[EN] GENDERING SEXUALITY: HUMAN RIGHTS ISSUES IN REPRODUCTIVE AND SEXUAL HEALTH

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ABSTRACT

The central challenges posed by recent international agreements such as the 1994 International Conference on Population and Development (ICPD) held in Cairo[1] and the 1995 Fourth World Conference on Women in Beijing[2] are the application of human rights principles to matters of reproduction and sexuality. This is particularly true in many African settings regardless of the entrenchment of human rights clauses in national laws and government policies that create enabling conditions for promoting reproductive and sexual rights. In addition to supporting a policy and legal

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[1] United Nations, *Report of the International Conference on Population and Development* Cairo, Egypt, 5-13 September 1994. United Nations Doc. N.Y. A/Conf. 171/13 Rev.1, U.N. Sales No. 95. XIII.I8 [hereinafter Cairo Programme]1994.
[2] United Nations, *Report of the Fourth World Conference on Women [*Beijing Declaration and Platform for Action], *United Nations Doc., New York, N.Y, A/Conf. 177/20, 1995.*

environment that is broadly directed to achieving gender specific human rights, international instruments like the Cairo and Beijing Programme and Platform for Action specifically obliged States to promote women's health, strengthen existing laws and activate legal reform in the areas of reproduction and sexuality. The Program of Action of the 1994 International Conference on Population and Development (ICPD) for example, calls on governments and international agencies to expand and transform existing programs and to offer reproductive and sexual health services that are "comprehensive, integrated, universally accessible and delivered in a manner consistent with health and rights objectives"[3]. The objective of these international meetings was clearly a promotion of the rights to human sexuality and responsible parenthood.

Clearly, the implications of a reproductive rights paradigm in the multicultural societies of Africa with statutory/common laws, customary and religious legal systems, are enormous, and reflect challenges that may require years to overcome. This is why despite the proliferation of the term 'reproductive and sexual rights' in international mandates and national policies in the past decade, the transformative nature of the rights framework for reproductive health and sexuality in many parts of Africa remain legally unexplored.

This session will explore human rights issues in reproductive and sexual health as seen from a gendered lens. The first part of the paper traces reproductive and sexual health rights as human rights from a jurisprudential perspective to the post Cairo era. It also looks at human rights issues in sexuality with references to sexual "others" and "outsiders", and the relevance of sexual rights in the African region. The second part perfunctorily reviews, as an African case study, the situation in Nigeria. It focuses on the indicators of capacity and willingness within the state, and the prospects and opportunities for human rights obligations envisaged in reproductive and sexual health. The paper concludes with a

[3] Supra n. 1 at para 7.2

proposal for legal academism and reform in the changing paradigms of sexual evolution, transformation and rights in Africa.

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INTRODUCTION

Until quite recently most Africans, especially in the sub Saharan region, considered reproductive and sexual rights as issues for discussion only by 'queers' and liberal feminist groups! Considering the typical traditional values and societal norms generally associated with sexuality, and in view of the fact that many Africans viewed reproduction and sexual practices as very private issues, it was more or less seen as a "taboo" to advocate for sexual rights, safe abortion and reproductive choice. Cultural practices like female genital mutilation were generally accepted in many societies, and were not considered harmful or illegal. Many of the health aspects of reproduction such as safe motherhood and family planning services, were dealt with principally through the public health sectors of government hospitals and management boards, and were not regarded as 'rights' per se[4]. Very few groups such as NGOs, IGOs, and private concerns, were involved in advocacy and awareness programmes associated with reproductive and sexual rights.

The past decade however has witnessed important socio-cultural and demographic changes in individual and general attitudes throughout the continent[5]. Factors such as rapid urbanization,

[4] Many of these government agencies addresses health issues generally through health management boards and ministries.
[5] In Nigeria, partly as a result of active advocacy against risky sexual behaviors by Non governmental organizations working on gender issues, and enactments of laws by states prohibiting female genital mutilation and protecting maternal health, the Federal Ministry of Health reported a reduction in HIV/AIDS prevalence from 5.8% to 5% in 2003. The 1999 Nigerian Constitution in Sections 17, 39 and Chapters II and IV also establishes legal and general obligations to protect human rights that can be applied to reproductive health rights and self determination.

education, international law and advanced technology have contributed to "watering down" common beliefs hitherto held in regard to human rights associated with sexuality, and reproductive rights in particular. Modern methods of family planning and fertility control are currently widely used in many urban areas and there's an increased awareness of reproductive rights as human rights that are basically gender specific[6]. There is also a growing awareness of contraceptive services, counseling and sex education. In Nigeria for instance, many now see the provisions of the Criminal Code, which criminalizes abortion except when done to save the life of the woman, as harsh and restrictive[7]. There is also more urgency in addressing the sexual needs of women beyond child bearing functions, with the result that there is increased advocacy for rights to safe abortion and protection against sexually transmitted diseases by many non governmental organizations. The HIV/AIDS pandemic in sub Saharan Africa has further added to growing concerns related to sexual orientations, health and gender stereotyping[8]. In Nigeria, female genital mutilation, a common traditional practice prevalent in the entire country, has been recognized as harmful to women's health, poising a risk for HIV infections, and is presently illegal in many states[9].

Of course, the endless debates over the relevance of sexual and reproductive rights in sub Saharan Africa have continued, despite the indicators of many States towards awareness and protection. In this regard, some national and state governments have taken significant steps towards policies and

[6] CEDAW was ratified on the 13th of July 1985 and since then there's been an increased societal awareness of gender specific human rights issues addressing violence against women and reproductive health. A number of Non governmental Organizations are also advocating for women's rights in Nigeria. A survey carried out by the Women's Health and Action Research Center (WHARC) in Benin City in 2003 showed a 67 % prevalence use of modern methods of family planning by young women between the ages of 20 and 44 years.

[7] Criminal Code, Laws of the Federation of Nigeria, CAP 77 Section 230 (1) 1990. See also Penal Code, CAP 84, LFN 1990, which makes abortion illegal except when done to save the life of the pregnant woman.

[8] In Sub Saharan Africa, there's empirical evidence to show that prevalent infection rates for women is almost two times higher than that for men. See Department of Health National Antenatal Survey in *The Impending Catastrophe: A resource book on the emerging HIV/AIDS epidemic in South Africa.* (Abt Associates/Love Life) 2000. See further Aniekwu N.I. Feminization of HIV/AIDS in sub Saharan Africa, forthcoming publication in QUEST: An International journal on African feminisms, 2006.

[9] For instance Edo State passed the Female Circumcision and Genital Mutilation (Prohibition) Law in 1999. Other states like Benue, Cross River, Delta, Ogun and Bayelsa have followed with similar legislations.

programs aimed at protecting the reproductive health of women in particular[10]. These actions remain significant in so far as they recognize the existence of international obligations as well as socio-cultural, religious, economic and political factors that affect the progress and development of sexual and gender specific human rights.

Following the endorsement and ratification of international instruments and covenants, many African countries are moving towards new and broader concepts of health and rights[11]. Forums such as the 7th women's health meeting in Uganda 1993[12], the International Conference on Population and development (ICPD) Cairo 1994[13], the Social Summit[14], the 4th World Women's Conference in Beijing 1995[15] and subsequent reviews have popularized and contributed to national discourses on reproductive and sexual rights. Only last month, the 2nd African conference on Sexual rights was held in Nairobi. The meeting was an active discourse on emerging issues in gender, sexuality and human rights in the African continent, with implications for sexual 'others' and 'outsiders' in the areas of protection and non – discrimination. These international instruments embrace existing human rights principles contained in earlier declarations such as the Convention on the Elimination of All forms of Discrimination Against Women (1979)[16], the African Charter on Human and People's Right (Banjul,

[10] For example, the Nigerian Sexual and Reproductive Health Policy and Strategy (2002), the National Policy on Women (2000), the National Policy on HIV/AIDS, the National Reproductive Health Policy and the National Policy on VVF are some national policies with significant relevance for reproductive health. See list of programs on reproductive health in Nigeria applicable to Edo state in Women's Health and Action Research Center (WHARC), Strategic Plan 2005 – 2009.
[11] Nigeria, for instance, has signed and ratified a number of international human rights instruments including the ICESCR, ICCPR, CEDAW, ICPD and the African Charter on Human and Peoples Rights.
[12] Seventh Women's Health Forum, Kampala, Uganda. UN/Doc/1. 2249/Uganda/93; 1993.
[13] Supra n. 1
[14] The World Summit on Social Development, Copenhagen, 1995.
[15] Supra n. 2
[16] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) opened for signature Dec.18, 1979, art. 12(1), 1249 U.N.T.S .13, 19 I.L.M. 33 (entry into force Sept 3, 1981) [hereinafter Women's Convention.].

1981)[17], the Nairobi Forward- Looking Strategies for the Advancement of Women (Kenya, 1985)[18] and the Vienna World Conference on Human Rights in 1993[19].

The Beijing Declaration and Platform for Action basically adopted the provisions of the Cairo Program of Action on reproductive and sexual rights and called on Governments to promote education on the human and legal rights of women in particular. This position was further endorsed by the ICPD + 5, ICPD + 10 and Beijing + 10 documents[20]. The latter documents address reproductive and sexual rights as human rights that imply responsibilities and obligations for States. The crucial question remains the *willingness* and *capacity* to follow through to implementation by using the maximum of available legal resources.

REPRODUCTIVE HEALTH

a. Concept

The concept of reproductive health has recently emerged in response to the fragmentation of the existing services related to reproductive orientations. With the positive definition of health as a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity, reproductive health therefore implies that people are able to have a satisfying and safe sex life and that

[17] African Charter on Human and Peoples's Rights, adopted June, 1981, art. 5(1), OAU Doc. CAB/LEG/67/3/Rev.5, 21 I.L.M. 58 (1982) (entry into force OCT. 21, 1986) [hereinafter Banjul Charter].

[18] The Nairobi Forward- Looking Strategies for the Advancement of Women adopted by the Third World Conference on Women to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, held in Nairobi, Kenya, July, 1985. See also the Declaration on the Elimination of Violence Against Women G.A. Res. 48/104, U.N. GAOR, 48th Sess, 85th plen. mtg., Agenda Item 111, U.N. Doc. A/RES/48/104 (1993) [hereinafter Declaration Against Violence].

[19] Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, Austria, 14 – 25 June 1993, Sect II, para. 41, U.N. Doc.A/CONF.157/23 (1993)

[20] See Key Actions for the further implementation of the Programme of Action of the International Conference on Population and Development, report of the Ad Hoc Committee of the twenty-first special session of the United Nations General Assembly, New York, July 1, 1999, U.N. Doc./A/S-21/5/Add.1 [hereinafter ICPD+5 Key Actions Document]. See also twenty third special session of the United Nations General Assembly on Women 2000: gender equality, development and peace for the 21st century (New York, 2000).

they have the capability to reproduce and the freedom to decide if, when, and how often to do so[21]. Because of reasons of impact, urgency and inequity, reproductive health has become a global concern.

A major burden of disease in females is related to their reproductive functions and potential, and the way in which society treats or mistreats women because of their gender. Issues affecting women's reproductive health include female genital cutting (or mutilation), sexual abuse, and domestic violence. Determination of health in general and reproductive health in particular, includes other factors beyond health care services. Lifestyles, behaviors and socio-economic conditions often play an important role in promoting or undermining reproductive health.

A global overview of reproductive health shows the magnitude of the problem and the health needs. Only 46 per cent of all deliveries worldwide take place in health facilities, 57 percent of deliveries are attended by skilled personnel, and about 68 percent of pregnant women receive prenatal care[22]. Every year about 515,000 women die worldwide from causes related to pregnancy and children birth[23]. Maternity is ranked as the primary health problem in adult women (ages 15 – 44) in developing countries, accounting for 18 percent of the total diseases burden. Maternal mortality shows greater disparity among countries than any other public health indicator[24]. For a woman in Africa, the overall lifetime risk of a maternal death is 1 in 16; while for her sister in more developed countries it is 1 in 2,500[25]. Of nearly 8 million infant deaths each year worldwide, around two-thirds occur before the end of the first month. About 3.4 million of these neonatal deaths occur during the first week of life[26].

The number of births a woman is expected to have in her lifetime has decreased and, as a consequence, there has been a decrease in her exposure to the risk of pregnancy and childbirth. As a world average,

[21] See Rebecca Cook, Bernard M. Dickens and Mahmoud F. Fathalla, Reproductive Health and Human Rights: Integrating Medicine, ethics and law. Oxford Press, 2002 at 12
[22] Sexual and Reproductive Health Research Priorities for the World Health Organization for the Period 1998 -2003. WHO, PCC (10)/1997/9, 30 May 1997 at 4-5
[23] Ibid.
[24] Ibid at 7.
[25] Ibid at 9.
[26] Ibid

women are now expected to have less than three births in their lifetime. In 1965, only about 9 percent of all married women of reproductive age in developing countries, or their partners, were using a reliable method of contraception[27]. In 1998, the United Nations estimated contraceptive use to be 55 per cent in less developed regions[28]. There are still large segments in Africa's population where needs of fertility regulations are not met by currently available contraceptive methods and services. It is estimated that at least 100 – 200 million couples are not using any method of contraception even though they want to space their pregnancies or limit their fertility[29]. Thousands of women around the world risk their lives and health to end an unwanted pregnancy. Every day, 55,000 unsafe abortions take place – 95 per cent of them in developing countries – and lead to the death of many women[30].

The World Health Organization estimates that more than 380 million new cases of sexually transmitted infections (including HIV) occur each year[31]. The human immunodeficiency virus continues to spread around the world, insinuating itself into communities previously little troubled by the epidemic and areas where AIDS is already the leading cause of death in adults. It is estimated that, in 2001, 5 million people were newly infected, 40 million were living with the infection, and 3 million (including women and children) died[32]. Estimates of the worldwide prevalence of female genital cutting rang from 85 to 114 million, with an annual rate of increase of about 2 million per year[33].Although progress has been made, these are still major concerns and shortcomings in sexual and reproductive health for women. An area of major concern is the continued violation of women's human rights and the accountability of states to international obligations.

[27] World Health Organization, Department of Reproductive Health and Research, The WHO Reproductive Library (Geneva: WHO, 2001, CD – Rom format).
[28] In United Nations, Women and Health: Mainstreaming the Gender Perspective into the Health Sector. Report of the Expert Group Meeting 28 September 2 October 1998, Tunisia.
[29] Ibid
[30] Supra n. 27
[31] Ibid
[32] Ibid
[33] Ibid

b. Definition

The concept of 'reproductive health' offers a comprehensive and integrated approach to health needs related to reproduction. It puts women at the centre of the process, and recognizes, respects, and responds to gender specific needs. The concept of reproductive health received great attention in the United Nations International Conference on Population and Development[34]. Fathalla F. while working with the World Health Organization (WHO) in 1987 provided a definition for the term 'reproductive health' that was published in 1988[35]. The definition was as follows:

> *Health is defined in the WHO Constitution as a 'state of complete physical, mental and social well being, and not merely the absence of disease or infirmity.' Reproductive health, in the context of this positive definition, would have a number of basic elements. It would mean that people have the ability to reproduce, to regulate their fertility; and that women are able to go safely through pregnancy and childbirth; and that reproduction is carried to a successful outcome through infant and child survival and well being. To this may be added that people are able to enjoy and are safe in having sex.*[36]

This definition was adopted and expanded in the Programme of Action developed at the International Conference on Population and Development (ICPD) in 1994, and at the United Nations International Conference on Women in 1995[37]. The full definition reads:

> *Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that*

[34] ICPD Supra n. 1 at para. 7.2
[35] M.F. Fathalla, 'Promotion of Research in Human Reproductive: Global Needs and Perspectives', *Human Reproduction,* 3 (1988), 7 – 10.

[36]Ibid at 9
[37] See Cairo Programme Supra n. 1 at para. 7.2.

> *people are able to have a satisfying and safe sex lie and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*[38]

In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well being. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases[39].

The *impact* of reproductive health is not limited to the individual, family, and society at large. It extends across national boundaries to the world as a whole. Two areas in reproductive health have, in particular, a major impact: the ability to regulate and control fertility, achievement of sexual pleasure and safety from sexually transmitted diseases (including HIV/AIDS). Inability of individuals, and particularly of women, in developing countries to achieve these goals not only affects the health of the people immediately concerned, but also has implications for global stability and for the balance between population and natural resources and between people and environment. It is also a violation of human rights.

[38] UN Department of Public Information, *Platform for Action and Beijing Declaration* 1995 at para. 94. Also in para. 7.2 ICPD Programme of Action, 1994.
[39] Cairo Programme at para. 7.2. The ICPD was endorsed by the U.N. General Assembly in its Resolution 49/128.

The *urgency* of reproductive health concerns in Africa indicates a problem which will likely get worse if reproductive and sexual rights issues are not addressed. Again, this sense of urgency is clear in the presence of discrimination and lack of human rights protection in matters of reproduction and sex, with implications for sexual intimacy, eroticism, fertility regulation and STDs including HIV/AIDS. Actions or inactions to implement sexual rights, including gender specific rights to health, in these times is a decisive factor in the world future. *Inequity* in gender stereotyping is another compelling reason for international concern about social injustices and violation of sexual rights with special implications for women. There is hardly any area of a country's economic, cultural and social lives in which inequity is as striking as in women's reproductive health concerns.

c. Sexual Health

Sex is a critical aspect of reproductive life and encompasses gender identities and roles, sexual orientation, health, eroticism and intimacy. As earlier mentioned, many of the aspects of reproductive health are duplicated in a definition of sexual health. Like reproductive health, sexual health is a state of physical, emotional, mental and social well – being related to sexuality and not merely the absence of disease, dysfunction or infirmity[40]. It aims at the enjoyment of life and personal relations, and is affected by the broader context of people's lives, including their economic circumstances, education, social and gender relationships and the traditional and legal structures within which they live. Sexual health services do not consist merely of counseling, treatment and care related to reproduction and sexually transmitted diseases[41]. It denotes, and is premised on, a positive and respectful approach to sexual orientations and relationships, free of coercion, discrimination and violence.

According to the Pan American Health Organization,

[40] Sexual and Reproductive Health Research Priorities for WHO for the Period 1998 -2003. World Health Organization. PCC (10)/1997/9, 30 May 1997 at 4-5.
[41] Supra n. 2 at para.94. See also Para 7.2 ICPD Cairo.

> *Sexual health is the experience of the ongoing process of physical, psychological, and socio-cultural well being related to sexuality. Sexual health is evidenced in the free and responsible expressions of sexual capabilities that foster harmonious personal and social wellness, enriching individual and social life. For sexual health to be maintained, it is necessary that the sexual rights of all people be recognized and upheld.*[42]

Accordingly, denying or obstructing means of achieving sexual health, that is, 'well being related to sexuality', may constitute treatment that is inhuman in negating individuals' sexual preferences, orientation, character and dignity. In recent times, sexual health has been seen as part of and within the context of general fundamental human rights, and sexual rights has become 'protected' by provisions of international human rights instruments on life and health[43].The relationships between law, gender, health and sexuality has produced a vast literature much of which has sought to engage in a conceptual and practice – based critique of law from a range of feminist and human rights perspectives. Yet notwithstanding the now well-established nature of this frame of analysis, and of critical discussion in the human rights constructions of such categories as 'reproduction' and 'rights', sexual rights continue to generate controversies in many cultural settings, especially in Africa.

REPRODUCTIVE RIGHTS

a. Concept

The notion of *reproductive rights* was probably introduced on a global scale at the 1994 International Conference on Population and Development (ICPD) in Cairo. The entire Chapter VII of the ICPD's Programme of Action addresses "Reproductive Rights and Reproductive Health" and a large portion of

[42] Pan American Health Organisation WHO, *Promotion of Sexual Health: Recommendations for Action – Proceedings of a Regional Consultation Convened by PAHO/WHO in Collaboration with the World Association for Sexology, Antigua Guatemala, Guatemala, May 19 – 22, 2000* (Washington, DC: PAHO, 2001), available in English at http://paho.org/English/HCP/HCA/PromotionSexualHealth.pdf, and in Spanish at http://ww.paho.org/Spanish/HCP/HCA/salud_sexual.pdf,last accessed 14 Apr. 2002.

[43] The 1993 Vienna Declaration on Human Rights was forced to confront demands for the recognition of non – hetero desire.

conference time was spent in discussions regarding reproductive issues and related rights[44]. One year later in Beijing, the Fourth World Conference on Women adopted the Platform for Action, a document of some 150 pages outlining proposals for actions to ensure women's equality[45]. The Platform largely echoed the statements made in Cairo with regard to reproductive and sexual health[46]. This was particularly evident in the Beijing document in paragraphs 95 (dealing with the definition of reproductive rights in the context of the universality of the human rights of women).[47]

Before entering into a definition of the reproductive rights advanced in Beijing, it is important to clarify the status of this document and the Conference from which it issued. Indeed, a great deal of the controversy surrounding reproductive and sexual rights stems from some confusion as to the role of the Conference on Women, and the legal implications of the final text adopted. The Beijing Conference, as all similar conferences, does not technically "develop international law" as claimed by some.[48] However, most rights referred to in the Platform are, in fact, grounded in binding human rights instruments that affirm the dignity, equality and health of all persons regardless of sex.[49] In this relation, the Cairo Programme and Beijing Platform are pro – active and international guidelines on how best to prevent and eliminate violations of these rights. It may also be convincingly argued that the Platform for Action reflects an international consensus with a motivating impact on legal and policy development.

In light of the many diverse actors who sought accreditation to the Beijing conference, it would appear that many of the participants viewed the documents adopted at the conferences as reflecting

[44] Supra n. 1 Ch. VII pps 7.4 – 8.2
[45] Supra n. 2
[46] See Paragraph 94 Beijing Platform for Action: almost identical with Para. 7.2 Cairo Programme of Action .
[47] Ibid. Beijing Platform at Paras. 95 and 223.
[48] Corinne Packer. Nordic Journal of International Law 67: p.79, 1998.
[49] See the United Nations Charter of 1945, the International Covenant on Economic, Social and Cultural Rights, opened for signature Dec. 16, 1966, Art. 12 on the *right to health*, 993 U.N.T.S. 3 (entry into force Jan.3, 1976) See also the Vienna Declaration and Programme of Action, Supra n. 19

"standards" or an emerging concept of law. From this perspective, it is only right that representatives of varying (even possibly dissenting) groups, organizations or religions were included in the discussions leading up to the adoption of a definition of reproductive rights and its subsequent affirmation as a human right. Primordial to its definition, it is first carefully and convincingly explained in the Beijing document that reproductive and sexual health are vital to one's health in general as described in Paragraph 94.[50] Based upon this definition, it is advanced in the Platform that a *right to reproductive health* can be deduced from the right to health in general.[51] However owing to low spending on public health, discriminatory policies, practices and social injustices, many are unable to obtain the reproductive health care they need. In this respect, it is reasonable to deduce that it is essential that we speak of an independent *right to reproductive health* – as a right among a number of others falling within the prescribed category of *reproductive rights* – or as simply one element of the already well established and more broadly ascribed "right to health". Ultimately this is probably a question which can only be answered by examining the specificities of health policies, domestic laws and cases depending upon the composite of international law binding upon the State in question.

Proceeding from the definition of *reproductive health* in paragraph 94 above, we find in the following paragraph of the Beijing Platform for Action, the definition of *reproductive rights,* as follows:

"*These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.…It also includes their right to make decisions concerning reproduction free from discrimination, coercion and*

[50] Supra n. 38

[51] See the 1988 World Health Organization (WHO)'s Constitutional definition of Health (visited feb.17, 2005). <http:www.who.org/about-who/en/definition.html>. See also paragraphs 89 and 95 Beijing Platform.

violence as expressed in human rights documents."[52] It may thus be concluded from the definition of reproductive rights in the Platform for Action that a number of reproductive rights are in fact rights derived from interpretations – interpretations agreed upon during the Cairo and Beijing Conferences as issuing from broadly established rights, such as the rights to dignity, privacy, health and freedom from discrimination. In light of this, it appears fair to conclude that the clearest definition of established and binding reproductive rights (i.e., rights concerning reproduction which already exist in human rights instruments and must therefore be respected and enforced by States Parties to the relevant instruments) lies in the statement of:

the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health.[53]

b. Evolution of Reproductive Rights

Control of reproduction and sexuality has a history that reaches back into antiquity. Over the centuries, governments have used criminal laws as a primary instrument to express and control morality, particularly through the prohibition of birth control and abortion or through penalizing and stigmatizing certain forms of sexual behavior. Gradually, however, with the spread of democratic governance, a realization has emerged of the harmful effects on the health and welfare of individuals caused by the punitive control of reproduction and sexuality. This has fostered an approach to laws and policies designed to promote individuals' rights in their health and welfare. A more recent approach challenges national laws by advocating increased access to reproductive and sexual health services as a matter of human rights and social justice[54].

These approaches, from criminalization, through the promotion of health and welfare, to an emphasis on human rights and justice, exist in many countries, and are not necessarily mutually exclusive. The

[52] Paragraph 95 and repeated in large part in paragraph 223 of the Beijing Platform
[53] Ibid at para. 95.
[54] Better Reproductive Health – Implementing the Global Agenda. Biennial Report, Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland 2002

tendency to use criminal law to punish and stigmatize disapproved behavior remains, but is waning because of an increased understanding that this approach is often dysfunctional. Many countries, even in Africa, have used a health and welfare rationale to legalize and, in some cases, provide or subsidize reproductive and sexual health services. An increasing number have reformed laws and policies facilitating the provision of reproductive and sexual health services because of a growing recognition of the importance of human rights in general, and reproductive and sexual health rights in particular[55].

The protection and promotion of rights relating to reproductive and sexual health have gained momentum in recent years, due in large part to the ICPD and Beijing Platform. These two conferences led to the recognition that the protection of reproductive and sexual health is a mater of social justice, and that the realization of such health can be addressed through the improved application of human rights contained in existing national constitutions and regional and international human rights treaties. The Programme of Action resulting from the Cairo Conference, and the Declaration and Platform for Action resulting from the Beijing Conference, were strengthened in subsequent reviews in 1999, 2000 and 2004[56] respectively.

The movement towards fostering compliance with reproductive and sexual health rights has been enhanced by the United Nations,[57] national and international nongovernmental organizations,[58] professional legal and medical associations,[59] and through academic initiatives. These efforts have been reinforced by research into women's perspectives on the exercise of their reproductive rights,[60] and

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[55] Information from reports of the CEDAW Committee, for Burkina Faso A/46/38 (1992) paras. 87, 95, 110 and 120 – 121; for Senegal U.N. Doc. A/49/38 (1994) PARAS. 671 – 672, 677, 685, 690 AND 701; for Uganda A/50/38 (1995) paras. 279, 297 and 307 – 308.

[56] UN General Assembly, *Report of the Ad Hoc Committee of the Whole of the Twenty-Third Special Session of the General Assembly: Further Actions and Initiatives to Implement the Beijing Declaration and the Platform for Action,* A/S-23/10/Rev.1) (New York: UN, 2000).

[57] UN Population Fund (UNFPA), *Ensuring Reproductive Rights and Implementing Sexual and Reproductive Health Programmes including Women's Empowerment, Male Involvement and Human Rights* (New York: UNFPA, 1998).

[58] Development Alternatives with Women for a New Era (DAWN), *Implementing ICPD: Moving Forward in the Eye of the Storm* (Suva, Fiji: DAWN, 1999); Health, Empowerment, Rights and Accountability (HERA), *Confounding the Critics: Cairo Five Years on* (New York: HERA, 1998); International Planned Parenthood Federation (IPPF), *Charter on Sexual and Reproductive Rights and Guidelines* (London: IPPF, 1996); Women's Environment and Development Organisation (WEDO), *Rights, Rights and Reforms: A Fifty country Survey Assessing Government Actions five Years After the International Conference on Population and Development* (New York: WEDO, 1999).

[59] See, for instance, Commonwealth Medical Association, *A Woman's Right to Health, Including Sexual and Reproductive Health* (London: Commonwealth Medical Association, 1996); R. J. Cook and B. M. Dickens, 'The FIGO Study Group on Women's Sexual and Reproductive Rights', *Int. J. Gynecol. Obstet.* 67 (1999), 55 – 61.

[60] R. P. Petchesky and K. Judd (eds.) *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures* (London and New York: Zed Books, 1998).

research into the challenges of protecting reproductive rights in different regions, especially in Africa.[61] These activities have been referred to collectively as 'the Cairo process'. The challenge ahead is to turn the political commitments made by governments in these conferences into legally enforceable duties to respect reproductive rights. There is a growing awareness in national and international circles to develop favorable practices and norms in addition to approval of international documents[62]. Thus the above commitments have been seen as a dynamic, ongoing lawmaking and implementation process through which non-binding commitments become politically, socially, and legally binding.

Empirical evidence that demonstrates the dysfunctions of many doctrinally based criminal laws has contributed to the modern movement in reproductive health away from reliance on concepts of crime and punishment, in favor of the promotion of health and rights. During the decade of the 1990s, for instance, abortion law reform was achieved in many countries.[63] Reforms have, however, been frustrated by religious and moral opposition, especially in Africa. In addition, some national constitutions have been amended to claim the protection of the right to life from the moment of conception, in attempts to restrict reproductive choices[64]. Efforts to institute sex education in schools have been challenged in many regions of the world, and barriers to the provision of reproductive and sexual health information and services persist[65].

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[61] Center for Reproductive Law and Policy (CRLP) and Estudo para la Defensa de los Derechos de la Mujer (DEMUS), *Women of the World: Laws and Policies Affecting their Reproductive Lives: Latin America and the Caribbean* (New York: CRLP, 1997): CRLP and International Federation of Women Lawyers – Kenya Chapter, *Women of the World: Laws and Policies Affecting their Reproductive Lives: Anglophone Africa* (New York: CRLP, 1997). See also references at Women's human Rights Resources website at: www.law-lib.utoronto.ca/diana.

[62] See Final report of the Special Rapporteur on traditional practices affecting the health of women and children, Mrs Halima Embarek Warzazi, U.N. Doc. E/CN.4/S UB.2/1996/6 OF 14 June 1996, para. 72.

[63] For example Guyana, Cuba and Nepal have reformed their criminal laws by legalizing abortion in many respects. See more countries that reformed their reproductive health policies since 1994 in R. J. Cook, B. M. Dickens, and L. E. Bliss, 'International Developments in Abortion Law from 1988 to 1988', *American J. of Public Health*, 89 (1999), 579 – 86. In 1997, El Salvador amended its Penal Code to remove exceptions to its prohibition of abortion, which had formerly permitted abortion to save a woman's life or when pregnancy resulted from rape; see Decreto No. 1030, Articles 133 – 7 (1998).

[64] See for instance the Constitutions of Gambia, Uganda and Swaziland on the right to life.

[65] These restrictions occur especially in Islamic territories. However, international courts have held that protection of health interests prevails over laws that seek to enforce moral imperatives. For instance, the European Court of Human Rights, established under the European Convention of Human Rights and Fundamental Freedoms (the European Convention), held that compulsory sex education "conveyed in an objective, critical and pluralistic manner" did not violate the rights of parents to ensure education of their children in conformity with their religious beliefs, in *Kjeldsen, Busk Madsen and Pedersen v. Denmark, 1 Eur. H. R. Rep. 711 (1976) [Danish sex Education case]*.

Defending and articulating a person's right to personal choice and freedom in decisions concerning the body, sexual functions and reproductive options are important aspects of what has emerged as movements to define and protect sexual and reproductive rights. Legal recognition of the importance of a person's self determination to health and well being is growing all over the world. For instance, it is increasingly unacceptable, for instance, for a husband to dominate his wife by the use or threat of violence, or to force her into unwanted sex or to continue an unwanted pregnancy[66]. Violence against commercial sex workers, who are vulnerable to abuse because their activities are often outside the protection of the law, is no longer tolerable in international circles[67]. Equally unacceptable is state enforcement of positive and negative population policies at the expense of individual human rights to reproductive choices[68].

The multiple dimensions of reproductive and sexual health have been developed through research undertaken in a variety of different disciplines, including empirical disciplines in health and social sciences, and normative research in law and bioethics. These studies have informed understanding of the causes and human consequences of reproductive and sexual ill health, and how human rights might be applied to prevent and remedy discrimination and violation. The protection of reproductive rights has evolved over time as countries have found the courage to step forward to address, and in some cases remedy, abuses of such rights[69]. Protective spheres for the advancement of vital interests relating to reproduction and sex have emerged out of these individual and collective struggles. These spheres are known collectively as reproductive and sexual rights. It is recognized that the content and meaning of rights evolve as they are applied in different countries to different concerns. Often, common patterns emerge in several states on how rights are most effectively applied, but those patterns are also subject to refinement and change depending on understandings about the meaning of reproductive and sexual

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[66] Views of the Human Rights Committee concerning the communication by Mrs Eumeeruddy – Czifra and nineteen other Mautirian women, No. R 9/35. See also Jejeebhoy, S.J. and Cook, R.J., "State Accountability for Wife-Beating: The Indian Challenge", The Lancet, 349 supplement, S110-S I12, 1997.

[67] *X and Y v. Argentina,* Annual Report of the Inter-American Commission on Human Rights 1996.

[68] See Commission on Human Rights – Preliminary report submitted by the Special Rapporteur on *Violence against Women; Its Causes and Consequences*. Ms. Radhika Coomaraswamy, U.N. Doc. E/CN.4/1995/42 of 22 November 1994, para.51. In this Report, it was submitted that India cannot implement population policies that are against individual interests.

[69] Since the Cairo Conference, Argentina and Guyana have enacted reproductive health laws and policies. State policies that protect and promote reproductive health within a wider program of women's health have also been enacted in Colombia and Brazil.

health. Accordingly, scope exists in many legal systems to move beyond criminal law prohibitions of choices in reproductive and sexual matters, to concepts of health, rights and individuals' enjoyment of their private and sexual lives.

HUMAN RIGHTS

a. Obligations in Reproductive Health

Since the evolution of human and reproductive rights, governments increasingly face a variety of obligations, including specific obligations that can be applied to particular circumstances, including core, immediate and long-term obligations to protecting women's reproductive health. The CEDAW General Recommendation on Women and Health, and CESCR's General Comment on Health explain that States have three different kinds of general legal obligations to implementation human rights[70]. They are:

- the obligation to *respect* rights, which requires states to refrain from interfering with the enjoyment of rights;
- the obligation to *protect* rights, which requires states actively to prevent violations of human rights by third parties; and
- the obligation to *fulfill* rights, which requires states to take appropriate governmental measures toward the full realization of rights[71].

The CEDAW General Recommendation on Women and Health explain the above obligations with respect to Article 12 of the Women's Convention in the following way:

> "The obligation to *respect rights* requires states parties to refrain from obstructing action taken by persons in pursuit of their health goals. States parties should report on how public and private health care providers meet their duties to respect women's rights to have access to health care".[72]

[70] Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No 24 on Women and Health, para. 29, Feb. 2, 1999 [Hereinafter General Recommendation on Health]. See also the CESCR's General Comment 14 on the Right to the Highest Attainable Standard of Health. UNESCOR 2000, UN Doc. E/C. 12/2000/4, 11 August 2000.

[71] CESCR General Comment 14.

[72] CEDAW General Recommendation on Women and Health, para 14.

The General Recommendation explains that states are obliged to change law or policies that require women to seek the authorization of their husbands, parents or health authorities to obtain health services, because such laws or policies obstruct women's pursuit of their health goals[73]. The Recommendation also states that the Women's Convention may be infringed by "laws that criminalize medical procedures only needed by women and that punish women who undergo those procedures. The obligation to *protect rights* relating to women's health requires states parties, their agents and officials to take action to prevent and impose sanctions for violations of rights by private persons and organizations."[74]

The Recommendation further explains that the duty to protect rights requires the "enactment and effective enforcement of laws that prohibit… marriage of girl children"[75]. This includes responsibility to develop health care protocols and programmes of gender training for health care providers and in the provision of health services, in order to identify, address, prevent and remedy the causes of unsafe motherhood. It goes on to make clear that "the duty to *fulfill rights* places an obligation on States Parties to take appropriate legislative, judicial, administrative and budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to heath care."[76] Studies have shown that high rates of maternal mortality and morbidity, and lack of access to contraception, provide important indications about possible breaches of duties to ensure women's access to health care.

In addition to these general obligations, CESCR has issued a General comment, which explains the minimum core obligations of Article 12 on the right to the highest attainable standard of health.[77] . This General Comment establishes that states have core obligations to provide essential primary health care in order to satisfy the right to the highest attainable standard of health. The General Comment explains, "core obligations are not subject to resource limitations or progressive realization, but that their realization is required immediately."[78]

The General Comment requires governments:

[73] Ibid
[74] Ibid at para 15
[75] Ibid
[76] Ibid at para. 17
[77] Supra n. 86
[78] Ibid at para. 19

(a) "to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups;

(b) "to ensure access to minimum essential food which is sufficient, nutritionally adequate and safe, to ensure freedom from hunger to everyone;

(c) to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and portable water;

(e) to ensure equitable distribution of all health facilities, goods and services;

(f) to adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of actions is devised, as well as their content, shall give particular attention to vulnerable or marginalized groups;

44(a) to ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;

(d) to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

(e) to provide appropriate training for health personnel, including education on health and human rights…"[79].

The General Comment explains that immediate obligations with regard to the right to health include the obligation to eliminate health related discrimination, for example in access to health care, and to take no retrogressive measures with regard to health, including withdrawal of services. The choice of rights to apply will depend on the immediate and underlying causes of reproductive ill health. Several human rights may be cumulatively and interactively applied to advance particular interests. Specific rights, clustered around the following categories, are often applied to different factors contributing generally to reproductive health:

- rights relating to life, survival and sexuality of the person;
- rights relating to health care;
- rights to non-discrimination and due respect for difference; and
- rights relating to reproductive self-determination[80].

[79] Ibid at paras. 43 - 44

The determination of which rights to apply will depend on:

- how the rights have been applied in the past by national courts, regional and international human rights tribunals ;
- an assessment of how successful their application might be in the future; and
- an identification of women's health issues that appear amenable to a human rights approach.

The application of human rights principles to sexual health generates further discourses and understanding that is helpful to foster compliance with international standards.

b. Human Rights and Sexuality

Sexual rights have recently emerged as a term used in the international discourses on human and reproductive rights. However, the issues considered under the rubric of sexual rights have a long history in the resistance(s) to society's regulation of sexuality. The advocacy for sexual rights, within the public and private spheres, is grounded in conceptual and activist work and research that has been done in a variety of fields, including human rights, reproductive health and gender issues.

International human rights law on sexuality is a relatively new development. In the last one and half decades, questions of sexuality and rights have been on the agenda of international conferences, court decisions and non – governmental organizations. Important battles have been fought and, to some extent, the privileging of heterosexuality, which is an inherent part of international human rights law, has been challenged[81]. Yet, the inroads made by sexual 'others' have been and still are vigorously contested by many African governments who participate in the international human rights system[82]. This contestation, which surrounds sexuality, takes place in a wider context of argument concerning basic values in international relations and law. In other words, the human rights field in this area(s) is a contested and shifting one, especially in the African region.

Human rights law envisages a particular type of subject and a particular model of that subject's relationship to government. The essence of human rights law is found in notions of the rational subject who has natural or inherent rights, protected by government under a social contract that enshrines the

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[80] Ibid
[81] Duggan Lisa. *Queering the State.* Social Text 39 (1994):1.
[82] Morgan Wayne. *Queering International Human Rights Law*; in Law and Sexuality: The Global Arena. (Stychin C., Herman D. ed.). 2001, 209.

rule of law.[83] Yet, this model is highly contested within the human rights field and is often questioned by countries that do not share the Western or European tradition upon which the model is based. Critical theorists who see fundamental flaws in this description of the subject and govern mentality also question it[84]. Dealing with these questions of law based on values which are somehow self – evident or shared, usually leads to a debate between 'universality' and 'cultural relativity' with these being put forward as the only two bases on which to build a theory of rights.[85]

Despite the uncertainty and shifting nature of the human rights terrain, human rights law is often analyzed as holding great promise for sexual 'outsiders'[86]. For example, human rights law gives legitimacy to claims to be treated equally. It can also be used as a mechanism to force hesitant domestic governments (mostly in Africa) to deal with a sexuality issue. The idea and language of human rights now permeate the arguments made by activists and lawyers when discussing sexuality.

Given our reliance on such ideas, pressing questions both at theoretical and practical levels concern what human rights law has to offer sexual outsiders. Can it help to overcome oppression which manifests itself in a range of ways from violations of the rights to life, health and reproductive self determination through to unfair treatment in day to day life? Human rights courts have addressed some of these issues, and international NGOs have been formed to advocate on these matters. For example, Amnesty International and the World Health Organization have recognized sexuality as a political and cultural issue.[87] Human rights conferences, including the 1993 Vienna Conference on Human rights, have been forced to confront demands for the recognition of rights to 'non – hetero' sexual desires and practices.[88] According to the World Health Organization,

"*Sexual rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents and are embedded in the ideal of women's enjoyment of their sexual autonomies. These rights include the right of all persons to the highest attainable standard of health in relation to sexuality, including access to sexual and*

[83] Ibid at 211.
[84] Spruill J. A Post Without a Past? Sexual Orientation and the Post – Colonial 'Moment' in South Africa. (Stychin C., Herman D. ed.). 2001, 4.
[85] Otto Dianne. "*Rethinking the 'universality' of human rights law'*, Columbia Human Rights Law Review 29(1997): 1.
[86] Above at n. 82.
[87] Amnesty International 1991 ICM Report (ORG) 52/01/92), Decisions of the 1991 Council (1991). Amnesty International has been increasingly active on sexuality issues.
[88] Heinze Eric. Sexual Orientation: a Human Right (Dordrecht: Martinus Nijhoff) 1995.

reproductive health care services. This capacity to enjoy reproductive and sexual lives is inextricable from the right to health and reproductive capacities" [89].

The conceptual foundations of sexual rights lie in at least two distinct but related histories[90]. One is the development of concepts and jurisprudence in women's human rights. The discourse on gender specific issues and sexual violence as a human rights violation has highlighted the way in which women's bodies are so often the targets of human rights abuses. The fact that women's lives (and the construction of their gender – roles in societies) are curbed by ideological constrictions placed on their freedom to exercise these rights, underscores the imperative that recognition of the right to bodily integrity and sexual autonomy will not be achieved on an individual basis, but only as social rights[91]. In other words, these constrictions view sexual rights as incomprehensible outside of the context of women's "social functions of reproduction and procreation"[92]. The second foundation for the notion of sexual rights is the work that has taken place on the right to health, and in particular, women's reproductive health rights. The development of the "sexual rights are human rights" paradigm has allowed for the expansion of the reproductive rights framework. This expansion has in turn extended the concept of women's rights to include issues of reproduction and sexuality that are often gender specific.

The discussion of sexual rights pushes the analytical boundaries of rights as individually held and socially constructed, and highlight the importance of acknowledging the multiplicity of identities of those pursuing these rights in private contexts[93]. This propels one to attempt an analysis of the relationship between sexuality and other identity categories (such as gender, religion, culture, law and politics), out of which a rights – bearing, socially embedded individual emerges. As Rhonda Copelon warns, while "sexuality is an important part of what constructs and constrains human identity, its influence is heavily dependent on gender, cultural institutions, ideologies and ideals"[94]. In other words, whether we like it or not, factors such as sexual orientation, gender, nationality, race, ethnicity, religion

[89] WHO/RHR/01.5, World health Organization, 2001. See also the Constitution of the World Health Organization, signed July 22, 1946, and entered into force on April 7, 1948, reprinted in WHO, BASIC DOCUMENTS (39th ed.) 1993.
[90] Fried Susanna T., Landsberg-Lewis Ilana. Sexual Rights: From Concept to Strategy. Women and International Human Rights law, 93 – 107, 1998.
[91] Ibid at 95
[92] Correa Sonia & Petchesky Rosaline, Reproductive and Sexual Rights: A feminist Perspective, in Population Policies Reconsidered: Health, Empowerment And Rights 107 – 126 (G. Sen, A. Germain & L.C. Chen eds., 1994).
[93] Ibid
[94] Rhonda Copelon & Rosalind Petchesky, *Toward an Interdependent Approach to Reproductive and Sexual Rights as Human Rights: Reflections on the ICPD and Beyond*, in From Basic Needs to Basic Rights: Women's Claim To Human Rights 343-68 (Margaret A. Schuller ed., 1995).

and social status remain essential components to be considered when defining, discussing, debating or seeking to protect sexual rights[95].

[EN] GENDERING THE INTERNATIONAL HUMAN RIGHT TO REPRODUCTIVE AND SEXUAL HEALTH

Many factors affect reproductive health, and its attainment is not limited to interventions by the health sector alone. Like sexual health, reproductive health is affected by the broader context of people's lives, including gender, economic circumstances, sexual orientations, social relationships and the traditional and legal structures within which people live. As explained above, sexual and reproductive health and behaviors are governed by biological, social and cultural factors, as well as legal and human rights protection. In recent times, reproductive health, like sexual health, has been seen as part of and within the context of general fundamental human rights, and is rooted in the provisions of international human rights instruments protecting life and health.

The language of reproductive rights became very visible after the World Conference on Human Rights in Vienna (1993), the International Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing in 1995[96]. However, the international recognition of rights to make choices in matters of reproduction can be traced to the late 1960s. In 1968, the 157 participants of the first International Conference on Human Rights, held in Tehran, recognized that "parents have a basic human right to determine freely and responsibly the number and spacing of their children and a right to adequate education and information to do so"[97]. In 1978 the Alma Ata Declaration included family planning as well as maternal and child health within the definition of primary health care.[98]

In 1979, the Convention on the Elimination of All Forms of Discrimination against Women (The Women's Convention) was adopted during the U.N. Decade for Women (1976 – 1985). The document provided that "State parties must take appropriate measures to eliminate discrimination against women

[95] Copelon R. and Petchesky R. at 349.
[96] Supra n. 2
[97] Final Act of the International Conference on Human Rights, Teheran, Iran, 12 May 1968, Res. XVII, U.N. Doc. A/CONF.32/41 (1968), in U.N. Department of Public Information, The United Nations and the Advancement of Women 1945 – 1995, at 167-69, U.N. Doc. DPI/1679, U.N. Sales No. E. 95.1.29(1995)
[98] See full text at "Achieving Reproductive health for all; the Role of the WHO in A.L. Waddell (ed.) WHO /FHE/95, p.2.

in the field of health care in order to ensure on a bases of equality of men and women, access to health care services, including those related to family planning''[99]. The Committee on CEDAW, the United Nations body that monitors compliance with the women's convention, addresses governmental obligations pertaining to reproductive health care[100]. In its General Recommendation on Women and Health, it declared that States Parties should "ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services"[101] Thus the right to reproductive health care gives rise to a governmental duty to ensure the availability of reproductive health services and remove existing legal barriers to reproductive health care. Ratified by 165 countries, CEDAW provides a strong legal support for the right to reproductive health and choice.

In 1992, the U.N. Conference on Environment and Development held in Rio De Janeiro reiterated "the right to decide on the number and spacing of one's children." It further affirmed that governments should provide health facilities, including "affordable and accessible reproductive and sexual health services, as appropriate for the responsible planning of family size"[102]. In 1993, at the Vienna Convention on Human Rights, member states recognized "on the basis of equality between women and men, a woman's right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels"[103].

In 1994, a new paradigm of reproductive health and rights based on "the right of reproductive choice" emerged. This occurred at the International Conference on Population and Development in Cairo. The Programme of Action adopted by 184 United Nations Member States enshrined the importance of human rights in protecting and promoting reproductive and sexual health[104]. The document stated that though it does not aspire to create new sets of human rights, "*one could affirm that the emphasis on reproductive rights and reproductive health, which is present in many parts of the document, introduces at least a new perspective on human rights. If not an enlargement, it certainly is an enrichment of international human rights..The highest attainable level of health is not only a fundamental human right for all; it is also a social and economic imperative because human energy and creativity are the driving forces of development*"[105].

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[99]Article 16 (1)(e). Supra n. 16 [Women's Convention.].
[100] Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No 24 on Women and Health, para. 29, Feb. 2, 1999 [Hereinafter General Recommendation on Health].
[101] Ibid
[102] The Rio De Janeiro Declaration and Agenda 21, United Nations Conference on Environment and Development, Rio De Janeiro. June, 1992.
[103] Supra n. 19 at para. 41, U.N. Doc.A/CONF.157/23 (1993)
[104] Supra n. 1 at para.7.3 [hereinafter Cairo Programme]1994.
[105] Supra n. 1 at Chapter VII.

This 2nd United Nations International Conference on Population and Development (the ICPD) took a broad view of human rights as including the promotion of safe motherhood, treatment and care for persons living with HIV/AIDS and other STIs, safe abortion, quality contraception and family planning services[106]. The ICPD strongly endorsed a new strategy for addressing population issues and focused on meeting the needs of individual women and men, rather than on achieving demographic targets[107]. Key to this new approach is empowering women within their families and communities and protecting their human rights, particularly those relevant to reproductive health. The ICPD specifically noted that reproductive health care should "*promote sexual health in order to enhance life and personal relations"*[108]. It set out the context and content of the reproductive health of individuals or couples and reaffirmed the rights of women as "*being central to all aspects of reproductive health*"[109].

Adopting the World Health Organization's definition of health, the Cairo Programme stated that reproductive health:

"eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and inappropriate or poor – quality reproductive health information and services; the prevalence of high risk sexual behavior; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives……Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well – being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the

[106] Supra n. 1 at 7.6
[107] Ibid at para 7.5
[108] Ibid
[109] Ibid

enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases"[110]

In 1995 at Beijing, China, the Fourth World Conference on Women produced two documents; the Beijing Declaration and Platform for Action. The Platform for Action further reiterated that women's reproductive rights is a human right and constitutes a vital part of reproductive and sexual health. The main points in the Beijing Conference were encapsulated in the Mission Statement to the Platform, of which the first and second articles states:

"the Platform for Action is an agenda for women's empowerment. It aims at accelerating the implementation of the Nairobi Forward – looking Strategies for the Advancement of women and at removing all the obstacles to women's active participation in all spheres of public and private life through a full and equal share in economic, social, cultural and political decision- making. This means that the principle of shared power and responsibility should be established between women and men at home, in the workplace and in the wider national and international communities. Equality between women and men is a matter of human rights and a condition for social justice and is also a necessary and fundamental prerequisite for equality, development and peace. A transformed partnership based on equality between women and men is a condition for people-centered sustainable development. A sustained and long-term commitment is essential, so that women and men can work together for themselves, for their children and for their society to meet the challenges of the twenty-first century. As an agenda for the action, the platform seeks to promote and protect the full enjoyment of all human rights and the fundamental freedoms of women throughout their life cycle".[111]

The Platform for Action identifies twelve focus areas as particularly germane to women's rights: poverty, education, health, violence against women, effect of armed conflict, economic structures and politics, inequality of men and women in decision making, gender equality, women's human rights, media, environment, and the girl child[112]. For the first time, women's issues became coterminous with human issues. The Platform was a major impetus that propelled the international community to recognize women's rights as human rights. The Cairo and Beijing documents stipulate that women possess these rights not because they belong to a particular culture or religion, but because they are

[110] Cairo Programme para. 7.3. See the full definition of reproductive rights in Supra n. 38 at para 7.2
[111] Supra n.2 at First and Second Articles.
[112] Ibid

human beings[113]. The Beijing Conference confirmed the centrality of reproductive rights in advancing the status of women and further reaffirmed women's rights to "*control their own sexuality and sexual relations and to decide upon these matters on an equal basis with men*"[114]. Paragraph 96 states explicitly that *"…[t] he human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence…*[115]" The Platform reinforced the *"equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, mutual respect, consent and shared responsibility for sexual behaviors and its consequences."*[116]. Like the Cairo Programme, the Beijing Platform explains that "*reproductive rights embrace certain human rights that are already recognized in national laws and international human rights documents and other consensus documents"*[117].

The Beijing documents thus strengthened the 1994 Cairo Consensus on reproductive health and rights, asserted women's right to bodily integrity, advanced the wider interests of sexual health and called upon governments and states to ensure the availability of services and remove existing legal barriers to reproductive and sexual health.

In July 1999, the United Nations, in a special session, reaffirmed and elaborated on the 1994 Cairo document. This meeting was a five-year review of the ICPD and the Programme of Action[118]. The adopted document ICPD + 5 is an important affirmation of the principles agreed to in 1994 and contain crucial strategies for further advancing and promoting reproductive rights. Both instruments enlarge existing principles contained in declarations of earlier international human rights charters and conferences. In 2000, the U.N. General Assembly on Women in their 23rd session to mark Beijing + 5, reviewed past achievements in the decade and articulated new strategies for women in the 21st century[119]. 178 states pledged their commitments towards effectively taking action and initiatives to overcome obstacles and to achieve the full and accelerated implementation of the Beijing Platform for

[113] See Supra n. 1 at 7.2 and n.2 at paras. 94, 95 and 96.
[114] Supra n.2 at para. 94.

[115] Supra n. 2 at Paragraph 96.
[116] Ibid at para. 96 (b) i
[117] Ibid at para. 95
[118] Key Actions for the further implementation of the Programme of Action of the International Conference on Population and Development, report of the Ad Hoc Committee of the twenty-first special session of the United Nations General Assembly, New York, July 1, 1999, U.N. Doc./A/S-21/5/Add.1 [hereinafter ICPD+5 Key Actions Document].
[119] Twenty third special session of the United Nations General Assembly on Women 2000: gender equality, development and peace for the 21st century (New York, 2000).

Action. Some of the areas identified for attention included health, violence, globalization, economy, human rights and political empowerment based on the principle of eliminating gender based discrimination[120]. In 2004, the ICPD + 10 reaffirmed the principles adopted in the preceding meetings and obliged states to "incorporate and implement the provisions of international instruments that protect health, equity and equality"[121].

Reproductive and sexual rights are thus highly interconnected and derivable from political, civil, social and cultural rights. They are indivisible and interdependent and share the same foundation on a global level with emerging "solidarity rights which demand international cooperation to ensure equitable development and peace and ultimately advance the quality and well-being of women and all people, in their communities and in everyday life, calling as it does for accountability of all actors and governments...even in the private sphere"[122]. Reproductive and sexual rights cannot be enjoyed or enforced in the absence of "other basic, economic and social rights such as food, shelter, health, social security, livelihood and education, elimination of poverty and renunciation of inequitable and discriminatory development, structural adjustment programs and environmental degradation"[123]. Even though the contents of international human rights laws have yet to be adequately applied to reproductive health matters in national contexts, the Cairo Programme, the Beijing Platform and other recent international conferences are nevertheless points of advancement in identifying particular steps that countries have agreed to take to achieve reproductive and sexual rights within specified time periods[124]. These documents may lack formal legal mechanisms to hold governments strictly accountable, but they establish general obligations that can be applied to advocacy for reproductive rights, sexual health and self-determination.

Overcoming barriers of implementation therefore requires national legislative strategies that hold government accountable to international obligations. For instance, the domestication of CEDAW and other international conferences into Nigerian law would complement the general anti-discrimination provisions of the Constitution by establishing clear, legal rules on the rights of women. Another way is to make states legally accountable to national and regional human rights monitoring systems. This strategy is in consonance with the international law of state responsibility that makes a state legally

[120] Ibid at p. 17.
[121] This Review was held in September 2004 in London
[122] Aniekwu Nkoli I. Gender and Human Rights dimensions of HIV/AIDS in Nigeria. African Journal of Reproductive Health. Volume 6 No. 3, 2002
[123] Ibid at 47
[124] See Cook, Rebecca J., "Duties to implement Reproductive Rights", Nordic Journal of International law 67: 1-16, 1998

accountable for breaches of international obligations that are attributable or imputable to the state or its agents.

As we have seen from the above, modern developments in international human rights laws and multi lateral conventions have enhanced prospects of state accountability for violations of gender specific rights. A useful framework developed under United Nations guidelines obligates states that have committed themselves to observances of such conventions to undertake the three kinds of duties necessary to protect reproductive rights[125]. These are to respect rights by providing for strict enforcement in national legislations, to protect rights by taking positive action against third party violators, and to fulfill rights by employing the authority of regional and international monitoring systems that afford women the full benefit of human rights protection[126].

REPRODUCTIVE HEALTH IN NIGERIA – AN AFRICAN CASE STUDY

Nigeria participated actively at the ICPD and Beijing Conferences, and is signatory to many of the follow – up review conferences, including the Beijing + 5 in 2000, the ICPD +10 Review in 2004 and the more recent African Protocol on Women's Rights. She was among the 189 nation states that approved the historic Programme of Action, which emanated from the ICPD. Below is a brief summary of the status of reproductive health in the country, with particular references to women's health.

a. Contraception and family planning

The right to determine "*freely and responsibly the number and spacing of one's children*" was first articulated by the international community at the International Conference on Human Rights in Teheran.[127] This principle has been reaffirmed in a number of subsequent international conferences since then, including the Beijing Conference. The Women's Convention, adopted in 1979 recognized international obligations to reproductive health and provided that States should ensure that men and women have "[t] he same rights to decide freely and responsibly the number and spacing of their children…."[128].

In Nigeria, the National Population Policy for Development, Unity, Progress and Self Reliance, developed in 1988, was the first national policy that sought to make family planning services easily

[125] United Nations, Concluding Observations of the Human Rights Committee, 11/18/96, CCPR/C/79/Add.72,para. 15
[126] Ibid
[127] Supra n. 106

[128] Supra n. 16

accessible to all couples and individuals at affordable prices[129]. This Policy provides that Government family planning clinics distribute contraceptives at low cost. Unfortunately, there is often a shortage of contraceptives at many government health centers. In addition, because clinics and hospitals within the public primary health care system are mostly located in urban areas, the availability of modern contraceptives in rural areas is extremely limited. Traditional and religious affiliations also constitute obstacles to the use of contraceptives, especially in the rural communities. Multiparity is encouraged in many customary settings despite attendant health risks, and modern methods of family planning are generally discouraged. Cultural beliefs and financial/economic dependency on the husband often prevent many women who desire to plan their families from doing so[130].

b. Safe abortion

The obligation to respect rights requires "*State parties to refrain from obstructing action by women in pursuit of their health goals… Barriers to women's access to appropriate health care include laws that criminalize procedures only needed by women and that punish women who undergo those procedures"*[131]. At the core of feminist legal theory and the reproductive rights discourse is the principle that a woman has a choice to decide if she wants to bear a child[132]. Governments are obliged to respect and protect this human right by ensuring that women can access the full range of quality reproductive health services, including safe abortion with considerations based on health and environments[133]. International legal support for a woman's right to safe abortion can be found in the aforementioned international treaties and other instruments[134]. The Programme of Action adopted at the ICPD called upon governments to consider the consequences of unsafe abortion on women's health[135]. In 1999, the ICPD + 5 Conference also affirmed that States train health service providers to ensure that abortions are safe[136].

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[129]See CRLP & Women's Center For Peace And Development, Women's Reproductive Rights In Nigeria: A Shadow Report 3 (1998)

[130] Aniekwu N.I. The Repugnancy Doctrine and customary law in Nigeria – A proposal for Restatement and Codification. The Nigerian Academic forum (A multi disciplinary journal) ISSN 1596 – 3306. Vol.5 No. 1 2003 at 62.

[131] Supra n. 2 at para. 93

[132] General Recommendation 21: Equality in Marriage and Family Relations, United Nations, Compilation *of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, HRI/Gen/1/Rev.2, 29 March 1996 at 124

[133] Aniekwu N.I. Criminal laws and legislative Policies relating to Abortion and Reproductive Rights in Nigeria. Annals of Medicine and Biomedical Research, University of Benin, Vol. 2 July 2003

[134] See Beijing Platform for Action Supra n. 2 at Article 97

[135] Supra n. 1 at para 7.5

[136] See the ICPD+5 Key Actions Document].

According to the Women's Convention, "discrimination against women" includes laws that have either the "effect or the purpose of preventing a woman from exercising any of her human rights or fundamental freedoms on a basis of equality"[137]. The International Covenant on Economic, Social and Cultural Rights also guarantees women the right to "the highest attainable standards of physical and mental health"[138]. It is presumed that this requirement will include post abortion health services.

In Nigeria, the Criminal and Penal laws prohibit abortion except when done to "save the life of the expectant mother"[139]. As a result of the country's restrictive laws, women undergo unsafe abortions at high risks to their physical, social and mental health. Between 10 and 50% of women who have had unsafe abortions in Nigeria require post-abortion medical attention due to complications arising from the procedure[140]. Despite criminal laws and sanctions, pregnancies are still terminated under unsafe conditions with grave consequences to the reproductive health of women and girls. Access to safe abortion is a necessary condition to safeguard women's health and protect reproductive rights.

c. Prevention and Control of HIV/AIDS and other Sexually Transmitted Diseases

The Beijing Platform recognizes that women's social subordination and unequal power relations to men are key determinants in their vulnerability to HIV/AIDS[141]. The World Health Organization has also noted that *"HIV/AIDS and other sexually transmitted diseases, the transmission of which is sometimes a consequence of sexual violence, are having devastating effects on women's health, particularly the health of adolescent girls and young women. They often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment"*[142]. Presently there is a "feminization" of HIV/AIDS and other sexually transmitted diseases in sub Saharan Africa. Research has shown that the social vulnerability and unequal power relationships between women and men are obstacles to safe sex and the control of sexually transmitted diseases[143]. Especially in Africa, the consequences of HIV/AIDS reach beyond women's health to their

[137] Supra n. 16

[138] International Covenant on Economic, Social and Cultural Rights, opened for signature Dec. 16, 1966, art. 12, 993 U.N.T.S. 3 (entry into force Jan.3, 1976) [Hereinafter Economic, Social and Cultural Rights Covenant].

[139] Criminal Code, Laws of the Federation of Nigeria, CAP 77 Section 230 (1) 1990. See also Penal Code, CAP 84, LFN 1990

[140] Safe Motherhood Inter-Agency Group, Statistics of Unsafe Abortion (visited April 7,2000) http://safemotherhood.org/init_facts.htm. Even developing countries like Peru, Colombia, Bangladesh and Nepal have liberalized their laws on abortion.

[141] Para. 98 recognizes that women have more physiological and biological vulnerabilities to the HIV virus than men especially in developing countries.

[142] World Health Organization, Sexual and Reproductive Health Research Priorities for WHO for the Period 1998 -2003, PCC (10)/1997/9, 30 May 1997 at 4-5.

[143] See UNAIDS Epidemic update: December 1999 5, 16 (1999).

role as mothers and caregivers and their contribution to the economic support of their families. In addition, many women's lack of access to adequate reproductive health care allow sexually transmitted infections to go undetected, leaving them even more physiologically susceptible to HIV infection. The prevention of HIV/AIDS and other sexually transmitted diseases are thus central to the rights to sexual health.

In Nigeria, where HIV is transmitted primarily through heterosexual contact, women are being infected at higher rates than men[144]. Recent studies indicate that the rate of HIV/AIDS is increasing faster among young women than among men in other lower income countries.[145]. According to the Nigerian National Action Committee on AIDS (NACA), over 4 million people are living with HIV/AIDS and the impact on women is one of the most pressing reproductive health concerns in recent times[146].

Because women's subordinate role in developing countries heightens their risk of HIV infection, governments are obliged to approach this epidemic with a gender perspective. HIV prevention strategies that are not gender sensitive are generally not protective of women's right to non-discrimination and health[147]. While discrimination against people with HIV/AIDS affects both sexes, infected women also contend with pervasive gender discrimination, making them doubly marginalized[148]. The Beijing Platform recognizes that women's social subordination and unequal power relations to men are key determinants in their vulnerability to HIV/AIDS[149] and notes that women "often do not have the power to insist on safe and responsible sex practices and have little access to information and services for prevention and treatment"[150].

d. Legal Protection against Harmful Traditional Practices including Female Genital Mutilation

[144] Aniekwu N.I. Expanding the National Response(s) to HIV/AIDS, Law and Human Rights in Nigeria. Benin Journal of Public law, Vol. 1 No. 1 2003.

[145] Senderowitz, Judith. Adolescent health: Reassessing the passage to adulthood. World Bank discussion papers 20 (1995). See also Aniekwu N.I. "HIV/AIDS in Sub-Saharan Africa – Reflections On Initial Reactions And Transmission Patterns." Annals Of Bio – Medical Sciences. University of Benin, 2004 at p. 7.

[146] See NACA Bulletin (2) 2005 at 17.

[147] Aniekwu N.I. The Feminization of HIV/AIDS in Sub – Saharan Africa. (Forthcoming) QUEST; An African Journal of Philosophy, 2006.

[148] Aniekwu N.I. The International Guidelines on HIV/AIDS and Human Rights – A Proposal for National Legislations. Nnamdi Azikiwe Law Journal p. 411 2005.

[149] Supra n. 2

[150] Supra n. 2 at para. 98.1. Fortunately, the new Reproductive Health bill is being privately sponsored at the National Assembly and hopefully will be passed into law. The bill contains provisions that directly address reproductive health issues for both men and women.

The Beijing Platform for Action states "*any harmful aspect of certain traditional, customary or modern practices that violates the rights of women should be prohibited and eliminated"*[151]. In addition, the Women's Convention enjoins, "*States parties to take all appropriate measures… [t]o modify the social and cultural patterns of conduct of men and women with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women…*"[152]

In Nigeria, certain customs and traditional practices severely compromise the health and lives of women and young girls. Practices that are consistently recognized as "harmful traditional practices" include female cutting or female genital mutilation, very early marriage, nutritional taboos and traditional practices associated with childbirth[153]. In many parts of the country, FC/FGM is performed upon girls between the ages of four and 12, and is practiced in some cultures as early as a few days after birth or as late as just prior to marriage or after the first pregnancy[154]. It is estimated that 130 million girls and women in developing countries have suffered FC/FGM and at least two million girls each year are at risk of undergoing some form of the procedure[155]. The practice carries a strong message about the subordinate role of women and girls in society and is a covert attempt to repress the independent sexuality of women by altering their anatomy. When performed on minors and non-consenting girls, FC/FGM violates a recognized human right protected in international and regional instruments[156].

e. Legal Protection against Domestic Violence including Sexual Violence in the Private Sphere

The term "violence against women" amounts to "*any act of gender based violence that results in or is likely to result in physical sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life*"[157]. Gender based violence, especially in Africa, is one of the physical realities of the economic, social,

[151] Ibid
[152] Supra n. 16
[153] Halima Embarek Warzazi. Third Report of the Special Rapporteur on Traditional Practices affecting the Health of Women and the Girl Child, para. 20, submitted to SubCommission on the prevention of Discrimination and Protection of Minorities, E/CN.4/sub.2/1999/14, July 9 1999.
[154] This is prevalent in the Ijaw and riverine areas of Delta, Ebonyi and Rivers states.
[155] Anika, R. Nahid, T. Female Genital Mutilation, A Guide to Laws and Policies World Wide CRLP and Research, Action and information Network for the Bodily Integrity of Women (RAINB+), Zed Books (2000), U.K.
[156] A Woman's Right to Health, Including Sexual and Reproductive Health. Commonwealth Medical Association, London (1996)
[157] See the 1993 United Nations Declaration on the Elimination of Violence against Women, Section 13, para. 2.

political and cultural inequalities that exist between men and women.[158]. Sexual violence, such as rape and forced sex in marriage, often impacts on women's sexual and reproductive health and autonomy. International human rights law specifically affirms women's rights to be free from gender-based violence, including rape and other sexual violence in the "private sphere"[159]. CEDAW has noted that gender based violence is a form of discrimination which seriously inhibits women's ability to enjoy rights and freedoms on a basis of equality with men because sexual violence in its various forms maintains women in sub – ordinate gender based roles and discriminates against them on the basis of sex[160].

In Nigeria, the criminal laws do not actively protect women against sexual violence in private and family life and this serves to perpetuate a culture of gender based violence. Forced sexual relations within marriage are accepted and tolerated and husbands are impliedly not criminally liable for sexual violence or marital rape.[161] Domestic violence is bound by the culture of silence and cases of sexual violence are often not reported. This has limited in practice the fulfillment of the Constitution's principle of non – discrimination and Nigeria's obligations under CEDAW[162].

In Part 1 Section 6 of the Criminal Code, unlawful carnal knowledge is the "carnal connection which takes place otherwise than between husband and wife"[163]. Sections 357 of the Criminal Code and 283 of the Penal Code further imply that marital or spousal rape is not recognized as a crime in Nigeria[164]. Section 282 of the Penal Code specifically excludes "sexual intercourse by a man with his own wife" from the definition of rape, "so long as she has attained the age of puberty"[165]. Sections 55(1) and 378 of the Penal Code also precludes as an offence "any act which does not amount to the infliction of grievous hurt and which is done by a husband for the purpose of correcting his wife, such husband and wife being subject to any natural law or custom in which such correction is recognized as lawful"[166].

[158] See Aniekwu N., Before Beijing and Beyond : The Emergence of Women's Rights as Human Rights. Knust Law Journal, University of Kumasi, Vol.1 Ghana. p. 2- 15, 2005.
[159] Ibid at 6.
[160] CEDAW, General Recommendation No.19 on Violence Against Women, 11th Sess., para.1, U.N. Doc.C/1992/L.1/Add.15 (1992) [hereinafter General Recommendation on Violence], especially at para. 5.
[161] See Report of the CRLP & International federation of women lawyers (f.i.d.a.-k), Women of the world: laws and policies affecting their reproductive lives, Anglophone Africa Progress Report 2001.
[162] As a ratifying state, Nigeria is bound to the obligations specified by CEDAW on eliminating domestic and sexual violence. See in particular, section 17 CEDAW supra n. 16.
[163] Criminal Code, Laws of the Federation of Nigeria, CAP 77, LFN 1990.
[164] Penal Code, CAP 84, LFN 1990.
[165] Ibid at Section 282.
[166] Ibid

Section 55 specifically allows for "reasonable chastisement" of a wife by the husband[167]. It would seem that the endorsement of violence against women in customary law has been transposed into statutory law. These legal provisions are not only diametrically at odds with Nigeria's obligation under CEDAW and other international instruments; they seem to undermine the basic tenets of statutory family law.

PROSPECTS AND OPPORTUNITIES FOR LEGAL OBLIGATIONS IN NIGERIA

Indicators of Capacity and willingness

Presently, there are indicators of state's capacity and willingness to protect women's reproductive rights in Nigeria. Key among these are the adoption of national policies on reproductive health, ratification of international human rights instruments, legislations by state houses of Assembly on reproductive health and gender issues, and Constitutional provisions on human rights.

a. National Policies on Reproductive Health

The National Health Policy became operative in October 1988 and aims at a level of health that "will enable Nigerians achieve socially and economically productive lives". It adopts the primary health concept as the main engine by which the "goal of health for *all* Nigerians can be attained". Some of the provisions include the strengthening of maternal and reproductive health care services. Since 1988 there have been numerous policies and programs on reproductive health and population issues, including the National Policies on Population and Reproductive health[168]. These national policies are generally targeted at primary health care centers and services to provide adequate family planning and counseling services in both the public and private sectors. With the adoption of the National Policy on Women in July 2000 and the National Sexual and Reproductive Health Policy and Strategy in 2002, there's an active "indication of willingness" by state to mainstream issues of gender into the health and social policies of Government[169]. Other laws with gender biases are the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act 2003 and the Child Rights Act 2003. There are also national policies on nutrition, HIV/AIDS and economic empowerment including the following:

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[167] Ibid

[168] National Health Policy and Strategy (1988, 1998). The Maternal and Child Health Policy (1994) also provides for maternal and child health facilities. Other federal Agencies and parastatals associated with strengthening reproductive health are the National Primary Health Care Development Agency (NPHCDA), the Population Activities Fund Agency (PAFA), the Department of Community Development and Activities (DCDPA) and the National Health Insurance Scheme.

[169] See the Nigerian National Health Policy and Strategy. Federal Ministry of Health, Abuja, [Annex 1].

- National Population Policy for Sustainable Development 1988 (revised in 2003)
- National Reproductive Health Policy and Strategic Framework (2001)
- National Policy on HIV/AIDS/STIs Control (1997)
- National Policy on the Elimination of Female Genital Mutilation (1998)
- National Adolescent Health Policy (1995)
- HIV Emergency Action Plan
- National Policy on VVF
- National Economic Empowerment and Development Strategy (NEEDS)
- The State Economic Empowerment Development Scheme (SEEDS).

The links between sexual and reproductive health and rights and sustainable development agreed on in Cairo were introduced into the Millennium Development Goals project report produced by the United Nations Secretary General in 2000. NISER has reflected these links in Nigeria's own progress report in 2003[170].

The links between sexual and reproductive health and rights and sustainable development agreed on in Cairo have also been introduced in the MDG project report produced by the UN Secretary General in 2005 and in various documents produced by the EU, UNFPA and the World Bank[171]. The eight Millennium Development Goals identify two goals for reproductive health and obliges governments to invest in these areas. These goals are aimed at reducing by three quarters the ratio of women dying in child birth and halt and reverse the spread of HIV/AIDS[172]. Unfortunately, the extreme fragmentation of health related policies in Nigeria have resulted in a lack of integration of closely related health care services, considerable duplication of effort and waste of resources[173]. Little effort has been made to evaluate national projects and programs for overall impact and effectiveness. There is also a dearth of effective monitoring mechanisms to track funds and resource allocation. This has led to the current limited understanding of the performances and impact of health related programs, thereby resulting in a loss of control over program design and development.

[170] Millenium Development Goals Nigeria. 1st Progress Report. NISER, Ibadan. September, 2003.

[171] Millenium Development Goals; Report of United Nations Secretary General, UN/ Doc. 00475/05, 2005.
[172] Supra n. 180
[173] Okonofua F. E. Proposal for the establishment of a National Institute of Reproductive health. Submitted to the Society of Gynecology and Obstetrics of Nigeria (SOGON), July 2004

b. Ratification of International Instruments

Nigeria has signed or ratified several international instruments that affirm the right to health with implications for the reproductive health of women[174]. The preamble to CEDAW acknowledges the existence of discrimination against women and makes it clear that continued existence of gender based discrimination violates the principles of equality of all persons and respect for human rights and dignity[175]. The African Charter on Human and People's rights adopted by the 18th Conference of Heads of States and Governments of the Organization of African Unity in June 1981 in Nairobi, Kenya, has been domesticated and made part of Nigerian law in Cap 10 of the Laws of the Federation of Nigeria[176]. Articles 2 and 18(3) of the Charter deal specifically with gender issues and prohibit discrimination on grounds of sex[177]. In particular, the Charter obliges the African Commission to establish a collaborative relationship with CEDAW and eliminate all forms of discrimination against women as stipulated in international declarations and conventions[178].

The Additional Protocol on Women's rights to the African Charter was passed in 2003 by the African Union in Maputo, Mozambique[179]. It was a direct response to women's needs and sets out specific standards and measures by which women's rights should be recognized and protected[180]. The document specifically protects women's human rights in Africa thereby breaking new grounds in international

[174]Some of these documents include the International Covenant on Civil and Political Rights, (the ICCPR), the International Covenant on Economic, Social and Cultural Rights (the ICESCR), the International Covenant on the Elimination of All Forms of Racial Discrimination (the Race Discrimination), CEDAW and the Convention on the Rights of the Child (the Children's Convention).

[175] Supra n. 16

[176] African Charter on Human and Peoples Rights (Ratification and Enforcement) Act, Cap. 10 Laws of the Federation of Nigeria 1990. In Gani Fawehinmi vs. Abacha (1996) 9 NWLR (Pt 475) 710, it was held that "Nigeria having promulgated Cap10 was obliged to fulfill her international obligations and that the provisions of the charter cannot therefore .....be inferior to decrees because no government will not be allowed to contract out by local legislation, its international obligations."

[177] African Charter on Human and Peoples Rights, 1981, Section 18 (3) which stipulates that "the state shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions".

[178] Ibid

[179] Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, 2nd Ordinary Session, Assembly of the Union, adopted July 11, 2003 [hereinafter Protocol on the Rights of Women in Africa].

[180] The Protocol is charged with supplementing the regional human rights charter, the African Charter on Human and Peoples Rights (the African Charter), and provides broad protection for women's human rights, including sexual and reproductive rights. See Articles 3 – 11.

law. It also contains provisions on the elimination of harmful traditional practice[181]. By January 2006, 17 countries had ratified the protocol including Nigeria.

CEDAW was ratified in Nigeria in 1985 without reservations and the Optional Protocol to the Convention was signed in September 2000. However, under Section 12 of the 1999 constitution, a treaty cannot have the force of law within Nigeria unless and until the National Assembly adopts it into law[182]. This means that gender specific international human rights instruments like the CEDAW that have been ratified in Nigeria but not yet domesticated by legislation and incorporated into national law, are not considered as part of the municipal law of the state *lex civilies*. This is despite the fact that CEDAW, the Cairo Program of Action and the Beijing Platform are points of advancement that Nigeria has undertaken to achieve reproductive rights within specified time periods[183]. It would thus seem that she embraces the *incorporation* doctrine, which says that international human rights norms that appear in ratified instruments are not part of domestic laws except by express adoption of the latter. This position has resulted in a weakened impact of international instruments and seems to deny the remarkable and comprehensive developments of human rights norms.

It is my view that the ratification and adoption of International treaties and instruments on human rights and gender issues by the State is indicative of her *willingness* to comply with international obligations on sexual and reproductive rights. According to Pats Acholonu of the Court of Appeal " I believe by being signatory to the convention….the sovereign government of Nigeria manifested its intention and perhaps willingness to abide by the tenets of the convention…."[184] This indication of *willingness* by State to promote and protect reproductive rights is also seen from her Constitutional *capacity* to protect other human rights.

[181] Ibid. Article 1[g] which states that "States Parties shall commit themselves to achieving the elimination of harmfull cultural and traditional practices and all other practices which are based on the idea of the inferiority or superiority of either of the sexes, or on stereotyped roles for women and men."
[182] Constitution of the Federal Republic of Nigeria (Promulgation) Decree No. 24 1999.
[183] See Popoola Ademola A. The role of the Constitution in the Domestic Application of International Human Rights Norms and Standards with Particular Reference to women. In Gender Gaps in the 1999 Constitution of Nigeria. (Akiyode-Afolabi Abiola ed) Women Advocates Research and Documentation Centre Proceedings (WARDC) 2002.

[184] Fawehinmi vs Abacha (1990) 9 NWLR (Pt 475) at 710

c. Constitutional Provisions on Human Rights

The Nigerian Constitution actively protects international human rights, but appears "*passive"* on gender specific human rights obligations[185]. For instance, the Nigerian Constitution does not specifically protect women against discrimination, but there are general provisions on human rights in Chapter IV, Sections 33 – 46, with Section 46 stating the procedures for enforcement[186]. It seems however, that there are quantitative indicators that can allow international human rights obligations to be extended into the realm of gender issues. The Constitution denies the right of the individual to health in the face of "overriding" public interest, but maintains that the "State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons" in Section 17 (3) (d)[187]. The Constitution goes on to add in the Fourth Schedule that the functions of the local government council shall include the "provision and maintenance of health services"[188]. In Section 17 (3) (h) the constitution directs its policy towards "ensuring that the evolution and promotion of family life is encouraged.[189]"

The rights and empowerment of women are fundamental prerequisites to their reproductive health. This entails "promoting increased awareness of women' rights to resources, health, education and employment."[190] The above Constitutional provisions put human rights obligations into operation and are further evidence of Government's capacity and willingness to "progressively achieve the realization of reproductive rights"[191]. However, effective implementation of such rights often depends upon legal and policy frameworks that are not fully expressed in the Constitution. For instance, the provisions on the Fundamental Objectives and Directive Principles of State Policy are non-justiciable and cannot be legally enforced in a court of law[192]. Section 6(6) of the Constitution prevents the courts from looking into whether or not the fundamental objectives and directive principles of state policy have been implemented[193]. Thus, it would appear that the provision for non discrimination in access to health care is not obligatory on the government. Factors such as the institutional capacity of the state, available

[185] Chapter IV, Nigerian constitution, 1999.
[186]See also Sections 18, 39, Chapters II and IV on Fundamental Objectives, Human Rights and Directive Principles of State Policy. Constitution of the Federal Republic of Nigeria (Promulgation) Decree No. 24 1999
[187] Ibid
[188] Ibid
[189] Ibid
[190] Aniekwu N.I. E*xamining the reproductive health and rights of Nigerian Women – a legal perspective* University of Benin law journal Vol. 6 (2) 2001.
[191] Ibid at 58
[192] Chapter II, 1999 Constitution.
[193] See especially Section 6 (6) c and d.

human, financial and technical resources also determine the extent and implementation of human rights to equality and non discrimination.

d. State Laws on Gender Issues

Several states have enacted specific laws on women's health and gender issues[194]. Although there are wide differences between policy and practice, these laws nevertheless indicate state commitments to protecting women's health and related matters. There are laws prohibiting discrimination in critical areas such as female genital mutilation, widowhood practices and early marriage[195].

At the federal level, the Marriage Act recognises that a person under the age of 21years is a minor but allows minors to marry with 'parental consent'[196]. Section 6.2.7 of the National Policy on Women calls for 'actions to discourage the withdrawal of girls under eighteen from schools for marriage through legal sanctions.'[197] In Bauchi, Kano, Borno and Gombe states, laws have been passed against withdrawing girls from school for the purpose of marriage, while Kebbi and Niger states recently enacted laws prohibiting early marriages[198]. The 1956 Age of Marriage Act, applicable in Eastern Nigeria, which stipulates the minimum age of marriage for both genders at 16 years, is also still in force in the Eastern Region[199]. Ogun and Ebonyi States have incorporated the Childs Right Act 2003 making 18 years the minimum age of marriage for both genders[200].

There have also been positive recent developments in the adoption of state laws banning female genital mutilation. This practice has been outlawed in more than 25 states including Cross River, Akwa Ibom, Delta, Edo, Osun, Rivers, Bayelsa and Ogun, covering strategic areas of the country where this practice is prevalent and widespread. The High Court laws provide that any custom or customary law that is

[194] For example, the Prohibition of Infringement of a Widow's and Widower's Fundamental Human Rights Law, No. 3, 2001, Enugu State; the Female circumcision and Genital Mutilation (prohibition) Law of Ogun State 2000; the Edo State law on Female Genital Mutilation; the Rivers State law on Reproductive health, and the Cross River State law on Girl Child Marriage and Female Circumcision (Prohibition) which criminalizes female genital mutilation and makes it illegal for girls under 18 to marry. In 1991 the Bauchi state legislature enacted the Prohibition of Withdrawal of Girls from School for Marriage law.

[195] Ibid

[196] Section 18 Marriage Act, LFN 1990.

[197] The Nigerian Policy on Women, Adopted in July 2000.

[198] Even though some Northern states have enacted affirmative laws that prohibit early marriage, the reverse is often the case in practice with many guardians and parents still forcing their female wards into marriage at very young ages. The sharia system also seems to encourage very early marriages.

[199] Age of Marriage Act, Eastern Region, Federal Republic of Nigeria, 1956.

[200] The problem with the state legislature is that it has refused to specify the minimum age of marriage for both sexes. Marriage and matrimonial causes are within the exclusive legislative competence of the federal government and so the federal legislature should show greater commitment in legislating against child and early marriages, especially for girls.

"contrary to natural justice, equity and good conscience is to be declared repugnant" and should not be enforced would appear to provide windows of opportunities to challenge many discriminatory customs relating to women's health and rights[201]. Edo State has been particularly active in enacting laws that promote and protect women's health. In 1999, the state House of Assembly passed the Female Circumcision and Genital Mutilation (Prohibition) Law; and brought the attention of the country to the harmful effects of the practice[202]. In addition, the state legislature enacted an edict against international sexual trafficking and prostitution, as well as a law for the monitoring of maternal mortality in Edo State; the Criminal Code (Amendment law) Edo State 2000 and the Edo State Maternal Mortality Monitoring Law (2001) on safe motherhood[203]. The legislature also increased the minimum age of marriage from 16 to 18 years.

In 2001, the state governor signed the Widowhood bill into law which aims to make provision for the prohibition of inhuman treatment of widows[204]. Although there hasn't been a dramatic reduction in maternal mortality, unsafe abortion and female genital mutilation, the laws nevertheless provide a legal framework within which activists can implement programmes and advocate for the abolition of practices that endanger women's health.

BEYOND VIENNA, CAIRO AND BEIJING

The struggle to incorporate recognition of reproductive rights into the international agreements of Cairo and Beijing indicates how strategic efforts to use the law to promote women's human and sexual rights are constrained by political and legal contexts. Feminist theories and legal activists have struggled with the question of how to insert sexual issues into a purportedly "neutral" body of law. Where equality is conceptualized as "sameness", the legal system imposes a regime of formal equality, which guarantees facially neutral treatments to 'men' and 'women'. However, there is a hidden bias in this model. According to this "sameness" model, persons (who do not conform to this standard) are denied the fruits of equality. This is particularly troubling since so much of sexual outsiders and women's

[201] See for example Augustine Nwofor Mojekwu v. Caroline Mojekwu 1997 7 NWLR pt 512 pg 532
[202] See the Female Circumcision and Genital Mutilation (Prohibition) Law, Edo State, 1999.
[203] Criminal Code (Amendment) Law, Edo State, 2000. See also High Court Laws, 2004, and Maternal Mortality Monitoring Law, of Edo State (2001).
[204] The Domestic Violence and other Related Matters Law, Edo State. (HA 17) 2001.

experiences of inequality relate to their sexual selves. In emphasising the sameness of women and men, the "sexual body", and particularly the "woman's body", is erased. The concepts of human and reproductive health rights help highlight why an alternative conceptualization of sexuality and equality is necessary.

While the above international conferences were undoubtedly catalysts for change, it is mainly through advocacy and the efforts of human rights activists and non-governmental organizations that principles are being translated into solid legislative and policy reforms in many countries. In Nigeria, legal responses to many of the recommendations of the international conferences and instruments have been weak, or at best, passive. Therein lies the problem. To fulfill the commitments made at Beijing and other international conferences, African governments must actively implement and realize reproductive and sexual health rights and integrate concepts in a non – discriminatory, participatory and multi-sectorial manner into official programs. While human rights advocacy will predictably continue to be at the forefront of strategies for change, states must legally implement the international obligations undertaken to protect reproductive health and sexual rights. Although a few African states have recently passed legislations that aim to protect women's health, the enactment of municipal laws and national policies on reproductive and sexual rights need to be accompanied by genuine efforts to enforce and implement international provisions.

The Beijing and Cairo Conferences bore a remarkable testament to the strength and vitality of human rights movements around the world. The parallel nongovernmental (NGO) forum in Beijing provided an extraordinary opportunity for the development and consolidation of transnational networks of interest among women, which suggests that the future of feminist and sexist interventions in international law burgeons with new possibilities. The language of equality, health and sexual rights, which dominated the Beijing Declaration and Platform for Action and the Cairo Programme of Action,

proved extremely effective in resisting moves by fundamentalist forces to claw back the advances that human rights lawyers have made since the adoption of the U..N. Charter in 1945 and the Vienna Conference in 1993.

CONCLUSION

Since the adoption of the ICPD Programme of Action in 1994, and the Beijing platform for Action in 1995, the policies and implementation strategies of many signatory states have reflected the broad view of reproductive health and sexual rights articulated at Cairo. In Nigeria and other parts of the African region, there are still key challenges in the realization of these rights. As mentioned earlier, legislative actions and reform have the indicators for protecting human rights, especially in the areas of sexuality and health. In addition, concerted efforts at awareness and sensitization by researchers, non governmental groups, government departments, international networks and policy makers will contribute to the desired impact for change and reform. In order to bring about such change, multiple approaches need to be adopted as part of a long-term strategy for achieving reproductive health and sexual rights.

In reflecting on the history of human rights and re-evaluating the emancipatory potential of feminist and sexist strategies, one must seek to understand the recognition of sexual and gender specific reproductive rights as a multidimensional and multi cultural project. Dealing with questions of law based on values which are somehow self – evident or shared, usually leads to a debate between ‘universality’ or ‘generality’ and ‘cultural relativity’ or ‘specificity’, with these being put forward as the only two bases on which to build a theory of rights. It must be remembered that both the discourses of human rights and development are effects and tools of global masculinist regimes, and

that it is inadvertent that such systems would necessarily produce feminist and homosexist resistances.

This writer suggests that further interventions in human rights would be more reflective of the multiplicity of women's identities and issues, and more effective in challenging the underlying masculinist form of international law, if links were forged between an expanded emancipatory human rights framework that is inclusive of reproductive health laws and a critical development paradigm inclusive of sexual rights. This would enable questions of sexual specificity and "otherness" to come to the fore and highlight issues in human rights that must be addressed.

The special challenge of protecting rights to reproduction and sexual orientation lies in the fact that suppression and subordination of sexual autonomy and freedom is often embedded in many societies and cultures of Africa. In Nigeria for example, despite several policies aimed at reducing reproductive ill health and protecting womens' issues, international goals are far from being realised. The challenge therefore must be faced of improving accountability mechanisms at domestic levels, by political, legal and other means, especially in the areas of reproduction and sexuality. For instance, the Cairo Programme of Action was specifically sensitive to prevailing inadequacies in international accountability of reproductive and sexual rights in many states. The document made clear that movement beyond Cairo depends on momentum generated through national and domiciliary legislative reforms.

In conclusion, reproductive and sexual rights in Africa may continue to mean very little if national and regional legal systems and human rights mechanisms are not used to ensure state compliance

with international commitments. To encourage compliance with international human rights standards, many committees created by Conventions to monitor reproductive rights observance have developed systemic standards of performance for ratifying states. Evidence of government acts or inactions that do not protect reproductive health and sexual rights are prospects of 'international humiliation' for non-commitment to obligations. This strategy is intended to focus state and political attention on sexual equality and gender specific human rights laws. However, it is clear that even this strategy at enforcing 'soft' international principles is not enough. More formal political and legal provisions in the various domiciliary systems, especially in the African region, are necessary to deter violations and discrimination. Human rights and reproductive health advocates and researchers working in collaboration with government machineries can also guide reform measures. Collaboration between health and legal professionals produces considerations for reproductive rights and offers the prospect of law reform that does not compromise or obstruct sexual health. In so doing, the legal and social consequences for human rights obligations can be adequately addressed and advanced.