WOMEN'S SEXUAL AND HEALTH RIGHTS IN NORMAL UNIONS IN IBADAN NIGERIA

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Unequal power relations between men and women in marriage often limit women's control over sexual activity, and their ability to protect themselves against unwanted pregnancy and sexually transmitted diseases including HIV/AIDS. This study through interviews with 114 women in a randomly selected community sample in Ibadan metropolis, examines how women have been able to exercise their sexual and health rights in conjugal unions. Findings reveal that between 57 percent of married women have been able to exercise their rights, while 43 percent perceive sexual rights as foreign import, designed to undermine culture, tradition and dignity. Also in terms of expressing their feelings to their spouses, it was revealed that women with higher level of education were over–represented, while those with lower level of education were less likely to express themselves. Therefore, failure to define discrimination of women as an issue of concern will further worsen the status of women.

Key words: Women, Sexual rights, Health rights, Normal unions, Nigeria

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Introduction

The position of women in society in relation to men and the subordination, oppression and marginalisation of women has attracted the attention of scholars, activists, feminists and development workers for a very long time. The issues relating to what has come to be known as the women question or why women are oppressed has become very prominent in the last few decades. Women's subordinate position has been linked intimately with the institution of marriage. The traditional form of marriage across cultures (whether patriarchal or matriarchal society) placed women at a disadvantage position (Aina, et.al., 2006). This, in fact, continues to serve as a base for the discrimination of women in almost all spheres of life, and in all societies through history.

According to a UN Report (1994), 'unequal power relations between men and women often limit women's control over sexual activity and their ability to protect themselves against unwanted pregnancy and sexually transmitted diseases including HIV/AIDS…'. Current data continue to show that 'one woman a minute dies of pregnancy-related causes'. Also, sexually transmitted diseases (STDs) afflict five times more women than men. Women are more vulnerable to HIV infection than men and are becoming infected at a faster rate. In Africa, HIV-positive women outnumber infected men by 2 million. With limited choices in sexual decisions, and the inability to abstain from sexual intercourse, women are forced to endure domination by their husbands in marital relationships. Thus, a link has been found between gender inequality and the sexual health conditions in any society. It is also a truism that the general neglect of women's health is a major hindrance to women's full participation in the development process. Any serious attempt at transforming the quality of life (including health) at the household level must necessarily have a better understanding of sexuality dynamics at this level, and much more importantly an appraisal of the marriage contracts as these exist in our society today.

It is against this backdrop that this paper examines the context of women's sexual and health rights in normal unions focusing on rights to make responsible reproductive choices; rights to sexual autonomy; rights to sexual expression; and rights to sexual freedom, going beyond the focus on ideological aspects of masculinity. The main question addressed in the study is, do women actually have any control over their sexuality within conjugal unions despite improved socio-economic status?

Literature Review

The literature is replete with assertions that because African society is largely patriarchal, men dominate family decision-making. The extension of this reality to sexuality appears to fuel some discord in the literature on who really determines timing and the frequency of sex between heterosexual married partners. Some studies report that men controls sexuality in conjugal unions than their female counterparts (Isiugo-Abanihe 1994; Oyekanmi 1999), and that women cannot resist sexual advances from their husbands even when they perceive their health is at risk (possibility of contacting STIs) (Bammeke 1999; Adewuyi 1999). In essence the position established by scholars indicates that women are at a disadvantage in sexual negotiation or control relative to their husbands' privileged and stronger position in African culture.

However some other studies have indicated that women exact considerable influence in negotiating sex in marriage. Orubuloye (1995: 231) observed that "Yoruba women would increasingly refuse to have sex with partners that are infected with HIV/AIDS". This was attributed to "their economic independence, the ease with which they could break up marriages and return to their families of origin, and the traditional expectation that it is primarily women who are responsible for ensuring that sexual relations do not take place during pregnancy and the postpartum period". Beside this, Orubuloye, Caldwell and Caldwell (1991) reported from a survey in Ekiti that at least 77 percent of female respondents indicate that they refuse sex to their husbands. Again, in a study conducted by Orubuloye et al. (1997) in Ekiti, it was reported that about 70 percent urban and 75 percent rural women claimed to have the right to resist sexual advances by their partners, particularly when they suspect that their husbands are engaged in extra-marital affairs. Also Ogunjuyigbe and Adeyemi (2005) observed in a study carried out in Lagos metropolis that women have some control over their sexuality in Africa, especially during breastfeeding, pregnancy, menstruation and sick period. In view of these discordant voices on the subject matter in Nigeria, more studies are needed. This justifies the present study.

Sexuality, Sexual Health and Sexual Rights: Clarifying concepts and definitions

Sexuality according to WHO (2004) is "a central aspect of being a human throughout life and encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction". While Sexual health according to WHO (2002) is "a state of physical, emotional, mental and social being in relation to sexuality: it is not merely the

absence of disease, dysfunction or infirmity". The 14th World Congress of Sexology (1999), approved the amendment to the declaration on sexual rights in establishing that "sexual rights are universal human rights, based on inherent freedom, dignity and equality of all human beings. Since health is a fundamental human right, so is the result of an environment which recognizes, promotes and defends sexual rights. Sexual health therefore, is that enabling environment wherein the sexual rights of an individual are protected. Sexual health can therefore be said to be in place in the context of a marriage where the following sexual rights are expressed:

- Rights to sexual freedom: These include rights of individual or both spouses to express their full sexual potential. It however excludes all forms of coercion, abuse, or any form of exploitation.
- Rights to sexual pleasure: These refer to the rights of both partners within the marriage context to engage in sexual pleasure which is a source of physical, emotional and spiritual well-being.
- Rights to sexual autonomy: Here, both spouses are able to make decisions about the sexual life within acceptable social ethics. This however presumes level of sexual equity between both partners in the marital union. It involves control of one's body from any form of feature or mutilation and violence of any sort.
- Rights to privacy: Closely related to sexual cautionary are the rights to sexual privacy. It includes rights to determine intimacy as long as it does not intrude on the other partners.
- Rights to sexual expression: For a sexually healthy marital union, there must be an unreserved expression of sexual acts by both partners which could take the form of communication, touch, and emotional expressions.
- Rights to make responsible reproductive choices: These rights imply that within the marriage context, partners can make reproductive choices as to the number of children and the spacing, as well as full access to means of fertility regulation.
- Rights to sexual education: These rights afford both partners to have access to productive and socially acceptable means of accessing sexual education.
- Rights to sexual health care: These should be available to both partners in the marriage union especially in the prevention and treatment of sexual disorders or other sexual health concerns.

The issue of sexual health has become very important, especially with the emergence of the pandemic of human immunodefiency virus (HIV) infection, increasing rates of sexually transmitted infections (STIs) and growing recognition of public health concerns such as gender related violence, and sexual dysfunction. In order to achieve sexual health, people must be empowered to exercise their sexual rights. A denial of such power is what usually leads to sexual violence. Sexual violence in marriage has been described variously, and encompassing a variety of un-holy experiences which include (see WHO, 2002):

- Rape within marriage, and/or while dating;

- Unwanted sexual advance,
- Forced marriage or child marriage
- Denial of rights to use contraception or to adopt other measures to protect against sexually transmitted disease,
- Spousal support for forced prostitution (usually because of personal gain) etc.

Africa, especially the sub-Saharan Africa has the worst indicators of women's health especially with regards to reproductive health. This is an indication that there is still a pervasive violation of women's rights especially their sexual rights, due to prevailing cultural practices in this part of the world. Sexual violence has its roots in cultural discrimination against women which supports the subordination of women in marriage and marital relations. Hence, women in most of the Nigerian cultures are meant to endure, rather than enjoy marriage. The discriminatory practices against women are often used to explain the social placement of women in most African societies – 'poor, powerless, and pregnant'. No doubt, the social placement of women in our society has implications for their sexual health, while the denial of power to exercise sexual rights continues to violate the rights of women to sexual health. According to WILDAF (2005), the overt emphasis on traditional values and lack of respect of women's consent in a marital union has impeded marital relations in many parts of Africa. Furthermore, failure to define discrimination of women as an issue of concern has further worsened the status of women and led to the violation of their sexual rights as espoused by the declaration of sexual rights.

Sexual rights within marriage in Nigeria

Nigeria is made up of three major ethnic groups - the Yorubas, Hausas and the Ibos with over 200 ethnic minorities. Ethnicity is therefore seen as a crucial variable in understanding marital sexual relations since it shapes reproductive health behaviour and attitude (Kritz and Makinwa – Adebusoye, 1995). For example, within marriage relations, the Hausas practice seclusion and restrict their spouses, access to formal education, employment outside their homes and restriction to associate. The Ibos and the Yorubas are open to social change and are less restrictive (Imoagene, 1990). These socio-cultural contexts have implications for marriage relations, specifically on sexual rights and ultimate sexual health of the woman. Although, the Ibos and the Yorubas are more disposed than their Hausa counterparts to social change, their women are far from being emancipated. The women in these ethnic groups are exposed to obnoxious traditional practices including food taboos, female genital mutilation (FGM), widowhood practices, and lack of access to critical resources among others (Centre for Gender and Social Policy Studies, OAU Ife, 2002).

Within the marriage relations in Nigeria, sexual and health behaviour are determined by ethnic grouping which an individual belongs. Although there are variations in sexuality relations within marriage across ethnic groups, Orubuloye, Cadwell and Cadwell, (1993) opined that the defined prescribed periods of sexual abstinences within a marital union which was practiced in many parts of Nigeria revealed that women's sexual rights were respected and encouraged. This view has been subsequently challenged. Isiugo – Abanihe (1994) and Jekwes et al (1999), argued that the patriarchal structure of the Nigerian society continues subjugate women. For example, the payment of bride wealth, a major feature in Nigerian marriages, has been used to argue for a point of view which continues to see women as properties to be bought and sold at will. It was observed that bride wealth payment influenced the perception of men in many societies in Africa, thereby influencing them to see women as a property to be acquired. This viewpoint underscores, why women even within the typical marital relationship in Nigeria is seen as a property, so also is her sexuality. She is seen as one who has been 'bought' to satisfy the sexual urges of her husband and she therefore can be handled as an object upon which the man's sexual prowess can be expressed.

Recent findings however indicate that improved socio-economic status is a direct correlate of increased ability to exercise sexual rights (especially with regards to women in Nigeria) (Ogunjuyigbe and Adeyemi, 2005). This implication is that women are likely to enjoy improved sexual health as their socio – economic status increases. Women's economic participation is a determining variable which affects her negotiating power within marital relationship. This gives her a degree of authority, which is a prerequisite to expressing her sexuality optimally.

To attain genuine sexual health in families, men and women must necessarily be free of coercion, discrimination, and violence linked to sexual health. The highest attainable standards of health in relation to sexuality is when a person is able to achieve the following -

- Access to sexual and reproductive health
- Access to sexuality education
- Ability to make informed sexuality choices,
- Freedom to choose sexual partner
- Freedom to decide to be sexually active or not
- Consensual marriage
- Decide whether or not to have children and
- Pursue a satisfying safe and pleasurable sexual life

Study Location

The study location was carried out in Ibadan, the capital city of Oyo State, Nigeria. Ibadan (Ìlú Èbá-odàn, the town at the junction of the savannah and the forest), is the third largest city in Nigeria by population (after Lagos and Kano), the largest in geographical area and cosmopolitan in nature. At independence, Ibadan was the largest and the most populous city in Nigeria and the third in Africa after Cairo and Johannesburg. It is located in south-western Nigeria, 78 miles inland from Lagos and is a prominent transit point between the coastal region and the areas to the north. Its population is 2,550,593 according to 2006 census results, including 11 local government areas. Until 1970, Ibadan was the largest city in sub-Saharan Africa (Onibokun & Faniran, 1995). Ibadan had been the centre of administration of the old Western Region- Nigeria since the days of the British colonial rule, and parts of the city's ancient protective walls still stand to this day. The principal inhabitants of the city are the Yoruba People.

Ibadan is a civil service town and highly urbanized city. It is made up of 3 distinct zones, namely, the inner core, made up of transitional area; traditional zone; and the sub-urban periphery (Brieger & Adeniyi, 1982). The inner core is characterized by indigenous people whose occupations are mainly petty trading and subsistence farming. The people are of low economic status. The transitional zone consists of both indigenous and non-indigenous people who are mostly Yoruba in ethnic origin. They are civil servants or are engaged in trading. They represent the middle socio-economic class. The periphery consists of people from diverse ethnic origins but mostly Yoruba. People in this area are professionals, businessmen and highly qualified academics and top civil servants. They represent the higher socioeconomic class.

Data and Methods

The analysis presented in this paper is based on qualitative data collected in the study population. Twelve focus group discussion sessions, comprising about six to ten people per group (and giving a total of 114 participants), were conducted to generate qualitative data. Four criteria were applied in forming the discussion groups: level of education, occupation, age and ethnic background (mainly Yoruba indigenes). FGD covered areas of spousal communication and decision making, gender roles in sexuality, sexual behaviour within the marriage and the use of contraception. The groups were organised among purposively chosen

members of the study population. The discussions were taped, after obtaining permission from participants. The tapes were transcribed, sorted and content analysed manually.

Results and Discussion

- ***Demographic characteristics***

Majority of the participants in the FGD were below 40yrs of age and in the sexually active, reproductive stage of the life-span. The mean age of the women was 30yrs. Also majority have post-secondary education. The least occupational group was trading, while others were involved in other different professions like lecturing, teaching, nursing etc.

- ***Family structure and communication***

Respondents reported both extended and nuclear family set up. For those from extended family set up, they reported that they rarely talked to their spouses or spent time with them. Most couples came together at night for sex, having only limited contact with the spouse during the day- a situation hardly conducive to the building of satisfying and harmonious relationships. There were no outings where the couple could enjoy some privacy and get to know one another. Several respondents rued the absence of such opportunities. As reported by a market woman (trader):

> We never used to talk much to each other. Where do I have the time?
> Me that I have to leave home early to go to the market to sell my wares.
> My husband has never spoken to me about going out, nor has he taken me out.

However, those in nuclear units reported discussions on daily household matter, non-task oriented sharing and outings with the spouse. Sharing household responsibilities provided opportunities for communication which brings them closer. Communication is a core element of the marital dyad upon which all sexual and non-sexual interactions rest. The complexity and multiplicity of factors involved in spousal sexual interactions include verbal and non-verbal communication, positive/negative aspects of the sexual relationship, presence/absence of violence and concern for the sexual health of the self and spouse. In order for intimacy to talk, the couple need to talk and spend time together. Such interactions were evident among some of the women, who reported that they (husband and wife) made time to talk to each other regularly about their daily routines, hopes and dreams. A respondent said:

> After coming back from work, we sit down to share the day's happenings.
> He tells me about his work, his problems, even shares any financial difficulties
> with me. I too tell him about what I did the whole day. We talk about the children,
> especially about their studies. We both enjoy each other's company. (A School Teacher).

Another woman who describes her union as a happy one said:

> We talk a lot about what we need to do in future, how to save money. We discuss about our lives. I personally love talking. When am burdened, I feel a lot better after talking to him, because of his kind advice. (A Nurse).

From the above, it can be inferred that respondents who reported a general satisfaction with the marital relationship had invested in 'relational communication' that enabled both partners to strengthen the relationship. Spouses who viewed their union as more than a mere contract involving role obligations engaged in open, non-task-based communication. On the other hand, for some other women, most communication revolved around practical issues and needs. They reported a general absence of 'relational communication'. As one of them said:

> We never spoke to each other, especially in the first few years of our marriage. Because babies came immediately (in succession) to prove my sexual adequacy. So where is the question of talking? (Secondary school teacher)

- ***Rights to sexual expression, sexual freedom and sexual autonomy***

One of the respondents reported only non-consensual sexual relation with her husband. She said:

> In the past so many years, there has never been any real discussion between us. He only wants one thing and that is sex. Both of us do our job by him wanting sex and I providing it. (Primary school teacher)

Such experience heightened marital dissatisfaction. While the productive and reproductive functions of marriage were fulfilled, neither intimacies nor the marital bond were strengthened. Most of these women viewed such interactions as only satisfying the husband's lust and reported the absence of the desire for sex or sexual pleasure. In the words of one woman:

> My heart never fluttered for him. I know he comes near me only to satisfy his lust. I never felt like talking, sharing or going close to him. (University Lecturer).

There was absence of any behaviours of intimacy among such couples, and women succumbed to non-consensual forced sex for fear of the consequences if they resisted or refused sex. As reported by another university lecturer, she said:

> Any time I say no, he will slap, tear my clothes and cover my mouth with his hand in order to bring me in control…..

Sex with her husband has always been non-consensual and forced, with the use of physical violence and verbal abuse to gain sexual access, in spite of her level of education or status. This contradicts previous findings that improved socio-economic status is a direct correlate of increased ability to exercise sexual rights (Ogunjuyigbe and Adeyemi, 2005; Wusu and

Isiugo-Abanihe, 2008). The unfortunate thing is most of these women are silent about these atrocities, consequently people do not believe it is happening. Another woman said:

> My husband has never kissed me on my cheeks not to talk of lips. He never touched my hair lovingly. I don't know what a man's loving touch is like. Whenever he wants to do it, it is done as if he is stealing something. He tears my clothes and it is over quickly (with his pant partially removed) [Polytechnic lecturer]

Yet another said:

> If I say no just for today, he will rain abusive words like, 'have you found another lover? Why have I married you if you can't do this much?' He will end up forcing it on me, and because of my children, I don't resist too much, because I am afraid for them. (A civil servant)

These experiences highlight the interplay between gender and sexuality. Gendered messages about being a male dictate social processes of living up to that image. Beliefs and images about masculinity and femininity result in the man feeling that they must initiate sex, and dominate and conquer their wives without being sensitive to their emotional needs. For these men, sex was a male right and marriage ensured unquestioned, unlimited access to the wife's body. This confirms why a female trader in one of the FGD sessions reported that: *"I have had cause to give in to my husband's sexual request even when I was having my period. Though it was messy, but how for do? He wants it and I must give him".* Meanwhile, there are some circumstances under which women in southwest Nigeria may and are indeed expected to refuse sexual intercourse with their partners, which includes the period before marriage, during menstruation, during the postpartum period (when breast feeding), on becoming a grandmother and on reaching menopause (Akinsete, 1997; Page & Lesthaeghe, 1981; Matthew, 1950). The above act has contravened this cultural law completely. The existence of prescribed periods of sexual abstinence reveal that culturally women have sexual rights which they are in fact expected and encouraged to exercise.

Several women talked about not being physically and psychologically prepared for engaging in sex on some occasions or responding to their husbands' demands by saying, "*when he forces himself, I am dry and it hurts a lot. If he cared for me and my feelings, he will wait till I am ready. But he never bothers, he his interested only in getting what he wants".* Coercive sex carries an inherent threat of tissue damage due to the absence of lubrication, and poses the risk of STIs and HIV. Husbands indulging in coercive sex used threat of taking a second wife or extra-marital affair to get their wives comply with their wishes. The threat of physical force and coercive sex is effectively use by husbands to ensure a woman's submission to their sexual demands.

However, the startling fact is that some women help to propagate this illicit act by explaining it away and saying that men are being controlled by their impulses and possessing beastly qualities, which corroborates previous findings by Ajuwon et al., 2001. In the words of one of the respondents:

> Some husbands have uncontrolled and unsatisfied sexual desires. They always want sex, and if you don't give it to them, they will beat you or deprive you of other benefits. (Female teacher).
>
> If a husband can not have sex with his wife at all times, whom should he have it with then? Sex is the major reason a man and a woman will get married (Female trader).
>
> What kind of husband is one who does not want to have sex with his wife at all times? "He asks for it because he likes me. Who else should he have it with? Is it the other woman? (Female trader).

To this group of women, sexual rights are foreign import, designed to undermine culture, tradition and dignity. Refusing sex with your husband is prompting him to involve in extramarital affair. In the words of some of the respondents:

> These female groups calling for the implementation of law against marital rape are just trying to introduce western ideas into our family system. A woman is supposed to be submissive to her husband in sex at all times. (Female teacher)
>
> A woman can refuse but then this woman will run the risk that she will be forced into sex. I would like to change it, but it cannot be done because a woman needs to follow the man. (A Trader)

So it is believed that even when negotiation is attempted the women reported that they are usually unable to prevent a forced sexual encounter. It is therefore, believed that it is impossible for a woman to reject sexual advances from her husband. With a critical look at the background of these categories, it was revealed that the proportion of women who said a woman can not reject sex from her, are still young in their matrimonial home. The fear of being divorced is another factor that may be responsible. Also, some of the women are wives of clergies; as a result *"they must submit their bodies to their husbands all the time"*. Also, the general view among this group of women when asked who initiates sex among spouses is that: '*Men initiate sex because women don't reveal their desires, even when they are interested they would never initiate sexual demand….'* Members of the group also chorused that it is inappropriate and bad manners for women to initiate sex. Other ways women send out erotic messages is through preparing delicious dishes for their husbands, dressing elegantly and being extra-nice to their husbands. Older women however believed that they

could reject their husbands' sexual advances if they are not willing or are not favourably disposed.

- ***Rights to make responsible reproductive choices***

Very few of the women had ever used or suggest condom with their husbands. For women who suspect their husbands of infidelity, suggesting condom use for marital sex poses multiple problems. Her request may be interpreted as indicating that she suspects not only that her husband is cheating but that the type of extramarital sex he is having is risky and, by implication, debauched. Moreover, the meaning of her request may be inverted by her spouse and turned against her with an accusation that it is she who is being unfaithful. In the words of one of the respondents:

> A woman asking her husband to use a condom is putting herself in the position of a whore. What does she need a condom with her man for, unless she is flirting around outside the married house? (Business woman*)*

In Yoruba land, it is a common practice that married women should be submissive to their husbands in fertility related matters and that they secure permission from their husbands before taking major decisions such as limiting fertility through contraceptives or other means. Among this major ethnic group, there is a popular proverbial adage which says *"Oko lo lori aya",* literally translated as "husband is the head of the wife". Westernisation and modernisation have not in any way affected this belief. Most of the of the respondents indicated that their husband would determine when to have sex while very few reported that the decision rests with women, that they play major role in the decision to use contraceptives. This role was further qualified in the focus group discussion when participants said "*we can take decision to use contraceptive but the permission of our husbands would be sought first before we can adopt contraception*". It was also revealed that men more than women had the final say concerning the number of children and when to have the children.

For others, the main reason for not using condoms was that they "*just didn't like it*"**.** Another felt that condom did not give any protection. Others did not use condoms because they had faith in their partners and few others said they wanted babies. However, the logic that follows from this is the fact that men, presumably, are granted the unconditional sexual access to their wives, and could exercise power to enforce this (Sen, 1999). Women generally lack sexual autonomy in many cultures of the world, thus, unwanted pregnancies as a result of powerlessness over contraception usage are the end result.

Implications of the study and conclusions

The findings of this study show that no doubt, men and women enjoy different and unequal privileges in marital relations, with women bearing most of the health burden in marital relations. There is relativity of power between men and women in sexual intercourse among married couples no matter the level of the woman's socio-economic status. However, the study further shows that regular spousal communication enhances the right of a woman over her sexuality. At the moment it is replaced by force and violence, which is instigated by the social conditioning of men to be more sexually expressive than women, and are therefore more likely to initiate sexual advances in a union.

The policy implications of the findings include instead of designing sexual health programmes to focus on just women or men alone, the sexual health needs of both partners should be given adequate attention in such programmes. Given that egalitarian conjugal relation is enhanced by modernization, it is therefore imperative that governments and NGOs in developing countries should pursue vigorously various development projects aimed at achieving a more modern society, especially programmes targeting improving women socio-economic status. This will empower women and increase their control over their sexual life in unions. An intervention programme on increasing women's knowledge of their sexuality and reproductive health services and sensitization of men in the city on the need to support their wives to access appropriate family planning services is recommended. Women need to be more empowered to exercise their sexual rights.

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