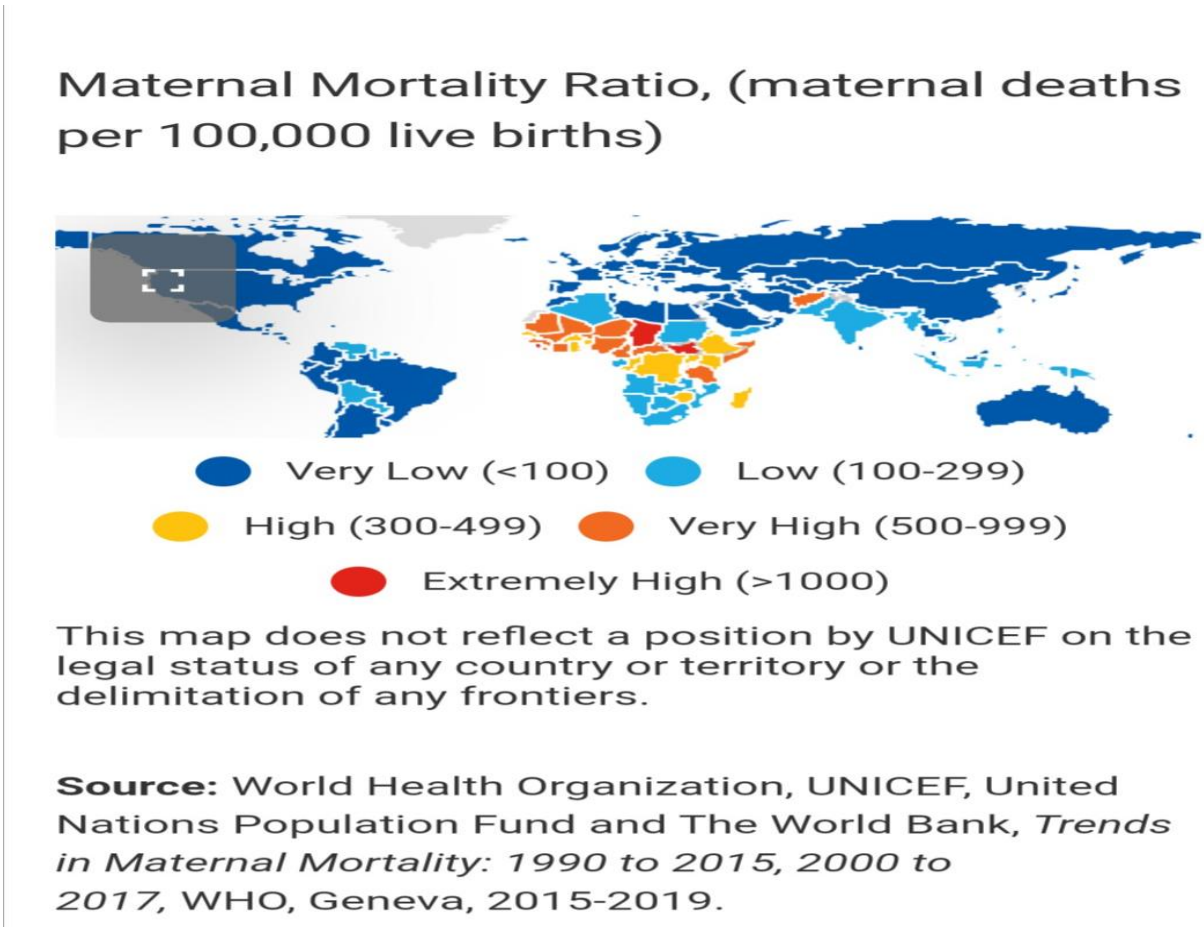

Source: UNICEF 2018.

From the above map, it can be shown that the number of women and girls who died each year from complications of pregnancy and childbirth declined from 451,000 in 2000 to 295,000 in 2017. These improvements are particularly remarkable in light of rapid population growth in many of the countries where maternal deaths are highest. Still, over 800 women are dying each day from complications in pregnancy and childbirth. And for every woman who dies, approximately 20 others suffer serious injuries, infections or disabilities (UNICEF, 2018).

Two regions, sub-Saharan Africa and South Asia, account for 86 per cent of maternal deaths worldwide. Sub-Saharan Africans suffer from the highest maternal mortality ratio – 533 maternal deaths per 100,000 live births, or 200,000 maternal deaths a year. This is over two thirds (68 per cent) of all maternal deaths per year worldwide. South Asia follows, with a maternal mortality ratio of 163, or 57,000 maternal deaths a year, accounting for 19 per cent of the global total. Furthermore, regional and global averages tend to mask large disparities both within and between countries (UNICEF, 2018).

Every region has advanced, although levels of maternal mortality remain unacceptably high in sub-Saharan Africa. Almost all maternal deaths can be prevented, as evidenced by the huge disparities found across regions and between the richest and poorest countries. The lifetime risk of maternal death in high-income countries is 1 in 5,400, compared to 1 in 45 in low-income. The global lifetime risk of maternal death nearly halved between 2000 and 2017, from 1 in 100,

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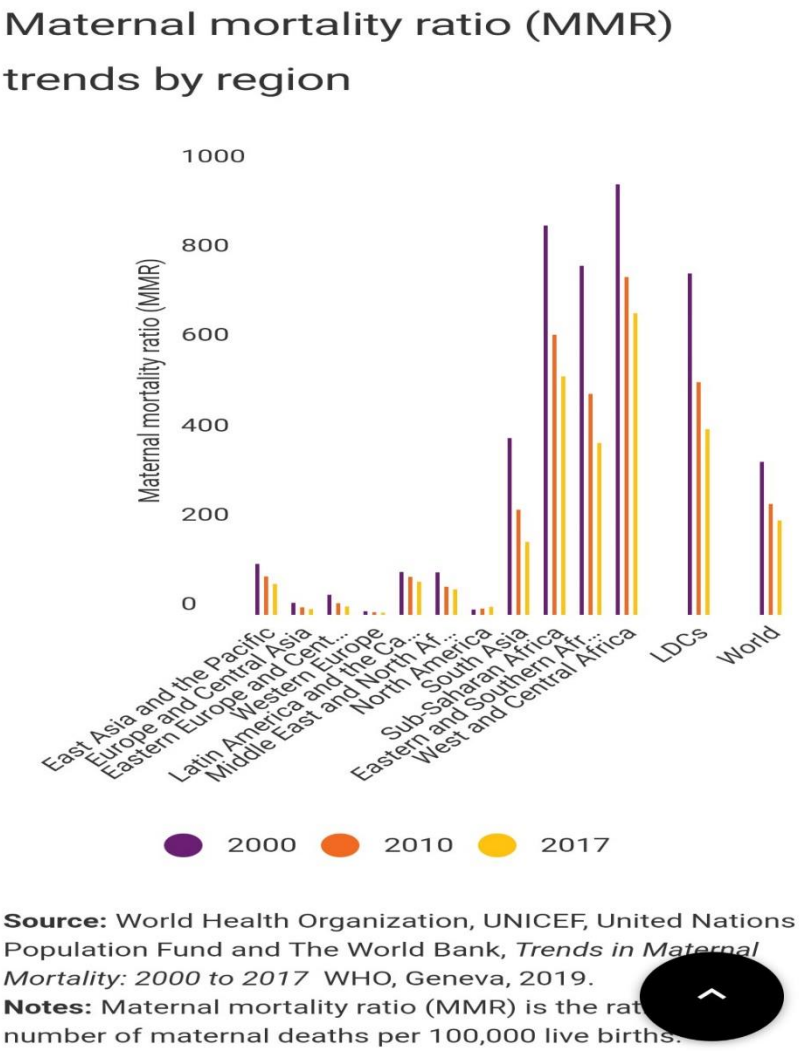
to 1 in 190 (UNICEF, 2018). The trend in global maternal mortality indicates that the countries of Sub-Saharan Africa are the worst hit as shown below in figure 3.

Figure 3: Trends in Global Distribution of Maternal Mortality Across the World Regions



Source: WHO 2018

Haemorrhage remains the leading cause of maternal mortality, accounting for over one quarter (27 per cent) of deaths. Similar proportions of maternal deaths were caused indirectly by pre-existing medical conditions aggravated by the pregnancy. Hypertensive disorders of pregnancy, especially eclampsia, as well as sepsis, embolism and complications of unsafe abortion also claim a substantial number of lives (UNICEF, 2018).

Life Expectancy

Life expectancy at birth reflects the overall mortality level of a population. It summarizes the mortality pattern that prevails across all age groups in a given year – children and adolescents, adults and the elderly. Global life expectancy at birth in 2016 was 72.0 years (74.2 years for females and 69.8 years for males), ranging from 61.2 years in the WHO African Region to 77.5

years in the WHO European Region, giving a ratio of 1.3 between the two regions. Women live longer than men all around the world. The gap in life expectancy between the sexes was 4.3 years in 2000and had remained almost the same by 2016 (4.4) (WHO, 2018).

Global average life expectancy increased by 5.5 years between 2000 and 2016, the fastest increase since the 1960s. Those gains reverse declines during the 1990s, when life expectancy fell in Africa because of the AIDS epidemic, and in Eastern Europe following the collapse of the Soviet Union. The 2000-2016 increase was greatest in the WHO African Region, where life expectancy increased by 10.3 years to 61.2 years, driven mainly by improvements in child survival, and expanded access to antiretrovirals for treatment of HIV (WHO, 2018).

Whilst it is believed that women tend to live longer than men in all regions of the world, the absolute gap varies greatly. This is determined by a combination of biological and socio-economic factors that are not fully understood due to the complex nature of societies and their socio-economic lives. However, maternal mortality, female infanticide, and male-bias in food and health care allocation in the household, are factors that can reduce female life expectancy. Figure 4 below shows that women outlive men in all regions although there are significant differences in the absolute life expectancy between regions and the life expectancy between women and men between regions.

A comparative analysis reveals that whilst in Central Asia women's life expectancy is six to eight years in their favour, in South Asia there is no gender difference in life expectancy (UNFPA, 1998). In South Asia there is some evidence of son preference and active discrimination against girls, through sex-selective abortion, female infanticide and discriminatory feeding. Sex discrimination is even greater against high birth order children (UNFPA, 1998).

Also, the analysis further unveiled the fact that in Western societies the gap between men and women has widened in the last decade. Women's life expectancy has increased whereas male life expectancy has stagnated or even decreased, as in Eastern Europe (UNFPA, 1998). Contributing factors for men in addition to greater vulnerability in infancy are causes of mortality associated with lifestyle such as from car accidents, violence, alcoholism, diseases of affluence, and HIV/AIDS. Significantly, for instance in the Russian Federation (see Figure 2 below) a twelve-year difference in favour of women is found, primarily as a result of a decrease in male life expectancy (rather than any improvement in women's life expectancy).

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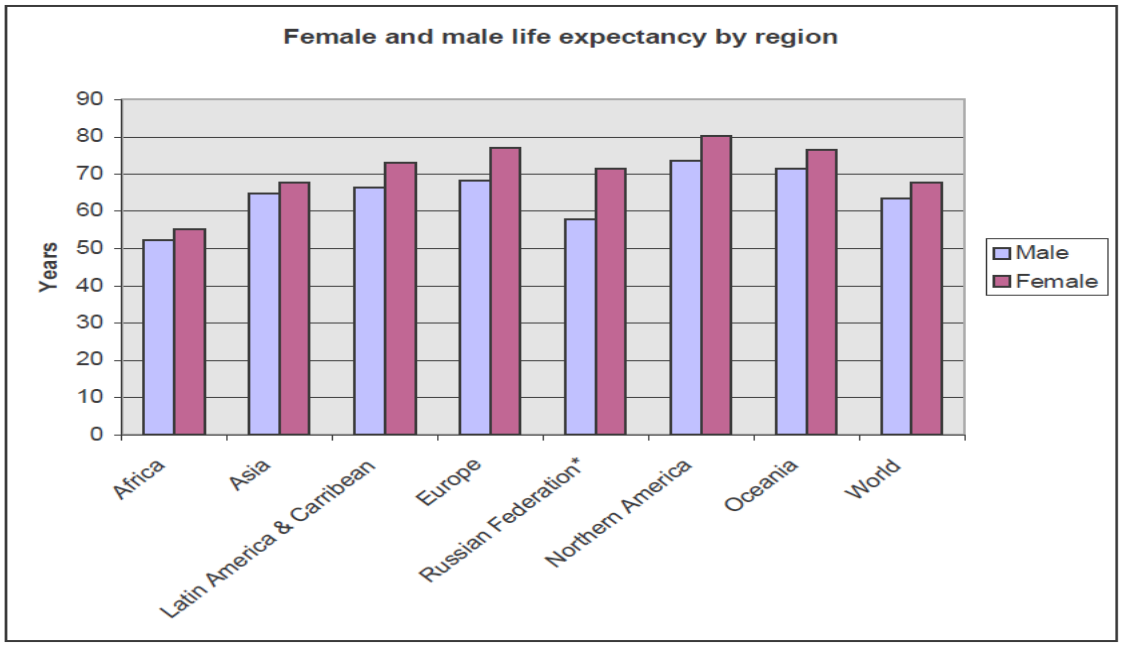
Figure 4: Comparison of Female and Male Life Expectancy by Region in 1998



Source: adapted from UNFPA 1998, Statistical tables

* as no aggregated data was available, the Russian Federation stands as one example of "countries with economies of the former USSR" (UNFPA 1998)

In Nepal women live on average half a year less than men, compared to the UK where women live on average five years longer than men. Table 3 below shows the absolute life expectancy at birth of females and males, and the absolute gap in years between them. In India, where families tend to favour boys to girls, women outlive men only by an average of one month. However, in Sri Lanka, women outlive men by four and a half years on average. We can see larger absolute gaps in life expectancy on average between women and men in the African countries listed compared to Asia. However, both men and women in nine African countries, according to UNFPA data, have an average life expectancy below fifty years (UNFPA, 1998).

Table 4: Female and Male Life Expectancy in Some Selected Countries in 1998

Table 3: Female and male life expectancy in selected countries

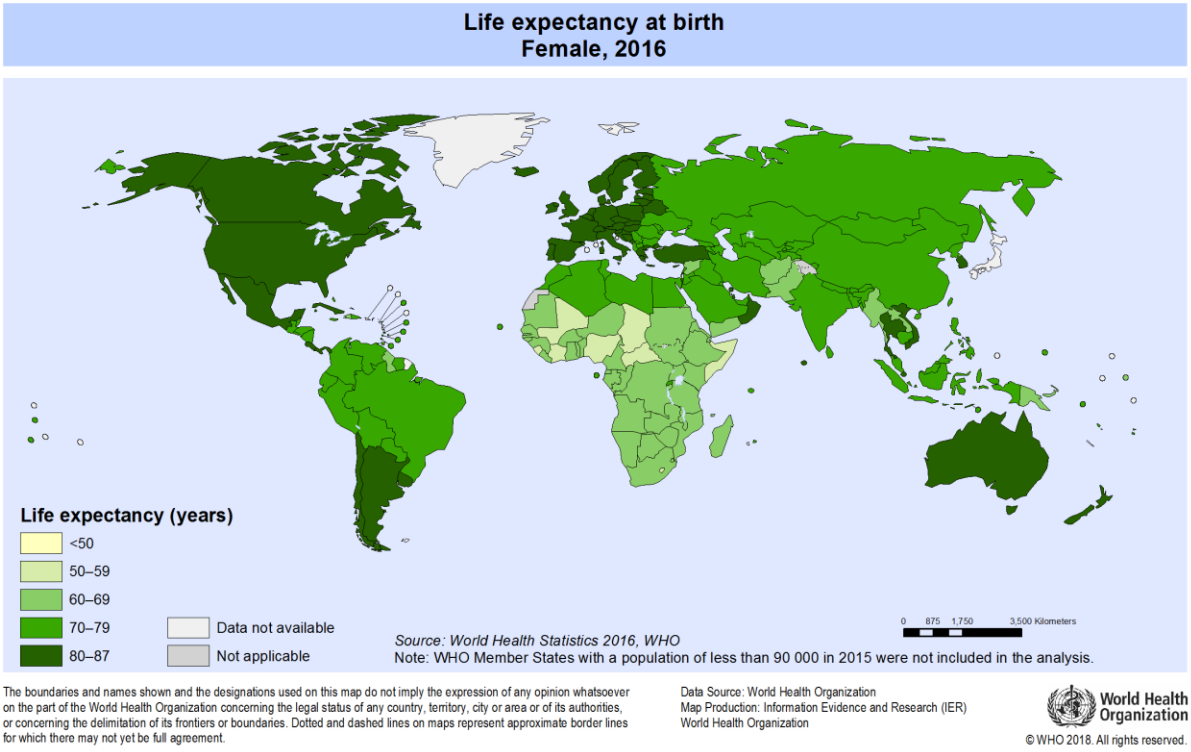
Country	Male (years)	Female (years)	Absolute gap (years)
Asia			
Nepal	57.6	57.1	-0.5
India	62.1	62.2	0.1
China	68.2	71.7	3.5
Sri Lanka	70.9	75.4	4.5
Africa			
Uganda	40.4	42.3	1.9
Botswana	48.8	51.7	2.9
Ghana	56.2	59.9	3.7
South Africa	62.3	68.3	6
Europe and N.America			
United Kingdom	74.5	79.8	5.3
United States of America	73.4	80.1	6.5
Finland	73.0	80.8	7.8
Hungary	64.5	73.8	9.3

Source: adapted from UNFPA, 1998, Statistical tables

Child mortality data for some countries show higher mortality rates among girls than boys. While infant mortality rates are generally higher among boys than girls for biological reasons, child mortality data for some countries show higher mortality rates among girls than boys. This is the case for India and China (World Bank, 1993, cited in World Bank, 1994: 15). For Pakistan, the ratio is as high as 1.6 female deaths per 1 male death. Other countries with a female: male ratio of child deaths of over 1 include: Togo, Dominican Republic, Cameroon, Mexico, Burundi, Niger, Guatemala, Peru, Zimbabwe, and Mali (World Bank report 1994).

The above comparative figures change positively after several years as the 2017 and 2018 indices indicate significant improvement in the life expectancy of women in comparison with women in several countries. However, the level of comparison still shows that women have a less life expectancy in developing countries especially in Sub-Saharan Africa due to complications in pregnancy, birth and maternal mortality rate in addition to HIV/AIDS and malnutrition as shown in the maps below.

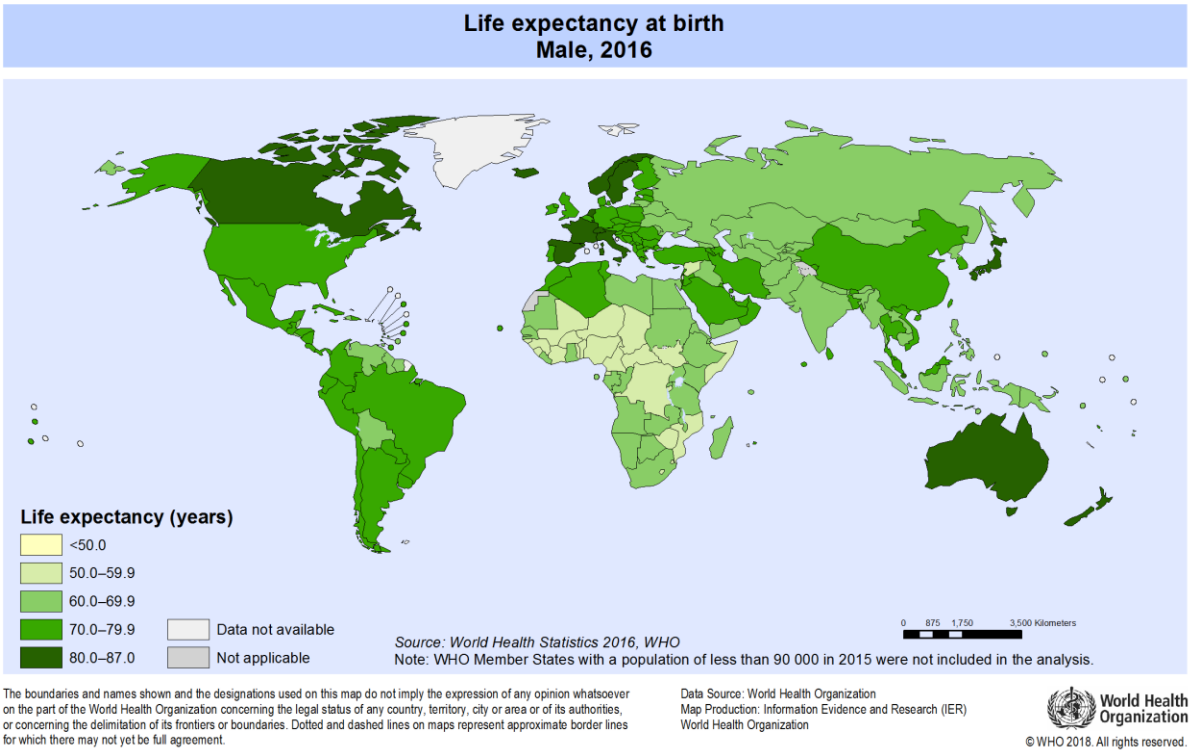
Figure 5: Global Life Expectancy at Birth for Female in 2016



Source: World Health Organisation 2018.

The life expectancy for male indicate a better performance as indicated in the map below.

Figure 6: Global Life Expectancy at Birth for Female in 2016



Source: WHO 2018.

Overall, the life expectancy of female should have been higher across the world but in developing countries like Sub-Saharan Africa the reverse is the case due to the factors that were identified above. This indicates a serious case of concern for policymakers towards gender health issues which is vital for societal well-being.

HIV/AIDS Prevalence

Whilst more men than women have contracted HIV to date, the gap is closing:
• 41 percent of those currently infected with HIV/AIDS are female;
• 31 percent of the 11.7 million persons who have died of AIDS are women;
• 46 percent of those who died of AIDS in 1997, were women;
• 8 million children under 15 have lost their mothers to AIDS, and many also lost their fathers, since the beginning of the epidemic (UNAIDS estimates, 1997).

The transmission of HIV/AIDS from men to women is 2-4 times more efficient than from women to men (WHO, 1995: 28) and adolescent girls may be more physiologically vulnerable to HIV infection than many older women (World Bank, 1994: 19). Women also progress to AIDS earlier than men.

In sub-Saharan Africa, women now form half of the estimated 20 million HIV-infected persons (see Table 4 below). In the Caribbean, with the next highest adult prevalence rate of 1.82

percent, 33 percent of those infected are female. In other developing regions, the proportion of those infected that are women varies from 20-33 percent (UNAIDS, 1997).

The percentage of women infected is high where heterosexual transmission dominates, again mainly in sub-Saharan Africa and the Caribbean. The percentage of women among those infected is particularly low in East Asia and the Pacific (13 percent) and Australia/New Zealand (six percent). Overall, the highest concentration of infected women occurs in Africa (80 percent of the global total) followed by South and Southeast Asia (13 percent).

Table 5: Regional Patterns of HIV/AIDS in 1997

Table 4: Regional patterns of HIV/AIDS

Estimations, 1997	Epidemic started*	Main modes of transmission*	% adults living with HIV/AIDS	% of adults living with HIV/AIDS which is female	distribution of adult women living with HIV/AIDS (%)
Sub-Saharan Africa	Late 70's, early 80's	Hetero	7.41	50	81.1
North Africa & Middle East	Late 80's	IDU, Hetero	0.13	20	0.3
South & South-East Asia	Late 80's	Hetero	0.61	26	12.3
East Asia & Pacific	Late 80's	IDU, Hetero, MSM	0.05	13	0.4
Latin America	Late 70's, early 80's	MSM, IDU, Hetero	0.52	18	2.0
Caribbean	Late 70's, early 80's	Hetero, MSM	1.82	33	0.8
North America	Late 70's, early 80's	MSM, IDU, Hetero	0.55	20	1.4
Western Europe	Late 70's, early 80's	MSM, IDU	0.23	21	0.8
Eastern Europe & Central Asia	Early 90's	IDU, MSM	0.09	21	0.3
Australia & New Zealand	Late 70's, early 80's	MSM, IDU	0.11	6	0.0
Total:			0.97	41	100.0
Million			29.5	12.1	12.1

Source: adapted from UNAIDS 1998; * UNAIDS, 1997. For more recent data on estimations of female/male HIV/AIDS infections and reported AIDS cases see WHO, 1998)
Note:
Hetero: heterosexual
MSM: men who have sex with men
IDU: Intravenous drug users

The above statistics were old data in usage but were presented for comparison to show the pattern of increase or decrease in terms of HIV/AIDS prevalence and distribution in the regions as shown in the map below.

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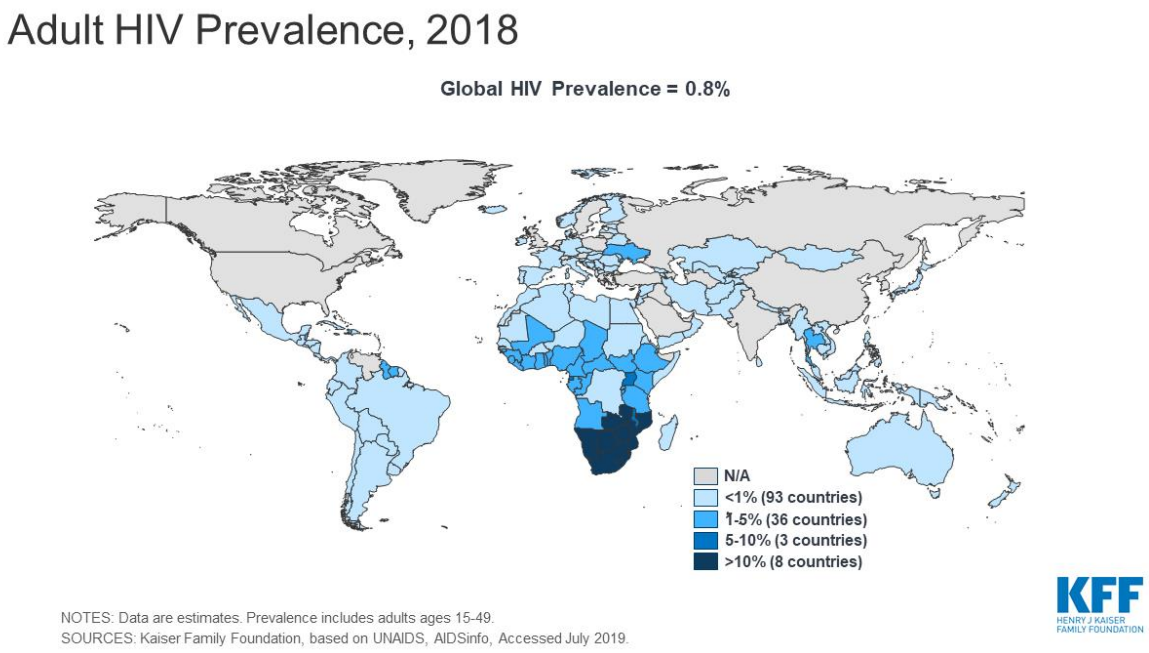
Figure 7: Global Regional HIV/AIDS Prevalence in 2018



Source: UNDP 2019.

The map above shows that the prevalence of HIV/AIDS is in East Africa followed by South and Sub-Saharan Africa. According to the *Global Burden of Disease* study, almost one million (954,000) people died from HIV/AIDS in 2017. To put this into context: this was just over 50% higher than the number of deaths from malaria in 2017. It's *one of* the largest killers globally; but for some countries – particularly across Sub-Saharan Africa, it's *the* leading cause of death. If we look at the breakdown for South Africa, Botswana or Mozambique – which you can do on the interactive chart – we see that HIV/AIDS tops the list. For countries in Southern Sub-Saharan Africa, deaths from HIV/AIDS are more than 50% higher than deaths from heart disease, and more than twice that of cancer deaths (WHO, 2018).

The large health burden of HIV/AIDS across Sub-Saharan Africa is also reflected in death rates. Death rates measure the number of deaths from HIV/AIDS per 100,000 individuals in a country or region. In the interactive map we see the distribution of death rates across the world. Most countries have a rate of less than 10 deaths per 100,000 – often much lower, below 5 per 100,000. Across Europe the death rate is less than one per 100,000. Across Sub-Saharan Africa the rates are much higher. Most countries in the South of the region had rates greater than 100 per 100,000. In South Africa and Mozambique, it was over 200 per 100,000 (WHO, 2018).

The health and mortality burden of HIV/AIDS across Sub-Saharan Africa has been large: we see this when we look at the share of deaths caused by the disease. This impact on health reflected in trends in life expectancy. In the visualization above shown above, changes in life expectancy occurred across select countries in Sub-Saharan Africa for which HIV/AIDS has had the largest toll. We see a dramatic drop in life expectancy around 1990 – which coincides with the rise of

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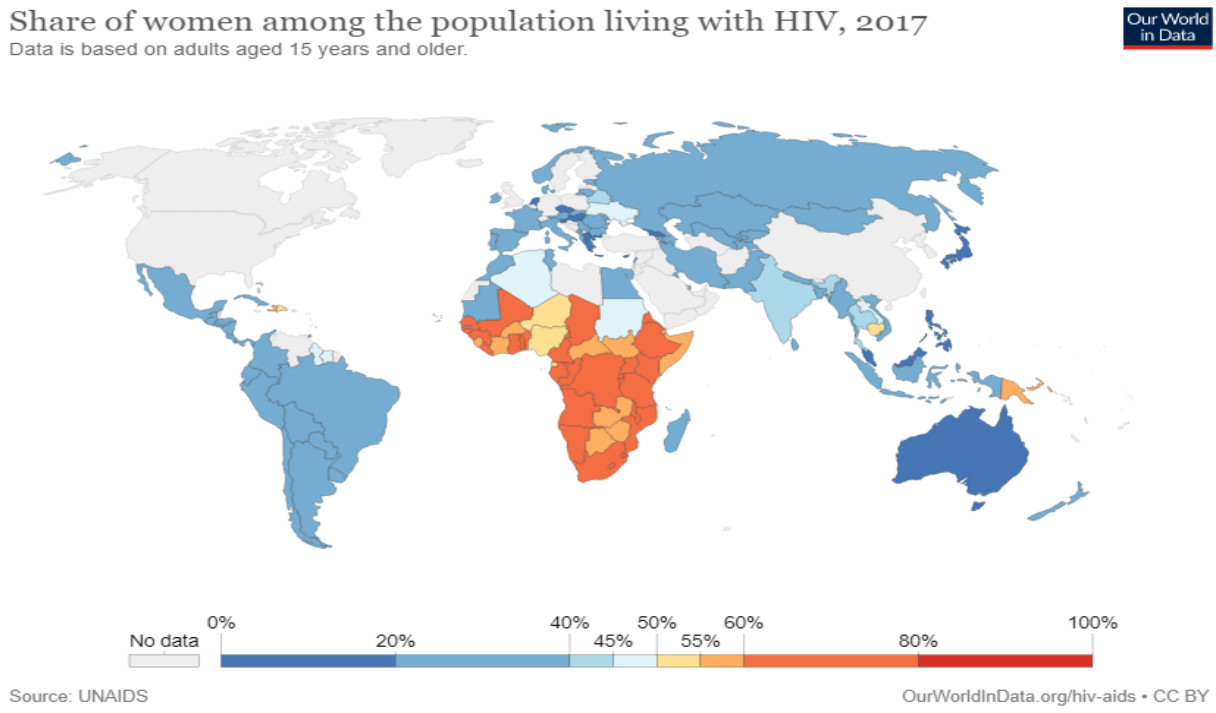
HIV. In Bostwana, life expectancy fell by a decade; in Swaziland it fell by two decades. Since the early 2000s – as progress has been made on tackling HIV – we see that life expectancy has been

As we see, HIV prevalence tends to be higher in women across Sub-Saharan Africa, although higher in males across most other regions. The trend in AIDS-related deaths shows the opposite: more men tend to die from AIDS every year than women. The reasons for differences in prevalence and death rates are complex; however, in general, across Sub-Saharan Africa women tend to be infected with HIV earlier than men and survive longer (explaining both the higher prevalence and lower annual AIDS deaths in women). There are a number of gender inequality and social norm issues which result in higher prevalence of HIV in females across many countries; women are at greater risk when they have a limited role in sexual decision-making and protection, role rates of sexual education and higher rates of transactional sex (WHO, 2018).

gure 7: Share of Women in HIV/AIDS in 2017 Globally



Source: WHO 2018.

Nutrition

Malnutrition indicators are rarely disaggregated by sex and when they are, show a mixed picture. Malnutrition rates, in fact, tend to be slightly worse for boys than girls in most countries. There

are some exceptions, for example, in Sri Lanka, Tunisia and Yemen, stunting is more prevalent among girls than boys. In some countries, girls are more likely than boys to be underweight e.g. Cameroon, Seychelles, Mali and Zimbabwe in Africa; China, Indonesia and Sri Lanka in Asia (Heike, 2000).

In South Asian countries, there is evidence of girls having poorer nutritional outcomes than boys:
• 59 percent of girls suffer from chronic malnutrition in Bangladesh compared to 56 percent of boys.
• 10 percent of girls suffer from acute malnutrition, compared with 7 percent of boys.
• overall, females achieve 88 percent of the satisfactory nutritional intake (IWTC, 1998 quoted in Heike, 2000).

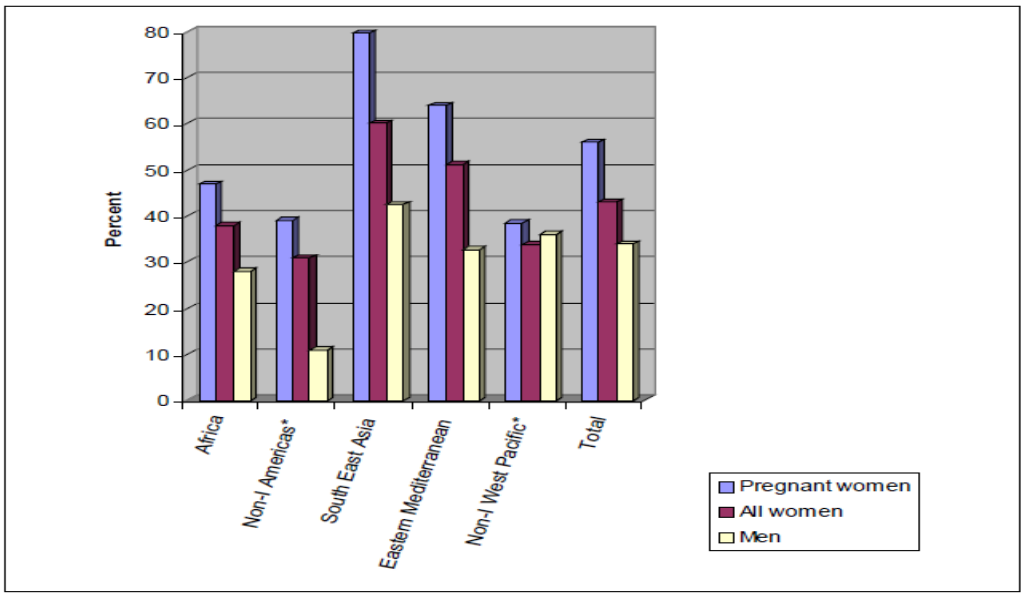
Women's nutritional status and their vulnerability to malnutrition vary throughout their lifecycle. Indicators that describe women's nutritional status include trends in Anaemia, low birth weight deliveries, measures of the body mass index (BMI), arm circumference, stunting (retarded growth due to chronic malnutrition) or underweight (WHO, 1997).

Anaemia

It is reported that 43 percent of all women and 34 percent of all men are anaemic in the developing world (WHO, 1997). Iron Deficiency Anaemia (IDA) is the most common nutritional deficiency worldwide with 90 percent of all affected people living in developing countries. Figure 3 below reveals the significantly higher incidence of Anaemia in women, particularly of pregnant women. South East Asia is particularly noted for the high incidence of Anaemia; almost 80 percent of pregnant women are anaemic. Anaemic women experience a higher risk of maternal mortality and morbidity. In general, Anaemia causes weakness and fatigue and thus reduces the capacity for production. In infants and children iron deficiency is associated with impaired physical and cognitive development which has life-long irreparable consequences.

Causes of Anaemia include inadequate intake of iron, increased need for iron (e.g. during growth or pregnancy), chronic blood loss, and limited capacity of the body to utilise iron (e.g. in the case of parasites and sickle cell Anaemia) (WHO, 1997). In order to sustain comparable levels to men, women would have to take in comparably greater amounts of iron, which is best accessible through meat products and green vegetables. Food taboos during pregnancy and biases in household food distribution may contribute to higher rates of Anaemia in women in certain countries (as illustrated in figure 8 below).
Figure 8: Prevalence of Anaemia Among Different Populations

Figure 3: Prevalence of anaemia among different populations



Source: adapted from ACC/SCN, 1997:35, based on national data from WHO
Note: *Non-I = Non-industrialised

Overview of the Situation in Nigeria

Nigeria as a developing country also has over years recognized the need to include women in its development initiatives thereby answering the global call on gender equality. All these programmed could not make positive impact into the lives of the Nigerian women due to the political ideology and the vision of the successive leaders and their wives as the first ladies who saw it as a crime to continue with the programme as it was first conceived and implemented but rather leaders changes styles and operations in order to suit the interest of their respective wives.

The creation of the Ministry of Women Affairs, the increase of the number of women in the Administrative and Political positions in the country are yet to be on the path to, talk less of producing the desired result. This problem is largely due to the inherent contradiction on the definition and the position of Inequality and Discrimination against women as contained in the Nigerian Constitution which is supreme document in the administration of Nigeria as a country.

The Nigerian constitution deals with discrimination based on sex in general as one of the prohibited grounds for which discrimination is prohibited. The definition of discrimination is contained in Section 42(1) (a) (b), (2) and (3) of 1999 Constitution of Federal Republic of Nigeria (CFRN) is. A non-Governmental organization called the Women Aid Collection (WACOL) operating under the auspices of the 1979 Convention on the Elimination of all forms of Violence Against Women (CEDAW) defined discrimination against women as:

> *"Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human*

> *rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field."*

Despite its prohibition of discrimination on grounds of sex the Nigerian Constitution is embedded in the patriarchal system which produced it. This is quite evident in the language which is utilizes, as well as many of its provisions:

Section 26 of the Constitution discriminates out rightly against women in the area of residency rights. It gives Nigeria men the right to acquire citizenship for their foreign wives by registration. Nigerian women, however, cannot legally extend the same right to their foreign husbands.

Section 29(4) (b) which provides that "any woman who is married shall be deemed to be of full age" is equally discriminatory and encourages child marriages.

Section 42 of the constitution which guarantees freedom from discrimination contains a proviso which indirectly permits discrimination. Under section 42(3), it is provided that nothing in subsection (1) of the section

> *"Shall invalidate any law by reason only that the law imposes restrictions with respect to the appointment of any person to any office under the State or as a member of the armed forces of the Federation or a member of the Nigeria Police force or to an office in the service of a body corporate established directly by any law in force in Nigeria".*

This implies that there can be a valid law or policy restraining the appointment of "any" person e.g. a woman, to any office in the State or armed forces or even an incorporated company. This provision can be used to justify discrimination against a woman by an appointing authority. The absence of definition of discrimination against women denies advocates legal backing on issues relating to discrimination especially on private matters and violations caused by non-state actors.

Section 12 of the Constitution restricts implementation of international treaties signed by Nigeria except the treaty has been "*enacted into law by the National Assembly"* The implication of this is that though some NGOs have signed agreement with Nigeria but they have no law authorizing their operations. This means that they are not recognized in the eyes of the law. The situation has made it difficult for them to make any positive impact in the fight against the discrimination of women in Nigeria. For instance, CEDAW has been signed and ratified by Nigeria, but it has not been transformed into a domestic law capable of enforcement.

Legal and Policy Framework

In Nigeria for instance, some measures were designed as legal and policy framework on gender. These are:

1. The National Gender Policy 2006 allows for the general protection of men and women. It allows for the protection of women against maltreatment, discrimination, obnoxious cultural practices and for equality in the socioeconomic sphere.

2. Nigeria has ratified some other international instruments which deal with women and gender issues, such as the Additional Protocol to The African Charter on Human and People's Rights on the Rights of Women in Africa 2003 and The African Union Solemn Declaration on Gender Equality 2004.

But all these as was noted earlier did not make any positive impact on the equality of women due to the contradictions in the operational documents that are hinged on the provisions of the constitution.

Inequality in Access to Health Care Services by Women in Nigeria

Since the Alma- Atta declaration and subsequently the Beijing Conference, Nigeria has taken "all appropriate measures" to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. However, the poor performance of the health sector did not help matters in the upliftment of health status of women to have equal access to health (Emmanuel-Ajayi & Gu, 2024). These abysmal failures were due to the poor infrastructure and facilities, outdated and inadequate equipment, inadequate trained and specialized health manpower, health policy contradiction of Government, corruption, etc. the assessment of the Nigerian Health Policy below could further testify to the above.

An Assessment of The Nigerian Health Policy Performance in Relation to Women's Unequal

Conclusion and Recommendation

From the above discussions on the comparative analysis of inequalities on access to health by women in developed and developing countries, we have seen some of the general measures of inequality and the specific ones related to health delivery service. The general ones were analyzed for the purpose of understanding the subject matter by throwing more light to the crisis of inequality. The ones related to health care were then given more attention and emphasis in order to bring out the central theme of the work. The result of the analysis revealed that inequality in access to health by women is obtained in both the developed and the developing countries but the problem is more prevalent and devastating in the developing countries, hence the need to act urgently, collectively and individually to address the problem.

Below are the recommendations for improved access to health services by women in order to reduce the inequality syndrome.

i. The WHO being the highest world body on health matters should declare state of emergency on health service and delivery in all countries of the world.
ii. Health policies especially in the developing countries should be reviewed in line with current changes in the statistics of the Health problems of women especially on maternal and child health.
iii. The strategic plans of countries on health should give more emphasis on women's access to health facilities as a strategy to improve the health status of women.

iv. Funding of health should be improved at individual Government's level, Regional and International especially on the areas of women vulnerabilities.
v. Health information systems should be improved and strengthened to provide more data for monitoring and evaluation on the health of women.
vi. Health human resource capacity building should be given priority in order to reduce the incidence of women being delivered by Traditional Birth Attendants and provide for more expertise and professional care especially in developing countries.
vii. The issue of poverty reduction should be pursued vigorously so that women can eat food as and when they need it so that they can be healthy and strong, especially placing emphasis on the availability of balanced diet.
viii. Governments should as a matter of urgency encourage research in the areas of women Health related problems for improved standard in women's Health care.
ix. Non-Governmental agencies that are serious in promoting the Health of women should be given support and encouragement by Governments.

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