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Reproductive Health and Rights: The Case of Northern Nigerian Hausa Women

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THIS PAPER LOOKS at some of the socio-cultural and political factors that impact on women's reproductive health and rights and the context in which they can be exercised in Nigeria, with special emphasis on Northern Hausa women.

The United Nations defines reproductive health as: a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have capability to reproduce and the freedom to decide if, when and how often to do so.

Implicit in this definition is 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 child birth and provide couples with the best chance of having a healthy infant (ICPD para. 7:2).

Bearing in mind the above definition, reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights 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 the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (UN 1996:58-59).

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We find the definition of reproductive rights developed by the Women's Global Network on Reproductive Rights (WGNRR) quite apt:

> Reproductive Rights (RR) means women's rights to decide if and when and how to have children regardless of our nationality, class, race, age, religion, disability, sexuality or marital status (WGNRR).

We share the belief that reproductive rights encompass a number of rights: the right to control one's body and reproduction; and the right to information and access to a wide range of reproductive health care ranging from contraception, abortion, ante-natal care, postnatal care and other medical services; the right to adequate nutrition (throughout life); the right to maternity and family leave as well as the benefits of child care are also included. It is important to note that part of the rights of women to their bodily integrity encompasses the whole notion of the absence of violence against women, rape and all other forms of sexual abuse which are on the increase world-wide (Ilumoka 1992).

There is a dearth of information on the reproductive rights and health of women in Nigeria. Where information is available it is incomplete or dated and not disaggregated. This in itself points to the lack of importance accorded to women's reproductive health. Good data collection and collation for policy formulation are essential to programming successfully. We argue that this is one of the factors that has contributed to women's lack of attainment of their reproductive health rights. We feel that policies both locally and internationally have failed to take account of women's needs. The lack of proper information and correct data only serves to worsen the situation in terms of policy formulation, implementation evaluation and monitoring.

Nigeria, with a population of 88.5 million (1992 Census),[1] is a complex, multi-religious, multi-cultural society. The country is broadly divided into the Muslim North, the Christian South-East and the mixed South-West, although indigenous religions are practiced in all the states. Politically, the country is divided into 36 states and a Federal Capital Territory (Abuja). Over 65 per cent of the population resides in the rural areas. Agriculture is the major occupation in rural communities while the informal sector is largest in urban areas. Ethnic, regional, gender and religious interests, as well as occupational affiliations, are important demarcations in Nigeria (Pearce 1992).

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1 The March 1992 census result figures is far below all projected figures that have been used nationally and internationally.

Overview

There are numerous social and cultural regulations which govern the lives of girls and women. Whereas the specific practices vary by region and ethnicity, generally socialisation patterns place enormous restrictions on girls, and demand from them a higher input of daily domestic labour than from boys. Moreover, females are frequently denied the same quantity and quality of food as their brothers. Given the well-known links between childhood deprivations and reproductive health, many health problems including stunting of the pelvic region, anaemia and susceptibility to infections can be traced to the lowered nutritional status of girls. Additionally, insufficient rest and other practices impact on girls reproductive health (Pearce 1992:14-15).

The situation of young girls in Nigeria cannot be fully understood without reference to the problem of early marriage. This occurs mostly in the North but also exists within some Muslim communities in the South. Young girls may be betrothed as early as the age of 11, and begin childbearing by the time they are 13 or 14 years old. The physical and psychological trauma is known to be immense and the problem of vesico-vaginal fistulae from prolonged obstructed labour remains critical in this situation. The maternal mortality rate of 21 per 1000 in the North is well above the national average and is partly related to the consequences of early marriages (Pearce 1992:16).

Hausa women in the rural areas are predominantly Muslim, have little or no formal education, and live in seclusion[2] (seclusion will be discussed in more detail below). They are also usually married before they attain menarche, which means child bearing starts even before a women is fully grown. Islam has exerted tremendous influence on their economic social and cultural life. Existing literature on the economic activities of Hausa women has shown that their participation in the household economy is fashioned by the influence of orthodox restrictive Muslim interpretations. In the rural communities of the Samaru environs a majority of the women are living in seclusion, hence all economic activities are performed within the confines of their homes. Anything that

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2 Seclusion is the practice that prohibits women from going outside their homes or domestic space. Seclusion ranges from forms where when a woman/girl is allowed out with her husband's permission to cases where she is not allowed out under any circumstances (for example, medical personnel are brought to the home when she is sick). Seclusion is widely practiced parts of northern Nigeria amongst the Hausa and a few communities among the Yoruba. See Imam 1994.

requires leaving the home is usually done by the children, such as hawking and marketing to purchase items (Imam 1992).

The gender division of labour is even more evident as the man provides most of the food, water, fuel-wood, some housekeeping money and shelter for the family. The woman is responsible for providing small amounts of food, labour for food preparation, child bearing and rearing as well as the care of the family in general. Once both husband and wife are able to fulfil their duties, the wife can, if permitted by the husband, pursue her own income generating activity (Longhurst 1985).

Existing social institutions like the family, religion, political and the legal system assign women an unequal position in society *vis-à-vis* men.

Community Culture

Early marriage is widely practiced in Hausaland. The usual explanation given for this is that it prevents promiscuity in young girls and as such a man has the right to marry off his ward or daughter to any man he thinks suitable without her consent (Muazu 1992). In many cases, the girl is too young to understand what is happening to her and is thus presented with an accomplished fact, even though there is religious injunction governing marriage. This Hadith[3] states:

> If a man gives his daughter in marriage in spite of her disagreement, such a marriage is invalid. A matron should not be given in marriage except after her consent and a virgin should not be given in marriage except after her consent (Hadith 5136 Chapter 42, Vol. VII, Sahih Al-Bukhari).

In northern Nigeria, which draws heavily on Maliki Law, a father is allowed to marry his daughter against her will. The argument is that she is too young to know her own mind, yet. Ironically she is not perceived as too young to bear and take care of children, a husband and a home.

In a typical scenario the young girl, between the ages of 10 and 15 years, is married off to a man old enough to be her father or grandfather who already has other wives. The man is allowed to use force when consummating the marriage: Some men even resort to incising, that is the cutting or puncturing of their young wives with a sharp object or blade to allow penetration. The forced penetration of the bride does enormous and lasting physical and psychological harm. The young girl is, in fact, usually raped. Although Nigerian law does not recognise marital rape it is still rape, but a man can do whatever he likes with a woman as

3 A Hadith is one of the religious texts of Muslims being a collection of the sayings of the Prophet or actions of his life.

long as they are married. Marriage is a legal cover under which a man may commit whatever atrocities he has a mind to, short of killing the woman.

There is documentary evidence that premature sexual intercourse is responsible for the high rate of carcinoma (cancer) of the cervix commonly seen in Hausa women, and it is believed that the number of cases would be reduced tremendously if sexual intercourse and pregnancy were delayed. There is a higher rate of anaemia, pre-eclampsia/eclampsia (acute blood poisoning with convulsive fits at time of child birth), and a high mortality and morbidity rate associated with teenage pregnancy (Ejembi 1990). These young girls, being children themselves, are physically and emotionally immature and unprepared for the stress of pregnancy and childbirth.

The 1982 Nigeria fertility survey (NFS) showed the mean age for marriage of women between 20-24 years of age to be 16.1 years. 24.3 per cent of the women surveyed were married before the age of 13; 37 per cent of them were 14 years old and over 50 per cent had reached the age of 15. If this figure is disaggregated, in northern Nigeria the average age for marriage is much lower. In a study conducted in Zaria, a predominantly Muslim Hausa/Fulani community, the prevalence of early marriage was confirmed. It was found that 83.4 per cent of the girls were married before the age of 14 years and 98.5 per cent before the age of 20 years (Ejembi *et al.* 1986).

These young girls who are neither fully physically nor psychologically developed end up pregnant but too small to allow the foetus to be delivered vaginally. Consequently, they suffer obstructed labour; labour which could last as long as two weeks. In the absence of surgical intervention the result is the death of the baby, and or vesico vagina fistulae (VVF), recto vagina fistulae (RVF), or both for the mother (Tahzib 1989:75).

There is also a high incidence of divorce among the Hausa, with women marrying more than once, sometimes thrice or more in their lives. This can be attributed to the fact that it is socially considered an abomination for a woman to die unmarried. We would like to argue that this is a method of coping with unbearable situation so as not to give the impression that women are passive. Contrary to this women have been known to do what is called *yaji* (which literally means pepper) where a women just gets up and leaves her matrimonial home for her parents home until, she is either divorced or her husband comes to do *biko* and ask her to come back.

The practice of seclusion or in Hausa *(Kulle)*,[4] in Hausaland, has come to be viewed as religious, although, there is evidence to show that female seclusion was a pre-Islamic custom elsewhere e.g. Persia. The practice of seclusion is associated with the spread and practice of Islam in northern Nigeria. Imam argues that there are three main positions on seclusion within Islam. The first, a more restrictive position, holds that women should not be allowed outside their homes. The second that women go out only if covered from head to ankles and wrist. The third, a more flexible type, women are allowed to go out as long as they are decently dressed, in this case the manner of dress is subject to place, time, and social context (Imam 1992:4-18). There is no clear Islamic injunction on female seclusion. In fact contrary to the general beliefs surrounding the practice women are allowed to pursue careers outside their home as illustrated in a Hadith where the Prophet said: *You have been allowed by Allah to go out for your needs (Hajah) (Bukhari 1976(7):120).*

Imam argues that the introduction of seclusion in Hausaland occurred around the fifteenth century. Seclusion was actually practiced by the *masu sauraita* or ruling class and upper class *mallami* (religious clerics) and later intensified during colonialism as a form of resistance to external domination (Imam 1994:200).

The Hausa culture of *Kunya* (modesty or shyness) ensures that girls are socialised to be shy and obedient. Therefore, issues relating to sex, sexuality and childbearing are considered taboo and not to be discussed. It is a Hausa custom for women to give birth at home in private, the traditional birth attendant (TBA) is called afterwards to cut the umbilical cord and clear up after the woman has had the child, except in the case of complications. Even when there are complications, generally nobody will dare to take the woman to the hospital, as a wife in seclusion cannot leave her matrimonial home under any circumstance without her husband's express permission. It is the men who are responsible for making the vital decision about seeking medical treatment or even hospitalisation for their wives and other members of their family. In a recent study conducted in Bassawa, 41 per cent of the respondents said their husbands would not allow them to attend ante-natal services; 38 per cent did not see the need for it, while the rest complained about the cost, quality of care and rudeness of hospital staff (Ejembi 1990).

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4 Seclusion is not a monolithic institution, it varies from community to community. It is also not synonymous with isolation (See Imam 1994 and others).

It is important to note that Hausa households, like other Nigerian households, are patrilineal and patrilocal: in essence there is largely unquestioned male dominance in the home. The main role assigned to the wife is that of reproduction and care of the family. A woman must submit herself to her husband whenever he desires to have sex as, according to the common Muslim belief in the area, if she denies her husband herself any time, God and all the angels will curse her. She is made to believe that, for her, paradise is under her husband's feet. In Nigeria male promiscuity is condoned, while a women must be a virgin at the time of marriage and remain faithful to her husband. Polygyny is the commonest form of marriage. In a survey of Zaria, 70.2 per cent of the women were found to be in polygynous unions. 42 per cent has two or more co-wives. The man who is *permitted*[5] up to four wives often still has sexual relations outside his matrimonial home and this exposes women to sexually transmitted diseases (STDs), a major cause of infertility in both men and women. However, when a couple is childless the blame is automatically put on the woman. With the stigma around STDs women are not likely to seek medical attention, often until it is too late.

Another Nigerian cultural practice very common among many groups in Nigeria is *female circumcision*,[6] a form of female genital mutilation (FGM). This practice where a traditional healer cuts off part or whole of the female external genitalia. It may be performed anytime from the first few days of life to the seventh month of the first pregnancy. It is still widely practiced in some communities, for instance, the Igbo, Yoruba, Urhobo, Edo, and Efik while on the decrease in some Hausa communities. Among the Hausa communities the *Sunna* type of FGM is practiced. This is considered the mildest form, where the prepuce of the clitoris (or the hood) is amputated rather than infibulation which is the complete cutting of the external genitalia and suturing, which is found in, for instance, in parts of the Sudan.

Lightfoot (1983:356-60) argues that FGM is a result of men's desire to gain control over women's sexuality. By amputating the clitoris, sexual freedom in women would be curbed. Existing patriarchal systems dictate that a woman can only marry one man, while at the same time allowing men the right to have

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5 There are differing views on the practice of polygyny in Muslim law. While it is permitted in some countries like Nigeria, it is prohibited in Tunisia and restricted in Yemen and India.

6 The term female circumcision is a misnomer, in medical terms what is a mutilation of a healthy organ rather than circumcision (Dorkenoo 1995:4-5).

several women. This restriction of women is coupled with sanctions meted out to women who dare transgress, all in an effort to preserve the male lineage. Entrenched myths, and beliefs help perpetuate the practice. The most common myths are that circumcision prevents promiscuity, and safeguards virginity, cleanliness and health. In so far as families are anxious to have their daughters acceptable for marriage, women usually do not question the custom, even though they may have suffered some of the health consequences themselves. Thus, both mother and daughter suffer in silence.

The health effects of FGM range from death as a result of infections or haemorrhaging, to infertility and obstetric complications, to abscesses and fevers. FGM is often cited as evidence of the powerlessness of women: their health continues to be sacrificed to satisfy the interests of others. FGM also reveals the ways in which women of different generations within the family and community often maintain opposing interests.

Gishiri cuts, a form of FGM widely practiced among the Hausa, is a traditional surgical cut whereby incisions are made in the vagina with a blade. This is done usually by a traditional health practitioner or a TBA, and is a procedure used to treat a number of ailments including obstructed or prolonged labour, coital difficulties, infertility, and painful intercourse (dsyuria). This too is another harmful cultural practice, and also a cause of VVF and RVF with their harmful social side effects. Women with VVF or RVF are ostracised from society. This is because of the stigma attached to the condition. Even when a women has had the repairs done she is still considered to be suffering from the condition, and thus she is often divorced by her husbands who no longer desire her. A lot of VVF victims end up as prostitutes trying to earn enough to pay for the repairs (Tazhib 1992). At the Ahmadu Bello Teaching Hospital (ABUTH) Zaria, which is a government owned health facility and cheaper than most, if not all, other (privately owned) health facilities, the cost is not less than N6000.00 for a single repair operation. Some women require anything from two to ten operations, depending on the extent of the damage.[7]

Women's Reproductive Health

It has been conclusively established within Nigeria that during the reproductive years, those most likely to suffer disability or death are those who have children early, high parity (five or more births) and late pregnancy. The early, continuous and late pregnancy syndrome has made Nigeria one of the most problematic

7 From personal discussions with doctors at the ABUTH Zaria, 1996.

regions of the world in the area of reproductive health. The regional differences in total fertility rates observed in 1981/2 have persisted into the 1990s. Thus, fertility is higher in the North with women bearing children earlier and later than women in the South.

By 1988, the nation had officially accepted the safe motherhood concept as an important approach for tackling the problems associated with pregnancy and childbirth. Some of the objectives of safe motherhood were incorporated into the national Policy on Population, particularly the emphasis on discouraging childbirth before age 18 or after 35 years of age, and on health education for fertility regulation or 'responsible parenthood'. Other national activities on safe motherhood have included information campaign workshops, professional conferences and Family Life Education Programs.

Health Coverage

An important dimension of reproductive health, though transcending it, is the provision of adequate health and welfare facilities serving women. In Nigeria, as part of the colonial legacy, but persisting since independence there is a pronounced unequal distribution of health facilities. The rural population, which make up 65 per cent of the total populace has access to only 30 per cent of the health services. With much pressure from non-governmental organisations (NGO) and interested groups, governments in the past have made some attempts at redressing the situation, but with the Structural Adjustment Program (SAP), the situation has worsened for the average Nigerian. The level of utilisation of health facilities is an indicator of health coverage. For 1989 there were 597 State and Local Government health institutions and 207 private ones in Kaduna State. In the 1989 Federal Office of Statistics (FOS) survey only 15.1 per cent of both urban and rural sample areas was within 1 km from a health facility. It must however be noted that there does exist an urban bias: 64.8 per cent of those in the urban areas had to travel 1-5 km, while 66.2 per cent of those in the rural areas had to travel over 10 km to the nearest health facility. At the same time it was found that a great majority of people residing in the rural areas (80.6 per cent) had not received any treatment for illness or injury within the last 14 days of the survey.

Kaduna State, like other states, has made attempts at implementing Primary Health Care (PHC), which is the provision of basic health care to all. Over the years it has set up a number of basic health centres aimed at bringing health care as close as possible to the community. Maternal Child Health (MCH) is a very important component of PHC. In 1985 54, 842 women received ante-natal care. In 1986 it had risen to 55,437. As of 1989 there were a total of 60 such health institutions in Kaduna State.

Table 1: Percentage of Distribution of Respondents by Distance from Health Facility, Who pay for Treatment and for Drugs, by Sector

	Urban Per Cent	Rural Per Cent
A. Distance from Health facility		
Less than 1 km	15.1	14.1
1 - 5 km	64.8	5.6
6 - 10 km	17.0	14.1
Over 10 km	3.1	66.2
	100.0 (358)	100.0 (234)
B. Whether pay for Treatment		
Yes	65.1	27.1
No	34.9	72.9
	100.0 (475)	100.0 (489)
C. Whether pay for Drugs		
Yes	68.6	29
No	31.4	71
	100.0 (490)	100.0 (460)

Source: UNICEF 1989:32

Maternal Mortality and Morbidity

The incidence of maternal mortality in Nigeria is reputedly one of the highest in Africa. Out every 100,000 women of childbearing age, 1,500 die from complications related to pregnancy. This comes to 70-80,000 Nigerian women in absolute numbers, which works out at about 1 women in absolute numbers, which works out at about 1 women dying every 10 minutes. In a study at ABUTH Zaria, 46 per cent of all deaths in 1987 were of women, while the

proportion was 44.2 per cent at the Kaduna branch of the hospital in the same year. Due to the lack of figures on live births it was impossible to determine the maternal death rate.

Statistics from the Kaduna State Health Management Board also showed that in 1986 women's death represented 53.4 per cent of total deaths, and in 1987 57.1 per cent. Similar to the situation in the ABUTH study, calculation of maternal death rate was not possible. Data from the Ministry of Finance does however show the rate of maternal mortality to be 7 per 1000 live births in 1986, and 2.6 in 1987 (see table 2). More recently ABUTH Kaduna and Zaria reported 10 maternal deaths each (7.34 per 1000 live births, and 6.8 per 1000 live births respectively) from July 1992 to June 1993 (see Table 3). Determining the exact cause of death was not possible because of the non-acceptance of *postmortem* examinations by the family of the deceased. However clinical conditions suggested sepsis and ruptured uterus with shock in Zaria and Kaduna respectively (ABUTH 1992, 1993). Information on the causes of maternal death round the state shows: *criminal* (i.e. Induced)[8] abortion, *ante partum* and *postpartum* haemorrhage and eclampsia as the major causes of death (UNICEF 1989).

Over 70 per cent of all deliveries are done under the supervision of TBAs. TBAs depend on skills passed down from generation to generation, practicing under unsanitary conditions which sometimes expose their clients to infections. Of 13,924 ante-natal bookings made at ABUTH Zaria from July 1991 to June 1992, only 1,456 delivered in the hospital. 23 per cent of these cases were emergency cases. From July 1992-June 1993 there was a total of 13,335 ante natal clinic bookings and a total of 1,472 deliveries: a slight increase from the previous year (ABUTH 1992, 1993). This shows a tendency for the hospitals to be used as a last resort, which can be partly attributed to the high cost of hospital fees. All this goes a long way in increasing the health risks for women within child bearing age.

8 Figures are not accurate as only a fraction of actual deaths are recorded. Many women die as a result of botched abortions and never make it to the hospital. More over, there is often no information on the several women who carry out abortions themselves, those who utilise private and smaller hospitals and those in rural areas (Population Council 1995:1).

Table 2: Maternal Mortality Ratio per 1000 Live Births, Kaduna State

Year	Total Live Births	Maternal Deaths	MMR
1985 a	114,382	804	7.0
1986	95,588	257	2.5

Source: UNICEF 1989: 61

Table 3: Maternal Mortality Rates from the ABUTHs Zaria and Kaduna, 1992-1993

Diagnosis	Zaria	Kaduna
Sepsis	5(50%)	-
Ruptured Uterus with Shock	-	4(40%)
Haemorrhage	2(20%)	-
Eclampsia	2(20%)	3(30%)
Anaemia	1(10%)	-
Post Partum Cardiac Failure	-	2(20%)
Obstructed Labour with Sepsis	-	1(10%)
Total	10(100%)	10(100%)

Source: Department of Obst. and Gyn., ABUTH, Zaria Annual Reports; 1992 and 1993

Fertility Regulation

The Hausa woman is expected to have as many children as 'God gives to her'. It is believed in some of these communities that a woman has a particular pre-ordained number of eggs which determines the number of children she has. In view of this, most women regard child-bearing as an obligation which they must fulfil to be complete. These women are unknowing of the numerous risks involved in constant child bearing some of them find out too late. Even when they are aware, they have no rights to complain under the watchful eyes of their husbands, parents and in-laws. It is considered sacrilegious for a woman to purposely prevent conception, after all God will provide. It is in line with this

dictate that a childless woman is regarded with pity and sometimes even contempt. Children, like the number of a man's wives, are a testimony of his wealth and capabilities, consequently, a lot of women who use contraception, do so secretly, without their husband's permission.

Male control of women's reproduction is reinforced by State policies. For instance, there are some State and Local Governments which insist on women coming with their husbands or that they must have written permission from husbands before they can receive any contraceptive device. There are however a number of health personnel (usually female) in hospitals and clinics in the urban areas who are sympathetic and willing to accept consent forms even when they know or suspect it is not from a woman's husband. It is not uncommon for women to get consent forms signed by people other than their husbands, all in an effort to control their own reproduction. At the same time these women are forced to use long-lasting contraceptives such as two or three monthly injectables like Deprovera, even when it was banned in the West, because these methods are not easily detected by their husbands. They use these methods often without knowledge or complete information about the side effects and possible long term complications (Usman 1991).

Table 4: Usage Rates for Family Planning in Nigeria (average prevalence) 1992

Zone	Use any Method		Use any Modern Method	
	June	September	June	September
Nigeria	16.3	20.2	8.7	10
Northeast	5.8	6.5	3.8	5.7
Northwest	12.8	11.6	6.3	5.4
Southeast	35.1	40.3	16.5	17.9
Southwest	19.6	19.4	10.7	10.9

Source: FOS (1992) Family Planning

While the utilisation level of modern contraceptive devices is quite low, women in Nigeria continue to use the age old autochtonous methods of contraception. As at September 1993, only 20 per cent of women of reproductive age used family-planning; 10.4 per cent used modern methods. The percentage of women who used modern methods was 5.7 per cent Northeast, and 5.4 per cent

Northwest. The majority of women rely on traditional methods. This can be explained by the fact that they have had control over the access of this knowledge.

Conclusion

The importance of a conceptual framework for women's reproductive health and rights, which views women in their totality can not be over emphasised. Women are burdened with domestic, economic and health-care roles through out their life cycle, all of which impact on their health. In addition, the low status of females within the household and beyond, leads to work overload, the neglect of personal health and the lack of appreciation of female contributions to the survival of others. Reproductive rights in whatever context must incorporate all women's economic, political, legal, educational, and general health concerns.

Nigerian women suffer a disproportionate lack of access to comprehensive reproductive health care. They face a number of socio-cultural and religious barriers as well as legal barriers in a patriarchal society, where male promiscuity is condoned. It is clear that for average Hausa women in northern Nigeria reproductive rights is one of the many basic human rights that they have been denied. Women's reproductive capacity and sexuality are not theirs to control but subject to family household authority extended (mother-in-law) and otherwise. It is also subject to political manipulation by those in authority. Policies aimed at improving gender and power relations are only palliative. Any discourse on reproductive health needs to question the stereotyping of motherhood and fatherhood and the gendered roles of men and women which places less values of the roles of women.

Issues like rape and other forms of sexual abuse are often swept under the carpet. This is a mere reflection of the way society views the arena of male and female relationships and their rights and responsibilities. This is further compounded by the lack of, or poor and enforcement of legislation in relation to sexual abuse and violence against female children/minors; for example, the practice of early marriage and female genital mutilation in Nigeria (SIDA 1994).

While advocating that there is a need to improve the over all status of women, policy aimed at improving the conditions of women through the lowering of fertility offers very little to women by way of support. In fact what tends to happen is the reinforcing of the already oppressive situation they are in. A genuine policy is one that empowers women, enables them take full control of their destiny, part of which is the direction of their sexuality and reproduction. Nigerian women and women in general, need to carve out a perspective that suits them in the context of their religious and culturally different societies. A

perspective which is distinct at the same time of one that fits within the global struggle defined by ourselves.

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