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Socio-Cultural Issues in Gender and Healthcare Utilization in South East Nigeria

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Abstract

The United Nations, the African Union and their agencies have made issues of gender and good health top priorities. Accordingly, improvement of maternal health care occupied number five of the eight-point Millennium Development Goals; just as the issue of good health and well-being constitute the third out of seventeen goals of the current Sustainable Development Goals of the United Nations. Although The World Health Organisation states that the healthcare delivery system of any given country should be a compact package geared towards promoting and ensuring the maintenance of good health for all, irrespective of gender, this has not been the case, especially in developing countries where there is gender inequity and inequality in accessing and utilizing good healthcare services. This paper interrogates how a people's socio-culture, interwoven with poverty and lack of education could constitute a threat to women's health, their wellbeing and life chances, particularly for the women in the rural areas of Southeast Nigeria. These were expounded within the framework of radical feminist theory, which explains the inequity, the relative powerlessness, discrimination, subjugation, exploitation and vulnerability of women as inherent in the socio-culture of patriarchal societies. The paper recommends the dismantling of all socio-cultural structures and practices that are hindrances and inimical to women's health as practiced in South East Nigeria; economic empowerment of families, especially women, through giving them access to land and credits for better income generation as well as giving more educational opportunities to women, especially those in the rural areas to enable them make critical life choices pertaining to access and utilization of appropriate healthcare services.

Key Words: ***Gender, healthcare, inequity, good health, culture, inequality***

Introduction

Gender as a concept has been hotly debated in various circles. While some think it is synonymous with biology (Murdock 1980; Eteng, 2011), others see it as socially constructed and different from biological characteristics (Oakley, 1972; Eteng, 2011). Since Gender refers to the socially constructed roles, responsibilities and identities for women

and men, it goes without saying that gender is not synonymous with women but refers to both sexes. Therefore, any discussion on gender issues is a discussion on both sexes.

It is important to note that the problem of gender inequality has existed in different societies over time, at the local, national and international levels with all its implications for discrimination, subjugation, exploitation and disempowerment of women. This inequality manifests in terms of the rewards of prestige, wealth and power attached to gender roles. Eteng, (2011) noted that nation states have given it national coloration, through political and social mobilization, the mass media, various women groups and NGOs. Indeed the United Nations and other international agencies have set in motion processes to address the issues involved. Accordingly, a number of laws, policies and agreements have been put in place to advance and protect women's rights. These include the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), to which Nigeria is a signatory, which guarantees women the exercise of all human rights and fundamental freedoms, including the right to good health and well- being on a basis of equality with men (CEDAW, 1979). Indeed, many of these rights are enshrined in the Nigerian constitution. But one thing is to have these rights stated in the constitution, another is to have the courage to implement its provisions.

In many countries of the world, especially the Third World, development policies are usually generally made on the erroneous assumption that the interest of all is catered for, irrespective of gender differences (Eteng, 2011). In addition, sustained considerations are seldom given to gender implications of such policies to determine how a people's socio-culture, which are most times said to be biased against women in highly patriarchal societies, could be impediments to the realization of the desired results (Eteng 2011).

Several factors determine people's ability to access and utilize healthcare services. Among these determinants is a people's socio- culture, which differentially impacts on the men and women, with several discriminatory and obnoxious practices against the women. Some of these socio-cultural practices that are inimical to women's health and which limit their accessibility and utilization of healthcare services include, widowhood practices, mortuary indignities, early and forced marriage, poor nutrition, female genital mutilation with all its

associated dangers to health, as well as the traditional and cultural beliefs attached to these practices, among others (Iheanacho 2006) In patriarchal societies, men exercise great influence over women on all fronts, including decision- making on issues concerning their own health (Azuh et al 2015). It is pertinent to note, however, that some of these very severe practices against women have been abolished in some states in Nigeria, while in other cases most women are suffering in ignorance or afraid to report to relevant authorities.

Feminist critics have faulted development strategies and grassroots interventions that failed to make significant progress towards improving the lives and status of women, especially the rural women. Moser (1989) noted that this failure could be attributed mainly to the use of welfare, poverty alleviation and managerial approaches that do not address the underlying structural factors that perpetuate poverty, inequality, the oppression and subjugation of women, especially in the rural areas.

These approaches make no distinction between the "condition" and "position" of women. Moser (1989) is of the view that focusing on the condition, which is the material state in which women live, (food, healthcare, water, housing, education etc.), curtailed their awareness of, and readiness to act against the less visible but powerful underlying structures that perpetuate injustice, which if not addressed could even be an impediment to the realization of the practical needs. While this subject has received some attention in Nigeria, a gap in knowledge still exists which this research intends to fill. Therefore, this paper sets out to examine the sociocultural dimension in gender and healthcare utilization as well as how lack of education and poverty could hinder women in healthcare utilization in mainly Southeast Nigeria.

Objectives of the Study

The general objective of the study is to examine the socio-cultural issues in gender and healthcare utilization in Southeast Nigeria, while the specific objectives are:

1. To examine gender issues in relation to harmful socio-cultural practices that prevent women from assessing and utilizing good healthcare;

2. To determine how poverty constitute a hindrance to women's utilization of healthcare
3. To examine how lack of good education constitute a hindrance to women's utilization of good healthcare

Some theoretical issues are discussed in the next section.

Theoretical Framework

The Radical Feminist theory according to Tong, & Barrell. (1992). which sees the underlying causes of gender inequity and inequality in accessing good healthcare, with the women at the receiving end, constitutes the guiding theoretical framework of interest for this study. The radical feminists believe that this situation is engendered by the patriarchy and is deeply rooted in the society. The framework enables us to seek explanations to this problem as it affects many Third World countries, particularly Nigeria. Women's vulnerability and relative powerlessness in this regard are intrinsically found in the patriarchy, which "describes a power relationship inherent in the structures and social relations within which the subordination and exploitation of women occur and it is used to explain the institutionalization of male power and domination over women" (Walby, 1980, p. 173-201 as cited in Burke, 2019, p. 243). Indeed, Nigeria has been described as "a society where patriarchy holds sway and certain salient socio-political structures (culture, religion, economy and polity) of the society are unjust and unbalanced, thus placing women on the receiving end, while men are at advantage" (Nnam et al., 2018, p. 35).

In order to explain the problem of why the inequity and inequality in accessing and utilization of health care services more appropriately, the radical feminists modified the position of the Marxist feminists who would argue that to understand why this problem, an analysis of the possible link between women's work status and their self- image within the context of an on-going economy has to be made (Holmstom, 1984, p. 464). Although the Marxist feminists went further to say that the situation would have been otherwise, were the women's production and gender roles in the family, at the workplace and in the community in general not subordinated to those of the men.

The Radical Feminists rather see the underlying causes of women's inequality deeply rooted in society. They also draw attention to the neglect of reproduction and derived subordinate sex- role of women in the household (Eteng, 2011). Thus, the radical feminists argue that the gender bias and inequity could be traced to the patriarchal system of power relationships in society. The system is characterized by male dominance, hierarchy and competition and is related to the gendered division of labour in society, with the family as the main perpetuator.

An important radical expression of women empowerment since the inception of feminist movement worldwide is persistent human rights advocacy as it affects women under patriarchal hegemony. (see Nnam et al., 2018; Burke, 2019). This advocacy has been consistently pursued by several women groups through the mass media, legal battles, demonstrations, social criticisms and intellectual discourses, as typified by recent happenings in Nigeria and the world over (see Nnam et al., 2018; Burke, 2019). Yet, women are increasingly exposed to servitudes that are somewhat unnoticed or sometimes noticed but ignored, because such acts find justification(s) in the culture and traditions of the people.

In considering the 'women question', radical feminists assert that women's oppression is the most fundamental, the most widespread and deepest human form of oppression buried deep in patriarchy's sex-gender system (Millet, 1970; Tong & Barrell,1992). These manifest in the forms of such anachronistic traditional practices as mortuary indignities, female genital mutilation, early and forced marriage, denials and deprivations resulting in poverty and lack of education, violence and threats in marriages among others. (see Agbo, 2001; Eteng & Njemanze, 2018; Iheanacho, 2006). For the radical feminists the root of women's oppression is biological, since relations of reproduction, rather than production is considered to be the driving force of history. Consequently, in order to liberate women, a biological not an economic revolution, as recommended by the Marxist feminists is required. The next section presents the review of literature in the forms of socio-cultural practices, poverty as well as lack of education and how these pose some hindrances on women's access and utilization of healthcare.

Literature Review

Forms of socio-cultural practices and their implications for healthcare utilization
Female genital mutilation

Agbo's (2001) analysis of cultural determinants of women's health in Nigeria, gives a vivid description of health dimension of women's subjugation. He opines that cultural expectation deprives women of their humanity and fundamental human rights. Female genital mutilation, which is performed for such reasons as curbing promiscuity and enhancing quick delivery of babies, sometimes with unsterilized equipment, endangers women's health, inflicts terrible pain and injury, causes infection and, at times, leads to death (Eteng, 2011). According to him, statistics have shown that about two million women are circumcised each year in Africa and Asia, some with grave consequences. Indeed while some cultures perform this act on newly born baby girls, other cultures in the rural areas of Nigeria, such as in the South-South, delay this practice until a girl attains the age of puberty. A girl undergoing this ritual is barred by tradition from seeking modern healthcare from hospitals. Meanwhile the pain is so severe and could lead to excessive bleeding and death.

Other forms of Socio-Cultural Practices

Obong and Uwagbute (2001), opined that health and nutritional status of rural women are determined by socio-economic, socio- cultural and educational factors. Foster-Carter (1985) also underscored this fact when he noted that in some developing societies, culture expects men and male children to eat first and take the lion's share, while women and girls must make do with what is left. Some cultures even go as far as forbidding women from eating certain high proteins foods, such as fish, eggs and poultry, whereas they are the ones that actually require higher nutritional needs than men, because of their reproductive function. Prohibition of consumption of good and nutritious foods on the part of the women translates to denying them good health and wellbeing. On the other hand, Eteng (2011) observed that some choices made by women themselves in the form of behaviour on their part, appear to suggest that they have internalized the lesser social value given to them on the grounds of their gender. Women's willingness to bear children at the detriment of their own health and survival, (most times under conditions of deprivation and lack), in order to

satisfy their husbands and society's preference for male children, as required by culture, are examples of women's behaviour that undermine their health and well-being.

Marmot (2005) stated that the cultural perspective on the use of maternal health services suggests that medical need is determined not only by the presence of physical disease but also by cultural perception of illness. It is also influenced by individual perceptions of the efficacy of modern health services and the religious beliefs of the people. (Lieberman, 2007). In fact more often than not decisions about maternal care are made by husbands or other family members because in some cultures wives are not allowed to take such decisions about where and when to access and utilize maternal healthcare.

In a study among the Hausa of Northern Nigeria, (Azuh et al., 2015) found that the

most important factors contributing to maternal deaths are a traditional and religious culture that under-values women; a perceived social need for women's reproductive capacities and health to be under strict control of the male, female illiteracy; marriage at an early age and pregnancy often occurring before maternal pelvic growth is complete as well as harmful traditional medical beliefs and others. It was found that a husband's approval has a greater effect on pre-natal health care utilization than whether a wife wanted the pregnancy or a wife's level of education (Addai, 2000). It has been argued that socio-cultural beliefs and the need for immediate and specialized healthcare services have hampered women's ability to access these services in many low and middle income countries including Nigeria Azuh et al., (2015) observed that apart from the ugly effect of the people's socio-culture on the maternal health of the women, the unavailability of quality modern healthcare services, poor access to and utilization of quality reproductive and other health services contribute significantly to the high maternal mortality level in Nigeria.

Mortuary indignities and widowhood practices

According to the United Nations (2001), widows are absent in statistics, unnoticed by researchers, neglected by national and local authorities and mostly overlooked by civil

societies organizations. These paint the picture of those forgotten by society. Yet the abuse of widows and their children in the name of culture and tradition constitutes one of the most serious violations of human rights and a big obstacle to both human and societal development today. Widows are known to endure extreme poverty, ostracism, violence, homelessness, ill-health, dehumanizing treatment, discrimination and deprivation across cultures of the world. (Encyclopedia of Death and Dying 2001). It is recorded that India has the largest number of widows in the world - 35 million(Indian census of 1991), which is 10% of the female population. A Loomba Foundation (2015) report says that in India where widows are often referred to as carriers of ill fortune and unwanted burdens on poor families, the status of widow is precarious and low. Widows in India are subjected to rituals in order to be cleansed and accepted into their new husband's homes upon remarriage. This practice exposes these widows to psychological adversities as well as health risks that may be involved. It is often necessary for a widow to comply within the social customs of her area because her economic well-being depends on it.

Generally, widowhood throughout Africa is a period of hardship and deprivation. It is a period widow's experience physical seclusion and are regarded as being in a state of contamination which requires purification. A woman whose husband dies is compelled to go through some dehumanizing widowhood rituals to be exonerated from being responsible for the husband's death or to prove her innocence. In this kind of atmosphere of superstition and suspicion, the woman who is usually the first suspect is compelled to go through several dehumanizing rituals such as; drinking the remains of the water used in washing the dead man's corpse, at other times it may involve crossing the coffin of the dead person. If for any reason a woman refuses to comply with these rituals to prove her innocence, she could be considered guilty of murder (Iheanacho, 2006). Ironically when a woman dies, the husband is never subjected to these kinds of treatment.

Studies have also shown that in addition to the humiliating treatments the widow is made to receive, she is restricted from eating certain foods, malnourished, and would have to remain indoors for about forty days or more (Korieh, 1996). Here again the socio-culture

denies the widow access and utilization of good healthcare at the time she is undergoing this ill-treatment, to which she is bound to comply.

In a study conducted by Iheanacho (2006) on widowhood practices in the South-South region of Nigeria, it was discovered that widows are forced to go through similar dehumanizing treatments, as well as physical and psychological abuses which are injurious to health, while she is not allowed to access or utilize good healthcare during periods of mourning. For instance, a widow is forced to drink the water used in washing the corpse of the deceased to prove her innocence, or made to swim across the bottom of the boat conveying the corpse of her husband, or is submerged in the river, or in other instances thrown across her late husband's coffin to ascertain whether or not her legs could strike the coffin, including taking an oath by walking across the corpse (Iheanacho, 2006). All these treatments are unleashed on widows in the midst of their pains and agony, in the name of making her prove her innocence.

In her study of widowhood practices in Igboland, Nzewi (1989) found that in certain parts of Imo State, specifically in Mbaise, a widow's ordeal begins immediately her husband's death is announced. The man's relations would demand a list of the man's property, such as houses, cars bank accounts etc. She is not supposed to hide anything otherwise she would be required to take an oath to prove she had not concealed anything. This practice is similar to what obtains among the Igbo in some parts of Abia and Ebonyi states, especially in bi-lineal descent communities that are significantly matrilineal. On the death of a man, his maternal relations would share out the man's property leaving the widow and her children impoverished and to suffer from then on.

Seclusion and isolation of a widow from the community for a certain period of time used to be a wide-spread practice in Igboland but these varied in intensity and duration. Korieh (1996) noted that a few days before the dead man was buried the widow must not have her bath and was required to sit on the ground. Her food was also prepared separately and she must be fed by another widow from a broken or old plates. Ubesie (1978), as cited in Korieh (1996), confirmed that before the advent of Christianity, widows in Uturu, a community in Igboland, were not allowed to have their bath for upwards twelve days and were denied food during this

period. At the end of the twelve days, she would be taken to the evil forest where her hair would be shaved, thereafter she would take her bath and eat.

The obnoxious aspect of these widowhood practices as demanded by the socio-culture in most parts of African societies is the neglect of personal hygiene, denial of access to healthcare services, as well as the abuse of human rights of widows, all in the name of customs and tradition. These could have very serious adverse effects and could constitute health hazards on the widows. A publication of The World Health Organization (1998) affirms this by indicating that factors that impact upon the economic status and health of a widow include "the long period of seclusion during mourning, deprivation of her husband's property, poor hygiene, maltreatment by relatives, enforcement of persistent wailing and being forced to sit in the same room with husband's corpse until burial". These are harmful socio-cultural and traditional practices many widows are made to go through during periods of mourning, and at the same are denied access to and utilization of healthcare when needed, as they must comply with tradition.

Early Forced Marriage

Marriage that is forced could be regarded as an act of violence and violation of the human rights of those involved. Early forced marriage affects both boys and girls, though the majority of those affected are girls (Eteng & Njemanze, 2018). According to them, early forced marriage is a socio-cultural practice that poses health hazards on the woman who at this early age would be too naïve to take decisions on issues of accessing and utilizing the appropriate healthcare when needed, especially during the pre-natal and post-natal periods. In this situation, the older ones, mainly the parents and older relatives who, manipulate the socio-culture, take advantage of the immaturity and naivety of the young couple to make decisions concerning the issue of access and utilization of healthcare for them. In some cases, health conditions that require modern methods of treatment are mishandled, as the older people, mainly illiterates, would want to handle them according to the dictates of culture and tradition. Given their state of immaturity, naivety and with little or no education, the young couple will acquiesce and succumb to the dictates of culture and tradition, most times with grave consequences.

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It is a known fact that boys and girls are affected by early forced marriage but girls feel the negative consequences more. Girls are forced into early marriages for several reasons. For instance, families in the developing world are more likely to abide by the dictates of cultural and religious norms to avoid stigmatization. Furthermore, families that are economically challenged could want to give out their daughter early in marriage in order to escape from poverty.

Girls who are forced into early marriages invariably are denied education and stand the risk of being illiterates all through their lives. Such girls are denied their early childhood and are not usually prepared for marriage and all that it demands. They usually face poverty, early divorce and abandonment as they are even too young to take decisions for themselves concerning access and utilization of healthcare facilities, and are forced to depend on their cultural dictates as handed down to them by illiterate parents and relatives. Since they are usually not mature for the strain of pregnancy and childbirth, they usually have complications during childbirth. The rising cases of Vesico-Vaginal Fistula (VVF) in Nigeria are also attributable to early forced marriages. In some of such cases the young woman who is denied the opportunity to access and utilize good Medicare, due to some superstitious beliefs and cultural practices, as well as a result of poverty faces stigmatization and is abandoned by the family.

Poverty as a hindrance to access and utilization of good healthcare

Poverty can be conceptualized as a condition where people's basic needs are not met because the inability to participate fully in the society's economic activities leads both to low income and low standard of living. As affirmed by the United Nations Development Programme (UNDP (2007) "poverty is the denial of choices and opportunities for living a tolerable life." Scholars have described 'poverty' as a situation of inability to access the basic necessities of life, such as food, healthcare, decent shelters and clothing due to the lack of income needed to acquire them (see Joseph, 2006; Arinze, 1995; Ewetan, 2005). It is a situation where the poor are unable to meet their social and economic obligations which include access and utilization of good healthcare services. Nnanna (2006) who painted a

grim picture of this phenomenon conceived of poverty as a self-reinforcing situation in which several forces and factors tend to perpetuate a vicious cycle of poverty. Also, poverty has become publicly recognized as a social problem that has engaged both global and local concerns. The issues of health, economic status, psychological state, socio-political deprivations, violence and civil strife as well as criminality are bound up with the phenomenon of poverty in the society (Omotola, 2010). It is on record that over 120 million Nigerians constituting over 70% of the population live in abject poverty. The case of the rural areas is worse as over two-third or 80% of the rural population, majority of who are women live below poverty line (Nigerian Bureau of statistics, 2012). As succinctly put by the International Fund for Agricultural Development IFAD (2014 Report) "The number of women in extreme poverty rose by 50% in the last twenty years", and the majority of the world absolute poor are women. (The United Nations Fund for Population Activities UNFPA, 2013**).** In Sub-Saharan Africa, extreme poverty and powerlessness afflict more than 80% of the women, while over 218 million people live in poverty (World Bank, 2006).

Women who have been acknowledged as the backbone of the family, the invisible workforce as well as the sustainers of the rural economy, continue to contend with a myriad of problems. These include lack of basic amenities and infrastructure, high maternal and infant mortality, inadequate medical attention, illiteracy, high incidence of communicable and non-communicable diseases, high labour drudgery, low income, inadequate food security, poor sanitary and substandard housing conditions, lack of safe water, poverty, as well as pervasive socio-economic deprivations among others (Eteng, 2011). Cultural factors have been known to impede efforts of women to overcome poverty. Women are subjugated to all manner of ideologies, rituals, indignities as well as practices and ceremonies that negatively impact their lives (Morris, 2008). Moreover discriminatory practices at all levels continue to prevent poor women from taking full advantage of economic opportunities that could pull them out of poverty (World Bank, 2006).

The United Nations Development Programme UNDP (2014) report observed that the high level of poverty in the rural areas of Sub-Saharan Africa is basically because of the

restricted nature of their income generating activities, especially among women. In a study of poverty in Bende Local Government Area of Abia State, Nigeria, Ifekwe and Kalu (2007) observed that income level was significantly related to the poverty status of the respondents, thus, the lower the income of the respondents mostly rural women, the greater their poverty level. Invariably this translates to their inability to access and utilize appropriate Medicare. In the case of Ebonyi State, the poverty level seems to be the highest in the southeastern part of the country as over 79% of the population live below poverty line (NBS, 2010). The rural dwellers, particularly the rural women constitute the greater percentage of the poor in the state.

In a study of the determinants and consequences of poverty among rural women in Ebonyi State, Eteng et al. (2015) found out that a number of socio-cultural practices which led to rural women's denial of access to education and high income generating activities translated to rural women's poverty, illiteracy and their inability to access and utilize basic healthcare services. Indeed rural poverty stems from the fact that the full potentials of women are not explored in economic activities because of gender biases.

Income generating opportunities for women in the rural areas of Africa and Nigeria are severely restricted due to cultural inhibitions and inadequate education. This does not only constitute formidable barriers to gender equality but engenders poverty among rural women and is detrimental to their health and well-being. Women are mainly engaged in subsistence agriculture and raising of homes (Payne & Nasser, 2003). UNDP (2014) report showed that women in rural African societies are majorly restricted to the production, processing and marketing of foods upon which majority of rural and urban population depend. Indeed, the 2009 World Bank survey on rural women in Africa stated that women play active role in Agricultural and rural livelihood as unpaid family labour, often without access to land, credit and other productive assets. Kwesiga (1999) also argued that women's contribution to general economy is under-estimated as women perform disproportionate amount of care work that goes unrecognized because it is not seen as economically viable. Women in Africa work as food producers, improving house-hold food and income security. Families in extreme poverty are even more dependent on women's

work both inside and outside the home resulting in longer days and more intense work for women. In a study conducted in East Africa, Mayada et al. (1994) argued that the major problem faced by women in securing credit is their perception as housekeepers. Also taking care of large families undermines women's ability to obtain credit. In most societies of Sub-Saharan Africa, women cannot own or inherit property. Studies have shown that in many societies in Africa, women are denied access to land and control of their productive resources with respect to solving their immediate problems thereby increasing their poverty level which in turn limits their access and utilization of good healthcare facilities (Eteng 2011; Eteng et al., 2015). This situation is highly pronounced in the rural areas where traditions and the rule of the patriarchy, such as in Southeast Nigeria, ensure that women live in deprivation which impoverishes them the more. Whereas an increase in women's earning capacity and access to economic resources would translate fairly into their bargaining power, overall wellbeing, as well as changes in intra household and communal relations.

It becomes clear from these shades of opinion that there is an urgent need to tackle the problem of poverty among rural women in South East State of Nigeria for the progress and development of the family, the state and the nation in general.

Education as a critical factor in access and healthcare utilization

Education has been described as an agent of empowerment (Kabeer 1999). Many scholars believe it enhances both the economic and social status of women, as well as their ability to take positive decisions affecting their lives and those of their families in a number of different social contexts. Writing about women and education in the Nigerian context, Anikpo (1998) observed that women education faced considerable handicaps right from the inception of modern formal education. At the same time female children were being discriminated against, preference was given to the males who became important source of colonial labour supply. Thus, the foundations of educational inequality between males and females were laid, in Nigeria. Although the situation has greatly improved, especially in the urban areas of Nigeria, and in the Southeast in particular, many women in the rural areas do not have access to education.

Educating women is essential to economic and political development as well as improving the status and wellbeing of women and their households. Synder & Tadesse (1995) have identified educational opportunities and economic empowerment as the two most pressing areas that must be addressed in Africa to improve women's status. No doubt education or literacy improves the status of women due to its influence on the financial status of the family and the ability of such women to make appropriate decisions concerning the healthcare of their households.

Educated women have the ability to challenge traditional roles as well as the power to choose in decisions relating to their critical life choices and that of their households. Wolf {1992: 225) agrees with this assertion that "education and increase in women's earning capacity give women room for maneuver within the home, as well as expanding their ability to make critical life choices and decisions in relation to issues as timing of marriage, choice of partner, family health issues, education of children etc". Thus, the higher the levels of educational attainment of mothers, the better the household welfare and the lower the probability of the household being poor.

It has been noted that the perception of women and their roles in traditional societies are formidable barriers to gender equality (Payne & Nasser, 2003). Men have higher social status and as a result more access to schooling and training. It is important to note that the empowerment of women and their participation in all spheres of the society is fundamental for their overall development. Das-Gupta (1987) agrees with the above assertion by indicating that studies in northern India as well as elsewhere in the world have shown that education enhances women's autonomy and increases their effectiveness even in the traditional roles assigned to them in their homes.

Marriage, it is often said illustrates difference in status between men and women and usually early marriages and emphasis on child bearing have prevented women from achieving educational equality in most Sub-Saharan African countries. Again the structure of family such as polygyny and share size (usually large) subjugate the status of womanhood since in most cases women who are left to cater for such families hardly had

time to engage in other activities (Payne & Nasser, 2003). Education of women has a powerful role in health utilization outcomes. It acts as catalyst for changes and transformer of high female autonomy.

Conclusion and Policy Implications

Thus far, the socio-cultural issues involved in gender and healthcare utilization in Nigeria and in Southeast in particular have been discussed in some depth, especially as it involves the rural people. Arising from this is the fact that certain socio-cultural practices, such as, = widowhood practices, mortuary indignities, early and forced marriage, poor nutrition, female genital mutilation with all its associated dangers to health, as well as the traditional and cultural beliefs attached to these practices are manipulated by the patriarchy in the name of the people's socio-culture to deny women access and utilization of appropriate healthcare when needed, especially those residing in the rural areas, . In patriarchal societies, men exercise great influence over women on all fronts, including family decision making and matters concerning their own health. These were expounded within the framework of radical feminist theory, which explains the inequity, the relative powerlessness, discrimination, subjugation, exploitation and vulnerability of women inherent in the socio-culture of patriarchal societies, such as is practised in South East Nigeria.

Although men are also affected by poverty, it is a truism that the feminization of poverty, especially in households with female heads cannot be denied. Rural women who have been acknowledged to be the backbone of the rural economy are denied access to land and credits, and are consigned to low-level income generating activities. The restricted nature of their income generating translates to poverty and their inability to meet the basic necessities of life, which include access and utilization of basic healthcare. Moreover discriminatory practices at all levels continue to prevent poor women from taking full advantage of economic opportunities that could pull them out of poverty (World Bank, 2006).

Education is a tool of empowerment. Educating both men and women is essential to economic and political development as well as improving the status and wellbeing of the individual and their households. Educated women have the ability to challenge traditional roles as well as the power to choose in decisions relating to their critical life choices and that of their households. It improves the status of women due to its influence on the financial status of the family and the ability of such women to make appropriate decisions concerning the healthcare of their households.

In view of the above, this paper recommends the following:

- The dismantling of all socio-cultural structures and practices, beliefs and norms which are usually manipulated by the patriarchy and which are detrimental to women's health;
- All levels of government in Nigeria (federal, State and local), non-governmental organisations, religious institutions, and local authorities as well as traditional institutions should be more involved in the creation of awareness at the grassroots level and the men should be sensitized on the harmful effects of these socio-cultural practices on women, to gain their support for change.
- Educational opportunities open to rural women in Nigeria should be increased. This will enhance their exposure to the modern world and their ability to take decisions in areas of concern in their lives, as well as improve their life chances.
- Social welfare services should be extended to families, especially in the rural areas to alleviate poverty in their homes. Rural women should be specifically empowered economically, by giving them access to and credits in order to raise their income levels and standard of living Good health and well-being for all will be achieved as stated in SDG goal number 3 with the removal of these impediments placed on women.
- Access and utilization of healthcare should be treated as a matter of social justice for every Nigerian. Governments at all levels should enforce the extant laws and already

existing human rights provisions to protect women in the various States in Nigeria where these social-cultural practices that inflict harm and psychological pains on women are still in practice.

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