

THE DEVELOPMENT OF REPRODUCTIVE HEALTH LAWS: CONSIDERATIONS FOR THE NIGERIAN LEGAL SYSTEM*

INTRODUCTION

An important legacy of the **ICPD Programme of Action** and the **Beijing Platform for Action**, is the recognition that laws and policies related to reproductive health issues should aim at realising women's reproductive health care needs, such as family planning and contraception, safe abortions, control and treatment of HIV/AIDS and other sexually transmitted diseases, prohibition of female genital mutilation, and education on human sexuality and responsible parenthood¹. Because international human rights norms set out broad principles rather than defining the precise content of national laws needed for their enforcement, one of governments' great challenges is to develop appropriate legislation on population and reproductive health that promote and protect human rights. In this respect, states have a duty to promulgate, implement and advance a comprehensive legal strategy designed to promote rights to health, including women's reproductive health.

Reproductive health issues are often perfunctorily addressed in a country's health policies, usually issued by government parastatals and agencies. However, these policies do not provide the legal framework to respect, protect and fulfil reproductive health rights as human rights stipulated by ratified international Conventions.² Another drawback to policy making is that policies commonly lack legal enforceability and may be replaced when governments change, creating the potential for instability in the manner in which reproductive health care services are provided. It is important therefore, to ensure that international obligations and respect for reproductive rights is protected in national law.

This paper provides some considerations for enacting a national reproductive health law which would integrate gender and reproductive health provisions into the Nigerian legal system. It is proposed that this strategy will specifically address women's needs and encompass a rights – based approach to reproductive health in the country.

CONSIDERATIONS FOR REPRODUCTIVE HEALTH LAWS IN THE NIGERIAN LEGAL SYSTEM

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1 United Nations Report of the International Conference on Population and Development; Document A/Conf. 171/13, New York, 1994. See also United Nations Report of the Fourth World Conference on Women, Document, A/Conf. 177/20, and New York, 1995 (hereinafter referred to as the ICPD Programme of Action and the Beijing Platform for Action).

2 The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights: A Compilation of Essential Documents. International Commission of Jurists, Geneva, 1997.

One strategy for formulating laws on reproductive health is to conceptualise issues into a separate national law. There are a number of national laws on reproductive health matters in African and non-African jurisdictions, and many commentators believe that this approach can better clarify reproductive health issues within the state's legal framework(s).³ Such a restructuring will take into consideration the fact that the existing framework is unable to sufficiently address reproductive health concerns and protect women's health⁴. For instance, rape and sexual harassment in the workplace and topical concerns such as damages and evidence of physical injuries can be adequately provided in a separate Reproductive health law to discourage acts of gender based violence and afford victims the benefit of legal protection and redress in the event of a violation⁵. Presently in Nigeria, there is no national law on domestic violence; this can only be prosecuted under **Section 355 of the Criminal Code**. There is also no law on marital rape; redress can be sought only by reliance on the above section for grievous bodily harm or assault. A national law on reproductive health matters can specifically provide for a minimum marriageable age for girls, thereby harmonising the present position where customary law requirements vary from locality to locality. A reproductive health law can also address and prohibit harmful traditional practices such as widowhood rites, female genital mutilation and discrimination arising from HIV/AIDS infections.

Another strategy is to include reproductive health issues into existing legal provisions and documents. This strategy offers the prospects of incorporating issues of reproductive health rights into the present law by integrating reproductive health issues within already existing legal framework(s). For instance, civil and criminal laws can be reformed or amended to include a reproductive health section and provisions made in the section to protect different aspects of reproductive rights⁶. Rape and sexual assault presently provided for in the criminal laws can be reformed with more victim - friendly provisions on remedies, culpabilities and liabilities in order to deter crimes of this nature, protect health and punish offenders and perpetrators of sexual violence. The present law requiring very strict standards of proof in both civil and criminal matters have been seen to constitute an infringement on a victim's right to adequate redress and compensation for sexual offences and in many cases, insufficient proof or evidence of physical injuries have negated an otherwise valid complaint of sexual assault. A reconceptualisation of the existing law to cover for instance, cases of intimate partner violence often occurring in marriage, is therefore necessary to protect women's health and rights. While taking into consideration the multipronged legal system and the cultural specificity of Nigeria, the state must also implement internationally accepted standards for reproductive rights protection and integrate these into the Nigerian legal framework. The following provide some considerations for such a structuring.

Safe Motherhood

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- 3 For a comprehensive listing of recent developments of Reproductive health laws in Africa, see the authors' Ph.D Seminar at the Faculty of Law, University of Lagos, THE DEVELOPMENT OF REPRODUCTIVE HEALTH LAWS: CONSIDERATIONS FOR THE NIGERIAN LEGAL SYSTEM, 9th November, 2006.
 - 4 Section 357 of the Nigerian Criminal Code requires corroboration before an accused can be found guilty of rape. This requirement obviously makes a conviction very difficult to establish. Section 360 of the Code makes an act of indecent assault a mere misdemeanour where the victim is a woman.
 - 5 For instance, the strict requirement by law for victims of sexual offences to show evidence of penetration have often caused a miscarriage of justice when victims wash themselves soon after the rape and cannot obtain hair, semen samples or other signs of penetration.
 - 6 Aniekwu N.I. Converging Constructions: A Historical Perspective on Sexuality and Feminism in Post Colonial Africa. *African Sociological Review*, South Africa, Vol. 10, 2006 at 147.

The term '*safe motherhood*' is a positive state of women's health, the significant reduction of maternal mortality and morbidity and its impact on infant mortality. It implies the provision of maternal health services in the context of primary health care based on the concept of informed choice, including education and information, safe abortions, prenatal care, maternal nutrition programmes, adequate delivery assistance that avoids excessive recourse to caesarean sections and provides for obstetric emergencies; referral services for pregnancy, childbirth and abortion complications; post-natal care and family planning⁷. Maternal mortality is the death of a woman while pregnant or within 42 days of termination of pregnancy irrespective of the duration of pregnancy or its management but not for accidental or incidental causes⁸. Maternal mortality, in the absence of safe motherhood, is the leading cause of premature death and disability among women of reproductive age in developing countries.

Nigeria has an extremely high maternal mortality ratio, one of the main indicators of the poor state of reproductive health. The **multiple indicator cluster surveys** (MICR) in 2004 reported a maternal mortality ratio of **704 per 1000,000** live births, implying that about 56, 000 Nigerian women die each year as a result of complications associated with pregnancy or childbirth⁹. Statistics indicate that Nigeria has the second highest rate of maternal deaths in the world with the **maternal mortality ratio** (MMR) being about 91 times worse than in the industrialised countries, highlighting what is one of the widest disparities in international public health¹⁰. Globally, around 78 % of all maternal deaths are the direct result of complications arising during pregnancy, delivery or the puerperium with the most common direct obstetric causes of death including haemorrhage, sepsis, pre-eclampsia and anaemia. Rankings for these diseases vary with location¹¹.

In recent years, illegally induced abortion has increasingly been recognised in Nigeria as a major cause of mortality in women of childbearing age. Despite the strict abortion laws, unsafe abortions are widely practised and account for a significant proportion of maternal deaths, particularly in younger women¹². Unsafe abortions also contribute to morbidity by increasing exposure to infections and the risks of haemorrhage and injury, which often impairs health and interferes with subsequent fertility. These deaths are mostly preventable if women had legal access to family planning services and safe abortions.

Gender Equity

According to **UNAIDS**, gender defines "*a persons' opportunities, roles, responsibilities and relationships...these roles and relations have a significant influence on the course and impact of reproductive health.*"¹³ In Nigeria, population programs and

7 REPRODUCTIVE RIGHTS 2000: MOVING FORWARD. The Centre for Reproductive Law and Policy (CRLP) 2002. See also Aniekwu N.I. Uzodike Eunice U., Legislating Gender, [Re] producing Rights: A look at African Case law in Diaspora, The Journal of Social Welfare & Family Law, Faculty of Law, University of Liverpool, U.K. 2008.

8 Ibid.

9 Status of CEDAW Implementation in Nigeria: A Shadow Report. Women's Aid Collective Report Nigeria – NGO CEDAW Report, Compiled for the Thirtieth Session of the Committee on the Elimination of All Forms of Discrimination Against Women. 2004. See also Okonofua F. Report of the Society of Gynaecology and Obstetrics of Nigeria (SOGON) 2005.

10 Okonofua at 27.

11 Ibid at 35.

12 Sections 230 – 232 Criminal Code, Laws of the Federation of Nigeria, 2004. See Okonofua, *ibid*, for specific data on maternal deaths arising from unsafe abortions.

13 UNAIDS. GENDER AND HIV/AIDS: TAKING STOCK OF RESEARCH AND PROGRAMMES. Geneva: Joint United Nations Programme on HIV/AIDS, 1999.

policies have made some impact in addressing gender issues and expanding women's access to contraceptives and health services, but there has been much less progress in other areas of reproductive health services for women such as the prevention and management of sexually transmitted infections, maternal mortality and HIV/AIDS. Poor nutrition for girls in childhood and adolescence remains a major factor in reproductive outcomes for women and children. Practices such as female genital mutilation, domestic violence and sexual trafficking continue despite medically proven risks and harm to the reproductive health of many women¹⁴.

The **ICPD** sets out clear principles that prioritises gender equality, equity and the empowerment of women, and emphasises the importance of a gender perspective in the design and implementation of health services¹⁵. It expands the notion of sexual health and reproductive rights to older established priorities such as safe motherhood and high quality family planning services¹⁶. The **Committee on Economic, Social and Cultural Rights** further restates the need to integrate a gender perspective in health-related laws, policies, planning, programmes and research in order to promote better health outcomes for both women and men.¹⁷

The **Nigerian Constitution** confers equality on all citizens of Nigeria, irrespective of ethnic groups, place of origin, sex, religion or political ambition.¹⁸ The provisions on human rights, fundamental objectives and directive principles of state policy highlight government's commitment to ensuring equality of men and women. **Chapter II** creates equal opportunities for both genders, even though the provisions are largely unenforceable by virtue of the restrictions inherent in **Section 6(6)**.¹⁹ The chapter emphasises the duty and responsibilities of all organs of government to direct its policies towards ensuring that there are equal and adequate opportunities for all irrespective of sex, education and employment in harnessing resources and access to health²⁰. In the same vein, **Section 34** provides for the respect of the dignity of the human person and **Section 42** states that no person should be discriminated against on the basis of sex. Under the Sharia law, the evidence of two women being equal to that of one man is itself a form of inequality²¹.

Studies in Nigeria have shown that between 34 and 61 percent of women experience some form of violence in marriage and available data suggest that in other African countries, nearly one woman in four experience sexual violence from an intimate partner.²² Rape and sexual assault by acquaintances and strangers is common. Unfortunately, the bill on **Prohibition of Violence against Women** is still pending

14. These practices are still prevalent all over Nigeria despite some state bills that have been passed to curb them. See Aniekwu N.I. Examining the Reproductive Health and Rights of Nigerian women. University of Benin Law Journal Vol. 6. No. 2 2001 at 56.

15. ICPD Programme of Action, Cairo, Egypt, 5-13 September 1994, in Report of the International Conference on Population and Development, U.N. Doc. A/Conf.171/13/Rev.1, U.N. Sales No. 95. XIII.18 (1995).

16. Ibid at para. 7.4.

17. International Covenant on Economic, Social and Cultural Rights. General Comment No. 14. The right to the highest attainable standard of health (paras. 18 and 19) E/C.12/2000/4, 2000.

18. Chapter IV, Constitution of the Federal Republic of Nigeria (Promulgation) Decree 1999.

19. Ibid at Chapter II.

20. See Sections 16, 17 and 18 of the Constitution on economic, social and educational objectives which, in essence, are directed towards the CEDAW objectives.

21. See Sharia and Women's Rights in Nigeria: Strategies for Action. A publication of Women's Aid Collective (WACOL) and Women's Advocates Research and Documentation Centre (WARDC) 2005.

22. Marge B. 'The Changing Environment for Reproductive Health'. Paper presented at the WBI core Course, Turin, Italy, 18-29 August 2003. See also Aniekwu N.I. Sexual Violence and HIV/AIDS in Sub-Saharan Africa: An Intimate Link. Paper presented at an International Conference on Human Rights, London School of Economics and Political Science, London, U.K. March 2006.

before the National Assembly and is yet to be passed into law. Trafficking of women and children and forced prostitution present equally serious problems in many states.²³ Many customary and religious laws are discriminatory of women's equal rights to custody of children in divorce proceedings, payments of maintenance and inheritance. Contextual factors such as women's status and lack of empowerment are equally contributory to the accessibility and quality of health services²⁴. This is one reason why the **National Policy on Women** articulates into a coherent whole "...all policies and programmes that will actualize the provisions of the Constitution."²⁵ It is thus absolutely essential that a gender perspective be placed high in the list of priorities in law enforcement, legislation, design and implementation of health services.

Health Sector Reform

In recent years, health reform has been promoted as a means of improving the effectiveness, efficiency, quality, equity and financial sustainability of health systems. Reforms have typically involved significant changes in the financing, payments, organization and regulation of health systems and have been described as "*sustained purposeful change to improve the performance of the health sector*."²⁶ Changes in the legal environment are also health reform measures that regulate health system performances such as governance capacity, skills, provision of health services, resources and accountability to consumers²⁷. Legal reform of health systems focuses on the need to integrate primary health care, gender equity, poverty reduction and human rights in legislative enactments for the achievement of health. A health reform programme further includes "*the protection and promotion of reproductive health and rights through laws and policies that address the treatment and management of sexual and reproductive health problems*."²⁸

In its' **World Health Report** in 2004, the World Health Organisation assessed the performance of the health systems of its 191 member states.²⁹ The report assessed and ranked countries' health systems, in terms of their responsiveness, legislations, overall goal attainment, level of health expenditure per capita, impact on health and overall performance³⁰. Nigeria had scores near the bottom of the 191 countries for every single one of these indicators³¹. The dismal performance of Nigeria, in spite of its human resources and intellectual capital in health, not to mention its natural resources, compared with many other African countries, is indeed a cause for concern. The high levels of morbidity and mortality, the limited and negative progress towards the attainment of the international goals for health and survival, and the inequities in the distribution of health resources bear testimony to the fact that the Nigerian health system

23. This is despite the fact that Sections 223 – 225 of the Criminal Code prohibits the trafficking of human beings, likewise the Penal Code. See also REPRODUCTIVE HEALTH STRATEGY – TO ACCELERATE PROGRESS TOWARDS THE ATTAINMENT OF INTERNATIONAL DEVELOPMENT GOALS AND TARGETS. World Health Organization, Geneva, 2004.

24. Aniekwu N.I., supra n. 14.

25. Section 1, National Policy on Women (NPW) Nigeria, 2000.

26. Tom Merrick. Which Health Reforms? Experience and Rationale, Paper presented at the WBI core Course, Turin, Italy, 18-29 August 2003.

27. Gaston Sorgho. Health Systems: What they are and how they vary, Paper presented at the WBI core Course, Turin, Italy, 18-29 August 2003.

28. World Health Organization. FIRST GLOBAL STRATEGY ON REPRODUCTIVE HEALTH. Adopted by the 57th World Health Assembly (WHA), p. 27, May 2004.

29. World Health Organisation. How well do health systems perform? In WHO Report. HEALTH SYSTEMS; IMPROVING PERFORMANCE, WHO (G – 2000b) Geneva 2004.

30. Ibid.

31. UNICEF and National Planning Commission, Abuja, Nigeria. CHILDREN'S AND WOMEN'S RIGHTS IN NIGERIA: AWAKE UP CALL. Situation Assessment and Analysis 2001.

has so far failed to contribute meaningfully to the national development goals of an egalitarian society.³²

To address the dismal state of the Nigerian health system, the Federal Ministry of Health proposed a series of health reform agendas for the Nigerian health sector. One of the key Reform Strategies for the health system in 2003 was the review and “redefinition of roles and responsibilities of *all* stakeholders in the health care delivery system”³³

The proposals of the Honourable Minister for Health include:

- the redefinition of roles and responsibilities of “all” stakeholders in the health care delivery system including the public and private sectors
- the reorganisation, restructuring and redefinition of functions and responsibilities of functions and responsibilities of the Federal Ministry of Health, State ministry of health and Local Government Areas on health issues
- the review of existing health policies and strategies (including the **National Health Policy** 1988 and the **Constitution of the Federal Republic of Nigeria** 1999) to remove ambiguities and overlaps in health system delivery
- the development of new enactments (e.g. a **National Health Act**) that redefines the national health system and functions of each level of government
- revitalisation of the **National Health Insurance Scheme** of 1999.³⁴

These proposals represent both opportunities and challenges for law and policy reforms on reproductive health care delivery in Nigeria. To satisfy human rights standards through private and public accountability for reproductive health and rights, the legal system can provide for the following:

- informed decision making
- free decision making
- privacy
- confidentiality
- competent delivery of services,
- safety and efficacy of products.

Some national health sector reform initiatives have instituted user fees for health services in order to cover the partial cost of health care and increase the standards of services³⁵. Health sector reform advocates explain that there is a need to raise revenues to be available for healthcare, but also that user fees might help to prevent selfish or irrational use of publicly funded health services³⁶. However, the **CESCR General Comment on the Right to Health** explicitly requires *states* ‘to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services’.³⁷ The Comment specifically requires government members to ensure that lending policies and credit

32. Aniekwu N.I. Health Sector Reform: A Perspective on Human Rights and Gender Issues, Local Environment: The International Journal of Justice and Sustainability, United Kingdom. Routledge, Taylor and Francis. pps 127 – 140, 2006.

33. Eytayo I. Making good health a real dividend of democracy for Nigerians under the new administration, Notes by Prof. Eytayo Lambo, Honourable Minister for Health, Abuja, August, 2003.

34. Ibid.

35. Cook Rebecca J., Dickens Bernard M., Fathalla Mahmoud F. REPRODUCTIVE HEALTH AND HUMAN RIGHTS – INTEGRATING MEDICINE, ETHICS AND LAW, 109 (Oxford University Press, 2003).

36. T. Merrick. Delivering Reproductive Health Services in Health Reform Settings: Challenges and Opportunities, Paper presented at WBI Core Course. World Bank Institute, Washington D.C. 2004.

37. CESCR General Comment 14. See paras. 18 and 19 on the right to the highest attainable standard of health: 11/08/2000. E/C. 12/2000/4.

agreements are regulated in legal documents in order to prevent abuse by health care personnel and ensure respect of the right to health.³⁸

In Nigeria, there are other costs that prevent women from seeking health care. These include transport, accommodation, drugs, supplies, as well as informal or under the table fees that health staffs impose. In African societies where more than 43% of women live below the poverty line or lack control over resources and are dependent on others for funds, fees of any kind can be a serious obstacle to availability and use of services.³⁹

Furthermore, **Article 12(2) of the Women's Convention**, addressing maternity services, requires states to grant '*free services where necessary*'.⁴⁰ Strategies to overcome barriers to access to health services in Nigeria will include legislating for means-related sliding fees, insurance schemes based on community membership or employment, community trust fund or loan schemes, with legal provisions conferring these benefits on deserving vulnerable groups.

Millennium Development Goals

One of the main features of the new approach to development assistance is a focus on results rather than inputs and on measuring progress toward the development goals agreed at major international conferences that were held during the 1990s.⁴¹ A key accomplishment of these conferences was to establish measurable goals towards which governments and development agencies could focus their efforts to improve the health and welfare of poor and vulnerable groups around the world. The International Development Goals grew out of the United Nations Declaration at the Millennium Summit adopted by member states in September 2000⁴². These goals were later expressed as the **Millennium Development Goals** in the subsequent formulation in 2002⁴³. The eight (8) MDGs provide the new international framework for measuring progress towards sustaining development and eliminating poverty and set a number of targets to be used in measuring progress towards these objectives.

Of the eight Goals, three are aimed at improving maternal health, reducing child mortality and halting the spread of HIV/AIDS. The others aim at reducing malaria and other diseases, eradicating poverty and hunger, achieving universal primary education, promoting gender equality, empowering women and ensuring environmental sustainability. The goals are closely related to health reform and are based on the principles of human dignity, equality and equity.

Among the specific targets are:

***To reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;
To reduce by two thirds, between 1990 and 2015, the under five mortality rate;
To have halted by 2015, and begun to reverse, the spread of HIV/AIDS.***⁴⁴

38. Ibid.

39. See E. Weissman, O.Sentumbwe – Mugisa, A.K. Mbonye, and C.Lissner, *Legalising Safe Motherhood in Uganda*, *Reproductive Health Matters*, 85 – 91, 1999.

40. *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature Dec.18,1979, art. 12(1), 1249 U.N.T.S .13, 19 I.L.M. 33 (entry into force Sept 3, 1981) [hereinafter *Women's Convention*.].

41. See the Cairo Programme, the Beijing Platform and the Social Summit documents.

42. See *The Millennium Development Goals in Nigeria: First Progress Report*. Nigerian Institute of Social and Economic Research (NISER). 2003.

43. *Millennium Development Goals; Report of United Nations Secretary General*. UN/ Doc. 00475/05, 2005.

44. Ibid.

These are critical challenges that Nigeria face in her efforts to implement commitments made at the conferences. Key among them are shortfalls in financial support for needed action, lack of implementation capacity and the rapidly changing legal, policy and program environments in which women's reproductive health can be protected. The design of health services or programs in Nigeria has altered substantially due to the many changes in the policy and lending environment in recent years⁴⁵. In the face of severe financial and organizational constraints, the State is making difficult choices about how and where to allocate human and financial resources on health care. In many countries, there is a greater tendency towards a broader approach of health system development and reform that includes instituting new legal arrangements for improved health care delivery, implementing sector-based rather than project-based donor funding, and enacting legislations that ensure accountability in health systems⁴⁶.

HIV/AIDS Reduction

International treaties, national laws and legislations continue to play important roles in addressing and reducing women's vulnerability to HIV/AIDS. At the international level, CEDAW and the declaration of the **United Nations General Assembly Special Session on HIV/AIDS**, amongst others, highlight the importance of legislating against gender based violence and addressing HIV transmission, treatment and care for AIDS patients⁴⁷. These international documents obligate governments to develop and monitor legislations and related programs aimed at reducing HIV/AIDS prevalence. Such agreements are being used to hold signatory governments accountable for addressing HIV/AIDS and gender equality in their respective countries through monitoring, reporting and advocacy.

The prevalence of HIV in Nigeria has been on a steady rise within the past decade. By the end of 2002, 2.7 million Nigerians were living with HIV/AIDS, translating into 400,000 new cases since the end of 1997⁴⁸. A 2000 government survey indicated that 5.4% of the population in Nigeria were infected with HIV/AIDS, with infection rates as high as 16.8% in many parts of the southern states and at least eight areas reporting prevalence rates higher than 10%⁴⁹. In 2000, President Olusegun Obasanjo indicated governments' intention to enact a law that would prohibit discrimination against persons living with HIV/AIDS and make HIV testing mandatory for couples intending to marry⁵⁰. The **AIDS Policy** states that "[t]he fundamental human rights of people living with AIDS and other STIs and their families shall be respected at all times"⁵¹. In addition, people living with HIV/AIDS may not be "discriminated against in any public or private health care facility" and carriers have "the right to the best available medical care and

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45. See Nigeria's situation analysis by Arlette Campbell White, Tom Merrick in Poverty Reduction, Reproductive Health and Health Sector Reform. Paper presented at the WBI Core Course, Turin, Italy, 18-29 August 2003.
 46. Aniekwu N.I. The Roles of Legislation and Human Rights in Health Sector Reform, Paper presented at the World Bank Institute National Course on Millennium Development Goals in Abuja, Nigeria. November, 2005.
 47. The UNGASS doc., paras. 17 (h), 2001.
 48. Aniekwu N. I. HIV/AIDS and Human Rights in Nigeria: A Perspective on International Guidelines, Journal of Medicine and Biomedical Research., College of Medical Sciences, University of Benin. Volume 2, No. 1, 2003.
 49. UNAIDS and WHO. EPIDEMIOLOGICAL FACT SHEET ON HIV/AIDS AND SEXUALLY TRANSMITTED INFECTIONS, NIGERIA, 2000.
 50. UNAIDS and WHO. GUIDELINES FOR SECOND GENERATION HIV SURVEILLANCE, 2000. See also Aniekwu N. I. "Expanding the National Response(s) to HIV/AIDS, law and human rights in Nigeria", University of Benin Public Law Journal Vol 1. No. 1. 2002.
 51. National Action Committee on AIDS (NACA). Situational Analysis Report on STD/HIV/AIDS in Nigeria, 2000.

understanding”⁵². According to the **2000 HIV Report**, “*the legal system has not been sufficiently adapted to the evolution of the [HIV/AIDS] situation, and the ethic committee on HIV/AIDS is not functional*”⁵³. Although the Federal Ministry of Health conceded that there are “gaps in existing laws on rights,” it points to international laws and human rights organizations, as well as to traditional and religious laws as potential resources in addressing the rights and ethics associated with HIV/AIDS issues⁵⁴.

Many states have started addressing HIV related issues in their legislations. In 2005, Rivers State passed a bill to prohibit discrimination of HIV positive employees in the workplace.⁵⁵ The Edo State house of Assembly is also proposing passing a similar bill to prohibit work related discrimination in relation to people with AIDS. Several networks of women’s groups have pushed for HIV specific laws and their enforcement in other states in the country. In Benin City, the Women’s Health Action Research Center, a nongovernmental organization advocating for the reproductive health and rights of Nigerian women, collaborated with the State legislature to draft a Domestic Violence Bill for the State house of Assembly⁵⁶. This bill contains provisions specifying civil and criminal liabilities in cases of AIDS infection arising from sexual violence.

Health Rights

There is an urgent need to affirm the right to health in the Nigerian Constitution as a fundamental human right. The present position merely includes the attainment of health as a social objective in promoting a social order founded on the ideals of freedom, equality and justice.⁵⁷ This is despite the fact that the right to health is recognised as a fundamental human right in numerous international instruments which Nigeria has acceded to. The **Universal Declaration of Human Rights** affirms “*everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing, medical care and necessary social services*”⁵⁸ The U.N. **Human Rights Committee** that monitors the **International Covenant on Civil and Political Rights** has elaborated the link between the right to life and the right to health.

The **International Covenant on Economic, Social, and Cultural Rights** provides the most comprehensive article on the right to health in international human right law. In accordance with **Article 12.1** of the Covenant, States parties recognise “the right of every one to the enjoyment of the highest attainable standard of physical and mental health”, and **Article 12.2** enumerates, by way of illustration, a number of “*steps to be taken by the States parties... to achieve the full realisation of this right*”⁵⁹.

The right to health is also recognised in **Articles 11.1 (f) and 12** of the **Convention on the Elimination of All forms of Discrimination against Women** of 1979⁶⁰. Other regional human rights instruments such as the **European Social Charter** of 1961 (Art. 11 as revised), the **African Charter on Human and People’s Rights of 1981** (Art. 16), and the **Additional Protocol to the American Convention on Human**

52 Ibid.

53 Supra n. 51 at paras 19 – 21.

54 Ibid at para 21.

55 A law to prohibit HIV/AIDS based discrimination in the workplace.

56 The Domestic Violence and other Related Matters Bill, Edo State. (HA 17) 2001

57. Section 17 of the Nigerian Constitution.

58. Universal Declaration of Human Rights, Article 25.1 Adopted 1948, G.A. Res. 217A (111), U.N. Doc. A/810 (1948).

59. International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12. Opened for signature Dec.16, 1966, 993 U.N.T.S 3 (entry into force Jan.3 1976).

60. Committee on CEDAW General Recommendation No. 24 on Women and Health, para. 29. 1999.

Rights of 1988 also specifically recognise the right to health⁶¹. This right has been proclaimed by the **Commission on Human Rights**, as well as in the **Vienna Declaration and Programme of Action** of 1993⁶². It is closely related to and dependent upon a wide range of socio – economic factors that promote conditions in which people can lead a healthy sexual and reproductive life. Since the adoption of the two International Covenants in 1966, the concept of health has undergone substantial changes and also widened in scope.⁶³ Additional determinants of health are being taken onto consideration by many states, such as resource distribution, gender differences, violence and armed conflicts.⁶⁴ HIV/AIDS has further created new issues for the realisation of the right to health. There's therefore an urgent need for prevention and education programmes in behaviour – related health concerns such as sexually transmitted diseases, reproductive health, environmental safety, education, economic development and gender equity⁶⁵.

With respect to the right to health, states have a legal obligation to provide persons who do not have sufficient financial means for necessary health insurance and health care. In Nigeria, there's a law that already backs the **National Health Insurance Scheme**⁶⁶. Human rights law also specifies the obligation to prevent any discrimination on internationally prohibited grounds in the provision of health services.⁶⁷ While the **ICESCR** provides for the progressive realisation of the right to health and acknowledges the constraints due to the limits of available resources, it imposes on the state various legal obligations, which are of immediate effect⁶⁸. International obligations further specify that the right will be exercised without discrimination of any kind, and emphasises the legal obligation to take steps towards the full realisation of **Article 12** of the Covenant in all its ramifications⁶⁹.

Treaty Obligations

In 2000, the **Committee on Economic, Social and Cultural Rights** recommended that states integrate a gender perspective in their health related laws and policies in order to promote better health outcomes for both men and women⁷⁰. The **General Comment** goes on to add that a major goal for legislators should be to aim at *“providing for a reduction of women's health risks, domestic violence and protection from harmful traditional cultural practices that deny them their full reproductive rights”*⁷¹. In addition, parliaments should refrain from *“limiting access to contraceptives and other*

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61. Additional Protocol to the American Convention on Human Rights in the areas of Economic, Social and Cultural Rights. (Art. 10) 1988.
 62. Vienna Declaration and Programme of Action, World Conference on Human Rights, Vienna, Austria, 14 – 25 June 1993, Sect II, para. 41, U.N.Doc.A/CONF.157/23 (1993).
 63. Article 19.2 of the International Covenant on Civil and Political Rights. Opened for signature Dec. 16, 1966, 999 U. N. T. S. 171, 6 I.L.M. 368 (entry into force 1976).
 64. See the reference to women's health in the Rome Statute of the International Criminal Court, opened for signature July 17, 1999, U.N. Doc. A/CONF.183/9 [hereinafter Rome Treaty].
 65. Aniekwu N.I., supra note 32.
 66. The National Health Insurance Scheme Act, 1999.
 67. The International Covenant on Economic, Social and Cultural Rights. General Comment No. 14 (paras. 18 and 19) E/C.12/2000/4, 2000 and the World Health Organization's first Global Resolution on Reproductive Health. Adopted by the 57th World Health Assembly; (hereinafter Resolution WHA55.19), 2004.
 68. The International Covenant on Economic, Social and Cultural Rights, at para 24.
 69. International Covenant on Economic, Social and Cultural Rights. Article 12. Opened for signature Dec.16, 1966, 993 U.N.T.S 3 (entry into force Jan.3 1976).
 70. Art. 20. Committee on Economic, Social and Cultural Rights, (General Comment 14): The Right to the highest attainable standard of health (Article 12) UN Doc. E/C. 12/2000/4, 11 August 2000.
 71. Art. 21, Ibid.

means of maintaining sexual and reproductive health...and limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law".⁷²

States are obliged to "adopt legislation or other measures to ensure equal access to health care and health – related services provided by third parties, to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct".⁷³ States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post – natal care and family planning.⁷⁴ The obligation to fulfil the right to health requires states parties, inter alia, to give sufficient recognition to the right to health in the national, political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health, especially for women and vulnerable groups.⁷⁵

The General Comment further adds that the failure to adopt a gender – sensitive approach to health and reduce infant and maternal mortality rates is indicators of the violations of the obligation to fulfil the right to health in many countries.⁷⁶ It provided that the incorporation of international instruments in the domestic legal order of states can significantly enhance the scope and effectiveness of remedial measures and should be encouraged. In **General Comment No. 3**, the Committee confirms that states parties have a legal obligation to ensure the satisfaction of minimum essential levels of the right to reproductive health enunciated in the **International Conference on Population and Development's Programme of Action (ICPD)** and subsequent reviews.⁷⁷ CEDAW that has been ratified by Nigeria is the primary international treaty that confers obligations on the state to protect women's access to health care in accordance with Article 12. Unfortunately, like other international instruments, it does not enjoy automatic enforcement in Nigeria due to Constitutional constraints, even though Section 12(b) of the Constitution provides that "*the National Assembly may make laws for the Federation or any part thereof...for the purpose of implementing a treaty*".⁷⁸

CONCLUSION

International and regional legal reforms in reproductive and sexual health matters are now apparent all over the world, further moving reproductive health issues from interests in health and rights to a base in legal principles. In 1981, the European Court of Human Rights condemned national laws that prohibited alternative sexual behaviours and relationships between same-sex couples whose partners give competent, voluntary consent.⁷⁹ Human rights standards, such as respect for privacy and choice in family life, have afforded individuals in some parts of the world, protection against restrictive legislative interventions in other sexual and reproductive choices⁸⁰. In 1988, the Supreme Court of Canada held that

72 Art. 34, Ibid.

73 Art. 35, Ibid.

74 Ibid.

75 Art. 36, Ibid.

76 Ibid.

77 Art. 43, Ibid.

78 Section 12(2), 1999 Constitution of Nigeria.

the restrictive Criminal Code provision on abortion was unconstitutional and inoperative⁸¹. The Chief Justice of Canada observed that: '*Forcing a woman, by threat of criminal sanction, to carry a fetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person*'.⁸² Following this decision, the provision was subsequently amended in 1990 and the conditions for legal abortion were liberalized.

From the foregoing, the scope exists in other legal systems to protect and advance health, reproductive rights and the enjoyment of people's private and sexual lives. Developments and reforms of legal systems in this direction have already occurred at different paces around the world, including Africa, and it now seems that an absence of domiciliary laws on gender and reproductive health matters is increasingly becoming internationally unacceptable.

79 Dudgeon v. United Kingdom (1981) 4 EHRR 149.

80 See generally R.J. Cook and B.M. Dickens, *CONSIDERATIONS FOR FORMULATING REPRODUCTIVE HEALTH LAWS* (Geneva: WHO, 2nd edn., 2000). See also Aniekwu N.I. *The Additional Protocol to the African Charter on Human and People's Rights: Indications of Capacity for African Municipal Systems*, 1 *LAW, DEMOCRACY & DEVELOPMENT*, Faculty of Law, University of the Western Cape, South Africa. (Forthcoming, 2009).

81 *R. v. Morgentaler* (1988), 44 *Dominion Law Reports* (4th) 385 (Supreme Court of Canada).

82 *Ibid.*