Beasts of Burden

A Study of Women's Legal Status & Reproductive Health Rights in Nigeria

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&
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TABLE OF CONTENTS

THE BACKGROUND

In 1993 and 1994, the Women's Rights Project of the Civil Liberties Organisation (CLO) conducted research into the condition of women in employment and police custody in Nigeria. One of the essential recommendations of that research was that further research be conducted into the legal status of women and their reproductive rights. It was necessary to understand the links between the legal status of women and their reproductive rights, and how both affected their opportunities for self-actualisation. The research proceeded on the premise that the practical application of law and policy in Nigeria does not do justice to the gravity of the issues involved in reproductive rights. It also set out to establish that there exists a disparity in the actual legal capacity of women in Nigeria *vis-à-vis* their *de jure* status in accordance with the three major legal systems in the country.

Project work commenced with a 2-day training-and-awareness workshop on the *Legal Status of Women and Reproductive Rights* at Premier Hotel, Ibadan, from July 5 to 7, 1995. The workshop served as opening discussions and training for the researchers on the issues the project sought to clarify. Justice Chukwudifu A. Oputa, a retired Justice of the Supreme Court of Nigeria presented the keynote address[1] and background paper. Two other papers were presented: "Women's Reproductive Health - An Introductory Analysis" by Prof. 'Peju Olukoya, and "Perspectives on Women's Reproductive Health and Rights - The Human Rights Paradigm" by Eze Onyekpere, Head of the CLO's Legal Directorate. These papers and the communiqué that came out of the workshop helped define the direction of the research and proved useful in the development of the research questionnaire and the structured interview schedule.

[1] See page 123 for the address.

Dr. (Mrs) E. Adenike Emeke

WOMEN'S REPRODUCTIVE HEALTH AND RIGHTS: CUSTOMARY LAW AND PRACTICE IN NIGERIA[125]

INTRODUCTION

Time was when the woman was seen solely as the property of the man and could be used as he liked and at his whims and caprices. At that time, she was seen as owned by the husband, and, in conjugal matters, she must make herself available to his advances and urges anytime they overtook him. Little or no consideration was given to the woman's health and reproductive rights. The only period she is "free" is during her monthly menstrual flow, at which time she, who days earlier had provided the gratification of the man's pleasure, is now regarded as "unclean", "filthy" and worthy of ostracisation. She is indeed ostracized, for during this period she must not cook the man's food, must not sleep in the man's room, and must go through a rigorous cleansing "ritual" at the end of her God-ordained, life-bringing and life-perpetuating monthly flow. The man seems to forget that without this fertility-indicating process new life cannot be begotten and man (here used in the generic sense) cannot reproduce himself. The Holy Books (i.e. Bible in the Old Testament and the Koran), philosophers like Socrates, Aristotle, and Shakespeare, as well as contemporary writers like Camara Laye have borne witness to this. They have also borne witness to the degrading position in which the woman has been held regarding her total personality and her reproductive status. This degrading status persisted for many

[125] Presented at the *National Policy Symposium on the Legal Status of Women and Their Reproductive Rights and Health*, organised by the Women's Rights Project of the CLO, March 11, 1997.

centuries in many cultures of the world. But with time it was realized that it was wrong for the man to have held the woman in such disdain, not acknowledging her dignity, relegating her to the margins of society and even reducing her to servitude. The wind of change started to blow through her slowly. The wind blew more strongly when the women themselves began to take up their own cause and to fight for women's rights which have come to be recognised (though still largely only in principle in many cultures) as human rights. A lot more still needs to be achieved in different spheres of the woman's personal rights, and the focus of this paper is some of those areas that need further delving into. There is a need for greater acceptance of the woman's personal rights by both men and women themselves. The need for real gender equality and fairness, as well as more protection for women must be recognised and pursued. In pursuance of this need for greater equity and fairness in women's health matters, women produced a broader conception of reproductive health at the 1994 International Conference on Population and Development (ICPD) held in Cairo. That conception that was hailed by Dr. Nafis Sadik, Secretary General of the ICPD, as a landmark of the conference, second only to the issue of gender equity.

DEFINITION OF REPRODUCTIVE HEALTH

According to the ICPD conception, 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.

The cornerstone of reproductive health is the recognition of the basic right of all couples and individuals to determine the number and spacing of their children, and to have the information to do so.

Women's reproductive health must be given serious consideration in Nigeria, since 19% of the female population - who in turn constitute about 49% of the total population - are within the reproductive age group of between 15 and 44 years.[126] Tanzania,

[126] Federal Ministry of Health and the National Population Bureau, *The Effects of Social and Economic Development*, 1985.

another African country, has a similarly high figure of 21% within the reproductive age group.[127]

A look at the problems related to reproductive health of women will improve our understanding of women's reproductive health and properly situate our discussion of women's reproductive rights within the framework of customary law and practice.

WOMEN'S REPRODUCTIVE HEALTH PROBLEMS

The problems related to women's reproductive health have taken a serious turn for the worse in Nigeria and many other African countries due to socio-economic reasons. Major among these problems are:

♀ **Sexually Transmitted Diseases (STDs):** The rate of sexually transmitted diseases is unacceptably high among women. A hospital-based survey in Ibadan showed that 641 or 60.9% of the 1,052 clients at the STD clinic of the hospital were female (Table 29). Three hundred and thirty-six or 52.42% of the women are married (Table 30); and a whopping 74.26% of them fall within the 21 - 40 reproductive age range (see Table 31).

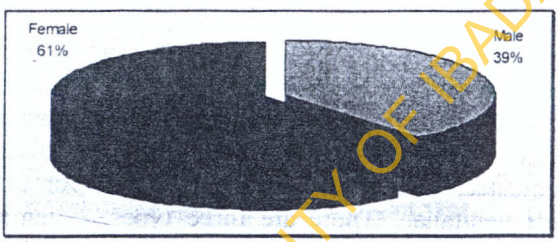

Chart 9: Attendance at STD Clinic by Sex

Sexually transmitted diseases are responsible for the frequent and troublesome disorders during the reproductive life of women. Many women experience vaginal discharge that they think is normal, but which are in fact telltale signs of STDs. The consequences of STDs include infertility, ectopic pregnancy, chronic pelvic pain, congestive dysmenorrhoea, menstrual disorders, and increased risk of foetal wastage and of HIV/AIDS.

♀ **Teenage Marriage and Pregnancy:** In some cultures in Nigeria, especially in the northern parts, young girls of 14 years of

[127] Laban, A.R., Mtimavalye, M. B. (1992), *Journal of Obstetrics and Gynaecology of East and Central Africa*, Vol. 1, No. 48.

age and thereabouts are forced into early marriage to men much older than them, men who have had or still have multiple sex partners. From the outset, the young female is open to the risk of contracting an STD from her husband. This early marriage also leads to early pregnancy in an ill-matured reproductive system, resulting in very great discomfort for the teenage mother. Often, pregnancy complications and or complications at delivery increase. The high incidence of Vesico-Vaginal Fistula (VVF) in northern Nigeria can be explained by the high incidence of teenage pregnancy.

♀ **Rape:** Rape is a sexual offence more often than not against a woman. Male rape victims are usually adolescents assaulted by adult males. Of 50 cases of sexual abuse studied by Aderibigbe in 1995, 38 (or 76%) were carried out by adult males against juvenile females under 18 years of age.[128] The victims were physiologically battered and this battering had implications for their reproductive health. They also stood higher chance of contracting STDs, becoming pregnant or undergoing abortion.

♀ **Female Genital Mutilation (FGM):** Female genital mutilation, a harmful traditional practice, happens in 20 African countries, Nigeria inclusive, and Sudan having 95% of her women genitally mutilated.[129] FGM, by means of which women's sexuality and reproduction is manipulated, can be defined as the partial or total removal of the female genitalia. There are three types of female genital mutilation:

- Clitoridectomy - partial or total removal of the clitoral prepuce.
- Excision - removal of the clitoris and, parts of the labia minora.
- Infibulation - removal of the whole clitoris, the whole of the *labia minora* and medial parts of the *labia majora*, leaving only a small opening - for urinating and menstruation. This is the worst type of mutilation.

[128] Aderibigbe, T., (1996) "Women's Rights: Law and Practice in Nigeria," in Layi Erinosho *et al* (eds.) *Women's Empowerment and Reproductive Health*, (Social Science And Reproductive Health Research Network), Ibadan.

[129] Toubia, Nahid (1995) "Female Genital Mutilation," in *The Network*, (bulletin of the Social Sciences and Reproductive Health Research Network), Number 2, December.

The age of mutilation or circumcision varies from three months to 17 years or just about the first pregnancy (Roberts, 1995). Possible complications include haemorrhage, infection, urinary retention, bladder and fistula formation, perennial lacerations at delivery or obstructed labour or need for anterior episiotomy. Female genital mutilation places a great strain on the reproductive health of the woman, as well as on the already inadequate health facilities in the country, while its benefits are doubtful.

♀ **Maternal Mortality:** Maternal mortality is a term used to describe the death of a woman during pregnancy, labour or the first six weeks of delivery. Statistics indicate that Nigeria has one of the highest rates of maternal mortality - 1,050 out of every 100,000 births compared with a rate of 2 - 6 of every 100,000 in developed countries like Sweden, the UK, the USA and Canada (Okonofua, 1996).

In a ten-year review of the trend of maternal death at the University of Benin Teaching Hospital, there were 144 maternal deaths out of 17,400 deliveries or a rate of 827 per 100,000 births. Death among these women occurred in 28% of the cases during pregnancy, 24% during labour, and 48% in the post delivery period (Orhue, 1996). The most frequent medical causes of death were haemorrhage (39%), unsafe abortion (31%), infection (15%), eclampsia (8%), and ruptured uterus (3%).[130]

A trend towards an increasing rate is in fact indicated by recent UNICEF projections.

♀ **Family Planning/Contraception:** The term "family planning" often encompasses two distinct concepts - contraceptive use and family planning services. Contraceptive use refers to any means by an individual or couple to avoid pregnancy, allowing women to meet their practical and strategic needs by enabling them to control how many children to have and when. Family planning services are organised services to provide contraceptive methods and ensure their

[130] Orhue, A.A.E., (1996), "Trends in Maternal Mortality At the University of Benin Teaching Hospital: A Ten Year Review", in *Women's Health Forum* (a publication of Women's Health and Action Research Centre, WHARC), Vol. 1, No. 3, December.

safe and effective administration. There are two major ways of planning the family - through artificial contraception and through natural family planning (NFP) methods. Many women in Nigeria have been found to employ artificial contraception with about 90% of the users using the Intra-Uterine Contraceptive Device (IUCD) and the pill. These methods are generally safe if they are used appropriately and by healthy women. But the reality is that many women are not healthy. Many of the women are not free of the health conditions such as Trichomas, candida, bacterial vaginosis, anaemia, and pelvic inflammation.

In the case of the IUCD, for example, the moment of insertion is crucial. A woman must be free of contraindicated conditions and insertion must be done under aseptic conditions to prevent the development of infections. Follow up must be regular and continuous, as a woman with an IUCD is more at risk of reproductive track infections (RTLs). For the pills, screening at first prescription and monitoring are necessary to ensure that the woman does not have contraindicated conditions. However, the reality in Nigeria today is that many users of the IUCD are not free of the contraindicated conditions, the aseptic environment needed for insertion is not present, and follow-up is neither regular nor continuous. In a survey carried out by this writer, it was found that many nurses carry out the IUCD procedure on willing clients in rooms within their houses whose conditions are far from aseptic. In addition, these nurses pay very little attention to the health conditions of their clients before insertion, the primary goal being their own monetary benefit. The Family Planning Clinic of the University Teaching Hospital, Ibadan, corroborated some of the findings of this writer. Apart from rendering family planning services, the clinic trains service providers. According to clinic officials, the private practice of many nurses it has trained, originally for service in the hospitals that sponsored their training, has caused a decline in consumer attendance at the clinic.

The pill is sold anywhere and everywhere, even in the market place by illiterate women who have very limited knowledge of the dynamics of screening and prescriptions.

The pill and the IUCD have implications for the reproductive health of the woman. Reproductive tract infections (RTLs) can be

aggravated by the presence of an IUCD. Lower tract infections may be spread to the upper tract, climbing up the thread of the IUCD, with serious health and fertility consequences to the affected woman.[131] The IUCD in a woman with cervical ectopy can lead to increased discharge, causing discomfort to the woman. This can further irritate the surface of the cervix, thereby aggravating the ectopy.[132] The IUCD can also intensify cervical cell changes when those changes are already present.

The IUCD causes greater menstrual flow, the increase being greater, ironically, for women with anaemia, thus aggravating their condition.[133] The IUCD can make genital prolapse, particularly the serious form, more uncomfortable. Moreover, because genital prolapse results in congestion of the genital organs, an IUCD may also lead a woman with prolapse to experience more than the usual increase in menstrual bleeding.[134] The danger that an infection in the urinary tract may spread to the reproductive tract is increased in the presence of an IUCD because it lowers the resistance of the genital organs.

The pill on the other hand is contraindicated for older women, those with high blood pressure, and for some suffering obesity. This is because of the risk these conditions contribute to the occurrence of cardiovascular disease. Through hormonal mechanisms, the pills

[131] Wasserheit, J.; Holmes, K., (1992), "Reproductive Tract Infections: Challenges For International Health Policy Programmes and Research", in A. Germane, K. K. Holmes, P. Piot, and J Wasserheit (eds.), *Reproductive Tract Infections: Global Impact and Priorities for Women's Reproductive Health.* New York: Plenum Press, pp. 7-33.

[132] Wasserheit, J.; Harris, J. R.; Chakraborty, J.; Kay B. A.; Mason, K., (1989), "Reproductive Tract Infections In Family Planning Population In Rural Bangladesh," *Studies In Family Planning*, Vol. 20 No. 2, pp. 69-80. See also Bang, Baitule et al, 1989.

[133] Zurayk, K., et al. (1993) "Concepts and Measures of Reproductive Morbidity," *Health Transition Review*, Vol. 3, No. 1 pp. 17 - 40.

[134] See Muir and Belsey, 1980.

might aggravate the conditions of cervical ectopy, and of suspicious cervical cell changes when these changes are already.[135]

A woman who is liable to some of the health conditions reviewed under reproductive health above, should possess some rights and should be protected by law to exercise these rights in order to help her have quality life. However, more often than not the reverse is the case.

APPRAISAL OF WOMEN'S REPRODUCTIVE RIGHTS UNDER CUSTOMARY LAW AND PRACTICE

Right is defined in law as: "An interest recognised and protected by the law, respect for which is a duty and disregard of which is a wrong." Reproductive rights were conceived at the ICPD Cairo Conference as embracing existing human rights as contained in the declarations of the 1993 Vienna World Conference on Human Rights. They include respect for the security of the person and the physical integrity of the human body as expressed in human rights documents.

Going back to the broad definition of right, the reality is that customary law in Nigeria does not recognise "an interest" called women's reproductive rights. Thus it has no respect for it as a duty and does not see disregard of it as a wrong. It is at the customary law level that the most intense exploitation of women's reproductive rights takes place. It is at this level throughout the world that women are taken advantage of most by their male counterparts. Under customary law in Nigeria, a woman cannot say "No" to her husband's sexual advances. If she is reported by her husband to her family she is in trouble, and the same fate awaits her if he report her to his own family. More often than not, no one wants to listen to her reasons for refusal Rather she is subjected to long sermons and reprimand by either her own mother, her mother-in-law, elderly relations on either side, or even her friends who may get to know about the issue. The reasons, which may hinge on health problems, are not given hearing

[135] Zurayk, Huda; Younis, Nabil; Khattab, Hind; "Rethinking Family Planning In Light of Reproductive Health Research," *The Policy Series In Reproductive Health, No. 1,* Cairo: The Population Council Regional Office for West Asia & North Africa, 1994.

and the woman may be looked upon as one who wants to break her own marriage.

Under both customary law and practice, and the *Criminal Code* (1990), the woman may in essence be raped by her husband since the law allows him to have sexual intercourse with her without her consent. This situation is not peculiar to Nigeria as this was also the position under the Common Law in England until the case of *R vs. R (Husband), 1991.*[136]

Under the *Penal Code* (1990) applicable in northern Nigeria a husband is permitted to chastise his wife for various offences, including refusal of conjugal advances as long as the chastisement does not amount to grievous bodily harm. Section 24 of the *Penal Code* defines grievous bodily harm as permanent deprivation of the power of sight, hearing or speech, disfiguration of the head or face, or hurt which causes the woman to be within or during a space or 21 days in severe bodily pain or unable to follow her ordinary pursuit. The case of Mrs. Hayishat B. illustrates the implications of this law. This 24-year old housewife and mother of two told her husband, Haruna, on December 15, 1992 that she was not in a position to respond to his sexual advances due to ill health. Hayishat was beaten up by her husband, who the following day filed a charge against her in the Customary Court. When the case came up for hearing, the presiding lay magistrate blamed Hayishat for not telling her husband of her ill health during the earlier part of the day, thus failing to prepare him for the possibility that his sexual urges will not be satisfied later. The lay magistrate appealed to Haruna not to divorce Hayishat, but to give her a second chance. He then asked Hayishat to beg her husband, and fined her some amount.

Many cultures in Nigeria are in support of family planning. In fact, there were in use over 12 traditional methods of family planning before the introduction of modern methods of contraception. Nevertheless, under customary practice the woman requires the consent of her husband before using any of the methods. The same often also applies concerning the use of modern contraception. The

[136] *R. vs. R. (Husband)* (1991), 2. A. B! R. 257.

woman is seen as not having a right to regulate her fertility or monitor her reproductive health without the husband coming in as a major deciding factor. The husband can take any step to deal with his wife, as illustrated by the case of Bolade who had had five children, three of which came at unplanned periods. Fearing to get pregnant soon again, she begged her husband to allow her insert the IUCD. After three months without a positive response, and with her fear mounting, Bolade had the IUCD inserted. Two days after, the husband felt the IUCD thread, asked Bolade what it was, and forcefully pulled out the device. In pain and bleeding, Bolade was rushed to the Family Planning Clinic at the University College Hospital, Ibadan, where the device had been fixed.

In considering the health implications enumerated earlier under the use of the IUCD and pills, it is obvious that the use of these methods does not promote the reproductive health of women. Rather, it likely result is a high rate of reproductive morbidity. In terms of reproductive rights, where is the right the woman enjoys in her reproductive status if she alone, not *she and her husband*, must use those artificial family planning methods? Right, according to Little, Fowler and Coulson (1955) connotes "That which is consonant with equity or the light of nature, that which is morally just or due."[137]

Where is the equity or the moral justification - and in essence the right - if the woman alone is subjected to all the possible risks enumerated in our consideration of the IUCD and the pill. The reproductive right of the woman is thus injured, hampered, and unfulfilled if she has to use artificial family planning methods. This is where the Natural Family Planning (NFP) method gains advantage over the artificial methods. Since it is natural, the risks are eliminated; into the bargain, it has been highly reliable.

Discriminatory laws that prohibit pregnant schoolgirls from continuing their education should be repealed, more so, when the same fate does not befall male student who father children. The two "offenders" should be given punitive measures. The shame of carrying a pregnancy out of wedlock, and the discomforts associated

[137] Little, W. Fowler, H. W., Coulson, J., *The Oxford University Dictionary on Hospital Principles*, 3rd Edition, Oxford: Clarenton Press, 1995.

with the different periods of gestation are enough punishments for the girl. The boy or man should also face the music in some way.

Customary practices that allow a man to have multiple sex partners jeopardise the reproductive health of a woman, since this risk factor has been linked to a high incidence of STDs. This practice is also discriminatory against the reproductive rights of women and it must be discouraged.

Very few cases of rape ever get to the courts. Most rape victims as earlier mentioned are adolescents assaulted by adults. These adults at times are people well known to the juveniles and their families. Because most Nigerian cultures frown at exposing family members or friends who commit crimes, the families of rape victims and the victims themselves shroud these cases in secrecy, rather than expose the offenders. This customary practice is a great infringement on the woman's reproductive rights. Little regard is given to the physical and, especially, psychological trauma suffered by the victim's: the paramount concern of the families is often the protection of the family name and honour. In the few cases that get to the juvenile or customary courts, it is found that the lay magistrate are not trained lawyers, but usually retired, respect and mature members of the society. They are, therefore, only expected to use their innate intelligence and wealth of experience to deal with these types of crimes. Their rulings are often not in conformity with the law, and, thus, not satisfactory in enforcing the rights of the women. Even cases that get to the High Courts do not fare any better in ensuring that justice is done to the victims of reproductive tract abuse. The case reported by Aderibigbe (1995) brings out this last point succinctly. Ade, a 5-year old girl was gang-raped by four boys between the ages of 18 and 20 years. Ade was so physiologically battered that her uterus had to be removed. The trial lasted several months at the end of which the boys got away with light sentences ranging between a few months to two years imprisonment with options of fine. Of course, the fines were promptly paid since the boys were from educated elitist families.

POLICY RECOMMENDATIONS

Any policy recommendation on women's reproductive health and rights must have the family structure as the nucleus, and must be able to gain the support of the family if it must be effective. It is not as if women are totally ignorant of the violation of their reproductive health and rights, especially within the family and by means of customary law. They are held back from reacting and claiming their rights only by their attachment to the family structure. The average Nigerian woman cherishes the family and would suffer, endure and undergo great torture - physical, psychological, or sexual - to keep family ties intact. This partly explains why there are very few formal divorce cases. Again, when one looks at the customary courts, the presiding judges are themselves men, old men who want to maintain the status quo. What then should be done to influence the family setting to release its subtle, elusive but nonetheless powerful grip on the reproductive health and rights of women?

Two major things that readily come to mind are education and persuasion. Let there be education regarding women's reproductive health and rights at the family level. All men, women, and children must be educated about the issue. The education must be education in its wide and all embracing sense. Adequate and correct information about reproductive issues must be given. For the upcoming generation in school, the curriculum must be designed to include this issue, and as Emeke has pointed out,[138] the designing of the curriculum must be professionally carried out, and it should be multidisciplinary in approach. For the adult members of the society, the Adult and Mass Literacy Programme must take on this issue within its curriculum. For those not enrolled in adult literacy classes, other ways of reaching out to educate and inform them must be employed. The radio and the television can be employed. The education and information can be disseminated via specifically and deliberately commissioned songs, plays, and jingles. If the

[138] Emeke, E.A. (1996), "Promoting Adolescent Reproductive Health: Role of NGOs. Sex Education and Parental Care," Paper presented at the National Conference of Society for International Development (SID), University of Ibadan Conference Centre, March, pp. 5 -9.

government accepts this policy recommendation, the details of content and modalities of implementation can be easily worked out.

Another major policy recommendation should focus on the *development* of the woman. Development is a process that will raise the standards of living, make possible the gains from information and education, and eventually bring about a positive practice of health and reproductive rights among women. A similar recommendation was made at the 1974 Population Conference in Bucharest, though not directly concerning reproductive health and rights, but on an issue very much akin to it - population policy. Development is one way in which women can take control of their own lives and make choices possible. Without choices, a person can have little self-respect and cannot hold her destiny in her hands. This was the case of Mrs. Haruna as reported by Mrs. E.M. Alabi, a Senior Programme Officer with the Inter-African Committee (IAC) on traditional practices. Mrs. Haruna, mother of two surviving children out of five, was under her sixth pregnancy. She registered with a traditional birth attendant for her antenatal care. When she went into labour, the traditional birth attendant was contacted to monitor the progress and deliver her. However, her labour became prolonged with the baby lying transversely. The traditional birth attendant took a good decision by referring Mrs. Haruna to a hospital. However, she would not go because her husband who had gone on a business trip was not available to grant her permission to leave the house and she could not take this crucial decision on her own. Moreover, tradition did not allow any other person to give consent on behalf of her husband.

All pleas warning her of the consequences of delay were ignored. Mrs. Haruna was quoted as saying she would rather die and go to paradise than disobey her husband and go to hell. And so Mrs. Haruna died. By the time her husband returned from his journey, she had already been buried. This is a woman obviously in need of intellectual and psychological development to enable her make crucial choices.

With development also comes greater *economic empowerment*. Low income is another factor that affects women's reproductive health and the ability of the women to fight for and

claim their reproductive rights. Economic independence or empowerment is not merely poverty alleviation. Rather, it is access to a decently paid job, to productive resources, and to credit to establish a worthwhile business venture. Poverty and economic dependence have direct correlation with health and the exercise of one's rights.

Another policy recommendation is the *co-operative society approach.* In the co-operative society, members have an opportunity to contribute money and take loans to finance their causes. Women should come together, adopt the co-operative society approach with the sole aim of furthering the cause of women's reproductive health and rights. Women should contribute towards the maintenance of their own reproductive health and give financial support to any woman needing such help in matters of reproductive health and rights. Where a woman is being explicit regarding her reproductive rights, the co-operative society should present a formidable backing for her to rescue her, and even if it becomes necessary to fight a legal battle, the co-operative society should foot the bill.

This co-operative society approach can work very well at the grassroots and community level if the women are helped to gain the awareness. After all, the approach works in respect of some other women's issues at the grassroots level. For example, in the Ibo-speaking part of Delta State, if a woman is sent packing by her husband in unjust circumstances, the "Adas"[139] bring her back to her family with pomp and pageantry, singing songs deriding the man. The husband pays a heavy compensation if he wants his wife back. The same derision happens to the woman if she is at fault and is judged to have disgraced her family.

This writer's advocacy is that this type of approach should be extended to the issue of reproductive rights. However, women will need some level of persuasion from you and I to adopt this approach for the context in focus.

The last policy recommendation that will be made in this paper is that women's reproductive health and rights issues should be looked at from a *women-centred perspective.* To achieve this,

[139] These are the first-born females of her kindred

reproductive health and rights policy should go beyond providing family planning services only. Reproductive health services should be provided at an equal, if not higher, rate of subsidisation as family planning services. Part of the objective of these advocated reproductive health services will be to help couples realise their reproductive intentions, without coercing them into the government's population reduction programme. This provision of reproductive health services, complemented by more structural interventions, can have the dual advantage of enabling society achieve its goal of a reduced rate of population growth, while also enabling individuals and couple achieve their own goals of self-determined and healthy reproduction, and reproductive well-being.

CONCLUSION

Women are major reproductive agents. Thus, their reproductive needs, which have physical, medical, economic and legal dimensions, must not be neglected since these needs have profound implications for the sustenance of human society. They must be treated with the respect they deserve.

Women must be accorded their reproductive rights and customary law must see the respect for these rights as a duty and their disregard as a wrong. The family structure must be positively influenced to give protection to women's reproductive rights and health. Education, persuasion, development, economic empowerment, the co-operative society approach, and a women-centred approach to reproductive issues are some policy recommendations worth considering in achieving women's reproductive rights. ♀