

**GENDER DYNAMICS AND WOMEN'S INVOLVEMENT IN
HEALTH DECISION-MAKING IN SELECTED
HOUSEHOLDS IN MAKURDI LOCAL GOVERNMENT
AREA OF BENUE STATE-NIGERIA**

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Abstract

Women have experienced various forms of discrimination and are exposed to varying treatments as regard power and the control of resources. Historically, women are known to have been subjected to divergent roles within the household such as domestic chores that go without remuneration, occupational seclusion and segregation into low income and low skill works and lack of representation in decision making within the family and community levels. Gender is a crucial consideration of human rights that impacts many priorities of maternal health outcomes. The dynamics of women's autonomy in decision making on health care in the household and the cultural factors determining the level of their involvement has not been studied in Makurdi Local Government Area. Thus, this paper examined the dynamics of women's health decision making in households in Makurdi Local Government Area of Benue State, Nigeria. The study utilized socialist feminism theory as the theoretical framework. Data for the study were elicited from 400 respondents across the selected council wards which include Fiidi, Wailomayo, Modern market, North-Bank 1 and Bar in Makurdi Local Government Area using semi structured questionnaire (SSQs) out of which 370 questionnaire copies were returned for analysis. Data was analyzed both quantitatively and qualitatively using the SPSS Version 24. The study found that women have less autonomy in health decision-making in households in the study area. Cultural factors such as the patriarchal nature of the African family system as well as religion were identified as the major determinants of women's involvement in health decision-making. The study findings indicated a positive association between women's socio-economic status and decision-making with regards to women's health. The study recommends the relegation of cultural norms that affect women's involvement in decision-making, especially in health-related matters. There is also the need for target-driven sensitization programmes to enable women navigate the dynamics of household health decision-making as well as other gender-related issues affecting them within the households.

Keywords: Gender, dynamics, health, women, decision, household, Makurdi.

Introduction

Women have often experienced various kinds of discrimination and exposure to unequal treatment in relation to power and control of resources (Sokoya, Farotimi and Ojewole (2014). Historically, women are known to have been subjected to various roles within the household such as domestic chores that go without pay, occupational seclusion and segregation into low skill works and lack of representation in decision making within the family and community levels. Seventeen sustainable development goals have been set to be achieved by 2030 (World Health Organization 2018). Gender equality is one of the cross-cutting issues highlighted in several of these goals. Fostering gender equality will contribute to and enhance the speed of achieving other goals including, for example, zero hunger (Sariyev, et al., 2020).

There are numerous studies in the literature which show that women's empowerment is a pathway to sustainable livelihoods. Women are more likely to invest in health and education (Sariyev, et al., 2020). Their empowerment has a positive impact on their health outcomes and that of the general household. Kabeer (2001) defines empowerment as an expansion of one's ability to make crucial life choices. Obviously, these choices not only affect one's own life but have significant effects at the household and community levels. Although access to economic resources, the political, and social and health status of women have seen some improvement, globally, women's empowerment is essential in health decision making. Empirical evidence reveals that household decision-making does not favour women unlike their men counterparts (Seidu, 2022). It has also been noted that the modernization of many subcultures which has allowed women to receive higher education, engagement in the labour force, marry at an older age, choose their partner and live apart from their extended families have been associated with a greater women's household decision-making (Seidu, 2022).

Several studies have examined the importance of mothers' decision-making autonomy within the household in influencing the use of maternal health services, comprising a growing body of literature focusing on this topic (Rizkianti, 2020). A study in Indonesia revealed that women's autonomy regarding household assets affected their decisions on reproductive health care (Rizkianti, 2020). Another study in Indonesia highlighted that pregnant women involved in decision-making within their households were more likely to use antenatal care (ANC) services compared to women not involved in such decision-making (Rizkianti, 2020). Other evidence also indicated that joint decision-making between a husband and wife increased the likelihood of the use of maternal health services (Rizkianti, 2020).

This study examines the dynamics of women's involvement in decision-making regarding the use of maternal health services in selected households in Makurdi Local Government Area of Benue State, Nigeria. It explored whether women who had high involvement in household decision-making experienced a higher likelihood of using self-care services, antenatal and postnatal care services, delivery services assisted by skilled birth attendants, and facility-based delivery compared to those with limited autonomy or decision making in the house hold.

Study Objectives

The aim of this study was to examine the dynamics of women's involvement in decision-making regarding the use of maternal health services in selected households in Makurdi Local Government Area of Benue State. The specific objectives were:

- (a) To assess the level of women's involvement in health decision-making in selected households in Makurdi Local Government Area of Benue State.
- (b) To ascertain whether or not, cultural factors determine women's involvement in health decision-making in selected households in Makurdi Local Government Area of Benue State.

Hypotheses

This study was guided by the following hypotheses:

H₀: There is no significant relationship between women's socio-economic status and their involvement in health decision making in the households.

H₁: Cultural factors do not determine women's involvement in health decision- making in the households.

Conceptual Clarification

In this study, two concepts, those of gender and health are clarified to avoid possible misunderstanding.

Gender: This refers to, an array of socially constructed roles, attitudes, behaviours and values, which determine to a large extent, women's differential access to resources and power, and-which are reflective of the political economic and social structure of society (Association of African Women for Research and Development, 1996b). Gender was first used as a phrase "the social relations of gender", for which gender has become a type of shorthand. The social relations of gender also known as "gender relations" seek to make apparent and explain the global asymmetry which appears in male and female rations in terms of sex roles in power sharing, decision-making, the division of labour, return to labour, both within the household and in the society at large.

The concept, gender relations, direct our attention to all the attributes acquired in the process of socialization: our self and group definitions, our sense of appropriate roles, values and behaviors and above all, expected and acceptable interactions in relationships between women and men (UNICEF, 1994).

Health: According to the World health Organization, WHO (1948), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. By 1986, the WHO further elucidated that health is an asset for daily life, and not the objective of living. Moreover, researchers in recent times have attempted to redefine health as the ability of the body to embrace new susceptibilities and maladies. This is anchored on the understanding that modern science has considerably raised human cognizance of diseases and how they act in the past few decades. Consequently, health means: (i) no critical indication of illness and that the person is performing normally (ii) numerous organs of the body are performing sufficiently as well as in relation to another homeostasis.

Within the context of this study, health is defined as the ability for man to stay active and productive. Essentially, health is a fundamental human right and the crux for productive life. Moreover, health is a vital part of economic development, which comprises individuals, government and international responsibility. Ultimately, health is a crucial factor to stimulate

labour productivity and since labour is a factor of production, good health implies increased productivity.

On one hand, studies have shown that at a micro level, a healthy person is more productive than a sick person, while at a macro level, a healthy population is productive than a population that is afflicted with ill-health. Though, the advantages of good-quality health are even more stirring when observed at a national (macro) level than at an individual (micro) level (Bloom, Canning & Sevilla, 2004).

Theoretical Framework

This study adopted the socialist feminism theory to interrogate gender dynamism and women's health decision making in households. Socialist feminism is a feminist theory which locates women's devaluation and the oppression within the patriarchal and capitalist ideologies and practices in society. According to Lerner (1986), of all the systems of human domination and oppression, the most fundamental structure of oppression is the system of patriarchy – the domination of women by men. Not only is patriarchy historically the first structure of domination and submission, it continues as the most pervasive and enduring system of inequality. According to socialist feminists, through participation in patriarchy, men learn how to hold other human beings in contempt, and to control them.

According to Faludi (1991), patriarchy exists as a near universal social form because men can muster the most basic power resource - physical force to establish control over women. Once patriarchy is in place, the other power resources such as the economy, ideologies, laws and emotions are structured to sustain it. According to Ritzer and Goodman (2004), socialist feminists believe that men create and maintain patriarchy not only because they have the resources to do so but because they have interests in making women serve as compliant tools because women satisfy diverse needs of men: women satisfy men's sexual needs, bear them children, are a useful labour force, are sources of emotional support, and are ornamental signs of male status and power. These useful functions mean that men everywhere seek to keep women compliant.

As a theory, socialist feminism draws heavily on the ideas of Engels (1972), to explain the capitalist devaluation and oppression of women. According to Engels, the subordination of women results not only from their biology, which is presumably immutable, but also from social relations that have a clear and traceable history and that presumably can be changed. The relational basis for women's subordination lies in the monogamous family-an institution aptly coined from the Latin word for 'servant'. Engels argued that the monogamous family is a fairly recent relational invention; that for much of prehistory men and women lived in kin structures in which women enjoyed relative autonomy primarily because they had an independent economic base as gatherers, crafters, storers, and distributors of essential materials. As society developed, hunting and gathering was replaced by herding and farming in which men's resources of strength, mobility, and technology derived from hunting roles gave them a systematic advantage over women due to the surplus goods they produced and owned as private property. In the new economic system, men as property owners needed both compliant labour force and heirs who would serve as the means of preserving and passing on their property. Thus, the monogamous marriage developed alongside the emergence of the state which was structured to protect the system of private property and to ensure the continuity of monogamous marriage. With this development, women became the property of

men at marriage; a property to be devalued and oppressed because women became completely dependent on men for survival (Ritzer and Goodman, 2004), (Haralambos and Holborn, 2008).

To set the women free, socialist feminists argue that both the oppressive structures of capitalism and patriarchy, must be dismantled through a socialist revolution resulting to a society in which there will be no private ownership of the means of production. Patriarchal structures on the other hand they argue, can only be dismantled with the reworking of women's consciousness so that each woman recognizes her own value and strength, rejects patriarchal pressures to see herself as weak, dependent, and second class, and works in unity with other women, regardless of the differences among them, to establish a broad-based sisterhood of trust, support, appreciation and mutual defense (McCaughy, 2001). By application, this theory helps to explain how women should be given freewill to take decision in regarding their health and general wellbeing without hindrance. The theory maintained that women have their fundamental human rights to take decisions and contribute to societal development; therefore, the theory best explains gender dynamics and women's involvement in health decision making in the society.

Methodology

Study Setting

This study is located within Makurdi Local Government Area. The local government area was founded in 1927 (Makar, as cited in Agwaza, 2012). The local government developed as a result of the activities of merchants who migrated and settled there for trade and commerce. Makurdi Local Government which doubles as the headquarters of Benue State is predominated by the Tiv speaking people alongside other ethnic groups including the Idoma, Igede, Etulo, Jukun, Igbo, Yoruba and Hausa, among others. Makurdi Local Government has a land mass of 34,059 square kilometers with eleven (11) council wards. It has a total population 300,377 (FGN, 2009). The geographical composition of the setting influenced the researcher's choice of the locality as the study area for this research.

Study Population

The general population of this study is made up of men, women and youth of 18 years of age and above, who constitute over 65% of the total population of the study area. However, due to time and other resource constraints, only 400 respondents were actually selected out of the pool to represent the entire population using Taro Yamane's sampling formula (1973).

Furthermore, the study employed both cluster and purposive sampling techniques to draw its actual respondents. Firstly, the local government was clustered into eleven council wards namely: Fiidi, Bar, Central, Ankpa -Wadata, Modern Market, North-Bank I and 2, Wailomayo and Clerks Quarters. Secondly, five council wards namely Fiidi, Bar, Modern Market, North-Bank I and Wailomayo were purposively selected from the local government. Thirdly, in each of the council wards, eighty (80) respondents were purposively selected making a total of 400 respondents. Fourthly, a sampling frame was developed for each of the council ward, using a proportional allocation of 0.001 across board. The primary data were elicited from the respondents using semi-structured questionnaire and interview methods of data collection. The data were subsequently analyzed both qualitatively and quantitatively.

Results and Discussion

Socio-Demographic Characteristics of Respondents

The socio-demographic characteristics of the respondents captured in this study included sex, marital status, age, occupation, educational attainment and income. In terms of sex, 258(69%) respondents were females while 117(31%) respondents were males, this is because the females were more involved and more preferred respondents in the research due to the fact that the study covers their decision-making when it comes to gender dynamics and women's involvement in health decision making. In respect of age, the data obtained indicated that 211 (56.27%) respondents were within the age category of 18 – 30 years, 143 (38.1350) respondents aged between 31 and 64 years, whereas 21(5.60%) respondents were in the age bracket of 65 years and above. By implication means, the sampled population is the most active segment who were readily available for the study and could give a more contemporary view about gender dynamics and decision making in the household. The marital status of respondents showed that 126 (34%) respondents were single and 162 (41%) respondents were married while 97 (26%) respondents were widowed. Married respondents are better informed about household decision making where the man is regarded as the head and chief decision maker. In the patriarchal society of ours, married women are more likely to experience obstacles or limitations in decision making where the man is alive and available.

Furthermore, the occupational distribution of the respondents indicated that 215 (57.33%) respondents had trading as their dominant occupation, 34 (9.06%) respondents were farmers, 38 (10.13%) respondents were artisans and 33 (8.81%) respondents were civil servants; 26 (6.94%) were students while 29 (7.73%) respondents were hunters/fishermen. The study also found out that 128 (34%) respondents had attended and/or completed primary education, 104 (28%) respondents had attained secondary school level and 84 (22%) respondents attained tertiary level of education, while 59 (16%) respondents were non-literate.

Finally, the statistics on respondents' current income status or purchasing power parity (PPP) indicated that 93 (24.80%) respondents were living on income or (PPP) less than NGN 50,000.00 (equivalent of USD 0.01 – USD 0.77 per day); 193 (51.47%) respondents were on annual income or (PPP) of NGN 100,000.00 – NGN 150,000.00 (equivalent of USD 0.78 – USD 1.16 per day), whereas, 89 (23.73%) respondents were earning an annual income of NGN 151,000.00 and above (equivalent of USD 1.17 and above per day). By implication, those women whose incomes are higher are more likely to be involved in health decision making as compared to lower income earners. This is because health decisions taken are financially involving and one with the financial ability/capacity to pay for healthcare automatically has more freedom to decide on when and where to shop for medical care. Therefore, the income of the respondents in one way or the other influenced respondents' views on gender dynamics and women's health decision making in households in Makurdi Local Government Area. The resultant data are summarized in Table 1.

Table 1: Socio-Demographic Characteristic of the Respondents

Variable	Frequency N= 375	Percentage % = 100
Sex		
Female	258	69
Male	117	31
Age (in years) Categories		
18 – 30	211	56.27
31 – 64	143	38.13
65 and above	21	5.60
Marital Status		
Married	152	40
Single	126	34
Widow/widowers	97	26
Educational Attainment		
Primary	128	34
Secondary	104	28
Tertiary	84	22
No formal education	59	16
Dominant Occupation		
Trading	215	57.33
Civil Servant	33	8.81
Farming	34	9.05
Artisans	38	10.13
Hunting/Fishing	29	7.73
Students	26	6.94
Income Per Annum (N)		
Less the N50,000.00	93	24.80
50,000 – 100,000.00	193	51.47
101,000 and above	89	23.73

Source: Field Survey, 2023

Discussion

Table 2: Level of women’s involvement in health decision making in households

Respondents	Frequency	Percentage (%)
High	45	12.16
Moderate	100	27.2
Low	215	58.1
Don’t know	10	2.7
Total	370	

Source: Field Survey, 2023

The data in table 2 indicate a low level of women’s involvement in health decision making in households in Makurdi Local Government Area. The table indicated that, 45 (12.16%) of respondents maintained that there is high level of women’s involvement in health

decision making. On the other hand, 100 (27.2%) of the respondents were of the view that there is moderate level of women’s involvement in health decision-making, whereas, 215 (58.1%) of the respondents were of the opinion that there is low level of women’s participation in health decision making. However, 10 (2.7%) respondents didn’t know whether there is any level of engagement of women in any health decision making process.

By implication, the study revealed that there is low level of women’s involvement in health decision making in Makurdi Local Government Area of Benue State. This outcome is in line with the view of Rizkianti (2020) who maintained that the level of women’s involvement in health decision is low, especially when women’s socio-economic status is low.

Table 3: Cultural Factors as Determinants of Women’s Involvement in Health Decision-Making in the Households

Respondents	Frequency	Percentage (%)
Yes	199	53.79
No	96	25.94
Don’t know	75	20.27
Total	370	100

Source: Field Survey, 2023

The data in table 3 indicated that 199 (53.79%) of the respondents agreed that certain cultural factors determine women’s involvement in health decision-making in the households. The respondents identified religion, the presence of herbalists and other traditional medicine, income among others, as the cultural factors that determine the involvement of women in health decision making in households. A total of 96 (25.94%) of the respondents were of the opinion that there are no cultural barriers that determine women’s participation in health decision-making in the households, while 75 (20.27%) of the respondents were non-committal as to whether or not cultural factors determine women’s involvement in health decision making in the households in the study area. The study findings about the numerous factors that determine women’s involvement in health decision making in Makurdi Local Government Area cohere with the views of Seidu (2022) who noted that household decision making, especially in the area of healthcare does not favour women due to factors such as patriarchy, religion and income, among others.

Table 4: Cultural factors that determine women’s involvement in health decision making in the household

Respondents	Frequency	Percentage (%)
Religion	58	15.7
Patriarchy	189	51.1
Income	87	23.5
Cheap patronage of traditional medicine	20	5.4
Others	16	4.3
Total	370	100

Source: Field Survey, 2023

Field records as shown in table 4 with regards to the cultural factors that determine women’s involvement in health decision making in the households. indicated that 58 (15.7%) of the respondents opined that religion is one of the predominant cultural factors that determine women’s involvement in health decision-making in the households. 189 (51.1%) of the respondents said the patriarchal nature of the society is another cultural impediment that determine women’s involvement in health decision making in the households. On the other hand, 87 (23.5%) of the respondents said that the income of women also determined their involvement in health decision-making in the study area. Whereas, 20(5.4%) of the respondents were of the view that low cost of traditional medicine determines women’s involvement in decision making, 16 (4.3%) of the respondents identified social and cultural norms as well as gender roles among others as determinants of women’s participation in health decision making. These findings tally with the views of Sokoya, Farotimi and Ojewole (2014) who identified cultural norms, religion, traditional medicine, among others, as predictors of women status in health care decision-making

Test of Hypotheses

Hypothesis One:

Ho: There is no significant relationship between women’s socio-economic status and their involvement in health decision making in the households.

Table 5: chi-square test on the relationship between women’s socio-economic status and their involvement in health decision making in the households.

Responses	O	E	df	Level of sig.	X ² -cal	X ² -tab	Decision
Yes relationship	605(7 6%)	43.7 (50%)	1	0.05	341.7	30.1 44	Rejected
No relationship	270(2 4%)	43.75(5 0%)					

Source: Field Survey, 2023

Table 5 shows that the chi-square (x^2) calculated value of 341.7 was greater than the chi-square table value of 30.144 checked at 0.05 level of significance and at 19 degrees of freedom. The null hypothesis which states that there is no significant relationship between women’s socio-economic status and their involvement in health decision making in the households was rejected. This implies that there is a significant relationship between women’s socio-economic status and their involvement in health decision making in the household. This suggests that women who are more educated are more exposed and more likely to be employed or obtain gainful job and have a source of income than those who are less educated. Sultana, (2011) noted that women’s economic contributions to the household makes it more evident for themselves and for their husbands that they should have a say in how the money is spent. Participation of women in economic activities and their ability to contribute financially to the family can significantly increase their role in the household decision making process.

Hypothesis 2:

Ho: Cultural factors do not determine women’s involvement in health decision- making in the households.

Table 6: Chi-square test of Cultural factors do not determine women’s involvement in health decision- making in the households

Responses	O	E	Df	Level of Sig.	X ² -Cal	X ² -tab	Decision
Has influence	605(76%)	43.75(50%)	1	0.05	421.21	30.144	Ho
No influence	270(24%)	43.75(50%)					Rejected

Source: Field Survey, 2023

The chi-square calculated value of 421.21 was greater than the chi-square table value of 30.144 checked at 0.05 level of significance and at 19 degrees of freedom. The null hypothesis which states that cultural factors do not determine women’s involvement in health decision-making in the households was rejected. This implies that cultural factors determine women’s involvement in health decision-making in the households. For many African societies and cultures, women are relegated to the background, they are not to be heard but only to be seen and this by implication constrains their active participation in household decision making and other related matters even up to decisions concerning themselves. According to Alemayehu, et. al., (2017), millions of women have little health care decision making autonomy in many cultures and tribes. African women are often seen having little participation in healthcare decisions.

Conclusion/Recommendations

This study examined the dynamics of women's involvement in decision-making regarding the use of maternal health services in selected households in Makurdi Local Government Area of Benue State. The study found out that women’s involvement in health decision making in the study area was constrained by factors which include but not limited to social and cultural norms, religion, income differentials and low cost of traditional medicine, among others.

Based on the findings of this study, the following recommendations are made for policy guidance and possible implementation:

1. Gender considerations are crucial to human development and development at all stages. Participatory and gender-sensitive environment require policies and programmes governed by principles of inclusivity. This means ensuring that both women and men have a voice in decision making especially when it concerns their health. A holistic and integrated approach to health must involve both women and men at all stages of the development process, from identification through decision-making to implementation.
2. Equal educational exposure of both sexes from an early stage should be adopted as a matter of social policy. The educational programmes should be structural and delivered in two stages. The content of civic education and literacy programmes should be simplified and translated into local languages for the realization of the desired impact. First, sustainable general awareness should be created about the apparent socio-economic mobilization benefits of educational literacy in the society. Secondly, there should be focus on specific women-centered health education or capacity endowment programmes targeted at mobilizing women for inclusive decision making in the households.

3. Some of the social and cultural norms such as gender roles that relegate women to the background should be discarded and those that allow women to participate in decision making should be upheld. By so doing, the level of women's involvement in health decision-making will be enhanced in the household.

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