

GENDER ANALYSIS OF THE NIGERIAN HEALTH SECTOR

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ABSTRACT

The paper analyzed the gender disparity in the Nigerian health sector. The study focused particularly on some states in Northern Nigeria that shared similar demographic characteristics. The paper provided an in-depth analysis of how women who constituted the largest percentage of health 'consumers' are dominated by men working in the sector. The paper revealed that the disparity between men and women or male dominance in the health sector is a result of the cultural orientation of the people in Northern Nigeria who give preference to male child education than females. It has established that long duration that students spent undergoing training has dissuaded the inhabitants of the Northern Nigeria who are Hausa and Muslim to enroll their female children into medical schools. This is because the culture of Hausa people and their interpretation of Islam demand women should be in hermatrimonial home at their teen age. Based on the findings, it has been recommended that there is the need for cultural reorientation to debunk the beliefs system that hinder women to acquire medical education and training.

KEYWORD

Women, Gender Analysis, Gender Disparities, Health Sector, Nigeria

1. INTRODUCTION

The analysis of gender has which emerged during the 1980s in Africa for the involvement of women into the mainstream health sector, It has challenged the dominant studies in the sociology and other social sickness disciplines that focused on male related substantive areas. Since then there is an upsurge studies in applied sociology to all areas of health, education, politics or economic planning and women participation in decision making. Introducing gender analysis into the social sciences requires that is should be simultaneously question men and women's status as well as their societal roles at the social stratification ladder. The impact of gender relations in situation that involves individuals or groups question the way social status and roles are determined by sex. This point has been echoed by Sow and Imam (1997: 34-35), in fact, it cannot deny the importance of collecting information on women in their social, legal political and economic condition in building scientific corpus.

The issue of women's health and empowerment mostly in underdeveloped countries like Nigeria has occupied a central place in contemporary human development discourse among the social workers, health practitioners, public policy makers, women activities and sociologists. Alubo (1997) pointed out that women's health has originated from currents, some of which have divergent worldviews and ultimate objective. This is because of high mortality (death), maternal mortality rates (high rate of women died in tropical Africa at childbirth). Infant mortality,

morbidity, unsafe abortion, V.V.F, Uterine ruptures and complicated pregnancies issues etc (Alubo, 1997). In Nigeria and most culture in Africa, women are home-makers, centres of the family, and the main custodians of social, cultural and fundamental values of any society. That is why any sustainable positive change is often best achieved through them. In fact, sustainable community development is not possible without addressing the challenges faced by women; understand their needs, demand co-operation and effective participation in all sectors of the society. Since the first United Nations conference of the International Women's year in Mexico, 1975; Fourth World Conference of the International Women in Cairo September 1994 and later Beijing in 1995, there has been a considerable number of studies on health, economy, education and reproductive rights of women across the world.

Based on the above encouraging information on women's condition of life women have become the prime work of Non-Governmental Organization such as Women in Nigeria, International Gender and Social Science Research (Inter-Gender) Reproductive Health Project. The Packard Foundation, Women Empowerment and Skills Development Centre etc Non-Governmental Corporate Individuals like MacArthur, Ford Foundation etc, Public policy makers and Women Activities. Perhaps very few people today would doubt the male dominance over female health workers in Africa and Nigeria in particular. This is because gender and inclusive access to quality and affordable healthcare services, availability and utilization opportunities in the society. In Africa, the structure of societal activities, right from individual, group and societal levels has been patriarchal hence preferential treatment given to male has been perpetuated from one generation to the other. Therefore, gender analysis of the Nigerian health sector has focused on issues that affected women working with the Nigerian health sector, medical schools and other auxiliary medical schools like College of Health Technology, and College of Nursing and Midwifery. It is apparent that most of the developing countries of the Sub-Saharan Africa women constitute the largest percentage of health services but are not the majority of the workers. The males have occupied dominant position of importance in the health sector from which they control public health policymaking and decision. This has a serious implication on the area of female health, life chances and reproductive rights as well as education in which the policies negate them based on the malestreaming and societal conspiracy Ityavyar (1986). The same disparity is also found in advanced world, the 2015 data, and women reported worse experiences getting needed care than men (CMS Office of Minority Health and RAND Corporation, 2017). Inequalities in negotiating and decision-making potential and access to resources have been documented within households. This has prompted questions about both research and policy which is based on the assumption that households function as units where each member benefits equally (United Nations, 2002).

2. GENDER ANALYSIS

According to Global Health Report (2018) conceived gender is as a social construction reflecting the distribution of power between individuals, and is influenced by history, laws, policies and politics, by economic, cultural, community and family norms that shape the behaviours, expectations, identities and attributes considered appropriate for all people-women and men, girls and boys, and gender-diverse people. How an individual expresses their gender identity varies across context, time, and place and through the life-course. Gender interacts with, but is distinct from, the binary categories (male, female) of biological sex. Gender also intersects with, and is shaped by, other axes of inequality e.g. age, education, economic position and power, race and ethnicity.

Gender is seen as a sociological role of men and women assigned by the society and the social processes shaping their expectations and interactions. Imam (1997:2) gender connotes the social and historical constructions of masculine and feminine roles, behaviours, attributes and ideology. Gender roles are socially constructed and not physically or biologically determined. Based on this, sex is not the same as gender. And no roles can men do that woman cannot do vice-versa. It is based on gender orientation and patriarchal explanation. Likewise, these gender construction is based on socialization process i.e. socially constructed, changes over time and differences of culture (Thio, 1987; Ityavyar, 2000).

Gender analysis is conceived as a close examination of a problem or situation in order to identify gender issues. It may categorically centre on women (or on men). It needs to be pointed out that gender analysis is not synonymous with women studies (studies specifically of women as a social group). The major focus of analysis is the social relations of gender, rather than women or men as strategic studies about women constitute a more recent area whose significance has been felt at many levels. Sow (1997:21) observed that gender analysis applies to social sciences which intervene to fill a void (by taking the sex variable into account) and to introduce a new dimension to research. Attitudes concerning this type of analysis vary according to researchers (both men and women) degree of understanding and sensitization or awareness). In this connection, the paper attempts to identify women's empowerment framework to analyse the gender issues in the health sector. This is with a view to identify the implications, obstacles and design an action programme and strategy so as to bail women from their oppression in the health sector.

2.1 THE NATURE OF THE SOKOTO STATE HEALTH SECTOR

Health according to World Health Organization (WHO) is a complete state of physical, social, mental well-being and not necessarily the absence of infirmity or disease. It is encompassing yet problematic because of the problem of reaching consensual definition by scholars on what constitute complete state of health (Erinosho, 1998:12). However, it comprises of all medical care i.e. use of substances, trained manpower, nurses, midwives, pharmacists, laboratory technicians, hospitals, clinics, dispensaries etc. It involves all that is required to cure diseases, institutions, personnel and medicine. It also involves health care need for good and balanced diet, food, shelter, sanitation, drugs and political engineering. There is also the talk environment and anything that is needed to maintain good health in terms of availability of good potable water, food, availability of staff, education etc.

Research and scientific evidence have shown that most Third World countries like Nigeria lacked access to basic, curative and preventive measure, while few have access to qualitative tertiary care. This is because this type of health care system is based on "market model and political economic model, in which resources allocation is determined, based on economic consideration and laissez-faire (Capitalism) healthcare too, is tied to a scarce resource. According to WHO (2012) in spite of government and partner efforts to strengthen health service provision in most countries in the Region, the users still find the health care and facilities inadequate. The findings show that local and community health services are under-resourced and require more investments to boost their capacity to deliver quality care and increase access for the poor and vulnerable members of society including older persons. Furthermore, under the political-economic model, resource allocation is politically determined and services are provided at no change at the delivery point (Klein, 1977). Similarly, the situation over the years compelled people to seek for treatment in private healthcare providers. In countries like Ethiopia, Kenya, Nigeria, and Uganda,

more than 40% of people in the lowest income quintiles continue to seek care from the private health sector International Finance Corporation, 2007).

On the situation of health system in Nigeria, Alubo (1991:32) opined that the distribution and provision of health and medical services has remained unchanged (i.e. separations differential access) since the colonial days. Inequality in the health services both replicates and mirrors the state structure and indeed, the Nigerian society (i.e. who have access to the quality services) are invariably the powerful, the privileged and the influential members of the Nigerian society. Women living at a margin of the society have been the most disadvantaged and suffered the brunt more because the majority does not have access in terms of money and become influential members of the society. Thus, it is safe to assert that healthcare system founded by the state is not for the benefit of women as contrary to what is contained in the policy statements of the government. In this regard, Alubo (1987:2) argued that the solution to Nigerian health problem cannot be assessed differently from its true economic and political independence (as distinct from the symbolic flag independence), being one fragment of this dependency on industrialized countries.

Most of the rural women suffered more by travelling long distances to reach healthcare facilities and the services are not effective and efficient to the satisfaction of the women. There are shortages of health personnel, lack of adequate training for the available health and medical care required coordination of service at various levels. Most of the health problems of Nigeria are preventable and communicable, curable and preventable diseases account for 95% of all deaths. Malaria, Kwashiorkor, Marasmus and water borne diseases (diarrhea, worms) account for 90% of all morbidity and mortality are not amenable to curative medicine. It is with these in mind Alubo, (1985), Ityavyar, (1987); Alubo, (1987) observed, that rural areas suffer most in medical facilities and basic amenities (pipe borne water, electricity and transportation) were lacking as poverty prevents people from accessing quality medical services. Medical facilities were understaffed and underequipped which is filled by illegal and indiscriminate hawking of drugs especially in rural areas and major streets in urban centres.

Furthermore, Alubo (1988) stated that access to and utilization of health care services depends on structural and even political factors which involve the entire arrangement of society and how health care services is organized and deliver to the people. The political factor entails the discriminatory provision of healthcare equipment, personnel and services to the sick that need them most. The power structure is vital, the higher the socio-economic background of class, the higher the quality of health care obtained. In Nigeria, the 1999 constitution of the Federal Republic guarantees the constitutional rights of its citizens to access healthcare. This constitutionally guaranteed right has not been achieved because it takes more than mere constitutional statement to translate the rights into reality. In 2016, the maternal mortality ratio in health facilities across Cross River state in Nigeria is disturbingly high, with 313 women dying from complications of pregnancy and childbirth for every 100,000 live births. Newborn outcomes are particularly alarming, with 58 newborns dying in the first few hours of life per every 1,000 born in health facility (Saving Mothers, 2016).

In the vein, education and skills development exposes men and women to social life outside the family. Subsequently, the level of education a woman achieves affects the number of children she bears between those who acquired education beyond primary and secondary school and who married immediately after primary or secondary school. Likewise, the chances of a safe delivery for an expectant mother in Nigeria are only marginally better than that of her counterparts in two

other countries. For instance, in every 1,000 births in Nigeria, 15 mothers die and only, 1 die in Zimbabwe. For instance, life expectancy in Nigeria was put in at 51 years as against those of Togo which is 54 years, Lesotho 56, Liberia 54, Zambia 54 and Zaire 53, based on this pathetic situation of women. However, The Zambia learning districts continue to make strong progress in saving the lives of women and newborns. In four years, the maternal mortality ratio decreased by 55 percent and the perinatal mortality rate decreased by 44 percent in target facilities, surpassing both SMGL goals (Saving Mother, 2016). World Health Forum (1989:158) in similar cases laments that working for the promotion of health of women means working for a steady development on all fronts. Maternal health care, improved nutrition, early warning of likely difficulties in pregnancy, more effective help during childbirth, improved family planning and immunization are investments in development. It is an affordable and productive investment. Sixteen (16) states had female children deprived of Early Childhood Education instead of 15 in the case of male and both gender pattern (Save the Children, 2015).

2.2 GENDER ANALYSIS OF THE NIGERIAN HEALTH SECTOR

Nigeria has the worst record of healthcare. More than 52% of children are diseased. One Doctor is to 100,000 patients, in 1979, it was 1 Doctor to 112, 555 Dentists, 1:307: Pharmacists, 1:129, 720, Radiographers, 1:275,400 hospital ratio 1:1, 80. Apart from this sorry state of the Nigerian health sector, most of the health facilities are located in urban centres, rural women, are excluded due to distance and poor transport system as well as bad road network that link cities and villages. Ironically, the majority of Nigerian populace lives in rural areas; they lacked access to healthcare services because the majority of medical personnel refused to live in villages. These left rural dwellers at the mercy of inexperienced Doctors posted to village for one year mandatory national service in Nigeria for university graduates. Gender Resources Books (2000) observed that the greatest problem facing Nigerian women is their inability to feed well and have access to medical care, while at the same time continue to produce children that they cannot cater for. Poverty is the most critical problem affecting them and children. Maternal mortality is always attached to the nutritional level of the mothers. This is because; a lot of the lactating mothers are prone to infections and parasitic diseases as a result of lack of unhygienic water, nutritionally deficient food and reproductive health services. They reproduce children, look after them and process the homes as home managers.

Women were deprived the privilege to participate in public-policy making and decision taking that affects their lives. The Nigeria annual budgets have little on the health related challenges affecting women, especially on reproduction. Gender Resource concluded that men have more access to healthcare delivery than women in Nigeria. Healthcare facilities which are specifically meant to provide healthcare services for women such as maternity centres are insufficient and decrepit. At least, 70% of Nigerian women deliver their babies in risky situations. As a result of traditional belief, male children get better access to health services when taken ill than girls. Some boys are more likely than girls to be given immunization and some tend to have better feeding than girls. Women education is one of the vital instruments for any societal development to succeed. It is for progress and liberation of the women folks. There is high rate of illiteracy in the country, which women were at a disadvantage. Ityavyar (1997) found out that about 6% of female adults are literate in Nigeria, while 25% of the male are literate. Women education is a powerful tool for socialization, nurture and civilization. In some parts of Northern Nigeria, religion and customs has kicked against Western education, where girls and boys are mixed in the same class. For this reason, Northern Nigeria lags behind the southern part in women literacy. Most of the conservative Muslim in the Northern Nigeria view women's enrollment into medical

education and profession as culturally wrong and against Islamic socialization which encourage girl-child to get married at the onset of menstruation. They perceived advancement of women education a taboo. In Northern Nigeria, women are regarded as delicate creatures that lacked full legal rights to pursue educational attainment and work like their male counterparts. The prevailing cultural and religious of Northern Nigeria disapproved women from joining professional jobs that requires rigorous training and long working hours out of home.

However, gender or women's role is a social construct, not biological implication i.e., transforming a biological being into a social being. The social construct has taken over nature as the cause of life and in so doing, the cultural and traditional outlooks of the people have sealed women in social constructs to the extent that, their active involvement in the health sector, is regarded as a violation of cultural norms and values. Globally, women suffer different forms of discrimination in terms of access to resources and their opportunities for education and training. This, in turn, hinders women's advancement which subsequently draws them into living in abject poverty and illiteracy. Early/Child marriage which a times is forced, has also has detrimental effects on women effective development. This is another factor which limits women chances in the medical profession and other social institutions. Once married, mostly women in Northern Nigeria are absolutely under the control of the husbands. They have no decision, opinion and power regarding their education, job and reproductive rights in the family. A female medical practitioner stated that for any woman who wants to practice medicine must first have an understanding husband because medical education demands students to dedicate almost the whole of their life to the profession. And the husbands of the female Doctors have to spend nights, days, evenings, and afternoons without their wives. The above is hardly come by because most husbands will not like the idea some because of cost, night-duty etc. This is because sometimes one spends the whole day in the hospital, a sojourn that sometimes stretches into the night.

Such an understanding husband is very difficult to come by especially in a highly suspicious society in which people are ridden-with gossip despite the fact that there are aspects of medical profession that are seen as the domain of women: midwifery and antenatal care. For instance, they are mostly monitored by a female. In most instances, Antenatal Clinic (ANC) is meant for pregnant women for safe delivery. Most people generally Muslims in particular, do not want a male medical practitioner to interfere with the privacy of their wives based on religious belief, hence want their wives to be examined by female nurses and doctors, because they are of the same sex. Most husbands feel that their wives are safer in the hands of fellow women. It is saddened to note the nonchalant attitude of some parents toward enrolling their daughters to formal schools. Most of the parents ironically preferred to allow their daughters to hawk on streets than sending them to formal school to address the lack of women in the field Obstetrics and Gynaecology, Paediatric and midwifery. One of the pioneer consultant gynaecologist in Aminu Kano Teaching Hospital observed that; it is difficult for a woman to go to the male doctor to tell him all her problems, but they have to do that because of the absence of female gynaecologists. Likewise in paediatrics (medicine of children), you find out more female there because they are inclined to babies. It is easier for them to fit in the ward. These are the areas that are critical to mothers and the children. That is why significant number of female nurses in Aminu Kano Teaching Hospital, Kano, Nigeria are found in O&G and paediatrician.

2.3 PATRIARCHAL FACTOR/MALE-STREAMING

This is another traditional harmful practice against women and children in Nigeria as far as access to healthcare and nutritional taboos are concerned. In virtually all human societies, women are discriminated, be it in social, health and sectors etc. They are victims of male dominance, sexual harassment and abuse and deprivation as a result of ignorance and the primitive socio-cultural practices that are detrimental to their wellbeing. Most people prefer to take their sick male children to hospital than girls. Poverty as well aids to the maltreatment of women in their matrimonial homes. This cultural attitude caused grave havoc and setback to the educational development of women which have cumulative health effects on the mothers and children in the society. Most male parents feel painful at the death of a male child than a female. These discriminations according to Gender Resource Book (2000:208) are reflected even in the distribution of health personnel. In 1995, Nigeria had a total of 18,330 Doctors out of which 15,119 were men and only 3,211 (17%) were women. Also out of the 1120 Dentists, only 337 (30%) were women. The above can be explained as a health profession that has a use and exchange value, in which access to the medical professionals is determined by the socio-economy of an individual (Alubo, 1997, Gusau, 1997). With the introduction of Structural Adjustment Programme (SAP) in Nigeria in the 1990s which was aimed at self-sufficiency, liberalization of trade and raises the value of Naira, it wrecked a lot of families and rendered them weak and incapable to cater for basic necessities due to economic hardship. As a result of the commoditization i.e. cash and carry transaction, a lot of parents cannot afford to sponsor their daughters to study beyond primary and secondary school levels. Therefore, most parents preferred to give them out to marriage. This has affected the lower class families, as the high-class families have privilege and access to send their daughters to tertiary institutions of learning. Thus, in spite of the contributions of women in the society, at home and economy, men still dominate the leadership positions in this part of the world.

Accordingly, it could be deduced from the above discourse that the gender roles has taken a masculine and feminine directions. This is vivid in assigning duties to each member of the family in most of the households in Africa. The role of the men is that of a husband and father, the bread-winner which are difficult and tasking jobs. While women are assigned roles as wives, mothers, which are soft, tenderly and kind-hearted roles. It is very hard for women to combine dual roles of the domestic and formal role of a nurse or doctor. Due to jealousy, most women do not like to leave their children with housemaids to cook for their husbands and vice-versa. Added with the above factor is, most men perceive the nursing profession as a derogatory because of the situation where one is subjected to a lot of errands of the medical doctors. Caring is associated with women; such emotional attachment to children, husband and other family portrayed them as naturally created to display affection. This is because medicine is about care; women are much more inclined to medical care. In medical practice generally, patience is a highly needed virtue and most males lacked such qualities because most men are aggressive, they find it difficult to fit in the nursing profession. Other reasons that encourage women nurses are the attitude of most males towards nurses. Some patronize the nursing profession because of marital ground which is at an advantage. Most men want nurses as wives to adequately take care of their children. Therefore, most women are influenced by the profession with a view to get husbands. It is also associated with cleanliness which modifies and polishes women.

Some women also find the nursing profession easier than medicine in terms of training and women generally like things that are easy. The practice of nursing is somehow less cumbersome as compared to medicine which requires extensive and difficult training. Therefore, women find

nursing profession better as there is no problem of job searching after graduation. Additionally, because of malestreaming and societal discrimination against women, women do not want to spend much time in school without marriage, hence young girls are enrolled into courses like nursing whose duration is not more than four years, to enable them graduate and marry before the age of 30. Besides, the entry requirements of nursing are not high like medicine. Another factor that aids male dominance in the health sector is that in medical practice, training and practice are stressful, frustrating and metric. Most women are brainwashed not to like stress because of gender construction based on socialization as opposed to men who can withstand stressful situations.

Similarly, the length of time in medical training also discourages female enrolment because most women in Northern Nigeria try to avoid staying in her parents' home above 30 years, this informed their thought to enroll into courses that they can graduate within the culturally specified time frame for marriage which is below the age of 30. For men, it is not an issue of concern how old a man is before graduation and marriage. Additionally, men's reproductive capacity continues till death, so they can afford to graduate even if they are above 30 years which is constructed as over-aged for girls to remain without a husband. Most men perceived the training of female as doctors as a waste of time and resources; because women end up in Kitchen.

However, the attitude of a parent towards female nurses has made the society to have less confidence in them and view them as rude, arrogant and immoral. This has contributed immensely in making the profession male-dominated even though there are a large number of women nurses. The society on its part attaches a lot of economic importance to being a Medical Doctor. The people also view medical doctor with high-esteem whose progress is a role model as well as achieved status, which is a product of determination, perseverance and dedication. However, such will not go well with women because of some socio-religious constraints. Women in the profession have to decide her time in attending to husband and children. For these reasons, female Doctors find it extremely difficult to marry earlier in life before 30 years of age because the would-be husband may think female Doctors will not have enough time for her matrimonial home. Also, most people in Nigeria feel generally, female doctors are rude, arrogant and opinionated hence men want a woman that is subtle and easily conforming to their wishes.

2.4 THE IMPLICATION OF GENDER ANALYSIS IN THE HEALTH SECTOR

The disparity between men and women in the health sector, are unequal which are almost totally in the area of family/societal relationship and transferred to the health sector. Based on this, women were oppressed and made to be at the mercy of men dominance. Even though they outnumber men in nursing profession yet male Nurses dominate even in Executives of Union activities. Female Nurses have been brainwashed to believe that they are helping male Doctors who do high tasking jobs in the theatre. Likewise, decision-makers and public health officials have always relegated women to the background. This is because men that constitute Board Members sidelined women coupled with a societal perception of making them be soft-hearted or soft spoken. Major decisions that affect them in terms of promotion, salary, discipline are male-centered and dominated in deciding their fate in their workplaces.

Similarly, it has been observed that the men domination of women in the health sector is technical and not numbered. The number is not determined based on technical skills where different Doctors provide quality services which determines salary and other related emoluments. As economists put it, the higher the demand, the higher supply; when the demand for healthcare

is high, the supply of Doctors will be low hence their salary and other entitlements skyrocket. However, the curriculum of Nursing profession makes women to be marginalized from the years of training that is 3 years as compared the to 6 years of medical studies. These differences in years of training and curriculum aid the disparity to expand and perpetuate. This is because from the beginning nurses were trained to be helpers in the profession and not to give instruction but to play their subordinate roles. These also affect the health setting to the detriment of Nurses and Midwives. This has affected their social-being in terms of their occupational welfare and condition of service. These have slow the pace of women empowerment in the health sector. Though they constituted the majority of providers and consume less of healthcare. They still lacked access to active participation in and control of the sector because of some socio-cultural factors which negate their educational attainment and progression in the medical profession.

CONCLUSION

Women constituted the largest proportion of the population of the world. Similarly, they have relationship with healthcare delivery facilities than men, for antenatal care as expectants mothers or postnatal as lactating mothers. In sum, it is evident from the analysis that women involvement in the health sector as providers and less consumer as well as their domination in the health sector is yet to receive the needed attention it deserves. Women are found in health sectors but certain socio-cultural factors i.e., their role definition, gender stereotyping, role-taking are constraints that aided in their domination. This has far-reaching negative consequences in terms of decision making that affects their well-being as par salary, promotion, and discipline. For women to regain their status they have many hurdles to cross ranging from public policy-making, patriarchal underestimation, organization and management of development by men, unequal access to education, employment leading to the unequal treatment triggered by socio-cultural and biological impediments in the society.

RECOMMENDATIONS

Therefore, development program should be women-centered not male-dominated. It should include women in terms of policy-making and implementation. There is also the need to involve men who are gender sensitive and conscious on the plight of women so that women can adequately contribute to the national development not only in health sector but in all social institutions. There should be emphasis on specific skill training programmes for women as regards their active participation in the health sector and other sectors of nation-building. There should be a massive orientation programme to debunk the misconceptions about prohibiting women to acquire advanced medical education which in turn affects their socio-economic status in the society. There should be need for mass campaign for enrollment of girl-child into formal education. There is need for cultural reorientation on the exploitation and subjugation of women as members of the oppressed class in terms of empowerment framework, welfare, accessibility, participation and control of their issues and matters. This would reduce the gap between women and their male counterparts not only in the health sector but other sectors.

The Government should establish legislation to protect women interests in all ramifications Federal character should be reviewed to involve men and women consideration in federal employment. The government should outlaw harmful practices against women and back such with legislation for proper operation. The Government should also assist women that are

divorced, widowed, refugees, destitute, ex-convicts, pensioners and all those who are unable to pursue their education with a scholarship.

Involving the women in the decision-making will affect their general well being not only in the health sector by providing for their basic needs i.e. health education and water facilities. Promoting the spirit of self-reliance for meaningful and sustainable professional involvement of women in health sector, there is need for the empowering of women to cleanse the excesses of men dominating all process. The paper wishes to appeal to and energize women to wake up from their slumber more greases should to their elbows they should be alive to their consciousness and responsibilities by projecting themselves as partners in progress by going shoulder with their male counterparts. Families, peers, the communities, 3 tiers of government, the donor agencies and development partners should continue to plan for the women general development in rural and urban areas. The paper wishes to recommend the way forward for development of women in health sector to be realized for effective and sustainable development in that vein, the public policy makers, donor agencies, private sectors, should all focus on removing the major constraints, they need to be conscientize to control their own destiny. Ministry for Women Affairs Statewide should sit up to vigorously pursue the course of and to advance the position of women forward and bring them into the limelight not only in the health sector but in all other sectors that involve them for sustainable development.

Women also should be involved in health sector development and empowerment as par decision-making and empowerment to partake in the medical profession and to have more access, participation and control. This is because access is important as most women lacked money because most of them are poor and money is needed for quality healthcare services. This affects them more based on their reproductive system. The government should outlaw the structural causes of gender gaps in the health sector in terms of the recognition of gender issues in health, public policy planning and programming. It should also set up strategy in motion for gender equity not only in the health sector but other sectors as well. There is the need to strengthen the gender rights from day one to give women the equal opportunity by encouraging them to study medicine and improve their social-economic wellbeing which will reduce the burden of domestic work.

There should be a massive public campaign on the need for parents to send their daughters to study medicine and enlighten the public on the gender sensitivity in education. There is need for the involvement of Non-Governmental Organizations like InterGender, Reproductive Health Project, Women Empowerment Agencies and Women Development Centre; they have a great role to play to bring about positive changes in women life.

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