REALISING ACCESS TO CONTRACEPTION FOR ADOLESCENTS IN NIGERIA: A HUMAN RIGHTS ANALYSIS

THESIS SUBMITTED IN ACCORDANCE WITH THE REQUIRMENTS FOR THE DEGREE OF DOCTORS OF LAW IN THE DEPARTMENT OF CONSTITUTIONAL LAW AND PHILOSOPHY OF LAW FACULTY OF LAW UNIVERSITY OF THE FREE STATE

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Declaration

I, the undersigned, hereby declare that the work contained in this study for the degree of Doctor of Laws at the University of the Free State is my own independent work and that I have not previously in its entirety or in part submitted it at any university for a degree. I furthermore cede copyright of the thesis in favour of the University of the Free State.

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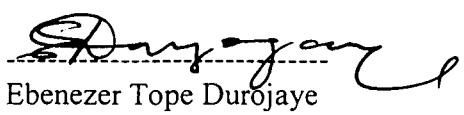

Ebenezer Tope Durojaye

Dedication

To the glory of the Almighty God the giver of immortal gladness and joy

SUMMARY

This study is an analysis of whether laws and policies made by the Nigerian government relating to access to contraception for adolescents are consistent with Nigeria's obligations under international human rights law. Adolescents, especially female adolescents, encounter challenges regarding their sexual health needs. For instance, more than half of those living with HIV in the country are female adolescents. Teenage pregnancy and the incidence of unwanted pregnancy are rife, leading to high cases of unsafe abortion. Nigeria is said to have one of the worst cases of unsafe abortion in the region. Moreover, the maternal mortality rate in Nigeria, estimated at about 1,000 deaths per 100, 000 live births, is one of the highest in the region. Most of the deaths occurring from pregnancy-related complications are among young women. Yet contraceptive use among this group is very low. Some of the factors restricting access to contraceptive information and services for adolescents include socio-cultural factors such as emphasis on chastity for female adolescents, negative attitudes on the part of health care providers and inconsistencies in laws and policies. Nigeria has ratified international and regional human rights instruments, including consensus statements, which obligate the government to take necessary steps and measures in realising access to contraceptive services for adolescents, especially female adolescents in the country.

Although Nigeria is not wanting in laws and policies relating to access to contraception for adolescents, gaps exist in these laws and policies as most of them do not specifically address the issue of adolescents' autonomy to seek contraceptive services, nor have they specifically addressed the needs of female adolescents. Therefore, the study is premised on the fact that, since female adolescents, compared with their male counterparts are more susceptible to sexual and reproductive ill health in Nigeria, it is necessary to pay more attention to their health needs than that of other groups in the country. Drawing from the experiences of feminist scholars, the study proposes that in analysing Nigeria's laws and policies relating to access to contraception for adolescents, the female adolescent question should be asked to ascertain how the interest of this group has been adequately catered for.

The study concludes by arguing that the Nigerian government has not demonstrated adequate political will in implementing existing laws and policies to ensure access to contraception for female adolescents. The government will need to embark on law reforms and awareness campaigns to remove barriers that restrict access to contraception for female adolescents. In addition, Nigerian courts will need to be more proactive in their decisions and adopt a purposive approach to interpreting the laws of the country to advance access to contraception to female adolescents. In doing this, Nigerian courts may need to ask the female adolescent question, which implies that decisions by Nigerian courts on cases bordering on the sexual health of adolescents must always reflect the lived experiences of female adolescents.

Key words: Adolescents, contraception, human rights, female adolescent question, Nigeria

OPSOMMING

Hierdie studie is 'n analise van die Nigeriese regering se wette en beleide rakende toegang tot voorbehoedmiddels vir adolessente om te bepaal of dit met die land se verpligting onder internasionale menseregte-wette ooreenstem. Adolessente, veral vroulike adolessente, kom voor uitdagings rakende hulle seksuele gesondheidsbehoeftes te staan. Byvoorbeeld, meer as die helfte van diegene in die land wat met MIV leef, is vroulike adolessente. Tienerswangerskappe en die voorkoms van ongewenste swangerskappe vier hoogty en lei tot hoë voorkoms van onveilige aborsie. Daar word beweer dat Nigerië van die ergste voorkoms van onveilige aborsie in die streek toon. Daarbenewens is die moedersterftesyfer in Nigerië, geraam op ongeveer 1 000 sterftes per 100 000 lewende geboortes, een van die hoogste in die streek. Die meeste van die sterftes wat weens swangerskapverwante komplikasies plaasvind, is onder jong vroue. Tog is die gebruik van voorbehoedmiddels in hierdie groep baie laag. Sommige van die faktore wat toegang tot voorbehoedingsinligting en -dienste vir adolessente verhinder, is sosio-kulturele faktore soos klem op kuisheid van vroulike adolessente, negatiewe houdings van gesondheidsorgverskaffers en onkonsekwenthede in wette en beleide. Nigerië het internasionale en streeks- menseregte-instrumente bekragtig, insluitend konsensusverklarings, wat die regering verplig om die nodige stappe te doen en maatreëls in te stel om toegang tot voorbehoedingsdienste vir adolessente, veral vroulike adolessente, te bewerkstellig.

Alhoewel Nigerië geen gebrek het aan wette en beleide wat met toegang tot voorbehoedmiddels vir adolessente verband hou nie, bestaan daar gapings in hierdie wette en beleide aangesien die meeste daarvan nie die kwessie aanspreek van adolessente se outonomie om voorbehoedingsdienste uit te soek nie. Die behoeftes van vroulike adolessente word ook nie spesifiek aangespreek nie. Hierdie studie gaan van die veronderstelling uit dat, aangesien vroulike adolessente in Nigerië in vergelyking met hulle manlike eweknieë meer vatbaar vir seksuele en voorplantingsverwante swak gesondheid is, dit nodig is om meer aandag aan hulle gesondheidsbehoeftes te skenk as enige ander groep in die land. Hierdie studie put uit die ervaring van feministiese vakkundiges en beweer gevolglik dat die analise van Nigerië se wette en beleide rakende toegang tot voorbehoedmiddels vir adolessente noodwendig die vroulike adolessent-vraag moet opper om sodoende te bepaal hoe daar vir die belange van hierdie groep voldoende voorsiening gemaak word.

Die studie sluit af deur te beweer dat die Nigeriese regering nie voldoende politieke wil demonstreer in die implementering van bestaande wette en beleide om toegang tot voorbehoedmiddels vir vroulike adolessente te verseker nie. Verder moet die regering wetshervorming en bewustheidsveldtogte onderneem om die struikelblokke tot toegang tot voorbehoedmiddels te verwyder, veral vir vroulike adolessente. Die Nigeriese howe moet ook meer proaktief wees in hulle besluitneming en 'n doelgerigte benadering aanneem om die landswette te interpreteer om toegang tot voorbehoedmiddels vir vroulike adolessente te bevorder. Om hierin te slaag, moet Nigeriese howe die vroulike adolessent-vraag vra, dit wil sê, besluite deur hierdie howe oor gevalle wat met seksuele gesondheid van adolessente verband hou, moet altyd die geleefde ervarings van vroulike adolessente weerspieël.

Sleutelwoorde: Adolessente, voorbehoedmiddel, menseregte, vroulike adolessent-vraag, Nigerië

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I have run the race fervently and I have fought the battle with all my might. Yet, neither strength nor victory belongs to man, but the Almighty God who is called 'great in battle'. To Him alone, all glory and honour belong.

Ebenezer Tope Durojaye
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LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and Peoples' Rights
ACRWC	African Charter on the Rights and Welfare of the Child
AIDS	Acquired Immune Deficiency Syndrome
ARH&D	Adolescent Reproductive Health and Development
ART	Anti Retroviral Therapy
CEDAW	Convention on the Elimination of Discrimination Against Women
CRA	Child's Rights Act
CRC	Convention on the Rights of the Child
CRR	Center for Reproductive Rights
CYPA	Children and Young Persons Law
DHS	Demographic and Health Surveys
EC	Emergency Contraception
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
FWCW	Fourth World Conference on Women
HCPs	Health Care Providers
HIV	Human Immunodeficiency Syndrome
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
MDGs	Millennium Development Goals
NGO	Non Governmental Organization
NPH	National Policy on Health
PEPFAR	President Emergency Plan Fund for AIDS Relief
PHC	Primary Health Care
PMCT	Prevention of Mother to Child Transmission
STIs	Sexually Transmitted Infections
UDHR	Universal Declaration on Human Rights

UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
US	United States
WACA	West African Court of Appeal
WHO	World Health Organization
WPOA	World Programme of Action

CHAPTER 1

AN OVERVIEW OF THE STUDY

1.1 Introduction

> Adolescent girls need, but too often do not have, access to necessary health and nutrition services as they mature. Counselling and access to sexual and reproductive health information and services for adolescents are still inadequate or lacking completely, and a young woman's rights to privacy, confidentiality, respect and informed consent is often not considered. [1]

Today, more than ever before in the history of humanity, adolescents constitute about half the population of the world. The number of adolescents worldwide is estimated at 1.1 billion (85% of them in developing countries). Half of this figure will have sexual intercourse by the time they attain the age of 16 and most of them by the time they are 20.[2] According to the World Health Organization (WHO), adolescents are people in the age group of 10-19 years, while young persons are within the ages of 15 to 24 years.[3] There is a high incidence of unwanted pregnancies in many developing countries. The World Health Organization (WHO) reports that of about 200 million pregnancies that occur each year, about 80 million are unwanted.[4] It has been estimated that about 10% of all pregnancies each year occur among teenagers.[5] Most of these pregnancies are either unwanted or unintended. Oftentimes, adolescents are forced to resort to clandestine and usually unsafe abortion methods to get rid of these pregnancies.[6] This is not only a traumatic experience for them, but can also result in loss of life. Indeed, complications

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[1] Beijing Declaration and the Platform for Action, Fourth World Conference on Women, China, September 4-15 1995, UN. Doc. A/CONF.177/20 1995 para 93.

[2] A Grunseit *Impact of HIV and Sexual Health Education on the Sexual Behaviour of Young People: A Review Update* (1997) 7.

[3] UNDP, UNFPA, WHO &World Bank Special Programme of Research, Development and Research Training in Human Reproduction *Progress in Reproductive Health Research* (2002) 1.

[4] World Health Organization (WHO) *A Tabulation of Available Data on the Frequency and Mortality of Unsafe abortion* (1994) 1.

[5] M de Bruyn & S Parker *Adolescents, Unwanted Pregnancy and Abortion: Polices, Counseling and Clinical Care* (2004) 7.

[6] FE Okonufua *et al* 'Attitudes and Practices of Private Medical Providers Towards Family Planning and Abortion services in Nigeria.' (2005) 84 *Acta Obstetericia et Gynecologica Scandinavica* 270.

due to unsafe abortions constitute close to 13% of maternal deaths worldwide.[7] Ensuring access to contraception for adolescents has a great potential to prevent some of the sexual health challenges that adolescents may experience.

Over the years, sexual and reproductive health needs of adolescents have continued to be ignored or treated with levity. This has resulted in unmet needs of adolescents' sexual health. One noticeable area of unmet needs is in regards to access to sexual health information and services, including contraceptive services. It is estimated that about 15 million adolescents within the ages of 15-19 years give birth annually.[8] The worldwide average rate for births per 1000 among young women in sub-Saharan Africa is put at about 143 compared to 25 and 59 in Europe and Central Asia respectively.[9] Equally, sexually transmitted infections (STIs), excluding HIV/AIDS, are the second most important cause of loss of health in women, especially young women.[10] Adolescents remain particularly susceptible to sexual and reproductive health problems due to the fact that they often experience unplanned sex and find access to health services difficult. Access to contraception can help in preventing unintended pregnancy, risks of pregnancy, STIs (including HIV/AIDS), and unsafe abortion among adolescents. Despite the importance of contraception to improving the health of women and girls, it has been found that knowledge and use of it is poor in many African countries.[11]

Whilst it is true that adolescents all over the world suffer from great neglect regarding their sexual health, the case of adolescents in sub-Saharan Africa is particularly worrisome. Available data with regard to the sexual and reproductive health conditions of adolescents in the region paint a very grim picture. For instance, young people within the ages of 15-24 constitute the greatest percentage of the estimated 23 million people living with HIV in the region.[12] Also, the greatest percentage of HIV/AIDS-related deaths in the region occurs among young people.[13] Moreover, high incidences of sexual violence are

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[7] DA Grimes *et al* 'Unsafe Abortion the Preventable Pandemic' (2006) 369 *Lancet* 1908, 1910.
[8] de Bruyn & Parker (note 5 above).
[9] World Health Organization (WHO) *Contraception Issues in Adolescents Health and Development*(2004).
[10] A Glasier *et al* 'Sexual and Reproductive Health: A Matter of Life and Death' (2006) 368 *Lancet* 1595.
[11] See for instance, United Nations *World Contraceptive Use 1998* (1999) 6.
[12] UNAIDS *AIDS Epidemic Update* (2008) 9.
[13] *Ibid.*

prevalent among adolescents in the region, especially in South Africa, where it is almost becoming an epidemic.[14]

Maternal mortality and/or morbidity associated with childbearing, a sadly preventable occurrence, remains a great threat to the lives of women, particularly young women, in Africa. While a woman's lifetime risk of dying during pregnancy in a developed country is put at about 1 in 2, 000, the lifetime risk of her counterpart in Africa may be as high as 1 in 16.[15] The major cause of maternal mortality among adolescents in the region is unsafe abortion. It is estimated that sub-Saharan Africa accounts for about 5 million (that is, about 25% of the total number worldwide) unsafe abortions every year.[16] In other parts of the developing world, deaths associated with unsafe abortion are estimated at 330 per 100,000 abortions. However, in Africa the figure is much higher at about 680 per 100, 000 abortions.[17] Ensuring access to comprehensive information and services on contraception for adolescents can prevent some of the sexual health challenges mentioned above. Sadly, however, despite the challenges facing adolescents worldwide, it has been observed that many governments have failed to take measures to adequately address the sexual health needs of young people, and access to comprehensive health care services for adolescents has remained acutely lacking.[18]

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[14] See for instance, Human Rights Watch *Scared at School: Sexual Violence against Girls in South African Schools* (2001) 21; see also South African Institute of Race Relations *South African Survey 2000* (2001)3.

[15] See World Health Organization (WHO) *Maternal Mortality in 1995* (2001) 42-47; See also RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (2003) 26.

[16] World Health Organization *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion in 2000* (2004) 6; S Singh 'The Incidence of Unsafe Abortion: A Global Review' in IK Warriner & IH Shah (eds) *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) 35-50; SK Henshaw *et al* 'The Incidence of Abortion Worldwide' (1999) 25 *International Family Planning Perspectives* 30-38.

[17] *Ibid* 15.

[18] G Barker & S Rich 'Influences on Adolescents Sexuality in Nigeria and Kenya: Findings from Recent-Focus Group Discussions' (1992) 23 *Studies in Family Planning* 199-210; JD Klein *et al* 'Adolescents and Access to Health Care' (1993) 70 *Bulletin of the New York Academy of Science* 219; DM Carter *et al* 'When Children have Children: The Teen Pregnancy Predicament (1994) 19 *American Journal of Preventive Medicine* 108.

1.2 The Situation in Nigeria

The majority of the about 140 million people in Nigeria are young people. The percentage of the Nigerian population under 15 years is approximately 40%.[19] It is estimated that women from the age of 15 years and above constitute about 2 million of the 4 million people living with HIV in the country.[20] The prevalence of HIV in the country, like in other parts of Africa, is three times higher in young women aged 15-24 years than their male counterparts.[21] The median age at first sexual debut among women between the ages of 15-24 years is put at 17 years.[22] This is an indication that adolescents in the country are likely to be exposed to sexual intercourse at an early stage of life. The rate of unwanted pregnancy among young people is very high, thus, leading to cases of unsafe abortions in the country. The end result is preventable loss of lives.[23] Indeed, it has been shown that unsafe, illegal abortion accounts for about 33% of all maternal deaths in the country.[24] Nigeria, with about 1, 000 deaths per 100,000 live births, is said to have one of the highest maternal mortality rates in the world.[25] Most of these deaths often occur among young women.

Generally, it is believed that the fertility rate among Nigerian women is very high. At the same time contraceptive use, particularly among young women, remains very low. For example, a study conducted among adolescents in Niger State in the northern part of the country has revealed that knowledge about contraception is around 35% to 63%, while use of contraception is put at about 0.7% to 12%.[26] This study further confirmed findings from earlier studies that adolescents in Nigeria usually become sexually active very early. Some studies have shown that about nine out of 10 male and female out of school

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[19] See Population Reference Bureau *2008 World Population Data Sheet* (2008) 2-11.

[20] UNAIDS 'Country Situation Analysis on Nigeria' available at http://www.unaids.org/en/Regions_Countries/Countries/nigeria.asp (Accessed on 8 May 2009).

[21] UNAIDS *Report on the Global AIDS Epidemic* (2009) 22.

[22] Federal Ministry of Statistics *National Demography and Health Survey* (2003) 14.

[23] See OM Ebuche *et al* 'Health care Provider's Knowledge of, Attitudes Toward and Provision of Emergency Contraceptives in Lagos, Nigeria' (2006) 32 *International Family Perspectives* 83.

[24] SO Ogunniyi & BL Faleyimu 'Trends in Maternal Deaths in Ilesa, Nigeria 1977-1988' (1991) 10 *West African Journal of Medicine* 400.

[25] WHO, UNICEF, UNFPA and World Bank *Maternal Mortality in 2005* (2007) 23.

[26] AM Sunmola *et al* 'Reproductive Knowledge Sexual Behaviour and Contraceptive use among Adolescents in Niger State of Nigeria' (2002) 6 *African Journal of Reproductive Health* 82.

adolescents[27] and 40% of adolescents in school in Lagos, become sexually active between ages 10 to 16 years.[28] This poses grave danger to the health and well-being of adolescents in the country. A more recent report has shown that the use of modern forms of contraception among sexually active female adolescents has increased in most parts of the country, but remains generally low.[29] It is estimated that the proportion of female adolescents using one form of contraception doubled from about 4% in 1993 to about 8% in 2003.[30] However, nearly one-third of sexually active young women aged 15-24 still had an unmet need for contraception at the end of 2003.[31] Several reasons account for low use of contraception among adolescents in the country. These include ignorance among adolescents, ignorance among health care providers and lack of youth-friendly health care services. Others are socio-cultural factors, negative attitudes by health care providers and an unfavourable policy environment.[32] These challenges underline not only the need for more information on adolescents' sexuality, but also accessible and youth-friendly health care services for adolescents. While it is agreed that the enactment of appropriate laws and policies may not necessarily address these challenges, there is no doubt that laws and policies can create an enabling environment for the realisation of access to contraceptive services for adolescents. For instance, laws and policies can facilitate access to sexual health information for adolescents and address discriminatory practices against adolescents in the health care setting.

Access to comprehensive sexual and reproductive health services for adolescents, particularly in the context of contraception, is important for a number of reasons.

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[27] See D Nichols *et al* 'Sexual Behaviour, Contraceptive Practice and Reproductive Health among Nigerian Adolescents' (1986) 17 *Studies in Family Planning* 100.

[28] BO Adenike & AO Omoboye 'Sexual Networking among some Lagos State Adolescent Yoruba Students' (1993) *Health Transition Review* 151; see also SC Ogbuagu & JO Charles 'Survey of Sexual Net-working in Calabar' (1993) *Health Transition Review* 105. This study reveals that adolescents in Calabar in the south-south of Nigeria become sexually active by age 15.

[29] G Sedgh *et al Meeting Young Women Sexual and Reproductive Health Needs in Nigeria* (2009) 12.

[30] *Ibid.*

[31] Federal Ministry of Statistics (note 22 above).

[32] See A Ilika & I Anthony 'Unintended Pregnancy among Unmarried Adolescents and Young Women in Anambra State, South East Nigeria' (2004) 9 *African Journal of Reproductive Health* 92; AO Arowojolu & AO Adekunle 'Perception and Practice of Emergency Contraception by Post-Secondary Students in South West Nigeria' (2000) 4 *African Journal of Reproductive Health* 56; see also AO Okpani & JU Okpani 'Sexual Activity and Contraceptive use among Female Adolescents: A report from Port Harcourt, Nigeria' (2000) 4 *African Journal of Reproductive Health*:40; O Alubo 'Adolescent Reproductive Health Practices in Nigeria' (2001) 5 *African Journal of Reproductive Health* 109.

Sustained investment in sexual health services for adolescents has the potential to prevent loss of lives and improve young people's health.[33] Information on sexual health helps adolescents, especially young adolescents who are yet to be sexually active, to delay sexual debut and take necessary precautions should they decide to engage in sexual activity. Moreover, access to comprehensive sexual health services, including contraceptive services, will help in preventing about one-third of sexual and reproductive ill-health prevalent among women of reproductive age across the world.[34] Also, it will help in satisfying the unmet need for contraceptive services among women, particularly unmarried women in developing countries (including Nigeria). This will, in turn, prevent about 52 million unwanted pregnancies all over the world, thereby saving 1.5 million lives.[35]

1.3 Focus of the Study

This study aims to analyse Nigeria's laws and policies, relating to access to contraception for adolescents with a view to determining whether or not they are consistent with the country's obligations under international human rights law. The study further highlights the need for the Nigerian government to adopt a rights-based approach to laws, policies and programmes relating to access to contraception for adolescents, paying special attention to the needs of female adolescents. The study aims to demonstrate that Nigeria, having ratified international and regional human rights instruments, has the obligation to take positive steps and measures with a view to realising access to contraception for adolescents (especially female adolescents), in the country. Thus, the thesis statement may be framed in this manner: a human rights analysis, using the concept of autonomy and feminist method of asking the female adolescent question can be useful in realising access to contraception for adolescents in Nigeria.

The main objectives of the study can be summarized as follows:

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[33] S Singh *et al Adding it Up: The Benefit of Investing in Sexual and Reproductive Health Care* (2004) 4-5.
[34] *Ibid* 5.
[35] *Ibid.*

(i) To appraise the relevance of a rights-based approach to sexual health matters such as access to contraception for adolescents in Nigeria;
(ii) To discuss the importance of the concept of autonomy in the realisation of access to contraception for female adolescents;
(iii) To evaluate the significance of the application of the female adolescent question as a method of realising access to contraception for adolescent girls in Nigeria;
(iv)To analyze the roles of the courts and other regional human rights bodies in the realisation of access to contraception for adolescents.

The research question for this study can be framed thus: is a human rights analysis useful in realising access to contraception for adolescents in Nigeria? The discussion that follows in this study will attempt to address this question.

Ever since the consensus statements and declarations made at the International Conference on Population and Development (ICPD) in Cairo[36] and the Fourth World Conference on Women in Beijing (FWCW),[37] both of which addressed the sexual and reproductive health of women, including adolescents, a wind of change regarding the protection of women's sexual and reproductive health, has blown across the globe (including Africa.). Nigeria has equally experienced this change. Over the years, the country has developed laws and policies that have implications for access to contraception for adolescents. Some of these laws and policies include the Constitution,[38] the Child's Rights Act,[39] the National Policy on Reproductive Health,[40] the Adolescents Reproductive Health Policy[41] and the National Policy on HIV/AIDS.[42]

However, certain discrepancies and inconsistencies exist in these laws and policies. For instance, the Child's Rights Act fails to include a provision relating to adolescents' right

[36] Programme of Action of the International Conference on Population and Development UN Doc.A/CONF 171/13 (1994).
[37] Beijing Platform (note 1 above).
[38] Constitution of the Federal Republic of Nigeria 1999.
[39] Child's Rights Act 26 of 2003.
[40] Federal Ministry of Health National Policy on Reproductive Health (2001).
[41] Federal Ministry of Health Adolescents Reproductive Health Policy (2007).
[42] Federal Ministry of Health National Policy on HIV/AIDS (2003).

to consent to treatment and is silent on issues relating to confidentiality of adolescents seeking health care services. In some situations, policies adopted by the Nigerian government would seem to contain elaborate provisions on access to contraception for adolescents than enacted laws. Such discrepancies may hinder access to contraceptive information and services for adolescents in the country, especially when one bears in mind that policies are not legally enforceable in Nigeria. Thus, this study will critically review these laws and policies with a view to determining whether they are consistent with Nigeria's obligations under international human rights law and whether they have addressed the needs of female adolescents.

In order to effectively evaluate laws and policies on access to contraception for adolescents in Nigeria, this study employs the concept of autonomy as a useful tool to measure whether laws and policies made by the Nigerian government are capable of facilitating or limiting access to contraception for female adolescents. In other words, the study seeks to review how the right to autonomy or self-determination of adolescents, especially female adolescents, in the context of access to contraception, has been adequately respected by laws and policies made by the Nigerian government. This review will be done bearing in mind that Nigeria has ratified international and regional human rights instruments which contain copious provisions that can be invoked to safeguard adolescents' access to contraceptive use in the country. Some of these instruments include, the African Charter on the Rights and Welfare of the Child (African Children's Charter),[43] the African Charter on Human and Peoples' Rights (African Charter),[44] the Convention on Elimination of All Forms Discrimination against Women (CEDAW),[45] the Protocol to the African Charter on the Rights of Women (Women's Protocol),[46]

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[43] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999).

[44] African Charter on Human and Peoples' Rights O.A.U. Doc.CAB/LEG/67/3/Rev.5 Adopted by the Organization of African Unity, 27 June 1981, entered into force 21 October 1986.

[45] Convention on the Elimination of All Forms of Discrimination against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

[46] Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005.

Convention on the Right of the Child (CRC),[47] one of the most widely ratified international treaties so far, and other relevant human rights treaties, consensus statements and declarations. These instruments guarantee core human rights, which can directly or indirectly be invoked to advance adolescents' right to seek and obtain services and information with regard to their sexual health.

Two of the above mentioned treaties, the CRC and the African Children's Charter, directly apply to the rights of adolescents. Both contain important provisions and principles such as the principles of the best interests of the child and the evolving capacities of the child, that are useful in ensuring access to contraception for adolescents. However, since the African Committee of Experts on the Rights and Welfare of the Child is still evolving, having just been constituted, the study will draw extensively from the wealth of experience of the Committee on the CRC in its interpretation and clarifications of the provisions of the CRC. The Committee, through its Concluding Observations on state reports and issuance of General Comments on specific rights and issues covered by the treaty, has addressed the sexual health needs of adolescents. For instance, the Committee has issued General Comments on specific issues such as Adolescents[48] and HIV/AIDS.[49] Although attention will be given to the CRC in this study, reference will be made to other relevant human rights instruments such as the CEDAW and the African Women's Protocol, which also contain important provisions that are useful in realising access to contraception for adolescents.

The study further discusses the important roles of courts and treaty monitoring bodies at international and regional levels in ensuring that female adolescents have access to contraception. It is believed that national courts through purposive interpretation of laws can remove barriers to access to contraceptive services for adolescents and advance their

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[47] Convention on the Rights of the Child. Adopted in 1989 U.N. Doc. A/44/49 entered into force Sept. 2, 1990.

[48] Committee on the Rights of the Child, Adolescents health and Development in the context of the Convention on the Rights of the Child , General Comment N0 4 CRC/GC/2003/4 Thirty-Second Session May 2003.

[49] Committee on the Rights of the Child, HIV/AIDS and the Rights of the Child, General Comment N0 3 CRC/GC/2003/3 Thirty-Second Session 2003.

sexual health and rights. Moreover, regional human rights bodies, such as the Expert Committee on the Rights of the Child, (through its promotional mandate of examining states' reports and protective roles of receiving individual communications on the violations of the right of the child), can help states parties to effectively realise access to contraception for female adolescents.

1.4 Gender Dimension of the Study

The focus of this study is on unmarried female adolescents, who are daily susceptible to sexual health challenges. The need to pay attention to this group has become imperative because of the patriarchal nature of the African society, which often compromises the sexual health needs of female adolescents. In a conservative and religiously polarised society such as Nigeria, where attempts are often made to subjugate women's freedom and fundamental rights, ensuring access to contraception for a female adolescent may be as challenging as a camel passing through the eye of a needle. Gender inequality is pronounced and often the norm rather than the exception in the daily lives of women and girls in Nigeria and many other African countries. Socio-cultural practices and religious tenets often combine to elevate men above women and suppress women's sexual autonomy. A corollary of this is denial of access to essential sexual and reproductive health care services (such as contraceptive services) for women in general and young women in particular. It is pertinent to mention here that section 42 of the Nigerian Constitution prohibits discrimination on the grounds of sex.[50] The implications and relevance of this provision to realising access to contraception for female adolescents is examined in detail in other parts of this study.

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[50] Section 42 (1) provides as follows:
A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person:-
(a) be subjected either expressly by, or in the practical application of, any law in force in Nigeria or any executive or administrative action of the government, to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions or political opinions are not made subject; or
(b) be accorded either expressly by, or in the practical application of, any law in force in Nigeria or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religions or political opinions.

It has been noted that gender inequality can damage the physical and mental health of millions of women and girls across the world.[51] Therefore, due to the large number of people involved and the seriousness of the problems, taking appropriate steps and actions to improve gender equity in the health sector and addressing women's right to health becomes one of the most important and direct ways of minimizing inequities in health and ensuring effective use of health resources.[52] Gender relations of power constitute one of the root causes of gender inequality and are among the most influential of the social determinants of health. Adherence to human rights principles and standards can become a powerful way of addressing the challenges posed by gender inequality.

Over the years, issues related to gender inequality and the subordination of women's rights to those of men have received the attention of feminist scholars across the world. Feminists have criticised the gender-neutral approach of laws generally, including human rights law, to discriminatory practices women encounter daily in their lives.[53] Bunch notes that poor understanding of women's rights as human rights is reflected in the fact that only few governments are committed, in domestic or international policy, to women's equality as basic human rights.[54] She argues further that this separation of women's rights from human rights has further entrenched the secondary status of women and highlighted the need to recognise specific women's human rights challenges.[55] Based on this, she suggests that there is a need for transformation of human rights from a feminist perspective. Such a transformation must not just emphasise on 'what has been called "women issues" but must also attempt at moving women from the margins to the center by questioning the most fundamental concepts of our social order so that they take better account of women's lives'.[56] She sums up her argument by saying that 'as long as

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[51] G Sen & P Ostin *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health Why it exists and how we can change it* (2007) viii.
[52] *Ibid.*
[53] See for instance, H Charlesworth 'Human Rights as Men's Rights' in J Peters & A Wolper (eds) *Women's Rights, Human Rights: International Feminist Perspectives* (1995) 103; see also H Charlesworth & C Chinkin *Boundaries of International Law* (2000).
[54] C Bunch 'Transforming Human Rights from a Feminist Perspective' in J Peters & A Wolper (eds) *Women's Rights, Human Rights: International Feminist Perspectives* (1995) 12.
[55] *Ibid*.
[56] *Ibid* 11.

any group can be denied its humanity, we are all vulnerable to human rights abuse'.[57] Similarly, Cook has called for a re-characterisation of human rights principles and standards so as to reflect the peculiar needs of women.[58]

These comments are very important and reinforce the need for the Nigerian government to always put female adolescents at the centre of laws, policies and programmes developed or adopted with regard to ensuring access to contraception for adolescents in the country. Thus, this study will adopt one of the methods of feminist scholars, 'asking the woman question' or 'asking the Nigerian female adolescent question', to address the challenges facing female adolescents as regards access to contraception in the country. In other words, the study will ask whether laws, policies and programmes enacted or developed by the Nigerian government have accommodated the peculiar life circumstances of the female adolescent. Asking the female adolescent question will enable one to critically review, from women's rights perspective, the gender implications of laws and policies formulated by the Nigerian government to ensure access to contraception for adolescents.

It should be noted that biological factors and lack of agency often render women more susceptible than men to sexually transmitted infections (STIs), including HIV/AIDS. This accounts for the fact that female adolescents bear the greatest burden of sexual and reproductive ill-health in many African countries, including Nigeria. As earlier stated, deaths resulting from pregnancy-related complications, unsafe abortions and high incidence of HIV are rampant among female adolescents in the region.[59] One need not be reminded that sex and society interact to determine who is well or ill, who is treated or not, who is exposed or prone to ill health and how and whose health risks are acknowledged or ignored.[60] Additionally, when an unwanted pregnancy occurs, it is the adolescent girl that carries the blame, shame and other associated repercussions. For

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[57] *Ibid* 12.
[58] RJ Cook 'Women's International Human Rights Law: The Way Forward' in RJ Cook (ed) *Human Rights of Women: National and International Perspectives* (1995) 5.
[59] See for instance, F Juarez *et al* 'Introduction to the Special Issues on Adolescent Sexual and Reproductive Health in Sub-Saharan Africa' (2008) 29 *Studies in Family Planning* 239-244.
[60] Sen & Ostin (note 51 above) 6.

example, she may have to abandon schooling, drop out to support herself and become stigmatised as a never-do-well in society.

Oftentimes, the responsibilities for maintaining sexual health, avoiding STIs, unwanted pregnancies and even proving fertility are usually placed on the door steps of adolescent girls.[61] Unfortunately, there is an erroneous belief or lack of understanding that adolescent males do not have a part to play in all these issues. The truth of the matter is that men and boys do have great roles to play in advancing the sexual health needs of female adolescents. However, this study will not dwell so much on this issue as it is beyond its scope. It is important to bear in mind that any attempt at realising access to contraception for adolescents must adopt a gender-sensitive approach. As mentioned earlier, this study borrows from feminist experiences by adopting the method of asking the female adolescent question to critique laws, policies and programmes enacted or developed by the Nigerian government with regard to access to contraception for adolescents. Just as in the case of 'asking the woman question' developed by feminist scholars to challenge the gender-blindness of laws, policies and decisions relating to women, asking the female adolescent question challenges the gender-neutral nature of laws, policies, programmes and decisions relating to access to contraception for adolescents in Nigeria. In sum, asking the female adolescent question enables policy makers or decision makers to put the female adolescent at the centre of all decisions taken in relation to access to contraception for adolescents

It is believed that this approach will help in eliminating discriminatory practices against women in general and adolescent girls in particular. Also, the method can facilitate unrestrained access to information and services for adolescent girls with regard to their sexuality. In addition, it must focus on prevention and treatment of diseases that affect women only, and adopt policies that will facilitate access to a wide range of quality health services, including sexual and reproductive health services, to women.[62] With

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[61] N Taffa *et al Adolescents Sexual and Reproductive Health: Review of Currents Facts, Programmes and Progress since ICPD* (1999) 5.

[62] R Cook & S Howard 'Accommodating Women's Differences under the Women's Anti-Discrimination Convention' (2007) 56 *Emory Law Review* 1052.

specific regard to female adolescents, laws and policies relating to contraceptive services must aim at removing barriers such as need for parental consent, non-respect for privacy and confidentiality and issue of cost which may deter female adolescents from seeking such services.

Experience has shown that women, particularly young women, have continued to bear the greatest burden of reproductive ill-health not only in Nigeria but the world at large. A UN report has estimated that women's reproductive health problems are about 36% of their health life compared to only 12% risk in men.[63] It has been observed, and rightly in our mind, that women have continued to die or suffer morbidity from sexual and reproductive health-related problems not because the world lacks the technology or know-how to address these problems, but because there is lack of political will to address the problems.[64] Unless this gender dimension is addressed, efforts made at facilitating access to contraception for adolescents may fail to achieve the desired aims.

While it is recognised that female adolescents are the burden bearers of sexual and reproductive ill-health in Nigeria, unmarried more than married female adolescents are more affected. Studies conducted across the country have shown that due to the idiosyncrasies of unmarried female adolescents they tend to engage in unprotected sex and are prone to unwanted pregnancy.[65] Moreover, certain cultural beliefs such as chastity and emphasis on virginity tend to put pressure on unmarried adolescent girls and sometimes compromise their sexual and reproductive health. Due to these beliefs, adolescent girls may shy away from seeking information or services relating to contraception for fear of being thought to be sexually active. All these factors would seem to justify the need to pay more attention to the sexual health needs of unmarried adolescent girls and to facilitate access to contraceptive information and services for them. This must include a respect for their privacy and confidentiality to seek sexual

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[63] United Nations Population Information *Network Report Guidelines for United Nations Resident Coordinators Systems* (1995) 7.

[64] A Rosenfield & C Maine 'Saving the Mothers' Strategies to Reduce Maternal Deaths' in *Countdown 2015: Sexual and Reproductive Health and Rights for All: Special Report: ICPD at Ten: Where are We Now?* (2004) 84.

[65] See Alubo (note 32 above); see also Adenike & Omoboye (note 32 above).

health services, particularly contraceptive services This point was aptly summed up at ICPD when governments noted that 'since in all societies discrimination on the basis of sex often starts at the earliest stages of life, greater equality for the girl child is a necessary first step in ensuring that women realize their full potential and become equal partners in development'.[66]

1.5 Methodology

The study is a desk-based research involving critical and systematic analysis of available material and literature on the subject matter. It relies extensively on information from primary and secondary sources such as national constitutions, legislation, policy documents, books, journals, court decisions, international human rights instruments and internet sources. Attempts are made to synthesize discussions on the philosophical concept of autonomy with the human rights definition of the term. The study explores the philosophical meaning of the concept of autonomy and then discusses the relevance of the right to autonomy for the realization of access to contraception for adolescents. Moreover, the study adopts the method of 'asking the female adolescent question' as the basis for critiquing Nigeria's laws, policies and programmes relating to access to contraception for adolescents.

Although Nigeria is the center-piece of the discussion, the study will draw lessons and experiences from other commonwealth jurisdictions such as South Africa, and the United Kingdom. The United Kingdom and Nigeria share the same common law legal system. While it is recognized that South Africa is a Roman-Dutch law jurisdiction, its laws share some similarities with that of Nigeria. This is because both countries were colonized by Great Britain. Moreover, Nigeria and South Africa are both sub-Saharan African countries with similar challenges regarding sexual health issues such as high incidence of teenage pregnancy and HIV/AIDS. Nigeria is only second to South Africa in terms of the number of people living with HIV in Africa.[67] The fact that in recent times South Africa

[66] ICPD (note 36 above) para 4.15.
[67] UNAIDS *AIDS Epidemic update* (2006) 6.

has developed a number of positive laws, policies and programmes to address some of the sexual health challenges facing adolescents in the country, makes it an ideal reference point in Africa. Moreover, there have been a number of important judicial decisions in South Africa and Britain on adolescents' sexual health which can be useful as reference points for Nigerian courts

In addition to South Africa and Britain, reference will be made to other jurisdictions, where necessary, to highlight best practices with regard to steps and measures taken to realise access to contraception for adolescents. This is essential since no nation can claim to be 'an Island unto itself'.[68] Drawing experiences from other jurisdictions will provide one with relevant information on how a similar challenge has been dealt with in those jurisdictions. It also provides a good platform for observing best practices and how such practices can be adapted to the Nigerian situation, where necessary. While it is recognised that a comparative study may have its limitations, especially when one considers the differences in socio-economic and cultural settings of countries being compared, nonetheless, it remains a very useful approach in identifying gaps in the development and implementation of laws, policies and programmes relating to adolescents in a particular country. It may also help in providing necessary information to measure a country's commitments to fulfilling its obligations under international human rights law.

1.6 Clarification of Concepts

A study on realising access to contraception for adolescents will no doubt have implications for the enjoyment of both sexual and reproductive health of adolescents. This is so when one considers the link between the two concepts. The notion of reproductive and sexual health gained worldwide recognition during the ICPD and the FWCW. At the ICPD, reproductive health was widely defined in the following way:

> 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

[68] This expression was made popular by renowned metaphysical poet J Donne in his poem 'To Whom the Bell Tolls'.

> functions and processes. 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 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. 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 enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.[69]

This detailed definition of reproductive health, which was later affirmed at the FWCW, would seem to have subsumed the concept of sexual health under reproductive health. The ICPD further described reproductive rights to include the 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. Reproductive rights also include the right to attain the highest attainable standard of sexual and reproductive health, which embraces the right to make decisions concerning reproduction free of discrimination, coercion and violence as already expressed in human rights documents.[70] From this definition, sexual rights would seem to have been conceived as part of reproductive rights. This has tended to blur the difference between the two. This approach has been criticised by some scholars as relegating the importance of sexual health to the background. For instance, Miller argues that while the ICPD raised to certain extent the profile of sexual health and rights, they were not truly promoted as fundamental rights in themselves but merely as a sub-set of reproductive health and rights.[71]

While it is noted that the concept of reproductive health over the years has captured the attention of the world, sexual health is more or less a recent development. As an evolving

[69] ICPD (note 36 above) para 7.2.
[70] *Ibid.*
[71] AM Miller 'Sexual but not Reproductive: Exploring the Junction and Disjunction of Sexual and Reproductive Rights' (2000) 4 *Health and Human Rights* 76-77.

issue, it has become a subject of controversy and constantly sparked debate across the world. This is so because issues relating to human sexuality are still generally viewed with suspicion and disapproval. In most countries where religion and culture play a great role in the lives of the people, issues of sexual health have been treated with kid gloves. Recently, however, the World Health Organization (WHO) has been focused on finding a working definition of sexual health. This definition comprehensively describes sexual health in the following words:

> Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.[72]

Similarly, an attempt was made at defining sexual rights broadly as embracing human rights that have already been recognised in national and international human rights documents, including consensus statements. They include the rights of all persons, free of coercion, discrimination and violence to;

> the highest attainable standard of sexual health, including access to sexual and reproductive health care services;
> seek, receive and impart information related to sexuality;
> sexuality education;
> respect for bodily integrity;
> choose their partner;
> decide to be sexually active or not;
> consensual sexual relations;
> consensual marriage;
> decide whether or not, and when, to have children; and
> pursue a satisfying, safe and pleasurable sexual life.[73]

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[72] World Health Organization (WHO) *Defining Sexual Health, Report of a Technical Consultation on Sexual Health* (2006) 5.
[73] *Ibid.*

No doubt from the definitions provided above, there would seem to be a link between sexual and reproductive health and rights. In other words, though the two concepts are distinct, nonetheless they are interrelated. However, Miller has observed that despite the broad attempt to define sexual health and rights, this attempt fails to engage fully with sexuality as a political and public construct through which sexual behaviours are given meaning and judged. [74] Exploring the linkages between the two concepts, Dixon-Muller[75] prior to Cairo, attempted to divide the elements of reproductive health care into two categories- sexual health and reproductive health-each with specific components. For sexual health, its components include protection from STIs, protection from harmful practices and violence, control over sexual access, sexual enjoyment and information on sexuality. On the other hand, the components of reproductive health include safe, effective protection from (and termination) of unwanted pregnancies, contraceptive choice and satisfaction with method, protection from harmful reproductive practices, safe pregnancy and delivery, contraceptive and reproductive information and treatment of infertility. She further submits that these components are shaped by characteristics of society at large rooted in 'social and economic institutions that determine power hierarchies and life choices based on gender, age, class, ethnicity and other distinctions; and by ideology of gender (and other differences) that each system elaborates'.[76]

Undoubtedly, a discussion on access to contraception for adolescents will intersect with the components of both sexual and reproductive health as outlined above by Dixon-Muller. This is because access to contraceptive services can help in preventing unwanted pregnancy, unsafe abortion, prevent transmission of STIs, including HIV/AIDS and reduce fertility rates among women generally. However, this study will focus more on the sexual health implications of denial of access to contraception for adolescents rather than its reproductive health challenges. Since unmarried adolescents form the subject matter of

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[74] See A Miller *Sexuality and Human Rights* (2009) 9, she argues further, while this definition focuses on individual bodies, it does not enumerate list of rights refer to as public and participatory rights –rights to advocate, to assemble, organise and call for change. Moreover, she asserts that emphasis was placed on sexual health information above other important forms of information (such as literature, cinema, art and other kinds of information) relevant in advancing individuals' sexuality.

[75] R Dixon-Muller 'The Sexuality Connection in Reproductive Health' (1993) 24 *Studies in Family Planning* 277.

[76] *Ibid* 276.

this discussion, it is important to explore how they can engage in sexual activities that will be free from coercion and unpleasant consequences.

Miller has rightly contended that a discussion on sexual health and rights goes beyond traditionally held notions of reproduction and heterosexuality.[77] Rather, such a discussion embraces diverse groups of people and issues including homosexual and heterosexual and reproductive and non-reproductive sexual activities. She particularly argues that limiting sexual relations to procreation alone will lead to the 'disappearance' of certain categories of people such as gay and lesbian and those who merely engage in sex for pleasure.[78] Miller's observation, which has received the support of Ngwena,[79] is quite pertinent for our discussion on realising access to contraception for adolescents. As studies have shown, adolescents in many countries become sexually active at an early age and may wish to engage in safe and pleasurable non-procreative sexual acts. Hence, the need to assure them the means of protection from negative consequences which this may bring.

1.7 Relevance of a Rights-based Approach to the Study

Several studies that have been conducted on health needs of adolescents have often focused on exploring public health care approaches to resolving the problems and challenges adolescents encounter in accessing treatment, including access to contraception. Most of these studies hardly lay emphasis on the relevance of applying human rights principles to hold governments accountable.[80] The application of a human rights-based approach to issues such as access to contraception for adolescents can act as a catalyst to advancing adolescents' sexual and reproductive health.

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[77] Miller (note 71 above) 86-87.
[78] *Ibid.*
[79] C Ngwena 'Sexuality Rights as Human Rights in Southern Africa with Particular Reference to South Africa' (2002) 17 *South African Public Law* 1.
[80] See for instance, N Low *et al* 'Global Control of Sexually Transmitted Infections' (2006) 368 *Lancet* 2001.

It should be borne in mind that realising access to contraception for adolescents forms part of the right to health guaranteed in several human rights instruments. Some of these instruments include article 25 of the Universal Declaration on Human Rights (UDHR),[81] article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[82] and article 12 of the Convention on Elimination of All Forms of Discrimination against Women (CEDAW).[83] Others include article 16 of the African Charter on Human and Peoples' Rights (African Charter)[84] and article 14 of the Protocol to the African Charter on the Rights of Women (African Women's Protocol).[85] However, the most authoritative of these instruments is article 12 of ICESCR, which guarantees the right to the highest attainable standard of health to every one. It similarly recognises the importance of other determinants of health such as drinkable water, nutritious food and clean environment to the enjoyment of this right. The Committee on the ESCR has observed that the right to health imposes the obligation on states to respect, protect and fulfill the right.[86] The extent of these obligations with regard to the sexual health needs of adolescents, especially as regards access to contraception, is considered in greater detail in Chapter 7 of this study.

It is recognised, however, that applying the language of human rights to issues as access to contraception for adolescents may sometimes be problematic. This is often due to the debate about human rights and cultural relativism and the uncertainty that sometimes surrounds the meaning of a rights-based approach. Indeed, skeptics of a rights-based approach to women's issues have argued that such an approach hardly ever yields positive results in the long run. They cite, as an example, the issue of female genital cutting/mutilation (FGC/M), which over the years has been addressed as a human rights

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[81] Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. Doc. A/810 (10 December 1948).
[82] International Covenant on Economic, Social and Cultural Rights, adopted 16/12/1966; G.A. Res 2200 (XXI), UN. Doc A/6316 (1966) 993 UNTS 3 (entered into force 3/01/1976).
[83] Convention on Elimination of All Forms of Discrimination against Women GA Res. 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.
[84] African Charter (note 43 above).
[85] Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005.
[86] The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/ para 33.

violation but has nonetheless, continued unabated. Tushnet[87] for instance, observes that recourse to the use of the language of human rights may add a rhetorical flourish to an argument, but provides merely an ephemeral polemic advantage often obscuring the need to explore political and social change. It is further contended that the individualism often promoted by traditional rights-based approach limits its possibilities by overlooking the relational aspect of life.[88] Tushnet's comments are germane to this study as they tend to remind us of the challenges that may arise in advocating for the right to sexual autonomy for adolescents in the context of contraception.

Smart, on different occasions, has similarly noted that attempts to utilise rights rhetoric in legal fora merely serve to empower the law and to reinforce its empire.[89] She notes further that resort to human rights law does not provide the key to unlock women's oppression. Other writers have argued that while the formulation of the right to equality may be useful in improving the position of women in society, a continuing reliance on rights principles may not after all be beneficial to women, as women's experiences and challenges are not easily transposed to a narrow rights-based language.[90] Moreover, rights discourse unduly simplifies complex power relations and their promise may be affected by structural inequalities of powers.[91]

While it is admitted that a rights-based approach to issues affecting women, including access to contraception, may not necessarily be the only solution, it nonetheless, remains a powerful tool in the international arena. This is because women in most societies operate from a very disadvantaged position, thus rights discourse offers a powerful language to frame political and social wrongs (such as human rights violations).[92] Adopting a rights-based approach to issues relating to access to contraception for female adolescents has the advantage of identifying who to hold responsible for violation of

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[87] M Tushnet 'An Essay on Rights' (1984) 62 *Texas Law Review*1371.
[88] See M Tushnet 'Rights: An Essay in Informal Political Theory' (1989) 17 *Politics and Society* 410.
[89] See for instance, C Smart *Feminism and the Power of Law* (1989)1-4; see also, A McColgan *Women under the Law* (2000).6.
[90] R West *'Feminism*, Critical Social theory and Law' (1989) 59 *University of Chicago Legal Feminism* 84.
[91] E Gross 'What is Feminist Theory?' in C Pateman & E Gross (eds) *Feminist Challenges: Social and Political Theory* (1986) 190-204.
[92] H Charlesworth 'What are Women's International Human Rights?' in RJ Cook (ed) *Human Rights of Women National and International Perspectives* (1995) 58-84.

women's and girls' rights. In particular, it places a duty on the state to ensure that adolescents' rights are respected, protected and fulfilled. Indeed, Fathalla *et al* have noted that respect for the fundamental rights of women is a key factor to empowering women.[93] For many individuals and groups, human rights principles can be empowering in that they provide means by which they can legitimately assert their interests.[94]

A rights-based approach to an issue such as access to contraception for adolescents not only offers a compelling argument for a state's accountability to ensure access to health care facilities, but may also help to ameliorate conditions that 'create, exacerbate, perpetuate poverty, deprivation, marginalization and discrimination'.[95] Potts has noted that accountability in the context of the right to health refers to the process, which provides individuals and communities with an opportunity to understand how a government has discharged its right to health obligations.[96] It also provides a government an opportunity to explain what it has done and why. Moreover, it requires a government to provide redress where mistakes have been made. In other words, it is a process that identifies which law, policy or programme that has worked so that it can be institutionalized and what is not working so that necessary amendments can be made.[97] Gruskin has noted that though the term 'right-based' approach has been subject to different interpretations, nonetheless, it has precipitated a robust discussion on the rights-based discourse and has kept this field 'alive and well'.[98] The World Health Organization (WHO)[99] has explained that a rights-based approach to a health programme entails the following;

(a) Using human rights as a framework for health development;

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[93] M Fathalla *et al* 'Sexual and Reproductive Health for All: A Call for Action' (2006) 368 *Lancet* 2097.
[94] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (2003) 148.
[95] S Gruskin 'Rights-based Approaches to Health: Something for Everyone' (2006) 9 *Health and Human Rights* 5.
[96] H Potts *Accountability and the Right to the Highest Attainable Standard of Health* (2008) 7.
[97] See Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (P Hunt) [99-101] UN Doc.A/HRC/7/11, 31 January 2008.
[98] Gruskin (note 95 above) 6.
[99] World Health Organization (WHO) *25 Questions and Answers on Health and Human Rights* (2002) 18.

(b) Assessing and addressing the human rights implications of any health policy, programme or legislation and
(c) Making human rights an integral dimension of the design, implementation, monitoring and evaluation of the health-related policies, programmes in all spheres, including political, social and economic.

An important element of a rights-based approach is the fact that it focuses on population groups considered to be marginalised or vulnerable in society.[100] These may include migrant workers, women, people living with HIV, adolescents, children and prisoners. In other words, 'A rights-based approach to access draws attention to the inequities in service delivery and the discriminatory practices that marginalise people and deny them the opportunity to seek care'.[101] This can be particularly true with regard to access to sexual health services for female adolescents, thus justifying the need to prioritise efforts towards fulfilling their sexual health needs and rights

Any attempt by a state to address issues relating to adolescents' health needs must be holistic in nature. For adolescents to be effectively empowered to access and use contraception as a way of avoiding sexual and reproductive ill-health, will require governments to address laws, policies and practices that continue to fan the embers of gender inequality in their countries. In addition, bearing in mind that the duty to fulfill adolescents' rights to health involves both facilitative and promotional measures, new laws and policies safeguarding the rights of adolescents or affording them more protection will need to be enacted. But mere enactment will not suffice as positive actions from the government will be needed.

[100] *Ibid.*
[101] Eldis Health Key Issues 'Universal Access to Sexual and Reproductive Health Services' available at www.eldis.org/health/Universal/index.htm (Accessed on 12 January 2010).

1.8 Limitations of the Study

A study of this nature is not without its limitations. One of the limitations of this study is the fact that it focuses on realising access to contraception for unmarried female adolescents and does not attempt to cover all adolescents. The danger in this is that the sexual and reproductive health needs of other categories of adolescents may inadvertently be undermined. Also, this study is based on laws and policies made by the federal government of Nigeria and not those of state governments. The reason for this is that Nigeria is a large country with about 36 states each empowered to legislate on health issues. Given the time frame for this study, it is unlikely that a comprehensive study covering the whole of Nigeria would have been adequately carried out. A consequence of this will be that, while important laws or policies relating to adolescents' sexual health may exist at the state level, these laws and policies may not be captured or discussed in detail in this study. It is also important to note that the 1999 Constitution of Nigeria, which is central to this study, is still relatively young. Therefore, the discussion around it may seem a bit 'hasty'.

Moreover, issues relating to sexual health and rights remain contestable and controversial in many societies.[102] Despite the moderate progress made since the ICPD and Beijing Platform with regard to sexual and reproductive health, there is still no consensus on the content and scope of sexual health and rights. Therefore, the suggestion in this study that human rights should be applied to a sensitive issue such as access to contraception for adolescent, in a conservative environment such as Nigeria, is potentially controversial. Indeed, the adoption of a rights-based approach to sexuality issues, despite its usefulness, remains highly debatable and has its own limitations.

[102] S Corea *et al Sexuality, Health and Human Rights* (2008) 3; see also, Miller (note 74 above) 7.

1.9 Structure of the study

Chapter 1 of this study (that is this chapter) serves as the introduction and provides an overview of the study. Chapter 2 of the study considers the meaning of the term 'autonomy' from socio-cultural and philosophical perspectives and discusses its relevance in ensuring access to contraception for adolescents. The chapter further discusses some of the important methods feminist scholars have adopted in addressing gender inequality and how these can be used to advance access to contraception for female adolescents in Nigeria. In particular, the chapter suggests that the method of asking the female adolescent question should be adopted to analyse laws, policies and programmes made or developed by the Nigerian government in relation to access to contraception for adolescents

In chapter 3, the study provides a brief background to the historical development of contraception. It then examines some important contraceptives that are often used by unmarried adolescents. The discussion here focuses on abstinence, condoms, emergency contraception and microbicides. Also, the chapter discusses barriers associated with socio-cultural practices and the health care setting that may hinder access to contraceptive services to adolescents and the implications of these barriers for adolescents' autonomous decision-making power in Nigeria. Thereafter, the chapter examines the relevance of the female adolescent question to realizing access to contraception for female adolescents.

The focus of chapter 4 is on analysis of the applicability of international law within the Nigerian legal system. It examines Nigeria's legal system and the constitutional provision in section 12 relating to the status of ratified international treaties, international customary law and consensus statements and clarifications provided by treaty monitoring bodies within the country. The chapter then discusses how Nigerian courts have interpreted this provision and the likely implications of such interpretations to an issue relating to access to contraception for adolescents in the country.

Chapter 5 of the study is an analysis of Nigeria's laws and policies that may have implications for access to contraception for adolescents. This chapter critically examines provisions of important laws such as the Nigerian Constitution and the Child's Rights Act, including some policies such as the Adolescent Reproductive Health Policy and the National Reproductive Health Policy, with a view to determining their implications for access to contraception for adolescents. The analysis of these laws and policies was carried out using the female adolescent question.

In chapter 6, the discussion is on the evolution of the language of rights to sexual health issues. Thereafter, the chapter examines the relevance of the rights to autonomy and health under international human rights law to advancing access to contraception for adolescents in Nigeria. An analysis of the importance of the cluster of rights (liberty and security of the persons, privacy and dignity) that make up the right to autonomy is carried out in this chapter.

Chapter 7 examines state reports by Nigeria and shadow reports by NGOs to some treaty monitoring bodies such as the Committee on CRC, the Committee on CEDAW and the African Committee of Experts on the Rights and Welfare of the Child. The underlying purpose is to evaluate whether the country has respected and advanced the sexual health and rights of adolescents, particularly female adolescents, in the context of access to contraceptive services. The chapter also discusses the importance of monitoring sexual health of adolescents at the national level and how it can improve a state's reporting obligations to treaty bodies.

The important roles of courts and regional human rights bodies in advancing access to contraception for adolescents, particularly female adolescents is the focus of chapter 8. This chapter discusses decisions of courts in other jurisdictions such as Britain, South Africa and Colombia on issues relating to access to contraception for adolescents and lessons that Nigerian courts can draw from these decisions.

Chapter 9 deals with the conclusion and recommendations.

CHAPTER 2

THE CONCEPT OF AUTONOMY AND ITS IMPLICATIONS FOR ACCESS TO CONTRACEPTION FOR ADOLESCENTS IN NIGERIA

2.1 Introduction

For several decades the battle over whether or not an adolescent should be treated like a human being capable of autonomous decision-making powers has raged intensely. Nowhere is this battle fiercer than in the area of consent to treatment by an adolescent, especially with regard to sexual health treatment. Societies have often construed children and adolescents as categories of people incapable of thinking, reasoning and acting like adults. Based on this misconception, children have been denied their fundamental rights, including their right to autonomous decision-making.

This chapter examines the concept of autonomy and its significance for adolescents in the context of access to sexual health services, particularly contraceptive services. The chapter discusses various issues that may intersect with an adolescent's exercise of his/her autonomy in sexual health matters. Thus, issues such as the construction of adolescents and their sexuality in Nigeria, autonomy and gender inequality, autonomy and cultural relativism and relational autonomy are considered. Although the discussion in this chapter, where appropriate, makes linkages between autonomy and human rights, it does not in anyway engage in a detailed discussion with the human rights aspect of autonomy, as this is dealt with in Chapter 6. More importantly, the chapter draws from the experience of feminist scholars in addressing gender inequality under the law and how this can be useful in advancing access to contraception for female adolescents. Consequently, the chapter proposes that in order to address issues relating to the sexual health needs of female adolescents in Nigeria, the female adolescent question would need to be asked. The female adolescent question enables one to contextualize the peculiar experiences of adolescent girls with regard to access to sexual health challenges. It also puts female adolescents at the centre of any measures taken to address these challenges.

2.2 The Philosophical Notion of Autonomy

The term 'autonomy' means different things to different people. Hence, different definitions and theories have been propounded with regard to this term. Feinberg, a political philosopher, has claimed that there are at least four different meanings of 'autonomy' in moral and political philosophy: the capacity to govern oneself, the actual condition of self-government, a personal ideal, and a set of rights expressive of one's sovereignty over oneself.[1] One might argue that central to all of these meanings is a conception of the person able to act, reflect, and choose on the basis of factors that are somehow his/her own. The word 'autonomy' literally means self rule, that is, *auto-nomos*. It was originally used in the context of the ancient Greek City states to symbolize their independence.[2] However, many of the recent conceptions of the notion of autonomy derive their root from Kant's writings on autonomy.[3] In his seminal work, the *Groundwork of Metaphysics of Morals,* Kant notes that autonomy is the property of the will of rational beings. He reasons further that to have a will is to be able to cause events in accord with principles. In other words, a rational being has a will as far as he/she can 'make things happen' in a way which may be explained like 'He/she did (caused) it because it is his/her principle to... (or for the reason that ...).[4] He explains further that in order to have autonomy, it is essential that one's will be free in a negative sense, that is, one is capable of causing events without being casually determined to do so. He adds that negative freedom implies the ability to cause events without being motivated in any way by one's desires. [5]

Kant opines that since willing requires acting on principles, in order to exercise this capacity, one must have some principles to which one is committed not because one

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[1] J Feinberg 'Autonomy' in J Christman (ed) *The Inner'Citadel: Essays on Individual Autonomy* (1989) 27-53.
[2] See A Slowther 'The Concept of Autonomy and its Interpretation in Healthcare' (2007) 2 *Clinical Ethics* 173.
[3] I Kant *Groundwork of the Metaphysics of Morals* (1969) 37-48.
[4] *Ibid.*
[5] *Ibid.*

desires to follow them nor because the principles are expected to lead one to anything one desires (or will desire).[6] He further argues that all rational beings have such principles and that they are committed to them simply by virtue of being rational. Thus, to have autonomy of the will is to be committed to principles in this way and to be able and disposed to follow them. The principles to which one is committed by reason of one's autonomy are the basic principles of morality. In other words, one is under a moral obligation to do something, if and only if, it is required by the principles one accepts for oneself as rational being free from determining causes and independently of all desires. Kant further maintains that having autonomy is the basis for human dignity, and for the idea that rational nature in every person ought to be treated as unconditionally valuable above all 'price'.[7]

It would appear that to be autonomous in Kant's sense, means deserving respect for one's own ability to decide for oneself, control one's life, and absorb the costs and benefits of one's choices. To that extent, a child or an adolescent would be regarded as lacking autonomy to act on his or her own. Implicit in this is that a child or an adolescent may not possess the autonomy to seek sexual health services, including services related to contraception. This may have serious implications for the sexual health of the adolescent, especially in a country like Nigeria, where adolescents' sexual health needs remain unmet. Hill has observed that this theory of autonomy propounded by Kant has today been rejected by many philosophers.[8] He provides a more expansive notion of the concept of autonomy by laying emphasis on self-respect. In Hill's view, the basis for respecting one's autonomy is that every human being is not only a rational being (as Kant suggests) but also a person worthy of utmost respect. This proposition is better placed to advance adolescents' access to contraception as it implies treating adolescents seeking sexual health treatment with self-respect and dignity.

In medical parlance, autonomy has been understood in a number of ways. For instance, it has been used in the libertarians' sense. That is, autonomy is used to mean being free to

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[6] *Ibid.*
[7] *Ibid.*
[8] TE Hill *Autonomy and Self-Respect* (1991) 14-15.

choose between two available options without external constraints. In other words, it is more or less used in the context of liberty to make a choice. Thus, respect for autonomy of a patient would mean accepting the choices made by a patient and desisting from interfering with such decisions. This will similarly include seeking informed consent before treatment is carried out on a patient. It must be noted however, that this does not mean that clinicians will always need to comply with a patient's request for a particular treatment. Slowther observes that 'the right to make a choice does not always entail an obligation on someone else to help you realise this choice'.[9]

It has been contended that a patient has a moral obligation to consider the implications of his or her choice on another person or even society as a whole.[10] Implicit in this is that a patient is expected to act responsibly while exercising his or her autonomous choices to medical treatment. For instance, if a child or an adolescent is invoking his or her capacity to consent to contraceptive treatment, the implications of such an action on society at large must be taken into consideration as well. What is not clear, however, is the degree to which others' interest must be considered *vis-à-vis* the right of the patient to act autonomously. While there are no agreed criteria for determining capacity of a patient to make an autonomous medical choice, Childress and Beauchamp have, however, suggested that such a patient should posses a 'substantial degree of understanding'.[11] This suggestion would seem to tally with recent judicial approaches in determining the capacity of an adolescent to consent to sexual health treatment, including contraceptive treatment, in some jurisdictions. For instance, in *Gillick* case, the House of Lords, in determining the legality of a health guidance, which permitted a girl under 16 to consent to sexual health treatment, reasoned that the crucial point to note in this regard is to ascertain whether the girl truly understands the nature of the treatment and its implications.[12] Once this can be ascertained, then there is no reason why such a girl should not be allowed to consent to sexual health treatment, particularly contraceptive

[9] Slowther (note 2 above).
[10] GM Stirrat & R Gill 'Autonomy to Medical Treatment after O'Neill' (2005) 31 *Journal of Medical Ethics* 127-130.
[11] TL Beauchamp & JF Childress *Principles of Biomedical Ethics* 5th edition (2000) 59.
[12] See *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security* [1986] 1 AC 112 and *R on the Application of Axon v The Secretary of State for Health* (2006) English and Wales High Court 37(Administrative Court) Case No CO/5307/2004.

services. The implications of this case for advancing the autonomous decision-making of female adolescents are explored further in Chapter 8.

2.2.1 Autonomy and Adolescents

Apart from the philosophical concept of autonomy examined above, it should be noted that autonomy has also been treated as a human right. Chapter 6 of this study discusses in detail the human rights implications of autonomy. However, the concern of this chapter is on the socio-cultural implications of autonomy for decision-making powers of adolescents. In some cases, however, the discussion in this chapter makes linkages with human rights discourse where it is necessary.

Historically, children have been treated like chattels/property or even 'less human'.[13] Thus, it was never in the contemplation of 19th century adults, in many parts of the world including Nigeria, to treat children as categories of people deserving of respect for their rights. Rather, children were seen as pawns perpetually subject to the whims and caprices of adults, especially parents. A child was viewed as an object of protection rather than a person with a right to self-determination.[14] Such a conservative and paternalistic thinking can become a stumbling block to realising access to contraception for adolescents in Nigeria. This is because adolescents in the country would be required to obtain parental consent for any health care services, including services related to contraception. However, this position began to change at the beginning of the 20th century. But even then, the issue of children's rights remains a contentious one. Many adults are still reluctant to accord children their due rights.[15] In particular, strong opposition still exists

[13] M Freeman 'Taking Children's Rights Seriously' (1992) *International Journal of Law, Policy and the Family* 52, 60; see also B Franklin 'Introduction' in B Franklin (ed) *The Rights of Children* (1986) 2.

[14] M Freeman 'Children as Persons' in M Freeman (ed) *Children's Rights: A Comparative Perspective* (1996) 3.

[15] See Franklin (note 13 above) 1, where the author notes that children, because of their age, have continued to be denied basic rights, which are taken for granted by adults. Children's rights to freedom and autonomy are limited in a number of ways including denial of what to wear, what film to watch, where to go, who to visit, whether to vote and so on. Because of these myriad limitations of children's rights, he refers to them as 'a silent and unrepresented minority'.

to the notion of children with autonomous decision-making capabilities.[16] It is often believed that such a notion is contrary to the cherished idea of the family and may interfere with parental responsibility. Indeed, most constitutions do not protect children's rights to the same degree as adults'.[17] This position reverberates in many African countries, including Nigeria. For instance, while the Nigerian Constitution prohibits discrimination on the grounds of sex, [18] it does not contain specific provisions relating to children or adolescents.

More importantly, opposition to children's exercise of their rights as individuals is usually brought to the fore when it relates to an issue such as consenting to medical treatment. At Common law, two different positions exist in this regard. One is that children generally were incompetent to consent to medical treatment independent of their parents or guardians.[19] The basis for this view is that essentially, a treatment intervention on a minor or a child amounts to an adverse interference with the welfare of the minor or child and thus, requires the prior consent of a parent or guardian, who has legal custody of the minor.[20] Clearly, this position seems to favour the protection of parental rights over a minor or a child until he/she attains the age of majority.[21] This position will no doubt impede access to contraception for adolescents as they may be regarded as immature to seek services related to contraception.

The other view is that, competence of children or minors to consent to medical treatment is a matter of fact depending on the ability of the minor or child to exhibit good understanding of the nature and importance of the treatment sought.[22] Because Nigeria is

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[16] *Ibid* 18, Franklin observes that two forms of approaches exist in relation to children's rights - protectionist and liberationist. The former supports parental control over a child while the latter favours the autonomous decision-making powers of a child.

[17] A Maradiegue 'Minors' Rights versus Parents' Rights: Review of Legal Issues in Adolescents Health care' (2003) 3 *Journal of Midwifery and Women's Health* 170, 17, according to the author, this is so because children are assumed (albeit erroneously) to be vulnerable, lack decision-making capability and the fact that parents play important roles in making decisions for their children.

[18] Constitution of the Federal Republic of Nigeria 1999.

[19] See for instance, PQR Boberg *The Law of Persons and the Family* (1977) 643.

[20] *Ibid* 645.

[21] See for instance, the case of *Van Rooyen v Wemer* (1892) SC 425, 428-429.

[22] SA Straus *Doctor, Patient and the Law* (1991) 171; see also, A Armstrong 'Traditionalism and Access to Health Care' in A Armstrong (ed) *Women and Law in Southern Africa* (1987) 221-236.

a former colony of Britain, it has retained this common law approach. Ngwena has observed, however, that the first position is not only anachronistic but also out of tune with the realities of modern times.[23] Therefore, he opines that the second position seems preferable as it reflects recent developments and changes relating to children's capability to act in certain situations, without parental or guardians' consent.[24] This position would seem to support the need to ensure access to contraceptive services to adolescents in certain circumstances (when they have exhibited understanding of the nature of treatment) in order to prevent sexual ill-health.[25]

However, it should be noted that determining whether a child or an adolescent has developed the capacity to make sexual health decisions or even act responsibly, is by no means an easy task. Dixon-Mueller has noted that children and adolescents experience sexual and reproductive health maturation earlier than cognitive maturation and girls mature earlier than boys on the average.[26]

In some jurisdictions like the US, there exist two doctrines as regards minors or young people's competence to consent to medical treatment. These are the 'mature minors' and the 'emancipated minors' rules. 'Mature minors' is the term used to describe older teenagers who understand the risk and benefits of a medical treatment.[27] In essence, the 'mature minor' doctrine is similar to the position under common law mentioned above. On the other hand, the 'emancipated minors' doctrine is used to describe a situation where a young person is free from parental control, married, serving as a member of armed force, pregnant or living away from home.[28] Because Nigeria adopts the common-law legal system due to colonial ties with Britain, the emancipated minor doctrine does

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[23] C Ngwena 'Health Care Decision-making and the Competent Minor: The Limit of Self-Determination' (1996) *Acta Juridica* 132, 140.
[24] *Ibid.*
[25] Recent development as exemplified by the South African Children's Act of 2005 seems to accord children the right to seek contraceptive services in certain situations. The provisions of the Act are discussed in great details in Chapter 5 of this study.
[26] See R Dixon-Mueller 'How Young is too Young? Comparative Perspective on Adolescent Sexual, Marital and Reproductive Transitions' (2008) 39 *Studies in Family Planning* 247, 257.
[27] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicines, Ethics and the Law* (2003) 283.
[28] *Ibid.*

not apply in the country. Moreover, due to the communal nature of most communities in Nigeria, a child or a young person without parents is easily accommodated by other relatives. The position under the American system will not be explored further in this study.

2.2.2 Autonomy and the Construction of Adolescents in Nigeria

Adolescence is often described as a stage between childhood and adulthood. It is typically a period where the major psychological task is to 'determine identity; develop power to make decisions and be in control; and develop a mature sexuality'[29] Development varies depending on the stages of an adolescent. The early stage of adolescence (10-14 years) usually witnesses the beginning of sexual maturation and abstract thinking.[30] During this stage, the adolescent is unable to grapple with the vicissitudes of life, and is often susceptible to peer pressures more than family members would have thought or expected.[31]

The stage of middle adolescence (15-17 years) is characterised by improved thinking skills and intelligence, great desire for emotional and psychosocial independence from parents and increased sexual awareness and interaction with the opposite sex. Most adolescents experience their first sexual acts at this stage.[32] While the last stage of adolescence (17-19) involves the manifestation of traits of maturity, independence and more settled ideas and opinions.[33] This is the stage at which the adolescent has fully manifested the qualities of an adult and is more interested in a serious relationship.

Despite these developmental stages in adolescents, in most societies adolescence has been equated with childhood. This position is unconsciously supported by the definition

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[29] WHO *Discussion Paper on Adolescents: Contraception Issues in Adolescents Health and Development* (2004) 6.
[30] WR Jenkins 'Overcoming Barriers to Health Services for Adolescents (1999) *Pace Law Review* 235, 236.
[31] Planned Parenthood 'Adolescent Sexuality' available at http://www.plannedparenthood.org/issues-action/std-hiv/adolescent-sexuality-6354.htm (Accessed on 3 December 2009).
[32] *Ibid.*
[33] WHO (note 29 above) 7.

of a child under the CRC where a child is regarded as anyone under 18 years of age. The implication of this is that adolescents like children, are viewed as vulnerable, dependent, weak and innocent.[34] This perception of adolescents has often meant that they are always deserving of protection and that steps need to be taken in order to afford them adequate protection in society. This is the beginning of a paternalistic view with regard to adolescents. Based on this, adolescents are viewed erroneously as asexual, incapable of anything good or unable to discern wrong from right, hence, parents and older members of society must save this 'neophyte' lest he/she destroy him/herself or even be destroyed by others. Locke, for instance, argues that a child is an irrational being incapable of thinking for itself. He states further that children cannot do what is rational since they are yet unable to see what is rational.[35] It is believed that the adolescent's mind exists in a state of *tabula rasa* –emptiness. Locke is not alone in this thinking, Mill completely excluded children in his doctrine of liberty. He reasoned thus, 'it is perhaps hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children...'[36]

Notably, social and cultural constructions of childhood and adolescence may differ greatly both between and within countries.[37] Thus, in many communities in Nigeria, the meaning attached to the word 'child' differs greatly from the western world. Generally under Nigerian customs, a child is accorded deep respect physically and spiritually, being a gift from God. Though cherished and valued, a child is never conceived as possessing any privileges in their own right.[38] Moreover, in some cultures a child is regarded as a person who has not attained the age of puberty. For example, in the case of *Labinjoh v*

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[34] C Piper 'Historical Construction of Childhood Innocence: Removing Sexuality' in E Heinse (ed) *Of Innocence and Autonomy: Children, Sex and Human Rights* (2000) 28-32.

[35] KP Winkler *John Locke: An Essay Concerning Human Understanding* (1996) 33-36; see also, D Archer *Children, Rights and Childhood* (1993) 8.

[36] See JS Mill *On Liberty* (1992) 22-23.

[37] V Morrow 'We are People Too': Children's and Young People's Perspectives on Children's Rights and Decision-making in England' (1999) 7 *International Journal of Children's Rights* 149.

[38] See B Owasonye 'Implementation of the Convention on the Rights of the Child in Nigeria' available at www.lawrights.asn.au/docs/owasanoye2001.pdf (Accessed on 23 January 2010), rather than a child possessing rights, he or she is duty-bound to obey and respect his or her parents, who exercise powers of control over him or her.

Abake[39] the Nigerian Supreme Court, while determining the age at which a person may legally enter into a contract under customary law, held that a person is deemed to have attained the age of majority and contractual obligations only if he or she has reached the stage of puberty. The import of that case is that an infant who has not attained the age of puberty is incapable of entering into a valid contract. Such a cultural belief, which has been affirmed by the Nigerian Supreme Court, can potentially limit the ability of an adolescent to express his or her autonomous decision-making powers. The likely consequence of this would seem to be that adolescents' capability to seek services related to contraception in the country will depend on whether or not they have reached the stage of puberty. This may be problematic in the sense that attaining the stage of puberty is not in itself a guarantee of maturity and ability to understand the nature of treatment being sought by an adolescent.

In some cases the concept of a child transcends the age of puberty. For instance, among the Yoruba people in the south west of Nigeria, a person of about 30 or 40 years may still be regarded as 'Omo mi' (my child) by his or her parents or elderly people in society. The implication of this is that no matter how old a person may be one may still be regarded as inexperienced to handle the challenges of life. Such a belief can limit adolescents' right to autonomy as they will be deemed as 'unwise' or 'imprudent' to make serious decisions affecting their lives. More importantly, this belief can be invoked to deny access to contraception for adolescents, especially female adolescents.

Also, among the Igbos of the south-eastern part of Nigeria, children are generally considered as one of the greatest blessings from God. Therefore, they are highly valued and cherished. This is often reflected in popular names such as *Nwakaego*; a child is worth more than money or *Akuakanwa*; no wealth is worthier than a child.[40] Moreover, just as in the case of the Yorubas, children's and adolescents' rights, are not accorded much respect by the Igbos. Children and adolescents are merely to be seen and not to be heard. In other words, they are not accorded the same rights and privileges given to

[39] *Labinjoh v Abake* (1924) 5 N.L.R.33.
[40] See Igbo People available at http://www.search.com/reference/Igbo_people (Accessed on 30 March 2010).

adults. This perception of children and adolescents can potentially limit adolescents' exercise of their autonomous decision-making powers. More importantly, the Igbos believe that children perpetuate a race or lineage, and in order to do so, children are expected to continue Igbo tradition and ways.[41] Therefore, a distinction is made between a male and a female child, particularly with regard to inheritance matters. While a male child is entitled to the right of inheritance under Igbo customary law, a similar privilege is not extended to a female child. This discriminatory practice tends to diminish the value of a female child compared with her male counterpart. It can particularly become a stumbling block to the realisation of access to sexual health services to female adolescents. This is because the sexual autonomy of a female child may not be given the same respect as that of a male child.[42]

The above construction of children and adolescents in Nigeria clearly indicates that children and adolescents have never been treated with same respect as adults, particularly with regard to decision-making. The implication of this is that children and adolescents are unable to decide whether or not to seek contraceptive advice or services even when the need for such arises. Moreover, the stereotype and differential treatment of female adolescents in some communities will likely perpetuate discrimination against adolescent girls. This can have negative consequences for the enjoyment of their sexual health.

2.2.3 Autonomy and the Construction of Adolescents' Sexuality

Human sexuality has remained one controversial and complex subject, which is often avoided by many. The discipline of human sexuality has often appeared to share a prevailing cultural view that sexuality is not an entirely legitimate study and that such study often casts doubt, not only over the research, but also on the motive and character of the researcher. Yet, sexuality has been described as an intrinsic part of human existence.[43] It has always been with man from time immemorial. According to

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[41] *Ibid.*

[42] This issue is explored further in Chapter 4 and the role of the courts in addressing discriminatory cultural practices *vis-à-vis* the Constitution is examined.

[43] RM Hogan *Human Sexuality: A Nursing Perspective* (1985) 20.

Goldenweiser, 'In the beginning was sex and sex will be in the end... I maintain –and this is my thesis- that sex as a feature of man and society was always central and remain such. ...'.[44] Perhaps the reason why sexuality has often been misconceived is because of its equation with sex, however, human sexuality is much more than sex.[45] In Fonseca's view, it is 'the quality of being human all that we are as men and women'.[46]

Unlike sex, which represents a physiological act, human sexuality connotes the totality of human beings. Indeed, sexuality is affected by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.[47] Mohamud and Murphy have identified six dimensions of sexuality which include sensuality, intimacy, sexual and reproductive health, social identity, sexual socialization and 'sexualization'.[48] They note further that human sexuality is seldom incorporated into sexual and reproductive health programmes. Yet, the great majority of threats to sexual health are not due to pathogens, lack of medicines or poor health services alone, but rather due to sexual relationships that are negatively influenced by gender-biased societal norms.[49] While human sexuality has been misconceived generally, adolescents' sexuality has always been treated with derision. In particular, it is noted that societies in the past have attempted to manage adolescents' sexuality through using tactics tainted with shame and guilt to curb sex before marriage, secluding or veiling of girls during adolescence and marrying off girls just before the onset of puberty.[50] Although these activities affect adolescents in general, they have more debilitating effects for female adolescents than their male counterparts. In actual fact, most of these activities are aimed at repressing female adolescents' sexuality. This construction of adolescents' sexuality tends to circumscribe their ability to exercise autonomous choices regarding their sexual health.

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[44] A Goldenweiser 'Sex and Primitive Society' in VF Calverton & SD Schmalhausen (eds) *Sex and Civilization (*1929) 53-66.
[45] See M Berer 'Sexual Rights and Social Justice' (2004) 12 *Reproductive Health Matters* 6.
[46] JD Fonseca 'Sexuality a Quality of being Human' (1970) 18 *Nursing Outlook* 25.
[47] See World Health Organization (WHO) *Technical Consultation on Sexual Health* (2006) 6.
[48] See A Mohamud & E Murphy 'Reproductive Health, Gender and Human Rights: The Sexuality Connection' in E Murphy & K Ringhein (eds*) Reproductive Health, Gender and Human Rights: A Dialogue* (2001) 4.
[49] *Ibid.*
[50] *Ibid.*

Today in many African societies, including Nigeria, hardly do discussions on sexuality, gender and human rights or the skills to negotiate sex and gender norms arise for adolescents or even female adults. Ominous silence seems to be the norm when it relates to discussing sexuality with adolescents or even among spouses in many societies in Nigeria.

Among different communities in Nigeria, premarital sex for adolescent girls is more or less regarded as a forbidden fruit that must not be tasted until marriage. This is based on the assumption that sexual activities for girls are not only injurious to them (because of fear of pregnancy and sexually transmitted infections) but also to the society at large. It is believed that early pregnancy can lead to school dropouts and make adolescent girls to be dependent on the society for daily survival.[51] This impermissible culture celebrates asexual girls as being good and urbane, while those who become sexual or even seek information about their sexuality are regarded as not only bad but also deviants. This has led Gagnon and Simon to conclude that 'learning about sex in our society is learning about guilt, conversely learning about how to manage sexuality constitutes learning how to manage guilt'.[52] In summing up this position, Pillard notes as follows:

> Society tolerates unbridled and even aggressive male sexuality as "natural" or lauds it as strong. Society valorizes lack of female desire, even while considering that lack inevitable, and so irrelevant, when women's lack of desire does not match male wants. People generally still view child rearing as women's gratification and their domain, and 'accept men's failure to do and value it as personal, private choice, off-limits to criticism...If those circumstances do not change, men will continue to fail to take their part of the responsibility for sexual intercourse and its potentially lifelong consequences, and women will continue to accede to sex inequality structured around and rationalized in terms of reproduction.[53]

The conclusion that can be drawn from the discussion above is that a negative construction of female adolescents' sexuality can limit access to contraceptive information and services to them and thus, jeopardize their health and well-being.

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[51] See DL Tolman & TE Higgins 'How being a Good Girl can be Bad for Girls' in N Maglin & D Perry (eds) *Bad Girls/Good Girls: Women, Sex and Power in the Nineties* (1996) 205, 206.
[52] JH Gagnon & W Simon *Sexual Conduct: The Social Sources of Human Sexuality* (1973) 42.
[53] C Pillard 'Our other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy' (2007) 56 *Emory Law Journal* 943.

2.2.4 Adolescents' Competence to make Sexual Health Decisions

Theoretically, autonomy can be equated with 'competence', that is, ability to give informed consent to accept or refuse treatment.[54] Thus, if a child lacks the maturity or capacity to understand the likely risks, benefits and consequences of a proposed medical intervention, he or she will be said to lack capacity to give informed consent to such medical treatment or procedure.[55] Buchanan and Brock have further observed that determining whether a child is competent to make a decision will depend on a particular situation. In other words, a 'person may be competent to make a particular decision at a particular time, but incompetent to make another decision, or even the same decision, under different conditions'.[56]

Equally, they argue that determining the competence of a child with regard to medical treatment is task-specific, in the sense that 'it is in relation to a specific treatment option rather than to treatment in the abstract', so that '[d]ifferent levels of medical procedures will require different levels of competence'.[57] The reason for this task-specific competence is attributed to the fact that surgery is not only more intrusive than medical treatment, but also requires a higher degree of understanding on the part of the patient than in medical treatment.[58] Although the focus of this study is in relation to adolescents' ability to consent to sexual health services, albeit a non-intrusive treatment, the point made by Buchanan and Brock can be useful in determining the competence or agency of an adolescent to consent to sexual health services. Rather than a general assumption that adolescents are incapable of making a valid decision on their own, the competence of an adolescent seeking sexual health services should be determined based on the 'particular adolescent'. In other words, a case-by-case evaluation of an adolescent should be carried out to arrive at a reasonable conclusion with regard to his/her competence to make sexual

[54] AE Buchanan & DW Brock *Deciding for others: The Ethics of Surrogate Decision-Making* (1989) 17.
[55] *Ibid.*
[56] *Ibid* 18.
[57] *Ibid.*
[58] Ngwena (note 23 above) 143.

health decisions. This will allow for a pragmatic approach to determining the agency of a particular adolescent in sexual health matters.

According to Belling and Eberl, a patient generally requires three kinds of capability to show that he/she is sufficiently mature to consent to medical treatment.[59] These include comprehension of facts and casual connections, full evaluation of the situation and acting according to his/her understanding. With regard to the first requirement, they argue that this primarily deals with intellectual capability to understand the facts (including possible complications or risks) in relation to the treatment sought, including the ability to judge the probability of success of a medical procedure.[60] The second has to do with the ability to make a value judgment, to understand possible alternatives available and to be able to determine which is best for oneself.[61] The third requirement deals with the ability to exercise self-determination, that is, being 'in a position to act in accordance with [one's] understanding' and being 'capable of reaching a decision in accordance with that understanding'.[62] It also includes the ability to link one's understanding with one's ultimate decision.

These explanations on what it takes for children or adolescents to make competent decisions without the help of an adult reveal some of the intricacies involved in adolescents' decision-making as regards medical treatment. However, one important point to note about these requirements is that they are not dependent on age or sex of the patient. In other words, children or adolescents who can satisfy any of these requirements should not be denied access to treatment. Moreover, the third requirement mentioned by Belling and Eberl, which relates to the ability to exercise self-determination, is very important in the context of realising access to sexual health services for adolescents. The term 'self-determination' may be equated with agency, that is, the ability of a person to make an independent decision relating to his/her sexual health. Thus, if it can be ascertained that an adolescent is capable of making an independent and responsible

[59] DW Belling & C Eberl 'Teenage Pregnancy in Germany: With Reference to the Legal System in United States (1995-1996) 12 *Journal of Contemporary Health, Law and Policy* 475, 494.
[60] *Ibid* 495.
[61] *Ibid* 496.
[62] *Ibid* 497.

decision regarding his/her sexuality, then his/her decision should be respected.[63] Indeed, Cook and Dickens have argued that one sign of adolescents' capacity to act responsibly is 'their understanding of the need to protect their reproductive health and their requesting contraceptive services (and/or condoms for STIs protection) when they are or about to be sexually active'.[64]

Arising from the above discussion, it is also important to note that the ability of an adolescent to exercise his/her agency may in certain situations be impaired by patriarchal traditions. From time immemorial, men have been known to be sexually 'reckless' while women and girls have been associated with sexual modesty. This in turn subordinates the sexual needs of women to that of both family and society.[65] It is often believed that sex could be a source of pleasure and power for men whereas for women sex has been associated with shame and harm.[66] As earlier noted, in most cultures in Nigeria, premarital sex especially among girls, is generally frowned upon.[67] However, in certain circumstances, the society is willing to condone premarital sexual activities of boys than of girls.[68] A study conducted in the country has shown that while boys may be permitted to go out and experiment with their sexuality so as to 'discover things for themselves', the sexuality of girls is often viewed in terms of 'vulnerability, danger, and by implication inferiority'.[69] This subordination of girls' rights to that of boys in the country has been summed up in the following words:

> The most pervasive and deeply entrenched culture or tradition of Nigeria is the role of women in society. In many parts of Nigeria, daughters from childhood are socialized into stereotypical roles. They imbibe an entire view of culture and society, aspirations bound by motherhood and wifehood functions with dispositions moulded in accordance with masculine/feminine dichotomy. While

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[63] RJ Cook *et al* 'Respecting Adolescents' Confidentiality and Reproductive and Sexual Choices' (2007) 98 *International Journal of Gynecology and Obstetrics* 182.

[64] RJ Cook & B Dickens 'Recognising Adolescents' "Evolving Capacities" to exercise Choice in Reproductive Healthcare' (2000) 70 *International Journal of Gynaecology and Obstetrics* 13, 20.

[65] K Luker *When Sex goes to School, Warring views on Sex – and Sex Education-Since the Sixties* (2006) 56.

[66] Pillard (note 53 above) 951.

[67] Action Health International (AHI) *Meeting the Sexual and Reproductive Health of Adolescents in Nigeria* (2000) 3.

[68] *Ibid.*

[69] CO Izugbara 'Home based Sexuality Education: Nigerian Parents Discussing Sex with Children' (2008) *Youth and Society* 575, 587.

> culture socializes daughters to be soft, meek and subservient, it socializes sons to be hard, aggressive and domineering.[70]

These kinds of negative attitudes merely limit women's and girls' agency to express their sexual autonomy. The corollary is that girls tend to shun seeking treatment or advice with respect to their sexual health needs, especially as regards contraceptive services, for fear of being thought to be sexually active. Indeed, some studies have shown that young people in Nigeria, particularly young women, often resort to self-help or visiting pharmacy shops for sexual health services, including contraceptive services, rather than visiting public health institutions for fear of being stigmatised.[71] Moreover, in some situations health care providers tend to deny health care services to adolescents on the basis that they lack the agency to consent to such services. This, in turn, exposes female adolescents to experiencing grave sexual and reproductive ill health. In most cases, laws are made with the intention of protecting female adolescents from sexual abuse, by restricting the age of consent to sexual intercourse for boys and girls. Sometimes most of these laws often prohibit consensual sexual acts between adolescents. Implicit in these laws is the fact that they are more or less camouflage for controlling the sexuality of female adolescents.[72]

2.2.5 The Nexus between Autonomy and Gender Inequality

The importance of gender and human rights to issues relating to the sexuality of adolescents cannot be overemphasized. This is because gender inequalities can undermine sexual autonomy of female adolescents and hinder preventive services in

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[70] CO Izugbara 'The Socio-cultural Context of Adolescents' Notion of Sex and Sexuality in South-Eastern Nigeria' (2005) 8 *Sexualities* 600, 606.

[71] See for instance, AO Arowojolu *et al* 'Sexuality, Contraceptive Choice and AIDS Awareness among Nigerian Undergraduates' (2002) *African Journal of Reproductive Health* 60, 61.

[72] See F Olsen 'Statutory Rape: A Feminists Critique of Rights Analysis' in DK Weisberg (ed) *Application of Feminists Legal Theories to Women's Lives* (1996) 460, where she notes that one challenge with such laws is that while they may tend to reduce incidence of sexual abuse of young people, at the same time, they tend to restrict the sexual activity of young people thereby reinforcing the double standard of morality. She concludes that such laws may later become a veritable tool in the hands of states to repress sexual desires, especially of young women. A good example of the negative effects of such laws is seen in section 16 of the South African Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2008 which purports to criminalise teenage kissing.

relation to sexual health for them. Moreover, as noted earlier, gender inequalities can predispose female adolescents to sexual ill health since they are more susceptible to STIs, including HIV/AIDS. The Committee on the CRC has noted that gender-discrimination combined with cultural taboos (regarding female adolescents' sexuality) not only serve as a limitation of sexual autonomy of female adolescents, but may also hinder access to preventive sexual health services to them.[73] Also, Packer has argued that gender inequality, incidence of violence against women and subordination of women and girls to men, all undermine sexual and reproductive choices of women.[74]

The act of treating children as if they are incapable of making prudent decisions on their own is not peculiar to children. Until recently, women were also deprived of their fundamental rights based on patriarchal tradition. Under patriarchy, women were denied their basic human rights and treated as less important than men. Moreover, they were merely assigned the roles of homemakers and child-bearers.[75] Such a conservative approach was aided by the dichotomy of public and private spheres of life which tends to shroud women's suffering and deprivation. Charlesworth *et al* have contended that this public/private dichotomy has been used by men as a veritable weapon of women's oppression.[76] Binion also argues that this dichotomy represents the very face of patriarchy.[77] Under this dichotomy, gender roles are constructed and women's subordination to men, cemented. Mackinnon may have hit the nail on the head when she observes that 'Gender is a question of hierarchy. The top and the bottom of the hierarchy

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[73] Committee on the Rights of the Child, HIV/AIDS and the Right of the Child, General Comment N0 3 CRC/GC/2003/3 Thirty-Second Session 2003 para 8.

[74] CA Packer *The Right to Reproductive Choice* (1996) 55.

[75] See MP Eboh 'The Woman Question: African and Western Perspectives' in E Eze (ed) *African Philosophy: An Anthology* (1997) 333-337; see also, A Mama 'Heroes and Villains: Conceptualising Colonial and Contemporary Violence against Women in Africa' in M Alexander *et al* (eds) *Feminist Genealogies, Colonial Legacies, Democratic Futures* (1997) 46-62; C Opara 'Hunters and Gatherers: Poetics as Gender Politics in Sam Ukala's the Slave Wife and the Log in your Eye' (1990) *7 Review of English and Literary Studies* 47.

[76] H Charlesworth *et al* 'Feminists Approaches to International law' (1991) 85 *American Journal of International law* 613, 629; see also F Olsen 'The Family and the Market' (1983) 96 *Harvard Law Review* 1497; S Tamale 'Gender Trauma in Africa: Enhancing Women's Links to Resources' (2004) 48 *Journal of African Law* 50-61.

[77] G Binion 'Human Rights: A Feminist Perspective' (1995) 17 *Human Rights Quarterly* 509; see also Charlesworth *et al* (note 76 above) 627.

are different, all right, but that is hardly all.'[78] Implicit in this is that women's or girls' autonomy are perpetually tied to the apron strings of either the husband or father. This public/private divide creates different rules and laws that apply to issues affecting women and girls. According to Charlesworth *et al,* the public/private dichotomy operates to render women invisible and almost to the point of denying their existence.[79] It should be noted that just as the home has been used as an avenue for the oppression of women, it has also been used as a site of oppression for children.[80]

Under the disguise of public/private dichotomy women and girls are not expected to freely express their sexual desires. That privilege belongs to men only, who not only determine when to have sex but can also flaunt their sexual desires. Women and girls are expected to repress their sexual desires and remain sexually passive. An attempt to act otherwise attracts public rebuke and condemnation. Pillard rightly captures the situation when she submits as follows:

> Men's lust has long been stereotyped as a powerful, natural force, and male virility celebrated, whereas women have been characterized as the objects of men's desires rather than subjects of their own. Women who express their sexual desire have historically been denigrated as dirty, threatening "sluts" or "whores," and women who have sex outside of marriage have been typed as "fallen," "ruined," "damaged," not "good girls," or "not marriage material"—terms simply not used against sexually active young men.[81]

Binion has traced the origin of this dichotomy to libertarianism, particularly to works of political philosophers such as John Locke.[82] She asserts that while Locke was ready to contest the existence of the divine right of kings, he was willing to condone patriarchal familial structure. Locke distinguishes between a royal power over the society and a father's power over his family, claiming that they are separate and distinct (despite the oppressive nature of the latter). No doubt this dichotomous argument can result in

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[78] C MacKinnon 'Feminism, Marxism, Method and the State: Toward Feminist Jurisprudence' (1983) 8 *Signs: Journal of Women in Culture and Society* 635.
[79] Charlesworth *et al* (note 76 above) 640.
[80] S Toope 'The Convention on the Rights of the Child: Implications for Canada in M Freeman (ed) *Children's Rights: A Comparative Perspective* (1996) 33, 47.
[81] Pillard (note 53 above) 951.
[82] Binion (note 77 above) 516.

profound consequences for women. Therefore, Binion submits that 'the Lockean separate sphere approach has also rendered women subject to the control of patriarchal familial authorities- father, brothers and husbands- with the understanding that familial matters are "private" and therefore, beyond the scope of governmental authority and intervention'.[83] In sum, the public/private divide is often invoked to shield away from governmental intervention certain familial acts, such as domestic violence, which may be harmful to the health and lives of women and girls. Moreover, this dichotomy can have the effect of denying autonomous decision-making powers to women and girls.

The dichotomy mentioned above plays out in various aspects of women's lives in Nigeria. In many cultures in Nigeria, it is often believed that the home is a sacred place and that whatever transpires there is not subject to public scrutiny. Therefore, based on this belief women generally, and young women in particular, have been subjected to various forms of abuse, including sexual abuse by their husbands, fathers or close relatives.[84] Worse still, these abuses experienced by women are regarded as 'family affairs' which must not be reported to outsiders or even law enforcement agents. Indeed, in exceptional cases where a woman is bold enough to report an act of domestic violence to the police, the police often advise that such matters should be settled amicably as it is a 'family issue'.[85] In other words, women and girls have had to stoically bear these violations of their rights in silence. Under this kind of oppressive and hostile environment, women and girls are unable to exercise control over their sexuality. Moreover, it becomes very difficult for adolescents, especially female adolescents, to seek services related to contraception, as they may be scared of the possible repercussions, should their parents find out about this fact. In a nutshell, the public/private dichotomy is a potential threat to the exercise of the female adolescent's autonomy, because it exposes women and girls to violence and shields them away from the state's intervention. The fear of violence (actual or perceived) subdues women and

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[83] *Ibid.*
[84] See Project Alert on Violence against Women *Beyond Boundaries* (2002) 21; JF Chuckwuma *No Safe Haven: A Report on Attacks on Women in Nigeria* (2002) 1.
[85] *Ibid.*

girls and makes it difficult for them to exercise their free will or choices in sexual matters.

2.2.6 Autonomy and Cultural Relativism

Added to the challenge of public/private dichotomy, is the debate with regard to culture and human rights. This debate disputes the universality of international human rights and instead claims that human rights must accommodate the cultural diversity of the people of the world. No doubt this debate is germane to an issue such as advocating for autonomous decision-making powers for adolescents with regard to their sexual health needs. This is more so when one bears in mind that the notion of autonomy originates from western libertarianism. The idea that an adolescent should be accorded the right of decision-making power independently of his or her parents seems somehow inconsistent with African lifestyle where emphasis is placed on communalism. Such a lifestyle can be very beneficial to adolescents as it can provide them with emotional and psychological support in time of need.

Cobbah echoes this fact when he observes that African communities thrive on communalism and togetherness rather than the notion of individualism often reflected in human rights law.[86] He notes further that the idea of individualism is more or less an abstraction, which tends to alienate an individual from the harmonious, congruous and holistic totality known to the medieval society. Such an idea contrasts sharply with the social life of Africans who believe greatly in 'groupness, sameness and commonality'. [87]

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[86] JAM Cobbah 'African Values and the Human Rights Debate: An African Perspective' (1987) 9 *Human Rights Quarterly* 309, 312; see also, B Ibhawoh *Imperialism and Human Rights: Colonial Discourse of Rights and Liberties in African History* (2007) 22, where he argues that one of the weaknesses of the Western conception of human rights is that it makes the individual, rather than the family or community, as the fundamental unit of the society.

[87] *Ibid* 320.

He concludes by arguing that the Western world can learn a lot from this Afrocentric way of life as it is suitable to advancing socio-economic rights in the world.[88]

Although one may argue that Cobbah's notion of communalism is today being eroded by globalisation and urbanisation in many parts of African societies, nonetheless, this idea still thrives in some Nigerian communities, particularly the rural areas. In these communities the idea of togetherness and living as one big family is still a cherished notion. A recent study by Izugbara and Undie would seem to confirm the communal nature of the Nigerian society. [89] The study conducted among the people of Ngwa in the south-eastern part of the country shows that the community, rather than individuals, have control over human bodies. This notion of 'communal ownership of the body' is evident in the people's conception of the offence of rape. When a woman is raped, it is believed that the whole community, and not just the woman's body, has been desecrated, since her body belongs to the community. Based on this notion, Izugbara and Undie conclude as follows:

> While we share the impression that rights are realizable, we recommend that a concerted effort be made to take into account how the individual's rights are linked to the community and to understand how rights are expressed. In many African cultures, rights are embodied in the community and the community sees the individual as part of it. If the community is seen as owning the body, then individuals will tend to seek their rights within the communal space, rather than standing alone. In such communities, discourses that assume universality about constructions of the body are likely to foster a disconnect and meet with resistance.[90]

The implication of such a belief is that adolescents, particularly female adolescents, may not be able to exercise their right to autonomy with regard to seeking sexual health services in relation to contraception since they do not have control over their bodies. Indeed, in *Fawehinmi v Akilu*[91] the Supreme Court has reinforced this idea by observing that under Nigerian culture every one is seen as 'his brother's keeper' and that whatever

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[88] *Ibid* 331.
[89] CO Izugbara & C Undie 'Who owns the Body? Indigenous Discourses of the Body and Contemporary Sexual Rights Rhetoric' (2008) 16 *Reproductive Health Matters* 159, 163.
[90] *Ibid* 166.
[91] *Fawehinmi v Akilu* (1987) 2 NWLR (PT 67) 767(SC).

affects one, affects the others. The issue before the Court in that case was whether the plaintiff, a legal practitioner and counsel to a slain journalist Dele Giwa, could lawfully compel the state to prosecute the defendant for the death of his client. The defendant had argued that since the plaintiff has no blood relation with the deceased journalist he lacked the *locus standi* to institute the action. But the Supreme Court, rejecting the argument of the defendant, noted that a strict adherence to the *locus standi* rule in this case would do harm to the communal lifestyle of Nigerians. The Court noted that communal, rather than blood ties, are what connect the people in Nigeria.

Although the reasoning of the Court in that case would seem logical and progressive, its likely implications for the sexual health needs of adolescents may have been underestimated. This is because a communal lifestyle as advocated by the Court, may limit the ability of an adolescent to exercise his/her sexual autonomy. While a communal lifestyle may ensure psychological and spiritual support for adolescents to make crucial decisions affecting their lives, it may, on the other hand, make it difficult for adolescents, particularly female adolescents, to exercise their sexual health choices with regard to issues such as seeking contraceptive services. The reason is that as shown above, such a lifestyle will require an adolescent to consult with his/her family members or even community before seeking services related to contraception. Given the construction of adolescents' sexuality discussed above, such a consultation may likely be met with a negative response considering the conservative nature of many communities in the country.

Other commentators have also expressed concerns about the universalistic nature of human rights *vis-à-vis* culture. For instance, Obiora has asked a rhetorical question: 'When feminists are skeptical toward culture and its constituent elements, when they advocate the protection of women's interests within universalistic norms and standards of human rights, how can it be ensured that what they prescribe as norms and rights for the

world at large are not at core reducible to customs of the West?'[92] She reasons further as follows:

> In material respects, what is "universal" has historically been the decision of the West, which appears to have preferred the art of fetishizing the particular as the universal without the advantage of empirical verification, and against the evidence of profound differences. [93]

Obiora is not alone in this view Mutua too has questioned why the dominant western model of human rights tends to reject the input of non-western cultures, insisting rather that these other cultures conform to the Western ideal or model.[94] Given the construction of children and adolescents in Nigerian communities discussed above, it remains unclear how these observations by Obiora and Mutua can be useful in advancing the sexual autonomy of children and adolescents to seek contraceptive services. In actual fact, it may be argued that cultural relativism may limit the sexual autonomy of adolescents. This is because adolescents will now be compelled to seek the support of third parties to make important decisions that affect them. This usually makes adolescents to shun seeking sexual health advice or treatment when in dire need.

While above observations regarding the influence of Western notions of human rights on other cultures may seem tenable, recent developments in Africa seem to reveal attempts at incorporating African values into human rights instruments. These can be seen in instruments such as the African Charter on Human and Peoples' Rights (African Charter),[95] the African Charter on the Rights and Welfare of the Child (African Children's Charter)[96] and the Protocol to the African Charter on the Rights of Women

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[92] See LA Obiora 'Feminism, Globalisation and Culture: After Beijing' (1996-1997) 4 *Indiana Journal of Global Legal Studies* 355, 358.
[93] *Ibid* 395.
[94] See M Mutua 'Savages, Victims and Saviours: The Metaphor of Human Rights' (2001) 42 *Harvard International Law Journal* 201, 205; see also, F Banda *Women, Law and Human Rights: An African Perspective* (2005) 44.
[95] African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.
[96] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999).

(African Women's Protocol)[97] all of which, to some extent, reflect human rights principles and standards that are African-biased. The African Women's Protocol, though influenced by documents such as the ICPD, the Beijing Platform for Action and the CEDAW, is a product of rigorous activism and inputs on the part of activists and women organisations based in Africa. Thus, the Protocol contains very radical provisions that legitimize the fight against gender oppression as an African struggle. Some of its provisions reflect the peculiar situations of African women and girls which can be useful in ensuring access to contraception for adolescent girls in the region.[98] Indeed, Mukasa has argued that by these provisions of the Protocol, it can no longer be said that 'women's rights are transplants from the western world with no roots in African values and norms'.[99] In a nutshell, the Protocol is a homegrown human rights instrument 'developed by Africans for Africans'.[100]

Despite the relevance of the debate on cultural relativism, some feminist scholars, however, have argued that the debate is a ploy to perpetuate patriarchy and shield negative cultural practices away from the purview of human rights.[101] Such an approach tends to underplay the serious, but deleterious impacts of culture on the life of women. Furthermore, Terry has argued as follows:

> Cultural relativism is simplistic. It fails to acknowledge that cultures are permeated by power relations, and that they are dynamic, sophisticated and constantly interacting with one another. If we take cultural relativism to its logical conclusion, we have to accept any behaviour, however cruel or degrading because it is condoned by the culture it happens in.[102]

She argues further that culture is generally dynamic and changes with time. Therefore, what may be culturally relevant years back may no longer be so today. In relation to women's right, Binion argues that 'Cultural relativists misunderstand or betray their own

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[97] The Protocol of African Charter on Human and People's Rights on the Rights of Women in Africa Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005.
[98] See for instance article 14 of the Protocol.
[99] RS Mukasa *The African Women's Protocol: Harnessing a Potential Force for Positive Change* (2008) 5.
[100] *Ibid.*
[101] Binion (note 77 above) 523.
[102] G Terry *Women's Rights* (2007) 47.

credo when they dismiss gender issues as "cultural". To do so is to argue that only men create and sustain culture'.[103]

In Obiora's view, 'governments that manipulate discourses of culture and community are often motivated to violate human rights standards because of an absence of political will rather than the existence of inescapable cultural differences which make the standards inapplicable'.[104] She submits that despite the controversy between universalism and relativism of rights, there is a common meeting ground, which is; the centrality of dignity as a universal value. According to Obiora, 'The general consensus is that the inherent dignity of the human person is not a matter for state consent, but an inviolable predicate for an international moral order'.[105] It transcends the boundaries of cultural and religious diversity. These observations readily provide a good ground to argue that religious and cultural beliefs that are often invoked to limit access to contraception for adolescents, particularly female adolescents, in Nigeria are not only unwarranted but also unjustifiable.

What is clear is that the issue of cultural relativism is not a mere academic debate but a serious issue which is daily invoked to limit the enjoyment of rights of Africans, particularly women. While it is true that not all cultural beliefs are inimical to the enjoyment of sexual health and rights,[106] the truth remains that most cultural beliefs have their origins in patriarchal traditions. Therefore, they remain a potential threat to the enjoyment of women's and girls' sexual health and rights. A good example in this regard is the issue of female genital cutting/mutilation (FGC/M). Despite its clear threat to the enjoyment of women's and girls' sexual health, the practice has continued to be justified

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[103] Binion (note 77 above) 523.
[104] Obiora (note 92 above) 387.
[105] *Ibid* 398.
[106] See for instance, S Tamale 'The Right to Culture and the Culture of Rights A Critical Perspective of Women's Sexual Rights in Africa' (2006) 16 *Feminist Legal Studies* 47-69, where she argues that 'Culture has numerous manifestations; it is not static but constantly changing and responding to shifting socio-economic and political conditions. In this sense, the value-assessment that is often made of cultures and cultural practices is misplaced, given that all cultures have aspects that are positive and others that disempowered. Needless to say, there are many cultural norms and values that are rights-supportive, egalitarian and uplifting; many aspects of 'African culture' promote and reinforce women's rights'.

on the grounds of culture and religion. Obviously such a justification is not only misplaced but also unconvincing.

2.2.7 Relational Autonomy

With specific regard to the concept of autonomy for women, Nedelsky has argued that the present conception of this term, which is based on liberal theory that emphasizes individualism, does not serve the interests of women and is inconsistent with feminist methodology.[107] She argues further that while the notion of autonomy is important for women and should be retained, however, it must be stripped of its liberal version. More poignantly, she asserts as follows:

> Feminism appears equivocal on its stance toward liberalism because it simultaneously demands a respect for women's individual selfhood and rejects the language and assumption of individual rights that have been our cultures primary means of expressing and enforcing respect for selfhood... Feminist perspectives and demands can guide the inquiry: they point to danger, define aspirations, and indicate the contours of an approach that transcends the limitation of liberal theory while fostering its underlying values.[108]

She notes further that the notion of autonomy goes to the heart of liberalism and of the powerful, yet ambivalent, feminist rejection of liberalism. The often familiar criticism levelled by feminists against liberalism is the fact that liberalism treats 'atomistic individuals as the basic units of political and legal theory', thereby failing to recognise the inherent social nature of human beings. Nedelsky believes that what really makes an individual autonomous is not the fact that such an individual is isolated from his/her environment, but that he/she enjoins a relationship with parent, friends, teachers, family and loved ones, which provides the support and guidance for his/her experience of autonomy.[109] More recently, she has developed the concept of 'relational autonomy' by

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[107] J Nedelsky 'Preconceiving Autonomy: Sources, Thoughts and Possibilities' (1989) 7 *Yale Journal of Law and Feminism* 7; see also, M Minow 'Interpreting Rights: An Essay in Honour of Robert Gover' (1986-87) 96 *Yale Law Journal* 1860, where she notes that rights are about solidarity and not individualism and that rights are relative but never absolute.

[108] *Ibid* 8.

[109] *Ibid* 12.

which she argues that equating autonomy with independence will amount to a distortion of our understanding of conditions for autonomy.[110] In her view, what makes autonomy possible is not being independent of others but rather engaging in constructive relationships. This is because autonomy is not 'a characteristic we simply achieve with adulthood, its flourishing depends on the kinds of relationships, both intimate and social, of which we are a part'.[111]

Morrow has also argued that there is a need for a more complex account of children, which should attempt to take account not only of children's competencies at different ages, but also their different cultural and social backgrounds and experiences.[112] Based on the findings of a study she conducted, she argues that children have come to recognise the limit of their autonomous decision-making and are willing to seek support and guidance from adults. According to her, the crucial point children made was that they, like other human beings, should be treated with respect and be involved in any decision that affects them.[113] While children recognise that important decisions should be made on their behalf, they, however, point out that parents should always involve them in such decisions. Another conclusion to be drawn from this study is that competence to participate in decision-making 'develops through a combination of experience and relationships and should not necessarily be seen as age-related'.[114] Morrow's findings would seem to confirm that in some situations children may lack the capability to make reasonable decisions regarding their sexuality. But such occasional lack of capability should not be seen as a general weakness of all children or adolescents. As noted above, the ability of a child to make a decision regarding his/her sexual health is better evaluated if this is done on a case-by-case basis. Such an approach will afford a child or an adolescent to be heard in a matter affecting him/her and to be treated as a human being. Morrow's view appears to support the concept of relational autonomy proposed by Nedelsky.

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[110] See J Nedelsky 'Judgment, Diversity and Relational Autonomy' in R Beiner and J Nedelsky (eds) *Judgment, Imagination and Politics: Themes from Kant and Arendt* (2001)111.
[111] *Ibid.*
[112] Morrow (note 37 above) 153.
[113] *Ibid;* see also, article 12 of the CRC.
[114] *Ibid* 166.

If Nedelsky's notion of relational autonomy were to be adopted wholly, it will then mean that an adolescent intending to seek sexual health treatment would need to seek the support of parents, friends or family members. While, as earlier noted, there is nothing wrong with this since it tends to promote the African communal lifestyle and provide emotional and psychological support to the adolescent, however, in a religiously and culturally polarised environment as Nigeria, the likely effect of this can be counter-productive. This is because adolescents, particularly female adolescents, may be deprived of their autonomous decision-making powers to seek sexual health services in relation to contraceptives. Indeed, Erdman has argued that the involvement of third parties in decision-making processes of adolescents on matters relating to their sexual health, is tainted with gender-biases since it is often based on the assumption that young women, (and not young people generally) lack the capacity to engage in moral decision-making.[115] Adolescents, especially female adolescents, are often uncomfortable to let their parents or guardians know about their visits to a hospital or clinic to seek sexual health services, because of the negative attitudes to such visits.

2.2.8 Opposition to Adolescents' Autonomy

Indeed, over the years parents, guardians, health care providers and society at large have continued to fret over adolescents' expression of their sexuality.[116] In most societies great displeasure and disapproval have been shown to such an act, especially if the adolescent is a female. In Nigeria for instance, a study has shown that about 80% of parents are opposed to use of contraception among female adolescents based on the unfounded fear that it may cause death, promote promiscuity or affect their fecundity.[117] Also, attempts at incorporating sexuality education into the curriculum of schools have often met with stiff oppositions from religious groups and conservatives who erroneously believe that this

[115] See J Erdman 'Moral Authority in English and American Abortion Law' in S Williams (ed) *Gender Equality and Comparative Constitutional Law* (2009) 108.
[116] See Maradiegue (note 17 above) 170.
[117] LA Briggs 'Parents' view point on Reproductive Health and Contraceptive Practice among Sexually active Adolescents in the Port Harcourt Local Government Area of Rivers State, Nigeria' (1998) 27 *Journal of Advance Nursing* 261, 265.

will encourage promiscuity among young people. Moreover, adolescents in general and female adolescents in particular, have continued to be kept in the dark by parents and guardians as regards issues relating to their sexual health needs. Such negative attitudes repress and drive underground sexual activities of adolescents and thus endanger their sexual well-being. Ives has noted as follows:

> The control of young people's sexuality is one of the most important areas in which young people are maintained as 'children', and consequently restrictive, but often confused, legislation abounds. Since the prevailing ideology is that girls are 'innocent' and not sexually active, it must be the male who is to blame for any sexual activity by the young female ... [118]

Curiously, some advocates of children's rights have expressed opposition to adolescents' exercise of their sexual autonomy. For instance, while Freeman argues that children should be entitled to the right to autonomy just like adults, because it is crucial to their existence, however, he cautions that this right should not extend to sexual decision-making capabilities of children.[119] He claims that stretching the right to autonomy for children to include sexual issues may be dangerous to them. This would seem to be a confusing approach to adopt. It would seem irreconcilable to hold on one hand that children, like adults, should be entitled to the right to autonomy and on the other hand limit the enjoyment of such a right to certain issues. A qualified right to autonomy for children is as dangerous as denying them this right in the first place. This would more or less reinforce the paternalistic view that children and adolescents are incapable of making truly independent decisions in certain cases. An important aspect of the right to autonomy is the respect for human dignity. All human beings regardless of colour, age or gender are deemed worthy to be called human. Freeman himself recognises this when he argues that children should be entitled to enjoy their basic human rights like every other individual. In addition they should be free to make decisions affecting them without interference from other people or even the state.[120] This tends to portray children and adolescents as worthy of human beings capable of making crucial decisions that affect their sexuality.

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[118] R Ives 'Children's Sexual Rights' in B Franklin (ed) *The Rights of Children* (1986) 143, 147; C Piper 'Historical Construction of Childhood Innocence: Removing Sexuality' in E Heinse (ed) *Of Innocence and Autonomy: Children, Sex and Human Rights* (2000) 26-43.

[119] Freeman (note 13 above) 68.

[120] *Ibid* 66.

The central point in the discussion of autonomy is to treat all individuals as worthy and capable of making decisions that affect their lives.

The adoption of the Convention on the Rights of the Child in 1989[121] marked a milestone in the recognition of children as rights holders. Its contents were a breakaway from the old paternalistic position where the welfare and protection of the child was the order of the day. The Convention, in a number of provisions, explicitly guarantees to children different rights, including their right to express their views freely in all matters affecting them.[122] Some of the provisions contained in the CRC can be invoked to advance the right to autonomy of children and adolescents, especially with regard to contraceptive services. For instance, the CRC under articles 5 and 12 recognises the principle of the evolving capacities of the child, which requires states to 'respect the responsibilities and duties of parents ... in a manner consistent with evolving capacities of the child'.[123] Erdman opines that the recognition of this principle is an affirmation of an adolescent's right to autonomous decision-making.[124] Also, Toope has noted that by virtue of the provisions of the Convention, children are no longer to be treated as 'object of social concern' but rather as claimants who have an 'ethical right to be heard'.[125] This can also be said of the Nigerian situation as recent events have shown positive attempts by the government to incorporate the provisions of the CRC into domestic law through the enactment of the Child's Rights Act.[126] The contents of this law are examined in detail in Chapter 5.

2.3. Drawing Experience from Feminists' Approaches to Gender Inequality

Over the years, women and girls have endured discriminatory practices due to their gender. These discriminatory practices can prevent women and girls from exercising their

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[121] Convention on the Rights of the Child. Adopted in 1989 U.N. Doc. A/44/49 entered into force 2 Sept. 1990.
[122] *Ibid* article 12.
[123] *Ibid.*
[124] Erdman (note 115 above).
[125] Toope (note 80 above) 49.
[126] Child's Rights Act no 26 of 2003.

autonomous decision-making power with regard to their sexuality. The concept of autonomy discussed above will only be meaningful to women in general and adolescent girls in particular, if they are assured of their right to equality. Feminists over the years have been able to respond to the inequality women experience by virtue of patriarchal traditions by coming up with methods which have been very useful in addressing the exclusion of women from international law. Generally, feminist jurisprudence has included a broad field of theories, questioning how the law fits into women's experience, querying the role of the law in perpetuating gender inequality and how the law can be of use in addressing this inequality.[127] The various experiences and approaches adopted by feminists in response to the subjugation of women in society can similarly be useful to the situation of female adolescents. Binion has rightly observed that while the focus of feminist analyses has been on the experience of women, 'a feminist approach might have implications for the rights of all disempowered peoples and raise questions about social organization generally'.[128] This, therefore, means that, female adolescents can benefit greatly from the experiences of feminists.

However, feminists themselves are not unanimous with respect to the kind of methods or approaches that can be adopted to address the challenges facing women. Thus, different methods and/or approaches have been suggested to address the exclusion of women by law. Notably, most of these methods or approaches are not free from criticisms. Barlett has, however, identified two main reasons why methods are essential to women's needs.[129] Firstly, without the use of methods, feminists are unable to challenge the existing patriarchal structure which has excluded women from the scheme of things. Secondly, understanding feminist methods helps in conferring legitimacy on women's demand for reform. These reasons no doubt are apposite to the situation of female adolescents, especially with regard to exercising autonomous sexual choices as regards access to contraception. In her seminal paper, Bartlett has identified three different feminist methods that can be adopted to challenge discrimination against women in

[127] Binion (note 77 above) 512; Pilliard (note 53 above).
[128] *Ibid* 513.
[129] K Bartlett 'Feminist Legal Methods' (1990) 103 *Harvard Law Review* 829.

society.[130] These include feminist practical reasoning,[131] feminist consciousness raising[132] and asking the woman question. Although these three methods are relevant in advancing women's rights, this study only focuses on the last method - asking the woman question.

2.3.1 Asking the Woman Question

This method tends to ask about the gender implications of any rule, social practice or judicial decisions in society. It is interested in knowing whether any decision taken with respect to the aforementioned has left women out of its consideration. If that is the case, in what way, what are the consequences and how can such omissions be redressed?[133] The woman question often demands putting women at the centre of every reform activity, including administrative actions or decisions by the courts.[134] According to Joyner, asking the woman question means 'examining how the law fails to reflect the experiences and values that seem more typical of women than of men'.[135] The method similarly recognises the fact that historically, women have been, and are, in fact, still, a disadvantaged group that requires special attention. Specifically with regard to law, asking the woman question would imply examining how the law has omitted to reflect experiences and values that are peculiar to women rather than men. Or in another sense, it may enquire into how existing law can be disadvantageous to women.[136] Asking the

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[130] *Ibid.*

[131] Practical reasoning as a method tackles problems not as 'dichotomized conflicts but as dilemmas with multiple perspectives, contradictions and inconsistencies. See Bartlett (note 83 above) 851. Feminist practical reasoning admits differences in human experiences and the importance of taking into consideration competing or inconsistent claims. However, it does not hide its bias by indicating which moral and political choices underlie that bias.

[132] In Mackinnon's words, feminist consciousness-raising refers to 'the collective critical reconstruction of the meaning of women's social experience, as women live through it. See C Mackinnon 'Feminism, Marxism, Method and the State: An Agenda for Theory' in N Keothane *et al* (eds) *Feminist Theory: A Critique of Ideology* (1982) 29. Feminist consciousness-raising aims at creating knowledge through exploring experiences that derive from sharing of life events; see also, J Bender 'A lawyer's Premier on Feminist Theory and Tort' (1988*) Journal of Legal Education* 3, 9. The kernel of consciousness-raising is to draw the attention of governmental and non-governmental institutions and the public at large, via the media, campaign, lobbying and even arts, to the challenges women encounter by reason of patriarchy.

[133] *Ibid* 837.

[134] RJ Cook 'Human Rights and Reproductive Self-Determination' (1995) 44 *The American University Law Review* 986.

[135] C Joyner *United Nations and International Law* (1997) 183.

[136] Cook (note 134 above).

woman question operates on the assumption that certain laws are not only neutral, but may also be biased towards women by entrenching patriarchal traditions. Thus, the woman question aims at exposing the lacuna in the law with regard to women's needs, and how this might be corrected.

The woman question queries the various forms of inequalities women have been subjected to, demanding whether there is justification for women's different roles and subjugation in society. With respect to judicial decisions, the woman question will ask if a judge handling a divorce suit or a rape case, for example, has taken into consideration, before arriving at his or her judgment, the peculiar 'life experiences' of women. Far from applying the law in a neutral sense, the woman question will require a judge to reflect on the disadvantaged position of women and how this may have implications for them in such cases. Asking the woman question in the situations mentioned above, is more or less challenging the status quo which has placed men above women in many societies, including the Nigerian society.

In what may be regarded as justifying the need to ask the woman question, Wishik opines as follows:

> If in the course of our criticism of law and collection of information about women's experiences of law, we fail to ask all the questions about how to know, as well as about what is known, we risk legitimizing patriarchy again, even as we attempt to change it.[137]

The woman question can be asked in a number of situations. When feminists seek equality in access to employment and to equal pay, equality in voting rights and

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[137] HR Wishik 'To Question Everything: The Inquiries of Feminist Jurisprudence' (1985) 1 *Berkeley Women's Law Journal* 64, 68. Wishik has further asked seven important questions feminists often asked, which include: (i) What have been and what are now all women's experiences of the 'Life Situation' addressed by the doctrine, process, or area of law under examination? (2) What assumptions, descriptions, assertions and/or definitions of experience - male, female, or ostensibly gender neutral - does the law make in this area? . . . (3) What is the area of mismatch, distortion, or denial created by the differences between women's life experiences and the law's assumptions or imposed structures? . . . (4) What patriarchal interests are served by the mismatch? . . . (5) What reforms have been proposed in this area of law or women's life situation? How will these reform proposals, if adopted, affect women both practically and ideologically? . . . (6) In an ideal world, what would this woman's life situation look like, and what relationship, if any, would the law have to this future life situation? . . . and (7) How do we get there from here?

prohibition of sexual violence, they can be said to be asking the woman question. Also, when Cook suggests the re-characterization of human rights law to be more responsive to women's needs, she is merely asking the woman question.[138] Furthermore, when Bunch calls for the transformation of human rights to pay more attention to women's rights,[139] she is asking the woman question. In modern times, feminists ask the woman question in various areas of human lives. For instance, they ask: why should women require corroboration before they are believed in rape cases; or why should girls undergo female genital cutting/mutilation (FGC/M) or be subjected to virginity testing? Or why should women and adolescents require consent of their husbands or parents to seek medical attention? At other times they have asked: why should a woman be punished by a religious law for engaging in a consensual sexual act with a man who may escape punishment for simply denying knowing the woman? Specifically, in relation to the status of girls, Lees and Mellor have asked: why is it that so few girls develop to their full potential, why are they subject to discrimination in the home and outside and why are they subject to sexual abuse and harassment?[140]

By asking these questions, feminists are able to expose how institutions, political choice and institutional arrangements combine to perpetuate the subordination of women in society. In the absence of the woman question, the suffering of women usually due to their sex is often rendered invisible and almost ignored. Thus, further exacerbating women's position in society. The woman question helps in revealing the fact that women's disadvantaged position in society is a product of patriarchy, rather than their inherent characteristics.[141] Equally, it helps to expose the hidden effects of certain laws that are discriminatory against women based on their sex, thereby revealing how social structures harbour norms that subjugate women's rights as compared to men in society. The essence of asking the woman question does not necessarily require that a decision must be in favour of a woman. Instead, what it does is that it allows a decision maker to

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[138] See RJ Cook 'Women's International Human Rights Law: The Way Forward' in RJ Cook (ed) *Human Rights of Women: National and International Perspectives* (1995) 5.
[139] C Bunch 'Transforming Human Rights from a Feminist Perspective' in J Peters & A Wolper (eds) *Women's Rights, Human Rights: International Feminist Perspectives* (1995) 12.
[140] S Lees & J Mellor 'Girls' Rights' in B Franklin (ed) *The Rights of Children* (1986) 164, 165.
[141] Bartlett (note 129 above) 843.

reflect on the gender implications of his or her decision so that in the end the decision will not be biased towards women.

Essentially, the woman question attempts to uncover hidden biases against women in the law and politics. In Bartlett's words, 'asking the woman question confronts the assumption of legal neutrality, and has substantive consequences only if the law is not gender-neutral. The bias of the method is the bias towards uncovering a certain kind of bias'.[142] Its major concern is to question the systemic exclusion of women from law and the affairs of things. Moreover, the substance of the woman question lies in the fact it seeks to uncover, disadvantage based on gender.

2.3.2 The Female Adolescent Question

This method can be very useful in evaluating laws and policies dealing with the sexual health needs of female adolescents. More particularly, one can borrow from the experience of feminists to ask the Nigerian female adolescent question to challenge laws, social practices and policies relating to the situation of female adolescents in the country. In evaluating laws or policies (such as the Constitution, the Child Rights Act, National Policy on Adolescents and National Policy on Reproductive Health) made by the Nigerian government to advance the autonomy of adolescents to seek contraceptive services, one may ask the Nigerian female adolescent question by examining how these laws, or policies have omitted to take into account experiences or values that are more typical of female adolescents and not of male adolescents. Such a question would need to take into cognisance the fact that female adolescents in most parts of Nigeria are disadvantaged and are more susceptible to sexual and reproductive ill-health than their male counterparts. Also, asking the Nigerian female adolescent question needs to take into account the patriarchal nature of the Nigerian society, which often elevates male sexuality above female sexuality and the implications of this for female adolescents' sexual autonomy. Moreover, issues relating to the sexual health needs of female

[142] *Ibid* 847.

adolescents have not been given adequate attention by the government. In a nutshell, asking the female adolescent question seeks to expose the inadequacies in laws, social practices and policies in Nigeria with regard to female adolescents' experiences and how these can be remedied.

Asking the Nigerian female adolescent question provides a useful tool to critique legislative or judicial actions taken in regard of female adolescents. This method allows for a gender-sensitive appraisal of measures and steps taken by the Nigerian government to advance the sexual autonomy of adolescents to seek contraceptive services. It will equally require decision-makers in Nigeria to take into account the fact that female adolescents have been historically disadvantaged, particularly as regards their sexuality, and to reflect this in any decision taken for this purpose. This will enable the decision makers to be sensitive to the gender implications of their actions with a view to correcting the past injustices experienced by female adolescents and advancing their sexual autonomy. In this regard, asking the female adolescent question seeks to achieve social or corrective justice, thus, sharing some semblance with substantive equality.

But asking the woman question or the female adolescent question is not without its challenges. As pointed out by Spellman, the question may arise as to which woman or female adolescent is this question meant to protect, taking into consideration the diversity of women.[143] The question that may be relevant to the woman in the urban area may not suit the needs of the woman in a rural area. For instance, while the priority of a woman in an urban setting may be to attain equal pay for equal work done with her male counterpart, a woman in a rural area may be concerned about how to feed herself and her children. Also, the concern of a heterosexual woman will be different from that of a homosexual woman. Thus, the kind of woman question that will be asked in these situations cannot be the same. But even if asking the woman question may not necessarily meet the needs of all categories of women, it is not in doubt that all women experience one form of disadvantage or another. Hence, asking the woman question will

[143] E Spelman *Inessential Woman: Problems or Exclusion in Feminist Thoughts* (1988) 186.

still be relevant in challenging the institutions and structures that support or condone patriarchy in society.

In addition to the above mentioned methods, Fineman has similarly proposed the 'gendered life' method.[144] According to her, this method is based on the premise that women as a group share the potential for experiencing 'diverse situations or statuses', including ideological and political appendages, in which their gender becomes culturally relevant. She reasons that because of these experiences, women are provided the opportunity to develop a perspective which is grounded in their appreciation of and response to the gendered nature of the world we live.[145] While this method acknowledges diversity in women's experiences and life situations, it presumes that with the revelation of gender as a central social and cultural consideration, attention of women can be effectively directed towards tackling and questioning the gendered implications of women's lives.[146] Fineman further opines that the concept of 'gendered life' is necessary to generate arguments admitting that recognition of difference is crucial to remedying socio-cultural disadvantages often imposed on women. More cogently, she submits thus: 'it is an affirmative position, arguing for remedies and for differentiated treatment to rectify existing pervasive social and legal inequality'. [147] This position seems to coincide with the application of substantive equality to issues affecting women's rights.

In a way, Fineman's 'gendered life' approach seems to be *in tandem* (if not the same) with asking the woman question. Both methods seem not only to be calling attention to social and political institutions and legal frameworks that may likely perpetuate the disadvantaged position of women in society, but also how these institutions can be challenged. In essence, they both recognise that legal, political and judicial decisions must take cognisance of the disadvantaged position of women and aim at remedying the situation or preventing further harm to women. Thus, they can both be useful in addressing challenges faced by female adolescents as regards their sexual health needs,

[144] M Fineman 'Feminist Theory and Law' (1995) 18 *Harvard Journal of Law and Public Policy* 349, 355.
[145] *Ibid.*
[146] *Ibid.*
[147] *Ibid* 356.

particularly in relation to access to contraception. Moreover, both seem to be advocating for the application of substantive equality (rather than formal equality) in steps and measures taken to remedy the disadvantaged position of women.

While one is not advocating that an adolescent should engage in sexual activity, when he or she is not prepared for such, it is, however, important that an adolescent should be guaranteed the right to accurate information regarding his or her sexuality. Adolescents, particularly female adolescents, should be provided with the full and comprehensive range of information on how to protect themselves. Such information must not be limited to abstinence alone, but should holistically include the use of contraception and other methods of preventing sexual ill health. Thereafter, the adolescent may take the decision whether or not to engage in sexual activity. Of course, he or she may be guided by an adult in coming to this decision where necessary. But, where he or she freely makes the decision, his or her view should be respected once it is ascertained that he or she understands the implications of his or her actions. To say that children and adolescents should be allowed to exercise their autonomous decision-making capability in every issue, save sexual issues, amounts to nothing short of double standards. It is like falling into the same old pitfall of paternalism, where children are regarded as 'incompetent, irresponsible, naïve and innocent', appendages that have been found not only to be false but also misleading. By asking the female adolescent question, it will be expected that laws, policies, programmes and even judicial decisions relating to adolescents' sexuality, will always give special consideration to the peculiar circumstance of female adolescents.

2.4 Conclusion

This chapter has considered the concept of autonomy and its relevance for adolescents' sexual health needs. The chapter started with the philosophical notion of autonomy as postulated by Kant. From the discussion on Kant's notion of autonomy, it has been demonstrated that this notion does not adequately protect the needs of children and adolescents but merely relate to adults. Thus, Hill's conception of autonomy, which is

based on respect for human's worth irrespective of age, race or sex to make personal decisions, is more appropriate in advancing the autonomy of children and adolescents.

The chapter also discusses other issues relating to autonomy such as the competence of an adolescent to make sexual health decisions. In this regard, it has been argued here that recognising adolescents' (particularly female adolescent's) agency to seek sexual health services, including access to contraception, will help in advancing their sexual health and rights. Adolescents should be treated with dignity like other human beings and their sexual choices must be respected. Although the notion of relational autonomy as proposed by Nedelsky and Morrow is important, its application in a conservative environment like Nigeria might limit the ability of female adolescents to seek sexual health services. As Erdman has correctly pointed out, it is not so much a problem to involve a third party in adolescents' decision-making, but the challenge is that such a process sometimes tends to deny or repress the autonomous decision-making of adolescents.[148] Here lies the danger.

More importantly, the chapter examines the construction of children and adolescents in Nigerian communities. The discussion here has shown that although children and adolescents are greatly valued and cherished, they are often regarded as incapable of making informed decisions regarding their lives. While children and adolescents are regarded as incapable of making informed decisions regarding their sexual lives, female adolescents have been the target of this unwritten rule. Thus, premarital sex among adolescent girls is discouraged. This tends to limit the autonomy of adolescent girls to make crucial decisions regarding their sexuality. A conclusion that may be reached in this regard is that the ways children and adolescents are construed in a society will likely have implications for the exercise of their sexual autonomy.

As shown from the discussion above, feminists have adopted different methods to challenge the exclusion of women from protection under international law. One of such method is asking the woman question. This approach can similarly be adopted to

[148] Erdman (note 115 above) 130-132.

advocate for access to contraception for female adolescents in Nigeria. The crux of the feminist debate has been that, international law, including human rights law, has often been developed in a patriarchal fashion. Thus, it has tended to pay scant attention to the peculiar needs of women. Consequently, feminists have called for the 're-characterisation'[149] or 'transformation'[150] of human rights law so that it reflects the peculiar needs of women. While the various methods adopted by feminist scholars to challenge women's subordination in society are all useful, asking the woman question or the female adolescent question would seem to provide a practical model to adopt in order to advance the autonomy of female adolescents to seek contraceptive services in Nigeria. This is not because it is not without limitations, but despite its limitations it remains a viable method to adopt in questioning gender-insensitive laws, policies and programmes relating to adolescents' sexual health needs in society. Asking the female adolescent question requires putting female adolescents at the centre of all actions taken concerning them. If properly applied, this method can become a very useful tool to measure a government's commitment to advancing the sexual health needs of female adolescents in a country.

[149] See Cook (note 138 above) 5 where she argues that there is an urgent need for the re-characterisation of law so as to address human rights violations experienced by women.
[150] Bunch (note 139 above) 12 has argued that if the needs of women must be met, then it is necessary that transformations of laws, including human rights law take place to advance women's rights.

CHAPTER 3

NATURE, TYPES, KNOWLEDGE AND USE OF CONTRACEPTION AMONG ADOLESCENTS IN NIGERIA

3.1 Introduction

During the International Conference on Population and Development (ICPD) in 1994 the international community affirmed the importance of ensuring universal access to sexual and reproductive services for adolescents.[1] In particular, the gathering recognised the need for adolescents' access to information and services on contraception.[2] Subsequently, this position has been reiterated at several other meetings. Contraception remains an important means of preventing sexual health harm to adolescents. Studies have continued to show that adolescents in Nigeria, like other countries, are becoming sexually active at an early age. For instance, a study of secondary school girls has revealed that about 12% of the students commenced sexual activity at the age of 11.[3] This situation is not peculiar to Nigeria, as a study among 786 adolescent girls in KwaZulu-Natal, South Africa has shown that half of the sampled girls commenced sexual acts before the age of 16.[4] Even in a more advanced country like the United Kingdom (UK), there exists documented evidence of early sexual activity and incidence of unwanted pregnancies among adolescents.[5]

As discussed in Chapter 2, due to cultural practices and patriarchal nature of African society, boys are more involved in premarital sex than girls. In some parts of Nigeria, most girls engage in sex for the first time during marriage because early marriage is

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[1] Programme of Action of the International Conference on Population and Development (ICPD). Adopted in Cairo 5-13 September 1994, UN Doc. A/CONF. 171/13 1994.
[2] *Ibid* para 6.4.
[3] IC Anochie & EE Ipeme 'Prevalence of Sexual Activity and outcome among Female Secondary School Students in Port-Harcourt, Nigeria' (2001) 5 *African Journal of Reproductive Health* 63.
[4] N Manzini 'Sexual Initiation and Childbearing among Adolescent Girls in KwaZulu-Natal, South Africa (2001) 9 *Reproductive Health Matters* 44.
[5] LD Jacobson *et al* 'Teenage Pregnancy in the United Kingdom in the 1990s: The Implications for Primary Care' (1995) 12 *Family Practice* 232.

common. Oftentimes, when girls engage in sex outside of marriage, it is usually with older male partners and often induced by financial gain or even coerced.[6] A study among 2, 460 secondary girls in South Eastern Nigerian states has revealed that only 36% had been involved with sexual partners of their age, while about 25% had been involved with older businessmen. The study further revealed that these girls were unlikely to restrict intercourse to the safe period of their cycle when they are involved with older partners than when they are involved with boy friends of their age.[7]

Bearing all this in mind, it is necessary to assure adolescents access to contraceptive use. Thus, this chapter traces the origin of contraception, its types and use among adolescents. The chapter also discusses different forms of contraception that female adolescents commonly use. Equally, the chapter examines factors that hinder access to contraception for adolescents and some of the consequences of lack of access to contraception. It concludes by examining the link between asking the female adolescent question and access to contraception.

3.2 Origin of Contraception

Contraception originally refers to any means of preventing pregnancy. There are different types of contraception including natural barrier, hormonal and surgical methods. The historical development of contraception is rooted in controversy and moral sentimentality. As far back as 1727, Defoe in his essay, 'Conjugal Lewdness of Matrimonial Whoredom', condemned the use of contraception referring to it as 'the diabolical practice of attempting to prevent childbearing by physical preparations'.[8] His view was influenced by religious belief that sexual activity in marriage is meant solely for procreation. While the use of contraception has spanned several years, a remarkable increase was noticed during the 19th century. According to Gordon, the development of

[6] MJ Teminn *et al* 'Perceptions of Sexual Behaviour and Knowledge about Sexually Transmitted Diseases among Adolescents in Benin city, Nigeria' (1999) *25 International Family Planning Perspectives* 186-190; see also FI Omorodion & O Olusanya 'The Social Context of Rape in Benin City, Nigeria' (1998) 2 *African Journal of Reproductive Health* 37.

[7] U Amaznigo *et al* 'Sexual Activity and Contraceptive Knowledge and use among in-School Adolescents in Nigeria' (1997) 23 *International Family Planning Perspectives* 28.

[8] See R Shortoll 'Contra-Contraception' *New York Times* 7 May 2006.

contraception as a form of birth control is more an issue of politics than of technology.[9] This was due to the initial opposition from both political and religious groups to the use of contraception. She further notes that the early development of the birth control movement may be classified into three stages. Firstly, the 'voluntary motherhood' stage during the second half of the 19th century. During this stage, emphasis was placed on choice, freedom, and autonomy for women. In Gordon's words, 'voluntary motherhood was a basic plank in the feminist platform, much more universally endorsed than woman suffrage and reaching further to describe and change the total plight of women than any other single issue'.[10]

Secondly, there was the stage of the adoption of the term 'birth control' around 1910-1920. This period not only witnessed the adoption of a new concept, but also a new organisational phase in feminist movement.[11] It was a period significant not only for emphasising on women's autonomy but also for revolutionalising society and empowering the powerless (working class women).

Thirdly, the period of the liberal reform movement, produced the use of the slogan 'planned parenthood' around the 1940s. This stage witnessed a broader and liberal approach to the demand for contraception. At each of these stages the interests of different classes of women were taken into consideration. In summary, Gordon argues that these stages have shaped the understanding of women's struggle for freedom, particularly as regards their sexuality. In her view, these stages can be interpreted in two ways. Firstly, they can be regarded as part of a continuous process away from a solely woman-centered, feminist use of birth control. Secondly, these three stages delineated 'the rise and fall of a broad of the social analysis of the contribution that reproductive self-determination could make to over-all human liberation'.[12] From Gordon's observation, it is clear that the recognition of contraception as a form of birth control has

[9] L Gordon *Woman's Body, Woman's Rights: A Social History of Birth Control in America* (1979) ix.
[10] *Ibid* xx.
[11] *Ibid.*
[12] *Ibid.*

had a chequered history emerging from being referred to as 'diabolical' to becoming an important means of family planning.

Contraception as a means of preventing pregnancy or birth control gained more attention as a result of concerns raised by an English political economist, Thomas Malthus at the beginning of 19th century. Malthus had argued, in one of his essays,[13] that while the world's population was growing at geometrical proportion, food and other resources were moving at an arithmetic proportion. Therefore, he concluded, albeit pessimistically, that unless drastic measures were taken to curb the geometrical growth of the world's population, there might come a time when the number of people in the world would outnumber available resources.

Malthus's theory sparked debates around the world and elicited more attention to be paid to birth control methods. In the conservative world of that time, campaigning for the use of modern methods of contraception was a very difficult task. In actual fact, any attempt at disseminating information on contraception was captured under the common law offence of obscenity.[14] Gordon argues that a strong correlation exists between the subordination of women and the prohibition of birth control; the latter having been used as a means of enforcing the former.[15] Some of the earliest proponents of contraception such as Charles Bradlaugh, Margaret Sanger and Anne Besant were persecuted and condemned as 'corrupters of public morality'.[16] Sanger particularly deserves a special mention, because as far back as 19th century, she had asked the woman question with regard to use of contraception. She argued that high fertility rate among poor women, especially black Americans, was a threat to their health and well-being. Therefore, she advocated for the use of contraception contrary to the popular belief then.

Similarly, a publication around 1830 titled 'Fruits of Philosophy' by Knwolton - an American exponent of birth control - which argued for birth limitation through the use of

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[13] TR Malthus *An Essay on the Principle of Population* (1798) 6.
[14] See CT Dienes *Law, Politics and Birth Control* (1972) 11.
[15] Gordon (note 9 above) 4.
[16] See J Stevas *Obscenity and the Law* (1966) 70-74. The three were convicted for libel because they published a book promoting the use of contraceptives.

contraception incurred the wrath of the American government and led to his trial.[17] The belief then was that such information was injurious to society. Thus, since courts are the *custos moram* (custodians of public morals) they have the obligation to prevent the contamination of societal morality.[18] The prohibition of contraception at that period was further reinforced by a Christian's belief influenced by Augustinian teaching that sexual intercourse was inherently evil and could only be justified if procreation was its end.[19] Thus, couples that used any 'evil appliance' to prevent procreation were not regarded as worthy of 'the name man and wife, were no longer covered by the license of matrimony, so to speak; they were in moral sin'.[20] Undoubtedly, such a conservative view of contraception is not only capable of repressing women's sexual autonomy, but may also perpetuate gender inequality. Though contraception was initially developed to curb population growth, it is now used to prevent STIs, including HIV/AIDS.

Before colonisation, different communities in Nigeria relied on traditional methods of contraception. These methods, which included the rhythm, abstinence and withdrawal, were often applied irregularly. Although the use of modern methods of contraception in Nigeria gained recognition in the 1980s, when serious concerns were expressed about the exponential growth of Nigeria's population, activities relating to family planning, including use of contraception date back to 1950s. In Lagos around 1958, contraceptive services were offered for the first time to postpartum women by medical officers of health at registered maternal health clinics.[21] However, the government's involvement in contraception at the national level began around 1981 and 1985, when the Fourth National Development Plan was launched.[22] This involvement was consolidated by the formulation of a National Policy on Population in 1988.

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[17] Dienes (note 14 above) 12.

[18] This was clearly reflected in judicial decisions such as *Commonwealth v Sharpless* (1815) 2 S & R (Pa) 91, 103 Per Judge Yeats cited in CT Dienes *Law, Politics and Birth Control* (1972) 11, where the court stated that 'The corruption of the public mind in general...must necessarily be attended with the most injurious consequences and in such instances; courts of justice are, or ought to be, the school of morals'.

[19] Gordon (note 9 above) 7.

[20] *Ibid.*

[21] RD Wright 'A Family Planning Programme for Nigeria' a paper presented at the Annual Conference of Association of Surgeons of West Africa, Lagos, Nigeria 10 January 1968.

[22] L Lacey *et al* 'A Tool for Monitoring the Performance of Family Planning Porgammes in the Public and Private Sectors: An Application in Nigeria (1997) 23 *International Family Planning Perspectives* 162.

Significantly, the historical development of contraceptive use in Nigeria has focused more on married women than unmarried adolescent girls. The reason, as discussed in Chapter 2, was based on the unfounded belief that making contraception available to young women will encourage them to engage in sexual activity. Therefore, for a very long time the autonomy of young women to exercise choices with regard to their sexuality was undermined and given little attention. This deserves the need to ask the female adolescent question in order to challenge this conservative construction of the sexuality of female adolescents. One may ask: why should adolescent girls be excluded from those that can benefit from the use of contraception?

Contraception gained more popularity and public acceptance during the 1990s following the two momentous meetings which took place at that time - ICPD and FWCW. These meetings explicitly emphasised the right of all persons to determine the number timing and spacing of their children. More importantly, the emergence of the HIV/AIDS pandemic in the country towards the end of the 1980s and its subsequent devastating effects, led to the popularisation of abstinence and condoms as forms of contraception. From 1986, when the first reported case of HIV occurred in the country, the prevalence has since frog-jumped from a mere 1.8% in 1991 to about 5.8% in 2001, before stabilizing at 4.4% currently,[23] thereby necessitating a more renewed effort to tackle its further spread. The impact of the prevalence was more felt among young people aged 15-24 years than in any other group in the country. One of the methods devised at that time was the massive campaign for the use of condoms. This has continued to date, albeit, at a much slower rate.

3.3 Types of Contraception

In this section of the study, the discussion is not based on all forms of contraception, but rather, focus is on some contraceptives which are commonly used by unmarried

[23] See Federal Ministry of Health (FMOH) *National Seroprevalence Sentinel Report* (2003) 5.

adolescents. The following are some of the commonly used methods of contraception by unmarried adolescents.

3.3.1 Abstinence

This is often described as the surest and safest means of contraception. It implies total abstinence from sexual acts. Over the years, abstinence has received great support mostly from religious groups and some developed countries such as United States. It is often recommended for adolescents, especially unmarried adolescents, as the most appropriate option to prevent unwanted pregnancies and STIs. Abstinence has become more popular in the era of HIV/AIDS pandemic and its devastating effects among young people in sub-Saharan Africa. In Nigeria, abstinence as a form of contraception is zealously preached, not least the fact that the country is benefiting from the United States government's President Emergency Plan Fund for AIDS Relief (PEPFAR) project, but also because the country is religiously polarised. The PEPFAR project, which is providing support to about 15 developing countries across the world, makes it a condition precedent for any of the recipient countries to ensure that the money received through it will not be used to promote the use of condoms or sex work, but rather abstinence as the best option in the fight against HIV/AIDS.

Several non-governmental organisations (NGOs) and health activists have criticised this approach as not only unreasonable but also a violation of the right to information and expression. Indeed, a court in the US has held that this policy by the US government is in violation of the right to information guaranteed under the American Constitution.[24] Contrary to the abstinence-only approach, research has shown that it is not only unrealistic but also failing adolescents who are becoming sexually active every day

[24] In the case of *Alliance for Open Society Intern., Inc. v. U.S. Agency for Development* 430 F.Supp.2d 222 a Federal judge in the Southern District of New York ruled that this law violated Constitution's guarantee of freedom of speech contained in the First Amendment of the US Constitution. This decision would seem to be responsive to the peculiar needs of female adolescents who are most in need of information related to their sexuality.

without proper information on other options they could adopt. [25] Moreover, the meaning of abstinence may be uncertain and misleading to some adolescents. For instance, in a study among young people in America a substantial number of those interviewed believed that engaging in oral or anal sex constituted abstinence.[26] This clearly exemplifies the danger in over-reliance on abstinence as the best form of contraception for young people. It is instructive to mention here that the new US government, led by President Obama, has announced its intention to discontinue with the abstinence-only rule.[27] This is highly commendable and will go a long way in providing adolescents in Nigeria with a variety of options to protect themselves from sexual harm.

Undoubtedly, abstinence or delay of sexual debut among adolescents is good and can be important in reducing incidence of early or unwanted pregnancy among young people. It is believed that girls having sex under the age of 16 are three times more likely to become pregnant than those who first have sex over 16 [28] The truth, however, remains that while abstinence is good and can be a plausible choice for unmarried adolescents, it should never be celebrated at the expense of other forms of contraception. Abstinence is not within the control of adolescent girls who might be susceptible to violence or sexual abuse. Several studies have shown that adolescent girls in Nigeria are daily susceptible to sexual violence and are exposed to sexual health harms.[29] Therefore, it will be illogical to continue to advocate for abstinence without providing adolescents with other possible options.

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[25] See for instance, MM Bersamin *et al* 'Defining Virginity and Abstinence: Adolescents' Interpretation of Sexual Behaviour' (2007) 41 *Journal of Adolescent Health* 182-188; see also, K Haglund 'Sexually abstinent African America Adolescent Females' Description of Abstinence' (2003) 35 *Journal of Nursing Scholar* 231.

[26] *Ibid.*

[27] See Word Press 'Obama cuts Abstinence Programs for 2010 budget' available at http://www.es.wordpress.com/2009/05/09/obama-cuts-abstinence-programs-for-2010-budget (Accessed on 27 August 2010).

[28] See A Testa & L Coleman *Sexual Health Knowledge, Attitudes and Behaviours among Black and Minority Ethnic Youths in London* (2006).

[29] See for instance, A Ajuwon *et al* 'Sexual Coercion: Learning from the Experiences of Adolescents in Ibadan, Nigeria' (2001) 9 *Reproductive Health Matters* 128; see also, OI Fawole *et al* 'Prevalence of Violence against Young Female Hawkers in three cities in Southwestern Nigeria' (2002) 102 *Health Education* 230.

An abstinence-only message or policy undermines the autonomy of female adolescents to make important choices with regard to their sexuality. It does not reflect the lived experiences of girls who are daily susceptible to coerced sex. Young people, especially young women in need of information on sexual health, should be provided with choices to make if they cannot abstain from or are prone to coerced sex. This will not only be in their best interests, but will also advance their sexual health and rights. One must ask the female adolescent question here by inquiring into the practicability or logicality of the policy of abstinence-only in a society where adolescent girls do not have control over their sexuality. Will an abstinence-only policy protect female adolescents from sexual ill health? Is abstinence within the control of female adolescents? These questions will challenge the inherent gender-blindness of adhering to abstinence-only policy with regard to the sexual health needs of adolescents. Often, abstinence denies that adolescents, particularly female adolescents, are capable of exercising autonomous choices regarding their sexuality.

3.3.2 Condoms

These are forms of contraception made up of a latex rubber and are about 0.065 to 0.085 millimeters thick.[30] They are of different sizes, shapes, textures, flavours and even colours.[31] Condoms provide protection from unwanted pregnancies and are effective in preventing STIs, including HIV/AIDS. Also, condoms are effective as a form of protection against cervical dysplasia – a condition if left untreated can lead to cervical cancer. In some cases condoms are made out of biological products such as lambskin. Though these types of condoms are as effective as others, however, they do not effectively provide protection against STIs, including HIV/AIDS.[32]

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[30] *Ibid.*

[31] See M Berer 'Condoms, Yes! Abstinence, No!'(2006) 14 *Reproductive Health Matters* 6.

[32] Women's Health Channel Contraception www.womenshealthchannel.com/.../index.shtml (Accessed on 23 November 2009).

In addition to the male condoms, female condoms are now available for use. The female condom is made up of a plastic, tunnel-shaped device that is closed on one end.[33] The close end is placed over the cervix. Female condoms are expected to be worn by women some hours before sexual activities in order to serve the dual purpose of preventing pregnancies and STIs (including HIV/AIDS).[34] An important advantage of the female condom is that it is controlled by the woman. This is a very significant feature, particularly in a country such as Nigeria, where patriarchy is the order of the day and negotiation of male condom is not within the power of women. In the era of HIV/AIDS pandemic, the female condom has the potential of advancing women's sexual rights and reducing their vulnerability to the epidemic.[35] Moreover, its adoption challenges the existing social order which often elevates male sexuality above female sexuality. With the female condom, adolescent girls are able to take a more active part in sexual acts and are able to prevent negative consequences of sexual ill health. If properly fitted, the female condom may not be noticed by a woman's sex partner during sexual intercourse.[36] It has no known medical side effects. To this extent, the female condom is an important tool to advance the sexual autonomy of female adolescents. However, unlike the male condom which is said to be about 90% effective, the female condom is about 80% effective.[37]

Compared to male condoms, female condoms are usually expensive and not easily accessible. This is a major disadvantage because the majority of women and girls, particularly in rural areas, will be denied access to them. In Nigeria, the use of condoms, especially the male condoms, is popular among young people.[38] This may be attributed to the fact that at the early stage of the campaign against HIV infection in the country, the

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[33] *Ibid.*
[34] *Ibid.*
[35] Berer (note 31 above) 13.
[36] Women's Health Channel (note 32 above).
[37] See Encyclopedia of Public Health 'Contraception' available at http://www.enotes.com/public-health-encyclopedia (Accessed on 29 April 2009); see also D Hollander 'Failure Rates of Male and Female Condoms Fall with Use' (2005) 31 *International Family Planning Perspectives* 94.
[38] See AO Arowojolu *et al* 'Sexuality, Contraceptive Choice and AIDS Awareness among Nigerian Under graduates' (2002) 6 *African Journal of Reproductive Health* 60-70; AM Sunmola *et al* 'Reproductive Knowledge Sexual Behaviour and Contraceptive use among Adolescents in Niger State of Nigeria' (2002) 6 *African Journal of Reproductive Health* 82.

use of condoms was popularised by the HIV prevention programmes of those times. Even today, HIV/AIDS prevention programmes among young people still echo the 'ABC'- A for abstinence, B for be faithful and C for use of condoms - approach. Usually, condoms are purchasable over the counter in the country without the need for medical prescription.

While the effectiveness of condoms is not in doubt, however, this can be affected by certain factors including exposure to heat, time of manufacture, correct and consistent use.[39] Often improper use, breakage and failure of condoms are common among adolescents probably due to lack of experience and sometimes anxiety during sexual activity.[40] There is yet no known side effect of condoms and if properly used, condoms can prevent STIs, including HIV/AIDS and unwanted pregnancies to a great extent.[41] A report has shown that male condoms provide an impermeable barrier against STI pathogens during vaginal intercourse but provide a lesser degree of protection against genital ulcers diseases such as HPV.[42] Currently, condoms are regarded as the best form of contraceptives for dual protection, despite their limitations.[43] A major gender-related challenge with the use of the male condom is that its success depends largely on men. Because of the power imbalance between men and women in the country, this can be problematic for female adolescents. In actual fact, male condom usage can limit the sexual autonomy of female adolescents as they may be unable to negotiate safe sex. Therefore, it may be necessary to ask the female adolescent question in order to challenge the status quo which gives men the privilege to determine whether or not to use the male condom.

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[39] Berer (note 31 above) 11.

[40] MA Gold *et al* 'Emergency Contraceptives: A National Survey of Adolescents Health Experts' (1997) 29 *Family Planning Perspectives* 15.

[41] TKS Ravindran & M Berer 'Contraceptive Safety and Effectiveness: Re-valuating Women's needs and Professional Criteria' (1994) 3 *Reproductive Health Matters* 8.

[42] See National Institute of Allergy and Infectious Diseases. *Workshop Summary: Scientific Evidence on Condom Effectiveness for Sexually Transmitted Disease (STD) Prevention* (2001) 6.

[43] *Ibid;* see also, A Glasier *et al* 'Sexual and Reproductive Health: A Matter of Life and Death' (2006) 368 *Lancet* 1595, where it is contended that due to the high rate of condom failure, it can hardly be said to protect against unwanted pregnancy. The authors therefore, suggest additional means of dual protection for adolescents.

3.3.3 Emergency Contraception

Emergency contraception (EC), sometimes referred to as the 'morning after' pill, is a form of oral contraception that when taken within 72 hours of sexual intercourse can prevent pregnancy. First documented in medical history as far back as the 1960s, the EC is an important means of reducing risks of pregnancy among victims of sexual assault.[44] In the mid-1970s, a Canadian physician, Dr. Albert Yuzpe, developed the modern form of the EC as an oral contraception.[45] This contains ethinyl estradiol and DL-norgestral or levonorgestrel which makes it an easy option for all women to use to avoid unwanted pregnancy. [46]

Whilst the safety and effectiveness of the EC has never been in doubt, religious groups and conservatives in society have continued to oppose it. The crux of this opposition is based on the fallacious argument that EC interferes with pregnancy and therefore amounts to an abortifacient.[47] Also, there is the belief that the promotion of EC among adolescents will lead to promiscuous behaviour thereby increasing the spread of STIs, including HIV/AIDS.[48] However, advocates of EC have contended that in light of the prevalence of sexual violence against women, particularly young women and high incidence of unwanted pregnancies, the logical and reasonable to do is to make EC available for young women. They reject the assertion that EC is an abortifacient.[49]

Indeed, recently a court was called upon to decide on the true nature of EC in the case of *Smeaton v The Secretary of State for Health and others.*[50] In that case, the plaintiff acting

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[44] C Effertson 'History and Efficacy of Emergency Contraception: Beyond Coca-Cola' (1996) 28 *Family Planning Perspectives* 44-48.
[45] S Woodson 'Is Emergency Contraception Going over the Counter? Exploring the Evidence as the FDA Prepares its Decision' (2004) 7 *AWHONN Lifelines* 507.
[46] *Ibid.*
[47] See RJ Cook *et al* 'The Legal Status of Emergency Contraception (2001) 75 *International Journal of Gynecology and Obstetrics* 185, 186; see also, A Heimburger *et al* 'Expanding Access to Emergency Contraception : The Case of Brazil and Columbia ' (2003) *Reproductive Health Matters* 150, 151.
[48] See for instance, E Muia *et al* 'Emergency Contraception in Nairobi, Kenya: Knowledge, Attitudes and Practices among Policy makers, Family Planning Providers and Clients, and University Students' (1999) *Contraception* 223, 226.
[49] Cook *et al* (note 47 above) 151.
[50] (2002) EWHC 610 (Admin) High Court of Justice of England and Wales.

on behalf of the Society for the Protection of Unborn Children (SPUC) in the United Kingdom had brought an action before a court claiming that the prescription and supply of EC amount to a criminal act under the law, since the EC or the morning-after pill brings about the miscarriage of a pregnancy contrary to provisions of the Offences against Persons Act 1861. However, the Court in rejecting this argument held that the EC is often used before the process of implantation of a pregnancy takes place and hence it is incapable of de-planting an already implanted egg. In other words, EC merely prevents a pregnancy from taking place but does not interfere with an already formed pregnancy. This decision is a vindication of the position of the advocates of EC that have continued to insist that EC is not an abortifacient. It is also a positive development in advancing the sexual autonomy of female adolescents. In rejecting the argument that EC is abortifacient, the Court is asking the female adolescent question given the fact that only girls make use of EC and are exposed to the challenge of unwanted pregnancy due to unprotected sexual act. Pregnancy among young adolescents as stated earlier, is dangerous and can be life-threatening. Therefore, the decision of the Court, which was founded on empirical evidence, is a positive response to the peculiar life circumstances of women and adolescent girls in many societies. The truth is that many women, especially young women, try as much as they can to avoid pregnancy at the early stage of their lives. Thus, classifying EC as an abortifacient would have denied them an important means of preventing unwanted pregnancy, and consequently put their lives and health in danger.

Nigeria is one of those countries with dedicated products approval for EC in form of tablets containing 0.75mg of the progestogen levonorgestrel known as Postinor.[51] In Nigeria, EC is a non-prescriptive substance and can be obtained over the counter at pharmacies and chemists' shops.[52] This is a positive development as it may facilitate access to the product for female adolescents in the country. However, due to ignorance on the part of adolescents and even health care providers about the use of EC, fewer adolescents than necessary are currently making use of it. For instance, a study of

[51] EP Renne 'Postinor use among Young Women in South Western Nigeria: A Research note' (1998) 6 *Reproductive Health Matters* 107.
[52] *Ibid.*

prevalence of EC use among undergraduate students in a Nigerian university has revealed that only 18% of about 510 undergraduates interviewed could identify 72 hours as the period within which the EC could be used after sexual intercourse.[53] Further corroborating this lack of knowledge or poor information, a study among young women in South-western part of Nigeria has revealed that some of these young women either abuse the use of EC or use it with the intention to abort a pregnancy. [54]

Despite the controversy that surrounds the use of EC and poor knowledge displayed by many young people, it has remained very useful in a number of ways. EC can save a woman the agony of an unwanted pregnancy, particularly where the woman has experienced sexual assault.[55] It is not expected to be used routinely; rather it should only be used after sexual intercourse.[56] EC as an oral contraceptive is usually a combination of estrogen and progestin or progestin only. It prevents a pregnancy by helping or inhibiting ovulation, by stopping the fertilization of an egg or by stopping the implantation of a fertilised egg in the uterus. This is achieved by retarding the development of the egg and by obstructing or delaying its release from the ovary. Since this process usually occurs before the union of the sperm and egg, a fertilised egg never gets to be implanted in the womb.[57] In fact, it is argued that EC may protect against cancer of the ovaries.[58] However, EC is ineffective once implantation has taken place since it cannot be used to interfere with an existing pregnancy.[59] Although it is widely believed that when EC is taken within 72 hours after an unprotected sex, it can reduce the chance of a pregnancy, some commentators have questioned this assertion claiming that it is misleading and not always true.[60] Supporting this view, a study conducted in Lothian, Scotland has shown

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[53] EM Aziken *et al* 'Knowledge and Perception of Emergency Contraception among Female Nigerian Undergraduates' (2003) 29 *International Family Planning Perspectives* 84, 85.
[54] Renne (note 51 above).
[55] N Sogukipinar *et al* 'Postcoital Contraception in Turkey' (2003) 80 *International Journal of Gynecology and Obstetrics* 159,160.
[56] Cook *et al* (note 47 above).
[57] J Green 'Refusal Clauses and the Weldon Amendments' (2005) 26 *International Journal of Legal Medicine* 401, 403.
[58] See Women Health Channel (note 32 above).
[59] See Center for Reproductive Rights *Government Worldwide put Emergency Contraception into Women's Hands: A Global Review of Laws and Policies* (2004) 4.
[60] See A Glasier *et al* 'Advanced Provision of Emergency Contraception does not Reduce Abortion Rates' (2004) 69 *Contraception* 361-366.

that despite the fact that some women received an advanced supply of EC the rates of unwanted pregnancy in the area was still as high as in other areas where EC was not freely supplied in advance.[61]

To the extent that EC prevents unwanted pregnancies, which is a major concern among young people in Nigeria, it is potentially important in advancing the sexual autonomy of female adolescents. Moreover, it helps to respond to the female adolescent question. Given that only women experience pregnancy and since the essence of the EC is to prevent unwanted pregnancies, removing barriers limiting availability and accessibility of EC to women, including young women in Nigeria, is more or less asking the female adolescent question. Studies have shown that adolescent girls are more scared of getting pregnant than being infected with STIs.[62] Therefore, when the risk of pregnancy is removed for adolescent girls, they are able to express their sexual autonomy without any fear.

While EC's effectiveness with regard to prevention of pregnancy is put around 95%, it offers no effective protection from STIs, including HIV/AIDS.[63] It is also likely to have side effects such as nausea, breast tenderness, spotting, weight gain, mood changes, and headaches.[64] As at 2005 at least 50 dedicated products for EC are said to have been registered in about 109 countries across the world.[65] Of the registered products, 36 are progestogen only pills, containing 0.775 mg of levonorgestrel pill and 7 products containing 1.5 mg of levonorgestrel per pill. About 8 products made up of combined pills containing 0.25 mg of levonorgestrel and 50 mg of ethynil estradiol per pill are equally registered.[66] Currently, EC is in use in 16 African countries as part of national guidelines, out of about 38 countries surveyed. About 19 out of these countries (including Nigeria)

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[61] *Ibid.*
[62] See A Bankole *et al Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences* (2006) 17.
[63] Cook *et al* (note 47 above).
[64] Women Health Channel (note 32 above).
[65] See International Consortium for Emergency Contraception 'Dedicated Emergency Contraception World wide' available at http://www.clae.info/Fichanumero6%5B1%5D.pdf (Accessed on 10 May 2009).
[66] V Shiappacasse & S Diaz 'Access to Emergency Contraception' (2006) 94 *International Journal of Gynaecology and Obstetrics* 30, 305.

surveyed, do not have any guidelines on EC. However, one or more dedicated products are available in 15 countries that do not have any guidelines on EC.[67] This tends to confirm the ubiquity of EC in the region. In so far as it helps women, especially young women to avoid unwanted pregnancies, EC can become an important tool of advancing a woman's right to exercise autonomous choices with regard to her sexual and reproductive health.

3.3.4 Microbicides

Topical microbicides are substances that are applied either in the vagina or the rectum to reduce the risk of infection.[68] They are in the form of a gel, cream, suppository, film, sponge or vaginal ring.[69] Current research has shown that microbicides provide a great promise for the womenfolk in part, because they do not require the active participation or even knowledge of the male partner.[70] They are substances that are capable of killing bacteria, viruses and parasites. Microbicides can substantially reduce transmission of STIs, including HIV/AIDS, when applied to the vagina or rectum.[71] The development of microbicides is particularly important in a country such as Nigeria where the estimated number of young women infected with HIV is more than that of young men.[72] Moreover, since Nigeria is the second country after South Africa with the largest number of people living with HIV,[73] making microbicides available to young women in the country will go along way in reducing the number of infected persons and mitigate the impact of HIV on young women. This measure would fill an important gap for women who are unable to

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[67] *Ibid.*
[68] C Woodsong 'Covert Use of Topical Microbicides: Implications for Acceptability and Use' (2004) 30 *International Family Planning Perspectives* 94.
[69] PAHO *The UNGASS Gender and Women's Vulnerability to HIV/AIDS in Latin America and the Caribbean,* (2002) 22.
[70] Woodsong, (note 68 above) 94.
[71] SS Abdool & QA Karim *HIV/AIDS in South Africa* (2005) 233; See also M Potts 'The Urgent Need for a Vaginal Microbicide in the Prevention of HIV Transmission' (1994) 84 *American Journal of Public Health* .188.
[72] See Federal Ministry of Health *National HIV sero-prevalence and Sentinel Survey* (2005); see also JM Mann 'HIV Prevention: An Update on the Status of Methods Women Can Use' (1993) 83 *American Journal of Public Health* 1379.
[73] UNAIDS *AIDS Epidemic Report* (2008) 12.

successfully negotiate for safer sex.[74] Effective microbicides are not yet available but as many as 60 products, including 11 that have proven safe and effective in animals are being tested in many countries.[75]

Microbicides contain selected anti-infective agents, which women may insert in the vagina before sexual intercourse in order to protect themselves and their partners from STIs, including HIV/AIDS.[76] These products can be classified by their dominant mechanism of action. They kill sexually transmitted pathogens, enhancing normal vaginal defense mechanisms, inhibiting early steps in the viral life cycle and entry into mucosal cells and interrupting the viral life cycle after infection.[77]

The effectiveness of microbicides should be assessed against the public health objective, which is to prevent the spread of STIs, including HIV/AIDS epidemic among women, by preventing transmission of HIV virus. If the effectiveness of microbicides is to be achieved, then it would be necessary to ensure that they are available, accessible, and above all acceptable, particularly to the male partner. For instance, the key problem with the condom is that it calls upon the woman to assert dominance in the sexual act which is usually controlled by the man. This contributes to the ineffectiveness of the condom.[78] Therefore, one of the major advantages of microbicides is that they will enable women and girls to assert their sexual autonomy and put them in the driving seat of preventing STIs, including HIV/AIDS. The emergence of mircrobicides as a woman-centered device, which assists women to enjoy sex without fear of harm and empower them to control their sexuality, challenges the *status quo*, and is more or less a response to the

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[74] M Potts 'Thinking about Vaginal Microbicide Testing' (2000) 90 *American Journal of Public Health*.188; see also M Potts *et al* ''Contraception and Safer Sex in HIV Infection' in MA Johnson & FD Johnstone (eds) *HIV Infection in Women (*1993) 243.

[75]Abdool & Karim, (note 71 above) 233; see also JG Vail *et al* 'Improving Topical Microbicide Applicators for Use in Resource-Poor Settings' (2004) 94 *American Journal of Public Health*.1089; see similarly, ME Bentley *et al* 'Acceptability of a Microbicide Among Women and Their Partners in a 4-Country Phase I Trial' *(*2004) 94 *American Journal of Public Health*.1159.

[76] A Stone 'Potential of Vaginal Microbicides in HIV control' (2004) 97 *Journal of the Royal Society of Medicine* 158.

[77] PF Harrison *et al* 'Topical Microbicides for Disease Prevention: Status and Challenges' (2003) 36 *HIV/AIDS* 1291; HP Koo *et al* 'Context of Acceptability of Topical Microbicides: Sexual Relationships' (2005) 61 *Journal of Social Issues* 68.

[78] Z Stein 'HIV Prevention: The Need for Methods Women Can Use' (1990) 80 *American Journal of Public Health* 460, 461.

female adolescent question. Unlike the male condoms, the use of microbicides is not necessarily dependent on the man. A woman can 'secretly' use them without the knowledge of the male partner.

Since microbicides are being developed, they must go through rigorous safety testing before becoming available to consumers. Several trials are currently being conducted in many African countries, including Nigeria, to determine their efficacy and safety. The outcomes of such trials are anxiously being awaited. Health activists and researchers are working closely together to ensure that the clinical testing of microbicides is thorough and ethical. If the testing reveals limits on a product's safety such implication will have to be clearly specified on the product labeling when it becomes publicly available. They are also considering developing a microbicide that would be non-irritant and non-toxic hence side effects free.[79]

3.4 Contraceptive knowledge among Adolescents

Surveys across the globe, especially in developed countries, have shown that most adolescents tend to show fairly good knowledge of contraception.[80] This knowledge about contraception is also evident in some developing countries, particularly in Asia, Latin America and Northern and Southern Africa [81] A compilation of data from Demographic and Health Surveys (DHS), since 1990 has shown that quite a substantial number of adolescent women in about 37 countries in the world can at least identify one form of contraception.[82] The compilation similarly reveals that in about 21 countries, eight out of ten or more adolescent women are aware of one method of contraception. However, this study shows great disparity in the level of knowledge found among

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[79] GCM *Microbicides would be the most important innovation in reproductive health since the Pill* Global Campaign for Microbicides *http:www.global-campaign.org/* (Accessed on 14 December 2009).
[80] National Research Council & Institute of Medicine *Growing Up Global: the Changing Transitions to Adulthood in Developing Countries* (2005) 4; see also, United Nations 'Adolescents Reproductive Behaviour: Evidence from Developed Countries' (1989) 2 *Population Studies* No 109 Add.1 New York.
[81] *Ibid*; see also, SL Curtis & K Neitzel *Contraceptive Knowledge use and Sources; DHS Comparative Studies* No 19 (1996) 12.
[82] AK Blanc & AA Way 'Sexual Behaviour and Contraceptive Knowledge and use among Adolescents in Developing Countries' (1998) 29 *Studies in Family Planning* 106-116.

adolescents in sub-Saharan Africa. For instance, knowledge is found to be lowest in Madagascar, where fewer that half of all adolescent women knows of one method, whereas knowledge is highest in Kenya, Rwanda and Zimbabwe, where at least close to 90% of adolescent women show familiarity with some contraceptive methods.[83]

In Nigeria, the 2003 DHS indicates that about eight out of ten women and nine out of ten men know at least one modern method of family planning.[84] It further states that knowledge is highest with regard to the pill, injectables and male condom. With regard to contraceptive knowledge among adolescents, knowledge in the country is said to be one of the lowest in sub-Saharan Africa.[85] A study conducted among secondary school girls in the South–eastern part of the country has revealed a low level of knowledge of effective contraception.[86] Another study has shown that adolescent girls often resort to crude and potentially injurious methods of avoiding pregnancy due to poor knowledge on effective contraception which can serve the same purpose.[87] This is an indication that more efforts are needed to ensure access to information and services on contraception to adolescents in the country.

3.5 Prevalence use of Contraception among Adolescents

Although over the years contraceptive use among women in the developing countries has increased, the percentage of women still using one form of modern contraception in developing countries is far lower than that of the developed countries. This fact is no-where more evident than in the soaring fertility rates in most developing countries, particularly African countries, when compared to the developed countries. On average, while a woman's fertility rate during her lifetime in some developed countries is around

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[83] *Ibid.*
[84] Federal Ministry of Statistics *Demographic Health Survey* (DHS) (2003) 62-64.
[85] Blanc & Way (note 82 above).
[86] See AO Okpani & JU Okpani 'Sexual Activity and Contraceptive use among Female Adolescents: A Report from Port Harcourt, Nigeria' (2000) 4 *African Journal of Reproductive Health* 40; O Alubo 'Adolescent Reproductive Health Practices in Nigeria' (2001) 5 *African Journal of Reproductive Health* 109-119; BO Adenike & AO Omoboye 'Sexual Networking among some Lagos State Adolescent Yoruba Students' (1993) *Health Transition Review* 151-157.
[87] See Alubo (note 86 above); corroborated by F Okonofua 'Abortion and Maternal Mortality in the Developing World' (2006) *28 Journal of Obstetrics and Gynecology Canada* 974-979.

one child, the fertility rate for her counterpart in some African countries is about 5 children.[88] This attests to the fact that women in African countries have an unmet need for contraception, which is a cause for concern considering the pervading poverty level in many African countries. Indeed, it has been found that approximately 55% of unmarried adolescents in West Africa, 47% in Eastern and Southern Africa and 32% in Central Africa have an unmet need for contraception.[89] It is estimated that about 60% of unmarried female adolescents in Nigeria have an unmet need for contraception.[90]

A woman is said to have an unmet need for contraception, 'if she is married, in a union or sexually active; is fecund (able to conceive a pregnancy); does not want to have a child in next two years; and is not using any contraception, either modern or traditional'.[91] The commonest reason given by most women for this unmet need is lack of access to services. Moreover, most of unmarried women do not see the need for contraceptive use until they are married.[92] An exponential increase in population size that is not matched by adequate sustainable resources poses great threats to the lives and well-being of the people, particularly women. It should be noted that access to contraception constitutes an aspect of the right to the highest attainable standard of health. Therefore, African countries in general and the Nigerian government in particular, are obligated to ensure availability, accessibility, acceptability and quality contraceptive services to adolescents.

Although Blanc and Way[93] in their analysis seem to indicate that more unmarried adolescents than their married counterparts are using contraceptives in sub-Saharan Africa, recent studies across the region have tended to debunk this assertion. For instance, a study has shown that of the about 29% of women at risk of pregnancy, 73% are found

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[88] Population Reference Bureau *World Population Data Sheet: Demographic Data and Estimates for the Countries and Regions of the World* (2008) 4.
[89] AE Biddlecom *et al Protecting the Next Generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancies* (2007) 17.
[90] G Sedgh *et al Meeting Young Women's Sexual and Reproductive Health in Nigeria* (2009) 7.
[91] G Sedgh *et al Women with Unmet need for Contraception in Developing Countries and their Reasons for not Using a Method* Occasional Report No 37 (2007) 5.
[92] *Ibid.*
[93] Blanc & Way (note 82 above).

in Africa.[94] Also, a study among adolescents aged 15-19 in Ghana, has shown that only 74% of all males, 51% of females not in a union and 38% of females in a union reported using a modern contraceptive method. In another study conducted among students aged 12-19 of randomly selected schools in Yaoundé, Cameroon, it was found that only 41% of those surveyed use a method of contraception.[95] Similarly, a study conducted in KwaZulu-Natal, South Africa, revealed that while 45% of adolescent girls reported having communicated with their first partner about using a contraceptive, only 35% actually used a method of contraception.[96]

When adolescents have cause to use any form of contraception at all, it has been found that most of them are more likely to use the male condom than any other form of contraception. A Kenyan study among sexually experienced secondary school students has found that the condom was the method of contraception most frequently used at last sexual intercourse.[97] In the KwaZulu-Natal study mentioned earlier, it was found that the majority of surveyed adolescent girls, who were able to use a form of contraception, were using a male condom, the pill or injectables.[98]

3.5.1 Contraceptive use among Adolescents in Nigeria

Generally, contraceptive use in Nigeria is low, but even lower among adolescents. The 2003 DHS has indicated that about 13% of currently married women are using a method of contraception, including about 6% of them using a modern method of contraception.[99] It states further that urban women are more than twice as likely as rural women to use a

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[94] See S Sigh *et al Adding it up: The Benefits of Investing in Sexual and Reproductive Health care* (2005) 18; see also, R Gorgen *et al* 'Sexual Behaviour and Attitudes among Unmarried Urban Youths in Guinea' (1998) 24 *International Family Planning Perspectives* 65-71where a study among about 3, 603 unmarried adolescents aged 15-24 in Guinea has shown that more than half of the sexually active respondents have never used a contraceptive.

[95] L Hessburg *et al Protecting the Next Generation in Ghana: New Evidence on Adolescents Sexual and Reproductive Health Needs* (2004) 4; see also, P Kamtchouing *et al 'Sexuality* of Adolescent Students in Cameroon' (1997) 25 *Contraception Fertility Sex* (Paris) 798-801.

[96] Manzini (note 4 above).

[97] K Kingu & LS Zanbin 'Contraceptive use among High School Students in Kenya' (1995) 21 *International Family Planning Perspectives* 108-113.

[98] Manzini (note 4 above).

[99] Federal Ministry of Statistics (note 84 above) 67.

method of contraception. According to the DHS, about 17% of adolescent women (the majority of whom are unmarried) have an unmet need for contraception.[100] While on average Nigerian women want large families, about 17% of married women still want to limit their family size or wait for sometime before their next birth, but their contraceptive needs are unmet.[101] The gap existing between urban and rural women in terms of usage of contraception is an indication of imbalance in access to contraceptive services in these areas. It may imply lack of availability and accessibility of contraception in rural areas. Thus, the Nigerian government will need to take measures to advance access to contraception for women and girls in the rural areas. The Committee on ESCR has hinted that failure by a state to remove barriers to health care services and goods (including contraception), for vulnerable and marginalised groups such as women, children, adolescents and those in rural areas, will amount to a breach of the state's obligation to realise the right to health of its citizens.[102] In other words, physical accessibility to contraceptive services must be assured to women and girls in rural areas. This is because female adolescents are more prone to sexual ill health than their male counterparts. A detailed discussion on the right to health and access to contraception is carried out in Chapter 6. Taking positive steps to facilitate access to contraception for women and girls in a society is more or less asking the female adolescent question.

Furthermore, several studies conducted in the country have shown a significant low level of contraception use among adolescents. For example, a study among 2, 460 secondary school students in South-eastern part of the country has revealed that only 17% of those surveyed had ever used a contraceptive method other than abstinence.[103] In another study conducted among 400 adolescents aged 12-24, it has been revealed that less than one fifth of sexually active adolescents are using a method of contraception to either avoid

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[100] Allan Guttmacher Institute 'Early Childbearing in Nigeria: A Continued Challenge' (2004) *Research in Brief* 6.
[101] Federal Ministry of Statistics (note 84 above).
[102] The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 34.
[103] U Amazingo *et al* 'Sexual activity and Contraceptive Knowledge and use among in-school Adolescents in Nigeria' (1997) 23 *International Family Planning Perspectives* 28-33.

pregnancy or prevent infection.[104] Also, a study among sexually active undergraduate students in Benin, Edo state, has shown that about 39% of those surveyed had ever used a method of contraception.[105]

The corollary of low contraceptive use among women, particularly young women, is high fertility rate and unwanted pregnancies. As at 2003, the total fertility rate in Nigeria was estimated at 5.7. Although this is a modest decline from previous years, nonetheless, it remains somewhat high.[106] The importance of this is that, the average Nigerian woman who is at the beginning of her childbearing years will give birth to 5.7 children by the end of her life making it one of the highest in the region.[107] Moreover, a recent report has confirmed that one third of sexually active young women have experienced an unmet need for contraception at the end of 2003.[108] Given the fact that the majority of childbearing in Nigeria is to young women, these figures represent serious threat to the lives and health of female adolescents. As mentioned earlier, early pregnancy and birth to an adolescent carries with it the danger of mortality and morbidity. The high incidence of unwanted pregnancies and HIV infection among female adolescents are not only indications of low use of contraception, but also reflect imbalances in gender relations in the country. This will require the Nigerian government to embark on measures that will facilitate good access to quality contraceptive services to adolescents in the country. For adolescents who use a method of contraception, the male condoms remain the commonest form likely to be used.[109]

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[104] CO Odumegwu *et al* 'Parental Characteristics and Adolescents Sexual Behaviour in Bida Local Government of Niger State, Nigeria' (2002) 6 *African Journal of Reproductive Health* 95.
[105] Teminn *et al* (note 6 above).
[106] Federal Ministry of Statistics (note 84 above) 52-54.
[107] *Ibid.*
[108] Sedgh (note 90 above) 12.
[109] Federal Ministry of Statistics (note 84 above) 64.

3.6 Factors Limiting Access to Contraception for Adolescents

Cook *et al* have identified four crucial factors –referred to as the four 'Ps'-that contribute to the determinant of human health.[110] These include providence, people, politicians and providers of health. They observe that providence determines the genetic constitution of every human being inclusive of the diseases for which we can become susceptible to. According to them, whether a human being is born a male or female is determined by the constitution of the chromosomes. By people, they mean that the kind of lifestyle behaviour a person adopts can have implications, not only for the health of that person, but also for the health of others. For instance, unwillingness or refusal of a male to use a condom during sexual intercourse can have implications for the health and well-being of a female adolescent. Concerning politicians, they are of the view that politicians and legislators can become catalysts for shaping our societies. This can be done through development and enactment of appropriate policies and laws and allocation of adequate resources to the health care sector. With regard to providers of health, they argue that with the recent advances in medical technology, it becomes imperative for health care providers to ensure that they protect, maintain and restore health of all people and in particular the vulnerable groups such as women, adolescents and children. These four determinants are equally crucial to the health needs of adolescents. As this study will show, the four Ps referred to by Cook *et al* also play important roles in the context of realising access to contraception for adolescents in Nigeria.

Furthermore, several other factors, aside from these determinants, can also limit access to contraception for adolescents in developing countries, including Nigeria. These factors can be classified under three broad headings -socio-cultural factors, barriers associated with the health care setting and legal and policy factors. The focus of this study is on the last factor (legal and policy), which is discussed extensively in Chapter 5. However, since there is a correlation between these factors, it is necessary to engage in a brief discussion on the impact of other factors on access to contraception for adolescents. Therefore, what

[110] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicines, Ethics and Law* (2003) 18.

follows is a brief discussion on the socio-cultural and health care-related factors that hinder access to contraception for adolescents.

3.6.1 Socio-cultural Factors

In a male-oriented society like Nigeria, where adolescent girls are expected to be in the dark with regard to their sexuality and discussion about sex between parents and wards is almost taboo, little can be known by adolescent girls regarding means of avoiding pregnancy or preventing transmission of STIs. Time and again, parents and guardians are failing in their responsibilities to equip their young ones with the essential information they require for their healthy growth. Most parents in the country do not realise the fact that they are the primary sexuality educators of their children. Oftentimes, in the name of tradition or religion, parents deliberately eschew talking to their young ones or even pass wrong messages across to adolescents that may rather confuse or mislead them.[111] But the truth remains that adolescents want to be talked to by their parents or guardians. This clamour for communication between parents and adolescents is captured in a plaintive plea by a 14-year old girl from Botswana as follows: 'In my country Botswana, there is a serious problem of communication between parents and their children. This is a cry from our hearts. Parents talk to us! Without your communication, guidance and dialogue we are a lost generation'.[112] Although this plea is from an adolescent in Botswana, it nevertheless captures the plight of most adolescents in Nigeria.

Also, because of cultural and religious practices in Nigeria, adolescent girls are censured from seeking information about their sexuality and any girl that defies this censure is tagged 'irresponsible', 'immoral' and 'unsuitable for marriage'.[113] As discussed in Chapter 2, the sexuality of adolescents, particularly female adolescents, is often construed

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[111] J Hughes & AP McCauley 'Improving the Fit: Adolescents' Needs and Future Programmes for Sexual and Reproductive Health in Developing Countries' (1998) 29 *Studies in Family Planning* 233; see also, CA Packer *Using Human Rights to Change Tradition: Traditional Practices Harmful to Women's Reproduction Health in Sub-Saharan Africa* (2002) 2.

[112] UNAIDS *Force for Change: World AIDS Campaign with Young People* (1998) 5.

[113] See C Nzioka 'Dealing with the Risks of Unwanted Pregnancy and Sexually Transmitted Infections among Adolescents: Some Experiences from Kenya' (2001) 5 *African Journal of Reproductive Health* 133, 137.

negatively in most of Nigerian communities. There is often fear that exposing unmarried adolescent girls to contraception is more or less a license to promiscuity in society.[114] This fear is more pronounced in the northern part of the country where Sharia law operates. Sharia forbids an unmarried adolescent girl to engage in sexual acts or to seek information related to her sexuality. Also, Ojo has contended that among Christian groups in Nigeria, biblical injunctions have often been cited to justify opposition to premarital sexual activity among young people.[115] He argues further that in most cases Christian religious beliefs have been invoked to suppress sexual pleasure and anatomy of the people, particularly adolescents. Therefore, harmless sexual activities such as masturbation, oral sex, or engaging in non-procreative pleasurable sex have been condemned as sinful and unacceptable.

These negative societal norms and values about adolescent girls are often used as a weapon of social control of women and their sexuality.[116] Hence, rather than relying on information from parents or guardians, studies have shown that most adolescents look elsewhere for information as regards their sexuality.[117] For instance, a study among young people in Nigeria has shown that most adolescents' source of information about sexuality is from either their peers or the media.[118] The prohibition of information related to one's sexuality to adolescent girls based on cultural and religious beliefs is often rooted in patriarchy. The whole essence of such practices is to preserve a girl's virginity or morality for her future husband. It represses female adolescents' sexuality and denies them the right of agency in sexual health matters. From the discussion on autonomy in Chapter 2, one of the important points made was that denying adolescents, especially female adolescents, the right of agency in sexual matters will erode their dignity as human beings. This is because the whole essence of autonomy is respect for human's

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[114] See for instance, LA Briggs 'Parents' view point on Reproductive Health and Contraceptive Practice among Sexually active Adolescents in Port-Harcourt Local Government Area of Rivers State, Nigeria' (1998) 27 *Journal of Advanced Nursing* 261-266.

[115] M Ojo 'Religion and Sexuality: Individuality, Choice and Sexual Rights in Nigerian Christianity' a paper presented at a seminar on Understanding Sexuality in Lagos 9 June 2009.

[116] AA Apomfo "When we speak Women listen": Gender Socialisation and Young Adolescents Attitudes to Sexual and Reproductive Issues' (1991) 5 *African Journal on Reproductive Health* 198.

[117] Alubo (note 86 above) 117.

[118] Sunmola *et al* (note 38 above) 83.

worth, regardless of differences in sex or gender, to make decisions that affect his/her life. The fact that in most cases male adolescents are not subjected to similar prohibition or censure raises the issue of discrimination or gender inequality. Pillard could not have put it better when she asserts as follows:

> Various forms of inequality and stereotyping contribute to a status quo in which many women get pregnant in circumstances in which they either do not want children, or want children yet feel they cannot have them. Girls and women disproportionately are taught to be in denial about their own sexual urges, and yet rely inappropriately on their sex appeal. The denial occurs both ways: Women are expected to deny the presence of their sexual desire (to guard chastity), and to deny its absence (to be sexually responsive to men). In a world in which such denial is the norm, women will lack the kind of agency and 'responsibility needed to meet their own desires for pleasure, well-being, support, and meaning in their lives. When the vast majority of women are (hetero) sexually active, yet women-controlled contraception is not recognized as a basic component of health care, it should not be surprising that millions of women face unwanted pregnancies.[119]

This warrants asking the female adolescent question. For instance, why should adolescent girls be made the custodians of chastity in many Nigerian cultures? Or put in another way, why should female adolescents be assigned the role of 'moral gatekeepers'? One may further ask: why should adolescent girls, who will find information related to their sexuality more useful, be kept in the dark about this fact? Considering the fact that lack of access to sexual health information may result in unwanted pregnancies or morbidity or injury to female adolescents, this prohibition is unwarranted and has failed to take into consideration the 'life experiences' of adolescent girls. Therefore, it has become important that this cultural or religious belief must be challenged and condemned with a view to eradicating it. It should be borne in mind that articles 5 of CEDAW and 2 of the African Women's Protocol enjoin states parties to take necessary steps and measures with a view to addressing cultural and religious practices that discriminate against women. Moreover, states are enjoined to embark on education and campaign programmes to achieve this purpose.

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[119] C Pillard 'Our other Reproductive Rights Equality in Sex education, Contraceptive Access, and Work-Family Policy' (2007) *Emory Law Journal* 943.

In some other situations, undue adherence to social norms has led adolescents to engage in unhealthy sexual behaviours inimical to their health. For example, a study in south-eastern part of Nigeria has shown that most people associate sexual virility with boys and that unless a boy has experimented with sex he is not fit to be regarded as a 'real man'.[120] One of the respondents in the study captured this social belief in this way: 'A boy is not a boy until he sleeps with a girl. My friends used to call me a small boy until I had sex. Personally, any body that has not slept with a girl is not a boy to me'.[121] The study also confirms that it is normal for boys to have multiple sexual partners and engage in multiple sexual relationships. Some of the respondents claim that they find the use of condoms uncomfortable and prefer having sex 'flesh to flesh'. This reinforces patriarchal tradition and would seem to coincide with Gilligan's observation in her seminal work *In a Different Voice: Psychological Theory and Women Development.* In that book, Gilligan observes that male and female children tend to exhibit different characteristics while growing up.[122] Essentially, Gilligan's study attempted to ascertain whether there is a distinctively feminine way of thinking or solving problems different from that of men. In her work, Gilligan has observed that young girls think and act differently from young men when they are called upon to solve a moral problem. According to her, girls tend to evoke the 'ethic of care' and tend to see things in terms of relationship, responsibility, caring, context and communication.[123] However, boys usually rely on the 'ethic of rights' or 'justice' and tend to analyse problems in abstract terms of right and wrong, fairness, logic, rationality, winners and losers, thus, ignoring context and relationships.[124] Indeed, traditional social psychology believes that 'normal' and natural behaviour for men include aggression, tenacity, curiosity, ambition, responsibility and competition. By contrast 'normal' behaviour for women includes passivity, affection, emotion, obedience, and responsive approval.[125]

Gilligan's seminal work has found support in Gordon's work. Gordon has observed that:

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[120] CO Izugbara 'The Socio-cultural context of Adolescents' Notions of Sex and Sexuality on Rural South-eastern Nigeria' (2005) 8 *Sexualities* 600, 608.
[121] *Ibid.*
[122] C Gillian *In a Different Voice: Psychological Theory and Women Development* (1982) 25-51.
[123] *Ibid* 164.
[124] *Ibid.*
[125] H Eisenstein *Contemporary Feminist Thoughts* (1984) 11-26.

> The socially defined requirement of femininity came to include the motherly characteristics- softness, self-effacement, passivity, sensitivity, and so forth- and to preclude fatherly ones- power, assertiveness, freedom and so forth.[126]

In Charlesworth's view, the conclusion that can be drawn from Gilligan's analysis is that 'just as traditional psychological theories have privileged a male perspective and marginalised women's voices, so, too, law privileges a male view of the universe'.[127] It may be added that in many Nigerian communities, cultural beliefs and religious tenets tend to privilege male children at the expense of female children. A likely consequence of this situation is that adolescent girls are readily deprived of their autonomous decision-making capability with regard to sexual health matters. Gender inequality coupled with the low status of women and girls will often make it difficult for them to express their sexuality and seek sexual health services, including services related to contraception. This does not augur well for any society as it tends to compromise the health needs of adolescent girls and put their lives in danger. This warrants asking the female adolescent question. Why should culture and tradition be used as excuses to repress the sexual autonomy of female adolescents? It will therefore, be necessary in accordance with provisions of CEDAW[128] and the African Women's Protocol[129] for the government of Nigeria to work hard in order to address socio-cultural factors that hinder access to contraception to adolescent girls in the country.

A study conducted in Lagos, Nigeria has shown that the level of education of an adolescent is crucial to his/her knowledge of preventing factors that can dispose him/her to sexual and reproductive ill health.[130] The more educated an adolescent the better his/her chances of taking precaution to prevent unwanted pregnancies and STIs.[131] Similarly, another study has shown that poverty and lack of resources can play a major

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[126] Gordon (note 9 above) 10.

[127] See H Charlesworth 'What are women's International Human Rights?' in RJ Cook (ed) *Human Rights of Women National and International Perspectives* (1995) 65.

[128] See article 5 of CEDAW which provides that states to must take necessary measures including education programmes to address cultural practices that are harmful to the health of women.

[129] Article 5 of African Women's Protocol also provides that states must take all necessary measures including education and awareness programme to eradicate discriminatory cultural practices against women and girls.

[130] MA Ogunlayi 'An Assessment of the Awareness of Sexual and Reproductive Rights of among Adolescents in South Western Nigeria' (2005) 9 *African Journal of Reproductive Health* 108.

[131] *Ibid.*

role in determining access to health care services, including access to contraception for adolescents.[132] The issue of cost as regards contraception can be particularly challenging in a world where it was estimated in 2000 that about 22.5% of young people were living below 1USD per day.[133] Nearly 90% of these young people live in developing countries, including Africa. Of the number of young people living in sub-Saharan Africa, about 60 million of them live in extreme poverty.[134] And less than 5% of these poorest young people worldwide are currently using a method of contraception.[135] The situation may affect female adolescents' capability to express their sexual autonomy and to negotiate condom use.

Moreover, poverty may also limit female adolescents' capability to seek contraceptive services as they may be unable to afford the cost of contraception. Experience has shown that poor women and girls tend to forgo their sexual self-determination due largely to lack of economic power. For instance, a study in Nigeria has shown that adolescent girls from less-well off households are more likely to have sex without using contraception than their peers from better-off households.[136] In other words, poverty aggravates gender inequality and suppresses women's and girls' sexual autonomy. The Committee on ESCR has noted that the cost of health care services and goods, including contraception, must not be unduly burdensome to marginalised and vulnerable groups in society.[137] Moreover, states are under obligations to remove barriers to economic accessibility to health care services and goods within their jurisdictions.

3.6.2 Barriers in the Health care Setting

It is ironic that the health care institution that ought to serve as a beacon of hope to adolescents has turned out to be a place of disillusionment for them, not least, because of

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[132] See Alubo (note 86 above).
[133] M de Bruyn & S Parker *Adolescents, Unwanted Pregnancy and Abortion: Polices, Counseling and Clinical Care* (2004) 7.
[134] *Ibid.*
[135] *Ibid.*
[136] UC Isuigo-Abanihe & KA Oyediran 'Household Socio-economic Status and Sexual Behaviour among Nigerian Female Youth (2004) 19 *African Population Studies* 81.
[137] General Comment 14 (note 102 above) para 12.

the judgmental attitudes of health providers and unfriendly nature of the health care setting. While studies have identified the health care institution as a possible place where adolescents can seek information and services on contraception, many adolescents tend to avoid using it. [138]

Most adolescents, especially female adolescents, often shy away from seeking advice on contraception from health care providers because they fear they might be misunderstood or misjudged. Adolescents are quite sensitive to their surroundings, especially when they have become sexually active, hence, they tend to show some discomfort when they are not certain that this fact will be kept away from their parents or guardians.[139] Although all adolescents experience challenges with regard to access to sexual health services, the situation is much more difficult for female adolescents. Negative attitudes on the part of health care providers are often targeted at female adolescents. While commenting on challenges in the health care sector obstructing access to EC in developing countries, Shiappacasse and Diaz have observed that lack of privacy, unfriendly attitudes towards adolescents and high cost of the product often act as stumbling blocks to adolescents' access to the product.[140]

Hobcraft and Baker have identified four major barriers to adolescent's access to sexual and reproductive treatment in the health care setting. These include poor remuneration of health care providers, a working environment poorly equipped to deal with young people, personal biases of health care providers and uncoordinated parallel programmes in the health care system.[141] These concerns are particularly true for many developing countries, including Nigeria. In Nigeria for instance, the doctor-patient ratio is relatively uneven at

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[138] M Amuyunzu-Nyamonap *et al* 'Qualitative Evidence on Adolescent's views of Sexual and Reproductive Health in Sub-Saharan Africa' available at http://www.agi-usa.org/pubs/2005/03/01/or16.pdf. (Accessed on 11 May 2009).

[139] See for instance, AS Erukhar *et al* 'What is Youth-Friendly? Adolescents' Preference for Reproductive Health Services in Kenya and Zimbabwe (2005) 9 *African Journal of Reproductive Health* 51, 52.

[140] Shiappacasse & Diaz (note 66 above) 302.

[141] G Hobcraft & T Baker 'Special needs of Adolescent and Young Women in Accessing Reproductive Health: Promoting Partnership between Young People and Health Care Providers' (2006) 94 *International Journal of Gynecology and Obstetrics* 351, 352; see also, D Breaken *et al* 'Access to Sexual and Reproductive Health care: Adolescents and Young People'(2007) 98 *International Journal of Gynecology and Obstetrics* 172.

28 doctors to 100, 000 people (that is, one doctor to about 3, 572 patients), [142] thus, putting undue pressures on health care providers. Worse still, poor remuneration and acute shortage of essential facilities in the health care sector have combined to make access to health care services, especially with regard to contraception, difficult for young people in the country. Due to this poor working environment, heath providers sometimes are overburdened and work under pressure, which make them vent their frustration on their patients, particularly adolescent patients.

Experience has shown that oftentimes, health care providers exhibit little knowledge or skills with regard to responding to adolescents' health needs, including access to contraceptive services. In some cases the environment may appear too cold for adolescents' comfort.[143] This situation often puts adolescents in a dilemma and sometimes betrays their confidence in the health care system so that they are reluctant to seek contraceptive advice even when in dire need. An adolescent seeking medical treatment is quoted as follows:

> I didn't know what to do. When a friend finally told me about the clinic, I was so relieved, but also nervous about going. The person at the reception just kept making me fill in forms, and it was a strange environment. I didn't know where to look, sit or stand. Eventually I was called in, very loudly, so I felt a bit vulnerable. I was on my own.[144]

Sometimes, health care institutions are located far away from reach of adolescents and they operate at such a time of the day that does not take into account the peculiar circumstances of adolescents. This could sometimes be frustrating for adolescents as confirmed in this statement:

> I gave up going to the clinic in the end; it was too difficult; trying to get there after school, trying to cover up my growing belly, trying to act normally. I felt like I had intruded the last time I was

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[142] Africapedia 'Doctor-Patient Ratio in Africa' available at http://www.africapedia.com/wiki/index.php?page=DOCTOR%20PATIENT%20RATIO%20IN%20AFRICA (Accessed on 6 June 2009).

[143] *Ibid*; see also, OM Ebuche *et al* 'Health care Provider's Knowledge of, Attitudes Toward and Provision of Emergency Contraceptives in Lagos, Nigeria' (2006)32 *International Family Perspectives* 83, 89.

[144] Hobcraft & Baker (note 141 above) 353.

there, like she just didn't have time for me. I felt silly and young when I started crying, and I hate feeling like that.[145]

It is important that health care facilities are not only friendly, but also that the confidentiality of adolescents within the health care system is guaranteed. This will include an assurance that others will not find out about adolescents' visits to a health care facility and that personal information about them and their sexuality are conducted in private. This assurance is more pertinent as regards advice on contraception for sexually active adolescent girls. Studies have confirmed that inability of most health care facilities to assure adolescents confidential health care services has been responsible for poor use of the health care system by most adolescents.[146] The health care settings will need to be particularly sensitive to the needs of female adolescents. While access to sexual health care services may be difficult for all adolescents, it can be particularly challenging for female adolescents. They are more likely to experience early sexual debut and its attendant consequences such as STIs, including HIV/AIDS and unwanted pregnancies. Therefore, the health care setting would need to address prejudices and stereotypes often associated with female adolescents seeking sexual health treatment or advice. Unlike their male counterparts, female adolescents have always been viewed as incapable of independent decision-making powers with regard to sexual health matters. This will need to be urgently addressed by making health care institutions responsive to the needs of female adolescents.

More often that not, the requirement for third-party involvement in adolescents' decision-making is usually aimed at controlling adolescent girls' sexuality. It is often believed that if female adolescents are allowed unrestricted access to sexual health services, including contraceptive services, they may become 'sexually untamable'. Female adolescents have always been classified as categories of persons who are unable to make decisions on their own. This tends to cast female adolescents as less emotionally and mentally strong as their male counterparts to make crucial decisions relating to their sexuality. This raises

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[145] *Ibid.*

[146] See World Health Organization (WHO) *Consent and Confidentiality: Increasing Adolescents' Access to Health Services for HIV and Sexual and Reproductive Health; Report of Regional Consultation* (2007) 4.

the question: why should female adolescents be treated as lacking capacity to make independent decisions compared to their male counterparts in matters relating to their sexuality? It will be recalled that the definition of sexual rights provided in Chapter 1 embraces the right of an individual to determine whether or not to engage in sexual activity and ensuring that such activity is safe and pleasurable. Adolescent girls seeking sexual health treatment in health care setting must not only be treated as autonomous beings but must also be guaranteed confidential services. Under no circumstance must they be singled out for discriminatory practices. As noted in Chapter 2, the concept of autonomy is premised on respect for all individuals to make decisions affecting their lives. In other words, autonomy guarantees sexual and reproductive self-determination. Although the various testimonies relating to the challenges adolescents encounter in the use of the health services described above occur in some developing countries, adolescents in Nigeria equally face similar challenges.

In line with the suggestions of both the Committees on ESCR[147] and on CEDAW[148], the government of Nigeria must ensure access to contraceptive services for female adolescents in an acceptable manner. Acceptability refers to the fact that services must respect the dignity of female adolescents and must be ethically compatible to their needs. Addressing challenges that female adolescents encounter in health care setting with regard to their sexual health, will require actions both within and outside the health care sector.[149] This is because issues of gender relations operate across such a wide and diverse spectrum of human life and in such inter-related ways.[150] Therefore, the Nigerian government must adopt a multi-sectoral approach, (involving civil society groups, professional bodies and policy makers) in order to remove the barriers female adolescents encounter in accessing contraceptive treatment in the health care setting. Moreover, the adoption of gender mainstreaming in the health care setting may be a desirable long term goal to ensure a gender-sensitive response to the needs of female adolescents.

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[147] See General Comment 14 (note 102 above) para 12.
[148] See General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 para 18.
[149] G Sen & P Ostin *Unequal, Unfair, Ineffective and Inefficient: Gender Inequity in Health Why it exists and how we can change it* (2007) 1.
[150] *Ibid.*

3.7 The Female Adolescent Question and Access to Contraception for Adolescents in Nigeria

In Chapter 2, reference was made to Bartlett's discussion of the three feminist methods or approaches to addressing challenges faced by women.[151] These methods or approaches are all important to the discussion on realising female adolescents' autonomy to seek contraceptive services. This is because feminist methodology has often focused on the lack of attention to the needs of women, including their human rights and well-being. The focus of discussion in this section of the study will be on how asking the female adolescent question can be useful in advancing access to sexual health services, including contraceptive services for female adolescents in Nigeria. Generally, the Nigerian society tends to privilege male adolescents' sexuality over that of female adolescents. Thus, while boys are permitted to express their sexual desires, girls are expected to remain sexually passive. This is a more or less sociological construction of boys' and girls' roles in society. Due to this construction, boys and girls are assigned different roles and responsibilities while growing up.

Writing on the experiences of female students in Nigerian universities, Odejide has observed that female students are usually portrayed and treated as subordinates to their male counterparts. She notes further that this is due to traditional cultures and social familial factors, which often perceive women as fragile, dependent on male protection and in need of surveillance and control of their behaviour.[152] It is further revealed in Odejide's study that female students' sexual agency is limited as compared with their male counterparts by some cultural and traditional beliefs. This negative construction of

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[151] See K Bartlett 'Feminist Legal Methods' (1990) 103 *Harvard Law Review* 829. The author has identified three feminist methods to addressing the challenges that women daily face in their lives. These are practical reasoning, feminist consciousness-raising and asking the woman question, see Chapter 2 paragraph 2.3.1.

[152] A Odejide 'What can a woman do? Being Women in a Nigerian University' (2007) 8 *Feminist Africa* 42, 45.

female adolescents' sexuality can make it difficult for them (adolescent girls) to exercise their autonomy and seek access to contraceptive services in the country.

Therefore, in order to break this negative perception or attitudes towards female adolescents' sexuality, the female adolescent question may need to be asked. It would be necessary to ask: why is it that female adolescents' sexuality is treated as less important than that of male adolescents under customary practices in the country? It will also be necessary to ask: why is it that female adolescents cannot exercise their right of agency like their male counterparts? It might also be necessary to ask: why is the health care system in Nigeria unwelcoming to female adolescents? The female adolescent question can similarly be asked with regard to the different types of contraception discussed in this chapter. For instance, one may ask: why is it that the female adolescent often finds it difficult to negotiate condom use with her partner? Given the fact that female condom empowers women to take control of their sexuality, the question may be asked: why is it more expensive than the male condom? Or why is that female condom is usually not available for most female adolescents, particularly those in rural areas? With regard to the use of microbicides, the female adolescent question will be interested in knowing what the Nigerian government has done to ensure that they are made available as soon as possible to protect female adolescents from HIV transmission. While in the case of EC the female adolescent question may inquire into the reason why information about the product is still lacking and why availability and accessibility of the product is still a major challenge in the country.

It will also be necessary to ask whether Nigeria's laws and policies relating to children and adolescents have addressed the peculiar needs of female adolescents. Do laws and policies in Nigeria guarantee unhindered access to sexual health services for female adolescents? Or do female adolescents need to seek parental consent before they can access sexual health services? Does the Constitution clearly contain provisions that can protect female adolescents from discrimination? The discussion in Chapter 5 relates to the assessment of Nigeria's laws and policies that may affect access to contraception for adolescents.

Moreover, the question may be asked whether Nigerian courts have given attention to the female adolescent question. One will need to inquire if Nigerian courts have interpreted provisions of the laws in such a way as to reflect the 'life situation' of female adolescents. In particular, have the courts paid attention to the lived experiences of female adolescents in cases involving their sexuality? Put in another way, what is the thinking of Nigerian courts with regard to female adolescents' sexuality? Or how can Nigerian courts in their decisions reflect the female adolescent question, particularly with regard to issues relating to the sexual health of female adolescents in the country? A detailed examination of the roles of the courts in advancing the sexual health of adolescents is carried out in Chapter 8 of this study.

The American case of *H.L v Matheson*[153] is a good example of how a court may fail to apply the female adolescent question to an issue sensitive to the health of female adolescents. In that case, an application was filed in court to challenge Utah's statute which requires that parents of minors seeking abortions must be notified of such medical procedure, but did not require such notification for parents of minor seeking prenatal medical services. The Court in justifying this law held that for a pregnant minor the choice of continuing with a pregnancy does not require medical decision that involve their parents as would be needed in the case of abortion. According to the Court, if a young girl decides to carry her pregnancy to term, the medical decisions to be made do not involve so 'potentially emotional and psychological consequences', unlike if she decides to abort the pregnancy. This decision fails to clearly make an inquiry into the life situation of adolescent girls who may experience an early pregnancy. In most cases such pregnancies are uncomfortable for them and may be prejudicial to their health. Pregnant young girls are more likely to die during childbirth compared with women within the ages of 20 and 30. Moreover, forcing a young girl to endure a pregnancy which she does not want can be mentally and psychologically traumatic. Therefore, had the Court taken these situations into account perhaps it would have reached a different conclusion. As shall be discussed in Chapter 8, the application of the female adolescent question requires

[153] (1981) 450 US 398.

the courts to break away from their conservative thinking and adopt a new approach of activism and gender-sensitivity.

3.8 Consequences of Unwanted or Unintended Pregnancies

Ordinarily, pregnancy ought to be a thing of joy, particularly when it is wanted. However, for many women in developing countries, including Nigeria, pregnancy has become life-threatening, especially when such pregnancy is unwanted or unintended. Unintended pregnancies among adolescents may be a result of non-use or wrong use of contraception, contraception failure or the belief that risk of pregnancy does not exists due to the young age of the woman or even the erroneous assumption that one act of sexual activity cannot lead to pregnancy.[154] A study has shown that approximately 80% of young girls in Nigeria become pregnant before they turn 20.[155] Early or unintended pregnancy among adolescents can be particularly precarious to their health and lives. Young women aged 10-14 are five times more likely to die during pregnancy than women in their twenties.[156] In some other cases adolescents are likely to experience miscarriage or stillbirth. This is often due to the underdevelopment of the pelvic bones and birth canal thus making the pelvis too narrow to accommodate the baby's head, thereby, necessitating prolonged or obstructed labour, increase risk of haemorrhage, and infection, or even permanent danger to her bladder and bowels.[157]

In most cases due to the shame and stigma often associated with teenage pregnancy in most parts of Nigeria, adolescent girls are sometimes forced to seek abortion. But because Nigeria still maintains a restrictive abortion law, most of these adolescent girls are left with no other option but to resort to unsafe or backstreet abortion, thereby endangering their lives and health. Studies have shown that the abortion rate per 1, 000

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[154] IK Warriner 'Unsafe abortion: An overview of Priorities and Needs' in IK Warriner & IH Shah (eds) *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action* (2006) 1, 7.
[155] E Ransmon & N Yinger *Making Motherhood Safe: Overcoming Obstacles in the Pathway to Care* (2002) 6.
[156] de Bruyn & Parker (note 133 above).
[157] *Ibid* 8.

girls aged 15-19 in Nigeria is 60.[158] This is relatively high compared to other developed countries such as Germany 3.6, Netherlands 4.2 and France 10.2 respectively.[159] It is estimated that 90% of all abortions in Nigeria take place informally and clandestinely.[160] Moreover, most of these abortions are performed by unskilled or untrained health care providers. The above scenario warrants asking the female adolescent question. Given the fact that young women's lives and health are daily endangered by unwanted pregnancy in Nigeria, the Nigerian government has not made it a priority to prevent these deaths by ensuring them universal access to contraceptive services. Why has the Nigerian government failed to create a conducive environment for the realisation of access to contraceptive services for female adolescents? Or why has the Nigerian government turned a blind eye to the sexual health needs of female adolescents, despite grave threats to their health and lives?

Pregnancy for a young girl could put an abrupt end to her dream of becoming somebody useful in society. This is because she might have to withdraw from school, thereby narrowing her chances of access to good jobs and better sources of income, thus, perpetuating the vicious poverty cycle among women in many African countries

3.9 Conclusion

This chapter has examined the history of contraception, noting that discussion on contraception has always been controversial. As far back as the 17th century, proponents of contraception have been made the subject of vilification and persecution. The basis for the opposition against the use of contraception is rooted in religious beliefs and doctrines, which emphasise that sexual intercourse is solely for the purpose of procreation. Unfortunately, in a conservative and 'religious' country like Nigeria, these beliefs and doctrines are still widespread and they threaten access to contraception for adolescents.

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[158] Population Reference Bureau (PRB) *Youth in sub-Saharan Africa: A Chart book on Sexual Experience and Reproductive Health.* (2001); see also, Ransmon & Yinger (note 155 above) 6.
[159] AN Feijoo *Adolescents Sexual Health in Europe and the US: Why the Difference*? (2001) 4.
[160] Izugbara (note 120 above) 602.

Moreover, they limit the ability of adolescents, especially female adolescents, to exercise their autonomy with regard to sexual health matters.

The chapter has also discussed some contraceptives which are commonly used by adolescents to prevent sexual ill health. The discussion here is not exhaustive but merely illustrative. Two broad challenges to access to contraception for adolescents, socio-cultural factors and problems within the health care institutions, have been identified. The negative construction of adolescents' sexuality in Nigeria tends to limit the ability of adolescents to exercise their autonomy with regard to seeking contraceptive services. Also, lack of knowledge and negative attitudes on the part of health care providers often prevent adolescents from seeking sexual health advice, particularly in the context of contraception. These situations require the government of Nigeria to take positive measures with a view to removing these barriers to adolescents' access to sexual health services.

Ensuring access to contraception for young people can bring about positive and healthy sexual development. This in turn will lead to the advancement of the sexual health and rights of adolescents. It has been pointed out that provision of contraception for about 210 million women in need will prevent about 23 million unplanned births, 22 million induced abortions and close to 14, 000 pregnancy-related deaths.[161] Despite this fact, and the fact that adolescents across the world are using one form of contraception more than before, it is worthy of note that many adolescents still lack good access to contraceptive use in Nigeria. The reason is not because most adolescents do not want to use a form of contraception, but because most adolescents still lack basic information and knowledge about contraception and experience some difficulties making use of the health care system. Hence, the continued high incidence of unwanted pregnancy and unsafe abortion yearly recorded in the country. Given that this scenario affects the health and lives of female adolescents more than their male counterparts, this requires asking the female adolescent question. One may ask: why is that the Nigerian government has not taken appropriate measures to address barriers to access to contraception for female

[161] Glasier *et al* (note 43 above) 1602.

adolescents? Since these socio-cultural factors repress adolescents' sexuality and hinder access to sexual health services to them, one expects a more positive and cogent response from the Nigerian government.

Therefore, as a matter of urgency, the Nigerian government must take proper measures to remove all barriers to contraceptive information and services for adolescents. Such measures must address the socio-cultural factors, which often limit access to information and knowledge on sexuality to adolescents. Also, in line with the General Comment 14 of the ESCR,[162] the government of Nigeria must ensure that services in relation to contraception for adolescents must be accessible, affordable, acceptable and of good quality. This will require the Nigerian government to establish more youth-friendly clinics for adolescents, especially female adolescents in rural areas, and subsidising treatment and advice related to contraception. It will also require the government to ensure that clinics are located within the reach of female adolescents, particularly those in rural areas.

Furthermore, it might be necessary for the government of Nigeria to embark on education and awareness programmes, particularly in rural areas, to dispel misconceptions about adolescents' sexuality. Experience has shown that ignorance often fuels cultural practices that are discriminatory against women and girls. Hence, the need for education programmes that will target community leaders and members on issues relating to the sexual health needs of adolescents, particularly female adolescents. Moreover, it will be necessary to conduct training for health care workers so that they are more responsive to the sexual health needs of adolescents in general and female adolescents in particular.

[162] General Comment 14 (note 102 above) para 12.

CHAPTER 4

THE RELATIONSHIP BETWEEN INTERNATIONAL HUMAN RIGHTS LAW AND NIGERIAN LAW

4.1 Introduction

The first step any signatory state needs to take with regard to showing commitment to the enforceability of a human rights treaty is to ratify that treaty. But, this is not enough, as ratification may not necessarily translate to applicability of a treaty domestically.[1] Therefore, it may also be necessary for a state to take additional steps to ensure the domestication of human rights treaties, particularly those treaties relating to the sexual health of adolescents. This, not only signifies willingness on the part of the state to fulfill its legal and moral obligations under international law, but also to uphold individuals' rights. However, the mere fact that a ratified treaty has not been domesticated does not preclude courts from referring to it in order to evaluate the degree of a government's commitment to realizing rights in general and adolescents' rights in particular.

Thus, this chapter will examine the historical development of the Nigerian legal system and the applicability of international law under the Constitution. It seeks to delineate the connection between these two precepts with adolescents' rights to enjoy sexual health. In doing this, the chapter considers the approaches under the Monist and Dualist schools of thought with regard to the relationship between municipal law and international law. This chapter also considers the relationship between the Nigerian Constitution and ratified international human rights treaties, rules of customary international law and 'soft law'.

Essentially, the chapter considers the place of international law including human rights law within Nigeria. Nigeria, like most common law African countries, adheres to the approach of the dualist school, but earned the distinction of being the only country in

[1] F Viljoen 'Application of African Charter on Human and Peoples' Rights by Domestic Courts in Africa' (1999) 49 *Journal of African Law* 1.

Africa to have directly incorporated the African Charter into its domestic law. This provides great opportunities for Nigerian courts to apply international human rights law to advance adolescents sexual rights. In reality, while Nigerian courts sometimes apply the provisions of the African Charter, this application has not been done consistently. This can have implications for the advancement of adolescents' right of autonomy to seek sexual health services.

4.2 History of the Nigerian Legal System

By virtue of the fact that Nigeria was colonized by Great Britain, its legal system is essentially influenced by English law. Shortly after the cession of Lagos to the British in 1861, the British colonial administration formally made Lagos part of its colony and established a court there in 1862.[2] Subsequently, via Ordinance No 3 of 1863, the British colonial government introduced English Law into the Colony of Lagos from March of that year.[3] The Colony also had its first Supreme Court established in 1863.[4] Thereafter, the West African Court of Appeal (WACA) was established to hear appeals from the highest courts in each of the British settlements, while further appeals were laid with the Judicial Committee of the Privy Council sitting in the United Kingdom.[5] By virtue of the Supreme Court Ordinance of 1876, the common law of England, doctrines of equity and statutes of general application in force in England on 24 July 1874 became applicable law enforced by the court in Lagos. It should be noted that the statutes were only applied subject to local circumstances.

During the colonial period, the British colonialists paid little or no attention to issues relating to the rights of children and adolescents. The colonial masters were more concerned with consolidating their hold on colonized territories than bothering with 'inconsequential' issues such as children's rights. This was hardly surprising as the notion of the rights of children was still at its infancy then. The first colonial legislation

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[2] A Obilade *Nigerian Legal System* (1978) 17.
[3] *Ibid.*
[4] See The Supreme Court Ordinance No 11 of 1863.
[5] Obilade (note 2 above) 18.

dealing with children was the Children and Young Persons Ordinance of 1943. This piece of legislation was specifically meant to deal with issues relating to the juvenile justice system in the country. It focused mainly on improving the juvenile justice system to make it more responsive to the needs of children who came into contact with the criminal law. This legislation also contained provisions relating to the welfare of young persons and treatment of young offenders. It had no provisions relating to the health of children neither did it contain provisions relating to the rights of children, particularly the autonomous decision-making powers of children.

The Children and Young Persons Ordinance has undergone several amendments since it was first enacted in 1943.[6] It has since been enacted into law by different states of the federation.[7] The Ordinance was later revised and incorporated into Nigeria's Federal Law in 1958.[8] This lukewarm attitude of the colonial masters to children's rights was equally reflected in the little attention given to women's rights. Indeed, it has been contended that respect for women's rights fared badly during colonialism in Nigeria. [9]

After the historic amalgamation of Nigeria in 1914, a new Supreme Court was established by virtue of the Supreme Court Ordinance of the same year. The provisions establishing the court, to a great extent, were *in pari materia* with those of the 1876 Supreme Court Ordinance. Thus, the law to be administered by the Court included the common law of England, the doctrine of equity and the statutes of general application, which were in force in England on 1 January 1900. The Supreme Court Ordinance was further amended in 1943 when a new Supreme Court of Justice was established for the whole country to replace the former Supreme Court and the High Court of the Protectorate.

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[6] See for instance, Children and Young Persons Ordinance 44 of 1945, Children and Young Persons Ordinance 27 of 1947, 16 of 1950 as well as Children and Young Persons Act Cap 131 Laws of Nigeria 1954 and Cap 47 of 1955.

[7] See for example, Children and Young Persons Law Cap 26 Laws of Lagos 1970.

[8] See Cap 32 of the Laws of Nigeria and Lagos 1958.

[9] See for instance, MO Okeme 'Domestic, Regional and International Protection of Nigerian Women from Discrimination: Constraints and Possibilities' *African Studies Quarterly* 6, no. 3 available at URL: http://web.africa.ufl.edu/asq/v6/v6i3a2.htm (Accessed on 25 June 2009); see also, T Pearce 'Women, the State and Reproductive Health Issues in Nigeria' (2001) 1 *Jenda: A Journal of Culture and African Women Studies* 1.

Between 1946 and 1960, the country witnessed a series of changes in its constitutional development. First, the Richard Constitution was introduced in 1946, to be replaced by the Lord Macpherson Constitution of 1951, which was in turn replaced by the Oliver Lyttleton Constitution of 1954.[10] Arguably, the 1954 Constitution officially transformed Nigeria into a federal state.[11] It should be noted here that none of these constitutions contained provisions relating to the human rights of the citizens, including rights of children. Thus, one may conclude that during early stages of the constitutional development of the country, there were no conscious attempts at guaranteeing rights of children and adolescents. Perhaps the British colonialists, just like the indigenous people, did not believe that children and adolescents were entitled to any rights but were rather to be treated as objects of care. This has been the belief of adults and parents all over the world for so many years until very recently when children are now viewed as rights holders.[12]

The 1960 independence Constitution was a product of rigorous consultations, deliberations and political maneuvering between the British colonialists and nationalists agitating for independence. For the first time in the history of constitutional development in Nigeria, a Bill of Rights was included in the Constitution. These provisions recognized individual rights such as the right to life, dignity and liberty. There were no specific provisions relating to the rights of children under this Constitution. This was a serious omission, which must have been influenced by the nonchalant attitude of the British colonialists to children's rights. Subsequent constitutions adopted in the country would seem to have been affected by this omission. Thus, from the period of independence to date, no Nigerian Constitution has contained specific provisions relating to children's rights. However, the various rights recognised under the 1960 Constitution could similarly be used to advance the rights of children.

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[10] See RT Suberu *Federalism and Ethnic Conflict in Nigeria* (2001); see also KA Kalu 'Constitutionalism in Nigeria: A Conceptual Analysis of Ethnicity and Politics' (2004) 6 *West African Review* 23.

[11] *Ibid.*

[12] The adoption of the Convention of the Right to Child in 1989 U.N. Doc. A/44/49 entered into force Sept. 2, 1990 marks the beginning of a new dawn in the recognition of Children as rights holders.

Under the Republican Constitution of 1963, it was no longer necessary for the Queen to give assent to bills, as this responsibility was given to the prime minister who was also the head of government. A new Supreme Court, which acted as the highest court of appeal, was established to replace the erstwhile Federal Supreme Court. Also, the Judicial Committee of the Privy Council ceased to become a court in Nigeria. The democratic dispensation put in place shortly after independence did not last long though, as the military took power through a *coup d'état* in January of 1966. From then until 1999, the greater part of Nigerian political history was under different autocratic military regimes.[13]

The military not only purloined the wealth of the nation but also ruled with iron hands and showed little regard for individuals' fundamental human rights. In actual fact, successive military regimes ruled the country via decrees. The fundamental rights provisions of the Constitution were suspended and the judicial arm of government was castrated through the introduction of 'ouster clauses'. These were clauses inserted in decrees forbidding the courts from entertaining any suit arising from any act committed pursuant to a decree or an edict. Many scholars criticised this approach calling it a constitutional aberration and an attempt to usurp the powers of the judiciary.[14] Indeed, the African Commission on Human and Peoples' Rights in one of its Resolutions on Nigeria condemned the gross violations of human rights in the country and expressed concern 'over promulgation of decrees and laws ousting the application of the African Charter on Human and Peoples' Rights and preventing the courts from intervening in cases of human rights violations'.[15] The whole country was turned topsy-turvy and virtually every facet of life witnessed one form of decay or another. In particular, little attention was paid to the health care sector, as all levels of the health care institutions were deprived of basic infrastructure needed to function effectively. More importantly, the sexual and reproductive health of the citizens, especially adolescents, was given little or no attention.

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[13] It should be noted that between 1979 and 1983 a civilian government, under the leadership of Alhaji Shehu Shagari ruled the country for a short period.

[14] See for instance, A Ojo *Constitutional Law and Military Rule in Nigeria* (1987) 8; see also B Nwbabueze *Military Rule and Constitutionalism* (1992) 12-30.

[15] See Resolution of the African Commission on Human and Peoples' Rights on Nigeria 1995. 17th Session.

Budgetary allocations to the health sector were woefully inadequate[16] and governmental programmes to address major epidemics such as HIV/AIDS, which could impact negatively on the health of adolescents, were almost non-existent.

In May 1999, over twenty years' reign of military rule came to an end, when a new democratic dispensation under President Olusegun Obasanjo was ushered in. A new Constitution known as the 1999 Constitution came into operation replacing the 1979 Constitution. The 1999 Constitution contains a number of important provisions such as the provisions in chapter IV dealing with the fundamental human rights of the citizens. While these provisions were meant to protect the rights of all citizens, they remain particularly useful in advancing adolescents' rights in the country. The Constitution, which is based on the principles of freedom, equality and justice, clearly provides in section 1(3) that the Constitution is supreme and that any law that is inconsistent with it shall be declared null and void according to its inconsistency. The implications of this provision, *vis-à-vis* international treaties that have been ratified by the country, will be examined later in this chapter.

4.3 Sources of Nigerian Law

The major sources of Nigerian law include Nigerian legislation, English law (consisting of common law, doctrines of equity statues of general application in force in England on 1 January 1900 and statutes and subsidiary legislation), English law made before 1 October, 1960 and extending to Nigeria, customary law and judicial precedents. The focus of discussion here is to examine the nature of attention and recognition accorded the rights of children and adolescents under these different sources.

[16] See for instance, PANOS *Patent, Pills and Public Health: Can TRIPS Deliver?* (2002) 12, it was estimated that Nigeria allocated a mere 2.5% of its total budgetary spending in the year 1998 to the health sector.

4.3.1 Nigerian Legislation

Nigerian legislation consists of statutes and other subsidiary legislation. The former relates to laws made by the legislature, while the latter refers to laws made by the executive arm of government with the permission of the legislature. Other forms of Nigerian legislation include ordinances made during the colonial period, decrees made by the federal government and edicts made by state governments during the military regime. Currently, the 1999 Constitution is regarded as the most important of all Nigerian legislation. Past Nigerian legislation serves as a source of law by acting as a sort of inspiration to new legislation. For example, the present Constitution derives its inspiration from the 1979 Constitution, while the 1979 Constitution in turn derived inspiration from the provisions of the 1960 and 1963 Constitutions respectively. Until recently, there was no Nigerian legislation specifically dealing with the rights of children in the country. The recent enactment of the Child's Rights Act (CRA)[17] marks a new beginning in the advancement of children's rights in the country. The CRA now serves as a source of inspiration to other state laws on children's rights and provides an opportunity to advance adolescents' sexual health in the country. A detailed discussion on this Act and other legislation is carried out in Chapter 5.

4.3.2 English Law

English law has been apart of Nigerian law since its introduction into the colony of Lagos in 1863. This consists of the common law, doctrines of equity, statutes of general application in force in England as of 1 January 1900, statutes and subsidiary legislation on specified matters and English law (statutes) made before 1 October 1960 and extending to Nigeria which are not yet repealed. Some Nigerian enactments that have received English law into the country include the Law (Miscellaneous Provisions) Act in force as a federal law throughout the country and different other enactments in force in Lagos, the former western states, the northern states and most of the eastern states. The provisions of these laws are substantially the same. Concerning the date '1 January

[17] Act 26 of 2003.

1900', it is now agreed that this date is applicable to English statutes and does not in any way relate to the common law or the doctrines of equity. To argue otherwise would amount to overreaching the intent of the law.

Notably, after several years of independence, Nigeria has continued to apply some of the English laws referred to above despite the fact that most of these laws are outdated and have in fact been repealed or amended by the British government. For example, the restrictive abortion law as reflected in the Nigerian criminal code, which was inherited from the British government, has since undergone reform in Britain while this provision has been retained in Nigeria.[18] More importantly, with regard to medical treatment for minor children, the common law position to the extent that treatment can only be provided to a minor if parental consent has been sought is still adhered to in Nigeria. The implication for an adolescent girl is that she may not be willing to seek advice or treatment in relation to contraception in the health care setting. Indeed, as discussed in Chapter 3, studies have shown that one of the reasons some adolescents, especially female adolescents, shun public health institutions is the fear that their privacy may not be guaranteed and visits may be made known to their parents or family.[19] It should be noted that this common law rule has been modified in Britain by virtue of the House of Lords decision in the *Gillick* case.[20] In that case, the Court held that a doctor could provide contraceptive services to a girl under 16 without parental consent, if it is satisfied that the girl has sufficient understanding of the treatment and its implications. A detailed discussion of this case is carried out in Chapter 8. While this case is not binding on Nigerian courts, it serves as a persuasive authority and the principles established can be applied to the situation in Nigeria. Therefore, this development is an indication that the

[18] By virtue of the Abortion Act of 1967 the abortion law in Britain was liberalized.
[19] AS Erukhar *et al* 'What is Youth-Friendly? Adolescents' Preference for Reproductive Health Services in Kenya and Zimbabwe' (2005) 9 *African Journal of Reproductive Health* 51, 52; see also G Hobcraft & T Baker 'Special Needs of Adolescents and Young Women in Accessing Reproductive Health: Promoting Partnership between Young People and Health Care Providers' (2006) 94 *International Journal of Gynecology and Obstetrics* 351; D Breaken *et al* 'Access to Sexual and Reproductive Health Care: Adolescents and Young People'(2007) 98 *International Journal of Gynecology and Obstetrics* 172.
[20] *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security* [1986] 1 AC 112.

time has come for the Nigerian government to update its legal system to conform to modern realities, especially as regards adolescents' sexual health needs.

4.3.3 Customary Law

Customary laws are customs accepted by the members of a certain community as binding among them. Customary law as a source of Nigerian law may be classified into ethnic or non-Muslim customary law and Muslim customary law.[21] The former is usually unwritten while the latter is written. Ethnic customary law may differ from one state to another and even within a particular state. This often poses great challenges with regard to uniformity of customary law in the country. Despite the unwritten nature of ethnic customary law, it is binding on members of a particular community and is recognised as law by the members of an ethnic group. According to the court in the case of *Olawoyin v Omotosho,*[22] ethnic customary law is 'a mirror of accepted usage'. Under customary law and prior to the advent of colonialism, children had always been treated with great respect among different ethnic groups in Nigeria. The birth of a child, particularly a male child, to any family was often seen as a blessing and celebrated with fanfare. However, as pointed out in Chapter 2, children and adolescents were not regarded as rights holders or persons wise enough to make important decisions concerning their daily existence. It was the belief in many cultures that children and adolescents would always require the guidance and wisdom of the elderly in society for them to successfully go through the crucibles of life.[23] Thus, parents and guardians often made decisions, including health-related decisions, on behalf of children. The assumption was that children and young people in general were incapable of making competent and morally valuable decisions without the help of parents or guardians.[24] Under this paternalistic belief, it was almost impossible for children and adolescents to exercise choices in relation to their sexuality. As observed in Chapter 2, this attitude towards children and adolescents has the tendency

[21] See Obilade (note 2 above).
[22] [1961] All NLR 304, 309.
[23] B Owasonye 'Implementation of the Convention on the Rights of the Child in Nigeria' available at www.lawrights.asn.au/docs/owasanoye2001.pdf (Accessed on 23 January 2009).
[24] The veracity of this assumption has been questioned by some authors. See for instance, J Erdman 'Moral Authority in English and American Abortion Law' in S Williams (ed) *Constituting Equality: Gender Equality and Constitutional Law* (2009) 107.

to undermine the autonomy of adolescents and bar them from making crucial decisions relating to their health.

Generally, customary law is flexible and changes with time. One would have expected that this flexibility would be used positively for the development of Nigerian society. However, despite several years of socio-economic development and changes in Nigeria, women and girls have continued to be subjected to discriminatory practices all in the name of custom and tradition. Stereotypical beliefs and practices continue to assign different roles to men and women in society. These different roles have helped in perpetuating patriarchal tradition which accords women's rights little or no respect.[25] Moreover, as Chapter 2 has shown, the enjoyment of women's and girls' sexual health is sometimes made subject to that of men. A situation which often makes it difficult for adolescent girls to seek information or services related to their sexuality. Thus, in most cases adolescent girls, as revealed in Chapter 3, tend to remain passive and reluctant with regard to seeking preventative health care services such as contraception, which could help to prevent sexual ill-health. This sexual subjugation of women and girls also makes it difficult for them to negotiate safer sex in the country. This may account for the high prevalence of HIV/AIDS among young women in Nigeria.[26] Indeed, some of the concerns of feminist scholars with regard to customary law are the fact that it tends to reduce women to second class citizens and devalues their humanity.[27] Therefore, feminism has questioned the justification for the continued adherence to customary law that remains discriminatory against women. [28]

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[25] See for instance, AA Aderinto 'Subordinated by Culture: Constraints of Women in Rural Yoruba Community, Nigeria' (2001) 10 *Nordic Journal of African Studies* 176.

[26] Federal Ministry of Health (FMOH) *National HIV/Syphilis Sero-prevalence Sentinel Survey* (2005) 34.

[27] See for instance, MP Eboh 'The Woman Question: African and Western Perspectives' in E Eze (ed) *African Philosophy: An Anthology* (1997) 5; see also F Banda *Women, Law and Human Rights: An African Perspective* (2005) 6-15.

[28] See M Wanyeki *Women and Land in Africa: Culture, Religion and Realising Women's Rights* (2003) 30-45; see also G Terry *Women's Rights* (2007) 46. Interestingly, however, some feminist scholars are beginning to argue that culture can be a source of promoting women's rights in Africa, see for instance, S Tamale 'The Right to Culture and the Culture of Rights: A Critical Perspective on Women's Sexual Rights in Africa' (2008) *16 Feminist Legal Studies* 47.

The application of ethnic customary law in Nigeria is subject to the repugnancy test. This test requires that for any ethnic customary law to apply, such a customary law must not be repugnant to natural justice, equity and good conscience. It would appear that a customary law will fail this test if it is 'barbaric or uncivilised'.[29] Thus, in *Edet v Essein,*[30] the court held as repugnant to natural justice and contrary to good conscience, a customary practice which permitted the plaintiff to take custody of children of a marriage on the grounds that he was the first to pay dowry on a woman before her subsequent marriage to the respondent, and that as a result he remained the husband of the woman, unless and until the respondent had refunded the plaintiff the initial dowry paid.

Perhaps another important criterion which Nigerian courts should have adopted to determine the suitability of customary law would have been its consistency with human rights principles. Such an approach will enable the courts to ask the woman question or the female adolescent question in cases bordering on women's rights. Most of the cases referred to above on this subject matter, were decided when the respect for human rights was still a relatively emerging issue in Nigeria. Therefore, little or no attention was paid to human rights issues raised by some of these discriminatory cultures and practices. More recently, however, the Court of Appeal in *Mojekwu and others v Ejikeme and others* [31] has held that a customary practice which denies women rights of inheritance is not only discriminatory but also repugnant and contrary to natural justice, equity and good conscience.

However, Nigerian courts, surprisingly have, in some situations, held that certain customary practices that are discriminatory against women are not repugnant to natural justice, equity and good conscience. For instance, in *Nezianya v Okagbue,*[32] the Nigerian Supreme Court held that a customary law among the Onitsha people of the Eastern part of the country, which denies inheritance rights to a female child, was not repugnant to natural justice. More recently, in *Mojekwu v Iwachukwu* the Supreme Court has also held

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[29] See *Esugbayi Eleko v Office Administering the Government of Nigeria* [1931] AC 662, 673 Per Lord Atkin.
[30] (1932) 11 NLR 47.
[31] [2000] 5 NWLR 402.
[32] [1963] All NLR 352; see also *Onwuchekwa v. Onwuchekwa* [1991] 5 NWLR 739.

that a similar customary practice was neither discriminatory against women nor repugnant to natural justice equity and good conscience.[33] Although the Supreme Court upheld the Court of Appeal's decision in *Mojekwu v Mojekwu*[34] to the extent that the respondent widow and her family were entitled to the disputed property, the Court berated the Court of Appeal for applying the repugnancy test doctrine to the *Ili Ekpe* custom[35] and for declaring it to be inconsistent with international human rights instruments. These decisions failed to consider the woman question raised by discriminatory cultural practices in the country. It was indeed a missed opportunity for the highest court in the country to condemn cultural practices that infringe on women's enjoyment of their fundamental rights. Had the Supreme Court asked the woman question in these cases, it would have been easier for the court to find that these cultural practices were not only products of patriarchy but also discriminatory to women and potentially harmful to their sexual and reproductive rights.

This clearly shows that reliance on the 'repugnancy test' to determine the suitability of a customary law may not be appropriate for cases relating to gender inequality. This is because this test does not capture women's true 'life experiences' but at best relies on abstract conjunctures often determined by male judicial officers of the colonialists at that time. Therefore, there is a need for Nigerian courts to engage in a more rigorous analysis of customary law and practices which may threaten women's enjoyment of their human rights. Such an analysis must reflect women's lived experiences. Decisions as those above may tend to compromise women's and girls' sexual and reproductive health as they may further lead to the perpetuation of sexual subjugation of women and girls, a situation which will make it difficult for women and girls to seek protective methods such as contraception.

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[33] *Mojekwu v Iwachukwu* [2004] 4 SC (Part II) 1.

[34] [1997] 7 N.W.L.R. 283, the Court of Appeal in that case declared a customary practice among the Igbo people of south eastern Nigeria, which denies right of inheritance to a female child as repugnant to natural justice and inconsistent with international human rights standards. Upon appeal to the Supreme Court the names of the parties in the case changed to *Mojekwu v Iwachukwu* [2004] 4 SC (Part II) 1, since the original respondent in the case became deceased.

[35] This is a notorious custom among the Igbos of the south eastern part of Nigeria, which denies right of inheritance to a female child.

Moreover, the reluctance of the Supreme Court to declare discriminatory inheritance customs as inconsistent with the Constitution and human rights principles and standards has created uncertainty in the equality jurisprudence of the country. Given that the Supreme Court is the highest court in the country, its position in *Mojekwu* case that customary laws, which do not accord women the same status as men in inheritance matters are not necessarily discriminatory, may have created a bad precedent for lower courts to follow in subsequent cases. This can lead to a situation where courts will refrain from applying human rights principles and standards to customary laws and practices that are potentially discriminatory against women. The important role of the courts in advancing the sexual health needs of adolescents is discussed further in Chapter 8.

Muslim customary law, on the other hand, is essentially believed to have derived from the teachings of the Koran, the practice of the Prophet (the *sunna*), the consensus of scholars and analogical deductions from the holy Koran and the teachings of the Prophet.[36] However, this assertion has been questioned by some commentators, claiming that Sharia is not God-given nor is its practice uniform throughout the Muslim world.[37] It is sometimes referred to as Islamic law. The applicable Sharia law in Nigeria is that of the Maliki school of thought.[38] Sharia as practiced in Nigeria was originally intended to regulate affairs of Muslims in civil matters. However, with effect from 2000, some states in the northern part of Nigeria introduced Sharia as state laws regulating both civil and criminal matters among the people. This approach sparked controversy and debates among the citizenry. The basis of contention by some commentators has been that this action is in contravention of section 10 of the 1999 Constitution, which forbids any state from adopting any religion as a state religion.[39] It is, however, interesting to note that to date there has been no constitutional challenge or ruling by the court on the constitutionality or otherwise on the introduction of Sharia as a state law in the north.

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[36] AA Fyzee *Outline of Muhammadan Law* (1964) 18-21.

[37] See AM Imam 'Women's Reproductive and Sexual Rights and the Offence of Zina in the Muslim Laws in Nigeria' in W Chavkin and E Chesler (eds) *Where Human Rights Begin: Health, Sexuality, and Women in the New Millennium* (2005) 65-94.

[38] See for instance, section 14 of the Sharia Court of Appeal Law (Northern Nigeria Laws 1963 cap 122) which enjoins Sharia Court of Appeal in the northern states to administer Muslim law of the Maliki school.

[39] For a detailed analysis on the constitutionality of Sharia in Nigeria, see A U Iwobi 'Tiptoeing through a Constitutional Minefield: The Great Sharia Controversy in Nigeria' (2004) 48 *Journal of African Law* 111.

Some provisions of Sharia are likely to have negative consequences for the enjoyment of women's (especially young women's) sexual and reproductive rights. For example, Sharia criminalises consensual sexual activities between two individuals outside of marriage.[40] It also discourages the use of contraception, especially among unmarried adolescents, as they are not expected to engage in premarital sexual activity. More controversially, the system apportions sentence to death by stoning to anyone (especially women) who is convicted of the offence of adultery. In the celebrated case involving *Amina Lawal* [41] a Sharia Court had sentenced the defendant to death by stoning for having a child outside of wedlock. Ironically, the man said to be involved with Amina and responsible for the pregnancy in question was acquitted by the same court for lack of evidence. Under Sharia law, the testimony of a man is sufficient to acquit him of the offence of adultery, while that of a woman charged for similar offence requires corroboration by four eye-witnesses.

However, on appeal, the Sharia Court of Appeal overturned the conviction on technical grounds. Again, the Sharia Court of Appeal failed to address the woman question raised by this case. If the Court had asked the woman question in this case, it would have discovered that Sharia law criminalises adult consensual sexual acts outside of marriage to control women's sexuality and to subjugate women's rights to that of men. Unfortunately, the Court merely glanced over this very important issue and relied on technical reasons for setting aside the sentence of death passed on Amina. The Sharia Court of Appeal could have inquired into the reasons for such a law which stipulates uneven modes of testimony in adultery cases for men and women and the implications of this for women. Given that the offence of adultery usually involves men and women, an important woman question which the Court missed to ask was: why must women, unlike men, require four eye-witnesses before they can be believed in a case of adultery? Such a

[40] In one case Bariya Ibrahima Magazu, a 17 year-old girl, was indicted under the Zamfara law for engaging in premarital sex resulting in pregnancy; on conviction she was sentenced to 100 lashes. See 'Nigerian Flogging Condemned' (2001) BBC news, available at, http://news.bbc.co.uk/1/hi/world/africa/1132168.stm.(Accessed on 12 May 2009).

[41] *Commissioner of Police Katsina State v Amina Lawal and Yahaya Mohammed* unreported case no 9/2002 delivered on 20 March 2002 (Sharia Court).

requirement creates the impression that women are not credible witnesses. This kind of stereotype and differential treatment of women merely reinforces gender inequality and subjugation of women in society. The failure of the Court to comment on the gender implication of this provision of the Sharia law, has led to a situation where this provision of the law has been invoked on different occasions to limit women's sexual autonomy. Restrictive provisions as these are not only insensitive to the female adolescent question, but can also make it particularly difficult for adolescents to have access to contraception in the country.

The gender-neutral position adopted by the Sharia Court of Appeal in *Amina Lawal* can be contrasted with the gender-sensitive approach adopted by the Ugandan Constitutional Court in a similar case. In the case of *Ugandan Association of Women Lawyers and 5 others v The Attorney General,*[42] the petitioners filed a case in court to challenge the constitutionality of certain provisions of the Divorce Act,[43] which provides for disparate treatment for men and women. A provision of the Divorce Act requires that a man need only prove adultery to obtain a divorce while a woman must prove aggravated adultery. The Ugandan Constitutional Court reasoned that the contested provisions of the Divorce Act are inconsistent with the Ugandan Constitution since they discriminate on the basis of gender.[44] More importantly, the Court noted that these provisions of the Divorce Act violate women's constitutional right to equality and are inconsistent with the principle of equality, which is a core value of the Ugandan Constitution. No doubt, this decision of the Ugandan court is more consistent with asking the woman question, in that the Court questioned the rationale for differential treatment of men and women in divorce matters. Moreover, the Court traced the origin of the Divorce Act to the colonial period and concluded that it represents a patriarchal tradition that has outlived its usefulness, thus, the Court declared the contested provisions as a nullity. This decision serves as a good

[42] Const. Petit. No. 2 of 2003 [2004] UGCC 1(3/10/2004).
[43] Specifically sections 4(1) & (2), 5, 21-24 and 26 of the Divorce Act chap 249 of Laws of Ugandan were being challenged.
[44] Article 21 of Ugandan Constitution of 1995 prohibits discrimination on the basis of sex, race, colour ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

model of how the court can ask the woman question in cases relating to gender inequality in general and women's sexual health needs in particular.

As noted in Chapter 1, Nigeria has ratified different international and regional human rights instruments; therefore, the country is obligated to ensure that customary laws and the Sharia do not interfere with the enjoyment of women's and girls' rights. Specifically in this regard, article 2 of the African Women's Protocol requires the Nigerian government to take adequate measures to eliminate discriminatory customs and practices that endanger women's health and well-being. Also, article 5 enjoins states to take necessary measures, including legislative and public awareness campaigns, with a view to eliminating customs and practices that are discriminatory against women or expose them to violence. These provisions would seem to require that Nigerian government takes positive steps to minimize the negative impact of customary laws and the Sharia on the enjoyment of female adolescents' sexual health.

4.3.4 Judicial Precedent

Under the common law, the doctrine of judicial precedent often implies law found in judicial decisions. This is also referred to as the *ratio decidendi* (the reason for a particular judgment.) Usually, by virtue of the doctrine of *stare decisis* a decision of a higher court, based on law and not chance remarks, is expected to be followed by a lower court. Thus, such a decision is said to be binding on the lower court. On the other hand, a decision of a court of concurrent jurisdiction is only of a persuasive authority on the other. Section 6 of the 1999 Constitution established different superior courts of records in Nigeria. At the apex is the Supreme Court, which happens to be the highest court of appeal in the country. Thus, any decision made by the Court is automatically binding on the Court of Appeal, the next court in the hierarchy, and other lower courts. However, in the event of two conflicting decisions of the Supreme Court on a particular issue, the Court of Appeal will be at liberty to follow either of the conflicting decisions. At present, there has been no decision by the court at the apex dealing with the rights of adolescents to seek sexual health treatment, including contraceptive services. Thus, in the absence of

direct judicial precedent, Nigerian courts may refer to decisions in other commonwealth jurisdictions as persuasive authorities. In this regard, the decisions of English courts such as in the *Gillick*[45] and *Axon*[46] cases can be relied on as persuasive authorities to advance access to contraception to adolescents in the country.

4.4 Nigerian Constitution and Health Needs of the Citizens

The 1999 Constitution of Nigeria, like other previous constitutions, does not contain any provision specifically recognising the right to health in the country. This is not peculiar to Nigeria as other Commonwealth countries, including Canada and India, do not guarantee the right to health as an enforceable right under their constitutions. The provision that makes reference to health in the Constitution is found in section 17, in chapter II of the Constitution. While section 17(1) of the Constitution provides for 'freedom, equality and justice', section 17(3)(d) places an obligation on the state to ensure that there are 'adequate medical and health facilities for all persons'. However, this section is under chapter II of the Constitution, which is captioned 'Directive Principles of Government Policy,' and which according to the Constitution is not justiciable.[47] But, under chapter IV of the Constitution, there exist a number of fundamental rights provisions that can be invoked directly or indirectly to address adolescents' access to contraception. A detailed analysis of these provisions is carried out in Chapter 5.

Under the Constitution, by virtue of the federal status of Nigeria, legislative powers are shared between the federal and state governments.[48] Also, the Constitution establishes three arms of government including the legislature, executive and the judiciary. The Constitution further contains provisions relating to the powers and responsibilities of both

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[45] *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security* (note 20 above).

[46] *R on the Application of Axon v The Secretary of State for Health* (2006) English and Wales High Court 37 (Administrative Court) Case No CO/5307/2004.

[47] See s 6(6)(c) of the Nigerian Constitution 1999, which provides that all rights, including the right to health, listed in chapter 2 of the Constitution, shall not be made justiciable. For a critical analysis of this provision see O Nnamuchi 'Kleptocracy and its Many Faces: The Challenges of Justicability of the Right to Health care in Nigeria' (2008) 1 *Journal of African Law* 1.

[48] See section 4 of the Constitution of Nigeria.

the federal and state governments. This is done through the classifications of these powers into exclusive and concurrent lists.[49] The exclusive list contains matters, which are entirely left for the federal government to legislate on to the exclusion of other levels of government.[50] Examples of items under this list include foreign affairs, immigration and currency.[51] Under the concurrent list, both the federal and state governments have the powers to legislate on these matters.[52] Matters that fall under this category include education, water resources, health and transportation.[53]

However, it should be noted that in the event of a conflict between the federal and state governments on matters under the concurrent list, the laws made by the former will prevail over the latter.[54] Thus, even though both the federal and state governments have powers to make laws and regulation regarding the health sector, it is still the responsibility of the federal government through the Federal Ministry of Health, to ensure proper coordination and organization in this sector. Therefore, in the event of the health care sector failing to meet the needs of the population, especially vulnerable groups such as women, children and adolescents, it is the federal government that will be held responsible for this shortcoming. Moreover, since it is the federal government of Nigeria that accedes to international human rights treaties, it is only logical that the federal and not the state government, is held accountable for failure to fulfill obligations imposed under these treaties. In other words, failure to meet the sexual health needs, including contraceptive needs, of adolescents will be blamed on the federal government.

Over the years, Nigeria's health sector has been undergoing difficult times not least because of poor funding and acute shortage of needed facilities. This, in turn, has meant

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[49] *Ibid.*

[50] Section 4 (3) of the Constitution provides as follows: 'The power of the National Assembly to make laws for the peace, order and good government of the Federation with respect to any matter included in the Exclusive Legislative List shall, save as otherwise provided in this Constitution, be to the exclusion of the Houses of Assembly of States'.

[51] See Part 1 of the Second Schedule to the Constitution.

[52] See Section 4(4) of the Constitution.

[53] See Part II of the Second Schedule of the Constitution.

[54] Section 4(5) of the Constitution provides that 'If any Law enacted by the House of Assembly of a State is inconsistent with any law validly made by the National Assembly, the law made by the National Assembly shall prevail, and that other Law shall, to the extent of the inconsistency, be void'.

poor remuneration and low morale of health care providers.[55] Oftentimes, health care workers embark on strikes to protest poor funding of the health sector or poor remuneration, thus putting the lives of patients in danger. In short, the public health care sector is ailing and has been described as 'mere consulting clinics'.[56] The resultant effect on the population has been debilitating infrastructure and poor delivery of services. This is evident in the unacceptably high maternal mortality rate, low life expectancy,[57] and denial of treatment to vulnerable groups such as women, children, adolescents, people living with HIV and people living in rural areas.[58] Although the decay in the health care sector began during the military era, the civilian governments that took over after 1999 have not fared better in terms of funding of the health sector. Access to sexual and reproductive health, especially for young people, has remained very challenging.

4.5 The Constitution and International Human Rights Instruments

As noted in Chapter 1, Nigeria has ratified international and regional human rights instruments such as the Convention on the Rights of the Child (CRC),[59] the African Charter on the Rights and Welfare of the Child (African Children's Charter),[60] the Convention on Elimination of All forms of Discrimination against Women (CEDAW),[61]

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[55] See E Durojaye & O Ayankogbe 'A Rights-Based Approach to Access to HIV Treatment in Nigeria' (2005) 5 *African Human Rights Law Journal* 287, 299.

[56] This phrase was made popular by the different military junta that ruled the country between 1983 and 1999. They have often cited the breakdown of infrastructure in the health care sector as one of the justifications for usurping political powers in the country. But unfortunately, they left the health care sector worse off.

[57] As at 2004 the average life expectancy for Nigerians was put at around 45 years compared to 54 and 55 years respectively for Togo and Senegal see WHO *The World Health Report 2006: Working Together for Health* (2006) 172, 174.

[58] See for instance, Federal Ministry of Health *Report on the Study on Access to Health care for People Living with HIV and AIDS in Nigeria 2002* (2006), where it is reported that women, including young women living with HIV face discriminatory attitudes from health providers more than their male counterparts.

[59] Convention on the Rights of the Child. Adopted in 1989 U.N. Doc. A/44/49 entered into force 2 Sept. 1990.

[60] African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999).

[61] Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

the African Charter on Human and Peoples' Rights (African Charter)[62] and the Protocol to the African Charter on the Rights of Women (Women's Protocol)[63] that can be used to advance adolescents' access to contraception in the country. However, ratified treaties under Nigerian law do not automatically become enforceable in the country, unless incorporated into domestic law. This approach is not in any way peculiar to Nigeria as other countries of the world adopt the same approach. It touches on the relationship between international law and municipal law, an issue that has become a subject of controversy and disagreement amongst scholars at international law. This is not merely an academic debate, as the position held by a state on this issue will determine the attitude of a government and its courts towards the application of international law domestically.[64] This can have implications for the advancement of adolescents' sexual health and rights under national law. For, if a municipal law adopts a restrictive approach to the application of international law and norms, then the various human rights principles and standards relating to children and adolescents under international law may become inapplicable to them under the municipal law.

Apart from the relevance of international treaties to advancing adolescents' sexual health and rights, it is also important to examine the legal significance of customary international law and 'soft law' such as consensus statements, general comments or recommendations and concluding observations issued by treaty monitoring bodies. These non-binding instruments impose moral obligations on states and help in further clarifying the nature of a state's obligation towards realising adolescents' access to contraception under international law. Through the issuance of concluding observations, treaty monitoring bodies are able to review states' reports with a view to determining their compliance with their obligations under a particular treaty. Moreover, this may create an avenue for these bodies to ask the female adolescent question with regard to the sexual health needs of adolescent girls. Although treaty bodies, unlike a court, adopt lesser legal

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[62] African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.
[63] The Protocol of African Charter on Human and People's Rights on the Rights of Women in Africa Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005.
[64] See GV Glahn *Law among Nations: An Introduction to Public International Law* (1996) 5.

rules and procedures when issuing concluding observations, sometimes, the informal procedures before these bodies, reveal that concluding observations may operate in form of a judgment. [65]

Crucially, despite the relevance of human rights principles in advancing adolescents' sexual health needs, feminist scholars have expressed great skepticism with regard to international human rights norms. In actual fact, feminists have contended that international human right norms have failed to respond to the peculiar needs of women. [66] The basis for this contention is that international human rights norms and standards have been developed in a male-oriented manner and have failed to take into account the peculiar 'life experiences' of women. However, as will be demonstrated below, while some of these criticisms remain valid and tenable, recent developments as evidenced by the activities of treaty monitoring bodies show that more attention is being given to the peculiar needs of women and girls.

General Comments on the other hand, are regarded as 'the means by which a UN human rights expert committee distils its considered views on an issue which arises out of the provisions of the treaty whose implementation it supervises and presents those views in the context of a formal statement of its understanding to which it attaches major importance'.[67] In addition, General Comments provide interpretative guidance with regard to specific rights or deals with other cross-cutting issues.[68] They also provide detailed content in a comprehensive and coherent way to the rather generally worded provisions of a human rights treaty, in a manner which is not possible when a treaty body comments on an individual state's reports. [69] A major criticism of the relevance of

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[65] K Mechlem 'Treaty Bodies and the Interpretation of Human Rights' (2009) 42 *Vanderbilt Journal of International Law* 907, 924.
[66] See H Charlesworth *et al* 'Feminists Approaches to International Law' (1991) *American Journal of International law* 613, 629; see also, G Binion 'Human Rights: A Feminist Perspective' (1995) 17 *Human Rights Quarterly* 509.
[67] P Alston 'The Historical Origin of General Comments in Human Rights Law ' in L B Chazournes and V Gowlland-Debbas (eds) *L'ordre Juridique International, UN System en quete D'equite et D'universalite-Liber Amicorum Georges Abi-saab* 763,764.
[68] Mechlem (note 65 above) 927.
[69] *Ibid.*

General Comments is that sometimes they are not contextual but mere abstract developments of contents of a right.[70]

The monist school of thought argues that no distinction exists between international law and municipal law and that the two are one and the same. It further maintains that there is only an existing legal order, known as the *grundnorm*, from which all norms exist in form of a hierarchy. The monists further argue that municipal courts are obligated to apply the rules of international law without any need for adoption by the courts or legislative transformation.[71] The basis of the monist school of thought position is that international law and municipal law are interrelated and should be seen to be complementing each other. This will allow for easy harmonization of both laws within a country.

However, it seems as if there is no consensus as to which of the norms (international or municipal) is higher than the other. Some monists like Wenzel and Lorn hold the view that municipal law occupies a higher pedestal whilst others such as Kelsen are of the view that international law is of a higher norm than municipal law.[72] A major criticism levelled against the monists approach (especially the claim of superiority of municipal law) is the fact that it fails to realise that it is usually states which consent to the application of rules of international law, permit such rules to be binding on them, and in some cases transfer authority, which they possess to some degree, to international law.[73]

In most civil law countries in Africa, monism seems to be the preferred choice. Thus, international law is directly incorporated into national law either through the provisions contained in the preamble[74] or somewhere in the body of the Constitution.[75] Despite this position of the monist, however, Viljoen has argued that in reality monism promises

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[70] *Ibid.*
[71] See J Dugard *International Law: A South African Perspective* (2005) 47.
[72] Glahn (note 64 above) 6.
[73] *Ibid* 7.
[74] See for examples the preamble to the Constitution of Madagascar of 1992 which incorporates the African Charter , ICCPR, ICESCRE, CEDAW and the CRC as an integral part of its law, see also the preamble to the Burkina Faso Constitution of 1991.
[75] See for example, article 132 of the Constitution of the Republic of Niger 1999, where it provides that treaties ratified have superior authority to other legislation; a similar provision exist in article 42 of the Cameroonian Constitution of 1996.

much more than it delivers. His submission is based on the fact that despite the constitutional promise that international human rights law is an integral part of domestic law, internal measures (such as adoption of legislation) are still necessary to give effect to the application of treaties within national law.[76]

The dualist school of thought on the other hand, argues that the rules and principles of international law and municipal law are far apart and completely distinct from each other. According to the dualists, championed by Triepel and Anzilotti, the sources of these two systems differ greatly from each other. Whilst municipal law is often derived from age-long customs and conventions applicable in a particular state and legislative enactments, international law on the other hand is mainly derived from custom grown up in a community of states and treaties agreed upon by independent states.[77] They also argue that international law governs relations among states and between states and other international entities, whereas municipal law regulates relations between citizens of a particular state and also between them and their state.[78] It is also contended that there is lack of a central commanding authority under international law unlike in municipal law where a national government controls the affairs of its citizens. Thus, international law can only be applied by domestic courts if 'adopted' by such courts or by an act of legislative transformation. A major weakness in the argument of the dualists is the fact that a clear-cut separation of international law from municipal law does not exist in actual practice. This position was confirmed by a Kenyan Court of Appeal when it held that in reality the rigid distinction between the monist and dualist theories, often associated with civil and common law countries, is a mere façade and is no longer tenable.[79] According to the Court, current thinking seems to support the fact that both customary international law and treaty law can be applied by state courts where there is no conflict with the state's law, even in the absence of a domesticating legislation.[80] The two systems, in reality, complement each other.

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[76] F Viljoen *International Human Rights Law in Africa* (2007) 533.
[77] Dugard (note 71 above).
[78] *Ibid.*
[79] *Mary Rone v Jane Rono and another* Civil Appeal 66 of 2002.
[80] *Ibid.* 11-12.

In consequence, it does appear that the position of the monist school of thought will be more favourable to advancing children's and adolescents' rights under national law than that of the dualist school of thought. This is because the monist approach tends to recognise the supremacy of international law principles and standards over municipal law. Thus, under this approach, international human rights principles and standards relating to children and adolescents that are contained in binding human rights instruments will be easily invoked to advance the rights of children and adolescents. In other words, important provisions contained in instruments such as the CRC, the African Children's Charter, CEDAW and the Women's Protocol including the clarifications provided by treaty monitoring bodies will be useful in advancing access to contraception for adolescents. However, the truth remains that most countries of the world adopt the dualist position rather than the monist approach. Even with the adoption of the dualist approach, opportunities still exist for states to advance the sexual health needs of adolescents in their countries. But, as discussed in Chapter 2, a major criticism levelled against international law in general, is that it is more or less a semblance of patriarchy and has failed to recognise women's sufferings and needs.[81] To this extent, feminists may argue that neither the adoption of monist nor dualist approach will make up for this serious deficiency.

The provision dealing with the relationship between international law and municipal law in the Nigerian Constitution is found in section 12 (1) of the Constitution. It provides that: 'No treaty between the Federation and any other country shall have the force of law to the extent to which any such treaty has been enacted into law by the National Assembly.' The import of this provision would seem to be that unless a treaty has been enacted into domestic law by the legislature, it cannot be enforced in Nigeria. This would seem to coincide with the reasoning of the dualist school of thought.[82]

With regard to section 12 of the Nigerian Constitution dealing with treaties ratified by the country, the only human rights instrument that will pass the test of incorporation so far is

[81] See Charlesworth *et al* (note 66 above).
[82] See E Egede 'Bringing Human Rights Home: An Examination of Domestication of Human Rights Treaties in Nigeria' (2007)51 *Journal of African Law* 249,250.

the African Charter. This is the only human rights treaty to have been enacted into domestic law by virtue of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act Chapter 10 Laws of the Federation 1990. On a number of occasions, the courts have invoked the human rights provisions of the African Charter. For instance, in the leading case of *Ogugu v The State,*[83] the Supreme Court of Nigeria held that the African Charter having being incorporated into Nigerian law has thus become enforceable before any court in the country.

However, the most recent and authoritative decision on this issue was in the case of *Abacha v Fawehinmi.*[84] In that case, the respondent/applicant had filed an application before a lower court challenging his unlawful arrest by armed security agents of the state and subsequent detention without trial, claiming that it violated his rights to liberty and dignity guaranteed under chapter IV of the Nigerian Constitution and the provisions of the African Charter. The appellant had filed a preliminary objection to the suit arguing that since the arrest of the respondent took place under Decree 2[85] of the then military government, the court was barred from entertaining the case. A Lagos High Court had struck out the suit claiming that it lacked jurisdiction to entertain the case.

On appeal to the Court of Appeal, the respondent had raised the point that since some of his rights violated were guaranteed under the African Charter, the provision of the African Charter should supersede the decree and thus, conferred jurisdiction on the court to entertain the suit. In its judgment, the Court of Appeal agreed with the submission of the respondent by holding that the African Charter having being incorporated into Nigeria law, occupies a very special status and that its enforcement in the country could not be limited by the provisions of a decree.

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[83] (1994) NWLR (Part 366) 1.
[84] [2000] 6 NWLR (Part 660) 228.
[85] State Security (Detention of Persons) Decree No. 2 of 1984. This Decree permits the government to arrest and detain for a considerable period of time anyone found to be a threat to the security of the country. It ousts the jurisdiction of the court to examine the legality or otherwise of any action done pursuant to the provisions of the decree.

On further appeal to the Supreme Court, the implications of section 12 of the 1979 Constitution (which is similar to section 12 of the 1999 Constitution) had been canvassed before the court. The Supreme Court held that while the African Charter has become part of Nigerian law and therefore enforceable in the country in accordance with section 12 of the 1979 Constitution, it is not in any way on a higher pedestal than the Constitution of the country. According to the court, in the event of any conflict between the provision of the African Charter and any legislation in the country, the former will supersede. But if there is a conflict between the African Charter and the provisions of the Constitution, the latter will take preeminence. This position was clearly set out by lead judgment of Ogundare JSC as follows:

> No doubt Cap. 10 is a statue with international flavour. Being so, therefore, I would think that if there is a conflict between it and another statute, its provisions will prevail over those of that other statute for the reason that it is presumed that the legislature does not intend to breach an international obligation. To this extent, I agree with their Lordships of the Court below that the Charter possesses "a greater vigour and strength" than any other domestic statute. *But that is not to say that the Charter is superior to the Constitution as erroneously, with respect, was submitted by Mr. Adegboruwa, learned counsel for the respondent* (emphasis supplied).[86]

One of the justices had said that no matter how important or beneficial an international treaty may be to the country, it is not enforceable in Nigeria unless it has been incorporated into domestic law. The implication of this decision is not yet ascertainable. While it is true that a treaty that has not been domesticated into Nigerian law may not be enforceable directly, it is submitted that there is nothing wrong for a judge to draw inspiration from such a treaty. The Supreme Court in the *Abacha* case would seem to have rigidly applied the provisions of the law. It was not so much about what was said but rather what ought to have been said but was not said. The case had presented the Court with the opportunity to clarify the position of the provisions of the African Charter (including those on socio-economic rights) *vis a-vis* the Constitution. However, the Court failed to avail itself of this opportunity. It is not as if the decision was wrongly decided, but the failure of the Court to address this important issue, exposes dourness and lack of judicial activism on the part of the Court.

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[86] *Abacha v Fawehinmi* (note 84 above) 289.

Notably, the fundamental human rights provisions of the Nigerian Constitution derive their inspiration from a human rights instrument, the UN Universal Declaration on Human Rights. Therefore, Nigerian courts should be able to draw inspiration and experience from international human rights standards when dealing with issues relating to the sexual health of adolescents in the country. It remains unclear, however, what the implications of the Supreme Court decision in *Abacha* case are for the sexual health needs of adolescents in the country. The statement of the Court in that case to the effect that 'being so, therefore, I would think that if there is a conflict between it and another statute, its provisions will prevail over those of that other statute for the reason that it is presumed that the legislature does not intend to breach an international obligation' seems to provide an avenue to advance adolescents' sexual health needs in the country. This statement can be broadly interpreted to mean that where the African Charter, which contains important human rights such as rights to health, information, dignity and life, all useful in advancing adolescents' access to contraception, is in conflict with a statute such as the Child's Rights Act, which contains limited provisions on the rights of children, the former will supersede. It will be interesting to see how Nigerian courts will react to this position of the Supreme Court when an opportunity arises.

As would be expected, the decision has become a subject of debate among commentators. For instance, Egede[87] has noted that the position of the Court in coming to the conclusion that the African Charter is not superior to the Constitution is correct and that to hold otherwise would have been absurd considering the provisions of section 1(1) and (3) of the Constitution.[88] He, however, faults the statement of one of the justices in the case claiming that ratified treaties no matter their beneficial nature to the country cannot be enforced or be of any benefit to the country unless it has been so incorporated. He reasons that this would seem to detract from the whole essence of entering into treaties by states and may deprive Nigerians the benefits of protections under human rights treaties

[87] Egede (note 82 above) 254.

[88] The combine reading of these provisions (similar to the 1979 Constitution) is to the effect that the Constitution is the supreme law of the land and that if any law is inconsistent with the Constitution, the Constitution shall prevail and such law shall be declared null and void to the extent of its inconsistency.

the country has ratified.[89] There seems to be some logic in this view. For, if the principles contained in ratified human rights treaties such as the CRC and the African Children's Charter were not to be considered by Nigerian courts, then the essence of ratifying a treaty will become a mere cosmetic exercise.

Indeed, Nigeria as a member of the international community is expected to take adequate steps not to defeat the purpose of treaties it has ratified.[90] Beyani has noted that 'It is a trite principle under international law that a state is responsible for failing to carry out its international obligations on account of the deficiency of its legal system'.[91] Also, Agbakwa argues that the Supreme Court in the *Abacha* case adopted a conservative and retrogressive approach to the interpretation of section 12 of the Constitution.[92] Another commentator has observed that the approach of the Supreme Court in this case seems problematic and superficial in nature as it is capable of eliciting confusion with regard to the true status of the African Charter within Nigerian domestic law.[93] No matter the level of criticisms levelled against this judgment, it remains the authoritative legal position in the country until it has been overruled.

One important question arising from the decision in *Abacha* case is to the effect that: What are the status of the socio-economic rights (including the right to health) guaranteed under the African Charter, but unjusticiable under the Constitution, before Nigerian courts?[94] As noted above, this question was not specifically addressed by the Supreme Court in that case. Thus, some courts in the country have gone ahead to invoke the socio-

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[89] Egede (note 82 above).
[90] See MN Shaw *International Law* (2003) 818.
[91] C Beyani 'Towards a more Effective Guarantee of Women's Rights in the African Human Rights System' in RJ Cook (ed) *Human Rights of Women: National and International Perspectives* (1995) 285, 299.
[92] See SC Agbakwa ''Retrieving the Rejected Stone: Rethinking the Marginalisation of Economic, Social and Cultural Rights under the African Charter on Human and Peoples' Rights' unpublished LLM thesis, Dalhousie Law School, Canada (2000) 159.
[93] C Onyemelukwe 'Access to Anti-retroviral Drugs as a Component of the Right to Health in International Law: Examining the Application of the Right in Nigerian Jurisprudence' (2007) 7 *African Human Rights Law Journal* 446, 469.
[94] For a detailed discussion of this issue, see ST Ebobrah 'The Future of Economic, Social and Cultural Rights Litigation in Nigeria' (2007) 1 *Review of Nigerian Law and Practice* 109; see also S Ibe 'Beyond justiciability: Realising the Promise of Socio-economic Rights in Nigeria' (2007) 7 *African Human Rights Law Journal* 225.

economic rights in the African Charter to cases before them. For example, in *Festus Odaife*[95] case, a Federal High Court has held that failure on the part of prison officials to provide access to treatment to four HIV positive prisoners was in violation of article 16 of the African Charter. According to the court, article 16(2) obligated Nigerian government to ensure that all persons within its territory are guaranteed access to health services including life-saving drugs.

In another decision of a Federal High Court, in the case of *Gbemre v Shell Petroleum Development Corporation and 2 others,*[96] the applicant brought a claim on behalf of his community, challenging the continued flaring of gas by the defendant arguing that it was injurious to the existence of the community. The Court held that the continued flaring of gas by the defendant was in violation of the rights to life and dignity of the applicant guaranteed under the Nigerian Constitution and articles 16 and 24 on the rights to health and clean environment of the African Charter. According to the court, the provision of the Nigerian legislation which permitted continued flaring of gas in the applicant's community was inconsistent with the applicant's rights to life and dignity under section 33 and 34 of the Nigerian Constitution and articles 4, 16 and 24 of the African Charter. The case is now currently on appeal to the Court of Appeal.

Though these two decisions are commendable and appear proactive, as they provide opportunities for advancing adolescents' sexual health and rights through the provisions of the African Charter, they need to be taken with a degree of skepticism. This is due to the fact that the doctrine of judicial precedent, which is to the effect that a decision of a higher court is binding on a lower court, is well recognised in the Nigerian legal system. Both decisions would seem to suggest that the African Charter can be invoked to fill in the gap existing in the Constitution with regard to the enforcement of socio-economic rights in the country. Even though the position taken by the courts in these cases would seem to have been endorsed by some commentators,[97] it remains highly contentious in

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[95] *Festus Odaife and others v Attorney General of the Federation and others* (2004) AHRLR 205 (NgHC 2004).
[96] Suit no FHC/B/CS/153/05. Judgment of the Federal High Court 2005.
[97] See for instance, Ebobrah (note 94 above); see also Onyemelukwe (note 93 above).

light of the Supreme Court's decision in *Abacha* case. Indeed, Egede submits that any conflict between the provisions of the African Charter and the Nigerian Constitution should be resolved in the favour of the Constitution.[98]

In a recent decision by the ECOWAS Community Court of Justice in the case of *Registered Trustee of SERAP vFederal Government and another*[99] it has been held that Nigerian government is legally obligated to ensure to its citizens the right to education guaranteed under article 17 of the African Charter. In arriving at its decision, the Court had rejected the argument of the Nigerian government that the right to education is a mere directive policy under Nigerian Constitution and of no legal force. According to the Court, since article 17 of the African Charter guaranteed the right to education and since Nigerian government has ratified this instrument, the Court has the jurisdiction to enforce the provisions of the Charter. This position of the Court is captured in these words:

> It is well established that the rights guaranteed by the African Charter are justiciable before this Court. Therefore, since SERAP's application was in pursuance of a right guaranteed by the provisions of the African Charter, the contention of the government that the right to education is not justiciable as it falls within the directive principles of state policy cannot hold".[100]

Given the fact that the decision of the ECOWAS Court is not binding on Nigerian courts but can at best be of persuasive authority, and bearing in mind the position of the Supreme Court in *Abacha* case, the legal implications of this decision remain uncertain. Experience has shown that Nigerian courts are more likely to follow the decisions of the Supreme Court or other superior courts than decisions by regional bodies such as the ECOWAS Court. Therefore, it is more plausible that Nigerian courts will follow the position of the Supreme Court which gives pre-eminence to the Constitution of Nigeria in the event of a conflict with the African Charter. It is important to state here that the ECOWAS Court merely held that the provision of article 17 of the African Charter on the

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[98] Egede (note 82 above).
[99] Suit [No ECW/CCJ/APP/0808] Judgment delivered on 23 November 2009 cited in S Ebobrah & A Tanoh *Compendium of African Sub-Regional Human Rights Documents* (2010) 298.
[100] *Ibid*

right to education was enforceable before it, but never commented on the enforceability of this provision before Nigerian courts.

It would appear that the position taken by the Supreme Court in *Abacha* case with regard to the status of the African Charter is correct. The mere fact that an international treaty has been incorporated into domestic law does not necessarily elevate the treaty above the Constitution. This is particularly true of a dualist state like Nigeria. As earlier noted, the dualists hold the view that differences exist between international law and municipal law. As correctly noted by the Supreme Court, the incorporation of the African Charter into domestic law by virtue of the African Charter Act qualifies it as an 'Act' of the National Assembly and can be enforced by the courts like every other legislation in the country. If that is the case, the provision of section 1(3) of the Constitution which provides that the Constitution is the supreme law of the land and that any law that is inconsistent with the Constitution shall be declared null and void according to its inconsistency will equally apply to the African Charter Act. While it is noted that essentially the provisions of the African Charter Act are the same as the African Charter itself, and that section 1 of the Act provides that state shall give effect to the provision of the African Charter, it is submitted that this must be interpreted in line with section 1(3) of the Constitution. Although as stated earlier, there are circumstances in which courts in dualist states do apply international law to domestic cases, especially where this will not conflict with domestic law, it would appear that the case in question does not fall under such circumstances.

Even in some monist countries where the constitution clearly provides that international law forms part of the law of the land, the courts are still reluctant to elevate international law above the constitution. A good example is the case of Senegal. Under the Senegalese Constitution of 2001, it is provided that treaties or agreements duly ratified shall have an authority superior to that of the laws, subject, for each treaty and agreement, to its application by other parties.[101] Senegalese courts have construed this provision to mean

[101] See article 98 of the Constitution.

that international law is superior to national laws but not to the Constitution itself.[102] This clearly exemplifies the fact that whether in a dualist or monist state, courts are generally reluctant in according superior status to international law over the national constitution.

The position adopted by the Supreme Court in the *Abacha* case seems to be the same under the British system. Although it is recognized that Britain has an unwritten constitution unlike Nigeria which has a written one, the legal systems in both countries, as mentioned earlier, are similar. Generally, treaties ratified by Great Britain are not binding on the country unless they have been so enacted into domestic law by the parliament. This position has been reiterated in a plethora of cases. For instance, in *Higgs and another v Minister of National Security and others* [103](cited with approval by the Supreme Court in *Abacha* case), The Privy Council noted as follows:

> In the law of England and the Bahamas, the right to enter into treaties was one of the surviving prerogative powers of the Crown. Treaties formed no part of domestic law unless enacted by the legislature. Domestic Courts had no jurisdiction to construe or apply a treaty, nor could unincorporated treaties change the law of the land. They had no effect upon citizens' right and duties in common or statute law. They might have an indirect effect upon the construction of statutes or might give rise to a legitimate expectation by citizens that the government, in its act affecting them, would observe the terms of the treaty.

In the earlier case of *Malone v Metropolitan Police Commissioner,*[104] an English court while considering the obligation assumed by United Kingdom under article 1 of the European Convention for the Protection of Human Rights and Fundamental Freedom noted as follows:

> The United Kingdom as a High Contracting Party which ratified the Convention on March 8, 1951, has thus long been under an obligation to secure these rights and freedoms to every one. That obligation, however, is an obligation under a treaty which is not justiciable in the courts of this country.[105]

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[102] See Viljoen (note 76 above) 532.
[103] [2000] 2 AC 228.
[104] [1979] Ch 344.
[105] *Ibid* 378.

These decisions would appear to summarize the dualist position under English law and put to rest any doubt, that as a general rule, unincorporated treaties within Britain are precluded from having legal incidence in municipal law.[106]

In South Africa, the provision that deals with the relationship between international treaties and the Constitution is found in section 231 of the 1996 Constitution. The section confers on the executive the powers to enter into treaties on behalf of the country, but states further that, such treaties will only become binding within South Africa only after they have been incorporated into law by the legislature.[107] Although section 231 adopts the phrase 'international agreement', rather than the well known term 'international treaty', it is argued that the former phrase is wide enough as to include the latter.[108] The requirement under section 231 (2) for an Act of parliament or other form of 'national legislation' in addition to parliamentary approval for treaties to become law in the country is a departure from the provision of the Interim Constitution of 1993. The Interim Constitution had sought to harmonise international law and municipal law by eliminating need for such approval.[109]

Interestingly, section 231 (3) provides that 'technical', 'executive' and 'administrative' agreements that do not require ratification or ascension, as distinguished from formal treaties, which require parliamentary approval, will become binding on the country upon signature. It would appear that the intention of the framers of the Constitution here is to facilitate day to day agreements entered into with other countries without necessarily over burdening parliament. In the absence of definitions for these words 'technical', 'executive' and 'administrative', Dugard argues that there may likely arise disputes as to their true meaning.[110]

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[106] See DE Pollard 'Unincorporated Treaties and Small States' (2007) 3 *Commonwealth Law Bulletins* 389,391.
[107] See section 231 (2) and (4).
[108] See Dugard (note 71 above) 63.
[109] Section 231 (2) of the Interim Constitution had provided that 'Parliament shall ...be competent to agree to the ratification of or ascension to an international agreement negotiated and signed by the executive'.
[110] See Dugard (note 71 above) 60.

4.6 The Constitution and Customary International law

It is generally accepted under international law that certain principles or peremptory norms that have become so established or well-entrenched form part of customary international law.[111] Some of the norms under international law that have become rules of customary international law include the abolition of slavery, freedom from torture, acts of genocide and respect for the right to life. It is not yet settled under international law whether the right to health has become part of the rules of customary international law. Indeed, some scholars would argue that the right to health is not sufficiently established enough to qualify as a rule of customary international law. In the case of *Flores v Southern Peru Copper Corporation*[112] it was held by an American court that the contents of the right to health are insufficiently definite to form part of the rules of customary international law. However, it should be noted that there are strong indications that the UDHR, which guarantees the right to health in article 25, is increasingly being recognised as forming part of the rules of customary international law. For instance, Humphrey has argued that some of the norms set out in the UDHR constitute part of customary international law.[113] In that case, this will provide a good platform from where to argue that realising access to sexual health services, including contraceptive services, for adolescents constitutes rules of customary law which states are expected to fulfill.

This assertion remains, however, debatable and would require further clarification in future. However, the right to life has been recognized as forming part of the rules of customary international law. Therefore, it can be argued that since lack of access to contraception among adolescent girls may lead to unwanted pregnancies, which may eventually lead to loss of health and lives, ensuring access to contraception for adolescents is a peremptory norm. While this statement is subject to debate, it is now agreed, going by recent decisions of regional tribunals such as the European Court of

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[111] *Ibid.*
[112] 343 F.3d 140 (2003) US Court of Appeal Second Circuit.
[113] JP Humphrey 'The Universal Declaration of Human Rights: Its History, Impact and Juridical Character' in BG Ramcharam, (ed) *Human Rights: Thirty Years After the Universal Declaration* (1979) 21- 38.

Human Rights,[114] Inter-American Court of Human Rights[115] and the African Commission, that the right to life also imposes obligations on states to prevent unintentional loss of lives.[116] However, as discussed in Chapter 2, feminist scholars have questioned the ability of international law including the UDHR to advance women's human rights. Feminists have argued that the entire international law system, which produced the UDHR and even the language of the instrument, are largely male-oriented. It is further contended that the doctrine of *jus cogens* or rules of customary international law reflect a male perspective of what is fundamental to international society, a view which may not be shared by women.[117] For example, feminists have argued that the exclusion of sex discrimination from the list of *jus cogens* is a clear indication of little attention paid to the gross injustice which results from such discrimination.[118] Therefore, they submit that the UDHR could not have adequately protected the needs of women.[119] While these observations of feminists are valid, recent developments evident by the activities of treaty monitoring bodies such as the Committee on CRC and Committee on CEDAW have shown that international human rights law is being interpreted in a way that accommodates the peculiar needs of women and girls. This point is explored further below.

Significantly, section 12 of the Constitution merely relates to applicability of treaties and is silent on the status of customary international law in the country. Interestingly, no other provision of the Constitution deals with this issue. It is therefore uncertain how the courts in Nigeria would approach this issue. However, it is most likely that Nigerian courts will follow the position in Great Britain, bearing in mind the similarity in the legal systems of these countries. Under the British system of government, the courts have often treated customary international law as forming part of British law. This position has been

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[114] See for instance, *Tavares v France* App No 16593/90 Euro. Comm. HR.
[115] See for example, *Villagran Marales et al v Guatemala* Series C No 65 19 November 1999(IACHR) para 144.
[116] See for instance, *International Pen and Others (On behalf of Ken Saro Wiwa) v Nigeria* (2000)AHLR 212(ACHPR 1998).
[117] See H Charlesworth & C Chinkin 'The Gender of Jus Cogens' (1993) 15 *Human Rights Quarterly* 63, 67.
[118] *Ibid* 70.
[119] Charlesworth *et al* (note 66 above) 624.

established by the courts in a number of cases. For instance, in the celebrated case of *West Rand Central Gold Mining Co Ltd. v The King,*[120] the court was called upon to answer among other questions whether customary international law formed part of the law of Great Britain. The court had responded that only such parts of international law that had either been accepted by Great Britain or that had been so widely accepted that it could not be supposed that any civilized state would repudiate them formed a part of the law of England. Thus, from this decision it would appear that only rules of customary international law that have either been generally accepted or specifically accepted by Great Britain would be binding on it.

Even though Nigerian courts have not had the opportunity to clarify the position of rules of customary international law, it is more likely that the position in Britain will be followed by the courts. This can be deduced from the Supreme Court's statement in *Ibidapo v Lufthansa Airlines* when the Court said that 'Nigeria, like any other Commonwealth country inherited the English Common law rules governing municipal application of international law'.[121] The position in other Commonwealth countries such as South Africa is similar to that of Great Britain. Thus, for several decades South African courts have treated rules and principles of customary international law as part of municipal law of the country.[122] Moreover, such rules and principles of international law were neither treated as foreign laws, nor were they required to be proved before they were applied by the courts.[123]

This position has now been given constitutional endorsement in South Africa under section 232 of the 1996 Constitution. It provides that 'Customary international law is law in the Republic unless it is inconsistent with the Constitution or any Act of the Parliament'. Thus, one may say that while the country adopts a dualist approach to implementation of ratified treaties within the country, it opts for the monist approach with regard to customary international law. An important part of the South African

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[120] [1905] 2 KB 391.
[121] [1997] 4 NWLR (Part 498) 124, 150 Per Wali JSC (As he then was).
[122] Dugard (note 71 above) 51.
[123] See for instance, the case of *South Atlantic Islands Development Ltd. v Buchan* 1971 (1) SA 234 (c).

Constitution which is not found in the Nigerian Constitution is the relevance accorded international human rights law. Section 233 of the South African Constitution urges every court, while interpreting any legislation, to give credence to international law if such legislation will be inconsistent with international law. Also, section 39 of the Constitution requires courts to consider international law when interpreting the provisions relating to the Bill of Rights in the Constitution. This provision readily provides an avenue for South African courts to apply international human rights principles to cases before them.

Indeed, recent developments from jurisdictions with similar dualist backgrounds as Nigeria has shown that domestic courts are beginning to apply international human rights law standards to cases before them. Supporting this view, Axelrod has argued that courts in dualist states now rely on international law principles in deciding cases brought before them.[124] He cited examples from court decisions in India and South Africa to support the assertion that customary international law can be invoked by a court in cases bordering on the human rights of the citizens. He argues further that while Indian law, as is the case in Nigeria, requires legislative implementation of treaties, in order for them to be enforceable, customary international law has always been considered as an appropriate source of jurisprudence in so far as it does not conflict with domestic legislation.[125] In his view, principles of customary international law are deemed to be part of the law of humanity and are therefore, necessarily applicable if a state wishes to be viewed as an upstanding member of the international community. He buttresses his point by citing the decisions of the Indian court in *Gramophone Company of India v. Birendra Bahadur Pandey.*[126] The case deals with commitments to other countries, balancing India's obligation to provide free transit of goods to Nepal under the Convention on Transit Trade of Land-Locked States against India's own copyright provisions. Even though the commitment in question centres primarily on treaty standards, the court nonetheless, expresses considerable interest in the application of international law principles. The

[124] M Axelrod 'Implementing Customary International Law in Domestic Courts' a draft paper prepared for the Annual Meeting of the International Studies Association Panel on 'Domestic Courts as International Actors' 22 March 2006 San Diego, Canada.
[125] *Ibid.*
[126] 1984 SCR (2) 664, (21 Feb 1984) (hereinafter *Gramophone*).

conclusion that can be reached from this analysis is that international human rights principles and standards are becoming useful to courts in dualist states. This provides an opportunity for Nigerian courts to advance sexual autonomy of adolescents in seeking contraceptive services.

The position of the South African Constitution under section 233 is a welcome development as it permits courts to invoke principles under international human rights treaties or instruments even though such treaties have not been ratified by South Africa. It provides an opportunity to invoke human rights principles and standards, including rules of customary international law, to advance human rights, particularly adolescents' sexual health and rights. This was the situation in the *Grootboom*[127] case where the Constitutional Court relied extensively on the clarifications provided by the Committee on the Covenant on Economic Social and Cultural Rights with regard to states obligations under the Covenant in its General Comments 3[128] to arrive at its decision in that case. The Court adopted this approach even though South Africa has merely signed but not ratified the Covenant on Economic Social and Cultural Rights. Although the Court did not accept wholly the guidelines provided in General Comment 3, especially as regards the interpretation given to the 'minimum core contents' of socio-economic rights, nonetheless, it was greatly influenced by the reasoning of the Committee of ESCR in that General Comment. The Court held that government's policies with regard to housing fell short of expectation as it was unreasonable and incapable of meeting the needs of those in urgent needs. This decision can be invoked to hold government accountable, if its policies and laws with regard to adolescents' sexual health needs, are unreasonable and failing to meet the urgent needs of adolescents, particularly female adolescents.

This approach by Commonwealth countries to customary international law does provide a window of opportunity for realising access to contraception for adolescents. As pointed out earlier, some of the rules of customary international law such as the right to life and

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[127] *Government of the Republic of South Africa and others v Grootboom and others* 2001 (4) SA 46 (CC); 2000 (11) BCLR 1169 (CC).

[128] The Nature of States' Parties Obligations UN Comm. On Economic, Social and Cultural Rights General Comment 3, 5th Sessions UN doc. E/1991/23, Annex III.

some of the provisions of the UDHR provide strong justification to argue that Nigerian courts should consider these rules while dealing with cases relating to adolescents' sexual health and rights.

4.7 The Constitution and 'Soft law'

The provision of section 12 of the Nigerian Constitution is silent on the status of soft laws within the domestic law. 'Soft law' often refers to declarations and resolutions made by governments at different meeting and fora. Sometimes, the term is use to include clarifications provided by treaty monitoring bodies in the form of general comments or recommendations and concluding observations to states parties. Generally, 'soft law' is not legally binding on states, however, it imposes moral obligations on states and provides a very good interpretative source of law under international law.[129] Over the years, several declarations and resolutions have been made at international and regional levels that can have implications for the enjoyment of adolescents' sexual health, particularly in relation to contraceptive services and information. For instance, at both the International Conference on Population and Development (ICPD)[130] and the Beijing Platform of Action,[131] governments of the world agreed that it was essential to ensure comprehensive access to sexual and reproductive health care services for women and adolescents throughout their life cycle.

Moreover, it was agreed that by 2015 universal access to sexual and reproductive health services, including services related to contraception, should be available to all. Also, at the regional level, African governments at both the Abuja Declaration[132] and the Maputo Plan of Action,[133] committed themselves to allocate at least 15% of their annual budgets

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[129] See H Hillengenberg 'A Fresh Look at Soft Law' (1999) 10 *European Journal of International Law* 499.

[130] Programme of Action of the International Conference on Population and Development (ICPD). Adopted in Cairo 5-13 September 1994, UN Doc. A/CONF. 171/13 1994.

[131] Beijing Declaration Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1(1995).

[132] African Summit on HIV/AIDS, Tuberculosis and other Related Infectious Diseases, Abuja-Nigeria April 24-27 2001 OAU/SPS/ABUJA/3

[133] Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010 (Special session at the African Union Conference of Ministers

to the health sector to meet the challenges posed by HIV/AIDS and other diseases in the region. The Maputo Plan of Action has further emphasised the need to improve the health needs of adolescents by ensuring them access to comprehensive sexual and reproductive health care services, including services related to contraception, by the year 2015.

With regard to treaty monitoring bodies, General Comments 3[134] and 4[135] of the Committee on CRC, General Comments 14 of the Committee on ESCR[136] and General Recommendation 24[137] are some of the relevant clarifications with regard to the right to health, including issues relating to access to contraceptives for adolescents. Also, some of the treaty bodies, in their concluding observations, have made reference to the importance of ensuring access to sexual health services, including services related to contraception to adolescents. In addition to all these, decisions by regional tribunals such as the African Commission can be relevant in advancing the sexual health of adolescents.

Generally, Nigerian courts have not attached much importance to 'soft law' in their decisions. For instance, in the *Festus Odaife*[138] case, despite the fact that the court invoked the provision of article 16 of the African Charter to hold that the Nigerian government was in violation of the right to health of four HIV positive prisoners, the court did not refer to any clarification by treaty monitoring bodies on the right to health. Equally, the court failed to refer to any decisions of the African Commission on the issue. This can be regarded as an omission on the part of the court. The Court could have referred to the International Guidelines on HIV/AIDS[139] and General Comment 14 of the

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of Health on the universal access to comprehensive sexual and reproductive health services in Africa, September 2006) Sp/MIN/CAMH.

[134] Committee on the Right of the Child, HIV/AIDS and the Right of the Child, General Comment N0 3 CRC/GC/2003/3 Thirty-Second Session 2003.

[135] Committee on the Right of the Child, Adolescents Health and Development in the Context of the Convention on the Right of the Child, General Comment N0 4 CRC/GC/2003/4 Thirty-Second Session May 2003.

[136] The Right to the Highest Attainable Standard of Health UN Committee on Economic, Social and Cultural Rights General Comment 14, UN Doc. E/C/12/2000/4.

[137] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1

[138] *Festus Odaife* case (note 95 above).

[139] Notes from the consultative meeting on International Guidelines on HIV/AIDS and Human Rights. UNCHR Res. 1997/33, UN Doc. E/CN.4/1997/150 (1997),

ESCR[140] as interpretative guides in that case. The former contains specific guidelines states are expected to adopt in the context of HIV/AIDS, while the latter is an authoritative interpretation of the nature of obligations required of states regarding the right to health guaranteed under the ICESCR. These documents could have assisted the Court in coming to a more informed conclusion with regard to the nature of the Nigerian government's obligations to the four HIV infected prisoners. The reason for this attitude of the court could be because of the inexplicit position of the Constitution on 'soft law' or probably lack of knowledge on the importance of 'soft law' on the part of the judges. 'Soft law' as earlier mentioned, not only imposes moral obligations on states, it also lays down guidelines and principles to hold governments accountable to their promises and commitments. As will be discussed in Chapter 8, the decision in *Festus Odaife* case provides hope in the realisation of adolescents' sexual health and rights. The fact that the court affirms the applicants' right to health as guaranteed under the African Charter gives some hope that in future Nigerian courts will invoke the provisions of the African Charter to cases relating to adolescents' sexual health and rights.

It is hoped that in future Nigerian courts will give more recognition to the relevance of 'soft law', especially General Comments and Concluding Observations of the Committee on CRC and the Committee on CEDAW, in advancing adolescents' sexual health and rights in the country. Indeed, there is no reason why courts should not refer to Concluding Observations made with regard to Nigeria by these Committees in order to arrive at a decision on a case dealing with adolescents' sexual health needs. Already in a country like South Africa, courts are beginning to accord recognition to the importance of 'soft laws' in their decisions. For instance, in the *TAC* case,[141] the Constitutional court did make reference to the clarification provided by the Committee on ESCR in General Comment 14 to arrive at its decision. Reference to soft law can open the widow of opportunity to ask the female adolescent question in Nigeria. Most of the interpretations provided by the Committees on CRC and on CEDAW have tended to question existing patriarchal traditions and seek to advance the sexual and reproductive health needs of

[140] General Comment 14 (note 136 above).
[141] *Minister of Health and ors v Treatment Action Campaign* (TAC) [2002] 10 BCLR 1033 (CC).

women and girls. For instance, the General Comments 3 and 4 of the Committee on CRC and General Recommendation 24 of Committee on CEDAW contain important explanations that are useful in advancing the sexual autonomy of women and girls and protecting them from sexual ill health.[142] In other situations, while examining states' reports, these Committees have challenged cultural and religious practices that are discriminatory against women and girls and harmful to their health and well-being.[143] The Committees have also called upon states to repeal laws that may hinder access to health services to women and girls. By so doing, these Committees are asking the woman or female adolescent question.

4.8 Conclusion

This chapter has discussed the historical development of the Nigerian legal system. It has been noted that by virtue of colonization, Nigeria adopts the same common law legal system as that of Britain. Thus, like most Commonwealth countries, Nigeria has adopted the dualist system. This implies that international law is not enforceable in the country unless it has been incorporated into local law. In addition to this, Nigeria also recognises customary law and Sharia as applicable legal systems within the country. The adoption of a tripartite legal system by the Nigerian state can potentially hinder access to sexual health services, particularly contraceptive services, to adolescents. As discussed above, some cultural practices and provisions of Sharia can impair women, especially young women, from enjoying their sexual health rights. It would therefore, be necessary that the Nigerian government takes adequate measures in order to address this challenge.

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[142] See for instance, General Comment 3 of the Committee on CRC para 11 where the Committee notes that the female child is often subject to harmful traditional practices, such as early and/or forced marriage, which violate her rights and make her more vulnerable to HIV infection, because such practices often interrupt access to education and information. See also, General Comment 4 of the Committee on CRC para 20 where the Committee expressed concern that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties; General Recommendation 24 of Committee on CEDAW para 12.

[143] See the Concluding Observations of the Committee on CRC: Nigeria 2005.

Unfortunately, Nigerian courts have not risen to the occasion in striking down customary practices that perpetuate discriminatory acts against women and girls. On the few occasions that the Supreme Court had the opportunity to deal with this issue, the reaction of the court was to say the least, unsatisfactory. The Court failed to address the gender dimension raised by customary practices that deny women the right of inheritance. Rather than adopt a proactive approach to interpreting the law by asking the woman question, the Court merely turned a blind eye to the patriarchal nature of customary law and its implications for women's rights. Similarly, the approach of the Sharia Court of Appeal to the offence of *zina* in the *Amina Lawal* case was disappointing and a missed opportunity to ask the woman question with regard to such discriminatory religious laws. As noted earlier, Sharia requires a more stringent proof of evidence from a woman than a man in adultery cases. This failure on the part of the Nigerian courts to address the negative consequences of cultural and religious laws, poses great danger to the sexual health needs of female adolescents in the country. More often than not, cultural or religious reasons are cited to deny adolescents access to sexual health information and services. This, undoubtedly, is a violation of adolescents' human rights under international law.

Furthermore, the constitutional provisions relating to the status of international law in the country are restrictive and the interpretations provided so far by the courts have not been encouraging. International human rights law principles and standards are potentially useful in advancing the sexual autonomy of adolescents to seek contraceptive services. For instance, the interpretations provided by treaty monitoring bodies by way of General Comments or Recommendations and Concluding Observations have all been relevant in advancing the sexual autonomy of female adolescents. Although the provision of the Constitution dealing with the applicability of international law in Nigeria is silent on the status of soft law, nothing should prevent Nigerian courts from making reference to these interpretations when necessary. This will afford the courts the opportunity to advance the sexual health needs of adolescents, particularly female adolescents.

The non-inclusion of a provision in the Nigerian Constitution permitting courts to invoke principles of international law, when interpreting human rights provisions in the

Constitution, is a major shortcoming which deserves urgent attention. The approach adopted under the South African Constitution remains a good reference point for possible reform. This will enable the courts to give more attention to the peculiar needs of female adolescents. Equally, a restrictive application of the decision in *Abacha* case can limit the effective enforcement of human rights treaties, even when they have been incorporated into domestic law. Those who would likely suffer most from this development are vulnerable groups, including women, children and adolescents. It is hoped that Nigerian courts will be more dynamic and progressive in their application of international human rights principles and standards relating to adolescents' sexual health in future.

CHAPTER 5

NIGERIA'S LAWS AND POLICIES RELATING TO ACCESS TO CONTRACEPTION FOR ADOLESCENTS

5.1 Introduction

In order to determine the level of commitment of a government to meeting the sexual health needs of adolescents, one must examine whether laws and policies made by that government are consistent with its human rights obligations under international law. This chapter will examine laws and policies made by the government of Nigeria, which intersect with access to contraception for adolescents. This will be done by determing whether these laws and policies are responsive to the female adolescent question. When asking the question, it should be borne in mind that Nigeria is a federal state with 36 state governments and each state is empowered by law to enact its own laws and policies on health matters. It is not, however, the intention of this study to examine all laws and policies dealing with adolescents in the country.

For the sake of coherence and clarity of the discussion, this chapter will be divided broadly into two sections. The first section will deal specifically with laws relating to adolescents sexual health, while the other section deals with policies relating to adolescents sexual health. The chapter will only focus on some key laws and policies made by the federal government. While the focus will be on laws and policies made by Nigerian federal government, the chapter also draws from experiences and best practices from other jurisdictions especially South Africa and Britain which share similar legal backgrounds as Nigeria. The choice of these countries is informed by recent developments with regard to adolescents' sexual health needs in the two jurisdictions. The two countries have initiated programmes aimed at specifically addressing sexual health challenges facing adolescents. Therefore, the experiences of these countries can serve as good models for legal or policy reforms in Nigeria.

SECTION A

5.2 Legislation Relating to Adolescents in Nigeria

This section of the study examines important laws that have been made that may directly or indirectly impact on the sexual health needs of adolescents in the country.

5.2.1 The Constitution

As noted in Chapter 4, the Nigerian Constitution does not contain specific provisions relating to the sexual health needs of adolescents. However, chapter IV of the Constitution contains some provisions that can be invoked, albeit indirectly, to advance the sexual health needs of adolescents in the country. Some of these provisions include the right to privacy, right to dignity, freedom from non-discrimination, right to liberty and right to life. The human rights provisions of the Constitution are essentially influenced by the Universal Declaration on Human Rights (UDHR).[1] The UDHR and international human rights law in general, as observed in Chapter 2, have been criticised for being gender-neutral and failing to adequately reflect the specific human rights challenges women experience.[2] A similar criticism may apply to the human rights provisions of the 1999 Constitution, which are couched in a language that is gender-neutral and seems to be insensitive to the peculiar situations of Nigerian women.[3] Some of these provisions on human rights are discussed below. Because of its importance to the position of women and girls in Nigeria and the realisation of access to sexual health services, the discussion on equality and non-discrimination has been given more attention than other rights. As noted in Chapter 2, one of the barriers to the exercise of women's autonomy is the problem of gender inequality and the subordination of women.

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[1] Universal Declaration of Human Rights, G.A. Res. 217 A (III), U.N. Doc. A/810 (10 December 1948)

[2] See H Charlesworth *et al* 'Feminists Approaches to International Law' (1991) 85 *American Journal of International Law* 621.

[3] This is not unexpected when one considers the historical antecedents of the 1999 Constitution. This Constitution is greatly influenced by the preceding 1979 Constitution, which was drafted by a 50-member Constitutional Drafting Committee (CDC) all made up of men. In the same vein, the majority of the 35 member Committee that drafted the 1999 Constitution were men.

5.2.1.1 The Right to Life

Section 33 of the Constitutions guarantees the right to life. The section provides that 'no one shall be intentionally deprived of his life save in accordance with the provision of the law'. Even though on the surface, this provision seems to apply to everyone, it merely obligates the Nigerian government to observe due process before capital punishment is imposed. A narrow construction of this provision does not seem to accommodate the reality of women, especially young women who continue to die of pregnancy-related complications or unsafe abortion.

Regardless of the fact that section 33 of the Nigerian Constitution is framed in a negative and gender-neutral way, it can still be invoked creatively by Nigerian courts, in a gender-sensitive sense to hold the Nigerian government accountable for unnecessary loss of lives among adolescents. This will be so especially, if such loss of lives is attributable to the government's failure to provide access to contraception to female adolescents so as to prevent unwanted pregnancies and their attendant consequences. There is now a growing consensus that the violation of the right to health may result in the violation of the right to life.[4] This broad interpretation of the right to life so as to impose positive obligations on states to preserve lives has been the position of some national courts and international tribunals in recent times. For example, the Indian Supreme Court has held that failure on the part of a government hospital to provide emergency treatment to a citizen amounted to a violation of the right to life guaranteed under article 21 of the Indian Constitution.[5] The Court explained in that case that the Indian government could not rely on the excuse of a lack of resources to justify its failure to preserve the loss of lives.

Also, the African Commission on Human and People's Rights (African Commission), reaffirming the positive nature imposed by the right to life under article 4 of the African

[4] See for instance, The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 3; see also, AE Yamin 'Not Just a Tragedy: Access to Medication as a Right under International Law' (2003) 21 *Boston University International Law Journal* 370.

[5] *Pachim Banga Khet Majoor Samity v State of West Bengal* (1996) 4 SCC 37.

Charter on states in *International Pen and others (On behalf of Ken Saro-Wiwa)* case,[6] has stated as follows:

> The protection of the right to life in article 4 also includes a duty for the state not to purposefully let a person die while in its custody. Here at least one of the victims' lives was seriously endangered by the denial of medication during detention. Thus, there are multiple violations of article 4

Furthermore, the Inter-American Court on Human Rights has held that the maltreatment of street children by the Guatemala government is a violation of the right to life of the children. In coming to this conclusion, the Court observes that:

> The fundamental right to life includes not only the right of every human being not to be deprived of his/her life arbitrarily but also the right that he/she will not be prevented from having access to conditions that guarantee a dignified existence. [7]

In *Tavares v France,*[8] the European Commission on Human Rights was called upon to determine a complaint filed on behalf of a woman who had died during childbirth. The complaint alleged that the death constituted a violation of the right to life guaranteed in article 2 of the European Convention of Human Rights. Although the complaint was dismissed on technical grounds, nonetheless, the Court held that the right to life guaranteed under the European Convention extended beyond a state's duty to abstain from intentional killing but also included taking necessary steps to protect unintentional loss of life. This can be interpreted to mean that a state must take positive steps to provide health related goods and facilities such as contraception in order to prevent unnecessary loss of life which may result from sexual ill health.

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[6] *International Pen and Others (On behalf of Ken Saro-Wiwa) v Nigeria* (2000) AHLR 212(ACHPR 1998).
[7] *Villagran Marales et al v Guatemala* Series C No 65 19 November 1999(IACHR) para 144; see also *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v Nigeria* Communication 155/96 decided at the African Commission's Ordinary Session held from 13 to 27 October 2001.
[8] *Tavares v France* App No 16593/90 Euro. Comm. HR.

The decisions in the above cases clearly and cogently emphasize the positive nature of the duty imposed by the right to life and the indivisibility and interrelatedness of the right to health with the right to life. These decisions coincide with the reasoning of some treaty monitoring bodies. For instance, the Human Rights Committee in its General Comment 6 has noted that the right to life should not be construed narrowly but that it intersects with other rights such as housing, food and health care.[9] The Committee has equally noted in one of its Concluding Observations that lack of access to reproductive health care services, including services related to contraception for women, is a violation of their right to life.[10] In particular, the Committee has consistently expressed grave concern over high rates of maternal mortality, framing it as a violation of women's right to life [11]

Also, the Committee on CRC has observed that the obligation of states to realise the right to life of adolescents include paying attention to their sexuality and eliminating all conditions that may be injurious to their health needs.[12] It should be noted that in order to ensure the health and survival of adolescents, it is imperative that they must be assured access to comprehensive sexual health care, including contraceptive services peculiar to their needs. In this regard, the Committee has noted that 'effective prevention programmes are only those that acknowledge the realities of the lives of adolescents, while addressing sexuality by ensuring equal access to appropriate information, life skills, and to preventive measures'.[13]

In Nigeria, where incidences of STIs, unwanted pregnancy, unsafe abortion and early pregnancy are rampant among adolescents due to lack of access to contraception, it is apposite to say that adolescents' lives are threatened. A recent study has shown that nearly one-third, that is, 28% of women of reproductive age in Nigeria have had an

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[9] The Right to Life UN GAOR Human Rights Committee 37th session Supp No 40.

[10] See Human Rights Committee Concluding Observation: Chile 30/3/99 UN Doc CCPR/79/Ad. 104,15.

[11] See for instance, Human Rights Committee Concluding Observations: Bolivia 01/04/97 UN Doc. CCPR/79/Ad. 74, 22; Concluding Observation: Guatemala 27/08/2001 UN Doc CCPR/CO/72GTM, 19.

[12] Committee on the Right of the Child, HIV/AIDS and the right of the Child, General Comment No 3 CRC/GC/2003/3 Thirty-Second Session 2003 para 11.

[13] *Ibid.*

unwanted pregnancy at one point in their lives.[14] Approximately one in five pregnancies in the country is unplanned. On the other hand, each year about 760,000 unsafe abortions occur in the country.[15] These data clearly show that the Nigerian government needs a paradigm change in its attitude and outlook towards female adolescents lives by ensuring that they have comprehensive access to contraceptive services. As a matter of fact, this is a pressing issue that borders on life and death.

In this connection, Nigerian courts will need to interpret broadly the provisions of the right to life, in such a way as to make it obligatory on the government to ensure access to contraception for adolescents. Given the fact that Nigeria operates a restrictive abortion law and bearing in mind the importance of contraception to preventing sexual ill harm and unwanted pregnancies, failure by the Nigerian government to ensure access to contraception for adolescents will amount to a violation of the right to life. This observation finds support in the dissenting opinion of the Human Rights Committee in the case of *KL v Peru.*[16] Here, the dissenting opinion notes that the right to life should not be construed narrowly. In that case, a woman pregnant with an anencephalic foetus claimed that the refusal by the Peruvian authorities to allow her to abort the pregnancy amounts to the violation of her right to life under the ICCPR. The dissenting opinion of the Committee had noted that 'it is not only taking a person's life that violates article 6 of ICCPR but also placing a person's life in grave danger as in this case'. While this case relates to abortion services, the reasoning expounded in the dissenting opinion of the Committee can also be applied to the denial of access to contraceptive services.

Considering that the negative consequences of lack of access to contraception weigh more on female than male adolescents, it will be expected that courts will reflect this gender dimension in their interpretation of the right to life. For instance, where emergency contraception (EC) has not been made available at public health care centres, this should not been seen as merely another failure by the government to provide health

[14] A Bankole *et al Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences* (2006) 4.
[15] *Ibid.*
[16] *KL v Peru* U.N. Doc. CCPR/C/85/D/1153/2003, 22 November 2005.

care goods and facilities. Rather, the implications of such failure for the lives of adolescent girls who may experience unwanted pregnancy and its attendant consequences, including loss of lives, should be emphasized by the courts. In other words, the interpretation of the right to life in such a situation should prompt the asking of the female adolescent question. Why has the Nigerian government not taken seriously the availability and accessibility of EC at public health centres compared to the male condoms?

It should be noted that the right to life is a fundamental right of which no derogation is permitted.[17] Therefore, the Nigerian government cannot claim that its inability to provide access to contraceptive services for adolescents is because of customary practices or religious tenets. Moreover, the argument of a lack of resources will not be a tenable excuse in this regard. In other words, a state cannot justify the violation of the women's right to life as a result of self-induced circumstances.[18]

5.2.1.2 The Right to Privacy

Another right, which can be used in advancing adolescents' sexual health, is the right to privacy guaranteed under section 37 of the Constitution. This section provides that 'the privacy of citizens, their homes, correspondence and telephone conversations and telegraphic communications is hereby guaranteed and protected'. The right to privacy generally implies the right to be left alone in peace. Privacy has also been defined as the desire of individuals for solitude, intimacy, anonymity and reserve.[19] The language of section 37 of the Nigerian Constitution is very similar to that of article 17 of the ICCPR. The right to privacy includes 'freedom from unwarranted and unreasonable intrusions into activities that society recognizes as belonging to the realm of individual

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[17] See Human Rights Committee (note 9 above).

[18] See G Shalev 'Rights to Sexual and Reproductive Health - the ICPD and the Convention on the Elimination of All Forms of Discrimination against Women' A Paper Presented at the International Conference on Reproductive Health, Mumbai (India), 15-19 March 1998 available at www.un.org/womenwatch/daw/csw/shalev.htm (Accessed on 26 August 2010).

[19] J Michael 'Privacy' in D Harris and S Joseph (eds) *The International Covenant on Civil and Political Right and United Kingdom* (1995) 333-354.

autonomy'.[20] Although the provision on the right to privacy appears to have been generally worded and does not seem to take into cognizance challenges women face in their daily lives,[21] nonetheless, it can be purposively interpreted to protect and advance the sexual autonomy of women and girls in the country.

With regard to sexual health, the right to privacy implies the right of an individual to be free from all forms of non-consensual interference with his/her body. It also means the right of an individual to make autonomous intimate decisions regarding his/her sexuality or body free from state interference.[22] Explaining further the importance of the right to privacy in sexual health matters under the South African Constitution, the Constitutional Court in *National Coalition of Gay and Lesbian Equality v The Minister of Justice,*[23] said as follows:

> Privacy recognizes that we all have a right to a sphere of private intimacy and autonomy, which allows us to establish and nurture human relationships without interference from the outside community. The way in which we give expression to our sexuality is at the core of this area of private intimacy. If, in expressing our sexuality, we act consensually and without harming one another, invasion of that precinct will be a breach of our privacy.

Also, the US Supreme Court in the case of *Roe v Wade* invoked the right to privacy to justify its decision that a woman can lawfully terminate a pregnancy within its early stage.[24] At the Beijing Platform, it was affirmed that human rights of women include 'rights to have control over their sexuality, including their sexual and reproductive health, free from discrimination, coercion and violence'.[25] This would seem to recognize the right to privacy of all women and girls to make important decisions affecting their bodies.

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[20] J, Shultz & M Castan *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 135.

[21] Women generally, and young women in particular in the country, lack control over their bodies and often find it difficult to determine when, how and with whom to have sexual intercourse. A study has shown, for instance, that young women are susceptible to coerced sexual acts in the country; see A Ajuwon 'Attitudes, Norms and Experiences of Sexual Coercion among Young People in Ibadan, Nigeria' in SJ Jejeebhoy *et al* (eds) *Sex Without Consent* (2005) 96-104.

[22] See Y Lai & RE Ralph 'Female Sexual Autonomy and Human Rights' (1995) 8 *Harvard Human Rights* 201, 233.

[23] 1999 (1) SA 6 (CC); 1998 (12) BCLR 1517 (CC) para 32.

[24] (1973) 410 US 113 (SC).

[25] Fourth World Conference on Women Beijing held on 15 September 1995 A/CONF.177/20.

Thus, in the case of an adolescent seeking sexual health treatment, it will amount to a violation of the right to privacy to make access to such treatment dependent on parental or guardian consent. Moreover, this will invariably undermine the right to sexual autonomy of adolescents. Studies have shown that such preconditions may bar adolescents from seeking treatment and conversely put their lives and health in danger.[26]

The Committee on CRC has noted that an adolescent seeking medical attention should be treated as an individual capable of making his/her decision.[27] Also, the Committee on CEDAW in its General Recommendation 24 has echoed that health care systems must be culturally acceptable to all women, including young women.[28] According to the Committee, a health system that fails to respect the privacy and confidentiality of women, especially young women seeking medical attention, violates their right. By these statements the Committee is more or less asking the female adolescent question. The onus, is thus, placed on Nigerian courts to interpret section 37 of the Constitution in a way that will advance female adolescents autonomy to seek sexual health services.

The age-long controversy surrounding the ability of adolescents to consent to medical treatment, which is often founded on the fact that parents are responsible for adolescents' treatment, is also applicable to adolescents in Nigeria. As noted in Chapter 2, this antediluvian construction of adolescents in Nigerian communities tends to deny adolescents agency to make decisions concerning their bodies. Therefore, it will be expected that Nigerian courts will strike down such a negative construction of adolescents by ensuring confidential access to contraceptive services for them. Given that this negative construction of adolescents is rooted in cultural and religious beliefs, and further considering that it is often targeted at female adolescents, it will be expected that the courts will order the Nigerian government to modify its laws with a view to removing obstacles to confidential access to sexual health services to female adolescents. This will

[26] AS Erulkar *et al* 'What is Youth-Friendly? Adolescents' Preference for Reproductive Health Services in Kenya and Zimbabwe (2005) 9 *African Journal of Reproductive Health* 51, 52.
[27] Committee on the Right of the Child, Adolescents Health and Development in the Context of the Convention on the Right of the Child, General Comment No 4 CRC/GC/2003/4 Thirty-Second Session May 2003.
[28] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 para 18.

be consistent with asking the female adolescent question. In addition, the Nigerian government may be required to take positive steps, including legislative, administrative and budgetary strides, with a view to facilitating access to confidential access to contraceptive services to female adolescents. For instance, the enactment of a law specifically empowering female adolescents to seek sexual health services without the need for parental consent may be necessary in this situation.[29] This will not only enhance the autonomy of female adolescents but will also ensure their good health and well-being.

A denial of access to sexual health services to adolescents, particularly female adolescents, based on the fact that they are incapable of making informed decisions, violates their right to sexual and reproductive self-determination or autonomy. Such a denial would seem to be inconsistent with the right of adolescents to be treated with respect and dignity. As discussed in Chapter 8, judicial decisions have now recognised that an adolescent whose capacities have evolved can make responsible and autonomous decision concerning his/her health needs.[30]

5.2.1.3 The Right to Information

The right to information is one of the most important rights recognized under international law in advancing the sexual health and rights of adolescents. As this study has shown in Chapter 3, one of the factors militating against access to contraception for adolescents in Nigeria is lack of knowledge and awareness on the part of adolescents. Although in most constitutions of the world, the right to information is not specifically guaranteed, however, this right is protected under provisions on freedom of expression, which usually encompasses the right to give and receive information. Under the Nigerian Constitution, the provision dealing with the freedom of expression can be found in section 39. This section provides that 'every person shall be entitled to freedom of expression, including freedom to hold opinions and to receive and impart ideas and

[29] A good example of such laws exists in the South African Choice on Termination of Pregnancy Act of 1997, which allows a girl under 18 to consent to abortion without the need for parental consent.
[30] See for instance, *Gillick v West Norfolk and Wisbech Area Health Authority and another* (1985) 3 All ER 402 and *R on the Application of Axon v. Secretary of State for Health* [2006] England and Wales High Court 37 (Administrative Court) Case No. CO/5307/2004.

information without interference'. In addition to this constitutional provision, Nigeria has ratified international treaties which guarantee the right to information. For instance, article 19 of the Covenant on Civil and Political Right guarantees the right to information of all.[31] More specifically, in relation to sexual health information articles 10(h) and 16.1(e) of CEDAW recognise the rights of women to access information related to family planning generally, including those in rural areas.[32] These provisions are broad enough as to include access to contraceptive information to adolescents, especially female adolescents.

Adolescents require accurate information with regard to their sexual health, including information related to contraception; otherwise they may take decisions which could be injurious to their health and lives.[33] In addition, empowering adolescents, especially female adolescents with accurate information regarding their sexuality, is one of the surest ways of advancing their right to sexual and reproductive autonomy. Ensuring access to sexual health information to female adolescents not only empowers them to take charge of their sexuality but also prevents unnecessary loss of life that may arise from sexual ill health.

If one considers the challenges adolescents encounter with regard to education and information on sexuality in the country, the above mentioned provisions are potentially relevant in holding Nigerian government responsible to ensure that these challenges are removed. Indeed, the Committee of CEDAW has urged states to provide without prejudice, access to information and education on sexual health information (including those related to contraception) to girls within their countries.[34] The Committee further explains that access to sexual health information and education forms an integral part of

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[31] International Covenant on Civil and Political Rights, G.A. Res. 2200, U.N GAOR, Supp. NO. 16 at 52, U.N DOC. A/6316 (1966), 999 U.N.T.S. 171, 174 (entered into force on March 23, 1976). (hereinafter ICCPR).

[32] Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.

[33] See Centre for Reproductive Rights (CRR) *Briefing Paper: Implementing Adolescent Reproductive Rights through the Convention on the Rights of the Child.* (Center for Reproductive Rights, New York, 1999) 4.

[34] See General Recommendation 24 of CEDAW (note 28 above) para 18.

the enjoyment of the right to health. According to the Committee, states are obligated to 'ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programs that respect their rights to privacy and confidentiality'.[35] Similarly, the Committee in its General Recommendation 21 has noted as follows:

> In order to make an informed decision about safe and reliable contraception measures, women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services as provided in article 10(h) of the Convention.[36]

In relation to children and adolescents, article 13 (1) of the CRC specifically guarantees young people, the right to 'seek, receive and impart information and ideas of all kinds'. This provision is broad enough to accommodate information related to contraception for adolescents. Under the African Children's Charter, article 14 (f) enjoins states to take measures to realise the right to health of children by developing preventive health care and family life education and provision of services. The Committee on CRC in its General Comments 3[37] and 4[38] has urged states to guarantee access to sexual health information and education (including those related to contraception) to adolescents. According to the Committee, states parties should refrain 'from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information'.[39] The Committee further notes that this will be consistent with realising the right to the highest attainable standard of physical and mental health and the right to life, survival and development for adolescents.[40]

Similarly, the Committee has noted, in its General Comment 4 as follows:

> Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of

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[35] *Ibid.*
[36] Committee on CEDAW General Recommendation 21 on Equality in Marriage and Family Relations' Thirteen Session, General Assembly Report Supplement No 38.(A/49/38) paras 1-10.
[37] Committee on the Right of the Child, General Comment N0 3 (note 12 above) para 15.
[38] General Comment 4 of CRC (note 27) para 28.
[39] General Comment 3 (note 12 above) para 16.
[40] *Ibid.*

> States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours.[41]

From the above explanation therefore, it is clear that the Nigerian government has a positive obligation to ensure access to sexual health information to adolescents, particularly female adolescents. Coliver has explained that women need basic information about their reproductive physiology including the ways diseases can be transmitted sexually, methods in which transmission can be minimized, the benefits and risks of various methods of contraception, and safe options to adopt when those methods fail.[42] She notes further that without information, an individual is unable to make crucial decisions with regard to matters concerning his/her reproductive health, thus resulting in violation of an individual's rights to liberty and dignity. [43] This clearly implies that access to sexual health information is fundamental to the exercise of sexual choices and healthy living of female adolescents.

The European Court on Human Rights in the *Open Door* case[44] has held that any attempt by a state to hinder access to sexual health information to its citizens will amount to a violation of the right to information under international law. In that case, the issue before the Court was whether an injunction granted by the Irish Supreme Court to prevent two women's health clinics from disseminating information to women in Ireland on how and where to obtain an abortion in England was in violation of article 10 of the European Convention on Human Rights.[45] While recognising the fact that the right to information is not absolute, the Court noted that any restriction on this right must be justifiable at law. According to the Court, even if Ireland had a legitimate interest in protecting the life of the unborn, the injunction had a disproportionate impact, because it prohibited counseling regardless of the age, health or circumstances of the pregnant women and posed a health

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[41] General Comment 4 (note 27 above) para 26.
[42] See S Coliver 'The Right to Information Necessary for Reproductive Health and Choice under International Law' (1995) 44 *The American University Law Review* 1279.
[43] *Ibid* 1288.
[44] *Open Door Counseling & Dublin Well Woman Centre v Ireland,* Eur. Ct. H.R. (ser. A) (1992) 246.
[45] Article 10 of the European Convention on Human Rights guarantees every one the right to freedom of expression.

risk to women who may likely terminate pregnancies at later stages without proper counseling. Although the *Open Door* case relates to abortion, it can be extrapolated to apply to cases concerning access to contraceptive services for adolescents. Also, the African Commission on Human and Peoples' Rights has held that the freedom of expression is a basic right that is essential to an individual's personal development.[46]

These decisions clearly delineate that the obligation of states with regard to the right to information is both negative and positive. In other words, states must refrain from obstructing adolescents' quest for information on sexual health and at the same time, states must ensure adequate access to sexual health information for adolescents. [47] This would imply that the Nigerian government must accelerate efforts to remove cultural and religious barriers to access to sexual health information for adolescents. Conversely, the government must enact laws and formulate policies that will facilitate access to sexual health information to adolescents, especially female adolescents. A proper interpretation of the provision on the right to expression under the Nigerian Constitution must ask the female adolescent question. For instance, why is it that: female adolescents are often denied access to sexual health information? Or why is it that the opposition to sexuality education is often based on the fact that it will make adolescent girls and not boys promiscuous?

5.2.1.4 The Right to Non-discrimination

The right to non-discrimination bolsters the drive towards meeting the sexual health needs of adolescents. The Nigerian Constitution in section 42 guarantees this right. This section provides that a 'citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not by reason only that he is such a person . . .' be subjected to discrimination. This provision unlike the South African Constitution of 1996, does not forbid discrimination based on marital status or age. These two grounds are crucial in protecting adolescents (especially unmarried adolescents) from

[46] See *Constitutional Rights Project and Others v Nigeria* (2000) AHRLR 227 (ACHPR 1999).
[47] See Coliver (note 42 above).

discriminatory practices, when seeking sexual health treatment. Notwithstanding the oversight of the drafters of the Constitution, it is argued that this section obligates the Nigerian government to ensure that it does not adopt policies or laws which may hinder access to contraceptive use for adolescents in the country.

Unfortunately, Nigerian courts are yet to develop a consistent jurisprudence with regard to section 42. An opportunity, however, that arose for the court in *Festus Odaife*[48] case to expound this provision was missed through a restrictive interpretation of the provision of this section. In that case, the Court held that a refusal by the Nigerian Prison officials to provide medical treatment for four HIV positive prisoners solely because of their HIV status was not in contravention of section 42 of the Constitution as the section does not explicitly forbid discrimination on the grounds of health or disease status. Undoubtedly, this is a narrow interpretation of section 42 of the Constitution and such an approach should be eschewed.[49] Rather, a more purposive approach to the interpretation of section 42 of the Constitution should have been adopted.

This narrow approach by the Nigerian court contrasts sharply with the purposive approach in other jurisdictions such as in South Africa. In the *Hoffmann*[50] case, the South African Constitutional Court has held that a denial of employment to an HIV positive prospective employee contravenes the equality clause in section 9 of the South African Constitution despite the fact that the section does not expressly forbid discrimination on the basis of HIV or disease status. According to the Court, the *raison d'être* of the equality clause in the South African Constitution is the preservation of the dignity of all human beings regardless of their social class or position in society. In the Court's view, given the fact that people living with HIV have always been subjected to negative prejudices, disadvantage and stigmatization, a denial of an employment opportunity because of the applicant's HIV status will further deepen discrimination against HIV

[48] *Festus Odaife and others v Attorney General of the Federation and others* 2004) AHRLR 205 (NgHC 2004) High Court.

[49] For a critical appraisal of the court's decision in that case, see E Durojaye 'Discrimination based on HIV/AIDS Status: A Comparative Analysis of the Nigerian Court's decision in *Festus Odaife and others v Attorney General of the Federation and others* with other Commonwealth Jurisdictions' (2007) 11 *Law, Democracy and Development* 133.

[50] *Hoffmann v South African Airways* [2000] 11 BCLR 1235 (CC).

infected persons and erode their human dignity. While it is noted that the provision in section 9 of the South African Constitution is broader than section 42 of the Nigerian Constitution and even allows for analogous grounds for non-discrimination, there is no reason why Nigerian courts should not adopt a purposive interpretation of section 42 of the Constitution.

A similar purposive approach was adopted in the Botswana case of *Makuto v State.*[51] In that case, the constitutionality of a provision which mandated a longer imprisonment term on someone convicted of rape if they were infected with HIV was the issue before the court. The Court gave a generous interpretation to section 15 of the Botswana Constitution to cover discrimination against persons living with HIV in the country. Although section 15 of Constitution does not specifically proscribe discrimination based on HIV status, notwithstanding, the Court held that the provision of section 15 is not meant to be exhaustive and as such can accommodate other grounds of discrimination such as HIV status. This reasoning of the Court coincides with the recent General Comment 20 of the Committee on ESCR.[52] The Committee had explained that the term 'other status' as used in the Covenant applies not only to HIV status, but also age and marital status. It therefore means that unmarried female adolescents should not be denied the right to enjoy socio-economic rights including access to contraception. Indeed, the Committee on CRC has noted that the provision of the Convention on the right to non-discrimination applies to adolescents' sexual health needs.[53]

5.2.1.4.1 Substantive Equality

The discussion above has demonstrated that a liberal and purposive interpretation of section 42 of the Nigerian Constitution should enable the court to hold Nigerian government in breach of its obligation under the section, if it fails to assure access to comprehensive sexual health treatment and services to adolescents. This will be so if the

[51] (2000) 5 LRC 183. Botswana Court of Appeal.
[52] The Committee in its General Comment 20 on Non-Discrimination in Economic, Social and Cultural Rights E/C.12/GC/20 25 May 2009.
[53] See General Comment 4 (note 27 above) para 6.

basis of failure to provide access is attributed to a lack of agency or marital status on the part of adolescents. Such a liberal approach must aim at achieving substantive rather than formal equality, that is, *de facto* rather than *de jure* equality. The notion of substantive equality implies that every individual is treated in the same manner taking into consideration each one's peculiar circumstances. In other words, substantive equality, as differentiated from formal equality, aims at promoting social justice and egalitarianism in a society, particularly for the marginalised or vulnerable groups.[54] Unlike formal equality, that is blind to socio-economic and gender differences, substantive equality recognises and accommodates differences or peculiarities associated with a group of people. Expounding this issue, Shalev has noted as follows:

> Equality requires that we treat the same interests without discrimination, and also that we treat different interests in ways that respect those differences. Failure to take into account the special health needs of women, so as to ensure their access to appropriate health information and services, constitutes discrimination. Equality is not a formal matter of guaranteeing to women the same rights as men and combating purposeful discrimination, but rather a substantive matter of ensuring the effective enjoyment of equal outcome in health status and well being.[55]

It should be noted that the provisions on non-discrimination in both CEDAW and the African Women's Protocol are tailored towards achieving substantive equality. The South African Constitutional Court in *Harksen and Lane*,[56] where the constitutionality of sections 21, 64 and 65 of Insolvency Act *vis-à-vis* section 8 of the Interim Constitution was the issue before the court, has elaborated on this issue. While interpreting the equality clause in section 8 of the Interim Constitution (similar to section 9 of the 1996 Constitution), the Court made a distinction between mere discrimination and unfair discrimination. According to Goldstone J, discrimination is referred to as an unequal treatment of people based on attributes and characteristics attaching to them. On the other hand, unfair discrimination is described as treating persons differently in a way which impairs their fundamental dignity as human beings, who are inherently equal in dignity.[57]

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[54] J Rawls *A Theory of Justice* (1971) 24.
[55] Shalev (note 18 above).
[56] *Harksen v Lane NO and others* 1999 (1) SA 300 (CC).
[57] *Ibid* para 46.

The Court further laid down the factors to consider in determining unfairness of discrimination in accordance with section 8 of the Interim Constitution (section 9 of the 1996 Constitution). These include the following:

(a) The position of the victim in the society,

(b) The purpose sought to be achieved by the discrimination,

(c) The extent to which the rights and interest of the victims of discrimination has been affected, and

(d) Whether the discrimination has impaired the human dignity of the victim.

The Court quoting from its earlier decision in *Hugo* case[58] said as follows:

> The prohibition of unfair discrimination in the interim Constitution seeks not only to avoid discrimination against people who are members of disadvantaged groups. It seeks more than that. At the heart of the prohibition of unfair discrimination lies recognition that the purpose of our new constitutional and democratic order is the establishment of a society in which all human beings will be accorded equal dignity and respect regardless of their membership of particular groups.

This statement is very important in that it underscores the relevance of respect for human dignity as the foundation of the prohibition of discrimination. More importantly, the statement is particularly relevant in the context of advancing the sexual health needs of female adolescents. As Chapter 3 of this study has shown, female adolescents often encounter discriminatory attitudes from health care providers and society as a whole in their bid to seek sexual health treatment, particularly contraceptive services.

The South African jurisprudence on equality has been substantially influenced by decisions from Canadian courts. For instance, the Canadian Supreme Court has enumerated in *Law v Canada (Minister of Employment and Immigration)*[59] (known *as* the Law Test) several factors that must be considered before establishing unfair discrimination under section 15 of the Canadian Constitution. Firstly, the position of the complainant in the society (that is, whether or not the complainant has been a

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[58] *President of Republic of South Africa and others v Hugo* 1997 (3) SA 1012.

[59] *Law v Canada (Minister of Employment and Immigration)* (1999) 1 SCR 497; 170 DLR (4th) 1 para 39.

disadvantaged person in the society) will need to be considered. Secondly, the purpose of the differentiation must be explored, that is, did the law aim to achieve a vital societal goal in favour of one who is vulnerable or had been disadvantaged? Thirdly, the impact of the differentiation on the rights of the complainant must be ascertained, that is, does the law impact adversely on his/her fundamental human dignity? The Court further emphasized in that case that, the paramount consideration in determining the violation of the equality clause of the Constitution is the protection of the dignity of the complainant. This approach of the Canadian Supreme Court is aimed at ensuring substantive equality and can be beneficial to Nigerian courts. The approach can be applied to affirm the right to equality of adolescents, especially female adolescents seeking contraceptive services in the country. Given that socio-cultural factors often limit access to contraceptive services to female adolescents in Nigeria, a proper interpretation of section 42 should protect female adolescents from such discriminatory practices.

Furthermore, in *Eldridge v British Columbia (Attorney-General),*[60] the Canadian Supreme Court has demonstrated the importance of substantive equality in access to health care services for vulnerable groups. In that case, some of the issues before the Court were premised on whether sections 3, 5 and 9 of the *Hospital Insurance Act* and the Regulations infringed section 15(1) of the Canadian Charter of Rights by failing to require hospitals to provide medical interpreter services for the deaf, if the answer is in the affirmative, whether the impugned provisions were saved under section 1 of the Charter. The Court held that failure to make money available for sign language interpretation that would equip hearing-impaired patients to communicate with health service providers in the same way that unimpaired patients can, constitutes discrimination in violation of the Canadian Charter on Rights and Freedoms. According to the Court, the adverse effects of discrimination are relevant in the context of people with disabilities. The Court further explained that:

> In the present case the adverse effects suffered by deaf persons stem not from the imposition of a burden not faced by the mainstream population, but rather from a failure to ensure that deaf persons benefit equally from a service offered to everyone. Once it is accepted that effective

[60] (1977) 151 DLR (4th) 577.

> communication is an indispensable component of the delivery of a medical service, it is much more difficult to assert that the failure to ensure that deaf persons communicate effectively with their health care providers is not discriminatory. To argue that governments should be entitled to provide benefits to the general population without ensuring that disadvantaged members of society have the resources to take full advantage of those benefits bespeaks a thin and impoverished vision of s. 15(1). It is belied, more importantly, by the thrust of this Court's equality jurisprudence. [61]

The Court summarized its position by noting that 'the principle that discrimination can accrue from failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public is widely accepted in human rights field'.[62]

This decision is relevant in ensuring equality for all and in particular for marginalised groups and people with disabilities in accessing treatment. The reasoning of the Court in this case can also be relied on to demand access to sexual health services for adolescents on an equal basis with other members of society. Moreover, it demonstrates that, where necessary, special attention may need to be given to the needs of female adolescents in order to ensure access to sexual health services (especially contraceptive services) peculiar to their need. This is because, as shown in Chapter 2, socio-cultural practices within Nigerian society tend to repress the sexual autonomy of female adolescents and treat them as inferior to men. The decision also confirms the fact that courts have an important role to play in holding governments accountable for failing to realise equal access to health care services for female adolescents. This issue is explored further in Chapter 8.

The positions of South African and Canadian courts with regard to equality jurisprudence discussed above can be of help in interpreting section 42 of the Nigerian Constitution. Following the decisions of the Canadian court, it will be expected that an analysis of section 42 of the Constitution by Nigerian courts will pay attention to the patriarchal nature of the Nigerian society and the disadvantaged position of women, particularly female adolescents. More importantly, the interpretation can be adopted to guarantee

[61] *Ibid* 7.
[62] *Ibid* 8.

access to contraception to female adolescents in the country. Given the construction of adolescents in Nigeria discussed in Chapter 2, one may argue that adolescents, particularly female adolescents, are a marginalised group. Therefore, their sexual health needs must be given special treatment compared to other members of society.

One of the core principles underlining the CRC is non-discrimination. This principle is guaranteed under article 2 and forbids discrimination against children. A purposive interpretation of the CRC would suggest a proscription of discriminatory practices against adolescent girls with regard to access to health care services including contraceptive services. The Committee on CRC has always endeavoured to give attention to gender issues in its interpretation of the provisions of the Convention. For instance, the Committee has explained that discrimination against girl children often leads to denial of access to sexuality information and services.[63] It further expresses concern about gender-based discrimination combined with taboos or judgmental attitudes to sexual activities of girls, which potentially limit access to information and preventive health care services such as contraception to them.[64] States are therefore urged to take adequate measures with a view to eliminating gender-based discrimination, which makes the girl child more vulnerable to STIs and HIV infection.[65]

Also, CEDAW in article 2 urges states to take measures to eliminate all forms of discrimination against women. Article 12 specifically provides for access to health care services to women on equal basis with men. This provision no doubt can be invoked to ensure access to contraceptive information and services to female adolescents. Indeed, the Committee on CEDAW has interpreted the provision of article 12 to apply to the needs of girls.[66] The Committee has urged states to eliminate discrimination in health care services to women and girls in their jurisdictions. Cusack and Cook have argued that the provisions of CEDAW obligate states parties to aim at improving women's position (in all spheres of life including health care setting) by eliminating all forms of

[63] General Comment 3 (note 12 above) paras 7 and 8.
[64] *Ibid.*
[65] *Ibid.*
[66] General Recommendation 24 of CEDAW (note 28 above) para 18.

discrimination against women with a view to ensuring both formal (*de jure*) equality and substantive (*de facto*) equality. [67] This seems to be consistent with the view of the CEDAW Committee in its General Recommendation 25, where the Committee observes that it is essential that states parties address the underlying causes of discrimination against women, and of their inequality. Therefore, the Committee recommends that measures must be adopted 'towards real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns'.[68]

Similarly, the Committee on ESCR has noted that access to health care services including sexual and reproductive health services should be guaranteed to all without discrimination as to sex or age.[69] More importantly, the fact that section 42 of the Constitution prohibits discrimination on grounds of sex provides an avenue to protect female adolescents in the country from discriminatory practices in relation to their sexual health needs. This provision can be invoked to hold that denial of contraceptives services to female adolescents in Nigeria, simply based on their sex, is a violation of the right to non-discrimination. Such an interpretation will accord with the position of the Committee on CEDAW in its General Recommendation 24 where it observes that failure to provide health care services peculiar to women's and girls' needs, will violate their rights to equality and non-discrimination.[70]

From the discussions above, it is clear that in order to realize substantive equality for female adolescents, in the context of access to contraception, the Nigerian government will need to take a number of measures. Firstly, in line with the provisions of CEDAW and the African Women's Protocol, the government must ensure that female adolescents have the same equality of opportunities as male adolescents regarding access to contraceptive services. In this regard, laws and policies will need to be made to ensure

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[67] S Cusack &R Cook 'Combating Discrimination based on Sex and Gender' in C Krause & M Sheinin (eds) *International Protection of Women's Rights: A Textbook* (2009) 206.
[68] Committee on CEDAW General Recommendation No 25, on art 4(1) of CEDAW, on temporary special measures, CEDAW/C/2004/I/WP 1/Rev 1, 30 January 2004, CEDAW, para 10.
[69] General Comment 14 of Committee on ESCR (note 4 above).
[70] General Recommendation 24 (note 28 above) para 14.

that female adolescents have access to contraceptive services on an equal basis with men. At the same time existing laws, policies or customs and practices which are discriminatory against female adolescents will need to be modified or abolished. Secondly, beyond laws and policies, the government may be required to take other measures aimed at social transformation or change such as embarking on awareness campaigns to eliminate cultural and religious practices that perpetuate discrimination against female adolescents. More importantly, given the negative construction of adolescent sexuality discussed in Chapter 2, the Nigerian government will need to take remedial or corrective measures such as establishing adolescent-friendly health care centres where adolescents, particularly female adolescents, can seek advice and services in relation to contraception. However, in adopting the above steps and measures, the female adolescent question will need to be taken into consideration. For instance, hitherto how has the law treated female adolescents with regard to exercising sexual choices to seek contraceptive services? Or how has the health care setting treated female adolescent seeking sexual health services? And what can be done to correct this?

5.2.1.4.2 Comparison with other Jurisdictions

Although the human rights provisions in the Nigerian Constitution may appear not to have explicitly addressed the challenges peculiar to the 'life experience' of female adolescents in the country, nonetheless, the various provisions on human rights remain important in advancing the sexual health needs of adolescents. It is noted that the non-discriminatory provision of the Constitution does not explicitly include marital status or age (two important grounds for non-discrimination useful to female adolescents) as grounds for non-discrimination. Moreover, the Constitution does not prohibit discrimination based on 'other status', a term which could have been used to include prohibition of discrimination based on age.[71] Despite these constitutional shortcomings, there is nothing preventing the courts from purposively interpreting these provisions in a way that the female adolescent question is asked. The primary responsibility of the courts

[71] In recent times, the phrase 'discrimination based on other status' has been interpreted to prohibit discrimination based on disability, sexual orientation and age. See for instance, the Committee on CRC Concluding Observations: Chad 21st Sess. UN Doc. CRC/C/15/Add.107 (1999) para 28.

is to give life to the provisions of a piece of legislation. It should be pointed out, though, that the extent to which this is done will depend on the degree of activism exhibited by a particular court. Chapter 8 of this study deals in detail with the roles of the courts in advancing the sexual health and rights of adolescents.

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An important point to note here is that unlike the South African Constitution, which contains explicit provisions protecting children's rights, including the principle of the best interests of the child, [72] the Nigerian Constitution lacks any specific provision relating to the rights of children. This would seem to be a great omission and a missed opportunity to definitely advance adolescents rights in the country. The fact that the principle of the best interests of the child is embodied in the South African Constitution is an indication that the South African government gives great priority to the rights of children and adolescents. This principle can be relied on to justify the need to ensure access to contraceptive services to female adolescents. Given that the Constitution is the supreme law of the land, an explicit provision relating to children's rights would no doubt have gone a long way in advancing the sexual health and rights of children and adolescents in Nigeria.

Also, section 12 of the South African Constitution recognizes a woman's right to bodily and psychological integrity including the right to make decisions concerning reproduction and to control over her body. A High Court has interpreted this provision to affirm the autonomy of women, including young women, to make vital decisions regarding their sexuality.[73] No doubt this provision is responsive to the female adolescent question in that it allows all women, including girls, to exercise their sexual autonomy on matters relating to their bodies. Implicit in this is that all women, including adolescent girls, can invoke this provision to seek preventive treatment such as contraceptive services. The crux of the debate on whether or not an adolescent seeking sexual health services should require parental consent is the respect for the self-determination of the adolescent. Under international law it is recognized that women, including young women, have the right to

[72] See Section 28 of the South African Constitution.
[73] See *Christian Lawyers Association v National Ministers of Health and others* 2004 [10] BCLR 1086.

make decision regarding their bodies. The Committee on CEDAW has noted in one of its General Recommendations that health care services must be respectful of the bodily integrity of women and girls.[74]

Furthermore, section 27 (1) (a) of the South African Constitution guarantees the right to reproductive health care for all. This would seem to mean that women and girls have the right to seek sexual health services, including services related to contraception. Given the historical antecedents of South Africa and the subordination of women's rights to men, this provision is significant in that it asks the woman or female adolescent question. Ngwena and Cook have argued that the right to access to health care guaranteed under section 27 of the South African Constitution is 'integral not only to the idea of self-determination or autonomy, but also to the rights to equality and human dignity'. [75] Thus, the right to health care guaranteed in section 27 must be provided to all citizens in consonance with the detailed provision on equality and non-discrimination in section 9 of the Constitution. This provision, as mentioned earlier, is broader than section 42 of the Nigerian Constitution as it prohibits discrimination on grounds such as age, martial status and gender. This provides a stronger platform to recognize and affirm adolescents' right to seek sexual health services such as contraception without hindrance. Moreover, the fact that the equality provision in the South African Constitution is founded on substantive equality requires that female adolescents' rights to seek contraceptive services should be safeguarded. It would seem that the provisions of the South African Constitution are more explicit than the Nigerian Constitution with regard to advancing the sexual health and rights of female adolescents.

5.2.2 The Child's Right Act 26 of 2003

This Act is a product of rigorous and tortuous civil society activism in the country. It has had a chequered history having been initially rejected by the legislature before it was re-presented and enacted into law. This law underlines the Nigerian government's attempt to

[74] General Recommendation 24 (note 28 above).
[75] C Ngwena & RJ Cook 'Rights Concerning Health' in D Brand & C Heyns (eds) *Socio-economic Rights in South Africa* (2005)107, 131.

domesticate the provisions of the CRC. Prior to this Act, attempts had been made to secure children's rights, albeit partially, in the county. In 1943, the Children and Young Persons Ordinance was enacted by the British colonialists. This legislation was retained in chapter 32 of the Laws of the Federation of Nigeria and Lagos as revised in 1958.[76] The Children and Young Persons Act was subsequently adopted as state laws when more states were created in Nigeria in 1967.[77] The Act deals with issues such as the custody and welfare of a child, treatment of young offenders and juvenile justice system in its entirety. It does not in anyway explicitly relate to the rights of a child. This has necessitated the agitation for a specific piece of legislation that will address the rights of the child as envisaged by the CRC. The dream for a child-rights specific law came true in 2003 when the Child's Rights Act was enacted.

The opening section of this law is a reinstatement of the 'best interests' principle. Thus, section 1 declares as follows: 'in every action concerning a child, whether undertaken by a private individual, a public or private body, institution or service, courts of law, or administrative or legislative authority, the best interest (sic) of the child shall be the primary consideration.' It is commendable that the drafters of this law have chosen to follow the example of the African Children's Charter rather than the provision of the CRC. As contended by some scholars, the 'best interests' principle contained in the former is more emphatic than the latter.[78] While the CRC provides that the best interests of the child shall be 'a primary consideration', the African Children's Charter adopts a more definitive phrase 'the primary consideration'. The likely implication of this would be that under the African Children's Charter, the 'best interests' of the child is accorded more importance than under the CRC. By virtue of the Act, a child shall be anyone under the age of 18. This is different from what Nigeria has under the Children and Young

[76] B Owasonye 'Implementation of the Convention on the Rights of the Child in Nigeria' available at www.lawrights.asn.au/docs/owasanoye2001.pdf (Accessed on 23 January 2009).
[77] *Ibid.* It should be noted that this piece of legislation is now known as Children and Young Persons Act Cap 32 Laws of the Federation 1990.
[78] See for instance, D Chirwa 'Merits and Demerits of the African Charter on the Rights and Welfare of the Child' (2002)10 *International Journal of Children's Rights* 157, 160; See similarly, A Lloyd 'Evolution of the African Charter on the Rights and Welfare of the Child and the Committee of the Expert; Raising the Gauntlet' (2002) 10 *International Journal of Children's Rights* 179, 183.

Persons Act (CYPA)[79] which defines a child as someone under the age of 14, while a young person is a person who has attained the age of 14 years but is under 18.

The Child's Rights Act contains a wide range of provisions protecting the human rights of children. The Act, in addition to conferring specific rights on children, similarly provides that the provisions on fundamental human rights under Chapter IV of the Constitution will equally apply to the needs of children.[80] This is a positive development as it puts to rest any doubt whether or not the human rights provisions in the Constitution can be invoked to protect the rights of children. Specific rights conferred on children under the Act include the right to survival and development,[81] the right to a name at birth[82] and the right of association and peaceful assembly.[83] Given that lack of access to contraceptive services for adolescents may lead to loss of health and life, the provision on the right of children to survival and development can be invoked to require Nigerian government to ensure access to contraceptive services for female adolescents in the country. This will coincide with the reasoning of the Committee on CRC in its General Comment 3 where the Committee explains that 'state obligation to realize the right to life, survival and development also highlights the need to give careful attention to sexuality as well as to the behaviours and lifestyles of children...'[84] More importantly, the Act provides in section 7 that a child shall have the right to freedom of thought, conscience and religion. It provides further that where necessary, parents and guardians 'shall provide guidance and direction in the exercise of these rights having regard to the evolving capacities and the best interest (sic) of the child'.[85]

The intention of the drafters of the Act is not clear. The question may arise: is the principle of the 'evolving capacities' of the child to be considered only when it relates to

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[79] Owasonye (note 76 above).
[80] See The Child's Rights Act 26 of 2003 section 3 (1).
[81] *Ibid* section 4.
[82] *Ibid* section 5 (1).
[83] *Ibid* section 6.
[84] See General Comment 3 (note 12 above) para 11, also, the Committee in its General Comment 4 para 16 urges states parties to provide adolescents with necessary sexual health information and services essential for their development and survival.
[85] *Ibid* section 7.

the right to thought, conscience and religion? Or is this principle applicable to all actions concerning a child? The fact that this phrase 'evolving capacities' does not appear in any other section of the Act gives the impression that it is limited to section 7 alone. If this is the case, then it is a serious omission on the part of the drafters. Although one may argue that the right to freedom of thought is a broad right which encompasses all actions by a child. However, there is the danger that this provision may be given a restricted interpretation, thereby limiting the evolving capacities of the child alone to the rights protected under section 7. This may negatively impact on children's and adolescents' right to seek sexual health treatment. To avoid this confusion, perhaps it would have been better for the drafters to adopt the same position as article 5 of the CRC, under which the 'evolving capacities' of a child is recognised as a limitation on parental responsibilities and rights with regard to all rights guaranteed under the Convention.

Under section 13 of the Act, a detailed provision relating to children's right to health is provided. The section provides that 'every child is entitled to enjoy the best attainable state of physical, mental and spiritual health'. It similarly enjoins government, parents, individual or guardians responsible for the care of the child to endeavour to provide the child with the best attainable state of health. The section also obliges Nigerian government to ensure 'the provision of necessary medical assistance and health care services to all children with emphasis on the development of primary health care'.[86] Children are expected to be assured provision of other determinants of the right to health such as good nutrition, clean environment, adequate technology to combat diseases and malnutrition and immunization from diseases. Interestingly, section 13 (5) of the Act makes it a criminal offence for a parent, guardian or any person who has the custody of a child to fail to ensure the child the best attainable state of health as provided under the section.[87] The reason for this punitive measure is not clear, however, it may be intended to ensure that children and adolescents enjoy to the fullest the right to health guaranteed under the Act.

[86] *Ibid* section 13 (3) (b).
[87] *Ibid* section 13 (5).

Perhaps what may be regarded as a major oversight on the part of the drafters of the law is the fact that it contains no provision relating to consent to treatment for children or adolescents. This is a major lacuna in the law, which requires urgent attention. In such an important piece of legislation relating to children, and considering the ever contentious issue regarding children's rights to seek sexual health treatment, one will not be wrong to say that the Child's Rights Act scores an own goal in this regard. As noted in Chapter 2, adolescents' sexuality has always been construed negatively in many Nigerian communities, thereby limiting the exercise of their sexual autonomy. No doubt an explicit provision dealing with consent to treatment for children would have affirmed the autonomy or agency of a child to seek sexual health treatment, including access to contraception. For instance, a provision stating that 'no child shall be denied access to health care services for the reason that he/she has not obtained the consent of his/her parents or guardian, provided such a child has understanding of the nature of treatment and the implications thereof' would have been suitable for this purpose. In essence, the focus of such a provision should be the ability of a child or adolescent to exhibit that his/her capacity to comprehend such treatment has evolved. The provision may enjoin a child or an adolescent to consult with parents or guardians where necessary, but his/her unwillingness to do so should not deter access to such treatment once there is evidence to show that his/her capacity has evolved.[88]

In a country like Nigeria, where cultural and religious beliefs remain an important part of the daily lives of the people, providing sexual health services for adolescents may even prove more difficult if not impossible. One way of overcoming this challenge will be for the appropriate ministry in charge of health to issue health guidelines relating to access to sexual health care services for female adolescents to all health care providers. Such guidelines should detail the circumstance under which adolescents should consent to sexual health services. These guidelines will bridge the gap between the law and what happens in practice. A good example of how such guidelines operate in United Kingdom is discussed below.

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[88] See for instance, RJ Cook & B Dickens 'Recognising Adolescents' "Evolving Capacities" to exercise Choice in Reproductive Healthcare' (2000) 70 *International Journal of Gynaecology and Obstetrics* 13-22.

Furthermore, the Child's Rights Act guarantees the right to education of every child.[89] It similarly provides that primary education shall be free and compulsory for every child. Every parent, guardian or individual in custody or care of a child has an obligation to ensure that the child is educated up to secondary school level.[90] This provision can be interpreted to allow access to sexual health information, including information on contraception, to adolescents. Under section 15 (5), the Act purporting to be acting in the interests of a female child, provides that a pregnant female child shall be allowed an opportunity to return to school upon delivery to complete her education. Much as this provision seems important, it does not really address discriminatory attitudes a pregnant female child may face in school.

A closer look at section 15 (5) will show that it is not intended to protect a pregnant female child who intends to remain in school during the period of her pregnancy. It merely allows such a child to return to school after delivery. This will likely encourage discrimination against a pregnant female child in school.[91] The greatest challenge relating to pregnancy in school is based on the fact that adolescent girls are often expelled from school the moment the pregnancy becomes public knowledge, irrespective of the fact that they are still strong and able to continue with their education. Rather than address this discriminatory act, this provision has unwittingly endorsed it.

The Act under section 8 recognises children's right to privacy and provides that no child may be subject to interference with his or her right to privacy. Also, in section 11 the right of human dignity of a child is guaranteed. The section provides that no child shall be subject to inhumane or degrading treatment. These two provisions, if properly applied, are no doubt very crucial to advancing adolescents' right to sexual autonomy, including access to contraceptive services. Other important rights guaranteed under the Act include

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[89] Child's Rights Act (note 80 above) section 15.
[90] *Ibid* section 15 (3).
[91] For instance, in the case of *Student Representative Council of Molepolole College of Education v Attorney General* [1995] (3) LRC447 (Botswana Court of Appeal), the constitutionality of a school regulation which obliges a pregnant female student to leave school was successfully challenged as being unfairly discriminatory against female students contrary to section 15 of Botswana Constitution.

the right of a child to non-discrimination on the grounds of ethnicity, group, community, place of origin, birth, sex, religion or political opinion.[92] Equally, the rights to movement,[93] leisure and cultural participation[94] of a child are protected under the Act. Furthermore, a marriage of a child below the age of 18 is prohibited under the Act.[95]

The provision relating to non-discrimination seems to have been inspired by section 42 of the Constitution. This provision, as noted earlier, is not broad enough as it does not explicitly forbid discrimination on the grounds of age, marriage, pregnancy or social status. Given the fact that the Child's Rights Act was conceived to specifically address the rights of children and adolescents, one would have expected a more comprehensive and adolescent-friendly non-discrimination provision. The Act could have aimed at addressing gender inequality and the disadvantaged position of female adolescents in the country. Failing to do so can be regarded as another missed opportunity for the Act to advance female adolescents' rights and address the female adolescent question. However, this inadequacy can be mitigated by providing a generous and purposive interpretation of the non-discrimination provision of the Act. As argued in the case of the Constitution above, since the non-discrimination provision of the Act prohibits discrimination on the grounds of sex, this can be interpreted to cover female adolescents as well. In other words, one can rely on this provision to require the Nigerian government to refrain from denying access to contraceptive services to female adolescents because of their gender.

A noticeable feature of the Child's Rights Act is its tendency to give rights to children with one hand and then take them back with the other hand. In other words, the Child's Rights Act contains a number of what may be regarded as 'claw back' clauses, where children's rights are made subject to the control of parents or guardians. For instance, section 8 (1) guarantees the right to privacy of a child, but under section 8 (3) this right is qualified to the extent that nothing in the section will prevent parents or guardian from exercising reasonable control over the child. While the intention of the drafters of this

[92] Child's Rights Act (note 80 above) section 10.
[93] *Ibid* section 9.
[94] *Ibid* section 12.
[95] *Ibid* section 21.

law may be to balance the right of a child with that of the parents or guardians, the danger here is that the ability of children and adolescents to enjoy fully the various rights guaranteed under the Act may be rendered impossible. The qualification of the right to privacy contained in section 8 may be invoked by parents or guardians to override the right to autonomy of a child to seek sexual health treatment including access to contraception. This can lead to serious health repercussions for female adolescents Experience has shown that young people will shun sexual health treatment if the details of such treatment are not kept away from their parents or guardians.

Although the Child's Rights Act contains important provisions that can be used to advance the sexual health rights of adolescents in the country, overall, the Act cannot be said to have adequately responded to the sexual health challenges encountered by female adolescents. To that extent, it may not be wrong to argue that the Act fails to respond to the female adolescent question. Bearing in mind the devastating effect of the HIV/AIDS pandemic, especially among young women, it is not clear why the Act fails to include a provision relating to the challenge posed by the epidemic to female adolescents. The Act is ominously silent on the issue of consent to medical treatment for children and does not contain a specific provision on the right to information for children. In a country where studies have revealed that adolescents lack proper knowledge and information with regard to contraception, more would have been expected from the Act than its present contents.

5.2.1 Comparison with other Jurisdictions

The position under the Child's Rights Act may be contrasted with that of the South African Children's Act of 2005.[96] Prior to the enactment of the Children's Act, the Child Care Act[97] was the prevailing law relating to consent to medical treatment for children and adolescents. An amendment to the Child Care Act in 1991 allowed adolescents over the age of 14 but under 18 to consent to medical treatment for him or herself or for his or

[96] Act 38 of 2005.
[97] Act 74 of 1983.

her child.[98] Prior to this amendment, the Child Care Act had retained a common law position to the effect that minors are presumed to lack competence to consent to medical treatment. Thus, such an adolescent will require the consent of his or her parents or guardians or in extreme cases, apply to the court for such consent in the absence of parents or guardians. However, this requirement would later be seen as constituting a stumbling block for adolescents under 14, who have either become sexually active or have been sexually abused, to seek sexual health treatment, including treatment for contraception. The attendant effects of this were high teenage pregnancy rates, prevalence of HIV among young people and delays in treatment for adolescents in the country.[99]

In a bid to correct these shortcomings in the Child Care Act, some radical provisions in the Children's Act were proposed. The latter law contains very important provisions which can be used to advance the autonomy of children and adolescents to seek medical treatment, including sexual health treatment. For instance, the Children's Act allows a child of 12 years and of sufficient maturity to give consent to medical treatment in certain circumstances.[100] The Act clearly provides that in the case of HIV testing, a child aged 12 with sufficient maturity to understand the implications of such a test may consent to an HIV test.[101] Significantly, the Act in section 134 provides that a child of 12 and over that age, may access contraceptive services without parental consent after a medical examination and a certification that there was no reason why such services should not be provided for the child. These are no doubt radical provisions which will advance adolescents' agency to seek medical attention, especially with regard to sexual health services. It will particularly facilitate access to sexual health services for female adolescents in the country.

However, one needs to point out here that the setting of the age of consent to 12 years under the South African law can be counter-productive in the sense that some children or

[98] See 39(4) substituted by section 13 of the Child Care Amendment Act 86 of 1991.
[99] See P Mahery 'Consent Laws influencing Children's Access to Health Care Services' (2006) *Health System Trust* 168, 170.
[100] *Ibid* section 129.
[101] *Ibid* section 130.

adolescents under this age, who may exhibit sufficient maturity and understanding might, nevertheless, sometimes be deprived of their right to consent to treatment.[102] With respect to this issue, Dickens and Cook[103] have observed as follows:

> Rigidly set ages below which mature minors legally require parental consent to receive therapeutic or preventative reproductive health services are frequently dysfunctional in that they prejudice adolescents' health and well being by creating barriers to care.

In essence, since there is no stipulated age of consent in medical law,[104] it is preferable that a law merely sets out the conditions that need to be met before consent can be given to medical treatment.[105] If at all there is any need for age of consent to be prescribed, it should merely be for administrative purposes and should not be made a condition precedent for medical treatment for children or adolescents. One must not lose the fact that despite the provisions of law, there are bound to be challenges and even opposition to realising access to contraception for adolescents under the age of 12. This is because health care providers are often judgmental and reluctant to provide unmarried adolescents with necessary sexual health services.

Unlike the Nigeria's Child's Rights Act, which adopts what may be termed 'diplomatic language' throughout - it refuses to explicitly mention words such as 'contraceptives' or 'sexual health'- the South African Children's Act explicitly contains provisions on contraception and HIV/AIDS for children and adolescents. It does appear that due to the travails the Child's Rights Act went through before it was finally passed into law, the final version of the Act seems to have been a compromise. It is more or less a balance between the wishes of child rights advocates and the conservatives in society who were initially opposed to the Act on religious and cultural grounds. The mere fact that the Act has only been adopted by few states in the country makes its implementation difficult if

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[102] *Ibid* 171.
[103] B Dickens & RJ Cook 'Adolescents and Consent to Treatment' (2005) 89 *International Journal of Gynecology and Obstetrics* 179, 183.
[104] See General Recommendation 24 (note 28 above) para 8.
[105] Dickens & Cook (note 103 above) 183.

not impossible.[106] Moreover, those states that have adopted the Act are merely paying lip service to its provisions and have not really shown enough political will with regard to implementing its provisions.

An important provision of the South African Children's Act which does not have an equivalent provision under the Nigerian Child's Rights Act, is section 10. This section provides that 'every child that is of such an age, maturity and stage of development as to be able to participate in any matter concerning the child, has the right to participate in an appropriate way and views expressed by the child must be given due consideration'. The significance of this provision, which is *in pari materia* with article 12 of the Convention on the Rights of the Child, is that it can be relied on to advance the sexual autonomy of female adolescents to seek contraceptive services. The provision does recognise children and adolescents as human beings worthy of consultation in all matters affecting them. At the same time, the Act in its preamble tries to strike a balance between the rights of the child and the important roles of family members by providing that 'it is neither desirable nor possible to protect children's rights in isolation from their families and communities'. In a way, this provision seems to align itself with the observations of scholars such as Nedelsky who have advocated for relational, rather than, absolute autonomy for children and adolescents.[107] According to her, relational autonomy allows members of the child's family to play a role in the child's decision-making.

Also, Himonga and Cooke have noted that the provisions of the South African Children's Act must be interpreted cautiously so as not to jeopardize the interests of children and adolescents.[108] They note further that the provisions of the Children's Act are too radical and ambitious and may 'over empower' children and adolescents in taking crucial

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[106] So far about 26 states out of 36 states of the federation have enacted the Act as a state law. Some of these include Abia, Anambra, Bayelsa, Ebonyi, Edo, Ekiti, Imo, Jigawa, Kwara, Lagos, Nasarawa, Ogun, Ondo, Oyo, Plateau, and Taraba. The legislative houses in both Osun and Rivers states have passed the law but awaiting assent from the governors of the states. See The Nigeria CEDAW NGO Coalition Shadow Report: Submitted to the 41st Session of the UN Committee on CEDAW (2008).

[107] J Nedelsky 'Judgment, Diversity and Relational Autonomy' in R Beiner and J Nedelsky (eds.) *Judgment, Imagination and Politics: Themes from Kant and Arendt* (2001)111.

[108] C Himonga & A Cooke 'A Child's Autonomy with Special Reference to Reproductive Medical Decision-making in South African Law: Mere Illusion or Real Autonomy?' (2007) 15 *International Journal of Children's Rights* 323, 352.

decisions relating to their sexual health. In particular, they question the rationale for arriving at the respective age thresholds for medical-decision making by children. They were particularly concerned about the provision that permits a 12-year old to consent to invasive medical treatment such as termination of pregnancy, since there is no empirical study in South Africa justifying this age threshold. In their view, they submit that 'it is unimaginable that 12 year olds in South Africa have the relevant capacities to make decisions about surgical operations and especially about the termination of their pregnancies'.[109]

While the concern of these authors may seem valid and genuine, one must also appreciate the basis for the radical provisions of the Children's Act. South Africa is a country that is currently experiencing the devastating effects of the HIV/AIDS epidemic and high incidences of teenage pregnancy and sexual violence against women and girls. Therefore, it was in a bid to respond to these challenges that the age threshold of the Act was arrived at. It must also be mentioned that these provisions of the Act were debated at different stages during the legislative process. Indeed, the South African Law Commission were said to have made wide consultations before the law was enacted. Moreover, while the concern of the authors may seem valid in the case of abortion, it may not be so in the case of contraception. Given the fact that girls now engage in sex at a very early stage and bearing in mind that girls are potentially susceptible to coercive sex, it is only pragmatic to allow access to contraception for a girl of 12. Indeed, as some child psychologists have shown the issue of competence to consent to medical treatment sometimes transcends age status.[110] Therefore, the problem is not really about the age but rather the ability of a child to show that his or her capacity has evolved.

Another important provision which is missing in the Nigerian Child's Right Act, but is explicitly guaranteed in the South African Children's Act, is the right of children and adolescents to information as regards their health. Section 13 of the Children's Act

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[109] *Ibid.*

[110] J Piaget & B Inhelder *The Psychology of the Child.* (1969), where they argue that sometimes a child of 10 may exhibit competence to consent to treatment, while at other time, a child over 12 may exhibit lack of such competence.

provides that every child has a right of access to information about his/her health status (including sexuality and reproduction) and the causes and treatment thereof, and that he/she has the right of confidentiality in this regard unless it is not in his/her best interests. No doubt this provision is intended to guarantee children's and adolescents' autonomy to seek health care services without the need for parental consent. It will particularly be useful for female adolescents who are the ones most likely to seek sexual health services including contraceptive services so as to prevent sexual ill-health. Given the ever contentious issue with regard to consent to medical treatment for children and adolescents, this provision will safeguard the rights of female adolescents to confidential sexual health treatment and services.

The British government has also taken some decisive steps in addressing the challenges facing adolescents in the country. Under section 8(1) of the Family Law Act of 1969, it is provided that a minor who has attained the age of 16 is competent to consent to treatment. This provision was a subject of interpretation by the House of Lords in the *Gillick* case discussed below. In 1989, the British government enacted the Children's Act, which is aimed at protecting the interests of children and advancing their welfare including a decent standard of living. However, just as in the case of the Nigerian Child's Rights Act, the British Act fails to give attention to the sexual health needs of children. In order to make up for the deficiency in the Children's' Act, the British government has in recent times issued directives or guidelines relating to adolescents' health needs. For instance, on some occasions the Department of Health has issued directives to health providers to provide sexual health services to girls under the age of 16, if they could understand the nature of the treatment and the implications thereof.[111] Such directives have become subjects of litigation on two important occasions. The first being the *locus classicus* case of *Gillick*,[112] and more recently, the *Axon*[113] case. In both cases, attempts

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[111] See for instance, UK Department of Health *Seeking Consent: Working with Children, Best Practice Guidance for Doctors and Other Health Professionals on the Provision of Advice and Treatment to Young People under-16 on Contraception, Sexual and Reproductive Health* (2004).

[112] *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security* [1986] 1 AC 112.

[113] *R on the Application of Axon* v *The Secretary of State for Health* (2006) English and Wales High Court 37 (Administrative Court) Case No CO/5307/2004.

made at challenging the legality and lawfulness of two different, but similar directives, issued by the Department of Health allowing a girl under 16 to exercise her right to autonomous decision-making capability with regard to sexual health treatment were rejected by the courts. A detailed analysis of these cases and their relevance for the female adolescent question is carried out in Chapter 8

An important point to note with regard to the directives or guidelines issued by the British Government is that they tend to supplement a gap or omission in the law and compel health care providers to comply with them. This may be a useful approach to adopt by the Nigerian government in order to advance the sexual autonomy of female adolescents in the country. Considering the fact that there is no legislation in the country that explicitly guarantees adolescents' access to sexual health services, the Federal Ministry of Health can issue guidelines that will compel health care providers to ensure access to contraception for adolescent girls without the need for parental consent. Ultimately, such guidelines or directives will save female adolescents from sexual ill-health and consequently be responding to the female adolescent question.

5.2.3 Criminal Code

Under the Criminal Code applicable in the southern part of the country, the age at which a girl can consent to sexual intercourse is 16,[114] whereas the age for boys is 14.[115] Thus, a sexual intercourse by an adult with a girl under 16 is regarded as a crime. This is often referred to as statutory rape. This kind of law is not peculiar to Nigeria many other countries have similar laws. The disparity in the Criminal Code with regard to the age of sexual consent is unwarranted and merely reinforces the patriarchal nature of the Nigerian society. It would seem to reinforce the traditional view that boys are expected to be sexually active while girls are expected to be reserved. Often, the reason for these types of laws is to protect children and young people from sexual abuse. The fact that the Criminal Code prescribes different ages of consent to sex for boys and girls, is a

[114] See Criminal Code Act, Cap 77 Laws of the Federation of Nigeria (1990) section 222 of the Code.
[115] *Ibid* section 216.

reinforcement of discriminatory practices against girls in society. It seems to send the message that girls, unlike boys, usually lack capacity to make decisions as regards their sexuality. Such an assumption is unfounded and merely leads to stereotyping of girls. The Committee on CEDAW has noted that prescribing a lower age of marriage for girls in comparison with boys would amount to an act of discrimination.[116]

Furthermore, as earlier mentioned, the purpose of statutory rape law to protect young people from sexual abuse, may sometimes become a veritable tool of repression of the sexual desires of adolescents, especially female adolescents. Therefore, some feminist scholars have questioned the rationale for retention of statutory rape laws in some jurisdictions. Olsen, for instance, has noted that one challenge with such laws is that while they may tend to reduce incidences of sexual abuse of young people, they at the same time, tend to restrict the sexual activity of young people thereby reinforcing the double standard of morality.[117] It is further noted that while originally statutory rape laws were developed to curb uncontrollable, excessive obsession of men for sex, it later became a veritable tool in the hands of states to repress and control sexual desires, especially of young women.[118] An objectionable consequence of this is that, such laws tend to exalt female chastity and treat young women as lacking in sexual autonomy.[119] In sum, it has been argued that statutory rape law is viewed broadly as an attempt by the state to 'criminalise sexuality'.[120]

The implication of statutory rape law will be that if a girl below the stipulated age of consent becomes sexually active she may be reluctant to seek advice from health care providers for fear of how they will react. This can be very dangerous as it tends to force sexual activities among adolescents underground. Indeed, studies have shown that health

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[116] See Concluding Observations of the Committee on CEDAW: Nigeria Forty-First Session 30 June -18 July 2008 CEDAW/C.NGA/CO/6.
[117] See F Olsen 'Statutory Rape: A Feminists Critique of Rights Analysis' in DK Weisberg (ed) *Application of Feminists Legal Theories to Women's Lives* (1996) 460.
[118] *Ibid.*
[119] *Ibid* 462.
[120] See C Ahumada 'Statutory Rape Law in Chile: For or against Adolescents?' (2009) *Journal of Politics and Law* 94, 96, this debate is not so much an issue in Nigeria. Therefore, this study will not dwell much on it as it is outside its scope.

care providers are always reluctant to provide advice and services on sexual health to female adolescents when they are consulted.[121] This is based on the fear that they might be regarded as facilitating the commission of an offence under statutory rape laws. The likely effect of this can jeopardise the sexual health of a female adolescent, who has become sexually active and cannot be provided with information or services on contraception. The Committee on CRC has noted that governments have the obligation to remove all obstacles to access to adolescents' sexual health needs.[122]

Overall, it does appear that the entire body of laws in Nigeria relating to the sexual health of adolescents contains important provisions that can be invoked to realise the sexual health needs of adolescents. However, some of these provisions are either inadequate or not explicit enough. Most of Nigeria's laws do not clearly contain provisions recognising adolescents' autonomy to seek confidential medical treatment including sexual health treatment. While this may not be a problem in itself, the mere silence on these important issues in a religiously and culturally polarised society as Nigeria, can give room for an interpretation which may be detrimental to the interests of adolescents in the country. In addition, there are some inconsistencies in the laws which may not be in the best interests of adolescents with regard to access to contraception.

The situation in Nigeria when compared with other countries such as South Africa and Britain, two countries that are faced with serious challenges with respect to health needs of adolescents, will reveal the shortcomings in Nigeria's law relating to adolescents' sexual health needs. South Africa has the largest number of people living with HIV in the world. The majority of the about 6 million people infected with the epidemic in the country are young people.[123] There is also a high incidence of sexual violence and teenage pregnancies in the country. On the other hand, Britain is regarded as a country

[121] Center for Reproductive Law and Policy (CRLP) & Child and Law Foundation(CLF) *State of Denial: Adolescents Reproductive Health in Zimbabwe* (2002) 54; see also J Sundby 'Young Persons' Sexual and Reproductive Rights' (2006) 3 *Best Practice & Research Clinical Obstetrics and Gynecology* 355, 357 where the author notes that minimum legal age for consent for sexual act can be used to create barriers to sexual and reproductive health services to young persons through restrictive interpretation by health care providers.

[122] See General Comment 4 (note 27 above).

[123] Department of Health South Africa *National HIV and Syphilis Prevalence Survey 2006* (2007) 7.

with one of the worst cases of teenage pregnancies in Western Europe.[124] The governments of these countries have in recent times taken a number of steps to address the various challenges they encounter.

From the above, it is clear that Nigeria's laws, unlike South Africa's, lack explicit provisions to realise access to contraception for adolescents. Although some provisions of the laws can be invoked indirectly to advance access to contraception to adolescents, it would have been better if the laws as in the case of South Africa contain specific provisions ensuring access to contraception for adolescents. Given that Nigeria has ratified both the CRC and the African Children's Charter, one would have expected its laws to contain more explicit provisions relating to access to sexual health information and services for adolescents. It might be necessary for Nigeria to revisit its Child's Rights Act, with a view to making it more adolescent-friendly like the Children's Act of South Africa. The affirmation of the right of a child of 12 to seek contraceptive advice and services, without the need for parental consent, is a radical step forward. This will not only advance the sexual autonomy of adolescents, but also responds to the female adolescent question. On the other hand, even in the absence of explicit provisions dealing with access to contraception for children and adolescents, the issuance of subsidiary regulations or guidelines by the appropriate ministry could be a feasible option for the Nigerian government to consider.

SECTION B

5.3 National Policies on Adolescents Sexual Health in Nigeria

In this section of the study, the focus is on policies made at the national level which may have implications for the realisation of access to contraception for adolescents in Nigeria. As stated earlier, the discussion is by no means exhaustive. Only a selected set of relevant policies have been discussed here.

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[124] LD Jacobson *et al* 'Teenage Pregnancy in the United Kingdom in the 1990s: The Implications for Primary Care' (1995) 12 *Family Practice* 232, teenage birth rates in UK are more than twice as high as in Germany, three times as high as in France and over five times as high as in the Netherlands.

5.3.1 National Policy on Health 2004

This policy is one of the most comprehensive policies relating to health, including sexual health in Nigeria. It was first introduced in 1998 but was later amended in 2004. Some of the important underlying principles and values of the National Health Policy include the following:

(i) The principle of social justice, equity and the ideals of freedom and opportunity already affirmed in the Nigerian Constitution of 1999;
(ii) The recognition of health and access to affordable health care services as a human right;
(iii) The pursuit of equity in health care and in health for all Nigerians as an important goal;
(iv) Emphasis on primary health care as a basic philosophy and strategy for national health development and;
(V) Ensuring good quality health care to all through cost-effective interventions that are targeted at priority health problems.

The Policy has as its major objective the strengthening of the national health system so that it is able to provide effective, efficient, quality, accessible and affordable services that will improve the health status of Nigerians. This is intended to be achieved through the health-related goals of the Millennium Development Goals (MDGs). Thus, the Policy sets its targets in the same manner as that of the MDGs as follows:
(i) To reduce by two-thirds, between 1990-2015 the under-5 mortality rate;
(ii) To reduce by three-quarters, between 1990-2015 the maternal mortality rate;
(iii) To have halted, by 2015 and begun to reverse the spread of HIV/AIDS and;
(iv) To have halted, by 2015 and begun to reverse the incidence of malaria and other major diseases.

In addition, the National Health Policy contains some important declarations and commitments on the part of the governments at the federal, state and local levels. Governments at all levels together with the private sectors commit themselves to realising the goal of heath for all citizens of Nigeria, so as to enable them to lead socially and economically productive lives at the highest possible level. Similarly, governments agreed that the health of the people does not only contribute to a better and higher quality life but is also essential for sustained economic and social development. More importantly, the Policy recognises the right of the people to participate individually and collectively in the planning and implementation of their health care. The Policy notes that primary health care is essential to attaining the goal of health for all people of the country. Therefore, primary health care services must be based on practical, scientifically sound, acceptable methods and technology that is made universally accessible to all individuals and families, particularly those in rural areas. Governments at all levels also undertake to exercise political will and mobilise resources for the realisation of the objectives of the National Health Policy.

No doubt the National Health Policy is a very progressive document full of promises. Although the Policy does not contain provisions specifically relating to adolescents sexual health needs, nonetheless some of its provisions can be invoked to advance access to contraception for adolescents. The fact that the Policy reaffirmed the health-related targets set during the MDGs, is an indication that the Nigerian government should take seriously the realisation of access to contraception for adolescents in general, and female adolescents in particular. It is interesting to note that the National Health Policy recognises health and access to affordable health care as fundamental rights. This is indeed, highly commendable and undoubtedly goes a step further than the Constitution. As noted earlier, the Constitution does not recognise the right to health as a justiciable right.

One can rely on this provision of the Policy to ensure access to sexual health services, including services related to contraception, to female adolescents in the country. The fact that the Policy aligns itself with the health-related goals of the MDGs is laudable and it is

hoped will translate into better attention being given to the sexual health needs of female adolescents in the country. In this regard, the Policy can be useful to courts in assessing government's commitments to realising access to sexual services for adolescents in the country. Courts can apply the provisions of the Policy as a guide in determining the reasonableness or otherwise of government efforts to meeting the sexual health needs of adolescents in general and female adolescents in particular.

Perhaps a major limitation to the provisions of the Policy is the fact that it is not a binding document like a piece of legislation. Policies generally serve as a guide and provide direction on governments' position regarding a subject matter. At best, they serve as persuasive authority to courts and impose moral obligations on governments. In corroborating this position, a Botswana court has held that the National Policy on HIV in that country, which prohibits HIV testing as a condition for employment, was merely a persuasive document lacking in legal authority.[125] The Court further explained that 'law' and 'policy' operate on different levels as the former is binding while the latter is not.

5.3.2 The National Policy on Adolescents 2007[126]

This is by far one of the most recent and comprehensive policies dealing with adolescents in the country. It contains a number of promising and ambitious provisions relating to adolescents and young people. The Policy acknowledges the various challenges with regard to sexual and reproductive health facing young people in the country. It affirms the need to imperatively and effectively respond to these challenges through properly designed and appropriate programmes and interventions. In its introductory words, the Policy provides as follows:

> Adolescence is a period of transition from childhood to adulthood. Adolescents constitute a distinct population with specific needs and concerns and thus merit special focus and attention

[125] *Rapula Jinson v Botswana Building Society* Case IC 35/05 Industrial Court of Botswana Gaborone Judgment of 30 May 2003.
[126] Federal Ministry of Health National Policy on Health and Development of Adolescents and Young People in Nigeria (2007).

> within a national development framework, hence, the need for specific policy that will provide a platform for effective programme actions.[127]

According to the Policy, lack of adequate attention to the health needs and development of adolescents, may render past investments in young people in the country a waste. The Policy adopts the definition given by the WHO to adolescents and young people and therefore applies to all young people within the ages of 10-24 years old. It clearly recognises the sexual and reproductive rights of adolescents and young people, acknowledging the fact that most young people engage in early sex without proper information about its consequences. The Policy denounces the continued denial of access to sexual and reproductive health information and services to young people in the country, referring to this as unwarranted violation of the rights of adolescents and young people.[128] It also condemns other violations of rights such as sexual violence and early marriage often experienced by female adolescents. Therefore, the Policy aims at creating an enabling environment for appropriate actions on the sexual and reproductive health needs of adolescents. It is commendable that the Policy is founded upon respect for human rights of adolescents, and in particular, female adolescents.

The Policy identifies some social-cultural challenges which contribute to the unhealthy development of adolescents in the country. These factors include poverty, unemployment, gender inequality, ethnic discrimination and the impact of social change on families and communities. According to the Policy, the home is the primary socialisation platform for the healthy development of young people. The Policy calls for a rights-based approach to addressing the sexual and reproductive health needs of young people. In particular, the Policy reaffirms the need to uphold gender equality in addressing challenges faced by adolescents in the country. This is highly commendable as it easily provides an avenue to frame the deprivations experienced by young people, especially young women in the country, as human rights violations. It also provides an avenue to hold the Nigerian government accountable for failing to address these violations. By its provisions on eliminating gender inequality among adolescents, the

[127] *Ibid* para 1.
[128] See *Ibid* para 2.1.1.

Policy seems to be responding to the female adolescent question. As this study has shown, adolescent girls encounter greater difficulty in realising their sexual health needs in Nigeria. Therefore, this provision would seem to call attention to the needs of female adolescents and obligate the government of Nigeria to take necessary measures to eliminate gender inequality.

However, the Policy in another section provides that strategies and interventions that will be adopted by it will be culturally sensitive and based on local values. The purpose of this provision is unclear. Bearing in mind the potential clash or conflict between human rights and culture, this provision may rather work against the interest of adolescents. It is a known fact that some cultural and religious practices often serve as barriers to the realisation of adolescents sexual health. For instance, some cultures permit early marriage while others prohibit premarital sexual intercourse. Practices such as these may tend to undermine the sexual health and rights of adolescents in the country and deny them access to contraceptive services. This is so since young people are not expected to engage in sexual activity.

Interestingly, the Policy aims at increasing the number of young people with adequate access to sexual and reproductive health information and services by 50% by 2015. It equally aims at reducing by 50% the incidence of unwanted pregnancies and child marriages. Also, about 75% reduction rate in maternal mortality ratio is aimed at by 2015. The Policy equally aims at integrating life skills education on HIV/AIDS and STIs into primary and secondary schools curricula in the country. Part of the strategies to achieve these goals include advocacy and resource mobilisation; provision of youth-friendly information and services on health care provision; a healthy safe and supportive environment; and the encouragement of behavioural change among young people. Considering the neglect over the years of adolescents' sexual health needs by the Nigerian government, the call for mobilisation of resources to meet the health needs of adolescents is overdue. This is more so when one bears in mind Nigeria's commitment under consensus meetings such as the Abuja Declaration where it was resolved that African governments should allocate at least 15% of their annual budgets to the health

sector.[129] Presently, Nigeria is said to commit about 5% of her annual budgetary allocation to the health sector, a far cry from the agreed 15%.[130]

In addition, the Policy proposes a multi-sectoral and decentralised approach to addressing the challenges of adolescents sexual and reproductive health needs in the country. Thus, different stakeholders, ministries and levels of governments are all identified as key to realising the sexual and reproductive health needs of young people. The participation and involvement of young people in the implementation of the various strategies contained in the policy is further recognised. No doubt these strategies are laudable and will certainly go a long way in advancing the sexual health needs of young people. However, the mere fact that the drafters of the Policy chose to be evasive with regard to the issue of contraception and do not explicitly recognise adolescents' autonomous decision-making powers seem to cast doubt on the commitment of the policy makers to realising adolescents' sexual health needs. An explicit provision relating to access to contraception for adolescents and young people, as a strategy to meet their health needs, would have helped in breaking the silence on this issue. Moreover, it will be reassuring of the Policy's true commitment to advancing adolescents sexual health.

5.5.3 National Reproductive Health Policy

This Policy is generally concerned with improving the state of reproductive health care services. Although its concern is with the entire population, nonetheless some of its contents are useful for addressing the sexual health needs of adolescents and young people. The National Reproductive Health Policy of 2001 is founded on the various consensus statements and declarations such as the ICPD, the Beijing Platform and the UN General Assembly Declaration of Commitment on HIV/AIDS of 2001. In line with the ICPD, the Policy aims at making available to all by the year 2015 comprehensive access to sexual and reproductive health care services. As a way of realising this goal, the

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[129] Abuja Declaration on HIV/AIDS, Tuberculosis and other Related Infectious Diseases by African leaders, April 2001 OAU/SPS/ABUJA/3.

[130] See Center for Reproductive Rights (CRR) & Women Advocacy Research Development Centre (WARDC) *Broken Promises: Human Rights Accountability and Maternal Death in Nigeria* (2008) 17.

Federal Ministry of Health initiated the drafting of a document known as the National Reproductive Health Strategic Framework and Plan 2000-2006.[131] This document addresses a number of issues including STIs, FGC, infertility and maternal mortality.

In addressing the challenges of STIs, which are very rampant among adolescents and young people, the Policy aims at integrating reproductive care services into primary health care services. It intends to do this through promoting community awareness of STIs, promotion of condom use, and promotion of behavioral change influencing safe sex, incorporating IEC and clinical services for STIs into reproductive health care services. Some of the objectives for realising this aim include improving political commitment and community support for the control of STIs, promoting positive health behaviour, expanding access to comprehensive and quality sexual and reproductive health care services and strengthening the health care sector to respond to the challenge of STIs through training of health care providers. The Policy fails to give special attention to the sexual and reproductive health needs of female adolescents in the country. Thus, one can say it fails to answer the Nigerian female adolescent question. While it is true that the Policy aims at catering for the reproductive health needs of the entire population, there is nothing wrong in addressing the special needs of adolescent girls who are more vulnerable to sexual and reproductive ill-health in the country.

The National Reproductive Health Policy seems to have adopted a more pragmatic approach to the sexual health needs of adolescents when compared with the Adolescent Reproductive Policy. In the sense that the former explicitly identifies use of condoms as one of the strategies to confront the sexual and reproductive health challenges facing adolescents and young people. By taking this bold stance, the Policy has been able to break the usual silence surrounding the promotion of condoms as a means of combating various sexual health challenges facing adolescents. Since studies have shown the correlation between low use of contraception and sexual and reproductive ill-health

[131] This document is currently being reviewed.

among adolescents,[132] the provision of the National Policy on Reproductive Health is a more realistic approach at addressing this challenge.

However, its limitation, like all policies, lies in its unenforceability under Nigerian law. Moreover, policies generally are susceptible to frequent modifications depending on changes in governments, thus creating a sort of instability in policy formulation. To avoid this it would have been better to ensure that some of the important provisions contained in this policy are enacted into law. This is because legal guarantees provide vulnerable groups such as children and adolescents with certainty and enhance their ability to enforce such rights.[133]

5.3.4 National Policy on HIV/AIDS

This Policy, which came into being in 2003,[134] contains a number of provisions dealing with the HIV/AIDS pandemic that could also be useful in advancing the sexual health needs of adolescents. The Policy recognises the importance of a human rights-based approach to addressing the spread of HIV in the country. It acknowledges the various problems posed by the epidemic stating that the major mode of transmission has been through heterosexual intercourse caused by risky sexual behaviour among sex workers, long distance drivers, ignorance on sexual issues among young people, and high prevalence of STIs. In order that the spread of the epidemic be reversed, the Policy advocates for change of behaviour and the widespread use of condoms among the general population, particularly among young people. The Policy identifies certain barriers to behavioural change, cultural beliefs and practices, subjugation and subordination of women's rights, lack of sex or family life education in schools and ineffective treatment methods. It, therefore, calls for the immediate removal of these barriers to effectively stem the further spread of the epidemic.

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[132] See for instance, U Amazingo *et al* 'Sexual Activity and Contraceptive Knowledge and Use among in-school Adolescents in Nigeria' (1997) 23 *International Family Planning Perspectives* 28-33.
[133] Center for Reproductive Rights and Policy (CRPL) *Reproductive Rights 2000: Moving Forward* (2000) 15.
[134] Federal Ministry of Health (FMOH) *National Policy on HIV/AIDS* (2003).

As part of its guiding principles, the Policy aligns itself with other relevant existing policies that are complementary to addressing HIV/AIDS in the country. It also affirms the principles of human rights, social justice and equity in tackling the pandemic and the need by the various governments in the federation to make information available to all. The major objectives of the Policy include promoting a multi-sectoral approach to fighting the epidemic, increasing awareness on HIV/AIDS among the public, fostering behavioural change, respecting rights of those already infected, removing barriers to prevention of the epidemic and ensuring that prevention programmes are developed and targeted at women, children, adolescents, young adults and other vulnerable groups.

Part of the strategies to realise these objectives include promotion of safe sexual behaviour, appropriate use of condoms, voluntary counseling and testing and adolescent-focused interventions. The Policy provides that women shall be empowered through education and appropriate legislation to protect themselves from unsafe sexual acts. Although the Policy maintains that abstinence is the best option for young people, it nevertheless, provides for the promotion of the use of condoms through the media and other mediums. Indeed, the Policy provides that condom outlets shall be established in locations easily accessible to those most at risk of HIV. It similarly recommends a holistic approach to preventing the spread of the epidemic among adolescents in higher institutions through promotion of information, education and communication (IEC) materials, abstinence, mutual fidelity and use of condoms.

In addition, the Policy boldly urges government, through legislation, to eliminate all barriers to universal access to condoms in the country. It should be noted that in furtherance to this Policy, a document known as the National Strategic Framework on HIV/AIDS 2005-2009 has been developed.[135] The document reiterates the fact that young women are more predisposed to HIV infection than their men counterparts. Therefore, it recommends a youth-friendly and gender-sensitive approach, including promotion of male and female condoms, in renewed efforts to halt the epidemic in the country.

[135] The National Strategic Framework on HIV/AIDS in Nigeria (2005).

Crucially, the Policy recognises adolescents as a target group and has adopted suitable strategies to meet their needs. The provision on contraception is an improvement on the Adolescents National Policy. Studies have shown that young people constitute the majority of those living with HIV in the country. More importantly, the prevalence among young women is almost three times that of young men in the country.[136] Therefore, the gender-sensitive approach of the Policy on HIV/AIDS is commendable as it goes a long way towards reinvigorating efforts to reduce the spread of the epidemic among young women. This will ultimately improve the sexual health of young people in the country. Indeed, one can argue that the HIV/AIDS Policy seems to have responded positively to the female adolescent question through its provisions. The Policy seems to have taken into consideration the negative impact of the HIV/AIDS epidemic on adolescent girls and has attempted to address this challenge through its laudable provisions. However, a major challenge to achieving the objectives of this Policy is the unenforceability of policy within Nigerian law. Even though the Policy on HIV/AIDS adopts obligatory language such as 'shall', in reality, this is more or less a hortatory word without binding legal effect.

5.3.5 The National Family Life and HIV Education Curriculum

In 2001 the government of Nigeria approved a National Curriculum on Family Life and HIV Education in secondary schools.[137] This curriculum was a fruit of robust deliberations and consultations with diverse religious and ethnic groups and civil society organizations. Some provisions of the curriculum are important and useful in advancing adolescents' sexual health. The approval of the curriculum was in itself a major victory for civil society groups and advocates of children's rights in the country. For a long time, a heated debate has ensued on whether or not sexuality education should be introduced in Nigerian schools. Civil society groups have argued that in light of the sexual and reproductive health challenges facing adolescents in Nigeria, a policy allowing the teaching of sexuality education should be developed and implemented across the country.

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[136] Federal Ministry of Health *National Surveillance on HIV/AIDS and STIs* (2005).
[137] National Family Life and HIV Education Curriculum for Junior Secondary Schools (2003).

This is based on the belief that an effective sexuality education programme with regard to young people can

- reduce misinformation;
- increase correct knowledge;
- clarify and strengthen positive values and attitudes;
- increase skills to make informed decisions and act upon them;
- improve perceptions about peer groups and social norms; and
- increase communication with parents or other trusted adults.[138]

However, this argument had been faulted by religious groups and conservatives who vehemently hold the view that introducing sexuality education in schools will corrupt moral values among adolescents in the country. As an alternative therefore, religious groups and conservative parents have advocated for abstinence-only education for schools. But after a series of meetings and consultations with these groups, a curriculum on teaching of life skills in schools was reluctantly acceded to. The debate about the appropriateness of sexuality education in schools is not limited to Nigeria. In other developed countries such as Britain and Demark, the issue of sexuality education in schools remains controversial. Indeed, the European Court of Human Rights has been called upon in the case of *Kjeldsen, Busk Madsen and Pedersen v Denmark*[139] to determine whether parents could oppose teaching of sexuality education in government schools. The applicants, who were parents of school going children, lodged several petitions to have their children exempted from sex education in concerned government schools. However, these requests were not met and all of the parents withdrew their children from the schools, claiming that their children's right to education under article 2 of Protocol 1 to the European Convention on Human Rights had been violated. The European Court of Human Rights rejected this argument holding that the introduction of sex education in schools did not in any way violate article 2 of the European Convention.

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[138] UNESCO *et al International Technical Guidance on Sexuality Education: An Evidence-informed Approach for Schools, Teachers and Health Educators* (2009) 2.
[139] 1 E.H.R.R. 737 (Application no. 5095/71; 5920/72; 5926/72) 7 December 1976.

This positive decision and interpretation of the law provides a great opportunity to advance the sexual health and rights of young people.

Certainly, opposition to sexuality education based on religious and cultural beliefs amounts to a violation of adolescents' right to sexual and reproductive autonomy. This is because all women have the right to information regarding their sexuality regardless of whether or not they are married.[140] Abstinence-only policies, as argued in Chapter 3, are unrealistic and tend to deny the fact that adolescent girls engage in premarital sex. Thus, such policies expose women and girls to engaging in unprotected sex and its attendant consequences. Moreover, such policies are often characterized by messages of gender inequality, thus, violating adolescent girls' right to equality and non-discrimination.

Undoubtedly, the approval of the Family Life and HIV Education Curriculum in schools signifies a commitment on the part of the Nigerian government to advance the sexual health needs of adolescents in the country.
The major goals of this curriculum are as follows:

> (i) To assist individuals in having a clear and factual view of humanity
> (ii) To provide individuals with information and skills necessary for rational decision making about their sexual health,
> (iii) To change and affect behaviour of humanity
> (IV) To prevent the occurrence and spread of HIV/AIDS.[141]

The curriculum deals with a wide range of issues such as human anatomy, puberty, self-esteem, values, decision-making, body abuse, assertiveness, communication, body image STIs, love, affection, negotiation, HIV/AIDS and so on. Issues such as menstruation in girls and ejaculation in boys are covered. The curriculum also deals with the meaning of gender and gender roles, the difference between high and low esteem and how this may influence an adolescent's decision-making, the different types of STIs that can be contracted, the modes of transmission and prevention of HIV and the need to care for and

[140] Center for Reproductive Rights (CRR) *Briefing Paper: Implementing Adolescents Reproductive Rights Through the Convention on the Rights of the Child* (1999) 7.
[141] *Ibid* (i).

respect the rights of those infected or affected by HIV. Madunagu has observed that the contents of this document would seem to have been watered down from its original contents as proposed by civil society groups.[142] For instance, throughout the document words such as penis, vagina, sex, homosexuality, masturbation, and contraception were deliberately avoided. Commentators are unanimous on the view that the contents of sexuality education for adolescents should be as broad and pragmatic as possible capturing diverse issues and topics.[143] At a minimum, sexuality education should include vital information about anatomy and physiology, puberty, pregnancy and STIs including HIV/AIDS.[144] In addition, it should address the relationships and emotions involved in sexual experience. More importantly, sexuality education must address the female adolescent question by promoting gender equality, self-esteem and respect for others.[145] Ultimately, it should aim at helping adolescents, particularly female adolescents, to develop autonomy through using skills such as communication, decision-making and negotiation.[146] It will not serve the interests of adolescents if the contents are selective and sidestep vital topics. Half education is as dangerous as no education at all.

While the document explains the meaning of negotiation in a general sense, it refuses to apply the meaning to sexual activity which is very crucial for protecting young girls from negative sexual health consequences. Moreover, words such as 'assertiveness' and 'decision-making' were not explained so as to accommodate the fact that adolescent girls can invoke them to seek access to contraception with a view to preventing sexual ill-health. Significantly, since this document was launched in 2003 it has been enmeshed in one form of controversy or another. To date, only 10 out of 36 states have adopted the

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[142] See B Madunagu 'Empowering Youths through Sexuality Education: The Challenges and Opportunities' a paper presented at a Seminar on Human Sexuality organized by the African Regional Sexuality Resource Centre 24 March 2005 available at www.africasexuality.org/download/report/Abuja2008%20Report.pdf (Accessed on 28 August 2010).

[143] See for instance, A Ajuwon 'Benefits of Sexuality Education for Young People in Nigeria' in E Maticka-Tyndale *et al* (eds) *Human Sexuality in Africa: Beyond Reproduction* (2008) 67-82; S Nganda 'Sex Education: Do our Teens Need it?' in E Maticka-Tyndale *et al* (eds) *Human Sexuality in Africa: Beyond Reproduction* (2008) 53-66.

[144] Sexuality Information and Education Council of the United States (SIEUC) Comprehensive Sexuality Education is HIV Prevention Fact Sheet available at http:// www.siecus.org/inter/FS_WomenHIV-*AIDS*.pdf. (Accessed on 28 March 2010).

[145] D Rogow & N Haberland, 'Sexuality and Relationships Education: Toward a Social Studies Approach', (2005) *Sex Education* 5(4) 333.

[146] *Ibid.*

policy.[147] Most of the states from the northern part of the country, due to religious reasons, have continued to oppose its implementation in their schools. In other parts of the country, where the curriculum is being implemented, there are challenges with regard to commitment on the part of governments, lack of funding and a dearth of competent teachers for the subject. It has been found that many of the teachers employed to teach the subject are either ill-equipped or inexperienced.[148] Besides, pockets of opposition to the teaching of sexuality education by parents still exist in these parts of the country. All these variables can lead to poor knowledge on sexual health on the part of adolescents in the country and even pose serious threats to their health and lives. Studies have shown that great benefits accrue to adolescents if they are exposed to sexuality education at an early age. [149]

In the wake of the HIV/AIDS epidemic in Africa, other countries such as South Africa have also developed curriculum in schools to address this challenge. One of such document is the *HIV/AIDS Emergency Guidelines for Educators.*[150] The document aims at providing guidance for educators in handling topics related to sexuality and HIV/AIDS in schools. This document contains detailed information on the mode of transmission and prevention of HIV. The language of the document is very explicit and unpretentious. It clearly emphasizes the importance of condoms (both male and female condoms) in preventing HIV/AIDS. While the document notes that the best thing for a learner is to abstain from sex until he/she is ready, it, however, notes that should there be any reason for a learner to engage in premarital sex he or she must use a condom.

According to the document, 'the best sex is when you don't have to worry about catching a deadly disease'. The document identifies some of the religious and cultural challenges involved in talking about sex to adolescents. It, however, suggests that in view of the

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[147] See G Sedge *et al Meeting Young Women's Sexual and Reproductive Health in Nigeria* (2009) 13.
[148] See Action Health Incorporated (AHI) *Enabling Access: Report of the Sexuality Education/Family Life Education Implementation Forum* (2003) 7.
[149] See Ajuwon (note 143 above) where he identifies some of the benefits of sex education to include comfort in discussing sexual issues, knowledge about sexual and reproductive health, perceived ability to adopt safer sex practices (including use of contraceptives), positive change in attitude and sexual behaviour and positive sexual and reproductive health outcomes.
[150] Department of Education *The HIV/AIDS Emergency Guidelines for Educators* (2002) 5-7.

devastating effect of HIV/AIDS in the country, such beliefs and practices should be put aside. It encourages educators to talk openly and frankly about sex with their learners with a view to empowering them to make appropriate decisions regarding sexual intercourse. The approach of the South African government would seem to be more practical and capable of advancing the sexual health and rights of adolescents in the country. The fact that the approach recognises the needs for adolescents in some situations to use contraceptives such as condoms is a positive step towards advancing the sexual autonomy of adolescents.

In addition to the discussion above on policies made by the government of Nigeria, there also exist some other documents from professional bodies which are relevant to the issue of access to sexual treatment to adolescents. An example of this is the Code of the Medical and Dental Council of Nigeria. The contents of this Code are considered below.

5.4 Code of the Medical and Dental Council of Nigeria 2004

This is a code that is regarded as an authoritative document that lays down rules and regulations with regard to the medical profession. It contains important provisions and guidelines relating to the nature of relationship between a medical practitioner and his or her patient. Equally, it lays down the minimum standard of behaviour expected of medical practitioners while providing services to their patients. Under article 3(c) (ii) of the Code, it is provided as follows:

> Children younger than 16 but not below 13, though considered as minors, but of clear mind and can grasp the benefits and consequences of accepting or rejecting a proposed treatment, 'Gillick competence,' can give an acceptable consent.

This provision is no doubt intended to instate the position of the House of Lords in the *Gillick* case. However, unlike the conclusion reached by the House of Lords in that case, this Code has introduced a minimum age of 13 for purposes of capacity to consent to medical treatment. This approach, as noted earlier, can be problematic in itself, in the sense that it may fail to give recognition to the principle of evolving capacities of the

child recognized by the CRC and the African Children's Charter. In other words, rather than base capacity to consent to treatment on mental capability, emphasis may be placed on age, which may not truly reflect maturity on the part of the child. Chinua has observed that the position adopted by the House of Lords in *Gillick* case, where the court emphasized on the capability rather than the age of an adolescent to consent to treatment if he or she understands the nature of such a treatment and its implications, is a better approach. Therefore, he submits that in the event of a child under 13 seeking medical treatment in Nigeria, it would be expected that Nigerian courts will follow this position.[151] Although, decisions by foreign courts are not binding on Nigerian courts, they nonetheless, serve as persuasive authority for the courts.

Recently, the International Federation of Gynecology and Obstetrics (FIGO) Committee has noted that improving the sexual and reproductive health of young people will reduce the likelihood of teenage pregnancies and its attendant consequences.[152] The Committee notes further that young people require unimpaired access to full ranges of sexual health services including education, counseling and a means to ask questions without embarrassment or guilt. It further notes that young people's rights to health services, particularly preventive services, within a conducive environment that respects their confidentiality, needs to be guaranteed. Therefore, the Committee recommends as follow:

> Healthcare providers should recognize that adolescents and youths can possess capacity to make substantial life choices for themselves. Chronological age should not determine a young person's rights to make sexual and reproductive health choices for themselves. Rights should be determined by their individual capacity to understand effects and implications of their choices.

From the above discussion, it does appear that there are a number of promising policies in the country that are useful in realizing access to contraceptive services to female adolescents. The policy framework appears to be more sensitive to the needs of female adolescents than the body of laws in the country. Indeed, policies relating to the sexual

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[151] See E Chinua 'The Horse and Ass Yoked: Legal Principles to Aid the Weak in a World of Unequals ' 91st Inaugural Lecture Series delivered on 20 September 2007 at the University of Benin, Nigeria.

[152] See FIGO Committee for the Ethical Aspect for Human Reproduction and Women's Health cited by J Milliez 'Adolescent and Youth Reproductive Health Care and Confidentiality' (2009) 106 *International Journal of Gynecology and Obstetrics* 271.

health needs of adolescents would seem to outnumber or compare favourably with those of South Africa and Britain. While it seems that there are important provisions in policies that are relevant in advancing access to contraceptive services for adolescents, the Nigerian government has failed to translate these policies into effective programming. In actual fact, most of the existing programmes addressing the sexual health needs of adolescents are run by local and international non-governmental organizations. This clearly demonstrates that the Nigerian government is not taking appropriate steps to realise the sexual health needs of adolescents in the country.

5.5 Programmes to meet Adolescents Sexual Health needs in Nigeria

The Nigerian government has not really taken practical steps and measures to implement some of the good provisions of its laws and policies. Indeed, a report has noted that laws and policies on adolescents in Nigeria are more or less paper promises due to ineffective implementation and poor funding on the part of government.[153] For example, the health sector is still grossly underfunded and government-initiated youth-friendly health care services still remain unrealisable for adolescents. The few youth-friendly centres that exist, are run by NGOs. Sometimes, the government's actions seem to contradict its policy goals and objectives. For example, due to the fact that the Nigerian government is benefiting from the United States government's President's Emergency Plan Fund for AIDS Relief (PEPFAR) project, there is a tendency for government's programmes to lay emphasis on abstinence at the expense of other modes of protection such as the use of contraception. In fact, in 2007 the government placed restrictions on the advertisement of condoms in the country.[154] These actions, no doubt, can have serious implications for access to contraception for adolescents and ultimately jeopardize their health. Happily enough, with the change of government in the United States, the promotion of abstinence at the expense of other means of protection has been relaxed.

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[153] See Sedge *et al* (note 147 above) 16.

[154] See All African News 'Nigeria: Condom Advert Banned' available at http://www.allafrica.com (Accessed on 29 December 2009).

Due to lack of youth-friendly sexual health centres for adolescents, many adolescents have resorted to self-help or other harmful practices in order to prevent sexual health harm. For instance, a study has shown that some adolescents have resorted to crude means of preventing pregnancy and other sexual ill-health due to lack of access to comprehensive sexual and reproductive health services.[155]

The above scenario seems to be a confirmation of a study carried out in the country in 2002. The Federal Ministry of Health and the Policy Project assessed the policy environment on sexual and reproductive issues relating to family planning, adolescents and HIV/AIDS, revealing that out of the three issues, government's performance was lowest on the issue of adolescents.[156] According to the report, while government is making appreciable progress with regard to the formulation of specific policies to address adolescents' sexual and reproductive health needs, it has failed abysmally in areas of political commitment, adequate funding, enactment of specific legislation to address the sexual health needs of adolescents and the establishment of an organizational structure on the part of federal, state and local governments. Moreover, the sexual health needs of adolescents in the rural areas would seem to have been completely neglected. In all, while government's performance was rated by the Policy Project to be good for HIV/AIDS/STI (60.8%), fair for family planning (52.4%), it was scored below average at 43.3% for adolescents' sexual and reproductive health.[157] This suggests a poor commitment on the part of the government of Nigeria to realizing adolescents' sexual health needs.

In contrast to the poor implementation of programmes relating to the sexual health needs of adolescents by the Nigerian government, the South African government, in conjunction with some NGOs, has initiated a number of programmes to realize the sexual health needs of adolescents. As a first step, the South African government drafted a

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[155] MJ Temin *et al* 'Perceptions of Sexual Behavior and Knowledge about Sexually Transmitted diseases among Adolescents in Benin City, Nigeria' (1999) 25 *International Family Planning Perspectives* 186.
[156] Federal Ministry of Health & The Policy Project *The Policy Environment Score: Measuring the Degree to which the Policy Environment in Nigeria supports Effective Policies and Programmes for Family Planning, Adolescent Reproductive Health and HIV/AIDS/STI* (2002) 17-20.
[157] *Ibid* 12.

comprehensive policy document known as the Adolescent and Youth Policy[158] which aims at promoting healthy adolescent development and recognises the need to ensure access to condoms, gender equality, and creating an enabling environment as part of the strategies to achieving its aims. Thus, the government, through its 'Love Life' programme, has facilitated the distribution of condoms and established youth-friendly health centres.[159] The programme has developed national standards for adolescent-friendly services in primary health care clinics. These standards provide the basis for an adolescent-friendly clinic accreditation programme, which includes intensive technical assistance and training to help clinics meet the accreditation criteria, as well as monitoring clinics' compliance with the standards. The goal is to get all 5,000 clinics, countrywide, to comply with the adolescent-friendly standards within three to five years.

Also, the South African programme has focused on multi-media HIV education and awareness programmes for adolescents and has established a nation-wide network of support programmes providing recreational services, skills training and sexual health education for adolescents.[160] Since September 1999, '*Love* Life' has opened five Y-Centres at Orange Farm in Gauteng; at Motherwell in the Eastern Province; at Kutwalanong in the Free States; and at Mandeni in KwaZulu-Natal. Y-Centres are multipurpose recreational venues for young people, designed to demonstrate that sexual health services for young people can be more effectively provided in non-clinical settings.[161] Moreover, education on life skills is being taught in primary and secondary schools across the country. These are positive developments that can go a long way in facilitating access to sexual health services, including contraception services, for adolescents in the country.

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The British government has also adopted programmes in schools, which will facilitate access to sexual health information and services to adolescents in the country. For instance, the government has introduced sexual health care advice services in high

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[158] See Policy Guidelines for Youth and Adolescents (2001)18-26.
[159] See Kaiser Foundation 'Love Life: South Africa's National HIV Prevention Programme for Youth' available at http://www.kff.org/about/lovelife.cfm (Accessed on 19 October, 2009).
[160] *Ibid.*
[161] *Ibid.*

schools in the country.[162] This programme is intended to bring closer to young people in school sexual health services which they would otherwise have found difficult to access in traditional health settings. A Department of Education Skills' guidance issued to support the establishment of this programme notes that it is important that young people should be encouraged to delay sexual activity. However, for those who are already sexually active, it is also important that they have access to services that will protect them from the consequences of unprotected sex.[163] This is a pragmatic approach to the sexual health needs of adolescents as it will guarantee confidential services to adolescents and potentially reduce sexual ill-health among them.

The discussion above has shown that the Nigerian government has not taken concrete measures towards effective implementation of programmes that can advance the sexual health needs of adolescents, as required by international human rights law. More particularly, the Nigerian government, compared to governments in South Africa and Britain, has not done enough to ensure access to contraceptive services for female adolescents. Given the challenges limiting access to sexual health services for adolescents, particularly female adolescents, one would have expected the Nigerian government to show more political will to address these challenges. Although on paper there exist a number of promising policies relating to the sexual health needs of adolescents, however, failure to effectively implement these policies has almost turned them into paper promises. It must be noted that one of the obligations on states under international law is to fulfill the right to health of adolescents. This requires states to take positive steps which must include designing and implementing appropriate programmes that will meet the peculiar needs of adolescents in general and female adolescents in particular.

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[162] See UK Department of Education Skills *Guidance on Extended Schools: Improving Access to Sexual Health Advice Services* (2005) 1.
[163] *Ibid* 2.

5.6 Conclusion

This chapter has discussed laws and policies, which may have implications for access to contraception for adolescents in Nigeria. It has been noted that though the Constitution does not contain specific provisions relating to children or adolescents, the human rights provisions of the Constitution can still be interpreted purposively to advance adolescents autonomy to seek contraceptive services. In this regard, the relevance of the rights to life privacy, freedom of expression and non-discrimination were discussed. It has been pointed out that the equality jurisprudence of the Nigerian Constitution has not been well-developed by Nigerian courts, particularly to advance women's and girls' rights to sexual health services. Therefore, it might be necessary for courts in the country to draw experiences from other jurisdictions such as South Africa and Canada in this regard.

The chapter has also noted that the enactment of the Child's Rights Act is a positive development in the advancement of children's and adolescents' rights in the country. However, the provisions of the CRA with regard to realising the right to sexual autonomy for children and adolescents leave much to be desired. The omission by the drafters of the CRA of a specific provision relating to consent to treatment for children and adolescents was a missed opportunity to advance the autonomy of children and adolescents in sexual health matters. To this extent, it may be argued that Nigeria's laws, unlike the case in other jurisdictions such as South Africa, have not done much to advance the autonomy of children and adolescents in the context of access to contraceptive services. Moreover, the provisions of the CRA seem to be gender-neutral and fail to pay particular attention to the needs of adolescent girls. For instance, there is neither a provision addressing the HIV/AIDS pandemic nor a specific provision relating to contraception. Given the devastating effect of the HIV/AIDS pandemic among young people in the country and high incidence of teenage pregnancy, it is inexplicable why these issues were omitted by the drafters. One of the criticisms levelled against the CRC is its gender-neutral approach

and failure to respond to the needs of adolescent girls.[164] The CRA risks the same criticism.

On the other hand, this chapter has shown that there are promising policies, which can be invoked to advance the autonomy of adolescents in seeking contraceptive services. Indeed, various policies discussed in this chapter contain a number of important provisions that can directly be applied to realise access to contraception for adolescents in general and female adolescents in particular. However, the language of some of the policies such as the Adolescents Reproductive Health Policy and the National Curriculum of Sex Education would seem to be ambiguously and restrictively drafted. Given the importance of sexuality education to the realisation of the right to sexual health autonomy, such a restrictive use of language can be counter-productive to the sexual well-being of adolescents.

Furthermore, while it can be said that Nigeria is not really wanting in laws and policies that can be used to advance the sexual health needs of adolescents, it would appear however, that the major challenge has been lack of effective implementation of these laws and policies. Moreover, the mere fact that some inconsistencies exist in the laws and policies can also make it difficult for adolescents to realise their sexual health needs, particularly with regard to contraceptive services. The government of Nigeria has not demonstrated enough political will to meet the sexual health needs of female adolescents, thereby failing to address the female adolescent question. Considering the fact that adolescents, particularly female adolescents, bear the brunt of sexual ill health in the country, the government should have adopted a more robust and pragmatic approach to realizing access to contraception for female adolescents. Such an approach would challenge the status quo by not only removing barriers to sexual health services for female adolescents, but also, implementing appropriate programmes that are sensitive to their needs.

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[164] D Fottrel 'One step forward or two steps sideways? Assessing the First Decade of the Children's Convention on the Rights of the Child' in D Fottrel (ed) *Revisiting Children's Rights: 10 Years of the Convention on the Rights of the Child* (2000) 1-14.

It would appear that the Nigerian government would need to show more political commitment to realising access to sexual health services, especially contraceptive services for adolescents. The examples of South Africa and Britain where positive efforts have been made to reform the laws and progammes implemented so as to facilitate access to contraception for adolescents in those countries, can serve as good models for the Nigerian government. There is a need for government-sponsored youth-friendly sexual health clinics for young people in the country. This will not only assure confidential sexual health care services to adolescents, but will also advance their sexual health and rights.

CHAPTER 6

THE APPLICATION OF INTERNATIONAL HUMAN RIGHTS LAW TO ACCESS TO CONTRACEPTION FOR ADOLESCENTS

6.1 Introduction

In the last chapter, some human rights provisions contained in the Nigerian Constitution were examined. In this chapter, the evolution of the language of rights to sexual health under international law is examined. Thereafter, the chapter discusses two important rights under international law (rights to autonomy and health) relevant in realising access to contraception for adolescents. The discussion in Chapter 4 has shown that though international treaties are not applicable in Nigeria unless domesticated, nonetheless, reference to international human rights principles and standards, including soft law, remain important in advancing the sexual health and rights of adolescents. Moreover, reference to intentional human rights law is sometimes necessary where gaps exist in the national law with regard to the realisation of certain rights. Thus, the need to examine some international human rights law principles and standards and how they can be applied to supplement the existing rights under the Nigerian Constitution. This can further enhance the realisation of access to contraception for adolescents.

The chapter focuses on the cluster of rights that make up the right to autonomy under international law. The philosophical definition and social construction of the concept of autonomy have already been examined in Chapter 2. Autonomy like other legal concepts is incapable of a precise definition. The right to autonomy is often used interchangeably with self-determination. In Packer's words, autonomy 'requires a certain degree of distance (both physical and mental) from the larger society in order to choose a cause of action or behaviour'.[1] With regard to sexual health, the right to autonomy or self-determination implies the right of an individual to take decisions freely and

[1] CA Packer *The Right to Reproductive Choice* (1996) 55.

independently of others devoid of discrimination or coercion on matters regarding his or her sexuality. An important element of the right to autonomy is the issue of choice. The right to sexual autonomy simply implies the ability of an individual to exercise control over issues relating to his or her sexuality.

Although nowhere is the right to autonomy specifically guaranteed in any human rights instruments, nonetheless, the right is intrinsically linked with other rights such as rights to privacy, liberty and security of the person and dignity. These combinations of rights form the basis of an individual's right to make choices with regard to his or her sexuality. They also support the fact that adolescents are entitled to seek confidential information and services with regard to their sexual health, especially in relation to contraception, without the need for parental consent.

In discussing the relevance of the components of the right to autonomy to realising access to contraception for adolescents, various interpretations and clarifications provided by treaty monitoring bodies, international and regional human rights tribunals and national courts will be referred to. Also, references will be made to various consensus statements or declarations at international and regional levels, which are useful in advancing autonomous decision-making of adolescents in the context of access to contraceptive services. Although these consensus statements are not legally binding, nonetheless, they represent international and regional consensus on specific issues and establish governmental commitments on those issues. The chapter then examines some of the concerns of feminist scholars with regard to the various rights discussed in advancing the sexual health needs of female adolescents. Given that a discussion on an important sexual health issue such as access to contraception has an implication for the physical and mental well-being of adolescents, a discussion on the right to health becomes inevitable. Thus, the discussion in the last section of this chapter centres on access to contraception as a component of the right to health under international human rights law.

6.2 The Evolution of the Language of Rights to Sexual Health

In Chapter 1, an attempt was made to define sexual health and to differentiate it from reproductive health. One of the important points made in that chapter is that reproductive health and rights have gained more recognition than sexual health and rights over the years due to the activism of the women's rights movement. Also in Chapter 2, the construction of human sexuality, particularly adolescents sexuality, by different communities in Nigeria was examined. The discussion in that chapter has shown that social construction of the sexuality of individuals may have implications for the enjoyment of their sexual health and rights. This section of the study discusses the emergence of the language of rights to sexual health issues. A historical discussion of this nature is essential for a better understanding of the notion of sexual health and rights. The notion of sexual health and rights first gained the attention of the world during the World Conference on Human Rights in Vienna 1993.[2] There, it was agreed that an act of violence against women 'impairs and nullifies' the enjoyment of their fundamental rights and freedom.[3] Prior to this time, there had been no international or national instruments on human rights that specifically mentioned sexuality or sexual rights. This is apparently due to a universal tendency to shy away from discussions relating to sexuality.

The notion of sexual rights was popularised by the activities of the gay and lesbian movement, advocacy surrounding women's reproductive health, population control, health as a human right, unwanted pregnancy, sexual violence, female genital cutting (FGC) and HIV/AIDS. All of these acted as a catalyst for the emergency formulation of sexual rights as a human rights concept.[4] The United Nations Declaration on Elimination of Violence against Women of 1993,[5] which specifically focused on the elimination of physical, sexual and psychological violence against women, further consolidated this

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[2] Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, June 1993, UN Doc. A/CONF.157/24.
[3] *Ibid* para 18.
[4] C Ngwena 'Sexuality Rights as Human Rights in Southern Africa with Particular Reference to South Africa' (2002) 17 *South African Public Law* 1.
[5] Declaration on the Elimination of Violence against Women General Assembly Resolution 48/104 of 20 December 1993.

development.[6] Both the Vienna Declaration of Action and the UN Declaration on Violence against women, brought to the fore the implicit recognition of sexual violence as a violation of human rights.

Perhaps the turning point in raising the profile of sexual rights as part of human rights occurred during the International Conference on Population and Development (ICPD) 1994[7] and the Fourth World Conference on Women (FWCW) Beijing 1995.[8] The ICPD urges states to 'Take all measures to eliminate all forms of exploitation, sexual abuse, harassment and violence against women, adolescents and children'.[9] Indeed, Parker[10] has asserted that this conference was the first of its kind where issues relating to sex, sexuality and sexual health were openly debated as a central point to the agenda. He further argues that these issues were considered not only as a form of violence against women, but as a violation of human rights, which deserve the utmost protection.

At the Beijing Conference, it was agreed that sexual rights include the rights of women 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.[11] Ngwena has noted that the language of sexual rights entered the discussions in Cairo and Beijing through the language of reproductive health and rights.[12] The language adopted at these two conferences seems to subsume sexual rights under reproductive rights.[13] Notwithstanding, it is incontestable that these conferences added impetus to the recognition of sexual rights as human rights. The Beijing Platform especially lays emphasis on the need to address the sexual and reproductive health needs of adolescents

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[6] *Ibid* see particularly, article 2 of the Declaration.
[7] Programme of Action of the International Conference on Population and Development (ICPD). Adopted in Cairo 5-13 September 1994, UN Doc. A/CONF. 171/13 1994.
[8] Beijing Declaration Platform for Action, Fourth World Conference on Women, 15 September 1995, A/CONF.177/20 (1995) and A/CONF.177/20/Add.1(1995).
[9] ICPD (note 7 above) para 6.9.
[10] R Parker 'Sexual Rights: Concepts and Action' (1997) 2 *Health and Human Rights* 31; see also C Ngwena 'Synchronising Traditional Legal Responses to Non-Consensual Sexual Experiences with Contemporary Human Rights Jurisprudence' in SJ Jejeebhoy *et al* (eds) *Sex Without Consent* (2005) 227-235.
[11] Fourth World Conference on Women (note 8 above).
[12] Ngwena (note 10 above) 228.
[13] See Report of Paul Hunt the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest attainable Standard of Physical and Mental Health E/CN.4/2004/4916 February, 2004.

worldwide.[14] Indeed, both the ICPD and the Beijing Platform treated children and adolescents as rights holders in all matters, including their sexuality. Whilst it is noted that decisions reached at these conferences are not binding on states, they no doubt constitute consensus statements and impose moral obligations on states to implement them.

In addition to the above-mentioned conferences, provisions of international and regional human rights instruments such as the International Covenant on Civil and Political Rights (ICCPR),[15] the International Covenant on Economic, Social and Cultural Rights(ICESCR),[16] the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[17] the Convention on the Right of the Child (CRC),[18] the African Charter on the Rights and Welfare of the Child, the African Charter on Human and Peoples' Rights[19] and the Protocol to the African Charter on the Rights of Women(African Women's Protocol)[20] are useful in promoting the sexual health needs of adolescents, especially with regard to access to contraception. Two of the rights protected under these instruments –rights to autonomy and health- are now considered in detail

6.3 The Right to Autonomy and Access to Contraception for Adolescents

As stated above, the right to sexual and reproductive autonomy or self-determination is firmly grounded in the combination of rights including the right to liberty and security of the person, the right to privacy and the right to dignity. It should be noted that an

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[14] See FWCW (note 8 above) para 8.3.
[15] International Covenant on Civil and Political Rights, G.A. Res. 2200, U.N GAOR, Supp. NO. 16 at 52, U.N DOC. A/6316 (1966), 999 U.N.T.S. 171, 174 (entered into force on March 23, 1976). (Herein after ICCPR).
[16] International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966; GA Res 2200 (XXI), UN Doc A/6316 (1966) 993 UNTS 3 (entered into force 3 January 1976).
[17] Convention on the Elimination of All Forms of Discrimination Against Women GA Res 54/180 UN GAOR 34th Session Supp No 46 UN Doc A/34/46 1980.
[18] Convention on the Rights of the Child. Adopted in 1989 U.N. Doc. A/44/49 entered into force 2 Sept. 1990.
[19] African Charter on Human and Peoples' Rights OAU Doc CAB/LEG/67/3/Rev 5, adopted by the Organisation of African Unity, 27 June 1981, entered into force 21 October 1986.
[20] The Protocol of African Charter on Human and People's Rights on the Rights of Women in Africa Adopted by the 2nd Ordinary Session of the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003) entered into force 25 November, 2005.

adolescent girl's right to prevent unwanted pregnancy or sexual ill health can only be realised if she is assured access to the different types of contraception, discussed in Chapter 3. Such an assurance must take place in an environment that respects her sexual choices. Therefore, a government that fails to 'put contraception in the hands of female adolescents' in order to prevent sexual ill health, will be in breach of its obligations under international law.[21] The purpose of this section of the study is to discuss the application of the different rights that make up the right to autonomy to the sexual health needs of adolescents, particularly access to contraception.

6.3.1 The Right to Liberty and Security of the Person

Several provisions of international human rights instruments can be relied on to uphold adolescents' right to liberty or self-determination with regard to seeking contraceptive information and services. For instance, articles 3 of the UDHR and 9 of ICCPR that both guarantee the right to liberty of a person, support adolescents' right to sexual and reproductive self-determination. Article 9 of ICCPR provides that 'Everyone has the right to liberty and security of person'. It further states that 'No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law'. The CEDAW does not have a specific provision on the right to liberty and security of the person. However, the provision that guarantees women the right to decide freely and responsibly the number and spacing of their children can be interpreted to entitle women and girls to make decisions regarding their sexuality. The right to liberty and security of the person remains one of the strongest rights to advance women's and girls' right to sexual autonomy. In Shalev's view, the right to autonomy in making health decisions, particularly sexual and reproductive health decisions, is founded upon an individual's fundamental right to liberty.[22] All individuals, including adolescents, have the liberty to make choices with respect to their sexual health. In other words, one is

[21] Center for Reproductive Rights (CRR) *Gaining Grounds: A Tool for Advancing Reproductive Rights Law Reforms* (2007) 102.
[22] C Shalev 'Rights to Sexual and Reproductive Health: The International Conference on Population and Development and the Convention on the Elimination of All Forms of Discrimination against Women' (2000) 4 *Health and Human Rights* 36, 46.

entitled to the recognition of one's capacity as a human being to exercise choices in the shaping of one's life.[23]

Although some of the provisions on the right to liberty are crafted in a way that is intended to prohibit arbitrary arrest or detention, the right has been applied to require governments to provide sexual health services when such lack of services will interfere with rights of individuals. Indeed, the Human Rights Committee has observed that a failure on the part of a government to enact appropriate legislation and ensure access to contraception and sexual health information amounts to a violation of the right to sexual and reproductive self-determination.[24] In one of its Concluding Observations to Argentina, the Committee has recommended that the state party take adequate measures and steps with a view to enacting laws that will facilitate access to comprehensive family planning services, including contraception, so as to provide women with options.[25] Also, the Committee has urged the government of Mali to ensure access to sexual health services to women and strengthen its family planning and sex education programmes in order to avoid unwanted pregnancies among young women in the country.[26]

At the regional level, the African Charter in a language similar to that of the ICCPR, provides in article 7 that 'Every individual shall have the right to liberty and security of his person. No one shall be deprived of his freedom except for reasons or conditions previously laid down'. On the other hand, the African Women's Protocol provides in article 4 that 'Every woman shall be entitled to her life and integrity and security of her person'. The African Commission is yet to interpret the provision on the right to liberty and security of the person in the context of access to sexual health services.

The right to liberty and security of the person may be used in two senses. Firstly, it may be used negatively to prevent non-consensual treatment or medical experimentation on an

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[23] I Berlin 'Two Concepts of Liberty' in I Berlin (ed) *Four Essays on Liberty* (1969)120-123.
[24] Center for Reproductive Law and Policy (CRLP) & Child and Law Foundation (CLF) *State of Denial: Adolescents Reproductive Health in Zimbabwe* (2002) 40.
[25] See Concluding Observations of the Human Rights Committee: Argentina, 17th Sess., 1883rd-1884st mtgs para. 14, U.N. Doc. CCPR/CO/70/ARG (2000).
[26] See Concluding Observations of the Human Rights Committee: Mali, 16/04/2003, CCPR/CO/77/MLI.

individual without informed consent. For instance, it is often generally believed that subjecting an individual to an HIV test without informed consent or forced sterlisation of women amounts to a violation of the right to liberty and security of the person. Secondly, the right to liberty may be applied in the positive sense to indicate that an individual has the right to seek sexual health treatment without restraint. In this regard, the right to liberty is equated with sexual and reproductive self-determination. For instance, it is often argued that women and girls have the liberty to seek safe abortion or contraceptive services without inhibition. Implicit in this is that states have the obligations to ensure that their laws and policies empower women and girls to exercise their right to liberty and that laws and policies that limit the exercise of this right violate women's and girls' rights. In the context of realising access to contraception for adolescents, the right to liberty and security of the person will require states to ensure that adolescents are provided with confidential care and services. Freeman has noted that 'Although control over reproduction and sexuality is certainly an essential precondition for women's ability to exercise other rights and to fulfill other basic needs, it is also a worthy and valuable end in its own right, and not merely a means to reach other ends'.[27] This clearly emphasizes the importance of the right to liberty for the realisation of adolescents' sexual health needs.

In Chapter 3, it has been shown that due to some barriers in the health care setting, which include lack of confidential care services and unfriendly attitudes of health care providers, adolescents, particularly female adolescents, tend to shun sexual health services or advice. This may provide an example of a breach of an obligation on the part of the Nigerian government to protect the right to liberty and security of the person of adolescents. To support this assertion Cook *et al* have argued as follows:

[27] LP Freedman 'Censorship and Manipulation of Reproductive Health Information: An Issue of Human Rights and Women's Health' in S Coliver (ed) *The Right to Know: Human Rights and Access to Reproductive Health Information* (1995) 5.

> If governments and agencies to which they delegate responsibility to administer health services fail to provide conditions necessary to protect reproductive and sexual health, they might be held responsible for the denial of the right to liberty and the security of the person.[28]

In recent times, national courts and human rights tribunals are beginning to affirm women's and girls' right to liberty and security of the person in the context of sexual and reproductive health. For instance, in the South African case of *Christian Lawyers Association v Minister of Health,*[29] a High Court has affirmed the right of a girl under 18 to seek abortion services without the need to consult with her parents or guardians. In arriving at this decision, the Court noted that to prevent such a girl from seeking abortion services will infringe on her right to reproductive choices. A detailed discussion of this case and its implications for the female adolescent question is carried out in Chapter 8. However, suffice it to say here that, the decision represents an affirmation of the liberty of adolescent girls to make important sexual choices affecting their lives.

The Committee on CEDAW in General Recommendation 24 has noted that while lack of confidentiality in health care services affects both men and women to certain degree, its effect on women and girls is more debilitating.[30] According to the Committee, lack of confidential health care services may 'deter women from seeking advice and treatment and thereby adversely affect their health and well-being'.[31] The Committee notes further that this will in turn deter women from seeking care for diseases of the genital tract, contraception or incomplete abortion or in cases where they have been sexually abused. This interpretation of the Committee is no doubt asking the woman or female adolescent question as it focuses on the peculiar health needs of women and girls.

This explanation by the Committee on CEDAW will require the Nigerian government to take more decisive and positive measures with a view to ensuring the protection of confidential contraceptive care and services for adolescents. Such positive measures may

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[28] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (2003) 164.
[29] *Christian Lawyers Association v National Ministers of Health and others* 2004 [10] BCLR 1086.
[30] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 para 12 .
[31] *Ibid* para 12 (d).

include training of health care providers to respect adolescents' confidentiality while seeking sexual health services. Also, the government will need to commit more resources to the health care sector to ensure that existing health care services are friendly and sensitive to the needs of adolescents in general and female adolescents in particular. Moreover, the government may need to repeal or abolish laws or practices that hinder or restrict access to contraception for adolescents. It may be necessary for the government to develop guidelines or regulations within the health care setting, which will instruct health care providers to show respect for adolescents' sexual health needs and treat adolescents as persons capable of consenting to sexual health services. In addition, health care providers must be prevented from notifying parents or guardians of adolescents that they have sought sexual health services in their clinics or health care centres. Where necessary, breach of confidentiality on the part of health care providers should be punished either by professional bodies or appropriate regulatory bodies.

6.3.2 The Right to Privacy

The right to privacy is guaranteed in numerous human rights instruments, including the ICCPR. Article 17 of the ICCPR provides that no one shall be subject to arbitrary interference with his/her privacy. Nowak has explained that this right relates to an individual's identity and autonomy. He notes further that an important basis of this right is the ability of human beings to strive towards self-realisation provided this does not interfere with the liberty of others.[32] Oftentimes, the right to privacy is understood to mean two things. Firstly, it means the right of an individual not to disclose information pertaining to him/herself, including the right to non-disclosure of sensitive information about an individual by another party. Secondly, it affirms the independent decision-making powers of an individual without undue interference. This latter sense is more relevant to the discussion on access to contraception for adolescents. Thus, the right to privacy of an adolescent entitles him or her to seek access to sexual health advice or treatment without any hindrance.

[32] M Nowark *UN Covenant on Civil and Political Rights: Commentary* (1993) 294.

Unless the privacy and confidentiality of adolescents is guaranteed, they may avoid seeking necessary help with regard to their sexual health, including contraceptive treatment. It must be noted that the right to independent decision-making on the part of adolescents in the context of sexual health services, inextricably intersects with their ability to exercise their right to health and dignity.[33]

With regard to women, Shalev[34] has noted that autonomy implies that:

> [a] woman seeking health care in relation to her fertility and sexuality is entitled to be treated as an individual in her own right - the sole client of the health care provider, and fully competent to make decisions concerning her own health. This is a matter, among other things, of the woman's right to equality before the law as to her legal capacity.

This observation is quite relevant to the situation of female adolescents, especially with regard to seeking contraceptive information and services. Therefore, the right to autonomy in the context of adolescents will mean guaranteeing their decision-making capability as regards intimate issues (such as contraceptive treatment) affecting them, and according them same respect as every other person regarding any action taken on those issues.

Under the CRC there is no clear-cut provision conferring autonomous decision-making power on adolescents. Rather, the CRC strives to strike a balance between parental rights and adolescents' decision-making power through the twin principles of 'evolving capacities of the child' and 'the best interests of the child'.[35] This subtle approach by the CRC can be attributed to the paternalistic view often expressed by most states that children and adolescents are incapable of 'rational' decision-making powers. Indeed, it

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[33] RJ Cook & B Dickens 'Recognising Adolescents' "Evolving Capacities" to exercise Choice in Reproductive Healthcare' (2000) 70 *International Journal of Gynaecology and Obstetrics* 13, 20.
[34] C Shalev 'Rights to Sexual and Reproductive Health –The ICPD and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), a paper presented at the International Conference on Reproductive Health, Mumbai (India), 15-19 March 1998.
[35] CRLP & CLF (note 24 above) 44.

has been argued that the provisions which seek to enhance the autonomy of the child under the Convention are one of its weakest.[36]

But the provision of article 12 of the CRC, which enjoins states to assure children the right to form and express their views in all matters affecting them, can be invoked to support the right to autonomous decision-making powers for adolescent with regard to sexual health treatment such as contraception. This observation receives support from the history of the drafting of the article. An initial draft of the article provided by Poland to the United Nations Human Rights Commission had included issues such as marriage and medical treatment as part of the matters children should form and freely express their views. [37] Indeed, the adoption of the phrase 'in all matters affecting the child' in the final version of the article is an indication that this article is intended to cover diverse issues, including health-related matters.[38] Therefore, it can be submitted that this provision is aimed at advancing the autonomous decision-making of children and adolescents on all issues, including their sexuality.

Furthermore, article 16 of the CRC does recognise adolescents' right to privacy. In some of its Concluding Observations to state parties to the Convention, the Committee on CRC has affirmed the need to guarantee adolescents' right to privacy while seeking sexual health information and services. For example, the Committee in its Concluding Observations to Djibouti has observed that lack of confidentiality can be a barrier to adolescents' access to sexual health services.[39] Equally, the Committee has enjoined states to ensure access to health care services to adolescents without the need for parental consent.[40] In General Comment 3, the Committee specifically urges states parties to ensure children's and adolescents' right to privacy and confidentiality in the context of

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[36] T Hammerberg 'The UN Convention on the Rights of the Child and how to Make it Work" (1990) 12 *Human Rights Quarterly* 97, 100.
[37] See S Detrick *A Commentary on the United Nations Convention on the Rights of the Child* (1999) 214.
[38] *Ibid.*
[39] See Concluding Observation of CRC: Djibouti UN. Doc CRC/C15/Add.131 para 46.
[40] Committee on the Right of the Child, Adolescents Health and Development in the context of the Convention on the Right of the Child, General Comment N0 4 CRC/GC/2003/4 Thirty-Second Session May 2003 para 31.

HIV/AIDS services.[41] Similarly, the Committee in General Comment 4 has noted that in order for the health and development of adolescents to be promoted, states are enjoined to respect strictly, their confidentiality and privacy, particularly with regard to health-related matters.[42] Considering the fact that one of the challenges facing adolescents in Nigeria is lack of access to confidential health care services, this interpretation would seem to require the Nigerian government to take necessary measures towards removing barriers to confidential access to contraceptive services for adolescents. It will also require the government to address cultural and religious practices that repress adolescents' sexual autonomy, particularly as regards access to contraception.

In addition to the above, article 16(1) of CEDAW guarantees a woman's right to decide freely and responsibly the number and spacing of her children and access to information and the means to do so. This provision would seem to be one of the most important provisions affirming an individual's right to sexual and reproductive health autonomy. Indeed, the Committee on CEDAW in its General Recommendation 24 has emphasized the need for women and girls to be assured their right to sexual and reproductive self-determination.[43] Similarly, the Committee in some of its Concluding Observations to states, has called on states to recognise women and girls as autonomous decision-makers by refraining from taking any action that will obstruct their health goals.[44] Equally, the Committee has pointed out the need to respect the free and informed decision-making of adolescents by constantly recommending to states parties to increase their access to sexual health information and services.[45] Obviously, this informed decision-making power of adolescents will apply to seeking contraceptive information and services.

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[41] Committee on the Right of the Child, HIV/AIDS and the Right of the Child, General Comment N0 3 CRC/GC/2003/3 Thirty-Second Session 2003 para 24.

[42] *Ibid* para 11.

[43] General Recommendation 24 of CEDAW (note 30 above) para 14.

[44] See for instance, Concluding Observations Committee on CEDAW Belize, 21st Sess., 432nd-433rd, 438th mtgs., paras. 56-57, U.N. Observations of the Committee *on* CEoc.CEDAW/A/54/38, paras. 31-69, (1999); Concluding Observations of the Committee on CEDAW: Greece, 20th Sess., 415-416th mtgs., para. 207, U.N. Doc. A/54/38, paras 172-212 (1999); Concluding Observations of the Committee on CEDAW: Mauritius, 268th & 271st mtgs, para. 211, U.N. Doc. A/50/38, paras. 160-217 (1995).

[45] See Concluding Observations of the Committee on CEDAW: Indonesia, 377th mtg., para. 284(c), U.N. Doc. A/53/38 (1998); and Concluding Observations of the Committee on CEDAW: Turkey, 16th Sess., 318-319th mtgs., paras. 184, 196, U.N. Doc. A/52/38/Rev.1, paras. 151-205 (1997).

Therefore, the Nigerian government must take necessary steps to ensure unhindered access to contraception for adolescents, especially female adolescents.

More importantly, the Committee on CEDAW has interpreted the provision on the right to health in CEDAW as guaranteeing confidential sexual and reproductive health information and services.[46] The Committee has called on states parties to ensure, through properly trained personnel, the right of male and female adolescents to sexual health services and information and to design programmes that will respect adolescents' privacy and confidentiality in health care services.[47] This observation of the Committee on CEDAW, it is submitted, equally applies to ensuring confidential contraceptive services to adolescents. As discussed in Chapter 3, the challenges adolescents, especially female adolescents, encounter with regard to access to sexual health services, due to the negative attitudes of health care providers deserve the attention of the Nigerian government. This is because the obligation imposed under article 16 (1) of CEDAW is a positive one, which requires a state to create an enabling environment for the exercise of contraceptive choices. In other words, there is an obligation of performance[48] or to ensure 'positive entitlement'[49] on the part of the state.

Even though the ICESCR contains no provision on the right to privacy, the Committee on ESCR has equally interpreted the right to health guaranteed under the Covenant to include the freedom of an individual to exercise his or her sexual and reproductive choices and the right to have access to 'safe, effective, affordable and acceptable methods of family planning of their choice as well as the right of access to appropriate health-care services . . .'.[50] The Committee has progressively recognised the right of adolescents to

[46] General Recommendation 24 of CEDAW (note 30 above) para 18.
[47] *Ibid.*
[48] N Fincancioglu 'Contraception Family Planning and Human Rights' in *UN Population and Human Rights: Proceedings of the Experts Group Meeting on Population and Human Rights* Geneva 3-4 April 1989 (1990) 89.
[49] R Dixon-Muller *Population Policy and Women's Rights: Transforming Reproductive Choice* (1993)13.
[50] The Right to the Highest Attainable Standard of Health UN Committee on Economic, Social and Cultural Rights General Comment 14, UN Doc. E/C/12/2000/4 para 23.

participate in decisions affecting their health care and has emphasised on the need to respect their confidentiality and privacy in sexual and reproductive health services.[51]

Under the African regional human rights system, the African Charter lacks a specific provision on the right to privacy. However, the African Children's Charter guarantees the right to privacy for children in its article 10. This provision is similar to that of article 16 of the CRC therefore, the interpretation provided by the Committee on CRC, as discussed above, will equally apply to the provision of the African Children's Charter.

During the ICPD it was affirmed that all individuals, including adolescents, shall have the freedom to decide freely without restriction, on matters regarding their sexual and reproductive health needs. More particularly, this consensus statement further made reference to the fact that adolescents needed to be assured of respect for informed consent, confidentiality and privacy so as to address issues of sexual abuse and other sexual and reproductive health matters.[52] This position was reiterated at the ICPD+ 5 when governments were called upon to guarantee access to appropriate youth-friendly health care services, including sexual and reproductive health care, to adolescents.[53] It was further agreed that such services should respect the confidentiality and privacy of adolescents. A similar position was taken at Beijing, where it was agreed that respect for adolescents' confidentiality and privacy in health care services is essential in guaranteeing their equality and securing their future.[54]

It must be stated here that the right to privacy is not an absolute right, thus, governments may restrict this right in certain circumstances. But, the restriction of the right must

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[51] *Ibid.*

[52] ICPD (note 7 above) para 7.45.

[53] Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development,(ICPD +5) U.N. GAOR, 21st Special Sess., New York, United States, June 30 – July 2, 1999, para. 10, U.N. Doc.A/S-21/5/Add.1 (1999) [hereinafter *ICPD+5 Key Actions Document*].para 73(a).

[54] FWCW (note 8 above) para 93; see also See Report of the Secretary-General "Implementation of the Outcome of the Fourth World Conference on Women and of the Special Session of the General Assembly entitled "Women 2000: Gender Equality, Development and Peace in the Twenty-first Century" (A/55/341). para 79(f).

accord with the Siracusa principles.[55] Under these principles, it was agreed that human rights are generally not absolute and that in some situations rights may be restricted in the interest of the society. However, this will only occur where, the limitation is in accordance with the law, it serves legitimate interest of the public, it is essentially necessary in a democratic society, a less intrusive means cannot be used to reach the goal and it is not arbitrary, unreasonable or discriminatory. The question may arise: can a government place a blanket ban or restriction on access to contraceptive services and information for children and adolescents? It would appear that such a blanket ban will be contrary to international human rights law, which recognises the principles of evolving capacities and the best interests of children and adolescents. Moreover, given the importance of contraception to preventing sexual ill health and unwanted pregnancies, it may be argued that such a blanket ban is unreasonable and discriminatory against girl-children and adolescent girls. This submission amounts to asking the female adolescent question, since female adolescents are more predisposed to sexual ill-health than their male counterparts.

6.3.3 The Right to Dignity

The crux of the respect for autonomy is the need to uphold human dignity. The right to human dignity is recognised in most international and regional human rights instruments. For instance, the UDHR in its preamble declares that 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world'. It provides further in article 1 that all human beings are born free and equal in dignity. In other human rights instruments, the protection of human dignity is often expressed in provisions relating to the right to be free from inhuman and degrading treatment. For example, article 7 of the ICCPR provides that 'No one shall be subjected to torture or cruel and inhuman or degrading treatment or punishment. In particular no one shall be subjected without his free consent

[55] United Nations Economic and Social Council (1985).The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights UN Doc ECN/4/1985/4Annex.

to medical or scientific experimentation'. This provision has often been interpreted to ensure that prisoners are treated in humane ways.

However, recent developments have shown that national courts and human rights tribunals are beginning to interpret this provision in a way so as to ensure that the dignity of women and girls is respected, protected and fulfilled, particularly in the context of sexual and reproductive health.[56] For instance, the Indian Supreme Court in the case of *Vishaka v State of Rajasthan,*[57] has explained that sexual harassment of a woman violates the constitutional guarantees of a woman's rights to life and dignity. In that case, a woman was gang raped by five men from the local community because she attempted to stop the marriage of a one-year-old baby. Relying on the Constitution's Directive Principles, the Court noted that the Indian government has the duty to secure just and humane condition and to renounce practices derogatory to the dignity of women. Therefore, it concludes that in this instance, the government has breached its obligations under international law to protect women from violence. This decision is commendable in the sense that it tends to respond to the woman question by holding the Indian government responsible for failing to take action to prevent women from violence. The reasoning of the Court here coincides with the position of the Committee on CEDAW in its General Recommendation 19,[58] where the Committee notes that a state may be held responsible for private acts of violence against women if the state fails to take necessary measures to prevent such violence.

Furthermore, the Human Rights Committee in *KL v Peru*[59] has explained that forcing a woman to carry a pregnancy to term against her will constitute inhuman and degrading treatment under article 7 of the ICCPR. The Committee notes further that this will be so when such a pregnancy is potentially harmful to the health and life of a woman and the government has failed to guarantee her access to safe abortion services. Also, the

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[56] See Cook *et al* (note 28 above) 170.
[57] (1997) 6 SCC241 (Indian Supreme Court).
[58] CEDAW, General Recommendation 19 on Violence against Women, UN GAOR, 1992, Doc.No.A/47/38 para 15.
[59] *KL v Peru* U.N. Doc. CCPR/C/85/D/1153/2003, 22 November 2005.

European Court of Human Rights in *D v United Kingdom*[60] has held that a forceful deportation of an HIV positive person to his country of origin where access to care and treatment could not be guaranteed amounts to inhuman and degrading treatment in violation of the European Convention of Human Rights. These interpretations can be applied to argue that a denial of access to contraceptive services to sexually active adolescents, solely based on their age, amounts to inhuman and degrading treatment and a violation of their right to dignity.

The word 'dignity is in itself difficult of precise definition. However, the court in *National Coalition of Lesbians and Gay* case has noted that at it least 'it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals and members of our society'.[61] Explaining the importance of the right to human dignity, Donnelly has noted as follows:[62]

> Human rights are 'needed' not for life but for a life of dignity...violations of human rights deny one's humanity, they do not necessarily keep one from satisfying one's needs. We have human rights not to the requisites for health but to those things 'needed' for a life of dignity, for a life worthy of human being, a life that cannot be enjoyed without these rights.

This explanation tallies with the observation made in Chapter 2 with regard to the importance of realising autonomy for children and adolescents. Simply put, treating children and adolescents as categories of people incapable of making decisions for themselves, diminishes their humanity and violates their human dignity. This was properly captured by Justice O'Regan of the South African Constitutional Court in *S v Makwanyane* in the following words:

> The importance of dignity as the founding value of the new Constitution cannot be overemphasized. Recognizing the right to dignity is an acknowledgment of an intrinsic

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[60] *D v United Kingdom* (1997) 24 HERR 423 (European Court of Human Rights).
[61] *National Coalition of Gay and Lesbians v Minister Justice South Africa*, CCT 11/98; [1999] (1) SA 6 (CC).
[62] J Donelly *Human Rights in Theory and Practice* (2003) 6.

> worth of human beings: human beings are to be treated as worthy of respect and concern.[63]

Under the African Charter, article 5 recognises an individual's right to dignity. It provides that 'Every individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status'. It further prohibits all forms of cruel, inhuman and degrading treatment against any human being. Also, article 3 of the African Women's Protocol guarantees women's rights to human dignity. It provides that 'Every woman shall have the right to dignity inherent in a human being and to the recognition and protection of her human and legal rights'. Article 3 further provides that 'Every woman shall have the right to respect as a person and to the free development of her personality'. While the African Commission is yet to specifically explain this provision in the context of access to sexual and reproductive health services, the Commission, in *Curtis Francis Doebbler v Sudan*[64] has given a broad interpretation to the legal obligations imposed by article 5 on states. In that case, eight Muslim university students on a picnic were arrested and charged with committing, in a public place, acts contrary to public morality, prohibited under article 153 of the Sudanese Criminal Law of 1991.[65] The provision of that law, prohibits acts such as girls kissing, wearing trousers, dancing with men, crossing legs with men and sitting and talking with boys. The girls were subsequently convicted and sentenced to fines and lashes, which would be carried out in public under the supervision of the national court. The complainants alleged that the punishment violated article 5 of the African Charter. In finding in favour of the complainants and requesting the abolition of the penalty of lashes in Sudan, the Commission noted as follows:

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[63] 1995 (3) SA 391(CC).

[64] Communication 236/2000, *Curtis Francis Doebbler v Sudan,* Sixteenth Annual Activity Report of the African Commission on Human and Peoples' Rights (Annex VII); see also, M Baderin 'Recent Developments in the African Regional Human Rights System' (2005) 5 *Human Rights Law Review* 133.

[65] Article 152 of the Sudanese Criminal Law of 1991 provides as follows: '1. Whoever commits, in a public place, an act, or conducts himself in an indecent or immoral dress, which causes annoyance to public feelings, shall be punished, with whipping, not exceeding forty lashes, or with fine, or with both. 2. The act shall be deemed contrary to public morality, if it is so considered in the religion of the doer, or the custom

> Article 5 of the Charter prohibits not only cruel but also inhuman and degrading treatment. This includes not only actions which cause serious physical or psychological suffering, but which humiliate or force the individual [to act] against his will or conscience.[66]

The Commission noted further that the prohibition of torture, cruel, inhuman, or degrading treatment or punishment is to be interpreted as widely as possible to encompass the widest possible array of physical and mental abuses.[67] From this broad explanation of the nature of the right to dignity by the Commission, it would appear that the provision of article 5 of the African Charter can be interpreted to apply to a denial of access to sexual and reproductive health services to an individual based on his/her age or sex. In other words, a denial of access to contraceptive services to a woman or girl, who may want to prevent sexual ill-health or unwanted pregnancy, can amount to a mental abuse. This will be the case when one bears in mind the psychological trauma and danger involved in carrying an unwanted pregnancy to term. It should be noted that when adolescents are prevented from seeking information and services with regard to their sexual health, particularly in relation to access to contraception, their dignity as human beings is impugned. Margalit has explained that dignity, unlike honour, is not a positional good. It is supposed to be accorded to everybody, by virtue of the most universal common denominator of being human.[68]

The decision in *Doebbler* case is highly commendable as the African Commission was able to demonstrate its sensitivity to the plight of adolescent girls. The fact that the Commission did not only find a violation of article 5 of the African Charter, but also requested that the government of Sudan should repeal the offensive provision of the Criminal Law, is a proactive step to advancing the sexual health of adolescent girls. Moreover, given that the aim of the Sudanese Criminal law is to control and repress the sexuality of adolescent girls, the African Commission by its positive decision calling for the repeal of the law, is in effect asking the female adolescent question. Why is the provision of article 152 of Sudanese Criminal Law targeted at girls and not at boys? As

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[66] *Curtis Francis Doebbler v. Sudan* (note 64 above) para 36.
[67] *Ibid* para 37.
[68] A Margalit *The Ethics of Memory* (2003) 220.

the Commission correctly pointed out, such a discriminatory approach of the law impugns the dignity of adolescent girls.

At the World Summit for Children, world's leaders resolved to take action to protect the rights of children and adolescents by respecting their dignity and securing their well being.[69] These consensus statements impose a moral obligation on the Nigerian government to ensure that adolescents in the country will be assured access to contraceptive services.

6.4 Feminist Criticisms of Children's Rights under International Law

Despite the above provisions relating to children's and adolescents' autonomy under international law, some feminist commentators have argued that the interests of children and adolescents, especially female adolescents have not been truly protected by human rights law. O'Neill for instance, has argued that a shift to the idiom of rights in any discussion relating to children tends to risk excluding and neglecting things that really matter to children.[70] While she does not doubt the efficacy of rights discourse on issues relating to children, she cautions about elevating such discourse to becoming the 'sole or fundamental ethical category'.[71] It is argued further that rights discourse often dispute the established powers and their categories and seek to empower the powerless. The problem with this is that the powerless in the society (like children) who lay claim to their rights often fail to recognise that the realisation of such rights is dependent on the power that be, the existence of which they deny.[72] Rather than relying on rights discourse with regard to children's issues, O'Neill suggests that imperfect obligations are very important in children's lives. According to her, 'imperfect obligations are traditionally thought to comprise matters such as help, care or consideration'. These are more or less concerns

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[69] UN General Assembly Resolution A World Fit for Children adopted at the Twenty-Seventh Special Session held on 11 October 2002 AR/RES/S-27/2 para 4.
[70] O O'Neill 'Children's Rights and Children's Lives '(1992) 6 *International Journal of Law and the Family* 24, 35.
[71] *Ibid* 36.
[72] *Ibid.*

that an ethic of care can address but are likely to be overlooked in an ethic of rights.[73] While she is not opposed to advancing children's rights, she cautions that an undue reliance on human rights instruments may lead to a false hope. She submits further that some of the provisions of these instruments can be likened to nothing short of 'manifesto rights'.

O'Neill's concerns coincide with that of other commentators discussed in Chapter 1. Even though feminist scholars have questioned the viability of human rights law to addressing women's and children's specific needs, most of them are unanimous in the view that laws remain an important tool for laying standards that are necessary to arrange human lives. It is further agreed that laws, including human rights law, can serve as the starting points for addressing human rights challenges faced by women and children.[74] Admittedly, human rights approach to issues affecting children has its limitations. However, it remains one of the most powerful tools of empowering disadvantaged and vulnerable groups such as children and adolescents.[75]

In Olsen's view, law has been developed in such a 'strikingly male-dominated atmosphere' and as such the values, goals and attributes associated with women have been accorded little respect in law.[76] In short, law (including human rights law) is 'male' and almost synonymous with the 'patriarchal system'.[77] With specific regard to the CRC, it is pointed out that the language is gender-blind and fails to include important provisions, such as the provision forbidding child marriage, relevant in advancing the

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[73] *Ibid* 38.

[74] See for instance, H Charlesworth 'What are Women's International Human Rights?' in RJ Cook (ed) *Human Rights of Women National and International Perspectives* (1995) 65; see also G Binion 'Human Rights: A Feminist Perspective'(1995) 17 *Human Rights Quarterly* 509.

[75] *Ibid.*

[76] F Olsen 'Children's Rights: Some Feminist Approaches to the United Nations Convention on the Right of the Child' (1992) *International Journal of Law and the Family* 192; see also C MacKinnon *Toward a Feminist Theory of the State* (1989) where she argues that essentially law is a personification of patriarchy .

[77] *Ibid*; see also, C Bunch 'Transforming Human Rights from a Feminist Perspective' in J Peters and A Wolper (eds) *Women's Rights, Human Rights: International Feminist Perspectives* (1995) 12, where she argues that generally women's human rights have not been treated as part of human rights, thus perpetuating the secondary position of women and therefore, highlighting the need to recognise specific women's human rights concerns; H Charlesworth *et al* 'Feminists Approaches to International Law' (1991) 85 *American Journal of International Law* 615.

rights of the girl child.[78] Olsen has indentified four different feminist approaches to critique the provisions of the CRC, namely, legal reformist, law as patriarchy feminists, feminist critical legal theory and post modern feminist.

The legal reformists are concerned about some important omissions in the CRC, which otherwise would have been in the interests of the girl child. They note, for example, that the CRC deals with child soldiers which is more in the interest of a boy child but omits to deal with child marriage that is a great problem for the girl child. The legal reformists thus question the gender-blindness of the Convention wondering if it is not contrary to the principle of sex discrimination.

The 'law as patriarchy feminist' is concerned about the unsatisfactory manner in which the Convention deals with interests often associated with girls or women. For instance, it expresses dissatisfaction with the ways the CRC deals with issues such as an appreciation of the importance of and pervasiveness of human relationships, a concern with ethic of care, issues raised by connection, rather than showing great concern for issues of separation and a concern for complexity, context and continuity.[79] It submits that the Convention could have been regarded more as an important document had more attention been accorded to feminists' view of rights.

Feminist critical legal theory reiterates feminists concern about the public/private dichotomy and the issue of consent and choice. While this group of feminists admits that the Convention is an attack on the public/private divide of life, it observes that the Convention can also become an instrument of reinforcing and perpetuating conventional notion of family as the centre of affective life and a sharp split between affective and productive life.[80] The feminist critical theory further contends that the CRC is full of contradictory rights. For instance, 'children's' right to care conflicts with their right to autonomy, their right to formal equality conflicts with substantive equality, their and others' right to security with 'their and others' right to freedom of action' and their rights

[78] Olsen (note 76 above) 195.
[79] *Ibid* 194.
[80] *Ibid.*

with the rights of others especially mothers'.[81] In such a confusing situation the rights of a girl child are likely to be affected the most.

The post-modern feminism is concerned with the false universalism approach of the Convention and the feminist critique of abstraction. This approach criticizes the Convention for dealing with children as 'unspecified, unsituated people' and gives much more attention to white, male and relatively privileged children.[82] By failing to challenge the categories through which the world is understood, the post-modern feminists conclude that the Convention has failed.

While one may argue that the foregoing criticisms of the CRC by Olsen are valid to some extent, it is also important to note that no piece of legislation or treaty is by any means a perfect document. Even the CEDAW specifically drafted to address the needs of women, has been criticised for its inability to live up to this expectation.[83] Therefore, the shortcomings of the CRC are not peculiar to it. Moreover, while the criticism relating to the gender-blindness of the provisions of the CRC may seem tenable, in recent times the Committee on CRC through its General Comments and Concluding Observations has paid great attention to the sexual and reproductive health needs of female adolescents. For instance, in its General Comment 4 the Committee notes as follows:

> Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents.[84]

No doubt this statement is a response to the female adolescent question as it specifically addresses sexual health challenges peculiar to adolescent girls. Prior to this time, the Committee at its Special Session on the 'Girl-Child' has noted as follows:

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[81] *Ibid.* 195.
[82] *Ibid.*
[83] Charlesworth *et al* (note 77 above) 632.
[84] General Comment 4 (note 40 above) para 31.

> In fact, girls are simply human beings who should be seen as individuals and not just as daughters, sisters, wives or mothers, and who should fully enjoy the fundamental rights inherent to their human dignity. The rights of the girl should in no way be ignored or neglected, but rather promoted and protected.[85]

The above statements of the Committee clearly show that the fears expressed by Olsen with regard to the gender-insensitivity of the CRC might, in actual fact, be misplaced. This is because the Committee has always aimed at adopting a gender-sensitive approach to interpreting the Convention.

While Olsen will not regard the CRC as a perfect instrument, she concedes that it remains an important human rights instrument that can advance the rights of children.[86] Fottrel also submits that taken as a whole, the CRC 'expands considerably the international law applicable to children through the sheer ambition and breath of its provision'. She argues further that, perhaps the most significant achievement of the Convention is its 'injection of child-centered perspective to international human rights law'.[87] In other words, the Convention can be regarded as a potential instrument for the advancement of children's, and particularly adolescents' autonomy. In Eekelaar's words:

> [T]he language of rights performs an important function. It acknowledges that there are certain things we should provide for children, not just because adults think it would be nice if they had them, but because we are prepared to recognize that children want them or can reasonably be assumed to want them. [88]

Charlesworth equally admits that despite its limitation, the use of human rights language can help in drawing the attention of the policy makers to the plight of the disadvantaged

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[85] Committee on CRC Special Session on the Girl Child CRC/C/38, 8th Session, 21 January 1995 para 283.

[86] Olsen (note 76 above) 217.

[87] D Fottrel 'One step forward or two steps sideways? Assessing the First Decade of the Children's Convention on the Rights of the Child in D Fottrel (ed) *Revisiting Children's Rights: 10 Years of the Convention on the Rights of the Child* (2000) 4.

[88] J Eekelaar 'Why Children? Why Rights? in P Alston & C Brennan (eds) *The UN Children's Convention and Australia* (1991) 4.

in society.[89] However, for human rights law to address the needs of vulnerable groups in society, such laws must accommodate the 'working experience' or 'gendered lives'[90] of women-including young women. Freeman has observed that opposition to rights discourse to children's issues based on other values as such love, relationship, companion and altruism, as suggested by some scholars may seem attractive;[91] but these values can only be useful in an ideal world, where there is harmony and children are accorded due regard and protection. However, as things are, we do not live in an ideal world, particularly with regard to advancing children's rights. Therefore, since children are often particularly vulnerable, they need rights to protect their integrity and dignity.[92] Cook has suggested that for human rights to truly address the needs of women, there is need for critical re-characterisation of human rights, and the implementation of such rights should become part of the central agenda of human rights work.[93] In essence, the language of rights is not in itself useless if it is properly used to advance the interests of vulnerable groups such as women, children and adolescents in society.

6.5. The Right to Health

In paragraph 1.7 of Chapter 1, the relevance of the right to health to this study was briefly explained. Here in this section of the study, by way of a follow-up discussion, the nexus between the right to health and access to contraception will be discussed in detail.

The right to health is one of the most important rights that can be invoked to assure access to contraception for adolescents. According to the World Health Organization (WHO), health is broadly defined as a state of complete physical, social and mental well being and not merely absence of disease or infirmity.[94] It is further stated that the

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[89] Charlesworth (note 74 above).
[90] M Fineman 'Feminist Theory and Law' (1995) 18 *Harvard Journal of Law and Public Policy* 349.
[91] M Freeman 'Taking Children's Rights more Seriously' (1992) 6 *International Journal of Law and the Family* 51, 55.
[92] *Ibid.*
[93] RJ Cook 'Women's International Human Rights Law: The Way Forward' in RJ Cook (ed) *Human Rights of Women: National and International Perspectives* (1995) 10.
[94] The Constitution of the WHO was adopted by the International Health Conference, New York, 19-22 June 1945; opened for signature on 22 July 1946 by the representatives of 61 states; 14 UNTS 185.

enjoyment of the right to health is a fundamental right of all. Though criticised for being too aspirational and utopian in nature,[95] this definition has provided a solid foundation for the recognition of the right to health in subsequent human rights documents that emerged after the WHO's Constitution. For instance, article 25(1) of the UDHR provides that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services'.[96] Perhaps the most comprehensive recognition of this right is contained in article 12 of the ICESCR, where it is provided that 'States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Article 12 (2) further contains among others, important determinants of the right to health such as prevention and treatment of diseases, essential for the enjoyment of the right.

It should be noted that the right to health as contained in these instruments does not by any means guarantee perfect health for all.[97] It is not in contention, however, that this right encompasses an obligation on a state to ensure access to preventative health services for all.[98] In other words, states are legally obligated to ensure access to preventive health services, such as access to contraception, for adolescents. The Committee on ESCR in its General Comment 14, while clarifying the content of the right to health, has urged states to provide access to comprehensive sexual and reproductive health care services (including access to contraception) for adolescents.[99] This is no doubt an implicit recognition of the fact that adolescents should be accorded autonomous decision-making power with regard to access to sexual health services, including contraceptive services.

With specific regard to the health of adolescents, article 24 of the CRC recognises the right of children to the enjoyment of highest attainable standard of health. Article 24(f)

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[95] See for instance, T Evans 'A Human Right to Health?' (2002) 23 *Third World Quarterly* 197, 198, where he argues that if the definition of health as provided by WHO in its Constitution is taken at a face value, then we may end up in an absurd claim to eliminate disease, infirmities brought by aging and even mortality.

[96] Universal Declaration of Human Rights, GA Res 217 A (III), UN Doc A/810 (10 December 1948).

[97] BC Toebes *The Right to Health under International Human Rights Law* (1999) 19.

[98] Center for Reproductive Law and Policy (CRLP) & Child and Law Foundation (note 24 above).

[99] General Comment 14 (note 50 above) para 23.

further enjoins states to develop preventive health care guidance for parents and family planning services. A careful look at this provision does not seem to explicitly refer to adolescents. Packer observes that this provision is worded in such a way as to give room for ambiguity.[100] According to her, the provision is capable of two possible interpretations. It could mean ensuring access to family planning services for the parents of an adolescent. Alternatively, it could imply ensuring access to family planning services to an adolescent in order to prevent unwanted pregnancies. The latter interpretation is more plausible. Clearly, the intention of the drafters of this article could have been made more explicit to avoid this unnecessary ambiguity.[101] The poor use of language here is a reflection of opposition to sexual health education and services for adolescents. Based on this, Packer submits that this provision neither includes nor excludes adolescents from preventive health care services.[102]

However, in its General Comment 4 the Committee of the CRC has urged states to develop and implement programmes that ensure provision of sexual and reproductive health services, including access to contraception, for adolescents.[103] The Committee further imposes obligations on states to ensure that health facilities, goods and services (including contraception) are of good quality and are sensitive to the specific needs of adolescents.[104] Also, in one of its Concluding Observations to Belize, the Committee has noted with great concern the high number of teenage pregnancies existing in the country and therefore urged the government of Belize to ensure comprehensive and appropriate access to sexual and reproductive health care services to all adolescents in the country.[105]

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[100] CA Packer 'Preventing Adolescent Pregnancy: The Protection Offered by International Human Rights Law' (1997) 5 *International Journal of Children's Rights* 85; see also; D Fottrel 'One step forward or two steps sideways? Assessing the First Decade of the Children's Convention on the Rights of the Child' in D Fottrel (ed) *Revisiting Children's Rights: 10 Years of the Convention on the Rights of the Child* (2000) 4. where the author castigates the drafting style of the Convention as being broadly framed to the extent that their meanings are ambiguous and/or they fail to improve on existing standards.

[101] See S Toope 'The Convention on the Rights of the Child: Implications for Canada' in M Freeman (ed) *Children's Rights: A Comparative Perspective* (1996) 33, 43, where the provisions of the Convention have been criticised for being 'loosely, if not sloppily' drafted; see also D Gomien 'Whose Rights (and whose duty) Is it? An analysis of the Substance and Implementation of the Convention on the Rights of the Child' (1989) 7 *New York Law School Journal of Human Rights* 161, 162.

[102] Packer (note 100 above) 85.

[103] General Comment 4 of the Committee on CRC (note 40 above) para 31.

[104] *Ibid* para 39(c).

[105] Committee on CRC Concluding Observations: Belize UN Doc CRC/C/146 2005 para 347.

A health care service that is sensitive to the needs of adolescents must no doubt respect their autonomous decision-making powers to seek preventive treatment such as contraception.

Furthermore, the right to health has been guaranteed under article 12 of CEDAW, which provides that states shall take all necessary measures to eliminate discrimination against women in the field of health care in order to ensure access to treatment for women on equal basis with men. This provision is very important in ensuring access to contraception for female adolescents. In addition to this provision, article 16 guarantees the right to family planning services for all women. Also, article 14 specifically guarantees access to family planning services for women in rural areas. Although these provisions of CEDAW adopt the use of the phrase 'family planning,' it is not in doubt that the phrase will include information and services related to contraception.

It has been argued that these provisions of CEDAW are one of the most explicit and perhaps broadest recognitions of the general right to contraceptive treatment for women, especially female adolescents.[106] In its clarification of the content of CEDAW, the Committee on CEDAW has observed that its provisions guarantee access to health care services, including services on contraception and STIs prevention to adolescents.[107] In what appears to be an affirmation of the sexual autonomy of adolescents, the Committee in its General Recommendation 24 has urged states parties to ensure access to sexual and reproductive health care services without prejudice to all women and girls.[108] This statement would tend to reinforce the need to ensure access to contraceptive services for adolescent girls.

At the regional level, the right to health is guaranteed in the major human rights instruments under the African human rights system. For instance, article 16 of the African Charter provides that every individual shall have the right to the best attainable state of physical and mental health. This provision is broad enough and would seem to

[106] CRLP & CLF (note 24 above) 40.
[107] General Recommendation 24 of CEDAW (note 30 above).
[108] *Ibid* para 21.

encompass access to sexual health services. Indeed, in the *Purohit* case the African Commission has held that 'Enjoyment of the human right to health as it is widely known is vital to all aspects of a person's life and well-being, and is crucial to the realization of all the other fundamental human rights and freedoms.'[109] It states further that this right includes the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind. In a similar vein, article 14 of the African Children's Charter provides that every child shall be entitled to the best attainable standard of physical and spiritual health. It further guarantees the right to preventive health care services for children. Undoubtedly, this provision of the African Children's Charter encompasses the need to facilitate access to contraception for adolescents.

The Women's Protocol, the most recent of human rights instruments in the region, contains elaborate and explicit provisions recognising the right to health, including sexual and reproductive health of women, in its article 14. This important article further provides that states should respect and promote a woman's right to control her fertility, decide the number and spacing of her children choose any method of contraception, self-protection from sexually transmitted infections, including HIV/AIDS, legal abortion in certain situations and family planning. Also, the provision enjoins states parties to take appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women, especially those in rural areas'.

By these unique and radical provisions, the African Women's Protocol has become a pace-setter under international human rights law as the first human rights instrument that clearly recognises women's sexual and reproductive health as human rights. It equally contains specific provisions on women's protection in the context of HIV/AIDS and access to contraception.[110] Banda submits that by these provisions, the Women's Protocol

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[109] *Purohit and Moore v The Gambia* Communication 241/2001 decided at the 33rd Ordinary Session of the African Commission held from 15th –29th in Niamey, Niger May 2003.

[110] See Center for Reproductive Rights (CRR) *Briefing Paper: The Protocol on the Rights of Women in Africa; An Instrument for Advancing Reproductive and Sexual Rights* (2005) 4-7; see also, E Durojaye 'Advancing Gender Equity in Access to HIV Treatment Through the Protocol on the Rights of Women in Africa' (2006) 6 *African Human Rights Law Journal* 187.

has blazed the trail in terms of explicit recognition of sexual and reproductive rights of women.[111] It should be noted that the Women's Protocol applies to all women, including girls. Therefore, it becomes one of the strongest human rights instruments that can be invoked to support female adolescents' right to access contraceptive services. It clearly accords female adolescents the autonomy with regard to their sexual health needs and protects them from sexual ill health.

It should be noted that the right to health also encompasses access to health-related information such as information on contraception. Articles 10(h) and 16.1(e) of CEDAW recognise the rights of all women, including women in rural areas, to access to information related to family planning. These provisions are broad enough to include ensuring access to information related to contraception for adolescents. Adolescents require accurate information concerning their sexual health, including information related to contraception. Otherwise they may take decisions which could be injurious to their health and lives.[112] Indeed, the Committee on CEDAW has urged states to provide without prejudice, access to information and education on sexual health information to girls within their countries.[113]

The Committee further explains that access to sexual health information and education forms an integral part of the enjoyment of the right to health. According to the Committee, states are obligated to 'ensure the rights of female and male adolescents to sexual and reproductive health education by properly trained personnel in specially designed programs that respect their rights to privacy and confidentiality'.[114] Also, the Committee on the ESCR in General Comment 14 has noted that the enjoyment of the right to health can only be realised if access to health-related information, including

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[111] See F Banda 'Blazing a Trail: The African Protocol on Women's Rights comes into Force' (2006) 50 *Journal of African Law* 72, 81; see also, DM Chirwa 'Reclaiming (Wo)manity: The Merits and Demerits of the African Protocol on Women's Rights' (2006) 53 *Netherlands International Law Review* 63.

[112] See Centre for Reproductive Rights (CRR) *Briefing Paper: Implementing Adolescent Reproductive Rights through the Convention on the Rights of the Child.* (1999) 4; see also, Packer (note 100 above) 47-76.

[113] See General Recommendation 24 of CEDAW (note 30 above) para 18.

[114] *Ibid.*

sexual health information, is guaranteed.[115] Moreover, the Committee has identified the essential elements of the rights to health, including sexual and reproductive health, to include availability, accessibility, acceptability and quality.[116] These elements are important in realising access to contraceptive services for adolescents. Therefore, states must ensure that contraceptive services are not only available in large quantity, but are also reachable, respectful of adolescents' rights, especially female adolescents, and of good quality.[117]

More importantly, the Committee on CRC in General Comments 3[118] and 4[119] has urged states to guarantee access to sexual health information and education to adolescents. According to the Committee, states parties to the Convention should refrain 'from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information'.[120] The Committee further notes that this will be consistent with realising the right to the highest attainable standard of physical and mental health and the right to life, survival and development for adolescents.[121]

Furthermore, the Committee has noted in its General Comment 4 as follows:

> Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours.[122]

Undoubtedly, these comments of the Committee on the CRC necessarily include information on contraception. This is so because information with regard to contraception

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[115] General Comment 14 (note 50 above) para 23.
[116] *Ibid.*
[117] For a detailed discussion on the relevance of these elements to health care services for women and girls see RJ Cook 'Exploring Fairness in Health care Reform' (2004) 29 *Journal of Juridical Science* 1-21.
[118] General Comment 3 of the Committee on CRC (note 41 above) para 15.
[119] General Comment 4 of CRC (note 40 above) para 28.
[120] General Comment 3 (note 41 above) para 16.
[121] *Ibid.*
[122] General Comment 4 (note 40 above) para 26.

can play important roles, in not only preventing unwanted pregnancies among adolescents, but also in preventing STIs, including HIV/AIDS.

In addition to the above mentioned human rights instruments, there are various non-binding consensus statements and resolutions useful in advancing adolescents' access to contraceptive services. For instance, at the ICPD it was agreed that states should ensure adolescents access to health care services so as to prevent unwanted pregnancies and STIs.[123] States were also enjoined to ensure that attitudes of health care providers do not constitute hindrance to access to sexual health services, including contraceptive services to adolescents.[124] At the five-year review of the ICPD, it was further reiterated that states should guarantee to adolescents access to sexual and reproductive health care services.[125] At Beijing, states reaffirmed the right to the enjoyment of highest attainable standard of health for women, including the promotion and protection of the health of girls.[126] This reaffirmation, which emphasizes that states should pay attention to the sexual needs of girls, is more or less asking the female adolescent question. Adolescent girls cannot enjoy the 'highest attainable standard of health' if they are susceptible to early or unwanted pregnancy or if they are exposed to STIs. Therefore, the call to the international community to pay more attention to the health needs of girls is a welcome development, as it recognises the peculiar sexual health challenges which adolescent girls may encounter in their daily lives. At the follow-up meeting to the Millennium Development Goals (MDGs) in 2005, it was reiterated that to achieve the health-related benchmarks of the MDGs, it would be necessary to assure universal access to sexual and reproductive health care services for all by the year 2015.[127]

The Maputo Plan of Action, which was the brain-child of African ministers of health, has recognised that facilitating access to sexual health services for adolescents is imperative

[123] ICPD (note 7 above) para 7.41.
[124] *Ibid* para 7.45.
[125] ICPD + 5 (note 53 above) para. 10.
[126] FWCW (note 8 above) para 106 (B).
[127] See The Draft Resolution of the High-Level Plenary Meeting of the General Assembly on the World Summit 15 September 2005 para 57 (g).

for attaining universal access to sexual and reproductive health services in the region.[128] It particularly urges African governments to implement policies and measures that support provision of sexual and reproductive health care services addressing the needs of adolescents in the region. Undoubtedly, such policies and measures must recognise the autonomous decision- making capability of adolescents to seek sexual health services

6.5 Conclusion

The discussion in this chapter has focused on the combination of rights that make up the right to autonomy and their relevance to realising access to contraception for adolescents. The chapter has identified the rights to liberty and the security of person, privacy and dignity as essential components of the right to autonomy. Where an adolescent is denied the right to make contraceptive choices, which he or she requires to prevent sexual harm, the right to liberty and security of the adolescent will be compromised. Also, failure to assure adolescents confidential access to sexual health services, particularly contraceptive services, will implicate the right to privacy of adolescents. On the other hand, denying access to sexual health services to adolescents based on grounds of age or incapability to make reasonable decisions will result in violation of the right to dignity of adolescents.[129]

The chapter equally discusses the relevance of the right to health to access to contraceptive services for adolescents. Given that contraception forms part of health goods and services, the recognition of this right is crucial to realising access to contraception for adolescents. In line with the observations of the Committee on ESCR, states must make contraceptive services available, accessible, acceptable and of good quality to adolescents. An important observation made with regard to the right to health is that adolescent girls cannot enjoy physical and mental well-being if they are continually exposed to sexual ill health. In other words, universal access to sexual health services and information, including contraceptive services, is imperative to ensuring good health to

[128] Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007–2010 (Special session at the African Union Conference of Ministers of Health on the universal access to comprehensive sexual and reproductive health services in Africa, September 2006) Sp/MIN/CAMH.
[129] Center for Reproductive Rights (note 21 above).

adolescent girls. The degree to which such access can be guaranteed will depend on whether existing laws and policies are able to facilitate or hinder access to sexual health services to adolescents.

From the above discussion, it is clear that the rights to autonomy and health, both recognised in various international and regional human rights instruments, can be invoked to facilitate access to information and services relating to contraception to adolescents. These instruments and other consensus statements reached by governments at various meetings impose legal and moral obligations on governments to respect, protect and fulfill the sexual health needs of adolescents. The affirmation of adolescent girls' right to autonomy enables them to exercise the sexual choices and seek preventative health care such as contraceptive services. This often challenges traditional belief that adolescent girls are asexual and are not expected to seek knowledge as regards their sexuality. In other words, affirming adolescent girls' right to autonomy is more or less asking the female adolescent question. This is because it empowers adolescent girls to take control of their sexuality and avoid sexual ill health.[130]

Moreover, decisions by national courts and human rights tribunals have shown that states have the obligation to take positive measures with a view to ensuring that adolescents exercise their right to autonomy to seek contraceptive services. In the same vein, states must not take retrogressive steps that will hinder adolescents from exercising their right to autonomy in the context of access to contraception. Implicit in this is the recognition of the right of adolescents to access information and services on contraception. As noted in Chapter 3, barriers to access to contraception for adolescents are rooted in socio-cultural practices and inappropriate laws and policies. Therefore, governments must do more than law reform and policy formulations, but must also take concrete and practical measures such as embarking on education programmes for community members and training for health care providers on issues relating to the sexual and reproductive health of adolescents.

[130] See for instance, Packer (note 100 above) 86.

A major observation however, by feminist scholars is the fact that provisions of human rights instruments relating to children, especially the CRC, are generally worded and fail to specifically meet the needs of female adolescents. In order words, some of these provisions fail to reflect the lived experiences of female adolescents. Regardless of this gap, however, human rights remain a viable tool for redressing women's and girl's disadvantages in society. Moreover, the criticisms levelled against the CRC for being gender-insensitive would seem to have been mitigated by the purposive interpretation of the instrument by the Committee on CRC. The Committee has often adopted a gender-sensitive approach to interpreting states obligations under the Convention in relation to access to sexual health services. This is a welcome development and it is commendable. It is hoped that in future when the Committee of Experts of the African Children's Charter begins to examine states reports submitted under the Charter, equal attention will be given to the gender dimension raised by such reports.

CHAPTER 7

NIGERIA' S REPORTING OBLIGATIONS TO TREATY MONITORIING BODIES AND ACCESS TO CONTRACEPTION FOR ADOLESCENTS

7.1 Introduction

The discussions in previous chapters of this study have examined Nigeria's laws and policies and the application of human rights to access to contraception. The purpose of this chapter it to critically assess whether Nigeria's reporting obligations to treaty monitoring bodies (at international and regional levels) have by any means advanced the sexual health needs of adolescents in general and female adolescents in particular. Emphasis here is on the aspect of the report to treaty bodies that concerns access to sexual health services for adolescents, particularly contraceptive services. These reports are evaluated to determine if they have responded to the female adolescent question. In other words, an enquiry is made whether reports by the Nigerian government have reflected the lived experiences of female adolescents as regards access to sexual health services, including contraceptive services.

The chapter further examines the relevance of using human rights indicators to monitor a state's obligations to ensure that the sexual health and rights of adolescents at the national level are realised. Monitoring a government's obligations to realise adolescents' sexual health and rights, can improve reporting obligations to treaty bodies. It can also draw more attention to the sexual health needs of marginalised groups such as adolescents, especially female adolescents, in a country.

7.2 Assessing Nigeria's Obligation to Respect the Rights to Health and Autonomy of Adolescents under International Law

The discussion in Chapter 6 relates to the relevance of the rights to autonomy and health in realising access to contraception for adolescents. In this section of the study, a careful analysis of some of the reports submitted by the government of Nigeria to treaty monitoring bodies is carried out. The analysis relates to reports submitted to bodies such as the Committee on CRC, the African Committee of Experts on the Rights and Welfare of the Child and the Committee on CEDAW, with focus on adolescents sexual health, particularly access to contraception. In addition to the government's reports, shadow reports by non-governmental organisations will be examined, where available, to enable a balanced assessment of the government's obligations to treaty monitoring bodies. The focus will be on whether actions of the Nigerian government are capable of advancing adolescents' autonomy to seek contraceptive services. It will also determine whether Nigeria is taking adequate measures to ensure the sexual well-being of adolescents, particularly female adolescents. In doing this, the method of asking the Nigerian female adolescent question will be applied.

7.2.1 Reporting Obligation under International Human Rights System

Nigeria ratified the CRC in 1991 and has so far submitted two reports to the Committee on CRC. The first report was submitted in 1995, while the second report was submitted in 2003.

In its second periodic report to the Committee on CRC,[1] the Nigerian government reported that the age for medical treatment and surgery in the country is 21 years in accordance with the common law position.[2] The report further stated that there is no legal age of consent for which a child may seek medical counseling or treatment without parental consent, as parents under cultural practices, continue to have influence over their

[1] Committee on the Rights of the Child: Consideration of Reports submitted by States Parties under Article 44 of the Convention. Second Periodic Reports of States Parties: Nigeria CRC/C/70/Add. 24.
[2] *Ibid* para 43.

children until they die.[3] This position, however, would seem to be inconsistent with Nigeria's obligations under the CRC. Under the CRC, a child is defined as someone under 18 but in some situations, a person under 18 can exhibit adult-like characteristics if his or her capacities have evolved. Adhering to the age of 21 as the age of medical consent in the country, will undermine the autonomy of a child and limit access to sexual health treatment, including treatment on contraception to majority of adolescents. This would seem to fly in the face of reports in the country, which have shown that many adolescents become sexually active at early age and often lack access to sexual health information and services.[4] The negative implications of this approach will be felt more by female adolescents who are more susceptible, compared to their male counterparts, to sexually transmitted infections, including HIV/AIDS and unwanted pregnancies.

The government of Nigeria further noted that its efforts at addressing discrimination against the girl child have been hindered by cultural practices such as boy preference and denial of inheritance rights to the girl child in some cultures.[5] As discussed in Chapters 2 and 3, cultural practices that are discriminatory against women and girls can hinder access to contraceptive services for female adolescents, as they may feel uncomfortable to seek advice and services related to contraception. The Nigerian government also stated in its report that due to cultural practices, the freedom of expression and the right to privacy of children are not usually recognised in many parts of the country. According to the report, the recent clamour for the right of a child to express him/herself would seem to be inconsistent with cultural practices in the country, which sanction a child to be merely seen and not to be heard. It states further that 'in Nigeria the relationship between children and parents is so intensive that the issue of a child's right to privacy hardly arises, as parents are always interested in the correspondence of their children and what relationships they entertain'.[6] While this may not be a problem, however, it is likely to erode the autonomy of adolescents, especially female adolescents, and deter them from seeking sexual health services, particularly contraceptive services. As pointed out in

[3] *Ibid* para 42.
[4] See for instance, A Bankole *et al Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences* (2006) 14.
[5] Committee on CRC Report (note 1above) para 72.
[6] *Ibid* 100.

Chapter 6, the right to autonomy with regard to adolescents implies their ability to make decisions pertaining to their sexuality without inhibition.

With regard to the health and well-being of children, the government admits that due to poor funding and lack of facilities in the health care sector, the health needs, including sexual health needs of children, have not been realised. Although the government has taken a number of steps to promote the health of children and preserve their lives, such measures are not having the desired results due to a paucity of funds allocated to the health sector. This can be regarded as a tacit admission of failure on the part of the government of advancing the sexual health needs of adolescents in accordance with its obligations under international law. The obligation of a state to fulfill the right to health, including sexual and reproductive health, requires that adequate resources must be allocated to meet the health needs of the citizens, especially the vulnerable groups such as women and adolescents. It would seem that the Nigerian government is failing in its obligations to advance adolescents' sexual health needs.

An alternative report submitted by NGOs to the Committee on CRC highlights the serious impact of the HIV/AIDS epidemic on young people, especially young women.[7] The report claims that despite the devastating effects of the epidemic on adolescents in the country, the government of Nigeria has not been forthright in its handling of the epidemic.[8] It is further observed in the report that children have been treated with little respect in Nigeria and their views and right of expression ignored or disregarded.[9] Although the report admits that things are changing for the better, however, children's views are still accorded little value in relation to matters affecting their lives. Moreover, girls are still treated with less importance than boys in different spheres of human endeavour. This is contrary to the provision of article 12 of the CRC which obligates states to respect the views and opinions of children and adolescents in all matters affecting them.

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[7] See The African Network for the Prevention and Protection of against Child Abuse and Neglect (ANPPCAN) *NGO Periodic Report on Nigeria* (2003).
[8] *Ibid* 1.
[9] *Ibid* 2.

It is clear from the government's report and the shadow report by the NGOs, that Nigeria has not accorded adolescents in the country their right to autonomy. Equally, enough attention does not seem to have been given to the issue of ensuring access to contraceptive services to adolescents, especially female adolescents, to improve their health. Moreover, the fact that the girl child has continued to experience discriminatory cultural and religious practices in every sphere of life, shows that little attention is paid to the plight of female adolescents. This provides an indication that the steps being taken by the Nigerian government to address the sexual health needs of adolescents have failed to respond to the female adolescent question. Corroborating this position, the Committee on CRC in one of its Concluding Observations to the government of Nigeria, has noted that girl children are still subjected to discriminatory practices and that insufficient attention has been given to their health needs, including sexual health needs.[10] This situation requires that measures taken by the Nigerian government to address the needs of adolescent girls must ask the female adolescent question. In essence, such measures must respond positively to the daily lived experiences of adolescent girls. For instance, there might be need to repeal or abolish laws and practices that discriminate against girls.

With regard to the combined (fourth and fifth) reports of the government of Nigeria to the Committee on CEDAW, it was reported that the government had taken a number of important steps towards advancing the rights of women and children.[11] The government highlighted some of the laws and policies that have been enacted or developed to this effect. In particular, the government reiterated that discrimination against women and girls is being addressed decisively in the country. It cited the introduction of the National Policy on Women as one of the steps taken to address gender-based discrimination.[12] This Policy essentially aims at eliminating all forms of discrimination against women and girls in accordance with the provisions of the Nigerian Constitution. Other measures that have been taken in this regard, include ensuring 'economic and social empowerment,

[10] Committee on CRC Concluding Observation on Nigeria 2005 CRC/C/146 adopted at the 1025th meeting held on 28th of January 2005.
[11] See Committee on the Elimination of Discrimination against Women: Summary Report of the 637th meeting held on January 2004 CEDAW/C/SR/.637 paras 3 and 4.
[12] *Ibid* para 5.

including the provision of micro-credits; the establishment of women's cooperative societies targeted at health, education, literacy and income-generating activities for women in the rural areas...'.[13] On paper the efforts taken by the Nigerian government towards meeting the needs of women may seem commendable. However, in reality things are not as rosy as the government has painted. Reports continue to show that women and girls still encounter discriminatory practices and their sexual health needs have not received adequate attention.[14]

In its sixth report to the Committee on CEDAW, the Nigerian government reported that it has introduced reproductive rights and maternal mortality education in schools in order to create awareness on these issues. It was further reported that the government has adopted a gender-sensitive approach in its efforts to stem the spread of HIV. It stated for instance, that gender mainstreaming has formed an important part of HIV/AIDS policy and programme developments. The report failed to highlight steps that the Nigerian government has taken in order to ensure access to comprehensive sexual and reproductive health services for adolescents, especially female adolescents.

In one alternative report to the Nigerian government's report to the Committee on CEDAW, it was reported that efforts made at advancing the rights of women and girls have been opposed by conservative groups in the country.[15] One such effort was the rejection of the Abolition of Discrimination against Women in Nigeria and other Related Matters Bill 2006, which was meant to domesticate the provisions of CEDAW. Religious leaders and conservative groups vehemently opposed sections 12 and 16 of the proposed Bill, which guarantee sexual and reproductive health to women and girls. It was argued that these provisions were meant to legalise abortion through the back door. More importantly, the report lamented the high incidence of STIs, including HIV/AIDS, among young women and the prevalence of unwanted pregnancies. It is reported that about 60%

[13] *Ibid* para 7.
[14] See for instance, Bankole *et al* (note 4 above).
[15] See The Nigeria CEDAW NGO Coalition Shadow Report: Submitted to the 41st Session of the UN Committee on CEDAW (2008) 2.

of new HIV infection rates occur among girls aged 15-25,[16] while about 72% of all deaths arising from unsafe abortions occur among girls.[17]

Furthermore, the report claimed that the Nigerian government has not done enough to prevent the need to resort to unsafe abortion and stem the spread of HIV among girls. In other words, the government has not done enough to ensure access to contraceptive information and services for girls in the country. This is an indication that the Nigerian government is not living up to its obligations under CEDAW. The Committee on CEDAW in its General Recommendation 24 has noted that failure on the part of states to ensure access to adequate and appropriate health care services, including sexual and reproductive health services for women and girls, amounts to an act of discrimination and a violation of women's and girls' sexual and reproductive rights.[18] Moreover, in its Concluding Observations to the government of Nigeria, the Committee on CEDAW has noted that discriminatory practices against women and girls are still pervasive and that the government should take decisive steps to curtail such practices.[19]

The Committee also enjoins the government of Nigeria to adopt a holistic approach to ensuring access to comprehensive health care including sexual and reproductive health care services for women and girls.[20] These comments on Nigeria's efforts to protect the human rights of women and girls clearly indicate that the government of Nigeria has not responded to the female adolescent question. Measures taken by the government to address discrimination against women and girls and advance their sexual health seem to be failing short of meeting the peculiar needs of women and girls as required under international human rights law. The missing link in all the measures taken by the government of Nigeria seem to be that women and girls have not been placed at the centre of the government's attempts to address their sexual health needs. Bartlett has

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[16] *Ibid* 47-49.
[17] *Ibid.*
[18] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 para 23.
[19] Concluding Observations of the Committee on CEDAW: Nigeria Forty-First Session 30 June -18 July 2008 CEDAW/C.NGA/CO/6 para 20.
[20] *Ibid* para 32.

observed that asking the woman question requires putting women and girls at the centre of any action, law, decisions or measures taken to address the challenges facing women.[21]

7.2.2 Reporting Obligations under Regional Human Rights System

The discussion in this section centres on Nigeria's reporting obligations under the African Children's Charter and does not include its obligations under the African Charter. Nigeria has recently submitted its combined initial and first periodic report[22] to the African Committee of Experts on the Rights and Welfare of the Child (Committee of Experts) in accordance with article 43 of the African Children's Charter. The country ratified the Charter in July of 2001 and ever since that time the country has not submitted any report to the Committee of Experts. The report, which drew extensively from Nigeria's 2005 report to the Committee on CRC, pointed out the importance of giving attention to the rights and protection of children as this is connected to realizing the lofty goals of the Millennium Developments Goals (MDGs). To this extent the report noted that the Nigerian government has given priority to the protection of the rights of women and children through its laws, policies and programmes. It was further reported that efforts have been made to ensure that laws enacted at both federal and state levels have taken into consideration the provisions of the African Children's Charter. The Child's Rights Act of 2003 was mentioned in this regard and that efforts are being made by state governments to adopt the Act.

The report further stated that contrary to popular view, the adoption of the Sharia law in some states of the northern parts of the country was not in anyway inconsistent with the provisions of the African Children's Charter. Rather, some provisions of Sharia are complementary to the Charter since they seek to protect children from sexual abuse and other forms of exploitation. This statement is, however, contestable given the fact that Sharia proscribes premarital sexual acts and limits the sexual autonomy of female adolescents. As pointed out in Chapter 4, this situation can lead to deleterious health

[21] K Bartlett 'Feminist Legal Methods' (1990) 103 *Harvard Law Review* 829.
[22] See Federal Ministry of Women Affairs *Nigeria's Initial and First Country Periodic Report on the Implementation of the African Union (AU) African Charter on the Rights and Welfare of the Child* (2006).

consequences for female adolescents, since they are denied access to vital information regarding their sexuality. The report also highlighted measures taken to address non-discriminatory practices against children in the country and to give recognition to the principle of the best interests of the child in all matters (including health matters) affecting children. With regard to political and social issues affecting children, the report stated that the Nigerian government has taken a number of steps to ensure the participation of children in all matters affecting them. The report for instance, mentioned the establishment of the 'Children Parliament' where children across the country are provided an avenue for airing their views on different issues affecting them.[23]

On issues affecting the health of children and adolescents, the report noted that the government of Nigeria has taken some preventative measures such as immunisation so as to combat some diseases that threaten the lives of children. Other measures include massive awareness programmes on the spread of HIV and provision of antiretroviral therapy for people infected with HIV in most parts of the country. Also, the report confirms the adoption of guidelines relating to adolescents' sexual and reproductive health. Even though this report admitted the serious impact of the HIV pandemic on young people in the country, it failed to highlight steps that have been taken by the Nigerian government to ensure access to preventive measures such as condoms or other contraceptives to protect young girls from further infection.[24] Moreover, there was no mention of steps taken to ensure that children and adolescents are assured of access to sexual health treatment, including access to contraception, without the need for parental consent. Rather, the report contained an admission that cultural practices and social factors have continued to hinder access to treatment for children and adolescents, particularly the girl child. In particular, the report notes that parental consent is still required before children can receive medical treatment and that the negative attitudes of health providers have continued to act as barriers to access to comprehensive health care services for children and adolescents.[25] This provides an indication that the Nigerian government is not taking positive measures to realise access to sexual health services for

[23] *Ibid* 43.
[24] *Ibid*.94.
[25] *Ibid* 110.

adolescents. It also indicates that the efforts being taken by the government of Nigeria to meet the health needs of adolescents have failed to address the peculiar needs of adolescent girls. In other words, these efforts have not responded to the female adolescent question.

Also, it was reported that discriminatory attitudes against children, especially the girl-child, are fuelling the spread of HIV among young people in the country.[26] Crucially, the report declared that lack of political will on the part of the Nigerian government has led to poor implementation of laws and policies relating to children and adolescents.[27] For instance, the report noted that the Nigerian government has not been forthright enough with regard to budgeting for issues affecting the needs of children and adolescents in general and their health needs in particular. These are strong indications attesting to the fact that efforts being taken by the Nigerian government to address the sexual health needs of adolescents, are falling short of its obligations under the African Children's Charter and other ratified human rights instruments relating to children and adolescents. As discussed in Chapter 6, the Committee on CRC has noted that states are obligated to take positive measures, including allocation of resources to establish youth-friendly health care services, in order to avail sexual health services to adolescents.[28] It should be noted that the African Committee of Experts is yet to issue its opinion on Nigeria's report. As a follow-up to the discussion in this section of the study, Chapter 8 highlights the ways the Committee can better advance the sexual health needs of adolescents in Africa.

It is clear from the reports submitted by the government of Nigeria to the various mentioned treaty monitoring bodies that inadequate attention has been given to the sexual health needs, especially contraceptive needs of adolescents. Measures taken by the government to ensure access to sexual health services, including services related to contraception, to adolescents are not highlighted in the reports. Moreover, no serious

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[26] *Ibid* 95.
[27] *Ibid.*
[28] See Committee on the Right of the Child, Adolescents Health and Development in the context of the Convention on the Right of the Child, General Comment N0 4 CRC/GC/2003/4 Thirty-Second Session May 2003 para 13.

efforts have been made to ensure that respect for adolescents' autonomy to seek such services is guaranteed. Also, reports by the Nigerian government are full of admissions of discriminatory practices against women and girls, but do not contain measures taken to urgently address this situation. This in a way suggests that measures that have been taken by the Nigerian government have not addressed the peculiar challenges facing adolescent girls. In other words, adolescent girls have not been placed at the centre of such measures. Concluding Observations from both the Committee on CRC and the Committee on CEDAW have confirmed that Nigeria is lagging behind in realising the sexual health needs of adolescents. Therefore, the government of Nigeria will need to show more commitment to ensuring that the sexual health needs of adolescents, especially female adolescents are realised.

7.3 Monitoring States' Obligations with regard to Adolescents Sexual Health

One way of improving states' reporting obligations with regard to adolescents' sexual health is to develop set of human rights indicators that may guide states in meeting their treaty based obligations. This can ultimately lead to better attention to the sexual health needs of adolescents in general and female adolescents in particular. It is a well known fact that unless proper avenues are created to ensure states' accountability with regard to human rights guaranteed in international, regional and national documents, these rights will amount to mere rhetoric.[29] Human rights indicators refer to information –quantitative or qualitative- that helps in telling whether duty-holders' (governments') actions or policies are in compliance with their obligations under international law or whether rights-holders (citizens) are enjoying basic rights guaranteed under international law.[30] Indicators can show trends, serve as signs, reveal symptoms and mark progress towards targets.[31] With regard to the right to health, including sexual and reproductive rights, the Committee on the ESCR has enjoined states parties to put the necessary machinery in

[29] See E Durojaye 'Monitoring the Right to Health and Sexual and Reproductive Health at the National Level: Some Considerations for African Governments' (2009) 2 *Comparative International Law Journal of Southern Africa* 227.
[30] M Greene 'What We Talk about When we Talk about Indicators: Current Approaches to Human Rights Measurement' (2001) 23 *Human Rights Quarterly* 1063, 1065.
[31] J Asher *The Right to Health: A Resource Manual for NGOs* (2004) 89.

motion with a view to using indicators and benchmarks to monitor the right to health within their jurisdictions.[32] Also, the Committee on CRC has urged states parties to the Convention to develop indicators for monitoring children's rights in line with their obligations under the Convention.[33]

Generally, monitoring of human rights involves a process where civil society groups or other bodies systematically keep track of actions or inactions of governmental institutions, non-governmental institutions or other authorities With regard to human rights of adolescents, particularly their sexual health and rights, monitoring of rights will be necessary to determine;

(i) the extent to which human rights, especially the sexual health and rights of adolescents, are being implemented;
(ii) barriers or obstacles to the realization of human rights -especially the sexual and health and rights of adolescents, and;
(iii) actual or potential violations. [34]

Human rights guaranteed in international, regional and national documents are meant to be promoted and protected. However, unless a government has shown enough commitment towards promoting and protecting rights, the different rights guaranteed in these documents will not be realisable. In other words, unless monitoring of rights is carried out (through the use of indicators) individuals (right-holders) might be deprived of their rights, while governments (duty-bearers) may shy away from their responsibilities. Landman has observed that despite the development and proliferation of international human rights instruments, disparity still exists between states' ratifications of these instruments and the actual implementation of the rights guaranteed.[35] Experience

[32] See The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 57.
[33] See for instance, Committee on the Rights of the Child, General Comment No. 2, The Role of Independent National Human Rights Institutions in the Promotion and Protection of the Rights of the Child, U.N. Doc. CRC/GC/2002/2 (2002).
[34] See Asher (note 31above) 71.
[35] T Landman 'Measuring Human Rights: Principles, Practice and Policy' (2004) 26 *Human Rights Quarterly* 906, 907.

has shown that at the national level, little attempt is made to follow-up states' obligations and commitments to implementing human rights.[36] Indeed, lack of political-will may result in failure by a state to improve on health-related budgetary allocations, policies and administrative practices (especially in relation to children and adolescents) to conform to human rights standards and principles.[37]

7.3.1 Relevance of Human Rights Indicators to Monitoring Sexual Health and Rights of Adolescents

The use of human rights indicators to monitor states' obligations in relation to children and adolescents are necessary for the following reasons:

(i) Monitoring of rights ensures that better policy formulations and opportunity to determine whether or not a state is making progress with regard to its obligations to respect, protect and fulfill adolescents sexual health and rights. Without the adoption of specific tools by a state to enable it to monitor whether or not progress is being made in the realisation of rights generally, and adolescents' sexual health and rights in particular, it will be impossible for such a state to know where it stands. Indicators are more or less warning signals informing a state about its shortcomings in living up to its obligations under international human rights law. In this regard, monitoring of rights can prevent the violation of human rights.

(ii) Monitoring rights also enables a state to identify the unintended consequences of laws, policies or practices relating to sexual health and rights of adolescents within its jurisdiction. For example, a state may enact a law or formulate a policy on children and adolescents barring access to sexual treatment, including contraceptive services, to them unless their parents or guardians consent to such treatment. While such a law or policy may be imbued with the good intention of protecting children, a likely consequence of such a law or policy will be that children and adolescents, particularly adolescent girls

[36] Asher (note 31above) 75.
[37] *Ibid.*

who have become sexually active, may avoid seeking treatment, especially sexual and reproductive health treatment, because of the fear that their confidentiality may not be respected. This may then result in deleterious consequences such as loss of health or lives for children or adolescents. The negative consequences of such a law or policy can only be revealed through constant monitoring of the implementation of laws or policies at the national level.

(iii) Monitoring of sexual health and rights of adolescents helps in revealing which actions of actors (state and non-state) are having an impact on the realisation of rights generally and the sexual health and rights of adolescents in particular. Monitoring of rights can reveal that actions of a state and some other people (non-state actors) within a state are impeding the enjoyment of the sexual and reproductive rights of adolescents. In other words, monitoring of rights ensures accountability on the part of state and non-state actors with regard to respecting sexual health and rights of adolescents. For instance, monitoring of rights may reveal that health care providers through negative practices are hindering access to sexual health services to children and adolescents within a country. This can obviously lead to the violation of the rights of adolescents and will require a state's intervention in this regard to stop such violation.

(iv) Another important aspect of monitoring human rights is the fact that it helps in bringing to the fore some neglected issues, which have often been treated with kid gloves. For instance, not until recently the sexual and reproductive health needs of children and adolescents, particularly adolescent girls, have not received sufficient attention in many African countries, including Nigeria. But through the activities of NGOs working in these areas, the deprivation of female adolescents sexual choices and health needs has been documented, thus raising concerns about the need for governments to pay more attention to their plight. Without monitoring of rights, such a lack of attention by governments may not be exposed and addressed.

It should also be noted that monitoring of sexual and reproductive rights at the national level provides a good avenue to ask the female adolescent question. During the

monitoring process questions may be asked as to how a government's laws or policies have addressed the peculiar needs of female adolescents, particularly in the context of access to contraceptive services. It may not be enough for a government to argue that it has made laws and policies relating to the sexual health of adolescents, but questions should be asked whether such laws and policies will advance female adolescents' autonomy to seek contraceptive services. Moreover, questions may be asked regarding existing laws, policies or practices to ascertain whether or not they unduly limit the sexual choices of female adolescents to access contraceptive services. If so, what are the steps being taken by the concerned government to repeal these laws or policies?

7.4 Methodology for Monitoring Sexual Health and Rights of Adolescents at the National Level

In order to determine the kind of indicators that will be necessary to monitor a state's obligations to realising the right to health, including sexual and reproductive health at the national level, an international organization known as Peoples' Health Movement (PHM) through its Right to Health and Health Care Campaign has developed a framework for monitoring governments' commitments to realising the right to health within their jurisdictions.[38] The framework consists of five important sets of questions which will serve as guidelines in ascertaining whether a government is living up to its duty to realise the right to health, including sexual and reproductive rights, in accordance with its obligations under international human rights law. The framework consists of the following questions:

(i) What are your government's commitments?

Here focus should be on the treaties a country has ratified and whether some reservations have been entered to those treaties. It will also include whether a state is a signatory to important consensus statements or declarations relevant to the sexual

[38] See Peoples' Health Movement (PHM) *The Assessment of the Right to Health and Health Care at the Country Level: A People's Health Movement Guide* (2006) 2-16.

health needs of adolescents. Issues such as whether there is a constitutional provision recognising the right to health as a justiciable right within a country or whether a state has adopted relevant laws and policies with regard to the right to health of adolescents will be important here.

(ii) Are your government's policies appropriate to fulfill these obligations?

In this part, the focus will be on laws and policies relating to the right to health, including sexual and reproductive health care services, particularly for adolescents. Also, it will be important to know whether these laws or policies are addressing important issues such as women's health, HIV/AIDS, STIs, teenage pregnancies and access to contraceptive services for adolescents. It will also be interesting to find out how these laws and policies are made. That is, whether the process was participatory involving affected communities, women, children and adolescents, people living with HIV etc. Issues such as privatization in the health care sector, user fees, quality of pharmaceutical products, and budgetary allocation to the health sector, particularly sexual health needs of adolescents, will equally be important to address here

(iii) Is the health system in your country adequately implementing interventions to realise the right to health and health care?

Here focus should be on availability, accessibility, acceptability and quality of health care services to the population, especially vulnerable groups such as women, children, and adolescents. Some important statistics such as the percentage of rural women and girls having access to sexual health services in comparison with their urban counterparts, the percentage of people with disability accessing health care services and the percentage of adolescents seeking sexual and reproductive health care services will be needed here.

(iv)Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?

Here the focus will be on efforts made by the government to remove barriers to health care services for the population, especially vulnerable and marginalised groups such as women, adolescents and people living with HIV. Information about the impact of governments' laws and policies relating to the right to health, including sexual and reproductive health care, on the lives of the vulnerable groups will be required here. Issues such as life expectancy, causes of death for adolescents which must be disaggregated for boys and girls and rural and urban, and measures taken to address teenage pregnancy or to reduce marginalisation of women and girls will need to be measured here.

(v) What does the denial of or fulfillment of the right to health including sexual and reproductive health in your country mean?

The focus here should be on which part of the core obligations of the right to health is not being met by a government at the moment. It should also address whether a government is moving towards universal access to health, including sexual and reproductive health care for the population, particularly the vulnerable and marginalised groups. Also, focus here will be on whether a government is taking retrogressive steps towards realising access to the health care services to the vulnerable and marginalised groups such as women, children and adolescents. In addition it might be necessary to ascertain which aspect of the right to health the government or any other duty bearer is violating.

This approach by PHM will no doubt provide human rights organizations and other institutions interested in monitoring states' obligations in relation to the sexual health and rights of adolescents, with a good framework to carry out this task. Indeed, this framework can be applied to an issue such as ensuring access to sexual health information and services for adolescents in a country. It is important to note that the female adolescent question must be asked at every stage of the assessment. In other words, the monitoring of rights at the national level must be gender-sensitive. This will

enable it to ascertain whether a state is making progress towards realising the sexual health needs of female adolescents.

MAIN AREAS TO ASSESS	RELEVANT ISSUES TO EXPLORE
1. What are your government's commitments? 1.1 What international or regional human rights instruments and consensus documents relating to the health needs of children and adolescents have your country ratified or signed?	Instruments such as the CRC, CEDAW, ICESCR, African Charter, African Children's Charter and the African Women's Protocol will be relevant here Consensus documents such as ICPD, Beijing Platform, ICPD+5, Beinjing+5, MDGs, World Summit on Children, Abuja Declaration, Maputo Declaration on Universal Access to Sexual and Reproductive Health services.
1.2 What national constitution, laws and policies exist in relation to the health of children and adolescents in your country?	Whether the provisions of the constitution explicitly recognize the right to health of children or adolescents or whether other provisions of constitution can be indirectly invoked to ensure access to sexual and reproductive health services for children and adolescents Whether the constitution recognizes the principles of the best interests of the child or the evolving capacities of the child. Whether there are other legislation in the country specially addressing the health needs including sexual and reproductive health of adolescents in the country Whether policies exists in the country that relate to the health needs including sexual and reproductive health needs of

	adolescents Do these polices refer to the integration of sexual and reproductive health services for adolescents or young people into primary health care services? Do they specifically refer to ensuring access to contraception for adolescents? Do they refer to ensuring universal sexual and reproductive health care services for adolescents? Do these policies specify amounts to be allocated to health needs of adolescents?
2. **Are your government's policies appropriate to fulfill these obligations?** 2.1 Which are the main policies and programmes relating to the sexual health needs of adolescents in your country?	Checklist • National strategy on reproductive health policy for adolescents • Adolescents/ Reproductive/ Family Planning/ Population policy • Women/Gender Policy • HIV/AIDS/STIs Policy • Curriculum on Sexuality/ Family Life education • Programmes on: Reducing teenage pregnancy Preventing STIs including HIV/AIDS Contraception awareness especially in rural areas.
2.2 Who are those involved in the development and implementation on	Whether the drafting of laws and policies relating to adolescents involves different

policies relating to adolescents' health in your country?	stakeholders including children, adolescents, parents, community or religious leaders, and governmental and non-governmental institutions. Are there bodies or institutions that adolescents can go to lodge complaints in the event of a violation of their right to health including sexual and reproductive health? If so are these bodies or institutions being used? Do these institutions or bodies provide appropriate redress for violations of rights?
2.3 What are the major issues relating to adolescents' health going on in your country?	What reforms are taking place in the health sector relating to adolescents and young people? Have public health services been privatized? If so what are the effects for access to health services for children and adolescents? What is the effect of user fees for adolescents, particularly female adolescents? Do health providers involve children or adolescents in decision relating to their health needs?
2,4 What proportion of the national budget is allocated to health in general	What is the government expenditure on health as a percentage of GDP?

and sexual and reproductive health in particular?	What is the overall (public and private) per capita spending on health care including sexual and reproductive health care? What is the percentage of government spending as a proportion of the total expenditure on health care? Has this percentage been falling? Does the health care system function to transfer money from taxpayers and patients to private enterprises? What is the government per capita spending in rural areas compared to urban areas? (In 2000, the World Health Organization estimated that $60 per person per year was needed for reasonable health care). How does the above compare with other countries with the same level of development?
2.5 Are there sufficient and qualified health care providers to meet the sexual and reproductive health needs of adolescents?	Some checklist to consider Ratio of doctors to population in rural areas compared to urban, • Availability of staff in different regions (particularly minority areas) to meet the special needs of adolescents , • Diversity of health care providers to reflect differences in religious and cultural background • Balance between female and male staff, especially in decision-making positions, • Number and quality of staff available for special needs of adolescents and young people, • Emigration of health staff, • Is the training of health staff adequate for the needs of the country.

3 **Is the health system in your country adequately implementing intervention to realize the right to health including sexual and reproductive health for adolescents?** 3.1 What is the position with regard to the availability of the health including sexual and reproductive health services, goods and facilities? What is being done by your government to ensure availability for vulnerable groups such as adolescents?	Some issues to consider will include; Effective and functioning health care including sexual and reproductive health care services for adolescents? The inputs and resources exist to ensure adequate and effective services to adolescents exist. Ensuring that proper attention is given to the health needs and sexual and reproductive health needs of adolescents.
3.2 What is the government doing to ensure access to quality and acceptability of health care services, goods and facilities including sexual and reproductive health care services for adolescents?	Issues to consider Government's regulation of the medical profession so as to ensure quality and standards in accordance with international requirements. Availability of health care goods and services such as contraception to meet the needs of adolescents Do health care services and goods meet the needs of adolescents? Are health care services • Respectful of adolescents' dignity? • Respectful of adolescents' privacy and confidentiality? • Sensitive to the peculiar needs of

	female adolescents?
4..**Does the health status of different social groups and the population as a whole reflect a progression in their right to health and health care?** 4.1 What steps are being taken by the government to remove barriers to the enjoyment of the right to health including sexual and reproductive health for adolescents?	Issues to consider will include • Measures taken to meet the specific sexual and reproductive health care of adolescents • Respecting the autonomy of adolescents to seek sexual and reproductive health care services and information • Measures taken to remove discrimination and stigma against adolescent seeking sexual and reproductive health care services such as HIV/AIDS, contraception and other STIs.
4.2 Can it be said that the health care service system is discriminatory?	Issues to consider How does the health system treat female adolescents? Is parental consent required before access to sexual and health information and services? Are adolescents seeking health services discriminated against on the following grounds: • Sex/gender • Religion • Ethnicity

	• Sexual orientation • Marital status?

Adapted with modifications from Peoples' Health Movement Guide *Assessment of the Right to Health and Health Care at the Country Level* (2006).

7.5 Conclusion

This chapter has examined Nigeria's reporting obligations to treaty monitoring bodies such as the Committee on CRC, Committee on CEDAW and the Expert Committee of the African Children's Charter. The discussion demonstrated that efforts made by the Nigerian government to ensure access to sexual health services, including contraceptive services for adolescents, especially female adolescents, do not adequately satisfy its obligations under international law. Although laws and policies have been made and programmes have been developed, all have not really addressed the peculiar needs of female adolescents in the country. This indicates that Nigeria is not taking concrete steps to address the female adolescents question in its laws, policies and programmes relating to the sexual health needs of adolescents. The fact that adolescent girls are still subjected to discriminatory cultural and religious practices, which deter them from fully having access to sexual health services, is an indication of the inappropriateness of the measures taken by the Nigerian government to advance the sexual health of female adolescents. Therefore, it will be necessary for the Nigerian government to design and implement gender-sensitive policies and programmes that are capable of advancing female adolescents sexual autonomy to seek contraceptive services in the country. Moreover, the government must ensure that it repeals or abolishes laws, policies and practices that prevent female adolescents from exercising their sexual choices to seek contraceptive services.

This chapter has also shown that monitoring of sexual and reproductive rights at the national levels by NGOs and civil society groups can help a government to improve on

its reporting obligations and focus more on the needs of vulnerable groups such as female adolescents. Monitoring of sexual health and rights of adolescents at the national level keeps a government on its toes with regard to its obligations in ratified treaties to make sexual health services available to adolescents, especially female adolescents. In most cases, government reports to treaty bodies tend to either under report violations of rights or exaggerate steps taken to realize rights, hence, the need for the involvement of NGOs and civil society groups in the reporting obligations of a state to treaty monitoring bodies.

NGOs and civil society groups can serve as important resource materials to a government in meeting its reporting obligations as regards adolescents sexual health and can even provide alternative reports to treaty monitoring bodies.[39] Alternative reports by NGOs and civil society groups are often found very useful by treaty bodies (since they usually contain independent and fairly accurate reports) as they enable these bodies to issue more balanced Concluding Observations or Recommendations to states parties. This can help a government not only to improve its reporting obligations to treaty bodies, but also to advance the sexual health needs of adolescents. Monitoring of rights at the national level is more likely to be successful where there is cooperation between governmental institutions and non-governmental organizations. Ultimately, monitoring of sexual and reproductive rights of adolescents ensures that a government is more accountable to meeting the sexual health needs of adolescents, particularly female adolescents.

One major challenge to effective monitoring of rights by NGOs or civil society groups at the national level in most developing countries is the lack of expertise or financial resources to enable such an activity to be carried out.[40] It is a well-known fact that some NGOs claiming to be working on children and adolescents' rights sometimes lack the knowledge and expertise with regard to the reporting process of treaty bodies such as the Committee on the CRC or the Experts Committee of the African Children's Charter. This lack of knowledge or expertise often makes it difficult for NGOs and civil society groups

[39] See L Woll 'Reporting to the UN Committee on the Rights of the Child: A Catalyst for Domestic Debate and Policy Change' (2000) *International Journal of Children's Rights* 71.
[40] *Ibid* 78.

to assist governments in meeting their reporting obligations under the ratified treaties and realizing children's and adolescents' sexual health needs.

CHAPTER 8

THE ROLE OF COURTS AND REGIONAL HUMAN RIGHTS BODIES IN REALISING ACCESS TO CONTRACEPTION FOR ADOLESCENTS

8.1 Introduction

Courts, regional human rights bodies and other institutions such as national human rights institutions (NHRIs) and non-governmental organisations (NGOs) have important roles to play in advancing the sexual health needs of adolescents, especially with regard to access to contraception. These institutions or bodies, as discussed in Chapter 7, can play great roles in monitoring governments' obligations to realising the sexual health needs of adolescents in their countries. They can also work together with governments to ensure speedy realisation of adolescents' sexual health needs. However, the focus of this chapter will be on the important roles of national courts and regional human rights bodies such as the African Committee of Experts on the Rights and Welfare of the Child in advancing the sexual health needs of adolescents, particularly with regard to access to contraception. However, due to the fact that courts are in the best position to provide remedies for the violations of rights at the national level and coupled with the problem of remoteness of remedies provided by international or regional bodies, the discussion in the chapter has paid greater attention to courts than regional human rights bodies.

Generally, courts are regarded as the last hope for the masses, particularly vulnerable and marginalised groups such as women, children, the poor and adolescents. Courts can hold governments accountable for their failure to live up to their obligation of realising the sexual health and rights of adolescents as guaranteed under national constitutions or international human rights instruments. Also, courts can set standards which will guide governments in ensuring the realisation of the right to health, including sexual health and rights of adolescents. Courts have the primary responsibility to interpret the law and give life to the provisions of laws generally. In this regard, courts are expected to demonstrate a level of activism and creativeness in advancing the human rights of citizens. In some

cases, courts have been found to champion legal reform through their decisions. For instance, the first recognition for the right to abortion in the United States was not through legislation, but rather, through judicial decision in the case of *Roe v Wade*.[1] Also, courts can become catalysts for change and transformation in society through their decisions. However, the extent of the roles courts can play in advancing health-related rights, including sexual and reproductive rights, will depend largely on the ability of courts to purposively interpret the provisions of constitutions and other laws. In Chapter 5, this study has shown that the potential of laws and policies to advance the sexual health of adolescents will depend on the interpretation given by the courts. Thus, this chapter examines how courts and regional human rights bodies can effectively realise the sexual health and rights of adolescents. More particularly, the chapter discusses how courts and regional human rights bodies can advance the autonomous decision-making powers of female adolescents by asking the female adolescent question. The discussion in this chapter benefits largely from courts' decisions in Britain, South Africa and Colombia. Before examining the roles of courts and regional bodies in the advancement of the sexual health of female adolescents, the chapter briefly discusses some challenges that may limit the positive roles of the courts in advancing adolescents' sexual health and rights at the national level.

8.2 Judicial Obstacles to the Realisation of Access to Sexual Health Services for Adolescents

The judiciary as an organ of state plays a crucial role in the promotion and protection of human rights in any society. Apart from resolving disputes between different levels of government and among individuals, it also safeguards the human rights of citizens, especially the vulnerable groups, by acting as a check on the excesses of other arms of government. For this reason, the court is sometimes referred to as the 'last hope of the common people'. Under the Nigerian Constitution the important roles of the courts are well recognized. For instance, section 6 of the Constitution provides as follows:

[1] (1973) 410 US 113.

The judicial powers vested in accordance with the foregoing provisions of this section -

(a) shall extend, notwithstanding anything to the contrary in this constitution, to all inherent powers and sanctions of a court of law

(b) shall extend, to all matters between persons, or between government or authority and to any persons in Nigeria, and to all actions and proceedings relating thereto, for the determination of any question as to the civil rights and obligations of that person;

(c) shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act of omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution.

These provisions clearly show that Nigerian courts are accorded wide powers to determine cases touching on different subject matters, save issues contained in Chapter II of the Constitution.[2] Additionally, section 46 of the Constitution contains an important provision which empowers the courts to give effect to the human rights provisions contained in Chapter IV. This section provides as follows:

(1) Any person who alleges that any of the provisions of this Chapter has been, is being or likely to be contravened in any State in relation to him may apply to a High Court in that State for redress.

(2) Subject to the provisions of this Constitution, a High Court shall have original jurisdiction to hear and determine any application made to it in pursuance of this section and may make such orders, issue such writs and give such directions as it may consider appropriate for the purpose of enforcement or securing the enforcing within that State of any right to which the person who makes the application may be entitled under this Chapter.

The combined reading of the above provisions of the Constitution would seem to provide a window of opportunity for actions to be instituted on behalf of adolescents before Nigerian courts, in order to realise their fundamental rights, including their sexual health and rights. For instance, an action can be instituted on behalf of adolescents to challenge the legality of a law or policy purporting to deny access to contraception for adolescents, especially female adolescents, either by reason of age or sex. As discussed in Chapter 5, constitutional provisions on the rights to life, dignity and non-discrimination can be

[2] See Chapter 4 of this study for a detailed discussion on the legal implication of section 6 (6) (c) of the Constitution.

invoked to advance the sexual health of adolescents. Therefore, Nigerian courts will need to be creative in interpreting the provisions of the Constitution in human rights cases, including violations relating to the right to health.

Despite the opportunity afforded by the provisions of the Constitution, issues relating to health generally and the sexual health of adolescents in particular, remain very controversial. Although the right to health, including sexual and reproductive rights, has been given recognition under international law, judicial enforcement of this right both at national and international levels has remained a bit slow. Courts generally, have remained skeptical about the nature and scope of the right to health. This is mainly due to the fact that the right to health forms part of social and economic rights that have often been regarded as non-justiciable.[3] It is equally believed that enforcing the right to health will erode the principle of the separation of powers. This reluctance by courts to enforce the right to health and other social and economic rights is evident in judicial deference to social and economic policy,[4] an unwillingness to accord socio-economic claims as invoking any 'fundamental values' within the powers of the courts to protect,[5] and a strong skepticism to recognise and give effect to 'positive' obligations relating to social welfare. In other words, it is often assumed that courts are not in the best position to make decisions intersecting with government's policies as this responsibility is best left to the executive or legislative arm of government.[6] This is based on the fact that decisions touching on policies have some financial implications which are not within the powers of courts to make.[7]

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[3] See L Fuller 'The Forms and Limits of Adjudication'(1978) 92 *Harvard Law Review* 352, 394; see also T Evans 'A Human Right to Health?' (2002) 23 *Third World Quarterly* 200.

[4] See for instance, the US case of *Dandridge v Williams* 397 US 471 (1970). The court had noted that the social, economic and even philosophical challenges often posed by public welfare programmes are not the business of the court.

[5] See for instance, the case of *Andrews v Law Society of British Columbia* (1989) 1 SCR 123 where Justice La Forest notes that the role of the court is not to second guess policy decisions but rather that the major responsibility of the court is to protect against any incursion into fundamental rights and values of the people.

[6] L Lester & C O'Cinneide 'The Effective Protection of Social-Economic Rights' in Y Ghai & J Cottrell (eds) *Economic, Social Cultural Rights in Practice* (2004) 17, 19.

[7] *Ibid.*

Consequently, health-related issues have been viewed as largely political rather than legal matters. This has led to a situation where domestic courts 'have been relatively reluctant to review health policies from human rights perspective', believing that doing so may exceed the appropriate democratic functions of the judiciary.[8] Such reluctance also affects issues relating to access to contraception for adolescents, which is a component of the right to health. An alternative argument to this debate, however, is that courts have the duty to monitor the activities of the other arms of government and that this can be done sometimes by ordering the other arms of government to perform certain acts.[9] This will not in any way interfere with the principle of separation of powers

The right to health has been recognised to various degrees in nearly two-thirds of national constitutions worldwide.[10] While the majority of these constitutions merely include the right to health under the directive policies of government, a few others, such as the South African Constitution, have explicitly recognised the right to health as a justiciable right. As discussed earlier in Chapter 4, the Nigerian Constitution does not recognise the right to health as a justiciable right. The implication of this is that Nigerian courts may be unwilling to affirm an adolescent's right to access contraceptive services. Indeed, there exists a dearth of jurisprudence on the right to health in the country. With the exception of the decision of a High Court in *Festus Odaife*[11] case, mentioned earlier, the Nigerian Supreme Court is yet to adjudicate on a case specifically relating to the violation of the right to health in the country. Even in South Africa where the right to health, including reproductive health care, has been explicitly recognised, courts have sometimes hesitated to affirm this right based on a lack of resources. For instance, in *Soobramoney*[12] case, the Constitutional Court relying on the test of rationality held that the inability of a government hospital to provide renal dialysis to a man was not in violation of the right to

[8] See L Forman 'Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy' (2006) *Journal of Law, Medicine and Ethics* 711.
[9] A An-Na'im 'To Affirm the Full Human Rights Standing of Economic, Social & Cultural Rights' in Y Ghai & J Cottrell (eds) *Economic, Social Cultural Rights in Practice* (2004) 7.
[10] See for instance, ED Kinney & BA Clark 'Provisions of Health and Health Care in the Constitutions of the World' (2004) *Cornell International Law Journal* 285.
[11] *Festus Odaife and others v Attorney General of the Federation and others* (2004) AHRLR 205 (NgHC 2004).
[12] *Soobramoney v Minister of Health, KwaZulu-Natal* [1997] 6 BCLR 78 (CC).

emergency care under the Constitution, since providing such treatment had some financial implications which could not be provided by the government. [13]

However, in one of its subsequent decisions, the Constitutional Court has taken a positive and radical step by directing the other arms of government to perform certain acts that will advance the right to health of the people. For instance, in the *Treatment Action Campaign*[14] case, the South African Constitutional Court ordered the government to put in place plans with a view to making available antiretroviral drugs (ARVs) that will prevent mother-to-child transmission of HIV in public health institutions in the country. The Court rejected the government's excuse of a lack of resources for its inability to make available ARVs to prevent mother-to-child transmission of HIV in public health institutions, claiming that it was unfounded. Moreover, the Court held that government's policies relating to access to life-saving medications for HIV/AIDS in the country had been unreasonable having failed to meet the needs of those in dire need. It therefore, ordered the government to commence a programme for the rolling out of ARVs to prevent mother-to-child transmission of HIV. This radical approach by the court affirms the view that in certain circumstances, it might be necessary for the court to evaluate laws and policies relating to the right to health, including sexual and reproductive health.

The decision in the *TAC* case underlies the important role of the courts in holding a government accountable to its obligations to realise the right to health, including sexual and reproductive health. It equally affirms the relevance of litigation as a tool for monitoring a government's obligations under national and international human rights documents to safeguard the right to health. In the words of Forman, the decision in *Treatment Action Campaign* 'broke the deadlock on a social struggle where political debates had consistently failed to achieve satisfactory outcome'.[15] The decision of the Court ordering the executive to commence a roll out programme for antiretroviral drugs to prevent mother-to-child transmission of HIV shows that courts can play an important

[13] For a critical appraisal of this decision, see C Ngwena 'The Historical Development of Modern South African Health-care System: From Privilege to Egalitarianism' (2004) *De Jure* 290.
[14] *Minister for Health v Treatment Action Campaign and others* [2002] 10 BCLR 1033 (CC).
[15] Forman (note 8 above) 719.

role in realising access to health goods and services. It also confirms the fact that, contrary to the deference position adopted in *Soobramoney*, courts can serve as a vital check on the other arms of government. This position can be useful to Nigerian courts in assessing laws and policies relating to access to contraception for adolescents in the country. It may also help Nigerian courts in assessing the effectiveness of policies and programmes developed by the Nigerian government with regard to access to contraception for adolescents.

In addition to the problem of justicability of the right to health, including sexual and reproductive rights, another challenge to realising adolescents' sexual health in court is the problem of the cost of litigation. In most legal systems, the cost of filing cases and securing the services of a legal practitioner is often prohibitive and almost unaffordable to vulnerable groups such as women, children and adolescents. Commenting on this challenge, Cook *et al* have noted that 'the transcending problem with the courts of law is that the justice they offer is frequently practically inaccessible to many people and interests'.[16] Thus, even when members of vulnerable groups have a genuine case to pursue in court they tend to shy away from seeking redress due to cost. This is particularly true of the Nigerian situation, where the justice system is to a great extent unfriendly to the poor and the disadvantaged in society. Adolescents are most likely to be affected by this problem as the majority do not have an independent source of income and depend largely on their parents or guardians. Added to this problem are delays in the administration of justice. It is an established fact that cases take a long time to be resolved in Nigeria. This often discourages people from seeking justice even when their rights have been violated. Moreover, this delay can particularly serve as a barrier to adolescents seeking redress for violation of their sexual health and rights in relation to access to contraception. Despite these challenges, however, the courts remain the most appropriate institution for safeguarding individuals' rights at the national level.

[16] See RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicines, Ethics and Law* (2003) 235.

8.3 Judicial Decisions Relating to Sexual Health Needs of Adolescents

As regards sensitive issues such as advancing the sexual health needs of adolescents, courts can interpret the law purposively so as to remove any barrier created under the law to adolescents' access to sexual health information and services. This will be necessary where the provisions of laws are unclear or conflicting with one another. In doing this, it will be necessary for courts to bear in mind the female adolescent question. In other words, the implications of a court's decision on the health of female adolescents should always be prioritized, because of their disadvantaged position in society and their susceptibility to sexual ill health. Cook has observed that courts can play a great role in holding governments accountable for failure to protect individuals' right to health either by allowing their agencies or private agencies to trample on the rights of citizens.[17] Judicial decisions often lay down precedents which are followed in subsequent court decisions.

In dealing with issues relating to the sexual health needs of adolescents, it may be useful for Nigerian courts to adopt the 'practical measure'[18] approach. This allows the courts to critically evaluate steps taken by the Nigerian government in realising the right to health of its citizens in general, and access to contraception for adolescents in particular. Whenever courts are faced with a case dealing with human rights violations in the context of access to contraception for adolescents, Nigerian courts may draw inspiration from international norms or standards and from the experiences of courts in other jurisdictions to ask the following questions:

- To what extent do policy and budgetary measures respect, protect and fulfil the right to health care services, particularly for vulnerable groups such as adolescents?
- Do these measures prioritise access to contraception for adolescents?

[17] RJ Cook 'Exploring Fairness in Health Care Reform' (2004) 29 *Journal of Juridical Science* 1, 7.
[18] See B Twinomugisha 'Exploring Judicial Strategies to Protect the Right to Access to Emergency Obstetrics Care in Uganda' (2007) 7 *African Human Rights Law Journal* 298.

- Are these measures faithful to accessibility, availability, acceptability and good quality in the context of access to contraception for adolescents in general and female adolescents in particular?
- Do these measures recognize the evolving capacities (autonomy) of adolescents on matters relating to their sexuality?
- How justified or reasonable are the measures?
- What are the gender implications of such measures?

These questions are by no means exhaustive, but rather, are only intended to serve as guides for the courts when dealing with issues relating to adolescents' sexual health in the context of access to contraception. Therefore, Nigerian courts are at liberty to further develop other relevant questions depending on the circumstances of a case. However, recourse to such questions as these will help the courts in coming to a logical conclusion on issues bordering on access to sexual health services (including contraceptive services) for adolescents. In addition, the set of indicators relating to adolescents' sexual health and rights discussed in Chapter 7 will equally be useful to the courts in determining the level of commitment of a government towards realising access to sexual health services for adolescents. For instance, a court may wish to know the nature of laws and policies that have been enacted in relation to access to sexual health services for adolescents. And whether these laws or policies facilitate or hinder access to sexual health services to adolescents, particularly female adolescents.

The significance of adopting the above mentioned set of questions and indicators, lies in the fact that they serve as a marking scheme for courts in determining governments' commitment to respecting, protecting and fulfilling the sexual health and rights of adolescents. In other words, they can serve as good criteria in assessing Nigeria's commitment to advancing the sexual health and rights of adolescents. Moreover, these questions will help Nigerian courts to achieve consistency in their decisions when dealing with issues such as access to sexual health services for adolescents.

Regarding the sexual health needs of adolescents, Nigerian courts are yet to make any pronouncement on such issues. Therefore, it is important to examine the approaches of courts in other Commonwealth jurisdictions (such as Britain and South Africa) with similar historical backgrounds or legal systems as Nigeria. In addition, decisions of courts in other jurisdictions that do not share the same legal system with Nigeria can also be helpful, especially if they serve as best practices on sensitive issues such as access to sexual health services for adolescents. These decisions will be evaluated based on two broad sub-headings affirmation of adolescents decision-making capability (autonomy) and recognizing the gender dimension of adolescents' decision-making powers (asking the female adolescent question).

8.3.1 Recognition of Adolescents' Decision–making Capability

As noted in Chapter 2, the capability of adolescents to exercise full decision-making powers with respect to sexual health matters is often doubted, hence the need to involve parents, guardians, the court or even health care providers. Although the need to involve a third party in decision-making by an adolescent is often stronger in cases relating to invasive medical treatment such as abortion, nonetheless, this requirement has been applied to all cases involving adolescents. With regard to abortion, it is believed that taking a decision on this issue involves emotional and psychological challenges, which an adolescent may not be competent to handle. Thus, in jurisdictions such as United Kingdom and United States, the involvement of third parties (parents, courts or health care providers) is often mandated in order to ensure that the adolescent come to a reasonable decision-making conclusion.[19]

In the context of contraception, experience has also shown that adolescents are often required to involve third parties before they are allowed access. For instance, in Nigeria, the involvement of parents and guardians in the treatment of adolescents is widely

[19] Third- party involvements in adolescents abortion decision-making are justified on two assumptions. First, that the involvement of third party often improves the moral quality of young women's abortion. Second, improvements in the moral quality of adolescents' abortion decision-making are required.

recognised.[20] This approach is rooted in paternalism or what Cook and Bernard referred to as 'parentalism'.[21] It is generally believed that parents or guardians have the moral and social responsibility to look after their children and wards. This responsibility includes providing for the health needs of adolescents. Thus, adolescents seeking medical advice, including sexual health advice, are expected to obtain their parents' consent before such an advice is rendered. While Nigerian courts are yet to address this issue, the decision of the House of Lords in *Gillick* case[22] centres on this controversial issue. In that case, a claimant had challenged as unlawful a guidance issued by the Secretary of State permitting a person under 16 to seek contraceptive advice and treatment. The question for determination before the court was whether a doctor could lawfully give contraceptive advice or treatment to a girl under 16 without the consent of the girl's parents. The majority decision of the Court was of the view that a doctor could lawfully give such an advice and treatment to such a girl if it was established that she had 'sufficient maturity and intelligence' to understand the nature and implications of the proposed treatment sought, and provided that certain conditions were fulfilled.

The approach adopted by the majority of the Court in that case seems to have taken into consideration the peculiar life experiences of young women seeking sexual health services. Rather than the conservative and restrictive approach of the minority in that case,[23] the majority had taken a more realistic approach by examining the incidence of teenage pregnancy among young women in Britain and the need to address such a challenge. According to the majority, rather than imposing a blanket restriction on a girl under 16 from consenting to sexual health treatment, the important consideration should be whether such a girl has the maturity to understand the nature of treatment being

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[20] This is based on the position at common law, which Nigeria inherited from its colonial master-Great Britain.

[21] RJ Cook & B Dickens 'Recognising Adolescents' "Evolving Capacities" to exercise Choice in Reproductive Healthcare' (2000) 70 *International Journal of Gynaecology and Obstetrics* 13, 15.

[22] *Gillick* v *West Norfolk and Wisbech Health Authority and Department of Health and Social Security*[1986] 1 AC 112 (House of Lords).

[23] The minority led by Justice Brandon had reasoned that a doctor could not provide sexual health treatment to a girl under the age of 16 without parental consent. This reasoning was based on the fact that such a girl could not have developed the maturity to consent to such treatment. Therefore, the minority submits that providing sexual health treatment to a girl under 16 will amount to aiding of a criminal offence under the Sexual Offences Act of 1956.

provided and the implications of such treatment. Although the majority admitted that the right thing to do would be for the doctor to advise the girl to inform her parents of such treatment, however, if she declines to do so, treatment should not be denied if she has exhibited the maturity to understand the nature of the treatment and its implications. In the view of the majority, 'parental rights to control a child do not exist for the benefit of the parent. They exist for the benefit of the child and they are justified only in so far as they enable the parent to perform his(sic) duties towards the child and towards other children in the family'.[24] This would seem not only to be a realistic approach, but also a gender-sensitive approach. Experience has shown that most of the adolescents who require sexual health treatment are females, therefore, the issue of parental consent (though affects all adolescents) tends to have more serious implications for female adolescents than their male counterparts.

The anti-Gillick judges (minority decision made up of Lords Brandon and Templeman) failed to see the gender implications of insisting that a girl under 16, who is seeking sexual health treatment, must obtain parental consent before being attended to by a health care provider. They had reasoned that a girl under 16 lacked the capacity to consent to contraceptive treatment without parental consent. The basis of the anti-Gillick judges' reasoning was rooted in conservatism and moral sentiment. For instance, Lord Brandon reasoned that to provide contraceptive advice to a girl under 16, to examine her with a view to her using contraception and to prescribe contraceptive treatment for her would encourage or facilitate the commission of an offence under the Sexual Offences Act of 1956.[25]

In Lord Templeman's view, a girl under 16 could not be said to be 'sufficiently mature' enough as to engage in sexual intercourse and thus be able to give valid consent to medical treatment, particularly with regard to contraceptive treatment. He too relied on the provision of the Sexual Offences Act to come to the conclusion that it was never the intention of the parliament to confer autonomy on a girl under 16 to make crucial

[24] *Gillick* case (note 22 above) Per Lord Fraser 170 D-E.
[25] This piece of legislation makes it a criminal offence to provide contraceptive facilities to a girl below 16 years of age.

decisions regarding her life. Lord Templeman reasoned further that parents have the right under the law to make decisions on behalf of 'the infants' on all matters in which 'the infant' is unable to decide.[26] To him, it may be possible for an infant to consent to a medical treatment in certain circumstances depending on his or her age of understanding. However, he concluded that a girl under 16 is incompetent to make decisions in relation to contraceptive treatment.

Two important conclusions can be drawn from the reasoning of the anti-Gillick judges. One is that, children are not 'persons' and therefore are not entitled to the rights of 'personhood' usually enjoyed by persons, that is, adults, particularly with regard to contraceptive services. The second is that, children are incompetent and immature and therefore, they do not possess the right to self-determination, albeit in relation to contraceptive treatment.[27] According to Erdman, these conclusions are not only misleading but also reinforce the paternalistic view of children.[28] She argues further that empirical evidence has shown that the involvement of a third party in adolescents' sexual health decision-making does not necessarily improve the quality of such decisions.

However, the pro-Gillick judges (majority decision made up of Lords Fraser, Scarman and Bridge) were more eager to advance the autonomy of a girl under the age of 16 by holding that a doctor could, in certain circumstances, provide contraceptive treatment to her without parental consent or knowledge. Lord Scarman rejected the argument of the anti-Gillick judges that parliament never intended to confer autonomous decision-making power on a girl under 16, claiming that there was nothing in the law to suggest this restrictive interpretation. According to him, the law has never treated the powers of parents over their children as 'sovereign' and 'unquestionable', rather such rights existed for the benefits and welfare of the child and must be exercised only if they are in the best interests of the child. In other words, the exercise of parental rights and responsibilities

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[26] J Pilcher 'Contrary *Gillick:* British Children and Sexual Rights since 1985' (1997) *International Journal of Children's Rights* 299, 304.
[27] *Ibid.*
[28] See J Erdman 'Moral Authority in English and American Abortion Law' in S Williams (ed) *Constituting Equality: Gender Equality and Constitutional Law* (2009) 107, 118, Erdman has argued that there is no basis for these assumptions as English Constitutional law has always denied the state authority to impose a third party veto over the decision-making capability of an adolescent based on age alone.

over the child is only justifiable if it satisfies the 'best interests' principle. Lord Scarman then summed up his argument in these words:

> [A]s a matter of law, the parental right to determine whether or not their minor child below the age of 16 will have medical treatment terminates, if and when the child attains a sufficient understanding and intelligence to enable him (sic) to understand fully what is proposed.[29]

After a careful review of important laws such as the Sexual Offences Act and other legislation, the majority came to the conclusion that none of these laws suggests that a child under the age of 16 cannot consent to contraceptive advice or treatment. In coming to such a decision, a doctor must consider the following conditions often referred to as 'Lord Fraser's Guidelines': (i) that the girl (although under 16 years of age) will understand the doctor's advice (ii) that the doctor cannot persuade the girl to inform her parents that she is seeking contraceptive advice (iii) that the girl is very likely to begin or continue having sexual intercourse with or without contraceptive treatment (iv) that unless she receives contraceptive advice or treatment, her physical and /or mental health are likely to suffer (v) that her best interests require the doctor to give her contraceptive advice and/or treatment without parental consent.[30]

These requirements, which must be satisfied by a girl under the age of 16 before being provided with contraceptive services, are intended to advance the sexual autonomy of adolescent girls to seek sexual health services, especially with regard to contraception. In other words, a girl under the age of 16, who is '*Gillick*-competent,'[31] will be regarded as mature and capable of making lawful decisions to seek contraceptive services without the need for parental consent. This is consistent with the principle of the evolving capacities of the child recognised in both the CRC and the African Children's Charter.

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[29] *Gillick* case (note 22 above) 423.
[30] *Ibid* 413.
[31] G Douglas 'The Retreat from *Gillick* '(1992) *Modern Law Review* 569.

In *Axon* case,[32] the court seems to have followed the same approach by the majority in the *Gillick* decision. In that case, a mother of five daughters challenged a health Guidance purporting to allow a girl under 16 to seek contraceptive advice and treatment without parental consent. According to Mrs Axon, such a health Guidance is unlawful and illegal. Justice Silber adopted wholly the reasoning of the pro-*Gillick* judges to refuse the application of Mrs. Axon challenging the health Guidance in question. He rejected the argument that a health Guidance, which allows a girl under 16 to seek sexual health treatment without parental consent or knowledge, was illegal or unlawful. According to him, 'the very basis and nature of the information which a doctor or a medical professional receives relating to the sexual and reproductive health of any patient of whatever age deserves the highest degree of confidentiality...'[33] The Court was not convinced by the argument that allowing a girl under 16 to consent to sexual health treatment would interfere with the right to family life.

While admitting that this issue may potentially pit the rights of parents against those of the child, the Court resolved that in such situations a balance must be struck between the conflicting interests. Relying on the decision of the European Court on Human Rights in the case of *Yousef v Netherlands,*[34] the Court asserted that in the event of a conflict between parental right and the right of an adolescent to autonomous sexual health decisions, the latter should take priority over the former. This, according to the Court, will be consistent with the principles of the best interests of the child and the evolving capacities of the child both recognised under the CRC. The Court further emphasised the importance of ensuring confidential sexual health treatment to adolescents, noting that without such assurance, young people will shun treatment thereby causing 'undesirable and troubled consequences' for them.[35] The reliance on the principle of evolving capacities of the child by the Court to arrive at its decision is an affirmation of the sexual

[32] *R on the Application of Axon v The Secretary of State for Health* (2006) English and Wales High Court 37(Administrative Court) Case No CO/5307/2004.
[33] *Ibid* Per Justice Silber para 62 .
[34] (2003) 36 EHRR 20 The European Court of Human Rights had held in that case that available judicial decisions support the fact that where the rights under article 8 of parents and of a child are at stake, the child's rights must be the paramount consideration.
[35] *Axon* case (note 32 above) para 66.

autonomy of adolescents to consent to sexual health services without parental consent. It is a welcome development and it is commendable.

The Court in *Axon* recognised the importance of third-party involvement in adolescents' decision-making, particularly with regard to invasive treatment such as abortion. However, the Court was not convinced that such an involvement should override the autonomy of the adolescent. This is a clear affirmation of the ability of adolescents to make crucial decisions with regard to their sexuality. It is a positive decision which can potentially be relied on to advance the sexual autonomy of adolescents and young people in general and adolescent girls in particular. In a world where the sexuality of adolescents (particularly female adolescents) has often been subjected to moralization, the decision in *Axon* provides a glimmer of hope for the realisation of the sexual health needs of adolescents, particularly in the context of access to contraception. The decision exemplifies pragmatism and sensitivity to the sexual health needs of female adolescents.

Another important case where the court has affirmed the autonomy of adolescents to consent to sexual health treatment without the need for parental consent is the South African case of *Christian Lawyers Association v Minister of Health.*[36] In that case, a High Court was called upon to determine the legality of section 5 of the Choice on Termination of Pregnancy Act (CTPA), which allows a girl under 18 to seek abortion without parental consent. The applicant in that case had challenged this provision as being contrary to sections 28(1)(b),[37] 28(1)(d)[38] and 9(1)[39] of the South African Constitution of 1996, and as such unlawful. In its judgment, the Court rejected this contention saying that the provision of CTPA allows every woman regardless of whether she is 18 or not to seek abortion during the first trimester and that there is no compulsion on such a woman to seek parental consent but that she is merely obliged to consult with her parents if she so desires. In arriving at its decision, the Court noted that under the CTPA 'all women' can

[36] *Christian Lawyers Association v National Ministers of Health and others* 2004 [10] BCLR 1086.
[37] This section guarantees the right of every child to family care or parental care.
[38] The section guarantees the right of every child to protection from maltreatment, neglect, abuse or degradation. In addition, section 28 provides that child's best interests shall be of paramount importance in every action concerning the child.
[39] This section guarantees the right to equality before the law and to equal protection benefit of the law.

consent to abortion services within the first 12 weeks and therefore the issue of age should not be a barrier, otherwise, the essence of the law will be defeated.

Moreover, the Court invoked the provision of section 12 of the South African Constitution, which guarantees the right to bodily and psychological integrity, to hold that a woman under 18 has the autonomy to make decisions regarding her sexuality. According to the Court, 'it cannot be in the interest of the pregnant minor girl to adopt a rigid age-based approach that takes no account, little or inadequate account of her individual peculiarities'.[40] This is a purposive approach to interpreting the law, which pays attention to the plight of young women in South Africa. By this statement, the Court seems to be asking the female adolescent question. The provision of section 5 of CTPA in question is broadly drafted in such a way as to limit the powers or influence of parents in decision-making of children or adolescents. Indeed, from the wording of this section, there is now a reduction in 'parental roles in decision-making from the authoritative role embodied in the notion of parental power under common law to voluntary consultation by the child, medical professionals acting as "gate keepers" to this potential parent/child consultation'.[41] To this extent, this provision adopts a more radical approach to children's and adolescents' autonomy than the CRC.[42]

While this decision seems to affirm the right of a young woman to seek abortion services, it, however, fails to critically evaluate the logic behind this conclusion. The Court seems to have been preoccupied with explaining the meaning of 'informed consent' generally without paying attention to an equally important issue raised in that case - capacity to consent to treatment for adolescents. In particular, the Court fails to elucidate its decision with reference to international human rights standards such as the principle of the evolving capacities of the child as contained in the CRC and the African Children's Charter. To this extent, one may argue that though the conclusion of the Court was correct, the means of reaching this conclusion are less than satisfactory. Bearing in mind

[40] *Christian Lawyers* case (note 36 above) para 56.
[41] C Himonga & A Cooke 'A Child' Autonomy with Special Reference to Reproductive Medical Decision –making in South African Law: Mere Illusion or Real Autonomy?' (2007) 15 *International Journal of Children's Rights* 323, 334.
[42] *Ibid.*

that South Africa has ratified both the CRC and the African Children's Charter, one would have expected the Court to invoke these instruments as aids in coming to its conclusion. It should be noted that section 39 of the South African Constitution enjoins the court to consider international law while interpreting the provisions relating to the Bill of Rights.

Notwithstanding these shortcomings in the *Christian Lawyers Association* case, an important lesson to be drawn from the case is that young women under the age of 18 are by no means less capable of exercising sexual health choices, particularly with regard to issues relating to abortion and contraception. What is important to bear in mind is that the adolescent girl making these choices must have made them having a good understanding of the issues and their implications. By affirming the autonomy of a girl under 18 to seek abortion services without the need for parental consent, the Court is more or less recognising the capability of female adolescents to make important sexual choices that concern them.

8.3.2 Recognizing the Gender Dimension of Adolescents' Decision-making Powers. (Making inquiries concerning the female adolescent question)

In matters relating to the sexual health of adolescents, courts can similarly play an important role in making inquiries into the female adolescent question with regard to cases brought before them. Chapter 3 of this study discusses the socio-cultural barriers, including barriers related to the health care setting, to contraceptive services for adolescents in Nigeria. On the other hand, Chapter 5 discusses how legal and policy framework may hinder or facilitate access to contraception for adolescents. Courts have an important role to play in removing these barriers. In doing this, courts will need to inquire into the situations or circumstances which often make it difficult for female adolescents to exercise their sexual choices, particularly with regard to access to contraception. Such inquiries are necessary, particularly in a male-oriented society such as Nigeria where studies have shown that male sexuality is privileged over female

sexuality.[43] In some cases, barriers to access to contraception for adolescents are often masked by gender inequality and patriarchal tradition. Thus, courts will be required to 'lift this veil' of patriarchy by analyzing the gender implications of cases involving adolescents. Such an analysis must take into cognizance the peculiar life circumstances of female adolescents in Nigeria. In essence, it must recognize that the low status of women and adolescent girls in the country constitutes a great threat to the realisation of their sexual health and rights. This is evidenced by the high rates of unwanted pregnancies, STIs, including HIV/AIDS and unsafe abortion.[44] Pillard correctly observes that:

> Various forms of inequality and stereotyping contribute to a status quo in which many women get pregnant in circumstances in which they either do not want children, or want children yet feel they cannot have them. Girls and women disproportionately are taught to be in denial about their own sexual urges, and yet rely inappropriately on their sex appeal. The denial occurs both ways: Women are expected to deny the presence of their sexual desire (to guard chastity), and to deny its absence (to be sexually responsive to men). In a world in which such denial is the norm, women will lack the kind of agency and responsibility needed to meet their own desires for pleasure, well-being, support, and meaning in their lives.[45]

Sometimes courts may need to demonstrate some degree of activism in order to strike down socio-cultural or legal barriers to adolescents' access to contraception. In other words, courts will need to do more than mere formal application or interpretation of the law, but where necessary 'lift the veil of patriarchy' behind such laws, customs or practices in order to address the root causes of discrimination against women and girls in society. This may require courts to demand evidence-based information and data rather than reliance on customary or religious beliefs. For instance, in *Axon* the Court was prepared to go a step further in a bid to determine the propriety or otherwise of a girl under 16 to seek sexual advice, without the need for parental consent, by relying on available data and statistics on teenage pregnancy in the UK. The mere fact that the Court in this case relied on a report showing an increase in teenage pregnancies among young

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[43] A Odejide 'What can a Woman do? Being Women in a Nigerian University' (2007) 8 *Feminist Africa* 42.

[44] See G Sedgh *et al Meeting Young Women's Sexual and Reproductive Health Needs in Nigeria* (2009) 2-20.

[45] C Pillard 'Our other Reproductive Choices: Equality in Sex Education, Contraceptive Access, and Work-Family Policy' (2007) 56 *Emory Law Journal* 943, 947.

girls under the age of 16 and low contraceptive use among young people in general in Great Britain, is an indication of the Court's willingness to base its judgment on established evidence rather than mere sentiment. The position of the Court seems to coincide with the suggestion of Cook and Ngwena to the extent that any decision that must be taken in relation to sensitive issues, such as the sexual health needs of adolescents, must be founded on empirical evidence rather than mere sentiment or morality.[46] Indeed, as mentioned above, there is no evidence justifying such involvement as it may not necessarily lead to good decisions for adolescents. Erdman, therefore, suggests that in determining whether or not a third party involvement in adolescents' decision-making is necessary, such a finding must be based on established evidence and fact rather than mere supposition.[47]

More importantly, in *Axon*, Justice Silber rejected the argument that permitting young people to seek treatment on sexual health without parental consent will encourage sexual immorality. Rather, he was of the view that if parents talk to their children about sexual health, they are less likely to engage in unprepared sex and less likely to conceive as young women.[48] This reasoning seems to be sensitive to the plight of young girls who might be in need of sexual health services but might face challenges due to the need for parental consent. It particularly speaks to the plight of adolescent girls in Nigeria, where, as shown in Chapter 3, religious and cultural beliefs often undermine adolescents' right to seek information and services with regard to their sexuality.

By considering the implications of lack of confidential sexual health treatment for an adolescent girl before arriving at its decision, the Court in *Axon* is more or less asking the female adolescent question. It is an indication that the Court is willing to put sexual health challenges facing adolescent girls at the centre of its decision. More importantly, the decision represents an affirmation of the right to sexual autonomy on the part of an adolescent girl with regard to seeking contraceptive services. In Bridgeman's view, the

[46] RJ Cook & C Ngwena 'Women's Access to Health Care: The Legal Framework' (2006) 94 *International Journal of Gynecology Obstetrics* 216.
[47] Erdman (note 28 above) 123.
[48] *Ibid.*

summary of the *Axon* case is that though parents are primarily responsible for the health and well-being of their young ones, such young people, however, can decide for themselves whether to seek advice, information and services as regards their sexual health needs without the knowledge of their parents.[49] The approach of the Court to invoke human rights standards and principles contained in international human rights instruments such as the CRC is highly commendable. Such an approach provides greater opportunities to advance adolescents' sexual health and rights, particularly in relation to access to contraception.

Limitations to the autonomous decision-making of adolescents, especially female adolescents, in matters of sexual health, particularly as regards access to contraception, are often hinged on the fact that female adolescents are incapable of making a developed moral decision. In other words, female adolescents are 'too immature', 'irresponsible' and 'too young' to engage in consensual sex. This belief tends not only to undermine the sexual autonomy of women and girls but also subordinate their human rights to that of men. Erdman has observed that moral-decision making has always been situated within a gender framework based on 'two hierarchically arranged standards of moral reasoning invariably associated with gender: the masculine glorified, the feminine designated'. [50] Pillard has also criticized the different roles which society often assigns to women and men, noting that such different roles tend to compromise sexual choices of women and girls.[51] In a patriarchal society such as Nigeria, where gender inequality is often very pronounced and women's and girls' rights are given little attention, female adolescents are bound to encounter some challenges in exercising their sexual choices. As discussed

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[49] J Bridgeman 'Young People and Sexual Health: Whose Rights? Whose Responsibilities? Commentary on *R* (on the application of Axon) v *Secretary of State for Health and Another'* (2006) *Medical Law Review* 418, 424.

[50] See Erdman (note 28 above) 124, relying on Gilligan's seminal work *In a Different Voice,* Erdman notes that masculine moral reasoning is associated with the impartial analytical resolution of abstract principles, while feminine moral reasoning is often associated with individualized and contextual decision-making. She therefore, submits that the assumption that young women lack capacity to making autonomous decision as regards their sexuality may be a deficiency of assessment rather than a deficiency in the standard by which moral capacity is assessed.

[51] Pillard (note 45 above) 953 where she asserts that 'responsibility for guarding chastity is assigned particularly to females; marriage is the only proper venue for sexual intimacy; men's sex drive and sexual satisfaction is privileged while women's is demonized or ignored; and childrearing is viewed as primarily women's responsibility. These ideas are traditional, historically familiar, and often rooted in fundamentalist or other religious belief'.

in Chapter 2, some cultural beliefs and practices still assign to women and girls secondary roles in the family. Thus, in some Nigerian cultures, it is still believed that reproduction is the primary function of women and girls and that a woman is expected to sexually please her husband. This in turn limits women's and girls' autonomous decision-making powers as regards sexual health matters. Therefore, the decision in *Axon* constitutes a positive step towards 'lifting the veil' of gender inequality which is often masked as custom and tradition.

Recent developments have shown that courts are beginning to strike down the sex-biased 'maternal wall' that has cabined women's sexual choices. Also, courts are beginning to demonstrate the willingness to question the gender implications of laws and policies limiting women's and girls' sexual choices.[52] For instance, the Colombian Constitutional Court has recently delivered a judgment relating to the sexual autonomy of a young girl to consent to medical abortion.[53] In that case, the Constitutional Court had been called upon to determine whether a 14 year-old girl could lawfully consent to an abortion and whether the provisions of the Penal Code criminalising abortion was constitutional. The Court had invoked principles and standards laid down under international human rights instruments and consensus statements to arrive at its decision. For example, the Court relied extensively on the provisions of the Convention on the Elimination of All forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child, including consensus documents such as the International Conference on Population and Development (ICPD) and the Beijing Platform for Action, to hold that a denial of the abortion right to a girl under the age of 14 constitutes a gross violation of the sexual and reproductive rights of a woman. The Court further held that criminalizing abortion violates the rights to health, equality, dignity and liberty of a woman all

[52] *Ibid* 942 where she argues that 'equality law increasingly apprehends the central role that both expectations about maternity and the realities of parenting play in sex discrimination. The legal project of enabling women and men freely to chart life courses without systematic, sex-based constraint confronts a long history and culture of traditional domesticity, which casts women primarily as mothers and family caretakers, and men primarily as breadwinners unfettered by direct family-care responsibilities'.

[53] See Sentencia C-355/06, 10 de mayo de 2006, Corte Constitucional [Constitutional Court] (Colom.).

recognised in various human rights instruments and consensus statements such as the Cairo and Beijing Declarations [54]

In arriving at its decision, the Court had reviewed the challenges women in Colombia face in realising their health needs, particularly with regard to safe abortion and sexual health services. According to the Court, such challenges, often due to restrictive laws, are not only violations of women's rights but further reinforce the subjugation of women in society.[55] More importantly, the Court reasoned that a girl of 14 who had exhibited a good understanding of the implications involved in a treatment could consent to an abortion. Beyond the fact that this landmark decision liberalises abortion law in Colombia, one other significance of the decision is that the Court tends to accord recognition to the right of a girl of 14 to exercise her autonomy with regard to issues relating to sexual health services, including seeking contraceptive services. Indeed, the Court affirms the rights of all individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. According to the Court, women, including girls, should not be treated merely as 'reproductive instruments in human race,' rather they must be recognised as independent entities capable of making autonomous sexual and reproductive health decisions.[56]

This is a radical challenge to the patriarchal notion referred to above, which generally subordinates women's rights to that of men and assigns reproductive roles as women's primary responsibility. Thus, denial of abortion rights or access to contraception is merely a means of perpetuating the status quo. Due to gender inequality, women and girls are usually unable to negotiate safer sex with their partners. This situation usually poses grave implications for women's and girls' health. Therefore, the recognition by the Colombian Constitutional Court of the right of a girl under 14 to seek sexual health services, including abortion and contraceptive services, is a bold attempt by the Court to 'lift the veil' of patriarchy, which the Colombian criminal law represents. The Court

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[54] See Women Link Worldwide (ed) C-355/2006 Excerpts from Constitutional Court Ruling that Liberalises Abortion in Colombia (2007) 25.
[55] *Ibid.*
[56] *Ibid.*

inquired into the logic behind this restrictive law and found that it was meant to limit sexual choices of women and girls. It then proceeded to affirm the sexual autonomy of a girl under 14 to make 'responsible' and 'reasonable' decisions relating to her sexuality.

More importantly, the Court invoked the provisions of the CRC by upholding respect for parental rights, but subject to the evolving capacities of a girl of 14 to make decisions relating to her human rights, including right to health and sexual autonomy. By so doing, the Court seems to be asking the female adolescent question. Rather than acting in abstraction, the Court seems to have contextualized the peculiar challenges confronting young women with regard to their sexual health needs in Colombia. Given the fact that Colombian society (just like the Nigerian society) is an essentially conservative and male–oriented one, this bold decision by the Constitutional Court symbolises a new dawn in the recognition of women's and girls' sexual autonomy

This decision by the Colombian Constitutional Court represents one of the most important roles of the court in carrying out legal reform. According to Cook, the decision is an unequivocal recognition of women's rights, particularly pregnant women, adolescent girls, rural women, poor women and indigenous women.[57] She notes further that the decision has set a new standard in the recognition of women's rights as human rights internationally. Perhaps, what is highly commendable about this decision is the ability of the Court to invoke human rights principles and standards contained in international and regional human rights instruments such as the CEDAW, CRC and the Inter-American Convention on the Prevention, Punishment and eradication of Violence against Women[58] (Convention of Belem do Para) to reach its decision.

In addition, the Court also relied extensively on interpretations provided by treaty monitoring bodies such as the CEDAW Committee and the Committee on the CRC. The Court particularly cited General Recommendation 24 of CEDAW on Women and

[57] See RJ Cook 'Foreword' in Women Link Worldwide (ed) C-355/2006 Excerpts from Constitutional Court Ruling that Liberalises Abortion in Colombia (2007) 7.
[58] The Convention was adopted at Belém do Pará, Brasil on June 9 1994 at the twenty fourth regular session of the General Assembly to the Organization of American States.

Health[59] to affirm that laws and policies, which inhibit women and girls from expressing their sexual autonomy are not only discriminatory, but also violate women's and girls' human rights. By so doing, the Court has demonstrated the relevance of 'soft law'; in advancing the sexual autonomy of adolescent girls to seek sexual health services. As noted earlier in Chapter 4, while 'soft law' is not legally binding on states, it remains an important source in clarifying the nature of a state's obligations under international human rights law. In particular, it can be invoked to determine the commitment of a state to realising the sexual health needs of female adolescents. This decision is a testament that courts can play a crucial role in freeing women and girls (by advancing their sexual autonomy) from 'historically routine conscription into maternity or motherhood'.[60]

8.3.3 Lessons for Nigerian Courts

When a court is confronted with issues relating to the sexual health of female adolescents, particularly in a patriarchal society like Nigeria, it is usually advisable that the court proceeds on the premise that laws and policies relating to adolescents are potentially patriarchal in nature and discriminatory against women and girls, until otherwise proved. This will enable the court to set its mind, from the outset, on the gender implications of a case and to clearly carry out an in-depth analysis of the gender implications of such laws or policies. At the end of the inquiry, a court is able to appreciate better the gender dimension of such laws and policies.

On the other hand, if a court were to proceed on the basis that laws and policies (especially customary law and practice) relating to the sexual health of adolescents are non-discriminatory until otherwise proved, then there is a tendency to miss the gender implications of such laws or policies. The latter approach can be problematic as shown in the Nigerian case of *Mojekwu v Iwachukwu.* [61] In that case, the Nigerian Supreme Court was asked to consider the discriminatory nature of a customary practice which denies inheritance rights to a female child. The Supreme Court proceeded on the premise that

[59] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1.
[60] Pillard (note 45 above) 943.
[61] *Mojekwu v Iwachukwu* [2004] 4 SC)Part II) 1.

customary laws were not generally discriminatory against women unless otherwise proved. Thus, the Court failed to appreciate the gender implications of customary laws for women's enjoyment of their fundamental rights. This approach of the Court is not only faulty, but also fraught with danger, especially when one bears in mind that custom and tradition have always almost, been determined by men. Moreover, in some situations custom and tradition have been employed as tools to deny women and girls their fundamental rights and control their sexuality. Had the Supreme Court proceeded on the basis that customary laws were potentially discriminatory against women until otherwise proved, it would have been easier for the Court to inquire into the gender dimension of the case. This would have enabled the Court to ask the woman question with regard to a customary law that denies the right of inheritance to female children. Why should such a discriminatory custom still be retained in this 21st century? Why in the first place should a distinction be made between a male and a female child?

It would appear that the essence of the Lord Fraser's guidelines laid down in *Gillick,* which was adopted wholly in *Axon,* is to put a female adolescent at the centre of an impending decision on her attempt to access contraceptive treatment. Rather than placing emphasis on parental power to consent on behalf of a girl under 16, the guidelines seem to prioritise the interests of such a girl over her parents. This approach seems to coincide with asking the female adolescent question. It would be important for Nigerian courts to adopt such a position should a similar case comes before them. Given the serious threats to the sexual health needs of adolescent girls in the country, one would expect that any interpretation that will be provided by the courts, as regards a female adolescent seeking sexual health treatment, will favour the girl and not unduly give regard to parental powers to exercise control. Bartlett has emphasised this when she asserts that the woman question must aim not only to question existing wrongs, but must also anticipate the remedy that will be brought through raising this question.[62] Cook has similarly noted that applying the woman question in judicial decisions involved understanding the disadvantaged position of women in society and reflecting this in the judgment of the

[62] K Bartlett 'Feminist Legal Methods' (1990) 103 *Harvard Law Review* 829, 866.

court.[63] It is one thing to acknowledge the challenges facing women in society; it is quite another for this to be reflected in any action taken to address this situation. Perhaps a remarkable distinction between the anti and pro-Gillick judges is the fact that the former represent conservatism, paternalism and 'welfarist approach' whereas the latter represent pragmatism, liberalism and recognition of the evolving capacities of the child.

While most of these decisions referred to above are not binding on Nigerian courts, no doubt they serve as good reference points and at the least as persuasive authority for Nigerian courts to consider in future should the need arise. It is hoped that in future when Nigerian courts are called upon to decide on issues relating to adolescents' capability to consent to sexual health treatment, including contraceptive services, the courts will live up to this expectation. While it is noted that some of the decisions above occurred under different contexts and situations from that obtaining in Nigeria, nonetheless, Nigerian courts possess the leeway to adopt the principles enunciated in these cases to deal with similar local cases. For instance, given the fact that adolescents in Nigeria, just like in Britain and South Africa, face a myriad of sexual health challenges, including early pregnancy, prevalence of unsafe abortion and STIs, including HIV/AIDS, there is no reason why the courts should not adopt the same position as in the *Axon* case. While one might argue that Nigeria is more culturally and religiously polarized compared to Britain or even South Africa, this should not in anyway deter the courts from affirming the sexual autonomy of female adolescents to seek contraceptive services. This is because culture and tradition are neither sacrosanct nor static, but change with time.[64] What may have been culturally relevant 20 years back may not be so today. Moreover, as mentioned earlier girls, more than ever before, are engaging in sexual acts at an early age.[65] Therefore, it is now an opportune time for Nigerian courts to note these developments and give more recognition to the sexual autonomy of women and girls.

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[63] RJ Cook 'Human Rights and Reproductive Self-Determination' (1995) 44 *The American University Law Review* 986.
[64] G Terry *Women's Rights* (2007) 45.
[65] See A Bankole *et al Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences* (2006) 14.

Furthermore, while one recognises that the level of exposure and development of a girl under 16 in Britain or South Africa may differ from one in Nigeria, this should not prevent the courts from affirming the autonomy of such a girl where available evidence points to her capability. What is crucial, as pointed out in Chapter 2, is for the court to evaluate the capability of such a girl on a case by case basis. This is because in some cases, a girl under the age of 16 may exhibit capability to consent to sexual health treatment, while in other cases such a girl may not. The rules need not be rigid, but must be able to assist the courts in coming to a logical conclusion with regard to the capability of a girl under 16 to consent to sexual health treatment without the need for parental consent.

It should be recalled that in *Festus Odaife* case,[66] a Nigerian court affirmed the right to health of four HIV positive prisoners by invoking article 16 of the African Charter. Although the court restrictively construed the provision of section 42 of the Nigerian Constitution dealing with non-discrimination to hold that HIV status was not one of the grounds for non-discrimination, nevertheless this decision provides a positive sign of judicial activism. However, as discussed in Chapter 4, the legal implications of this decision remain uncertain in light of the Supreme Court's decision in the *Abacha* case.[67]

A recent decision by a Sharia Court of Appeal also provides hope for advancing adolescent's sexual autonomy in Nigeria. In the case of *Karimatu Yakubu v Alhaji Paiko,*[68] the Court held that a marriage conducted on behalf of a teenage girl without her consent amounted to a violation of the rights to liberty and dignity recognised by the Nigerian Constitution. According to the Court, a father could not compel his daughter to marry against her free consent and wishes as this is against the Sharia family law practice. The Court clearly noted that under Sharia law, the consent of a girl in her marriage 'is both an indispensable requirement and a contractual right or at least a desirable one'. This is a very positive and commendable decision, which can be relied on

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[66] *Festus Odaife and others v Attorney General of the Federation and others* (2004) AHRLR 205 (NgHC 2004).
[67] *Abacha v Fawehinmi* [2000] 6 NWLR (Part 660) 228.
[68] Unreported suit no Appeal no CA/K80s/85 (Sharia Court of Appeal).

to argue that denial of access to contraceptive information and services to adolescents, especially female adolescents, is a violation of their right to autonomy. Without clearly advancing the reason for its decision in *Yakubu* case, the Sharia Court of Appeal was unconsciously responding to the female adolescent question when it condemned the notorious cultural practice of early or child marriage in the northern part of Nigeria. It is a known fact that early marriage not only undermines the rights of the girl child, but may also lead to deleterious health consequences such as obstetric fistula.[69]

However, it should be noted that the application of the female adolescent question by the courts should be a conscious and systemic effort and not a fortuitous occurrence. In other words, a court must develop a consistent approach to applying the female adolescent question to cases brought before it. Although the decision of the court in *Yakubu* represents a positive development in the advancement of adolescents' sexual health, the Court did not make a conscious attempt at inquiring into the female adolescent question raised by the case. Therefore, while the outcome is applauded, the means of reaching the outcome are less than convincing as they do not evaluate the gender dimension of the case. Given that early marriage is a cultural or religious practice, which potentially endangers the sexual health of adolescent girls, the Court could have evaluated from a gender perspective the rationale for retaining such a notorious and harmful cultural practice. Moreover, the Court could have invoked human rights principles and standards in treaties ratified by Nigeria as aids in arriving at its decision.

The two Nigerian cases referred to above have demonstrated that the courts are strategically positioned to advance adolescents sexual autonomy in the country. One can only hope that when the opportunity arises with regard to addressing issues touching on adolescents' sexual health needs, particularly as regards access to contraception, Nigerian courts will not be found wanting.

[69] This is a hole which forms in the vaginal wall communicating into the bladder or the rectum or both as a result of prolonged or obstructed labour.

8.4 Regional Human Rights Bodies

Aside from exploring internal means of realising sexual health and rights of adolescents, regional bodies or tribunals can equally be of great use in the realisation of the rights of adolescents. Experience has shown that in some situations where efforts aimed at realising internal remedies fail, resort to regional bodies can fill the gap. This section of the study focuses on one important regional human rights body that can play a great role in realising adolescents' human rights in general and, sexual health and rights in particular. While it is recognised that both the African Commission and the newly constituted African Court of Human Rights, have important roles to play in advancing the sexual health rights of adolescents in the region, the focus here is on the Committee of Experts of the African Children's Charter. Regional human rights bodies such as the Committee of Experts of the African Children's Charter can advance adolescents' sexual health and rights in the following ways:

- By articulating and applying international and regional human rights standards and principles on women's and girls' rights, when these rights have not been well protected at the national level;

- By providing adequate remedies for the violations of women's and girls' rights, when such remedies are not available at the national level;

- By encouraging states to undertake legislative and policy reforms so as to better protect the sexual health and rights of women and girls at the national level.[70]

The discussion that follows relates to the ability of the Committee of Experts on the African Children's Charter to advance the sexual health and rights of adolescents.

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[70] See for instance, Center for Reproductive Rights (CRR) *Briefing Paper: Reproductive Rights in the Inter-American System for the Promotion and Protection of Human Rights* (2002) 1.

8.4.1 The African Committee of Experts on the Rights and Welfare of the Child

This body of 11 independent members, created under article 32 of the African Children's Charter, is meant to ensure the full realisation of the rights of children guaranteed under the Charter. Its primary responsibility is to promote and protect the rights and welfare of the child. [71] Unlike the Committee on the CRC, the African Committee of Experts on the Rights and Welfare of the Child (Committee of Experts) has broader responsibilities than the former. This is because the Committee of Experts is not only charged with receiving and examining states' reports as stipulated under the African Children's Charter, but also has the responsibility to receive individual communications with respect to the violations of the provisions of the African Children's Charter.[72] Similarly, the Committee has the mandate to collect and document information and to commission interdisciplinary assessments of situations of African problems with regard to children's rights.

Other functions of the Committee of Experts include organizing meetings, encouraging national and local institutions concerned with the rights and welfare of the child, and giving its views and making recommendations to governments where necessary.[73] Moreover, the Committee is authorized to formulate and lay down principles aimed at protecting children's rights in Africa. To this extent, the Committee of Experts is a unique creation because of its progressive and action-oriented protective mechanism.[74] No other body either at the international or regional level has a similar mandate to this Committee. This unique creation of the Committee puts it in a position to realise adolescents' sexual health and rights in the region. Viljoen rightly submits that by this unique feature of the African Children's Charter, the instrument has progressively raised the bar in the promotion and protection of children's rights in Africa.[75]

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[71] See article 42 of the African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.0/49 (1990) (*entered into force* Nov. 29, 1999).
[72] *Ibid* article 44.
[73] A Lloyd 'Evolution of the African Charter on the Rights and Welfare of the Child and the African Committee of Experts: Raising the Gauntlet' (2002) *International Journal of Children's Rights* 179, 186.
[74] *Ibid.*
[75] F Viljoen *International Human Rights Law in Africa* (2007) 265.

The intention of the drafters of the African Children's Charter might have been that rather than saddling the African Commission on Human and Peoples' Rights with an additional responsibility of entertaining communications with respect to violations of children's rights, it would be better and perhaps more effective for a separate body to handle these violations. This is a commendable approach by the drafters of the Charter as it will ensure a better focus on children's rights including sexual health rights in the region. Moreover, it will enable the Committee to break new ground with regard to advancing children's rights in the region.

The Committee of Experts established under the African Children's Charter is a body of high moral standing, integrity, impartiality and competence in matters relating to the rights and welfare of the child.[76] Members are expected to serve in their personal capacity with the aim of promoting and protecting the rights guaranteed in the Charter.[77] Usually, members of the Committee are proposed and put forward by the relevant ministries and then elected by the African Union, paying attention to geographical and gender balance. Members of the Committee enjoy privileges and immunities[78] in order to strengthen its impartiality and to ensure effective service on the part of members.[79] For some years after the African Children's Charter came into force, the Committee of Experts on the Rights and Welfare of the Child could not be inaugurated due to some problems. However, at the 37th Assembly of Heads of State and Governments of the then Organization of the African Unity (OAU), now known as the African Union (AU), held in July 2001 in Lusaka, Zambia, the Committee was officially inaugurated. Yet the Committee only started considering its first set of reports from four states parties to the Charter at its 11th ordinary session held in Addis Ababa, Ethiopia in 2008, almost a decade after its inception.[80] This is a welcome development, and it is a sincere hope that this will be sustained despite the glaring fact that states parties are yet to familarise themselves with

[76] Article 33 (1).
[77] *Ibid* 33 (2) and 43 (a).
[78] Lloyd (note 73 above) 186.
[79] *Ibid.*
[80] These states parties are Nigeria, Rwanda, Mauritius and Egypt. For a detailed discussion on this, see BD Menzur & J Sloth-Nielsen 'An Ice Breaker: State Party Report and the 11TH Session of the African Committee of Experts on the Rights and Welfare of the Child' (2008) *African Human Rights Law Journal* 596.

the reporting Guidelines of the Committee.[81] This shortcoming, temporary though, should be overcome eventually.

The potential of the Committee of Experts to advance adolescents' sexual health needs, especially with regard to access to contraception in the region, lies not only in its ability to receive individual communications, but to also examine states parties' reports. This provides an avenue for the Committee to invoke the principles and standards recognised in the Charter and other relevant human rights instruments such as the CRC to affirm adolescents' sexual health and rights in the region. Drawing from the experience of the African Commission on Human and Peoples' Rights, the Committee of Experts can create important jurisprudence relating to adolescents' sexual health needs. Moreover, the mere fact that the Committee will not be hindered by the problem of justiciability of the right to health makes it a potent force for realising access to contraception for adolescents in the region generally, and Nigeria in particular. It should be noted that one of the most authoritative decisions of the African Commission on the right to health under the African Charter is the *SERAC*[82] case, which incidentally originated from Nigeria. The Commission found the Nigerian government in violation of the Ogoni peoples' rights to health, life, a clean environment and dignity guaranteed under the African Charter. This case has remained an important precedent in advancing the socio-economic rights including the right to health.

The decision in *SERAC*, therefore, must underpin decisions in future cases originating from Nigeria to the Committee on issues relating to access to sexual health services, including contraceptive services for adolescents. The Committee will hopefully be alive to its responsibility of protecting children's and adolescents' rights. The Committee in entertaining communications before it, dealing with access to contraception for adolescents, can equally resort to asking the female adolescent question in order to arrive at its decisions. Moreover, the Committee can order the review of laws and policies that hinder access to contraception for adolescents, especially female adolescents, within the

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[81] *Ibid* 615.
[82] *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

jurisdiction of a state party to the Charter. Also, the Committee can order a state party to formulate laws and policies that will facilitate access to sexual health services to adolescents.

Furthermore, in exercising its promotional functions with regard to examining states reports, the Committee can demand from states parties to show what steps they have taken in order to advance the sexual health needs including access to contraceptive services for adolescent girls in their countries. The Committee can do this by including in its reporting guidelines to states parties, a heading relating to access to sexual health services for adolescent girls. Already the Committee has noted that a state party report 'offers an important occasion for conducting a comprehensive review of the various measures undertaken to harmonise national law and policy with the Children's Charter and to monitor progress made in the enjoyment of the rights set forth in the Children's Charter'.[83] Although at present the Committee does not have a specific heading relating to access to sexual health services for adolescents in its Guidelines, however, under the heading 'health and welfare',[84] the Committee can raise questions as to what a state party has done to ensure access to sexual health services, including contraceptive services for female adolescents within its jurisdictions. The Committee can also inquire into how the sexuality of adolescent girls is construed and the implications of this for the enjoyment of adolescent girls' right to physical and mental well-being.

In addition to the above, the Committee may follow the footsteps of its predecessor, the African Commission, by passing resolutions which may be useful in advancing the sexual health needs of female adolescents in the region. In recent times, the African Commission has passed important resolutions relating to sexual and reproductive health in the region, some of which include the resolutions on HIV/AIDS[85], maternal mortality[86] and access to

[83] See para 3 of the Guidelines adopted by the African Children's Charter Committee issued pursuant to article 43 of the African Children's Charter Cmttee/ACRWC/2 II Rev 2.
[84] See *Ibid.* paras 17-18.
[85] See Resolution on the HIV/AIDS Pandemic–Threat against Human Rights and Humanity adopted at the 29th Ordinary Session of the African Commission held in Tripoli, Libya ACHPR Res.53/(XXIX)01, where the Commission urges African governments to ensure that all efforts aimed at combating the HIV/AIDS epidemic in the region are respectful of human rights.

essential medicines.[87] While these resolutions are not binding on African governments, they have tended to provide clarity on the nature of African governments' obligations with regard to these issues and the need to adopt measures to address them. The Committee of Experts can equally pass a resolution calling on African governments to address the sexual health needs of adolescents, especially female adolescents.

It must be pointed out here that recourse to international or regional human bodies has its own limitations. One of the major weaknesses of relying on international human rights mechanisms has to do with the problem of the enforcement and implementation of decisions by human rights bodies. As Cook *et al* rightly observe, this mechanism lacks the legal authority to enforce any decision made and are at best dependent on moral persuasion, diplomacy or political embarrassment.[88] Most human rights instruments do not usually provide enforcement mechanisms and the African Children's Charter is not an exception. Experience has shown that the enforcement of decisions of regional bodies is always difficult. For instance, some years after the decision of the African Commission in the *SERAC* case referred to above, the Nigerian government is yet to give effect to this decision. Nothing much has changed in the lives of the Ogoni people, as oil exploration has continued and pollution remains a great threat to the lives and economic conditions of the people. This clearly demonstrates that too much faith should not be placed in international human rights mechanisms to address internal human rights violations.

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[86] See the African Commission on Human and Peoples' Rights Resolution on Maternal Mortality in Africa Meeting at its 44th Ordinary session held in Abuja, Federal Republic of Nigeria, from 10 - 24 November 2008 ACHPR/Res.135 (XXXXIIII), where the Commission notes that due to high maternal deaths in Africa, maternal mortality should be declared a state of emergency in the region.

[87] African Commission on Access to Health and Needed Medicines in Africa at its 44th Ordinary Session held in Abuja, Federal Republic of Nigeria, from the 10th to 24th November 2008; ACHPR/Res.141 (XXXXIIII) 08, where the Commission calls on African governments to fulfill access to medicines by adopting all necessary and appropriate *positive measures* to the maximum of its available resources to promote, provide and facilitate access to needed medicines.

[88] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicines, Ethics and Law* (2003) 229.

8.5 Conclusion

This chapter has examined the roles of courts and regional human rights bodies in advancing the sexual health of adolescents, particularly with regard to access to contraception. Courts can breathe life into the provisions of the constitutions and other relevant laws to advance access to contraception for adolescents. This has been demonstrated in other jurisdictions such as Britain, South Africa and Colombia. Judicial decisions from these countries have demonstrated that courts can advance the autonomy of female adolescents to seek sexual health services, especially contraceptive services through purposive interpretation of laws and policies. Similarly, courts are well situated to ask the female adolescent question with regard to cases bordering on the sexual health of female adolescents. This can be done by questioning the rationale of restrictive laws, policies or practices, which tend to hinder access to sexual health services to adolescents in general and female adolescents in particular. Given that such laws, policies or practices often serve as camouflage for patriarchy, courts can strike them down or declare them unconstitutional or at variance with human rights principles and standards.

Nigerian courts can draw from the experiences of courts in other jurisdictions and adopt the same approach to similar cases within the country in order to advance the sexual health needs of adolescents. While it is admitted that the socio-cultural settings in the countries where these decisions emanate differ greatly from that of Nigeria, experience has shown that adolescents virtually anywhere in the world share similar sexual health needs and problems. Therefore, some of these decisions can still be applied to meet the sexual health needs of adolescents in Nigeria. For this to happen, however, Nigerian courts will need to exhibit some degree of activism and be willing to ask the female adolescent question in their judgments. The recent decision of the Sharia Court of Appeal in the *Yakubu* case, therefore, provides hope for the future.

Also, the chapter has examined the important position of the Committee of Experts of the African Children's Charter in advancing the sexual health needs of adolescents in the region, particularly Nigeria. The Committee is the only body in the world that is charged

with the responsibility of hearing individual communications specifically dealing with violations of children's rights. This opportunity can be used effectively to advance the sexual health needs of adolescents, especially female adolescents in Africa. The Committee can begin to question laws and policies made by states, which may interfere with female adolescents' autonomy to seek contraceptive services. It is expected in time the Committee of Experts will perfect its handling of states' reports and use these skills and experience to request states parties to pay more attention to the sexual health needs of female adolescents in their countries. Hopefully, the Committee will take a cue from the Committee on CRC, by issuing General Comments, or at the least, resolutions clarifying the contents of the African Children's Charter. Such a step will add vigour to the promotion and protection of the sexual health and rights of children and adolescents in the region.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

This study has examined whether laws and policies made by the government of Nigeria with regard to access to contraception for adolescents have been consistent with the country's obligations under international human rights law. In particular, the study has examined whether laws and policies made by the Nigerian government have advanced adolescents' (especially female adolescents') sexual autonomy to seek contraceptive services. The assessment of these laws and policies has been carried out by asking whether they have responded to the Nigerian female adolescent question. In other words, whether these laws and policies have actually addressed the peculiar life situations of female adolescents. Thus, this part of the study summarises the major arguments that have been made and provides recommendations to important institutions or bodies that may play a role in realising access to contraception for adolescents.

In Chapter 1 the research question was framed in this manner: is a human rights analysis useful in realising access to contraception for adolescents in Nigeria? From the discussions so far, it is clear that in a religiously and culturally polarised environment like Nigeria, the application of the language of rights to an issue such as access to contraception for adolescents may be challenging. There is a tendency for the society to misconstrue or misunderstand the relevance of human rights to sexual health matters. Chapter 2 establishes how different communities in Nigeria have construed, albeit negatively, children and adolescents and their sexuality. The discussion in the chapter shows that little or no attention has been accorded the rights of children and adolescents. Furthermore, from the discussions in Chapters 1 and 2, some commentators have expressed doubts in the viability of human rights discourse to address the needs of disadvantaged people, including women. For instance, Tushnet argues that the language of right raises more hope than it can actually deliver in meeting the needs of

disadvantaged groups in society.[1] Also, feminist scholars such as Charlesworth have argued that international human rights have failed to address the peculiar challenges of women.[2]

While the above concerns of feminists may seem tenable, a human rights approach or analysis to an issue such as access to contraception for adolescents remains very important in determining the level of a state's commitment on such an issue. As this study has shown, a human rights approach is useful in holding a government accountable to its obligations under international law regarding realising access to contraception for adolescents. Human rights serve as tools that 'direct government agencies, individuals, and institutions towards the appropriate shaping of their own policies and practices, and equip them with the principles and language to urge improvements in the policies and practices of others'.[3] Individuals, particularly vulnerable groups such as children and adolescents, often find the language of rights empowering since it provides means by which they can legitimately assert their interests.[4] This is particularly true of an issue such as realising access to contraception for adolescents. Adolescents, especially female adolescents, constitute members of disadvantaged groups that are often denied access to sexual health services. Hence, the usefulness of a rights-based approach in demanding that the government of Nigeria takes adequate measures to address this challenge. Such an approach is also useful in holding governments accountable for failing to meet the sexual health needs of adolescents, particularly female adolescents.

More importantly, the study has shown that female adolescents have continued to encounter discriminatory practices with regard to their sexual health needs. This underlines the relevance of the female adolescent question to call the attention of the Nigerian government to the peculiar needs of female adolescents. Also, the study has shown that the female adolescent question is an important feminist methodology that can

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[1] M Tushnet 'An Essay on Rights' (1984) 62 *Texas Law Review*1371-172; see also, R West *'Feminism,* Critical Social theory and Law' (1989) 59 *University of Chicago Legal Feminism* 84.

[2] H Charlesworth *et al* 'Feminists Approaches to International law' (1991) *American Journal of International law* 613.

[3] RJ Cook *et al Reproductive Health and Human Rights: Integrating Medicines, Ethics and Law* (2003) 148.

[4] *Ibid.*

be invoked to ensure gender equality in policies and laws relating to access to contraception for adolescents in Nigeria. Moreover, the use of the female adolescent question will help the courts to interpret laws and policies in a way that advances the sexual autonomy of female adolescents in the context of access to contraceptive services. In essence, the study has shown that the female adolescent question helps in challenging the status quo and patriarchal traditions that the Nigerian society represents. Also, asking the female adolescent question draws the attention of the Nigerian government to the neglect and lack of attention to the sexual health needs of female adolescents and calls for an intervention which must address this lack. Ultimately, it is hoped that this will lead to improved sexual health conditions for female adolescents. The discussion that follows in this section is a summary of the outcome of the study, with regard to Nigeria's obligations to realise access to contraception for adolescents.

9.2 Nigeria's Duties and Obligations under International Human Rights Law

At international law, a state has the three-fold obligation with respect to the right to health, including adolescents' health needs. These include the obligations to respect, protect and fulfill the right to health of adolescents, including ensuring access to contraception. The Committee on ESCR has noted that governments' obligations with regard to the right to health include ensuring availability of timely and appropriate health care services, including other determinants of health, such as water, food, health facilities, access to health-related information and services.[5] This requires the Nigerian government to take steps towards the prevention and treatment of diseases and facilitate access to health facilities, goods and services to all citizens, especially adolescents. The following discussion is aimed at evaluating how Nigeria has fared in realising access to contraception for adolescents. This evaluation is based on the findings of this study.

[5] The Right to the Highest Attainable Standard of Health; UN Committee on ESCR General Comment No 14, UN Doc E/C/12/2000/4 para 12.

9.2.1 The Duty to Respect

This implies that states must refrain from doing anything that will interfere with individuals' enjoyment of their right to health. In the context of adolescents, it means that states must refrain from acts or omissions which may prevent adolescents from accessing contraceptive services. In other words, laws and policies made by governments must not be seen to be impeding access to contraception for adolescents, particularly female adolescents. The obligation to respect equally forbids governments from taking retrogressive steps towards the realisation of the right to health.[6] It can be argued, as observed in Chapter 5, that the non-inclusion of specific provisions on consent to treatment and information for children and adolescents by the drafters of the Child's Rights Act in Nigeria, is a hindrance to adolescents' right to access sexual health treatment. While these omissions affect all adolescents in the country, the implications for female adolescents are graver. Indeed, the Committee on CRC has noted that failure of a state to include provisions on age of consent for counseling and medical treatment for adolescents is a violation of the right of children under the CRC.[7]

Furthermore, the fact that the provisions of the Constitution and the Child's Rights Act on non-discrimination are couched in a general language, excluding discrimination on grounds of age, martial status, economic status and pregnancy, provides an indication of failure on the part of Nigeria, in line with its obligations under international human rights law, to prevent unlawful discrimination. Although the Constitution forbids discrimination on the basis of sex, this may not really cover marital or age status. Moreover, Chapter 4 has shown that Nigerian courts have not given a generous or purposive interpretation of the constitutional provision on non-discrimination, thereby confirming the need for a specific provision to protect the needs of adolescents. This will ultimately be beneficial to female adolescents, who are usually in need of sexual health services more than their male counterparts. Thus, the panoply of Nigeria's laws and policies on access to

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[6] See BC Toebes 'Towards an Improved Understanding of the International Human Rights to Health' (1999) 23 *Human Rights Quarterly* 661, 676.

[7] See the Concluding Observations of the Committee on CRC: Austria, 15. May 7, 1999. UN Doc CRC/C/15/Add.98.

contraception for adolescents has not adequately responded to the female adolescent question.

Also, Chapter 5 establishes that provisions of some policies such as the National Policy on Adolescents are framed in euphemistic language when it relates to important issues such as access to contraception. This tends to cast doubt over the viability of these policies to advance the sexual health of adolescents in general and female adolescents in particular. Moreover, the inconsistencies existing in laws and policies on adolescents can equally interfere with access to sexual health services, including contraceptive services, for adolescents. For instance, the provision of the criminal law on statutory rape, which is intended to protect children and adolescents under the age of 16 from coerced sex, may be invoked negatively by health care providers to deny contraceptive services to adolescents.

The discussion in Chapter 3 has shown that access to information and services on contraception for adolescents is difficult in the country. This is attributed to socio-cultural factors, including lack of youth-friendly and culturally acceptable health services for adolescents, especially female adolescents. This may suggest that the prevailing environment in the country has not responded to the female adolescent question. In one of its Concluding Observations to the government of Nigeria, the Committee on CRC has chided the government with regard to poor access to sexual health services to adolescents, especially female adolescents.[8] The Committee urges the government to take adequate measures with a view to addressing this challenge. In particular, the Committee has urged the government of Nigeria to ensure that its laws and policies are in compliance with the provisions of the Convention.[9]

Similarly, the Committee on CEDAW has expressed concerns with respect to the poor attention given by the Nigerian government to the sexual health needs of women and

[8] See the Committee on CRC Concluding Observations: Nigeria 2005 CRC/C/146 adopted at the 1025th meeting held on 28th of January 2005.
[9] *Ibid* para 32.

girls.[10] The Committee has also expressed concern about the low rates of contraceptives usage leading to unwanted and unplanned pregnancies and the lack of sexuality education among young people, especially in the rural areas.[11] Therefore, the Committee has urged the government to increase women's and adolescent girls' access to affordable and accessible health care services, including sexual and reproductive health services.[12] It also urges the government to adopt adequate measures to increase knowledge of and access to contraceptive methods.[13] This seems to be in line with the Committee's observation in General Recommendation 24, where states were urged to ensure that affordable and acceptable health services, including sexual and reproductive health services, are guaranteed to women and girls.[14]

Both the ICPD and the Beijing Platform identify components of the right to the highest attainable standard of reproductive health from a woman's perspective.[15] They stress the importance of affordable, accessible and acceptable services throughout a woman's life cycle.[16] Acceptable services include gender-sensitive standards for the delivery of quality health care services, which must meet the peculiar needs of female adolescents.[17] Bearing these comments in mind, and taking into account the inexplicit nature of Nigeria's laws and policies on adolescents, one may argue that the country is not doing enough to meet the sexual health needs of adolescents, especially female adolescents.

9.2.2 Duty to Protect

This duty implies that governments must take necessary steps and measures to prevent a third party from interfering with the enjoyment of the right to health. In the context of

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[10] Committee on CEDAW Concluding Observations: Nigeria CEDAW/C/2004/ICRP.3/Add.2 adopted at the 30th session of the Committee held on 30 January 2004 para 35.
[11] Committee on CEDAW Concluding Observations: Nigeria 2008 CEDAW/C/NGA/CO/6 adopted at the 41st session of the Committee held from 30 June to 18 July 2008 para 33.
[12] Committee on CEDAW Concluding Observations: Nigeria 2004 (note 8 above).
[13] Committee on CEDAW Concluding Observations: Nigeria 2008 (note 11 above).
[14] General Recommendation 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1 para 18.
[15] International Conference on Population and Development (ICPD) UN A/CONF.171 (13) 18 October 1994; Fourth World Conference on Women Beijing held on 15 September 1995 A/CONF.177/20.
[16] *Ibid* para 25 and 223; para 92 and 106(e) respectively.
[17] *Ibid* para 223 and 95; para 103,106(c) and 106(g) respectively.

adolescents' sexual health, it would imply a government's obligation to ensure that third parties do not interfere with adolescents' enjoyment of their sexual health. Thus, as shown in Chapter 3, the challenges adolescents (particularly female adolescents) face in accessing sexual health services, due to non-availability of youth-friendly centres and information, may amount to a breach of the obligation to protect adolescents' right to health.[18] Similarly, the negative attitudes of health care providers towards adolescents, particularly female adolescents, seeking sexual health services and sometimes, the requirement for parental consent (as confirmed in Nigeria's state reports to treaty monitoring bodies discussed in Chapter 7), will result in breach of the duty to protect. This will be so, as shown in the case of Nigeria, where proper laws and regulatory framework are not in place to address these challenges. As this study has shown, the requirement for parental consent often deters adolescents, especially female adolescents, from accessing sexual health services, including contraceptive services. Significantly, the lack of adequate or appropriate provisions on non-discrimination against children either in the Constitution or the Child's Rights Act, can pave the way for third parties to adopt discriminatory practices against children and adolescents seeking health care services. Although as argued in Chapter 5, section 42 of the Constitution can be interpreted to cover discrimination against children and female adolescents, Nigerian courts have interpreted this section restrictively.[19]

Some studies in the country have shown that health care providers that are expected to provide information and services on contraception, sometimes lack adequate knowledge on contraception.[20] The result will be that adolescents will be denied access to the information and services on sexual health which they require. Moreover, opposition to the teaching of sexual health education to adolescents, based on religious and cultural beliefs, can predispose female adolescents to sexual ill health. This can further deny them access to sexual health treatment, in breach of the duty to protect. The Committee on

[18] See Toebes (note 6 above), where she argues that this obligation requires states to adopt legislation and other measures so as to ensure access to information and services relating to sexual and reproductive health.
[19] See for instance, the decision of the court in *Festus Odaife and others v Attorney General of the Federation and others* (2004) AHRLR 205 (NgHC 2004).
[20] See for instance, OM Ebuche *et al* 'Health care Provider's Knowledge of, Attitudes Toward and Provision of Emergency Contraceptives in Lagos, Nigeria' (2006) 32 *International Family Perspectives* 83.

CRC, in one of its Concluding Observations to Nigeria, has expressed concern about lack of proper dissemination of the principles and provisions of the Convention among community members and health care providers.[21] This, according to the Committee, has led to the violations of the right of children. Therefore, the Committee has urged the government of Nigeria to take appropriate measures to ensure that the provisions of the Convention are widely made known to the citizens.

More importantly, the Committee on CRC has urged the government to involve community leaders in sensitisation seminars, with a view to combating harmful traditional practices injurious to the health of adolescents.[22] This call is very important as it is capable of changing traditional views and perceptions with regard to children and adolescents in general, and the girl child or female adolescent in particular. As discussed in Chapter 2, cultural practices often limit and repress the sexual autonomy of female adolescents in Nigeria. Therefore, it will be important that training programmes should be extended to the rural areas, where cultural practices are well-entrenched. These training or education programmes should not be limited to traditional rulers but also involve men in general. Experience has shown that in many African societies men are hardly involved in sexual and reproductive health issues. This is often based on the erroneous belief that they have minimal roles to play in advancing sexual and reproductive health of women and girls. On the contrary, involvement of men in sexual and reproductive health matters can be beneficial to women and girls, as it may ensure better access to sexual health services. It can also prevent the violation of sexual and reproductive rights of women and girls.[23]

The Committee on CRC has further recommended systematic education and training as regards the provisions of the Convention for professional groups such as judges, health

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[21] Committee on CRC Concluding Observations: Nigeria (note 8 above).
[22] *Ibid.*
[23] PANOS *Young Men and HIV: Culture, Poverty and Sexual Risk* (2001) 4. This publication shows that while young women need to be assertive about their sexuality, it admits that this cannot happen in isolation as men also need to be involved. In particular young men need to respect their sexual partners and the human rights of women and girls in general.

care providers, teachers, social workers and children.[24] With regard to non-discrimination, the Committee has expressed regrets with the inadequacy or paucity of laws to appropriately protect children from discrimination. It has therefore, urged the government of Nigeria to adopt appropriate legislation to this effect.[25] These observations would seem to suggest that the Nigerian government is lagging behind in the protection and promotion of the sexual health of adolescents.

9.2.3 Duty to Fulfill

This duty imposes obligations on a state to ensure that it has taken adequate measures, including budgetary, legislative and judicial, with respect to realising the right to health of its citizens. Concerning adolescents, the duty to fulfill their sexual health needs requires a government to take steps and measures to ensure that access to sexual health services, particularly contraceptive services, are made available to adolescents. The absence of a specific provision in the Constitution recognising the right to health as a justiciable right, and the non-inclusion of a provision in the Child's Rights Act on the autonomy of adolescents to seek health care services (including contraceptive services), raises doubt as to whether Nigeria is meeting its commitment to realising adolescents' sexual health and rights under international law. The Committee on ESCR, in General Comment 14, has explained that fulfilling the right to health requires a state to take a holistic approach. This will include realistic legal and policy frameworks that will assure health care goods and services to all, especially marginalised groups such as children and adolescents.[26] Specifically, the Committee has noted that appropriate health care services must be provided to meet the peculiar needs of adolescents.[27]

Furthermore, fulfilling the right to health will require a state to commit its resources towards the realisation of health care services to all, and particularly the vulnerable groups such as women, children and adolescents. The Committee on ESCR realises that

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[24] Concluding Observations on Nigeria (note 8 above).
[25] *Ibid.*
[26] General Comment 14 (note 5 above) para 18.
[27] *Ibid* para 23.

some states, due to a lack of resources, may face the challenge of immediately realising the right to health for their citizenry. Therefore, such states would be required to take progressive steps towards realising this right. However, the Committee notes that certain obligations relating to the right to health, such as ensuring access to medicines, goods and services (including contraception) to the citizens and prohibition of discriminatory practices with regard to health care services are core obligations, which are not subject to progressive realisation.[28] In other words, poor states would still be expected to demonstrate that they have applied their meagre resources judiciously towards realising the right to health of their citizens. In the Committee's view, the crucial point to consider in this respect is: whether a state is unable or unwilling. For a country like Nigeria, which is regarded as the eight largest oil producing nation in the world, it is almost inexcusable if not embarrassing, that the health system has become a charade due to poor funding. Despite the huge profit the country has made on sale of oil over the years, it has woefully failed to deliver a decent health care system (including sexual and reproductive health care services) to its citizens. Worst affected are vulnerable and marginalised groups such as women, children and adolescents. There are few government-funded health care centres or institutions addressing the needs of adolescents. This calls for a more positive and expedite response from the Nigerian government.

Certainly, the problem with Nigeria is not that of want of resources but rather a case of misplaced priorities and act of kleptomania on the part of its rulers.[29] Government's spending on the health sector has hovered around 4 to 5% for some years. For a population of about 140 million people, this is grossly inadequate and merely attests to government's nonchalance towards the health needs of the people, especially children and adolescents. It has been rightly observed that to know the priority of a state one needs to monitor what it spends its money on.[30] Obviously from the spending of the Nigerian government so far, little or no priority has been given to health care needs (including

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[28] *Ibid.*

[29] See for instance, O Nnamuchi 'Kleptocracy and its many Faces:: The Challenges of Justiciability of the Right to Health Care in Nigeria' (2008) 52 *Journal of African Law* 1-42.

[30] See A Coen *et al* 'Are We There Yet? Women's Right' in *Countdown 2015: Sexual and Reproductive Health and Rights for All* (2004) 12-17; see also M Fathalla *et al* 'Sexual and Reproductive Health for All: A Call for Action' (2006) 368 *Lancet* 2095, 2097.

sexual health needs) of adolescents. The Committee on the CRC in one of its Concluding Observations to Nigeria has noted with concern the poor allocation of resources by the government to addressing the health needs of adolescents.[31] According to the Committee, this severe lack of resources for children's' rights in the country is often occasioned by widespread corruption and uneven distribution of resources.[32] Thus, the Committee has urged the Nigerian government to prioritise as a matter of urgency 'budgetary allocations and efficient budget management to ensure the implementation of the rights of children' in the country.[33] This observation of the Committee establishes the link between corruption and denial of children's and adolescents' sexual health needs. More often than not, the negative implications of this tend to affect female adolescents more than their male counterparts.

More importantly, the lack of political will on the part of the Nigerian government to ensure access to information and services on contraception to adolescents is a violation of adolescents' rights to health and life under international law. There is the need for the Nigerian government to redouble it efforts in ensuring access to contraceptives services to adolescents in the country. Such an effort must be holistic in nature including law reforms, adequate funding of the health care sector and design and execution of youth-friendly health care services. Moreover, it must be responsive to the female adolescent question. In this regard, the Committee on ESCR has noted as follows:

> To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women's right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence.[34]

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[31] Committee on CRC Concluding Observations: Nigeria (note 4 above) para 685 -686.
[32] *Ibid.*
[33] *Ibid.*
[34] General Comment 14 (note 5 above) para 21.

9.3 Recommendations

9.3.1 Need for Policy and Law Reforms by the Nigerian Government

From the discussions in this study, gaps exist in the provisions of the Constitution and the Child's Rights Act that may hinder access to contraception for adolescents. Therefore, there is a need for comprehensive reform of laws that may impact on access to contraception for adolescents in the country. For instance, the provision of section 42 of the Constitution on non-discrimination will need to be broadened to accommodate prohibition of discrimination on other grounds such as marital status, age and economic status or at the least include the phrase 'other status'. This will adequately protect adolescents, particularly female adolescents, from discriminatory practices when seeking sexual health services including contraceptive services. The fact that the few decisions by the Nigerian courts on this section have adopted a restrictive interpretation further reinforces the need for a possible amendment of the section.

Also, as Chapter 5 has shown, the non-recognition of the right to health as an enforceable right in the Constitution can potentially hinder access to contraceptive services for adolescents in the country. This is because a denial of health care services, including contraceptive services, may not be successfully challenged in court. Therefore, an amendment of the Constitution, which will explicitly recognise the right to health as an enforceable right, should be considered. Experience has shown that classifying socio-economic rights, including the right to health, as directive policies of government, has often led to such rights to be treated as less important compared with civil and political rights. Moreover, the decision of the Supreme Court in the *Abacha* case to the extent that where a conflict exists between the Constitution and the African Charter the former will supercede, may further limit the enforcement of socio-economic rights, including the right to health in the country.

It will also be necessary that the Constitution should be amended so as to specifically contain provisions relating to the rights of children. As it is, the rights of children are not given the deserved priority in the Constitution. This is certainly not in the best interests of children and adolescents. Considering the fact that the Constitution is the supreme law of the land, the inclusion of specific provisions relating to the rights of children and adolescents would be desirable. The South African Constitution can serve as a good model in this regard. Apart from the fact that the South African Constitution explicitly recognizes the best interest principle, it also contains detailed provisions protecting the rights of children. This is a clear indication that the South African government intends to take the rights of children seriously.

Furthermore, it would be necessary to harmonise certain inconsistencies that exist between some laws and policies relating to contraception for adolescents. As argued in Chapter 5, the provisions of the Criminal Code on age of consent can become a source of barrier to adolescents' access to contraceptive services. Moreover, while some policies such as the HIV/AIDS and Reproductive Health policies contain specific provisions relating to access to contraception for adolescents, laws such as the Child's Rights Act, are curiously silent on this issue. As pointed out earlier, this situation can limit sexual autonomy of female adolescents, particularly in the context of access to contraceptive services. Therefore, this requires an urgent intervention by way of an amendment to the law.

At present, the provisions of the Child's Rights Act are silent on the issue of consent for treatment for adolescents. Such a silence is regrettable, especially in a society where religious and cultural practices often prevent adolescents, particularly female adolescents from expressing their sexuality. The implication may be that parental consent will be required before an adolescent is allowed access to contraceptive services. This will not serve the interests of an adolescent, especially a female adolescent, who needs to avoid the risk of pregnancy or STI. Moreover, it will not only erase the expectation of confidential services to adolescents, but will also interfere with the right to sexual

autonomy of an adolescent.[35] Therefore, there is a need to amend the law so as to explicitly include provisions on circumstances under which children and adolescents can seek medical treatment, including contraceptive services. As mentioned earlier, the South Africa Children's Act presents a good model for the amendment of the Child's Rights Act. Under the South African Act, a child of 12 can now seek contraceptive services without the need for parental consent, provided he/she is *Gillick*-competent. While the Nigerian law need not necessarily adopt the same age for consent, given the differences in the two jurisdictions, the philosophy behind the law, which is to liberate children and adolescents from the 'shackles' of parentalism with regard to sexual health treatment, is worthwhile.

More pertinently, beyond law reform, the Nigerian government would need to demonstrate more political will to ensure the implementation of existing policies which contain relevant provisions relating to access to contraception for adolescents. As pointed out in Chapter 5, if the Nigerian government had been diligent and faithful in implementing existing policies in the country, adolescents, particularly female adolescents, would have been assured better access to contraceptive services. It is not enough to have good laws or policies in place, there must also be willingness on the part of a government to ensure the effective implementation of these laws and policies.

As this study has shown, Nigeria is not wanting in good policies with regard to access to contraception for female adolescents, what is lacking is proper implementation. The government of Nigeria should establish effective machinery to ensure full realisation of access to contraceptive services to female adolescents as already contained in several policy documents. This will require more allocation of resources to meeting the sexual and reproductive health of adolescents and establishing health care centres for them.

Time is running out and the target set to realise the Millennium Development Goals (MDGs) is drawing near. If the Nigerian government does not want to miss the target for

[35] Center for Reproductive Law and Policy (CRLP) & Child and Law Foundation (CLF) *State of Denial: Adolescents Reproductive Health in Zimbabwe* (2002) 52.

2015, the time is now to live up to its commitment of realising universal access to sexual health services for adolescents, especially female adolescents. The Nigerian government must take concrete and decisive steps aimed at removing barriers to access to contraceptive information and services to female adolescents. Where necessary, the government of Nigeria may need to adopt remedial measures, in line with the provisions of articles 4 of CEDAW and 2 of the African Women's Protocol, to facilitate access to contraception for female adolescents. Such measures will require the government to commit more resources and energy to meeting the sexual health needs of female adolescents. It will also involve empowering health care providers to be sensitive to the needs of female adolescents.

9.3.2 Funding and Training of Health care Providers

The health care setting remains a source of disillusionment for many adolescents due to its unfriendly nature and negative attitudes of health care providers. These problems can be overcome if government takes proper measures to improve the working conditions of health care providers and ensures the provision of adequate youth-friendly facilities. Experience has shown that health care providers often tend to exhibit negative attitudes towards their patients out of stress and frustration. These negative attitudes sometimes are as a result of poor remuneration or lack of essential facilities to work with. Therefore, the Nigerian government would need to commensurately compensate health providers with decent remuneration for their services and ensure that needed facilities, especially in rural areas, are guaranteed in public health care institutions. Also, it will be necessary for the Nigerian government to increase budgetary allocations to the health sector, especially on issues affecting the health needs of children and adolescents.

At present most of the programmes specifically relating to the sexual health of adolescents are funded by national and international NGOs. Indeed, a greater number of programmes focusing on the sexual health needs of adolescents, especially female adolescents are largely donor-driven. For instance, recent donors in this regard include the US Agency for International Development (USAID) and other private institutions

such as the Ford Foundation, the Bill and Melinda Gates Foundation, the Rockefeller Foundation, the David and Lucile Packard Foundation, PEPFAR and the John D and Catherine T. MacArthur Foundation. Sadly, the Nigerian government merely plays second fiddle in this regard by providing funding support to pockets of similar programmes.[36] Indeed, governments at the national and state levels do not have specific budgets for issues relating to the sexual health needs of adolescents in the country.[37] This is a gap that needs to be addressed.

Ordinarily, there is nothing wrong with donors funding health issues, especially in developing countries. However, the danger with this situation is that sometimes when donors decide to withdraw funding for certain programmes, it tends to leave the beneficiaries helpless and stranded. This can further jeopardize the sexual health needs of adolescents in general and female adolescents in particular. Moreover, experience with the PEPFAR programme has shown that donor-driven programmes may impose ideas and agendas on a country that may be to the detriment of the beneficiaries of such programmes. For instance, as discussed in Chapter 3, PEPEFAR requires countries that are benefiting from its fund to adhere to abstinence-only programmes as a way of preventing HIV/AIDS. However, as this study has shown, abstinence is not always a plausible option for female adolescents who are usually not in control of their sexuality.

Although the Federal Ministry of Health occasionally provides funding for projects and programmes relating to the sexual health needs of adolescents, these are not usually specifically budgeted for by the ministry. In a country where about 760, 000 unsafe abortions are recorded yearly among women, especially young women, this leaves much to be desired.[38] It is an indication that the Nigerian government is not living up to its obligations to promote and protect the sexual health needs of adolescents. Therefore, in line with its commitments under international and regional consensus documents,[39] it is

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[36] See G Sedgh *et al Meeting Young Women's Sexual and Reproductive Health Needs in Nigeria* (2009) 14.
[37] *Ibid.*
[38] See See A Bankole *et al Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences* (2006) 14.
[39] These include the International Conference on Population and Development 1994, the Beijing Platform of Action 1995, the Abuja Declaration on HIV/AIDS, Tuberculosis, Malaria and other related diseases and

imperative that the government redoubles its funding efforts in order to meet the sexual health needs of adolescents. More importantly, given the fact that the unmet need for contraception is a major cause of the high incidence of unsafe abortions in the country, the Nigerian government must improve access to contraceptive information and services for female adolescents.[40] Significantly, the Nigerian government will need to invest more on research and development of woman-initiated and controlled methods such as the female condom, vaccines and microbicides as these will advance the sexual autonomy of female adolescents and respond to the female adolescent question. Also, the government of Nigeria will need to make available, at public health centres, woman-initiated forms of contraception, including EC, without the need for a doctor's prescription.

Moreover, health care institutions must be run in a way that accommodates the special needs of adolescents, especially female adolescents. More importantly, continued education and training emphasizing the need to respect human rights of patients, especially adolescents, seeking treatment should be given to health care providers. The present attempt to incorporate sexual and reproductive health and rights issues into the curricula of medical schools in the country (a project initiated by an NGO), is highly commendable and should be encouraged and supported by the government.[41] This will go along way at addressing judgmental attitudes often displayed by health care providers towards adolescents, particularly female adolescents, seeking sexual health services. It will also be necessary to establish across the country youth-friendly health care centres or clinics focusing on the health needs of adolescents.

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the Gaborone Declaration. Under the first two documents the international community commits itself to giving more attention to the health needs of women and girls with a view to ensuring universal access to sexual and reproductive health services by 2015. On the other hand, the last two documents emphasize the need for African governments to allocate at least 15% of their annual budgetary allocations to the health sector.

[40] Bankole *et al* (note 38 above) 26.

[41] See BA Oye-Adeniran *et al* 'Promoting Sexual and Reproductive Rights in Nigeria through Change in Medical School Curriculum' (2004) 8 *African Journal of Reproductive Health* 85-91.

9.3.3 Need for Awareness campaigns on Adolescents Sexual Health Issues

In line with articles 5 of CEDAW and 2 of the African Women's Protocol,[42] the Nigerian government needs to embark on awareness campaigns in order to educate the public, parents, guardians and other stakeholders on the importance of sexuality education for young people in the country. Also, awareness campaigns will need to be embarked on to educate the public about the negative effects of some cultural or religious practices on the sexual health needs of adolescents, especially female adolescents.[43] It might be necessary for government to engage in dialogue with religious and community leaders to seek their support and allay their fears regarding the teaching of sexuality education in schools.

More importantly, parents and guardians must realise times are changing and adolescents are becoming sexually active at an earlier age more than ever before. Therefore, they can no longer ignore this fact, but must face the reality of our times and ensure that their children are well-equipped with necessary information regarding their sexuality. This will prepare young people for the challenges ahead of them and afford them the opportunity of making the right choices when the need arises for them to engage in sexual acts. Parents and guardians remain the primary sexual health educators of their wards. They cannot afford to shirk this crucial responsibility at this critical time. Parents, guardians and society at large should know that communications regarding sexuality to young people do not corrupt them. Rather, they make them delay sexual debut and enable them to make the right choices about their sexuality. [44]

Over the years, the only voices that have been heard with regard to the debate on children's right have been those of adults. Interestingly, children and adolescents have not been given enough opportunity to air their views. Many children and adolescents lack adequate knowledge with regard to their rights as contained in international and national

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[42] These articles enjoin states to take necessary measures including education and awareness to end cultural practices which discriminate against women and girls in tier countries.

[43] *Ibid.*

[44] See for instance., A Ajuwon 'Benefits of Sexuality Education for Young People in Nigeria' in E Maticka-Tyndale *et al* (eds) *Human Sexuality in Africa: Beyond Reproduction* (2008) 67-82; S Nganda 'Sex Education: Do our Teens Need it?' in E Maticka-Tyndale *et al* (eds) *Human Sexuality in Africa: Beyond Reproduction* (2008) 53-66.

human rights documents. It is therefore, necessary that awareness campaign and education programmes on the rights of children and adolescents, especially female adolescents, are embarked upon among children and adolescents in the country. It is a well-known fact that when people are aware of their rights they are more likely to demand them and challenge violations of such rights.

When children and adolescents are informed about their rights, including their right to sexual health, they are able to make important choices relating to their sexuality free from coercion and discrimination. More importantly, children and adolescents (especially girl children and female adolescents) should be more involved the in drafting process of laws and policies relating to their health. It should be noted that both the CRC and the African Children's Charter contain provisions affirming the rights of children to participate in political decisions of their countries.[45] This will give them the opportunity to make an important contribution to issues affecting their health and lives. Ultimately, it will go a long way not only in facilitating access to sexual health services for adolescents, but also in advancing the sexual autonomy of adolescents, especially female adolescents.

9.4.4 Working with NGOs

There will be need for the Nigerian government to foster a cordial relationship with NGOs and civil society groups working on issues relating to adolescents' sexual health needs. The relationship between governmental institutions and non-governmental organisations can be symbiotic in the sense that a government can benefit from the expertise and knowledge of NGOs, while NGOs can equally benefit from the government's resources and political will in executing their ambitious programmes.[46] This can go a long way in advancing adolescents' access to sexual health services, particularly in relation to contraception.

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[45] See for instance, art 12 of CRC and art 16 of the African Children's Charter.

[46] O Okafor & S Agbakwa 'On Legalism, Popular Agency and "Voices of Suffering": The Nigerian Human Rights Commission in Context' (2002) 24 *Human Rights Quarterly* 662, 690; see also, E Durojaye 'Turning Paper Promises to Reality: National Human Rights Institutions and Adolescents' Sexual and Reproductive Rights in Africa' (20008) 26 *Netherlands Quarterly of Human Rights* 547, 571.

Indeed, experience has shown that the activities of NGOs have often complemented government's efforts in ensuring access to sexual health services to adolescents. For instance, organisations such as Action Health Incorporated (AHI) and International Center for Reproductive Health and Sexual Rights (INCREE) have both been involved in breaking the silence with regard to sexuality education for adolescents, particularly adolescent girls through their programmes. The AHI has continued to run an independent youth-friendly health centre to cater for the peculiar needs of adolescents in Nigeria.[47] On the other hand, INCREE has continued to organise focus group discussions for adolescent girls where various issues relating to their sexuality and well-being are discussed.[48] These actions have helped to build the confidence and capacity of adolescents, especially adolescent girls to live a positive and healthy life. A major outcome of this is that adolescent girls have developed confidence and maturity with regard to making important sexual choices.

As mentioned above, there are different local and international NGOs working on issues relating to the sexual health of adolescents. Most of these organizations work on similar issues. It will be necessary for the government to coordinate the activities of these NGOs in order to maximise their complementary roles. Where necessary, duplication of roles and programmes should be avoided.

In addition, as discussed in Chapter 7, NGOs can work together with the government to develop a set of human rights indicators for the purpose of monitoring the sexual health and rights of adolescents. Such indicators will help the government to meet its obligations under international human rights law. In particular, it will help the government to improve in its reporting obligations to the Committee on CRC and the Committee of Experts on the African Charter on the Rights and Welfare of the Child (Experts Committee of the African Children's Charter). Indicators usually help in bringing the attention of a government to the compatibility of its laws and policies with its obligations

[47] See AO Esiet & C Whitetaker 'Coming to Terms with Politics and Gender: The Evolution of an Adolescents Reproductive Health Programme in Nigeria' in N Hiberland & D Measham (eds) *Responding to Cairo: Case Studies of Changing Practice in Reproductive Health and Family Planning* (2002) 149-167.
[48] INCRESE mission and objective available at http://www.increse-increse.org/index (Accessed on 22 February 2009).

under international human rights law. They also reveal the degree to which right-holders (for example adolescents) are enjoying basic rights guaranteed under international law.[49] Both government and NGOs can agree on a list of human rights indicators relating to the sexual health needs of adolescents, particularly in the context of access to contraceptive services. These indicators must reflect the lived experiences of female adolescents in the country.

Also, it will be important for NGOs and other institutions to assist the Nigerian government in their reporting obligations to treaty monitoring bodies. But where necessary, NGOs can equally submit independent or shadow reports to these bodies to counter state report on similar issue. Such reports will help to fill the void in government's reports and provides complementary information useful to both the government itself and treaty monitoring bodies.[50] Shadow reports also help treaty monitoring bodies to make balanced recommendations to a state party. More importantly, through advocacy and awareness campaigns, NGOs can help to draw attention to Concluding Observations made with respect to the state reports submitted by Nigeria to treaty monitoring bodies relating to children's and adolescents' rights.[51] They can also follow-up on such Concluding Observations with a view to ensuring their implementation. This will help in not only advancing the sexual autonomy of adolescents, but also in realising access to sexual health services including contraceptive services to them.

Additionally, the Nigerian government must liaise with women's groups and NGOs in developing policies or programmes relating to the sexual health needs of female adolescents. As shown in Chapter 5, well-designed programmes relating to the sexual health needs of adolescents is critical in increasing knowledge of contraception and can help to over come biases and misconceptions with regard to female adolescents' sexuality. Such programmes must necessarily be rooted in human rights principles and

[49] M Greene 'What We talk about When we talk about Indicators: Current Approaches to Human Rights Measurement' (2001) 23 *Human Rights Quarterly* 1063, 1065.
[50] L Woll 'Reporting to the UN Committee on the Rights of the Child: A Catalyst for Domestic Debate and Policy Change?' (2000) 8 *International Journal on Children's Rights* 71, 77.
[51] *Ibid.*

must advance gender equality and empower adolescents, particularly female adolescents to make crucial choices relating to their sexuality free from stigma, coercion and discrimination.

9.3.5 Need for Judicial Activism

Nigerian courts should develop a progressive and purposive interpretation of the provisions of the Constitution in order to advance the sexual health needs of adolescents. While it is admitted, as pointed out in Chapter 5, that the wording of some provisions of the Constitution is couched in restrictive language, the courts should be able to display some degree of activism in interpreting these provisions to affirm the sexual autonomy of female adolescents and guarantee them access to contraceptive services. In doing this, the courts should always give priority to the principles of the best interests of the child and the evolving capacities of the child. Also, Nigerian courts will need to be proactive in striking down laws, policies and practices that hinder access to sexual health services to adolescents. More importantly, courts should reflect in their decisions how they have addressed the female adolescent question with regard to cases relating to the sexual health needs of adolescents. This may require Nigerian courts to develop a systematic and consistent approach to asking the female adolescent question in their decisions.

Also, regional human rights bodies such as the African Committee of Experts on the Rights and Welfare of the Child should pay more attention to the sexual health needs of female adolescents in their works. For instance, the African Committee of Experts can include in their reporting guidelines to states parties a heading relating to how the sexual health needs of female adolescents have been addressed by states parties. Moreover, the Committee, in handling of communications submitted to it, can give life to the provisions of the African Children's Charter through purposive interpretation that will advance the special needs of female adolescents. The Committee can learn a lot in this regard from the experience of the European Court on Human Rights. [52]

[52] See for instance, Center for Reproductive Rights *Briefing Paper: Reproductive Rights in European Court* (2004) 8.

In sum, even those who do not approve of adolescent sex should accept that it will happen. The penalty for a female adolescent making a poor decision (to have sex) should not be (unsafe) abortion or unwanted pregnancy, leading to multi-generational consequences, such as an increased risk in neglect for the child born in those conditions. If society and the state are genuinely committed to protecting children and adolescents, they must admit that they cannot always be there to help children and adolescents make the right choice. Within this reality, helping a female adolescent minimize the negative effects (through contraception) of a 'poor' decision (having underage sex) is the only practical solution. In a rights-based environment, providing female adolescents with confidentially as regards contraceptive services may be emotionally difficult, but it remains the most realistic thing to do.

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