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UNVEILING THE VEIL OF MISOGYNY ON REPRODUCTIVE HEALTH OF GIRLS AND WOMEN IN NIGERIA

[Nijerya'da Kız Çocukları ve Kadınların Üreme Sağlığı Üzerindeki Misojini Perdesinin Kaldırılması]

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ABSTRACT

In post-colonial Nigeria, misogyny is a strong determining factor in societies. It has a profound impact on the reproductive health of girls and women in Nigeria. This research explores the deep interplay between misogyny and Nigerian girls and women's reproductive health, shedding light on misogyny as a pervasive influence that reinforces gender-based discrimination and undermines women's bodily autonomy. By unveiling the veil of misogyny on reproductive rights in Nigeria, attention is drawn to the systemic misogyny hindering the overall reproductive well-being of Nigerian girls and women. Through an examination of some factors, this essay unveils some misogynistic practices such as feminization of poverty and poor implementation of laws and policies, which erode women's reproductive rights in Nigeria. It highlights the crisis in the reproductive health of Nigerian girls and women, emphasizing the

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

urgent need for intervention. Proposing solutions, the essay advocates for grassroots outreaches, targeted education of girls, fair representation of women in policy-making, and legal, religious, and policy reforms. Elevating women's voices and providing comprehensive services aimed at dismantling misogynistic structures in Nigeria are sacrosanct to improving the reproductive health of girls and women in Nigeria. The research concludes that without deliberate efforts to gradually deconstruct misogyny, meaningful progress in girls' and women's reproductive health in Nigeria is a tall order.

Keywords: Misogyny, girls and women's reprodictive healt, Nigeria.

ÖZET

Post-kolonyal Nijerya'da misojini, toplumsal yapının önemli belirleyicilerinden biridir ve kadınlar ile kız çocuklarının üreme sağlığı üzerinde güçlü etkiler göstermektedir. Bu çalışma, misojini ile Nijeryalı kadınların ve kız çocuklarının üreme sağlığı arasındaki ilişkiyi incelemekte; misojinin toplumsal cinsiyet temelli ayrımcılığı pekiştiren ve kadınların bedensel özerkliğini zayıflatan yaygın bir unsur olduğunu ortaya koymaktadır. Nijerya'daki üreme hakları üzerindeki misojinin görünür kılınması, kız çocukları ve kadınların üreme refahını olumsuz etkileyen sistematik yapıları dikkatlere sunmaktadır. Çeşitli etkenlerin incelenmesi yoluyla bu çalışma, yoksulluğun kadınlaştırılması ve yasaların ile politikaların yetersiz uygulanması gibi kadınların üreme haklarını zedeleyen uygulamaları açığa çıkarmaktadır. Nijeryalı kadınlar ve kız çocuklarının üreme sağlığında yaşanan sorunlara vurgu yapan bu araştırma, acil müdahale gereksinimini ortaya koymaktadır. Çözüm önerileri kapsamında makale; taban düzeyinde çalışmaların artırılmasını, kız çocuklarının hedeflenmiş eğitiminin desteklenmesini, kadınların politika yapım süreçlerinde adil temsilinin sağlanmasını ve hukuki, dini ile politik reformların uygulanmasını önermektedir. Kadınların görüşlerinin güçlendirilmesi ve misojinist yapıları dönüştürmeye yönelik kapsamlı hizmetlerin sunulması, Nijerya'da kız çocukları ve kadınların üreme sağlığının iyileştirilmesi açısından büyük önem taşımaktadır. Araştırma, misojinin aşamalı biçimde dönüştürülmesine yönelik bilinçli çabalar olmaksızın, anlamlı ilerlemenin mümkün olmayacağı sonucuna ulaşmaktadır.

Anahtar sözcükler: Misojini**,** kız çocukları ve kadınların üreme sağlığı, Nijerya.

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

Introduction

Despite improvements in healthcare practices on reproductive health, both globally and locally, in Nigeria, women and girls still face a myriad of reproductive health challenges. Such challenges include a high rate of maternal mortality, female genital mutilation, a high rate of vesicovaginal fistula arising from prolonged obstructed labour in girls, unsafe abortion, limited bodily autonomy which leads to poor and harmful reproductive choices, and lack of unhindered access to family planning amongst others. Factors responsible for the poor state of reproductive health of women and girls in Nigeria include but are not limited to, poverty, poor health infrastructures, ignorance, limited access to skilled health workers, poverty, and inadequate sex education.

However, deep-seated misogyny constitutes a significant barrier to the reproductive health of women and girls in Nigeria. This paper sheds light on how misogyny is deeply intertwined with the reproductive health challenges faced by women and girls in Nigeria. It argues that addressing the problem of misogyny in Nigeria significantly improves the reproductive health of women and girls. By highlighting the relationship between misogyny and the poor reproductive health of women and girls, the paper contributes to the broader discussion on gender equality and emphasizes the importance of dismantling misogyny for the reproductive well-being of women and girls in Nigeria.

First, the paper provides an overview of the reproductive health issues affecting women and girls in Nigeria and then defines and examines misogyny within the Nigerian context. Second, it explores the link between misogyny and the poor reproductive health of women and girls. Third, it engages with the gender of metaphysics to establish that there is neither a logical nor scientific basis for considering one gender superior to another. Fourth, the paper argues that

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

improving the reproductive health of women and girls in Nigeria requires structural changes aimed at addressing and gradually dismantling misogyny. The paper concludes by emphasizing the urgent need for action to confront misogyny in matters relating to the reproductive health of women and girls in Nigeria.

Reproductive Health of Women and Girls in Nigeria

This section draws upon empirical evidence to briefly outline some of the reproductive health challenges that women and girls face in Nigeria. In 2023, the World Health Organisation (WHO) announces that Nigeria has a maternal mortality rate of 1,047 deaths per 100,000 live births (World Bank Group, 2024). This places Nigeria as the country with the second-highest maternal mortality rate globally (African Perceptions, 2024). In Nigeria, at least 40% of girls marry before the age of 18. For example, in Jigawa State alone, 78% of women aged 20–49 marry before age 18 (Girls Not Brides, 2024). In 2022, 100 of every 100,000 girls aged 15–19 give birth (World Bank Group, 2024).

Female Genital Mutilation (FGM) remains a widespread procedure that often involves the partial or complete removal of external genitalia that are important for sexual sensitivity (UNICEF, 2022). Currently, the rate of FGM in Nigeria is alarming, with around 19.9 million girls having undergone the procedure, most of whom are between 0 and 14 years of age (UNICEF, 2022). Research shows that FGM has no medical benefits but leads to numerous physical, emotional, medical, and social disadvantages. These include severe pain, bleeding, increased risk of infections, difficulty urinating, cysts, infertility, complications during childbirth, long term psychological trauma, lack of sexual pleasure, painful sexual intercourse, anxiety, and depression (UNICEF, 2022).

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

Furthermore, in Nigeria, estimates suggest that about 400,000–800,000 women live with Vesicovaginal Fistula (VVF) (Borgen Project, 2014). VVF **i**s a medical condition where an abnormal connection (fistula) develops between the bladder and the vagina, causing continuous and involuntary leakage of urine into the vaginal canal. VVF typically results from prolonged obstructed labor, during which pressure on the bladder and vaginal walls cuts off blood supply, leading to tissue damage and the formation of the fistula (Fistula Foundation, 2024). A significant number of women suffering from this condition in Nigeria are linked to early marriage and pregnancy, as young girls' bodies are often not developed enough for childbirth (Borgen Project, 2014). VVF has devastating consequences for affected women, including social isolation, psychological trauma, and complications in sexual and reproductive health. Many women with VVF face stigma and are ostracized from their communities due to the constant urine leakage, which makes the condition even more traumatizing (Fistula Foundation, 2024).

In Nigeria, abortion is legally restricted. It remains a criminal offense and is only permitted when the life of the pregnant womam is in danger. Unauthorized abortion can lead to imprisonment, often up to 14 years with no option of a fine (Criminal Code Act for Nigeria, 1990; Sections 228–233). As a result, women and girls who seek abortions in Nigeria often resort to unsafe procedures performed by unskilled providers. According to a study by Oyefabi et al., 40% of maternal deaths in Nigeria result from unsafe abortion (Oyefabi et al., 2016, p. 87).

Lack of bodily autonomy also contributes to poor reproductive health in Nigeria. About 12–13% of women and girls, including those who are married, are unable to access sustainable family planning because a partner or guardian disapproves (UNFPA, 2021). This leads to

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

unwanted pregnancies, sexually transmitted infections, and unsafe abortions. Furthermore, Nigeria is one of 43 countries with no law prohibiting marital rape (UNFPA, 2021).

These issues summarize the poor state of reproductive health among women in Nigeria. In the next section, I explore the intricate interplay between misogyny and the state of reproductive health for women and girls in Nigeria.

The Veil of Misogyny on Reproductive Health of Women and Girls in Nigeria

Misogyny is broadly defined as the "dislike of, contempt for, or ingrained prejudice against women" (Goodrich, 2024). In the preceding section, I examined the current state of reproductive health for women in Nigeria. If one were to assign a scorecard to the state of reproductive health for women and girls in the country, I assign it a rating of approximately 30%. Improving reproductive health outcomes for women and girls in Nigeria requires a clear understanding of the factors contributing to its current condition. Addressing these underlying determinants **is** essential to making meaningful progress. In what follows, I examine at least three major factors influencing the reproductive health of women and girls in Nigeria and explore their close relationship to misogyny.

One major determining factor responsible for the poor state of reproductive health of women and girls in Nigeria is the feminization of poverty. According to the National Bureau of Statistics (NBS), over 133 million Nigerians are 'multi-dimensionally poor'. That is, they are faced with significant deprivation in key areas of living standards, such as feeding, education, health care, and shelter (National Bureau of Statistics, 2022). This means that not less than 50% of Nigeria's population lives in poverty, and lacks adequate income for the most basic needs.

According to the World Bank women are more likely to experience multi-dimensional poverty and deprivation than men (World Bank Group, 2024). The National Bureau of Statistics (NBS)

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

reports that at least 47% of women live below the national poverty line (National Bureau of Statistics, 2022). This shows that in Nigeria, women experience poverty and deprivation more than men. According to UNICEF, poverty exposes women and girls to high maternal mortality rates, inadequate access to healthcare, high prevalence of early and forced marriage, lack of comprehensive sexual and health education, high prevalence of sexually transmitted infections and diseases, gender-based violence, low contraceptive use, and unmet family planning needs (UNICEF, 2017). Hence, not less than 30% of women living below the national poverty line will experience all or some of these. This is because economic dependency makes them more vulnerable and offers limited options to escape these reproductive health challenges.

There is a tight connection between misogyny, poverty, and poor reproductive health of women and girls in Nigeria. According to Sylvia Chant, misogyny and gender inequality limit the economic power of women greatly (Chant, p.210). Simply put, misogyny reinforces poverty for women. Feminization of poverty occurs when social and cultural policies reduce women's access to opportunities, resources, and decision-making power. This cripples the economic strength of women and poverty increasingly concentrates amongst women (Chant, 2006, p.210). A woman who does not have the minimum economic means of survival is vulnerable. This is why some men, in a bid to enforce the stereotype that a woman ought to be dominated, assume it is dangerous for a woman to be financially independent. Hence, they make it either difficult or impossible for her to work or take control of her finances even when she is allowed to earn (Jakobsen, 2014, Buvinic et al., 2009). In Nigeria for example, a significant percentage of women face restrictions from their husbands on employment (Enfield, 2019, p.7). A survey conducted shows that where women are restricted to traditional roles, they are often not allowed to seek paid employment, and the labour rendered in the home is unpaid (UN WOMEN, 2019).

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

Another factor responsible for the feminization of poverty in Nigeria is that a significant number of households are female-headed (Chant, 2006, p.204). That is, in many cases women with children are solely or largely responsible for the feeding, education, clothing, shelter, and healthcare of the children Chant, 2006, pp.204-205). In contrast, the children's father is often not responsible for childcare. The available legal structure in Nigeria to compel men to be effectively responsible for child support is almost non-existent. There are limited and inconsistent enforcement mechanisms to ensure paternal involvement in child support in Nigeria, especially after a separation or divorce. These women have limited support networks and face financial pressures that expose them to the problem of 'feminization of poverty'.

Another factor responsible for the feminization of poverty in Nigeria is that women and girls face disparities in education. It is reported that women and girls have lower rates of enrolment and completion at every level of education, especially in the northern regions of Nigeria. According to a UNESCO report, about 10.5 million children are out of school in Nigeria, and around 60% of these children are girls (UNICEF, 2023). This is more extreme in the northern region of Nigeria, especially In Borno and Yobe states. The gender gap in girls' school attendance is significantly lower than in boys. Hence, boys who have access to education, from an early age already have an undue advantage over girls who are denied access to education. This gap worsens as most of these girls are forced into early marriage. Feminization of poverty arising from disparity in education in Nigeria is a huge challenge.

Women and girls who live in poverty are less likely to have bodily autonomy, access to adequate health care services, sex education and reproductive awareness, and family planning services. Some of these are girls forced into early marriage and are consequently exposed to vesicovaginal fistula (VVF), which can lead to urinary incontinence, vaginal discharge, pain

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

during intercourse and while urinating, fever, nausea and vomiting, and abdominal pain, which is a poor state for a girl or woman already faced with poverty to be in. Women of lower socioeconomic status are more likely to experience adverse reproductive health outcomes.

Another major factor for the poor state of reproductive health of women and girls in Nigeria is the limitation of bodily autonomy. A significant number of women are unable to make personal choices about their reproductive health in Nigeria. Misogynistic structures and norms often empower men to make reproductive decisions for women. These men will often make reproductive choices for women that will end up benefiting them and not the women.

In the book 'Second Class Citizen' written by Buchi Emecheta (later discovered it was largely her true life story), the main character *Ada*, a Nigerian, married to Francis a Nigerian man, was forced to leave her job after she had a difficult cesarean section. It was their third child, and she was the primary provider in the household. *Ada* then decided to start using contraception without informing Francis. This is because Francis did not think it was proper to use contraceptives. *Ada* inserted a cap, but Francis discovered it one evening and beat her into a pulp, not minding she was still recovering from a difficult cesarean section. *Ada* then went ahead to have a fourth child against her desire (Echemeta, 1974, pp.139-145).

This unfortunately, is the situation many Nigerian women find themselves in. While women with higher levels of education have greater bodily autonomy, education does not isolate the problem of limited autonomy. Many educated women are forced to surrender their reproductive health choices to a man. In Nigeria, there are strong cultural and religious beliefs that reinforce the belief that a man is superior to a woman; hence, the head of the woman. This male-dominated structure limits the rights of women to make reproductive choices for themselves.

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

They are often forced to relinquish this right to a man or face social disapproval from religious bodies and family members, and in some circumstances, they experience gender-based violence when they refuse to relinquish this right to a man.

According to the United Nations Population Fund, studies show that about 64% of married women are unable to fully exercise their reproductive rights. They are unable to make decisions concerning the number of children they want, contraceptive use, and even sexual consent (UNFPA, 2020). According to this study, less than 56% of married women feel empowered to refuse sexual advances from their husbands, and less than 41% feel empowered enough to request condom use (UNFPA, 2020). Furthermore, a significant number of women are forced to have vaginal deliveries because their husbands refuse to consent to elective cesarean sections. There are some religious and cultural beliefs that a woman who undergoes a cesarean section lacks faith or is lazy. Hence, some men will not consent to elective cesarean section. This harms, not only the reproductive health of women but also the maternal mortality rate in Nigeria.

The third major factor contributing to the poor state of reproductive health among women and girls in Nigeria is the existence of policy gaps. In Nigeria, policymaking remains closely linked to political processes, yet women continue to be significantly underrepresented within the political sphere. The Senate and the House of Representatives are the legislative arm of the Nigerian government. In 2015, out of the 109 members of the Senate, only 7 were women. Out of the 360 members of the House of Representatives, only 22 were women. In 2019, out of 109 members of the Senate, only 7 were women. Out of the 360 members of the House of Representatives, only 11 were women. In 2024, out of the 109 members in the Senate, only 3 are women. Out of the 360 members of the House of Representatives, only 16 are women. These figures highlight a consistent pattern of gender disparity in policy-making in Nigeria.

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

The judiciary arm is significantly better as at least 32% of judges in Nigeria are women. Although the disparity is still a lot, the proportion of women in significant positions in the Judiciary arm of government is better than what is obtained in the Executive and Legislative arms of government.

The consequence of this disparity between men and women in government and politics is that men dominate policymaking in Nigeria and it is unlikely that the interests of women and girls will be well represented. There are gaps in legal protection and enforcement of the rights of women and girls in Nigeria.

The Child Rights Act (CRA) of 2003 prohibits abuse and harmful practices of any form against children. This includes Female Genital Mutilation (FGM), basic right to education and healthcare, and protection against child marriage. However, the enforcement of this law is limited. There are states yet to adopt the CRA; hence, the reach and effectiveness of the CRA are limited. States such as Zamfara, Gombe, Kano, Bauchi, and Adamawa are yet to adopt the act. Except those who are directly affected by these reproductive health issues are actively involved in policymaking, laws like this will not get to the stage of enforcement. Legal protection for girls against issues like child marriage, the right to education, and protection against FGM is inadequate.

Hence, although there is an act that prohibits child marriage and FGM, a study shows that in 2024, 19.2% of girls in Nigeria between the ages of 0-14 have undergone FGM (UNICEF, 2022). Another study shows that 30.3% of girls in Nigeria are married before the age of 18 (Girls not Bride, 2023). In Jigawa state, 78% of women aged 20-49 were married before the age of 18 (Save the Children, 2021). While it is commendable that FGM in Nigeria decreased

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

from 25% to 20% in 2024, it is important to note that Nigeria still accounts for about 10% of FGM done globally. Despite the disturbing data on FGM and child marriage, it is important to note that as of 2024, there are no confirmed reports of persecution under the CRA for child marriage or FGM. Enforcement mechanisms are weak. Even though there are laws prohibiting these acts, there is inadequate legal framework to ensure the laws are enforced. Thus, a lot of girls end up with poor reproductive health as a result of these violations. While the laws look good on paper, the executive and judiciary arms have little interest and willpower to enforce the laws. If there are more women involved in policymaking, the interest and willpower to enforce these laws will significantly increase.

On November 7, 2024, the Federal Government of Nigeria announced that pregnant women would have access to free cesarean sections in government hospitals. This policy aims to significantly reduce the maternal mortality rate that arises from unsafe birth methods, especially because of poverty. This is laudable and a huge leap in the war to reduce the high maternal mortality rate in Nigeria.

However, there **is** a huge policy gap that needs to be addressed; otherwise, the maternal mortality rate does not reduce significantly. Policies that do not address harmful cultural, religious, and misogynistic beliefs and practices, such as the belief that cesarean sections are a sign of laziness and lack of faith, may not be as effective as they should be**.** When laws and policies are poorly enforced, they do not serve the purpose they are meant to serve. These laws and policies need women who understand the reproductive health of women to be largely involved in the enforcement.

In 2015, women had 18% representation in the Columbian House of Representatives. In 2019, the representation increased to 27.3%, and in 2024 it further increased to 31.4%. On the 10th of

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

November 2024, they succeeded in passing into law a bill that bans child marriage in Columbia and protects the rights of minors who are already involved in child marriage (Plan International, 2024). The bill was championed by some lawmakers and civil society organisations such as 'Equality Now', and 'Girls not Brides'. The higher the representation of women in policymaking, the more likely that laws and policies that are beneficial to the reproductive health of women and girls will be made and enforced.

This section identified three major factors that are interwoven – poverty, limited bodily autonomy, and policy gaps - responsible for the state of poor reproductive health of girls and women in Nigeria and showed how the veil of misogyny strengthens these factors. The following section contends that misogyny lacks any logical or scientific justification.

Metaphysics of Gender

How gender is understood directly shapes policies, social norms, and individual rights. Raewyn Connell argues that gender inequality influences these domains in ways that limit access to human rights and essential services, including healthcare (Connell, 2009, pp.141–144). Hence, it is important to explore the metaphysical dimensions of gender. This supports the view that gender inequality lacks scientific or rational justification. This section presents key arguments and relevant studies to demonstrate that gender inequality is, at its core, a socially constructed phenomenon without legitimate basis. No gender identity holds an inherent or natural right to exercise prejudice over others.

Traditionally, gender has been defined as "the fact of being male or female" (Hornby, 2000). In contemporary discourse, however, it has expanded to include "a range of identities that do not necessarily fit within the usual division between male and female," as well as "the classes

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

(masculine, feminine, and sometimes neuter) into which nouns, pronouns, and adjectives are divided" (Hornby, 2000). While contemporary metaphysical and sociological thought increasingly conceptualizes gender as a fluid and socially constructed identity, this study focuses primarily on a binary framework. This focus is not intended to delegitimize non-binary or gender diverse identities. Rather, it reflects the socio-cultural context of Nigeria, where public discourse and policy predominantly operate within traditional understandings of gender closely tied to biological sex. Limiting the analysis to this framework facilitates a grounded, context-specific investigation.

This section examines the fundamental nature of gender from a philosophical perspective and its implications for identity, societal roles, and inequality. For instance, when gender is framed in ways that assign superiority to one identity and subordination to others, policies and institutions often reflect those hierarchies frequently failing to serve or protect those marginalized by such frameworks.

Although certain biological features may influence one's physical identity, they do not determine worth or superiority. Environmental conditions, access to education, income level, and social status all contribute significantly to personal identity and human development. There is no credible research that establishes any gender identity as inherently superior or inferior to others.

For example, in pre-colonial Yoruba societies, gender roles were shaped by contextual factors such as age, economic standing, and social influence (Badejo, 2022, p.101). Individuals assigned female at birth were not intrinsically considered subordinate. In some cases, depending on wealth, age, or role (e.g., regent or warrior), a person could occupy a position of authority

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

that surpassed others, regardless of gender. This context-dependence shows that hierarchy is not biologically or ontologically determined.

Various arguments within the metaphysics of gender support the case for equality among all gender identities. One such argument states that gender inequality is a social construct. Judith Butler argues that inequality is not a product of natural essence but of repeated social performances that reinforce hierarchies (Butler, 1999, p.143). Similarly, Simone de Beauvoir observed that historically, human societies have constructed hierarchies that privilege some gender identities over others, despite there being no natural basis for such divisions (Beauvoir, 1953, pp.33–36).

De Beauvoir emphasized that no one is born into inferiority; rather, societal expectations shape individuals into subordinate roles. These social expectations often result in limited educational, professional, and political opportunities; economic dependence; and restrictive gender roles. For de Beauvoir, the path to liberation involves rejecting these imposed limitations and embracing authentic self-determination (Beauvoir, 1953, p.267).

Another key argument is that gender-based hierarchies violate fundamental principles of human dignity, autonomy, and moral worth. In the absence of any social, political, or empirical justification for treating people unequally based on gender, any system that reinforces such inequality is unjust. These systems sustain harmful norms across both public and private life, undermining equal participation in education, politics, employment, and other areas of social existence. According to J.S. Mill, equality is a principle of justice, and any deviation from it constitutes social oppression that must be resisted (Mill, 1869, pp.4–10).

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

Psychological studies also challenge gender-based hierarchies. Hyde (2005) found that differences across various domains, cognition, communication, leadership, and effectiveness between people of different gender identities are minimal and insufficient to justify any form of inequality (Hyde, 2005, pp.581–583, 590). Similarly, Ceci and Williams (2011) examined underrepresentation in math-intensive fields and concluded that disparities are not due to ability, but rather to social and cultural biases, including exclusionary practices and systemic prejudice.

These findings demonstrate two key points: first, gender inequality lacks logical and scientific credibility; second, its impacts are both far-reaching and mutually harmful. Social and economic structures that exclude or devalue one group over another do not only limit those individuals' opportunities but often place unsustainable pressure on others within the system. For instance, when certain individuals are denied the opportunity to contribute economically, others may be burdened with disproportionate responsibility. Over time, such systems of inequality prove detrimental to everyone.

Given these outcomes, the persistence of gender-based discrimination raises serious ethical and practical concerns. The dismantling of unjust structures is therefore not only a moral imperative but also a path toward collective well-being.

Unveiling the Veil of Misogyny on Reproductive Health of Women and Girls in Nigeria

Nigeria ranks second in maternal mortality rate globally, with a rate of 576 deaths per 100,000 live births (Momoh, 2024). At least 40% of girls get married before the age of 18. Nigeria accounts for at least 10% of FGM done globally. It is estimated that about 400,000-800,000 women are living with VVF in Nigeria (Adama, 2014). 10-14% of maternal deaths in Nigeria are as a result of unsafe abortion (Oyefabi et al., 2016, p. 87). About 12-13% of women and

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

girls in Nigeria are unable to access sustainable family planning because a partner or guardian disapproves (UNFPA, 2021).

Some of the factors responsible for this poor state of reproductive health in Nigeria include poor and inadequate healthcare, poverty, low level of education, harmful religious and custom beliefs and practices, policy gaps, and limited bodily autonomy. I have argued in the section "The Veil of Misogyny on Reproductive Health of Women and Girls in Nigeria" that there is a tight connection between these factors and misogyny. In the section "The Metaphysics of Gender", I showed there is no ontological, logical, or scientific justification for misogyny. Hence, in addressing the state of the reproductive health of women and girls in Nigeria, there is a need to gradually dismantle misogynistic frameworks.

A major approach towards deconstructing the misogynistic framework in Nigeria is massive education and awareness, especially for women and girls. Nigeria will have to consider a curriculum that factors in basic lessons on reproductive health right from the primary schools. This should be basic and probably taught in the indigenous languages of each community. Right from a young age, Children must be educated on the importance of reproductive health and its direct impact on their lives. Despite the apparent simplicity of this objective, resistance is likely to emerge in certain regions of the country. Nevertheless, it remains the government's obligation to uphold and ensure the enforcement of every individual's fundamental right to education, at least up to the secondary school level. The Nigerian government, therefore, has a major role to play in ensuring every child, especially the girl child's right to education in every part of the country.

It is noteworthy that some curricula already contain lessons on basic hygiene and sex education

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

and this is taught in some schools under social studies, home economics, and basic science. Nevertheless, there is still a gap to be filled. Experts in research and teaching reproductive health such as family medicine doctors, obstetricians and gynecologists, public health educators, and NGOs specializing in reproductive health can join efforts with the government to make this happen.

Another approach that can make a huge impact is regular educational outreach in the rural areas in Nigeria especially. The World Health Organization reports that urban women in Nigeria are more likely to meet the milestones of their reproductive health compared to women in rural areas (World Health Organisation, 2015). Hence, regular outreach that emphasizes the importance of reproductive rights, antenatal care, contraceptive use, dangers of adolescent pregnancy, the importance of education, and financial independence should be held in the rural areas of the country. Region-specific experts, peer educators, religious leaders, and traditional leaders should be carried along in enforcing this. The role of traditional and religious leaders cannot be underestimated. This will help with the security of personnel, and the willingness of members of the communities to participate in these outreaches, listen and accept the teachings. Incentives such as sanitary pads, condoms, and free medical tests will have a positive impact on the success of these educational outreaches and effects on shifting some cultural norms.

Another major approach is massive reforms, legal reforms, social reforms, religious reforms, and cultural reforms. In a previous section, I mentioned how redundant some of the portions of the Child Rights Act (CRA) of 2003 are. There is a portion that prohibits abuse and harmful practices of any form against children. This includes Female Genital Mutilation (FGM), basic right to education and healthcare, and protection against child marriage. However, the enforcement of this law is largely limited in some states. The government will have to ensure

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

that policies and laws are strictly enforced. I explained in a previous section how several men do not participate in child support and how it perpetuates the feminization of poverty. It is not an easy feat to enforce child support in Nigeria. Even when the court rules that the man pays a certain amount towards child support, it is often too small and almost impossible to enforce payment. Legal reforms must include how to ensure that failure to comply with child support is criminalized.

Religion plays a huge factor in the socio-political affairs of Nigeria. The government needs to make some sort of regulations for religious houses. Religious platforms should not be deployed to spread hate, lies, and dangerous myths such as cesarean sections are for lazy women. Stereotypes like this contribute to the state of the poor reproductive health of women in Nigeria. Furthermore, Nigeria is a country where some mission houses have birth centers. Some of these mission homes rely on traditional birth attendants and prayers for delivery. This significantly increases the risk of maternal mortality. While it is not a bad idea for mission houses to have birth centers, it is one of the ways to ease the burden on government facilities and a cheaper means for pregnant women to deliver, these birth centers must be regulated, monitored, and close to health centres and hospitals that can intervene in cases of complicated birth processes.

Also, economic empowerment for women ought to be prioritized. If the feminization of poverty can be reduced, women are more likely to be able to have more access to their bodily autonomy. The poorer a woman is, the less likely she is to exercise bodily autonomy and make informed reproductive choices. Moreover, social and cultural policies that limit women's access to opportunities, resources, and decision making power such as discriminatory employment practices, require critical examination and dismantling. Economic empowerment for women

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

begins with the enforcement of their right to education; thus, ensuring equal access to education constitutes a foundational step toward meaningful empowerment.

I mentioned the poor representation of women in policy-making, leadership roles, and political positions as a barrier to the improved reproductive health of girls and women in Nigeria. Women are more likely to be more passionate about legal and institutional reforms that will affect reproductive health policies positively. It is therefore imperative for Nigeria to enforce gender quotas, whereby a fair percentage of elective positions are reserved for female candidates. In a country where there is strong gender bias, there will be a need to use quotas backed by law to push up female representation in politics. This will start from the level of political parties. Furthermore, the government will need to invest in political training for women to make up for the several years of exclusion.

By combining these approaches, misogynistic frameworks can be deconstructed. Thus, creating an environment that is safer for women, where they can exercise their bodily autonomy and consequently improve the reproductive well-being of girls and women in Nigeria.

Conclusion

This essay contends that while inadequate health infrastructure and limited access to skilled healthcare professionals are significant contributors to the poor reproductive health outcomes of girls and women in Nigeria, misogyny plays an equally critical, yet often underexplored, role. It demonstrates that misogynistic practices, including the denial of bodily autonomy, the feminization of poverty, systemic gender disparities in education and political representation, and rigid religious, social, and cultural norms deeply undermine reproductive health. The essay

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

argues that gender inequality lacks both scientific and logical justification and emphasizes the necessity of dismantling institutional and normative structures that sustain it.

The key contribution of this study lies in its integration of metaphysical, sociocultural, and policy based analyses to reframe reproductive health not merely as a biomedical issue, but as one intricately bound to gender justice. By foregrounding misogyny as a critical determinant of reproductive health, the essay offers an original lens that expands conventional public health discourse in Nigeria.

In addition to this conceptual contribution, the essay advances a range of actionable policy recommendations, the implementation of gender quotas in political and institutional leadership; the economic empowerment of marginalized gender groups through targeted microfinance and vocational programs; the enactment and enforcement of laws mandating comprehensive, culturally sensitive sex education; and targeted educational outreach, particularly in rural and underserved communities. It also calls for robust public awareness campaigns aimed at challenging misogynistic narratives, as well as legal, religious, and cultural reforms to align traditional practices with human rights standards.

Future research should explore the intersection of gender based stigma and access to reproductive health services in diverse Nigerian communities, including among non-binary and gender diverse populations. Further studies are also needed to assess the impact of policy reforms and educational interventions on reproductive health outcomes. Furthermore, interdisciplinary research combining feminist philosophy, public health, and development studies could yield deeper insights into how structural misogyny is reproduced in healthcare systems, and how it may be disrupted.

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

By centering misogyny as a structural and philosophical problem within reproductive health discourse, this study contributes to both academic scholarship and practical policy frameworks, offering a holistic path forward for improving reproductive health outcomes in Nigeria.

Temmuz/July 2025, 18(2), 1-25
ISSN 1309-1328

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