

Women's Reproductive Health: A question of human rights in the context of HIV/AIDS in Nigeria

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Introduction

The adoption of the United Nations Charter in 1948 kick-started the modern day conceptualization and application of human rights to the women's health. The Charter requires the United Nations to encourage "respect for the principle of equal right" by promoting "universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to ... sex". Further development of the Declaration into international human rights law came by two general covenants adopted by the General Assembly in 1966, namely the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights; and the development of a number of international and regional human rights conventions including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Protocol to the African Charter on Human and Peoples' Rights on Women's Rights in Africa(1981) brought to the fore the centrality of the rights of women to the development agenda.

CEDAW especially obliges States Parties in general "to pursue by all appropriate means and without delay a policy of eliminating discrimination against women" and, in particular, "to eliminate discrimination against women in the field of health care in order to ensure ... access to health care services, including those related to family planning." According to Sadik (2000), disadvantages women suffer in health are injustices in the light of preceding human rights law. For instance,

...maternal mortality can be explained as being due to (i) the immediate cause of lack of maternity care, (ii) the underlying causes of exhaustion and anemia associated with short intervals between births, and (iii) structural causes such as poverty. In the case of (i), the right to health care would require obstetric services to be available. In the case of (ii), the right to education, among other rights, would enable people to become literate and thereby learn of the health benefits of child spacing and having fewer children. Also, in the case of (iii), states may be legally responsible if they allocate national wealth disproportionately to expenditures that deny populations their basic needs.

These are clear infringements on human rights as understood within the terms of widely accepted international human rights treaties, especially, in the context of HIV/AIDS, women's powerlessness to protect themselves against HIV/AIDS due to lack of access to information, services, treatment and inability to negotiate safe sex, which are special cases of their inability to implement effectively their rights to health and overall well-being.

Research Methods

The objectives of the study include filling the gap on research on Sexual Rights, exploring the barriers that women face while making choices given the prevalence of transactional sex, sexual coercion and exploitation and finally discussing the implication of the violation of the right to their health and wellbeing. Descriptive and inferential methods were used in achieving the objectives of the study. These involve the use of secondary data such as relevant books, journals, magazines, Internet and the United Nations publications.

Patriarchy vs. Women's Reproductive Right and Health: Nigerian Context

Reproductive health includes everything that affects reproduction. In Nigeria, as in other parts of the African sub-region, these include safe motherhood, avoiding and treating sexually transmitted diseases (including HIV/AIDS), preventing unwanted pregnancy, and promoting responsible sexual behaviour. Sadik (2000) is of the view that it extends to the need for universal education, to gender issues such as male support for women's reproductive health, and to protection for girl children so that they grow up safe, healthy, and equal. Male support is an enabler for achieving reproductive health of women. Patriarchy determines the level of male support available to build on for achieving reproductive health. In most traditional societies, the level of a woman's empowerment does not necessarily correlate with the capacity to actualize and fully implement her individual agency decision making authority. What determines access to reproductive health and ability to implement the right of choice for individual women goes beyond information and empowerment to include the manner and degree of male control in the prevailing decision making environment at the household, community and national levels.

It is therefore essential to note that women health decision making is strongly influenced by underlying social stratification and socio-economic determinants within the framework of patriarchy. Invariably, inequitable distributions of health outcomes are the likely outputs of such situations. Also more importantly is the place of culture and unequal power relations at the household level in mediating access and control over resources and factors that are related to women's health and well being. Patriarchal ideologies and existing power structures shape processes, policies, behaviors and attitude and impedes on the rights of women to make independent reproductive health choices. Nigeria, as most countries in the Sub-Saharan Africa (with the exception of matrilineal societies), operates a patriarchal system that upholds the male sex as the superior decision maker in household relations. Power, control and authority and exercise of such are centralized around the men. They are seen as household heads, protectors, providers and primary bread winners. These gender ideologies of power and control transcend into every sphere of human relations between women and men including sexual relations. The fulcrum of the power struggles revolves around control of women's bodies (and by extension their sexuality) which personify the

site of societal reproduction. Brown and Hessini (2004) further note that society has found ways to exert control over women's bodies through laws, customs, traditions and value systems in such a way that the level of a woman's education and her ability to earn an income (which were hitherto considered as indicators of women's empowerment) might not affect the status of women vis-à-vis their right to autonomous reproductive decision making in highly restrictive societies.

In the post International Conference on Population and Development (ICPD) period, the Nigerian government developed a plethora of strategic frameworks. These policy documents become more relevant with the event of the HIV/AIDS Pandemic. These include among others national policy of health, strategic framework on Reproductive, HIV/AIDS Emergency Action Plan (HEAP) etc. However, lack of information on the applicability of these policies, overriding influence of traditional norms and practices, high fertility, inaccessibility and costly maternal services, lack of political will, capacity of institutional machineries, ineffective and inefficient systems, and poor infrastructure, militate against the achievement of women's reproductive health. Although the National Demographic Health Survey (NDHS, 1992) reports that total fertility declined from 7.1 children in 1980 to an estimated 6.0 in 1990, the difference is only marginal and not significant enough to affect development projections effectively. Also, Nigeria boasts of a national infant mortality rate of 87:100, and a maternal mortality rate of 1,000 per 100,000 live births (one of the highest in the world). Studies have shown that an estimated 30-40 per cent of these deaths are caused by complication from unsafe abortions (Population Council 1993). According to Osakue and Martin-Hilber (1998), contraception use is still low even in the event of HIV/AIDS. Only 14 per cent of married women and 13 percent of all women aged fifteen to twenty four had used any form of birth control in 1990. 43 per cent of these were using traditional rather than modern contraceptives and only 6 per cent of married women were currently using modern contraceptives.

Violence against Women

Increase in violence against women (VAW) is an indication of resistance to and breakdown of patriarchy and control of women (Africa Leadership Forum, 1999). In certain countries in Africa, incidence of VAW correlates with increase in HIV/AIDS and other sexually transmitted diseases (STD) and the standard of reproductive health for women. Although, there is no such study on Nigeria that has established these linkages, there is an emerging consensus that VAW increase vulnerability of women to HIV/AIDS infection and results invariably in undesired reproductive health outcomes. Recent estimates from the 2003 National HIV/Syphilis Sero-prevalence Sentinel Survey by the Federal Ministry of Health (2004) shows that there are 3,300,000 adults living with HIV/Aids in Nigeria. out of which 1,900,000 (57%) are women. In addition, UNAIDS/WHO Epidemiological fact sheet (2004) report that the median HIV prevalence among women attending antenatal care clinics in Nigeria show a progressive increase in all the zones from a minimum 2.9 percent in the South West to a maximum 7.9

percent in South-South. It is important to point out that the specificity (pregnant women) of the sample population for the study and the nature of the data itself forecloses any conclusive link or direct correlation between VAW and HIV/AIDS infection among women. Suffice is to say that VAW which prevent women's full enjoyment of their human rights. Patriarchy ideology by its very nature and practices encourages the dominance of the weaker by the stronger. It applies compulsion and coercive force that erodes the right of the individual to freedom of expression in whatever form desired. VAW is a mechanism and a means of keep women under the patriarchal dominance; and in perpetual submission and utter reverence of male power.

A good example is Female Genital Cutting (FGC) which is a major form of violence against women (VAW). The right to bodily integrity is an individual fundamental right. Such rights are violated when persons other than the individual decides on its implementation. Despite the health disadvantages of FGC to women on one hand; and the fact that it runs contrary to the Convention of the Rights of the Child (CRC), CEDAW and the Protocol to the African Charter on Human and People's Rights on Women's Rights in Africa; the incidence of FGC is still high in Nigeria. The continued perpetuation of FGC is ensured by patriarchal ideology of preserving male privileges and guaranteeing their control over women's sexuality. FGC is primarily undertaken to secure male privileges for virgin wives aimed at reducing promiscuity among women and girls.

Conclusions and Implications

The major outcome of the Vienna 1993 World Conference on Human Rights was a consensus that Women's rights are Human rights. Prior to this development the Universal Declaration of Human Rights adopted by the United Nations in 1948 incorporates ideas that certain individual rights are natural or inalienable. The second concept of human rights is one of social entitlement and the responsibility of the state to assure opportunity and results for attaining such rights. According to Dixon-Muller (1993), these rights include right to health, education, good standard of living, protection against unemployment, etc. It then presupposes that since these rights are inalienable and a responsibility of the state to assure these; then no person or institution can deny another person or group the exercise of these rights. These rights also include sexual and reproductive rights.

Beijing Platform for Action (1995) and the International Conference on Population and Development (1994) distinctly situate reproductive rights within the ambit of women's human rights. They define reproductive rights as the freedom to decide how many children to have; when to have them, the rights of couples to family planning information and services; the right to control one's own body which includes freedom from sexual assault, physical violence, unwanted or exploitative sexual relations and unwanted medical interventions or bodily mutilations. Women's rights to equal access to necessary health care (including reproductive health care) is recognized in Article 12 of CEDAW where states are urged to

“take all appropriate measures to eliminate discrimination against women in the fields of health care in order to ensure access to health care services including those related to family planning” (CEDAW, 1979). The health and reproductive rights of women and their right to food security are contingent factors to their fundamental right to life.

Ratification and Domestication of the Protocol on Women’s Rights in Africa and CEDAW is the first steps to guaranteeing the rights of women at state and national levels in Nigeria. The provisions of Article 14 (Health and Reproductive Rights), and Article 15 (Right to Food Security) of the Protocol on Women’s Rights in Africa provide some bench marks that Nigeria can aspire to attain once the Protocol is domesticated in Nigeria. Nigerian was among the first to sign to these documents but further action especially on the CEDAW to enable legislation has been delayed to the great disadvantage of attaining the health of women.

Institutional machineries with key responsibility of assuring implementation in Nigeria of women’s right to health are lacking in capacity. Also, lack of awareness of policy instruments and applicability are obstacles to issue of women’s reproductive health. It is necessary that learning is facilitated for actors in the health field which include both formal health providers (health professionals) and women who are fundamental to household production of health. This is especially the case for women who provide primary health care for sick family members with HIV/AIDS. With the cut in social spending necessitated by economic reforms, women have taken on a larger burden of care for sick family members. These women need to be empowered with information on how to protect themselves. Government must recognize and begin to take seriously its responsibility of providing social support and welfare programmes to enable cushion the burden of care.

In the case of health professionals, the level of ignorance of differential effect of how their work practices affect clientele, especially in matters of reproductive and reproductive choice is high. Cook et al (2003), in discussing issues of reproductive health note that legal management of matters affecting reproduction whether by legislators, legal administrators or practitioners or judges is undertaken with little perception of their medical or societal implications for reproductive health.” They further argue that health care providers and administrators and legislators tend to work within familiar local frameworks of law and health policy without specific regard to the significance of human rights principles applicable to reproductive health to which their states have committed themselves. This adequately describes the Nigerian situation with regard to the implementation of policies and programmes for women’s reproductive health in Nigeria.

There is an urgent need to localize, adapt and bring home the messages of human rights to the very masses for which it is intended. Violation of rights is

perpetuated when the victims does not realize that they have such rights. Women and men must be empowered with this information so that they can recognize this violations/discrimination and become change agents at various individual communal levels. Individual women organizations and community based organizations should be encouraged to spread the message of women's international reproductive health policies and national strategic frameworks in order to make it real to women and men at the local levels. This civil society engagement could be effectively implemented though mass community education facilitated by development and dissemination of simplified international and national human rights instruments/policies in local languages. Sensitization and training using these simplified documents would be done through indigenous traditional mechanisms for organizing and enforcing local authority and values. Traditional mechanisms such as age grades, rural women and men's associations, kinship/clan meetings, council of elders/chiefs etc could serve as sites for sensitization and training deliveries. Message dissemination can take advantage of both conventional and alternative media in addition to traditional mediums such as the Town crier and the gong system in Southern and Eastern Nigeria. Adoption and implementation of these strategies would contribute to building collective responsibility for women's rights within local communities in Nigeria

References

- Africa Leadership Forum. (1999) Final Draft of "Towards Improved Leadership for Women's Empowerment in Africa: Measuring Progress and Improving Strategy" Accra, Ghana.
- Africa Recovery Briefing Paper (1998), P. 11.
- Akukwe, C. (1999) "HIV/AIDS in African Children: A Major Calamity that Deserve Urgent Global Action. HIV/AIDS Pre-Education For Adolescents & Children" African Journal of Reproductive Health, 3(3), 5-24.
- Beijing Platform for Action, 1995.
- Brown, Tamara and Leslie Hessini. (2004) "The Power Dynamics Perpetuating Unsafe Abortion in Africa: A Feminist Perspective." African Journal of Reproductive Health, 8(1), 43-51.
- Convention on the Elimination of All Forms of Discrimination Against Women, 1979.
- Cook Rebecca, Bernard M. Dickens, and Mahmoud F. Fathalla. (2003) Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law, London, Oxford University Press.

- Denton, M. and V. Walters (1999) "Gender Differences in Structural and Behavioral Determinants of Health: An Analysis of the Social Production of health, Social Science and Medicine." *Journal of Social Science* 48(9), 122-1235.
- Dixon-Muller, Ruth (1993) *Human Rights, Women's Rights and Reproductive Freedom in Population, Policy and Women's Rights: Transforming Reproductive Choice*, USA, Praeger Publishers.
- Elabor-Idemudia, P. (1994) *Nigeria; Agricultural Exports and Compensatory Schemes: Rural Women's Production Resources and Quality of Life in P. Sparr (ed.) Mortgaging Women's Lives*, London. Zed Books.
- Federal Ministry of Health, Nigeria. (2004); 2003 National HIV/Syphilis Sero-prevalence Sentinel Survey International Conference on Population and Development, 1994.
- Norwegian Council in Africa. *Africa at Large: "Women's Rights will also mean health and food security"* in *Africa News Update* accessed on <http://www.afrika.no.detailed/6988.html>.
- Osakue, Grace and Adriane Martin-Hillber. (1998) "Women's Sexuality and Fertility in Nigeria: Breaking the Culture of Silence" in Rosalind P. Petchesky and Karen Judd (ed.) *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures*, London, Zed Books.
- Population Council (1993) "Prevention of Morbidity and Mortality from Unsafe Abortion in Nigeria", Report of a meeting held in 1991 by the Robert H. Ebert Program on Critical Issues in Reproductive Health and Population, Population Council, New York.
- Qualls, Alyssa. "Women in Nigeria Today" in *Africa Post Colonial Literature in English in the Post Colonial Web* accessed on <http://www.scholars.nus.edu>.
- Renee E. (1995) "Houses, Fertility and the Nigerian Land Use Act", *Population and Development Review*, 12(1).
- Rojas Maria. (1994), "Women in Colonial Nigeria in African Post Colonial Literature in English" in the *Post Colonial Web* accessed on <http://www.postcolonialweb.org/nigeria/precolwon.html>.
- Sadik, Nafis. (2000) "Reproductive Health and Gender Equality in the 21 Century: A New Reality", *International Lecture Series on Population Issues*.

UN Committee on the Elimination of Discrimination Against Women. Concluding Observations on Guatemala (New York, UN, 1994) Para 71, UN DocA/49/38.

UN. Universal Declaration for Human Rights (1948).

UNAIDS. Epidemiological Fact Sheet Nigeria, Update 2004.

UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva, UNAIDS 2000.

UNIFEM. The Quest for Gender Constitution in Nigeria, (2002), Lagos, Nigeria.