

GENDER INEQUALITY AND DISEASES IN NIGERIA: A CASE STUDY OF HIV/AIDS AND MALARIA

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ABSTRACT

Virtually all traditional African societies were characterized by various forms of inequality. To be sure, economic inequality was rare; but gerontocratic and gender-based practices that verged on the threshold of social inequality featured prominently. Contemporary African societies still harbour relics of this “unnatural” and counter-developmental phenomenon, but in varying degrees. There is no denying the fact that Western values and standards are gradually replacing some traditional norms and values in Nigeria. These changes notwithstanding, gender inequality still pervades and the level of awareness among women is still relatively very low. The traditional notion of women as second-rate members of societies who should not be entitled to equal rights with the male folk has constituted a clog in the wheel of the process of actualizing the Millennium Development Goals in Africa. This study focuses on gender related forms of inequality, which it correlates with the rate of spread of HIV/AIDS and malaria among women. It posits that some of our cultural practices bordering on gender inequality unfairly divest women of their “rights”. These practices and some natural factors make them more vulnerable. It therefore advocates a radical reconsideration of our “traditional” values and perspective, and suggests that public policies should incorporate practical approaches tailored towards achieving increased economic, political and educational empowerment as well as legal safeguards for women.

INTRODUCTION

Much study has been done to show that gender inequality impacts on development negatively (Anker and Dixon-Mueller, 1988; Evans, 1992; Saito, 1994; Hedman *et al*, 1996; UNDP, 1997; DFID, 1997; Watch and Reeves, 2000). There have also been studies on the effects of certain cultural practices on women’s health (World Bank, 1993, WHO, 1995; UNAIDS, 1997, 1998; UNFPA, 1998). The rate of spread of HIV is comparatively higher among young women. According to WHO/UNAIDS figures, 11-12 African women are infected for every 10 African men (UNAIDS, 2004). Over 50% of

adults (57% in 2004) within the age bracket of 15-49 living with HIV/AIDS in sub-Saharan Africa are women, most of whom are in their productive and reproductive years.

To enhance our purpose, it will be needful to first of all engage in an exposition of the key terms in the work and to discuss the various modes of transmission and spread of HIV/AIDS and malaria.

STATEMENT OF THE PROBLEM

Women in Nigeria still face a great deal of unpalatable conditions arising from harmful cultural practices (HCPs) and gender-based

roles, which are not equally experienced by the male folk. Some of these odds, granted, are embedded in biologically stipulated roles, for example, pregnancy, the throes of childbearing and certain risks associated with child delivery. However, a greater deal of the odds is deeply rooted in culture and social psychology. Women have been largely, and erroneously, regarded as second-rate members of society. This cultural disposition has impinged on public policies and discourses in ways that diminish women's rights to protect themselves against the odds that are staked against them. All these, in turn, have implications for their health and survival.

An estimate by the National Action Committee on AIDS (NACA), Nigeria, projects that by 2015, some 8 million Nigerians would have died from AIDS-related causes (Online, available: <http://www.nacanigeria.org>). HIV/AIDS and malaria constitute leading causes of death (Harry a, et al, 2008) and it is also important to note that not only do women constitute a greater percent of this number, but they are also more vulnerable. Differences in biological constitution, socio-cultural practices, and certain gender roles appear to significantly account for disparities in the rate of transmission and vulnerability between males and females.

OBJECTIVE OF THE STUDY

This work seeks to show that differences in the biological profiles and constitution of men and women, certain socio-cultural practices and systems of gender inequality have a huge bearing on the gender pattern in the spread of some diseases. To establish this trend, two major diseases, namely HIV/AIDS and malaria are isolated for our study. Our specific objective in this study thus consists in indentifying some key biological differences between men and women and key elements of gender inequality cum socio-cultural practices with a view to determining how they account for observed gender bias in the prevalence of HIV/AIDS and malaria. In other words, this work looks at the

various ramifications of gender inequality as well as the comparative biological constitution of women in order to show how these factors predispose women to two of the world's most deadly epidemics, HIV/AIDS and malaria. Women are more vulnerable to HIV/AIDS and malaria.

METHODOLOGY

The method of study adopted in this work consists mainly in extensive literature research and clinical survey. Data are collected from medical journals, hospitals, reviews, as well as literature on gender, culture and related areas. Empirical observations are also made where necessary. This gamut of literature is critically analysed. The Internet also constitutes a valuable source of data for this study.

DISCUSSION

In order to enhance a proper discussion, it would be relevant to clarify the concept of gender inequality and discuss its various manifestations. We shall also explain HIV/AIDS and malaria, especially their respective modes of transmission, and then, discuss the role of gender roles and differences in the biological constitution of men and men in determining variations in their degrees of vulnerability to the diseases.

Conceptualizing Gender Inequality

The *Wikipedia (Internet version)*, defines gender inequality as "the obvious or hidden disparities among individuals based on performance of gender". It notes that gender can be differentiated from biological sex and further points out that "gender has been construed as socially constructed through social interaction as well as biologically through chromosomes, brain structure, and hormonal differences." Although sex segregation tends to engender gender inequality, a fixed causal linkage between the two variables is yet to be established. According to Blackburn, *et al*,

“Frequently segregation, in the stricter, more narrow (sic) sense, is regarded as evidence of inequality, or even as directly measuring inequality. This is clearly not correct, as concentration of the sexes in different occupations does not necessarily mean that either is disadvantaged.” (Blackburn and Jarman 1997: 4; see also Blackburn, *et al*, 2001: 529)

As noted by Risman (2004: 1), gender discourse has been an age-old academic enterprise. In contemporary social science, four distinct social scientific theoretical traditions have been constructed to explain gender (Risman, 2004). One tradition focuses on the origin of sex differences—i.e. whether sex differences have a biological origin (Udry, 2000) or a social origin (Bem, 1993). Epstein’s (1988) *Deceptive Distinctions* presents a good model of the second tradition, which emerged as a reaction to the first and focuses on the social structuration of gendered behaviour as opposed to biology and individual learning. The third tradition, which also emerged as a reaction to the individualist thinking in the first, emphasizes social interaction and accountability to others’ expectations, focusing on how inequality is created and reproduced as a result of what has been referred to as “doing gender” (West and Zimmerman, 1987). Risman and some others regard these three traditions, termed respectively as the *sex-differences perspective*, the *structural perspective*, and the *doing gender interactional analyses*, as incompatible and proposed a fourth tradition known as the *integrative tradition*. This tradition, represented by Lorber (1994); Ferree, et al (1999); Risman (1998, 2004); and Connell (2002); treats gender as a socially constructed stratification system.

Generally, the integrative approach argues that “...gender is an institution that is embedded in all the social processes of everyday life and social organizations. [And] ... gender difference is primarily a means to justify sexual

stratification (Lorber, in Risman, 2004. 2). With ample cross-cultural, literary and scientific evidence, Lorber showed that gender difference is socially constructed and yet is universally used to justify stratification. The phenomenon of gender inequality manifests in diverse forms and pervades several institutions and facets of society—socio-cultural, religious and structural (IDEA, 2001: 107). Amartya Sen identifies seven forms of gender inequality, namely (1) Mortality inequality; (2) natality Inequality (3) Basic facility inequality (4) Special opportunity inequality (5) Professional inequality (6) Ownership inequality; and (7) Household inequality.

The family institution and its associated conjugal relationship, like other institutions of society, portray relations of gender inequality. As Brigit O’ Laughlin (1995:40-41) rightly posits, “...the conjugal relationship is an arena of cooperation and conflict, and this relationship may indeed be a sensitive register of gender relations.” The oppression of women derives substantially from patriarchy and its underlying assumptions and implications. Patriarchy’s chief institution is the family, and the family is a central part of society’s power structure; hence, it both sustains patriarchal power in public and also constitutes a source of women’s oppression (Millet, in Bryson, 1992: 198). Women’s oppression also involves a systematic and unreciprocated transfer of powers from women to men. And, as noted by Nielson, Women’s oppression consists not merely in an inequality of status, power, and wealth resulting from men’s excluding them from privileged activities. The freedom, power, status, and self-realization of men is made possible precisely because women work for them. Gender exploitation has two main aspects, transfer of the fruits of material labor to men and transfer of nurturing and sexual energies to men. (Nielson, in Mappes and Zembaty, 2002: 337).

The above argument is in line with Christine Delphy's materialistic analysis of women's oppression, which describes marriage as a class relation in which women's labour benefits men without a comparable remuneration. In Delphy's view, the exploitation of women consists not just in the sorts of work women do in the home, but in the fact that the tasks are performed for someone on whom they are dependent. Thus, as expressed in *Democracy in Nigeria* by the International IDEA, "efforts at redressing women's inequality should examine the unequal division of labour, access to resources, and the different ways in which women and men are affected by programmes and policies that are supposed to benefit society at large."

Ann Ferguson (1984; 1989) uses the concept of 'sex-affective production' to identify another form in which women's energies are transferred to men. Women, she notes, provide children with emotional care and men with both emotional care and sexual satisfaction. Yet, as a group, they do not receive a corresponding measure of either from men. The gender socialization of women makes them good at providing empathy, support and 'smoothing' over interactive tensions (Young, in Mappes and Zembaty, 2002: 338). This view has largely coloured society's perception of gender roles and led, as it were, to some kind of sex division of labour. The fact that those jobs considered to be men's exclusive province are comparatively

more rewarding and fulfilling further explains the trappings of power inherent in gender relations.

Another dimension of gender exploitation is the sexual exploitation of women which occurs within the institutional structure of the patriarchal family. The cultures of the various Nigerian ethno-cultural groups tend to offer some kind of immunity to men at the expense of women's freedom, health and comfort. A woman who commits adultery, for example, receives far greater public contempt and disapproval than a man who commits the same offence under similar circumstances. In some cases, marital infidelity by a woman inflicts severe suffering, sometimes culminating in death of the woman and/or other family members. On the contrary, the husband may commit the same offence without any direct repercussion. This double standard in marital sexuality, which derives basically from economic and generational inequalities, coupled with gender-based socio-cultural conditioning, further increases women's handicap in bargaining for condom use as a measure for preventing or at least reducing risk of infection during sexual intercourse. Worse still, a woman dares not require her husband to be tested for sexually transmitted infections (STIs) even if she is unsure of his health status. It has been noted that:

... the HIV epidemic has further complicated possibilities for condom use because, in a context where the risk of HIV is popularly associated with sexual immorality, suggesting a condom is tantamount to asserting that one's partner is risky and, hence, guilty of sexual impropriety. For women who suspect their husbands of infidelity, suggesting condom use for marital sex poses multiple problems. Asking for a condom may imply [that] she does not want to become pregnant, which itself can create tension because reproduction is so highly valued. Perhaps worse, her request may be interpreted as indicating that she suspects not only that her husband is cheating, but that the type of extramarital sex he is having is risky, and by implication, debauched. What is more, the meaning of her request may be inverted by her spouse and turned against her with an accusation that it is she who is being unfaithful.

According to the *Technical Report on the 2003 HIV Sero-Prevalence Sentinel Survey among Pregnant Women Attending Antenatal Clinics in Nigeria* by the Nigeria Federal Ministry of Health, “married women’s greatest risk of contracting HIV is through having sex with their husbands (Nigeria Federal Ministry of Health, 2004). The implication, as noted in an online ethnographic study, “Modern Marriage, Extramarital Sex, and HIV Risk in Southeastern Nigeria” is that more men are acquiring HIV outside marriage and infecting their wives than the reverse. Thus, cases of wife-husband transmission are fewer than husband-wife transmission.

Furthermore, women are targeted victims of certain forms of systematic violence such as rape. The Rape Crisis Center networks estimate that more than one in every three American women experiences an attempted or successful sexual assault in their lifetimes (See Young, in Mappes and Zembaty, 2002: 344). The rate is more than likely to be higher in Nigeria given the number of female teenagers who are into street hawking, housemaid and other such services that make them more vulnerable. As I. M. Young (2002: 345) rightly posits, “What makes violence a face of oppression is less the particular acts themselves ... than the social context surrounding them ...” Violence is systematic because it is directed at members of a particular group on account of the fact that they are members of the group. Female genital mutilation (FGM) is another form of violence against women in Nigeria. Like rape, the social and systematic character of this practice derives essentially from the fact that it is directed at members of a group because they are members of that group. Also, in some parts of Nigeria, women are hapless victims of various forms of violent and unhealthy burial rites. In some cases they may be made to drink some concoction made of their dead husband’s blood or the water in which the dead body was bathed, and other dirty items. What is more, she is compelled by the custom of *widow inheritance* to be inherited

by some man in the family, whose health status she has no rights to query.

Gender prejudices, which reinforce inequality, are also reflected in the attitudes of parents towards the education of their children. Male children in Nigeria receive a greater deal of sponsorship in formal education than the female children who are often educated in domesticity, or other menial vocations. This, as it were, lowers their level of awareness and financial capacity to avert certain preventable diseases. To be sure, a greater percentage of women are beginning to be formally educated. However, this reversal is not because of any deliberate preferential interest in female children but largely because general poverty and hardship have compelled many more a male child to fend for himself and to assume the role of breadwinners in many families.

The political and legal spheres also smack of a complex structuration of power in ways that touch on gender insensitivity and outright inequality. The Nigerian state has not practised federalism to its logical conclusions. As noted in *Democracy in Nigeria* (IIDEA, 2001:117), Nigerian federalism is yet to adequately accommodate the various political units (institutions of governance) and to recognize and respect the constitutional demarcation of powers and functions. It is further observed that “The 1999 Constitution, in line with the previous constitutions, has not fully integrated women’s needs, concerns and human rights.” The result is that women’s power to defend themselves against certain aggressions is drastically diminished.

What is HIV/AIDS?

HIV means human immune deficiency virus, a virus that lowers and rapidly destroys a person’s natural immunity and resistance to illnesses and diseases, causing the Acquired Immune Deficiency Syndrome (AIDS). There are HIV 1 and HIV 2, the former being common worldwide and the latter predominant in West Africa, Angola and Mozambique. AIDS refers

to the plethora of symptoms associated with HIV infection. HIV belongs to the lentivirinae subfamily of retroviruses which have an RNA genome. It has a reverse transcriptase, an integrase, proteinase, and membrane glycoprotein Gp 120. HIV reverse transcriptase is very error-prone and therefore introduces a high mutation rate in the viral genome. The target cells of HIV are mainly the immunological cells, for example, T-Lymphocytes (especially, CD₄⁺ cells), macrophages, monocytes, microglial cells, B-Lymphocytes and dendritic cells. The CD₄⁺ cells act as the main receptors. Other surface molecules that act as receptors and co-receptors for the virus are the chemokines, for example CCR5 and C_xCR₄.

Modes of Transmission of HIV

The most common modes of HIV transmission include: (1) Unprotected sex with an infected person or animal. It could also spread through oral sex and between homosexual as well as heterosexual partners; (2) Poorly screened or unscreened blood and blood products; (3) Prick with sharp objects contaminated with the virus; (4) Sharing of contaminated razors and scrapers; (5) Using contaminated toothbrush; (6) Percutaneous exposure following needle prick injury or injury during surgery; (7) Mother to child transmission (also known as vertical transmission); (8) Sharing of objects for intravenous drug use—needles, syringes, etc.

HIV 2 is less easily transmitted and less pathogenic than HIV 1. Whereas HIV 2 can be transmitted from an infected mother to her child, this appears to be rare (0-5% transmission rate in breast-fed infants in the absence of any intervention).

Contrary to the fears of many, HIV is not transmitted through mosquito bite, sharing of cups, or eating with an HIV-positive patient, handshake or sharing of towel with HIV-positive persons. Body fluids that harbour HIV

include semen, vaginal fluid, plasma/blood, breast milk, and saliva.

Clinical Features of HIV/AIDS

HIV/AIDS usually manifests the following clinical features: (1) At the initial stage, it is asymptomatic; that is, it may not have any special manifestations; (2) Protracted fever of up to or over one month; (3) Recurrent diarrhoea; (4) Weight loss of more than 10% of total body weight; (5) Tender lymphadenopathy or persistent generalized lymphadenopathy; (6) Oral candidiasis.

Malaria

Malaria is prevalent throughout the tropics and subtropics and it is a major cause of mortality and morbidity in both children and adults. It occurs in areas below an altitude of 1500m, excluding the Mediterranean littoral, the USA and Australia. Malaria is predominantly a disease of hot, wet climates, but it used to occur in Europe as far north as England and Denmark.

About 100 million people are attacked annually, out of whom 1% die. Following WHO-sponsored campaigns on prevention and more effective treatment, the incidence of malaria was greatly reduced from 1950-1960 but there has been a resurgence of it since 1970. In the 1980s, *Plasmodium falciparum* became resistant to chloroquine over a steadily increasing area. Most serious was the emergence of resistance in Africa, where it is now widespread. Major polymorphisms such as thalasaemia and sickle cell trait provide a selection advantage in regions where affected individuals are more resistant to severe manifestations of malaria.

Causes and Transmission of Malaria

Human malaria is caused by *Plasmodium falciparum* (*P. falciparum*), *Plasmodium ovale* (*P. ovale*), *Plasmodium vivax* (*P. vivax*) and *Plasmodium malariae* (*P. malariae*) which are carried by female anopheles mosquitoes. *Plasmodium falciparum* causes the most severe

type of malaria which can present with hepatic and other forms of infection. It is transmitted by the bite of female anopheles mosquitoes, in which the parasite undergoes a temperature-dependent cycle of development.

The mosquito becomes infected when it feeds on the malaria parasites. The development of the parasite in the mosquito takes 7-20 days. Sporozoites inoculated by an infected mosquito disappear from human blood within half an hour and enter the liver. After some days, merozoites leave the liver and invade red blood cells where further asexual cycles of multiplication take place, producing schizonts. Rupture of the schizonts releases more merozoites into blood and causes fever. *P. vivax* and *P. ovale* may persist in the liver cell as dominant forms—i.e. hypnozoites, capable of developing into merozoites months or years later. Thus the first attack of clinical malaria may occur long after the patient has left the endemic area, and the disease may relapse after treatment with drugs that kill only the erythrocytic stage of the parasite. *P. falciparum* and *P. malariae* have no persistent exoerythrocytic phase but recrudescence of fever may result from multiplication in the red cells of parasites which have not been eliminated by treatment and immune processes. Malaria may also be transmitted by blood transfusion or injection. Transplacental infection is also possible.

Effects on Red Blood Cells and Capillaries

Malaria is always accompanied by haemolysis and, in a severe or prolonged attack, anaemia may be profound. Causes of anaemia include haemolysis of both infected and uninfected erythrocytes, dyserythropoiesis, splenomegally causing sequestration of erythrocyte, haemodilution and depletion of folate stores.

Haemolysis is most severe with *P. falciparum*, which invades red blood cells of all ages but especially young cells. *P. vivax* and *P. ovale* invade reticulocytes and *P. malariae* normoblast, so that infections remain lighter. In *P. falciparum* malaria, red cells containing

schizonts adhere to the lining of capillaries in brain, kidney, liver, lungs and gut. Vessels become congested and the organs anoxic. Rupture of schizonts liberates toxic and antigenic substances which may cause further damage. Thus, the main effects of malaria are haemolytic anaemia and, with *P. falciparum*, widespread organ damage. *P. falciparum* does not grow well in cells that contain haemoglobin f, c or especially s. Haemoglobin s (Hbs) heterozygotes (AS) are protected against the lethal complications of malaria. *P. vivax* cannot enter red cells that lack the *dully* blood group. West Africa and American black people are protected.

Available research findings do not establish any difference in the manifestation of malaria that is traceable to gender differences other than the effect of pregnancy. In pregnancy, women become more vulnerable to malaria, which could cause maternal death, abortion, still birth and low birth weight.

The Gender Character of HIV/AIDS and Malaria

As mentioned earlier in this work, gender inequality, HIV/AIDS and Malaria are causally linked and there are both biological as well as socio-cultural factors that affect their spread and transmission. Studies have shown much discernible causal relationship between gender and HIV/AIDS than malaria. We may have to isolate the biological factors from the socio-cultural.

Biological Factors

During unprotected vaginal intercourse, the risk of having HIV and other STIs is 2-4 times higher for women than for men. One reason for that is that a woman has larger surface area of the genital mucosa that can be exposed to the semen, thus enhancing transmission of the infection. HIV-infection Semen contains a higher concentration of the virus than vaginal fluid. This makes the chances of male to female transmission higher than the reverse.

Table 1: Estimates of HIV Transmission Risk Per Contact

Sex Act	Estimates of Risk of Acquiring HIV infection per contact (%)
i. Female to male vaginal sex	0.0003-0.0014
ii. Male to female vaginal sex	2.3-20 and above
iii. Receptive anal sex	0.82
iv. Insertive anal sex	0.06
v. Receptive fellatio	0.04

Source: National AIDS Epidemic Update, 2006

The implication of the above table is that females are more at risk of contracting the virus than males under same conditions and sexual practices.

Also, young women have immature cervix and scanty vaginal secretion which reduce barrier to infection and increases young female predisposition. Furthermore, tearing and bleeding during intercourse increase predisposition to infection. This can occur during rough vagina sex, anal sex, dry sex or rape. Untreated STIs multiply the risk of HIV infection by 300-400% and it is more difficult to recognize STIs in women than in men. Women become more vulnerable again after menopause.

Another important gender factor in HIV infection is that women have lower viral load compared to men adjusted for CD₄⁺ cell count, race, IVDU, with 1.6-fold (1.1-2,3) increased risk of progression as men with same viral load in the absence of treatment. Women's viral load is approximately 20% lower than that of men with similar CD₄⁺ cell count. The implication of this is that men will come down with symptoms of the infection more easily than women.

As previously stated in this work, unlike in the case of HIV, biological differences between men and women do not bear very significantly on vulnerability to malaria between men and women, except for pregnant women. One reason why women face greater risk of malaria during pregnancy is that women's resistance ebbs when they are pregnant and they

tend to be susceptible to both malaria and HIV infections. Studies have shown that infection rates are highest in first and second parity women with lower rates in later pregnancies. Another reason as we have stated above, is that certain otherwise effective anti-malaria drugs are contraindicated during certain stages of pregnancy. Adolescent girls are very vulnerable to malaria and, in many parts of sub-Saharan Africa, adolescents are often parasitaemic and anaemic when they first become pregnant. (Gender and Health, 2007: 2)

Due to the gender role in parturition, women are further subjected to additional risk during child delivery both at orthodox and unorthodox settings. Here, infection could be acquired during labour and delivery. In most cases, they are iatrogenic either through unsterilized instruments or blood transfusion.

A typical African presentation is that the clinical picture of HIV infection in Africa differs in several respects from those of Europe and the United States where homosexuals form the majority of patients. In the United States the male to female ratio of HIV resulting from homosexuality is 9:1 while it is 1:1 in Africa, which bears a semblance to heterosexual transmission. Secondly, four major symptoms predominate in Africa. These include asthenia (the commonest), persistent diarrhoea and fever lasting for more than one month, sometimes accompanied by night sweats. These may appear together or in isolation. Opportunistic infections,

especially STIs, appear to be more prevalent in Africa, particularly among African women. Opportunistic infections account for 80% of death in patients with HIV/AIDS (Yusuf, et al, 2005).

Socio-Cultural and Institutional Factors

The gender character of HIV/AIDS and malaria derives substantially from the interplay of those sundry socio-cultural, psychological, economic, and juridical factors previously discussed. One is the economic marginalisation of women which, in extreme cases, leads to their impoverishment. This affects them in multiple ways such as ability to access treatment, proper and adequate nourishment. Poverty has also been identified as one of the factors responsible for prostitution. All these increase vulnerability to one infection and disease or another.

One dimension of economic marginalisation is sex division of labour. Apart from men having exclusive access to certain kinds of job, women, especially young girls, are mostly used as waitresses in hotels, house helps, street hawkers and other such jobs with high risks of paedophilia and other forms of sexual exploitation and violence. Not only are most of the women in those workplaces sexually abused; in many cases, they live in poor, wretched conditions, often bitten by mosquitoes. As we have stated earlier, rape occurs outside as well as within the marital relationship and has been responsible for many cases of transmission of various sexually transmitted diseases (STIs). As a result of the socio-cultural conditioning, which renders the women handicapped in sex bargaining, it is difficult for a wife to require her husband to determine his STI status, let alone bargaining for protected sex with her husband even if she suspects that he is infected. Female genital mutilation (FGM) also exposes women to the risk of HIV infection. Being essentially a local practice—in the sense of not being usually done by trained medical personnel—little or no caution is taken to prevent transmission of infection during the practice.

Cultural practices such as tattooing and scarification, which are more common among Nigerian women than men also make the former more vulnerable than the latter. Research has shown that these practices also promote the transmission of HIV. Poverty is also another very strong factor. Many women depend on men for sustenance. Driven by dire poverty, some women tend to engage in aberrant practices and behaviours, such as commercial sex work (CSW) that predispose them to greater risk of HIV infection. Furthermore, in Nigeria (or Africa generally) women are more at risk of rape than men, which places them at further disadvantage compared to their male folk.

Explanation for the linkage between gender inequality and malaria can be located within gender norms and values that influence the division of labour, leisure patterns, and sleeping arrangements. Another important gender dimension derives from unequal access to treatment of malaria and acquisition of preventive devices such as mosquito nets. These factors combine to largely determine patterns of exposure to mosquitoes for men and women. In some settings, the occupational arrangement may make men more vulnerable than women, for example if they work in mines, fields or forests at peak biting times, or migrate to areas of high endemicity for work (Gender and Health, 2007: pp. 1-2). However, in most cases the odds are greater against women.

CONCLUSION

Various institutions and facets of the Nigerian society portray glaring manifestations of gender inequality and harmful cultural practices (HCPs). Women are oppressed and marginalised; certain dominant stereotypes, norms and values rooted in social psychology combine with the existing gender character of the power equation to further exacerbate their plight. As amply shown in this work, in addition to certain natural cum biological factors, socially constructed norms, values, discourses and institutions combine to deepen gender inequities and

increase women's vulnerability to HIV/AIDS and malaria.

Attempts to address the problems posed by HIV/AIDS and malaria should therefore confront the gender-based policies, attitudes and practices that engender their spread. Women's capacity to protect themselves against, and secure treatment for, infections and diseases (where treatment is possible) should be enhanced through an integrated approach involving economic empowerment, education and enlightenment, equal opportunities for political participation, and 'cultural transvaluation'. Constitutional provisions should also be made for the protection of women's rights as citizens.

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