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Women, Religion and Health Policy in a Nigerian Community

Oyeronke Olademo (PhD)
University of Ilorin
Ilorin, Kwara State
Nigeria

Abstract

Focusing in recent decades on the city of Ilorin, in Kwara State, southwest Nigeria, I propose to consider the interrelationships and tension between religious convictions and healthcare policy, as a case study for evaluating the status of women in the Nigerian polity. My resolve on this approach is informed by the pervasive religiosity of the Nigerian nation and by the minimal attention accorded religion in policy formation and Nigerian women. The correlation between philosophy and religion mandates the serious consideration of religion in policy formation and execution. One foremost example is the case of Kwara State's health sector, especially noticeable in policies concerning child and maternal mortality. I intend to investigate the underlining principles among the people for certain practices that have presented serious challenges to health care policies and their implementation. While three major religions of Nigeria are adequately represented in Ilorin, Islam prevails over Christian and indigenous religions. Although the Islamic system of *sharia* is not practiced as the sole judicial system in Ilorin, Kwara State, the implications of *sharia*, which is practiced in conjunction with the civil justice system, for the status of women is apparent. An attempt will be made to proffer explanations and answers where applicable to critical questions. What is the role of religion in women's identity

formation? How does this role affect women's status in the society and health programs in Nigeria e. g maternal and child health and education policies? How may an appreciation of the status of women in the religious sector affect their reception and utilization of official health policies? Are there mutual avenues that accommodate the religious identity of women and explicate health issues? How may religion serve as a prism for re-evaluating the state's health care policy for women?

Key Words:
Women, Religion, Ilorin, Health, Policy-making

Introduction

Kwara state in Nigeria is bounded in the North by Niger state, in the East by Kogi state, in the West by the Republic of Benin and in the South by Oyo and Osun states. Residents of the state are a mixture of different ethnic groups consisting of the Yoruba, Fulani, Nupe and the Hausa. Yoruba culture and language are prevalent among these groups of people as evinced in their conduct, ethos and interpersonal relations. Instances of such cultural affiliations include the practice of facial markings, dress code and historical links with Ile-Ife. Ile-Ife is a town in Osun state Nigeria believed to be the site from which all Yoruba people originated and by extension the whole of the human race. The people engage predominantly in farming as a means of livelihood. In addition, they practice other professions such as weaving, woodcarving, pot making, Iron works and trading. Ilorin, the state capital has a fair share of representations from the ethnic groups enumerated above. Ilorin was founded around 1600-1700 A. D. (O'Hear 1983) and is located in-between latitude 8° 30″ North and longitude 4° 35″ East, with a tickly wooded savannah vegetation (Akande 2010). Also, Ilorin derived tremendous benefits from its location as the gateway between the south and northern parts of Nigeria. The people of Ilorin practiced African Traditional Religion before the advent of Islam through Shehu Alimi in the early 19th century. Presently however, Islam is the religion of the majority in Ilorin.

Health and healing practices presupposes sickness; it is therefore interlocked with a people's conception of sickness and diseases. The African people view sickness as an attestation to the fact that an individual is out of tune with nature and the supernatural, which is represented by the various deities. The physical signs are therefore a part of the story and not the whole story. Diagnosis and prescriptions for treatment and healing take into cognizance all these facts. The focus of the African health

policy can therefore be described as holistic and multifaceted. This notion on health and healing practices prevailed in Ilorin before the introduction of Western medicine. Physical manifestations of sickness as well as the underlining causes were tackled through rituals and pharmaceutical mixtures.

The introduction of Western medicine until recently limited the focus of health policies and healing practices to physical manifestations alone. Recent developments however show that this is changing as the possibilities of non-physical causes are being appreciated in the health institution in Ilorin.

Women are an integral and significant group in any society. Women in Ilorin, the Kwara State capital, Nigeria are at the center of health policies and implementation. Because religion constitutes a crucial aspect of these women's identity formation, it inevitable proffers serious implications for their understanding and appreciation of healing policies. In certain instances, religion could be a positive contributor to the affirmation of health policies and implementation, whereas at other times, religion may be a potent impediment. An analysis of this dynamic relationship between religion, health policies and women constitutes the focus of this paper.

Our methodology phenomenological, while data gathering is based on primary sources through observatory participation and interviews (structured and unstructured). The focus of the paper is limited to health policies and implementation with an emphasis on its effects on women in Ilorin Kwara State, Nigeria.

Women and Religion in Ilorin, Kwara State, Nigeria

Islam, the predominant religion in Ilorin recognizes women as a significant group and important individuals in the polity (Wadud 1999). Injunctions in the Quran are directed to male and female to buttress this stance. Women and men are enjoined to seek knowledge, to pray, to give alms (zakat) and to fast according to Islamic regulations. Social roles of women are appreciated as explicated in recommendations for the respect of mothers and care for wives (Mernissi 1995). These efforts are however mediated by stipulations that encourage inequality between the sexes (Q 4:34). In this regard, the witness of two females is equivalent to that of a man, disobedient wives may be denied conjugal rights or flogged on the legs if situation demands it and the inheritance rights of the female is at variance with that of the male. Examples like these reflect the subordinate position of women in Islam despite all good intensions. Moreover, leadership in Islam is strictly male precinct as females are exempted from leading congregational prayers except

for an all-female gathering. The reading, interpretation and recitation of the Quran is therefore invested in the male most often than not, as noted by Wadud "fourteen centuries of Islamic thought have produced a legacy of readings of the Quran written entirely by men". While international efforts on the part of some female Muslim scholars to interrogate these inequalities by appealing to female role models in Islam is acknowledged (Ahmed 1999, Wadud 1999, Mernissi 1999), the reality in the practice of Islam on the position of women is a different story entirely.

Practically, women constitute the majority of worshippers in any Muslim setting in Ilorin, Kwara State, Nigeria. Indeed, women's dedication to the religion is unshaken and absolute as their personal identity and the family welfare depends on their dedication to the worship of Allah. Women receive and process religious injunctions with little or no analysis due to illiteracy and lack of access to the 'power group' in the religion as earlier mentioned. Some religious injunctions that affect the welfare of women are scriptural (Quran and Hadith), whereas others emanate from the opinions of learned Islamic scholars on issues that are still considered contentious. For instance, the Quran enjoins two years of spacing for children while discussing procedures for divorce (Q 2: 233), whereas the instruction and practice of early marriage in Islam rest within the confines of scholarly engagements. Women in Ilorin have no way of ascertaining these, since they cannot read or write or communicate their opinions on these issues officially.

Women groups such as FOMWAN (Federation of Muslim Women's Association of Nigeria) seek to ameliorate if not eradicate these lapses but they are constrained by issues of class and methodology. These groups comprise of elite women who achieve what they cannot do individually, as a collective body. They do not however effectively attend to the yearnings of the ordinary petty trading Muslim woman in the society. Where the ordinary Muslim woman is a member of the group, she more often than not is a nominal participant with little or no contribution to decision making. Consequent to women's role as receivers of information and not decision makers who analyze and interrogate situations, their reaction to and appreciation of health issues and policies are minimal. The implication of this stance for the woman's health and the child's welfare is enormous. There is therefore a link between women's status and role in religion and their appreciation and reaction to health policies.

The African worldview is deeply religious and this explains why reactions to occurrences in every other sector of human endeavor bear an influence of religion. From birth, women's role and expectations in life are formatted by religious inclinations.

Consequently, gender classifications, professional possibilities and identity construction are all interlocked in religious disposition for the African person. Religious stipulations are of prominent concern to women and everything is done to abide by these instructions because such instructions are imbued with eternal rewards or punishment as the case may be. Submission and unquestioned obedience are some of the stipulations clothed in the garb of religion. Where health instructions conflict with religious expectations, the likelihood is high that these women would prioritize religious expectations above health instructions. It is however worthy of mention that religion makes provision for the health of women and children. The tension between religion and health policy may therefore arise from issues of understanding and interpretation rather than religious injunctions. Scriptural injunctions in Islam show that provisions are put in place for the health of women and children but the disparity in the theory and practice of religion, which predicates on interpretation and understanding may forestall this.

Religion and Health in Ilorin, Kwara State, Nigeria

Islamic injunctions make provisions for health care and healing practices for the Muslim person through two main avenues. The first is personal hygiene, which prophet Mohammed regarded as equivalent to fifty percent of faith. The second is the pursuit of knowledge, which prophet Mohammed regarded as obligatory for all Muslims, male and female (Quran 17: 82, 26: 80, 16: 69). Health issues relating to women and children are often classified as gynecology and pediatrics respectively. In addition, women are involved in family planning while children also partake of various types of immunization. We shall attempt a discussion and analysis of these injunctions in the light of contemporary developments in this section.

Gynecology

Certain practices based on informed and uninformed assumptions are attributed to Islam among the Ilorin women. These practices proffer serious implications for women's health and societal well-being. First, the assumption that one should have as many children as possible because children are gifts from God and any attempt to obstruct their birth is sinful and a sign of ungratefulness. Again, the argument continues that only God knows which of the children will survive and give the parents a befitting burial. Thus, child bearing is considered a chance game where one is never sure of the

final outcome from the beginning. Records of sayings in support of this fatalistic posture may be located among the people, an example being "Olorun lo mo omo ti yio sin ni", meaning "only God (Olorun) knows which of the children will burry you". Moreover, lack of menstrual blood is perceived as a sign of aliment hence everything is done by these women to ensure continuous flow of menstrual blood even after menopause. Sometimes this is done by appealing to traditional medicine, some of which may involve the burning of the vulva to elicit blood (Obasa 2017).

The two sources of authority in Islam, the Quran and the Hadith provide no backing for any of these assumptions or practices enumerated above. Nonetheless the practices remain and continue to affect women's appreciation of health care facilities. When confronted with this assertion, the women claim that the Islamic Mallams enlightened them on these issues and their leaders cannot be wrong. Every Islamic leader we spoke with denied ever perpetrating such unscriptural knowledge, so we ask-where did the information come from? More importantly is the inability of these women to read, interpret and analyze the Islamic scriptures due to illiteracy; hence the source of information and instruction remain external.

Family Planning and Immunization

The basic assumption of family planning is child spacing with significant consideration for the well-being of mother and child. Various methods of family planning such as daily pills, IUCD, injections, diaphragms and Norplant are available in health establishments for women at a nominal fee. Some women profess that to use any method of family planning is to obstruct the birth of a child that God has decided to give a couple. Further, the act of obstructing these births can only lead to ill health as the unfertilized eggs find outlets in various diseases.

Islamic injunctions in contrast to practices on ground among Ilorin women allow the use of the withdrawal method (i'tizāl) to avoid pregnancy and advocates for child spacing (Quran 2: 233). There is therefore a gap between scriptural prescriptions and actual practices and where this occurs it may be taken as an indication of impending change.

Immunization is aimed at arresting certain diseases to forestall children's death by building up adequate immunity against such diseases. The initial response of women in Ilorin was slow towards immunizing children against the six killer diseases (Diphtheria, Polio, Tetanus, Tuberculosis, Measles and Whooping Cough). The situation has been attributed to the unsubstantiated

belief that such immunization could be an attempt to render these children sterile by the developed world in a bid to curtail and control the population of developing countries (Abdulsalam 2017). However, results of healthy children who benefited from immunization have over the years compelled serious appreciation for the immunization efforts among the people. Moreover, these immunizations are given to the children free. The Nigerian government is committed to the immunization program as shown in the funds and efforts committed to the program. Health officials take immunization to the markets and homes to ensure that the program succeeds. The results in recent times have been most encouraging and the society is the better for it.

Women, Health and Religion in Ilorin, Kwara State, Nigeria

Women's role in the relationship between religion and health remain crucial to a positive outcome for the benefit of all in the society. The tripartite union of poverty, illiteracy and materialistic tendencies seem to perpetuate the vicious circle of malnutrition, early marriage, premature birth, low birth weight and pre-disposition to infections. This section will attempt to elicit this circle in sections.

Poverty

Inadequate diet constitutes the first manifestation of the influence of poverty on the Ilorin woman. A large number of the women exist on a grossly inadequate diet because a majority falls into the low economic strata. Consequently, these women cannot afford the meat group classification of food (Passmore and Eastwood 1986) rather; carbohydrate is pervasive in the diet. Such inadequate diets result in malnutrition and poor growth, which may manifest as inadequate development of the pelvis and secondary sexual characteristics-breast, widening of the hips and pubic hair. Complications that arise from these developments include problems at childbirth, difficulty in labor and the trio of VVF (viscous-vaginal Fistula), UVF (utero-vaginal Fistula), RVF (recto-vaginal Fistula) all of which are present with women in Ilorin. Though religion does not prevent women from taking any nutritious meal, its recommendation of polygamy results in large families in the face of scarce resources.

Poor or no visit to the hospitals by the women is another factor that may be attributed to poverty. Women are deterred from

visiting health care centers because of the cost. Alternatively, quacks are consulted and this results in complications that may endanger the life of mother and child. Again, whereas Christianity prohibits the use of any form of traditional medication or herbal mixtures for health purposes, Islam does not. Instances where Muslim clerics combine Islamic and traditional methods for healing activities buttress this stance. Consequently, women visit the quacks being convinced that the religion of Islam permits such. Also, the refusal of some women to attend hospitals has been attributed to Islamic recommendations on piety and chastity, whereby these women are reluctant to submit to physical examinations by medical practitioners. Hence, some stay at home to avoid a perusal of their anatomy by male doctors.

The preferred method of family planning among the women spoken to is the oral daily pill due to its cheapness. Women in Ilorin prefer this method because it is cheap and can be procured from non-qualified people and with considerable privacy. Due to the religious assumption that any woman involved in family planning is committing sin and regarded as being promiscuous, the use of the oral daily pill is secretly guided. The procurement and prescription of the pill is subject to secrecy hence there is room for quacks to offer inadequate care and advice.

Illiteracy

As earlier noted, Muslim women in Ilorin refer to Islam as the source of the injunctions and practices of early marriage. In some quarters, a female child may not experience her third menstrual circle in her father's house but should be married by then (As-Sayyid 1980). Female children are therefore married off early in life. One practice among the Ilorin that sustains early marriage is referred to as "saara", which may be translated loosely as "gift". This is a process whereby a girl is given in marriage by her father, with or without her consent, either to seal a deal or to reinforce a friendship. There is no provision for the education of such a girl and she may be a product of such a marriage too. Such a girl remains an illiterate and brings up children based on her intelligence and exposure in life. Religious requirements demand that women be housed separately from the men. In a polygamous setting, each wife has a specified period to attend to the husband. In a situation where a woman is ill or pregnant outside her schedule time to interact with the husband, getting permission to visit the hospital becomes a problem. This may lead to a late diagnosis of pregnancy thereby defeating the very purpose of antenatal care. When eventually the woman gets to the hospital, the

health care officer is the giver and interpreter of instructions on health matters. The woman can neither read nor write hence she responds only as far as her intelligence and surroundings would allow. On the other hand, health officials complain that these women give wrong histories of reproductive lifestyles. For example, due to the ease of divorce under the Islamic law (sharia) in Ilorin, it is possible for a woman to have four children each for four husbands in her lifetime. She will however not disclose this to the health official who may need such information to correctly access her case study in the hospitals. This stance could also be linked to the people's belief that it is wrong to count the number of a parent's children (a ki i ka omo f'olomo).

The compliance of the woman to instructions given at the hospital also depends on her educational background. Wrong dosage and defaulting in hospital appointments due to one social engagement or the other is common with these women. It is possible to attribute this to the lackadaisical posture of the women concerning their health. Some women are known to adhere rigidly to the dates of appointments irrespective of their health status. Thus, if a woman is ill days before her appointment to see the doctor, she may decide to wait until the appointment date due to ignorance. It may be submitted concerning women in Ilorin that illiteracy makes information dissemination on health issues difficult and it curtails the women's understanding and appreciation of health matters.

Materialistic Tendencies

Women in Ilorin prioritize economic pursuits above all other considerations and this has significant impact on their appreciation of health issues. Poverty and the need of each wife in a polygamous setting to provide for her children compel the women to engage in economic activities that involve some strain and long working hours in adverse weather conditions. The attention accorded hospital appointments for the mother and child is subject to the mother's economic activities. A clear indication of this stance emanate from the Nigerian government's commitment to the immunization of children against the six killer diseases. The immunization drugs are free in addition to the visits of health workers to markets and homes. Because the women do not need to leave their trading activities for immunization, the program has recoded tremendous success over the years among the people.

The women's quest for economic pursuit is interlocked with societal expectations. In this regard, religion and culture are fused in Ilorin as explicated in the marriage ceremonies, which span

seven days at least. On such occasions, the woman leaves her home for the bride's house irrespective of other appointments and needs. All hospital appointments for the mother and child are automatically cancelled. In addition some drugs may be suspended as well due to social stigma as is true of family planning drugs or immunization in case of the child. The environment for such ceremonies and gathering of a large number of people is usually vested with every possible infection through air, food, and water. Some misguided efforts may be made by the woman on returning home to rectify certain neglected areas such as drug dosage but this can only lead to chaos. An example is an increased dosage to cover up for the lost period, which in the case of the daily family planning pill may result in serious bleeding or pregnancy.

Polygamy and HIV/AIDS

It is obvious that polygamy presumes multiple sexual partners, what is less obvious is that some practices like polygamy and concubinage promote multiple sexual chains as well. Women in Ilorin are involved with both polygamy, which is seen as a religious injunction, and concubinage, which has been attributed to culture rather than Islam (Eyombo Anabi 2017). As a wife in a polygamous setting, the woman is under economic, social and psychological strains and may seek avenues to alleviate such. Economically, she needs to cater for the children's requirements and socially she will contend with other women for the attention of the husband. Often times this involves quarrels, abusive language and sometimes, diabolical measures. The psychological need of the woman includes the need to be appreciated and loved which may be construed as the explanation for seeking a concubine. However, for the purpose of this paper, the institution of polygamy and concubinage has proven injurious to women and children's health because they both perpetuate the spread of HIV/AIDS in the community. If a husband contacts HIV, his wives and the concubines of the wives and the wives of the concubines--the list is endless, all get the disease, and this is also true if one of the wives contacts the disease. Consequently, religion without adequate education, through polygamy sustains the spread of HIV. Presently, there are reports of death, the pattern of which may suggest the affliction of the HIV virus in Ilorin city. Instances where the father, mother and some of the children die in quick succession and after manifesting symptoms such as serious infections and loss of weight have been reported among the people in recent times. We note that some percentage of these patients leave the hospital never to return again once they are diagnosed with the disease. However there is

improved care for HIV patients at the University of Ilorin Teaching Hospital, with many placed on effective drugs and regular monitoring.

Religious bodies have done little or nothing towards providing adequate spiritual care for HIV/AIDS patients in Ilorin. Neither Islam nor Christianity provide counseling or care for patients. Sometimes topics on sexual abstinence outside marriage and marital fidelity do feature as focuses of sermons in the house of worship. This is especially targeted towards the youths and this though commendable is insufficient. Essentially, it would seem that the HIV/AIDS is regarded as a health problem that requires a health solution by the religious bodies. Mention should be made however of recent efforts to correct this lapse by some Christian groups in Ilorin.

Conclusion

An attempt has been made in this paper to analyze the position of women in religion and health policy formation in a community in Nigeria. The paper highlighted the Islamic injunctions on issues of health and compares them with the people's practices to show a disparity, which may be indicative of pending changes. Poverty, illiteracy and materialistic tendencies were identified as possible causative factors for some of the women's reactions to health issues in Ilorin, Kwara State, Nigeria. The connection between governmental commitments to health issues and the women's response was also mentioned. The role of religion in the spread of HIV was examined with a recommendation for proper education. It should be stated however that efforts towards the eradication of HIV/AIDS has been more from the non-governmental organizations and little had been done by religious bodies to address this issue with the seriousness it deserves.

Conclusively, it may be stated that a correct understanding of religious paradigm remains crucial to the success of any health policy in Ilorin. Women and their daily living experiences, which are usually largely informed by religious tenet, need to be accorded serious considerations before any health policy is put in place. Again, the need to provide education for the girl child cannot be overemphasized if health issues and facilities are to be optimally utilized.

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2. Mrs. Obasa- a nursing sister at the Maternity wing of the University of Ilorin Teaching Hospital since 1975, on 06/04/17.
3. Mrs. Ojo- the Matron of the Labor Room, University of Ilorin Maternity Wing of the Teaching Hospital22/11/16.
4. Dr. (Mrs.) Olubunmi Muokolu- a medical practitioner at the University of Ilorin Teaching Hospital 23/11/16.
5. Mallam Mohammed Mohammed a. k. a. Eyombo Anabi- a Muslim cleric in Pata area of Ilorin 05/09/17.
6. Mrs. Saliu, Mrs. Razak, Mrs. Sule, Mrs. Abubakar, Mrs.Ahmed, Mrs. Shehu, Mrs. Azeez and Mrs. Wasiu- all market women at the Pata, Ago and Oja-Oba markets in Ilorin, on 19/01/71.