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Sex and Sexuality Rights Issues: It Myth, Reality and Idiosyncrasy to Modern Day Nigeria

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Abstract
Poverty attitude towards sexuality and gender power relations, tensions between individual rights to privacy and self-determination and the rights of partners, families and communities as regards the practice of safe sex influence sexual health. Poor communication by and with health care providers on sexual issues mean that informed choices may be limited and services not offered. Sexual health is influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and STIs/RTIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. This paper seeks to consider the issues involved in sex and sexuality rights and how they have/have not been addresses by Modern day Nigeria in relation to its MDG by 2010. It would be observed that although Nigeria 2010 MDG has made copious provisions, yet it is inadequate to address the issue of sex and sexuality rights as this can only be possible where culture, tradition and religion gives way to reality.

INTRODUCTION

Biology, history, politics, religion, culture and law interact to regulate sexual expressions in ways that would promote or undermine health and in many countries these may target or affect people who have become addicted to sex. Poverty, attitudes towards sexuality and gender power relations, and tensions between individual rights to privacy and self-determination and the rights of partners, families and communities as regards the practice of safer sex also influence sexual health.[1] Poor communication by and with health care providers on sexual issues mean that informed choices may be limited and services not offered. Certain religious leaders and faith-based organisations emphasise or promote only sexual abstinence for young and unmarried people in spite of evidence that many are having unsafe sex and may have HIV, and need information and the means to protect themselves and their partners from sexually transmitted infections (STIs) and unwanted pregnancy. In many settings, people with HIV are expected not to have sexual lives, and their sexual health needs and rights may not even be considered. People living with HIV may be among the least able to access health services, yet are among those at highest risk for sexual health problems.[2]

Sexual health is influenced by a complex web of factors ranging from sexual behaviour and attitudes and societal factors, to biological risk and genetic predisposition. It encompasses the problems of HIV and STIs/RTIs, unintended pregnancy and abortion, infertility and cancer resulting from STIs, and sexual dysfunction. Sexual health can also be influenced by mental health, acute and chronic illnesses, and violence.

WHAT IS SEX?

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity", but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

SEXUALITY

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

[1] Kathy Shapiro and Sunanda Ray (2007) Sexual Health for People Living with HIV. Reproductive Health Matters. At: www.rhmjournallong.uk Accessed 17th January, 2013.
[2] International Community of Women Living With HIV/ AIDS, Gender Aids Forum, ICW Durban. Confronting marginalization together in the context of HIV/AIDS. At: www.icw.org/node/46. Accessed 11th January, 2013.

SEXUAL HEALTH

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.[1]

SEXUAL RIGHTS

Sexual rights include the sexual 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.[2]

Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right 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.

The responsible exercise of human rights requires that all persons respect the rights of others.

The contemporary struggle for sexual rights seeks to expose the concept of "power and resources: power to make informed choices about one's own sexual activity and resources to carry out such decisions safely and effectively."

SEXUAL HEALTH AND RIGHTS ISSUES INVOLVED IN SEX AND SEXUALITY RIGHTS

Addressing sexual health also requires understanding and appreciation of sexuality, gender roles and power in designing and providing services.[3] Understanding sexuality and its impact on practices, partners, reproduction and pleasure presents a number of challenges as well as opportunities for improving sexual and reproductive health care services and interventions. Sexuality research must go beyond concerns related to behaviour, numbers of partners and practices, to the underlying social, cultural and economic factors that make individuals vulnerable to risks and affect the ways in which sex is sought, desired and/or refused by women, men and young people. Investigating sexuality in this way entails going beyond reproductive health by looking at sexual health holistically and comprehensively. To do this requires adding to the knowledge base gained from the field of STI/HIV prevention and care, gender studies, and family planning, among others. Thus the following are some of the issues raised:-

1. HIV and STIs/RTIs,

In an HIV discordant relationship, making sure the HIV negative partner or partners, whether regular or casual, remain negative is particularly challenging. The risk of sexual transmission of HIV increases if the HIV positive partner has a high viral load, e.g. during seroconversion in the early stages of HIV infection and during late-stage disease. Between these stages the risk of infection is still present, but can be considerably lower.[4] Concurrent STIs facilitate HIV transmission through genital ulcers, inflammation of vaginal and anal tissue and under the foreskin of the penis, and concentration of HIV in STI-related discharge and secretions. Women who have unprotected vaginal sex and both men and women who have unprotected anal penetration are more vulnerable

[1] Report of a Technical Consultation on Sexual Health. 28-31 January 2002. Geneva7 WHO, 2006. At: www.who.int/reproductivehealth/ gender/sexual health. html#3. Accessed 17th January, 2013.

[2] Women and Health in the Beijing Declaration and Platform for Action, adopted at the 6th Plenary Meeting, on 15th September, 1995, in Beijing, China, Chapter Three, paras 89-111.

[3] Kathy Shapiro Opcit note 1. At page 2.

[4] Quinn TC, Wawer MJ, Sewankambo N, et al. (2000) Viral load and heterosexual transmission of human immunodeficiency virus type 1. New England Journal of Medicine;342(13):921–29.

biologically than men who penetrate their partners.[1]

Adolescent girls are at higher risk in unprotected penetrative vaginal sex because of immaturity of the genital tract. The increased vulnerability of the recipient of semen results from the larger surface area of the vagina or rectum relative to the penis and the longer period during which semen remains in contact with tissue. Rough, forced sex can cause abrasions and bleeding, enhancing transmission of HIV and hepatitis B.

The ability to practise safer sex depends on confidence, communication and trust in the partner and the relationship. These characteristics may or may not be present; indeed, sex may take place with little or no communication whatsoever and/or may be coerced. Health care workers, counsellors and educators need training and possibly sexuality education themselves in order to address sexual issues with HIV positive people professionally, in a sex-positive way and without judgment.

Safer sex promotion can only be effective if it considers people's real-world sexual desires and activities.[2] Case histories of how people in diverse HIV serodiscordant relationships have become infected (e.g. both among male factory workers in Zimbabwe and gay men in the USA) indicate areas for intervention such as improving perceptions of risk, addressing the link between low self-esteem, loss of control and unsafe sex, and teaching ways to show love and intimacy that incorporate condom use and other safer sex practices.[3]

The risk discourses of HIV researchers and educators may be different from those in the narratives of HIV positive people in their own seroconversion. A case-series study of seroconversion in Australia, in which men who had seroconverted were asked to give an account of the occasion on which they believed they were infected, found that the reasons they gave for their HIV infection varied depending on the context. Within regular relationships, breakdown of negotiated safety, love and intimacy, and fatalism were among the explanations given. In casual sexual encounters seroconversion was more likely to be explained in terms of pleasure, lack of control and related to particular sexual settings. The ways in which men understood their HIV infection were informed both by the risk discourse of HIV researchers and also by the discourses of love, pleasure and control.[4]

Sex workers often do not use condoms with lovers in order to differentiate them from commercial clients.[5] Where sex between men or with transgender people is criminalised or stigmatised, which is still the case in most developing countries, the need to hide these relationships from neighbours and family may lead to quick, unprotected sex in places like secluded cruising areas, which militates hugely against developing steady partnerships.[6] Safer sex is far more complicated to promote and practise in all these situations.

Not having sex at all is of course the safest path but of no help for those who wish to have sex or are forced to do so. Based on biological principles of disease transmission, safe(r) sex refers to sexual activities that avoid or reduce exchange of body fluids (semen, blood, vaginal fluids), avoid genital-to-genital contact and reduce risk of STI and HIV transmission, including re-infection. The most effective forms of safe(r) sex are:

- Non-penetrative sex (no penetration of the vagina, anus or mouth by the penis) including masturbation, mutual masturbation, kissing, sex-talking, massage and other forms of touching and stimulation.
- Mutual monogamy or polygamy between partners with no pre-existing infection. Protection depends on each partner being faithful, and no partner having a relationship outside the couple or circle.
- Use of male or female condoms alone, including for vaginal and anal sex and non-lubricated male condoms for oral sex.

There are also risk reduction approaches that are somewhat safe or safer than others rather than ''absolutely safe'', and their efficacy and acceptability will vary considerably. Evidence shows that consistent and correct condom use is the most effective risk-reduction strategy. Other risk reduction strategies, with differing and in some cases uncertain degrees of efficacy include withdrawal, oral sex, male circumcision for HIV negative men, maintaining a low viral load through antiretroviral therapy[7] and sero-sorting (people with HIV seeking relationships with positive partners).

Withdrawal (coitus interruptus) has been used for centuries as a risk reduction method for preventing

[1] Jones RB, Wasserheit JN.(1991) Introduction to the biology and natural history of sexually transmitted diseases. In: JN Wasserheit et al, editors. Research Issues in Human Behaviour and Sexually Transmitted Diseases in the AIDS Era. Washington DC7 American Society for Microbiology.

[2] Berger J. Resexualizing the epidemic: desire, risk and HIV prevention. Development Update 2004;5(3). At: www.sarpn.org.za/documents/d0001195/ 2-Resexualising the Epidemic- Jonathan_Berger.pdf . Accessed January 17th, 2013.

[3] Ray S, Latif A, Machekano R, et al. (1998) Sexual behaviour and risk assessment of HIV seroconvertors among urban male factory workers in Zimbabwe. Social Science and Medicine;47(10):1431–43. And Bernard EJ. BHIVA: Recent gay seroconverters explain why they became HIV-infected. Aidsmap News. 6 April 2006. At: www.aidsmap.com. Accessed January 17th, 2013

[4] Kippax S, Slavin S, Ellard J, et al. (2003) Seroconversion in context. AIDS Care;15(6):839–52.

[5] Ray S, van de Wijgert J, Mason P, et al. (2002) Constraints faced by sex workers in use of female and male condoms for safer sex in urban Zimbabwe. Journal of Urban Health: Bulletin of the New York Academy of Medicine ;78(4):581–92.

[6] Jolly S. (2005) Vulnerability, risk and sexual rights. Think piece for 'AIDS and Vulnerability' brainstorming workshop. UNAIDS/IDS, 23–24 June. At: bwww.eldis.org/cf/ rdr/rdr.cfm?doc=DOC20. Accessed January, 2013

[7] Castilla J, del Romero J, Hernando V, et al. (2005) Effectiveness of highly active antiretroviral therapy in reducing heterosexual transmission of HIV. Journal of Acquired Immune Deficiency Syndrome;40:96–101.

pregnancy. Since the early days of the HIV epidemic it has also been used by gay men (or the variation of temporary and partial penetration without a condom), e.g. in Australia,[1] for risk reduction. Withdrawal does not protect against other STIs, and its efficacy for HIV risk reduction has never been studied.

Oral sex is an exciting alternative to penetrative sex for many people. It is difficult to study HIV transmission through oral sex because most people engage in other sexual activities as well, though most STIs other than HIV (e.g. syphilis, herpes and gonorrhoea) are transmissible orally. The current consensus is that unprotected oral sex is an effective risk reduction strategy compared to unprotected anal or vaginal penetration. The UK's Public Health Laboratory Service estimates that 1–3% of HIV cases may be due to oral sex. One American study on the risks of HIV transmission from oral sex reported that of 122 gay men with HIV, 8% reported oral sex as their only risk activity. However, some of the men in this study who initially said oral sex was their only risk activity subsequently admitted having unprotected anal sex. A recent study did not find any cases of oral transmission of HIV over a ten-year period in over 100 couples where one partner was HIV positive and the other HIV negative.[2] Oral sex on a woman is considered even lower risk than on a man, and avoiding menstrual blood is sometimes suggested.[3]

Minimising risk can be achieved by use of condoms or other latex or polyurethane barriers over the vulva or anus, avoiding oral sex when the positive partner is likely to have higher viral loads and may be more infectious, when there is inflammation caused by common throat infections, allergies or STIs such as gonorrhoea, or bleeding gums or sores in the mouth or throat of the recipient, and avoiding ejaculation into the recipient's mouth if the giver is HIV positive.[4]

A 2005 study demonstrated the ability of HIV antiretroviral therapy to reduce heterosexual transmission of HIV in discordant couples by 80%[5] but the investigators and others have cautioned that even a small increase in sexual risk taking could cancel this out. Moreover, while mathematical modelling has also shown that reduced viral load may reduce risk in individual cases, in settings such as Uganda, with limited access to antiretroviral therapy, and because only people with advanced disease receive therapy, it is unlikely to have an impact on the epidemic at population level.[6]

The cervix is the primary site of infection for gonorrhoea, chlamydia and human papilloma virus and has more HIV receptors than the vagina.[7] Cervical barriers such as the diaphragm and cervical cap have been in use for decades for contraception. The diaphragm has been shown to decrease rates of gonorrhoea, chlamydia and pelvic inflammatory disease and results are pending of a clinical trial of the All-Flex diaphragm to prevent HIV transmission.[8] Newer barrier devices are also now available.

Anal sex practices are rarely addressed in sex education on the assumption that they do not happen, or at least not with women, and sex between men and transgender people may not be discussed at all. Yet a review of studies in the USA in 1999 on heterosexual anal intercourse showed in absolute numbers that approximately seven times more women than homosexual men had experienced unprotected anal intercourse.[9] Anal transmission of HIV from an HIV positive man to a receptive partner, male or female, is the highest risk mode of HIV transmission, after blood-to-blood transmission. In a number of countries adolescents have reported having anal sex to avoid pregnancy or to preserve virginity. In South Africa, 42.8% of a sample of women sex workers had anal sex with their clients. HIV prevalence in this group was 61.3% compared to 42.7% in those who did not engage in anal sex, controlling for age, number of clients per week and duration of sex work.[10] Unprotected receptive anal intercourse is ten times more risky than unprotected vaginal intercourse for acquiring HIV because anal mucosa is more delicate and easily damaged during penetration.[11] Tearing of rectal tissue, haemorrhoids, proctitis and other anal lesions have been experienced by some men who have sex with men and also increase

[1] Richters J, Knox S, Crawford J. (2000) Condom use and 'withdrawal': exploring gay men's practice of anal intercourse. International Journal of STD & AIDS; 11(2):96–104.
[2] Oral sex. Aidsmap. 21 December 2005. At: bhttp://www. aidsmap.com/en/docs/ C858FF44-5E81-4F59-8030- B5A3C7A93654.asp. Accessed 17th January, 2013.
[3] del Romero J, Marincovich B, Castilla J, et al. (2002) Evaluating the risk of HIV transmission through unprotected orogenital sex. AIDS;16(9):1269–97.
[4] Fellatio. Aidsmap. 13 July 2004. At: http://www.aidsmap.com/ en/docs/D2C102B1-1CE1-4243- 93E1-BA0DFEF60440.asp. Accesed 17th January, 2013.
[5] Gray RH, Li X, Wawer MJ, et al. (2003) Stochastic simulation of the impact of antiretroviral therapy and HIV vaccines on HIV transmission, Rakai, Uganda. AIDS;17:1941–51.
[6] Ibid
[7] Moench TR, Chipato T, Padian NS. (2001) Preventing disease by protecting the cervix: the unexplored promise of internal vaginal barrier devices. AIDS;5:1595–602.
[8] Minnis AM, Padian NS. (2005) Effectiveness of female controlled barrier methods in preventing sexually transmitted infections and HIV: current evidence and future research directions. Sexually Transmitted Infections;8:193–200.
[9] Halperin DT. (1999) Heterosexual anal intercourse: prevalence, cultural factors, and HIV infection and other health risks, Part I. Review. AIDS Patient Care and STDS; 13(12):717–30.
[10] Karim SS, Ramjee G. (1998) Anal sex and HIV transmission in women. American Journal of Public Health;88(8):1265–66.
[11] American Foundation for AIDS Research. HIV prevention for men who have sex with men. Issue Brief. June 2006. At: www.amfar.org/cgi-bin/iowa/programs/publicp/record.html?record=37. Accessed January 17th, 2013.

risk.[1]

Vaginal douching may remove natural fluids and bacteria such as lactobacilli which maintain the natural environment and pH of the vagina. Natural vaginal lubrication during sexual arousal facilitates penetration, with or without condoms. Negative associations of natural vaginal wetness with promiscuity in some cultures should be addressed. Water-based lubricants and saliva make vaginal and anal sex safer and are especially needed by sex workers and others for repeated acts of intercourse. They can also make sex more pleasurable. Water-based lubricants should be used with condoms, especially for anal sex, to prevent damage to anal tissue and condom breakage.[2]

Health workers and women need information on the dangers of inserting substances into the vagina to make it tight, dry or ''hot'' with astringents, detergents, bleach, chillies, bark and other substances.[3] Recent results from three randomised trials in Africa show partial protection (50–60% reduction in risk) from female-to-male vaginal transmission of HIV for HIV negative men who undergo male circumcision.[4] Consideration of male circumcision is particularly appropriate for women with HIV and their male partners who are untested or negative. No protective effect of male circumcision for women has been shown, and recruitment for the one trial looking at this issue was stopped early because of higher HIV incidence among the female partners of circumcised men compared to the uncircumcised control group.[5] Messages and counselling should stress that resumption of sexual relations before complete wound healing may increase the risk of acquisition of HIV infection among recently circumcised HIV negative men and may increase the risk of HIV transmission to female partners of recently circumcised HIV positive men.[6]

WHO/UNAIDS advise that ''any decisions about male circumcision must take into account cultural factors, risk of complications, potential to undermine existing protective behaviours and prevention strategies and health system constraints''. [7] Based on the currently available evidence, male circumcision is not recommended for HIV positive men as an intervention to reduce HIV transmission to women; nor is there information on the safety of male circumcision for HIV positive men, especially those with advanced immune suppression. Research has not yet been done on whether there is any protective benefit of male circumcision for sex between men when one is HIV positive, nor in heterosexual anal sex.

2. Unintended Pregnancy and Abortion,

Peer pressure and cultural norms and expectations, such as pressure to have early sexual experiences, for which they may not be prepared, having multiple partners and even expressing sexual violence[8] lead to unintended pregnancy and unsafe abortion. Lack of knowledge of reproductive biology, including the physiology of sexual response, fertility, the menstrual cycle, biological vulnerability to HIV/STIs their effects on pregnancy, contribute to poor attention to sexual health, dissatisfaction with sex and failure to realise reproductive goals.[9] One of the signature public health achievements in the United States in recent years said there has been the decline in both the teen pregnancy and the teen birth rates. Between 1990 and 2004, the teen pregnancy rate declined 38%;[10] in a similar trend, the teen birth rate declined 31% between 1991 and 2006.[11] This change was remarkably widespread; significant declines were documented in all states and among all racial and ethnic groups. Even so, it remains the case that one in three teen girls becomes pregnant at least once before turning 20, and the United States still has the highest rates of teen pregnancy and birth in the fully developed world. Most scholars agree that the decline was fueled by a combination of somewhat fewer teens reporting that they had had

[1] Training manual for men who have sex with men. New Delhi7 NAZ Foundation India Trust, 2001.
[2] Philpott A, Knerr W, Boydell V. (2006) Pleasure and prevention: when good sex is safer sex. Reproductive Health Matters;14(28):23–31.
[3] Levin RJ. (2005) Wet and dry sex – the impact of cultural influence in modifying vaginal function. Sexual and Relationship Therapy 2005;20(4).
[4] Gray RH, Kigozi G, Serwadda D, et al. (2005) Male circumcision for HIV prevention in men in Rakai, Uganda: a randomized trial. Lancet;369:657–66.
[5] Rakai Health Sciences Program. Study presents new information on male circumcision to prevent spread of HIV in Africa. Press release 6 March 2007.
[6] New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications. WHO/UNAIDS Technical Consultation Male Circumcision and HIV Prevention: Research Implications for Policy and Programming. Montreux, 6–8 March 2007. Conclusions and Recommendations. At: http://www.who.int/hiv/mediacentre/MCrecommendations_en.pdf. Accessed January 17th, 2013.
[7] Ibid
[8] Weiss E, Rao Gupta G. (1998) Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention. Washington DC7 International Centre for Research on Women.
[9] Action Research in Community Health and Development. Perceptions of male members about reproductive health matters: preliminary evidence from a tribal area of Gujarat. In: Men as Supportive Partners in Reproductive Health. Moving from Rhetoric to Reality. New York7 Population Council, 2000.
[10] Ventura SJ, Abma JC, Mosher WD, Henshaw S. (2008) Estimated pregnancy rates by outcome for the United States, 1990–2004. *Natl Vital Stat Rep*.; 56 (15):.
[11] Hamilton BE, Martin JA, Ventura SJ. Births: preliminary data for 2006. *Natl Vital Stat Rep*. 2007; 56:1–18.

sex and, in particular, better contraceptive use among those who were having sex.[1] Recent vital statistics data, however, reveal a 3% increase between 2005 and 2006 in the teen birth rate — the first such increase in 15 years[2] — showing clearly that rates that go down can go back up. A new group of girls turns 13 each year and there is no room for complacency.

Half of these pregnancies were among women not seeking pregnancy who nonetheless used no method of contraception in the month they conceived; the other half were among women who were using a method inconsistently or incorrectly. Significant disparities in the rate of unintended pregnancy exist among different socioeconomic, educational, ethnic and racial groups in the United States. In essence, unintended pregnancy rates are higher among women who are poorer, less-educated, and/or are black or Hispanic.[3]

In response to this challenging situation, about 18 months ago, the National Campaign to Prevent Teen Pregnancy (the Campaign) expanded its mission to include an added focus on reducing unintended pregnancy (referred to by the Campaign as "unplanned" pregnancy) more generally, especially among single young adults in their 20s where the problem is concentrated. As is true for teen pregnancy, unplanned pregnancy also carries a broad array of socioeconomic and health risks to women and men, to children and to the larger community.[4]

Other than some degree of actual contraceptive method failure, what lies behind these high rates of unintended pregnancy in the world today? The list of interrelated factors is remarkably long: lack of adequate sex education and a general discomfort with sexuality, the pernicious effects of poverty, improper use of specific contraceptive methods, poor communication between sexual partners, ambivalence about pregnancy, problems in obtaining access to the most effective contraceptive methods, increased public acceptance of non-marital child-bearing, inflated fears about the side effects of certain contraceptive methods and a culture that glamorizes sex yet rarely portrays it in responsible ways.

Emergency contraception (EC) can be used up to 5 days after unprotected sex to prevent pregnancy. Greater awareness of EC and its proper usage has the potential to drastically reduce the rate of unintended pregnancy. Given that unprotected sex is rarely a one-time occurrence, women need prompt access to ongoing methods of contraception, with the IUD (Copper-T intrauterine device) being an excellent option for both highly effective EC and long-term contraception.[5]

3. Infertility and Cancer Resulting from STIs,

Cancer of the cervix and ano-genital cancers in women and men are a complication of persistent infection with oncogenic strains of human papilloma virus (HPV). Lower-risk strains of human papilloma virus cause benign genital warts on the lower genitalia and anus in both sexes. They can be severe and persistent in people with HIV, but eventually resolve spontaneously without treatment. Globally up to 80% of newly sexually active men and women may be exposed to oncogenic strains of HPV, but most develop only transient infection. In a small percentage of women, HPV infection progresses to cervical intraepithelial neoplasia (CIN), a pre-ancerous condition that either regresses or progresses to invasive cancer.[6] Anal intraepithelial neoplasia (AIN) caused by HPV occurs with the same frequency in men who have sex with men as cervical cancer does in women and is probably higher among those with HIV.[7] A study of over 100 women with CIN and their male sexual partners indicated that consistent condom use can speed up regression of HPV associated lesions, clearance of HPV in women and regression of flat penile lesions in men, presumably by blocking repeated transmission and re-infection between partners.[8]

STIs are responsible for a significant burden of both short and long-term morbidity as well as mortality. For example, persistent infection with high-risk Human Papilloma virus (HPV) types is necessary but not sufficient for the development of cervical cancer. Untreated chlamydia infection can lead to serious sequelae of pelvic inflammatory disease (PID), ectopic pregnancy and infertility in females and urethritis, epididymitis, and reactive arthritis in males. During the 1980s, there was a rapid decline in reported STI diagnoses attributed to sexual behaviour changes in response to the HIV epidemic. From the mid 1990s, diagnoses of STIs increased

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1 Santelli JS, Lindberg LD, Finer LB, Singh S. (2007) Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *Am J Public Health*; 97:150–156.

2 Opcit note 31.

3 Finer LW, Henshaw SK. (2006) Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspect Sex Reprod Health*. 38:90–96.

4 In: Brown S, Eisenberg L editor. (1995) The best intentions: unintended pregnancy and the well-being of children and families. Washington (DC): National Academy Press;p. 50–90

5 Morgan G, Keesbury J, Kuria P, Calhoun L, Fotso JC. Characteristics and Patterns of Use of Emergency Contraception among Urban Women in Nigeria and Kenya, Presentation at 2011 International Conference on Family Planning, Dakar, Senegal; 2011.

6 World Health Organization, International Agency for Research on Cancer. IARC Handbooks of Cancer Prevention. Vol.10: Cervix Cancer Screening. Lyon7 IARC Press, 2005.

7 Kreuter A, Reimann G, Esser S, et al. (2003) [Screening and therapy of anal intraepithelial neoplasia (AIN) and anal carcinoma in patients with HIV-infection]. Deutsche Medizinische Wochenschrift;128:38, 1957–62.

8 Bleeker MS, Hogewoning CJ, Voorhorst FJ, et al. (2003) Condom use promotes regression of human papillavirus-associated penile lesions in male sex partnersof women with cervical intraepithelial neoplasia. International Journal of Cancer ;107(5):804–10.

due to both increased risk behaviour and improved ascertainment. Recent surveillance data from 2010 have indicated that rates of STIs appear to have stabilised, although at much higher rates than in previous years, and that the most commonly diagnosed bacterial and viral STIs were respectively chlamydia (189,612 diagnoses) and genital warts (75,615 diagnoses).[1]

Large-scale multi-country, multi-site trials of several HPV vaccines are underway.[2] A vaccine that is 90% effective against two oncogenic HPV strains, 16 and 18, causing about 70% of cervical cancer, has been evaluated and approved in the USA and Europe for use in (young) women.[3] There is currently a lack of knowledge of the prevalence of specific HPV types in women and men with HIV. Between 1996 and 2003 in the USA, of 202 HIV positive women who were receiving routine HIV care, 105 were positive for HPV, of whom 52% were positive for multiple types of HPV. Women in this study were often infected with different strains of the virus from the ones covered by the new vaccine, which were also associated with a high risk of pre-cancerous and cancerous cell changes.[4]

No data are yet available on the safety and efficacy of HPV vaccines for people with HIV, whether infected perinatally or sexually. Studies have found that women with HIV have a two- to six-fold increased risk of pre-cancerous cervical cell abnormalities,[5] and can develop invasive cervical cancer up to ten years younger than HIV negative women.[6] Progression to high-grade lesions is more rapid, and lesions are more resistant to treatment in the presence of HIV.[7] In women with HIV, lower genital tract cancers in the vagina and vulva, and cancers of the anus in women who have receptive anal sex are also prevalent. Overall, however, increased rates of invasive cervical cancer have not been associated with the HIV epidemic.[8] In 1992 the US Centers for Disease Control classified cervical cancer as an AIDS-defining illness. This is now being questioned since the relationship of cervical cancer to declining immune function, as determined by CD4 cell count and responsiveness to antiretroviral therapy, is unclear.[9] In the context of population-based cervical cancer control programmes, WHO recommends that women with HIV be offered cervical screening at the time of HIV diagnosis and thereafter ‘‘at the same frequency and with the same screening test as women not infected with HIV’’.[10]

4. Sexual Dysfunction

The sexuality of men and women are not uncommonly concerned about sexual dysfunction, including loss of libido, problems with erections and ejaculation, which may be related to illness or opportunistic infections, certain antiretroviral drugs or other medications. Poor treatment adherence and sexual dysfunction have also been reported.[11] Men with sexual dysfunction have also commonly reported recreational drug use, co-infection with hepatitis B and C, anxiety and depressive illnesses, peripheral neuropathy and lipodystrophy.[12] Health care providers can provide some reassurance that improvement in health will address some sexual dysfunction. Treating STIs, addressing concerns and providing simple behavioural interventions could increase positive men’s confidence. Health staff needs skills in sympathetic and knowledgeable responses to such problems, in particular to raise these issues in counselling so that women with HIV continue to comply with their treatment. A survey by letter of HIV clinical centres in the UK found that 60% had rarely or never asked women patients with HIV about sexual functioning.[13]

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1 Ibid p. 11
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5. Adolescent Reproductive Health

Adolescent reproductive health status of the adolescent in the world is poor especially in Nigeria. Paramount among the factors responsible for the current high levels of reproductive ill-health among adolescents is the observations that for many reasons, the average age first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls. From the NDHS (1990) study, the median age at first sexual intercourse was 16.6years, whilst about one third of women had had their first sexual intercourse by the age of 15 years. In a study of about 5 500 urban youths aged 12-24 years, 41% had experienced sexual intercourse and of these, 82% of girls and 72% of boys had had sexual intercourse by the age of 19 years.[1]

Young people in Nigeria are the ones most affected by HIV/AIDS epidemic. In 1998, 60% of the 20, 334 reported AIDS cases in Nigeria were within the age group of 15-24 years. This age group also suffers disproportionately from other sexually transmitted diseases. In an urban base study in Nigeria, 16.5% of 206 adolescents aged 17 to 19 years were found to suffer from various sexually transmitted infections. Recurrent or prolonged sexually transmitted infections constitute a high risk for subsequent development of cervical cancer.[2]
There is a high rate of teenage pregnancy. According to the 1990 population census, young people of age 15-24 years contributed approximately 29.3% of deliveries in Nigeria. About 2/5 of teenage pregnancies in the country are believed to end up in induced abortion, with many being carried out by quacks and in unsafe environment. On the whole, about 600, 00 induced abortions are believed to take place in Nigeria annually.[3]

6. Family Planning

The right to family planning education, information and services is central to reproductive choice and to women's sexual and reproductive health, especially given the risk of maternal mortality and the illegality of abortion in many countries. Family planning services are particularly important where abortion is illegal. In the Dominican Republic, abortion is illegal and birth control education is provided only by non-governmental organizations.[4] Arguably, where the State does not allow for safe legal abortion, its core obligation is at least to provide those family planning services that guarantee women their right to exercise reproductive choice.

Even in countries where abortion is legal, prevention of pregnancy is preferable to termination in terms of women's health. In many instances however, the legal opinion of abortion is not supported by adequate family planning services or measures. In the Czech Republic, for example, the government noted the high incidence of induced abortions as a major public health problem, mirroring the inadequate use of contraception. However, the costs of contraception are only partly covered by the general health insurance scheme (which in itself may reflect discrimination in the allocation of resources, given that these are services only women need). The Czech Republic report also pointed out that health care personnel sometimes lack sufficient knowledge about contraception.[5]

In Zimbabwe for example, where abortion is legal in some limited circumstances, the government subsidized contraception and there are no legal restrictions on the provision of planning services to minors. Yet sexually active girls are often turned away by health personnel's due to their age. These have resulted in high cases of unsafe sexual intercourse and HIV/AIDS victims and young people suffering from STIs.[6]

7. Contraception

Public health policy for sexual health has prioritised two major areas: effective contraceptive choice to avert unintended or early pregnancy; and the prevention of sexually transmitted infections (STIs) including HIV[7]. The HSE (Health Survey for England) 2010 provides data about reported sexual behaviour and access to services for the diagnosis and treatment of STIs, information which is vital for the evaluation and development of public health interventions for the prevention and control of STIs[8]. 92% of men and 94% of women aged 16-69 reported that they had ever had sexual intercourse with someone of the opposite sex. Fewer participants in the youngest age group, 16-24, reported that they had ever had sexual intercourse (68% of men and 74% of women), whereas 95% or more in all other age groups reported doing so. 3% of both men and women aged 16-69 reported

[1] Ladan M. T. (2006) Philosophy and Concepts of Reproductive Health and Rights: Issues, Jurisprudence and Contemporary Patterns of Violations of Women's Reproductive ad Sexual Health Rights in Selected Countries. Law, Reproductive Health and Human Rights. Joy Ngozi Ezeilo, Women Aid Collective (WACOL), Legal Resource Researhch & Development Centre (LRRDC).
[2] Quoted from the Nigerian National Reproductive Health Policy and Strategy: - (2001), Federal Ministry of Health, Abuja, Annex 1. P. 7
[3] Ibid. Pp 7-8.
[4] Human Rights Centre of Azerbaijan, Comments on Government Report (Trans, International League of Human Rights); IWRAW, Independent Report of Azerbaijan, Submitted to the Committee on ECOSOC Rights, Minneapolis: - Hubert Humphrey Institute of ublic Affairs, University of Minnesota, (1997), Pp 3, 11.
[5] Initial Report of Czech Republic, UN Doc.CEDAW/C/CZE/1, paras 175, 178, 215-16.
[6] Initial Report of Zimbabwe, UN Doc.CEDAW/C/ZWE/1 (July 20, 1996), p. 50.
[7] Han Y. (2001), The clinical observation of GyneFix IUD for emergency contraception. J Pract Obstet Gynecol;17:171-2.
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that they had ever had sex with someone of the same sex, and 2% reported that they had done so in the last five years.[1]

Just under a fifth of all women aged 16-54 reported that they were not currently having sexual relations with someone of the opposite sex (18%). Around two thirds of all women reported that they were using some method of contraception (68%), including 49% reporting non-surgical methods and 19% surgical methods. 14% of women said that they were not using any method of contraception.[2]

Among those aged 16-54 who were currently having sexual relations, 83% of women reported using at least one method of contraception. Use of contraception was lower among those aged 25-34 (78%) – the age group most likely to be pregnant or seeking to become pregnant, and those aged 45 and over (82%) – most likely to be menopausal. The proportion of women reporting surgical options increased with age.[3]

The most commonly reported methods of contraception were the male condom and the contraceptive pill, each mentioned by 22% of women currently having sexual relations. 7% of women said they used long acting reversible contraception. Reported use of all these methods was highest among those aged 16-24, and declined with age.

Most women who were having heterosexual sex and were not using contraception indicated that this was because of pregnancy, wanting to become pregnant, the menopause or possible infertility. However, among women aged 16-54 currently having sexual relations, 3.2% were at risk of unplanned pregnancy. Of those aged 16-69 who reported ever having heterosexual or homosexual sex, women were more likely than men to report a doctor-diagnosed STI (12% and 9% respectively). However, similar proportions of men and women reported having had more than one STI (2% of each sex).[4]

MYTHS, REALITY AND IDIOSYNCRASY

Culture, religion and government policies especially in Nigeria would hamper the realization of these sexual health and rights issues discussed globally which ought to be used by individuals to make informed decisions. Some of the myths involved are that one; discussing sex is taboo in many cultures, making the delivery of education to health workers and the discussion of safer sex by them with people living with and at risk of HIV very difficult. Two; sex is seen as sacred and should only be discussed by married couples, three; contraception is a no go area due to religion and culture, four; abortion is not only a criminal offence under the Penal Code of northern Nigeria but even religion frown at it whether or not it is as a result of rape.[5] Certain health educators, governments and faith-based organisations have been inclined to give simple ‘‘do’’ or ‘‘don’t do’’ messages, including ‘‘ABC’’, but the reality is more complex.[6] The imbalance of power between men and women in most cultural settings limits women’s ability to protect themselves.[7] This imbalance of power makes women powerless. Many women and girls are forced to accept sexual relationship that puts them at high risk of HIV/AIDS & STIs are unable to insist on the use of condoms by their partners. While women are expected to remain faithful in marriage or in a relationship, a woman cannot compel her husband to do the same.[8] In most societies, fertility is highly prized, cultural norms and attitudes leaves no place to childless woman and a woman’s fertility and her relationship with her husband would often be the source of her social identity. The norm of motherhood as the ideal form of self worth and identity for women cannot agree with use of contraception and also abortion being legalized.[9]

Decisions based on safer sex information require some understanding of biological principles of disease transmission, while many cultures operate with different belief systems of health and disease. The reality is that sex between older, more sexually experienced men and younger women (and vice versa), having more than one partner, having multiple partners (as with selling sex), and frequent partner change, loss of self-control leading to

[1] World Health Organization, International Consortium for Emergency Contraception, International, Federation of Obstetrics and Gynecology, and International Planned Parenthood Federation. Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNGECPs). WHO; 2010 [cited 2012 Jan 4]. Available from http://www.cecinfo.org/PDF/WHO_RHR_HRP_10.06_eng.pdf.

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[3] Chloe Robinson, Anthony Nardone, Catherine Mercer, Anne M. Johnson (2011) Sexual Health. The Health and Social Care Information Centre. Pp 1-3.

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[6] Monech supra note 20.

[7] Aisha Haruna (2009), HIV/AIDS, Women & Human Right Violations in International Law. Bayeyo University Journal of Public Law (BUJPL). Departmnet of Public Law, Bayero University, Kano. Vol. 1 No. 1. December, 2009.

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unsafe sex may occur under the influence of alcohol or drug use and even sex between young people without anyone knowing since it is a taboo to be discussed in the house thus making HIV/STI prevalent without any remedy. The Protocol[1] to the African Charter on the Right of Women Art. 14 (2) (c) is the first human right instrument to articulate a woman's right to abortion. Art. 4 (1) (f) of the same Protocol provides for states to "provide adequate, affordable and accessible health services including information, education and communication programmes to women especially those in the rural areas."

There are certain odd behaviours amongst people especially sexual right issues especially on rights of individuals to decide whom to have sex with, when, where and how to have it.

MODERN DAY NIGERIA AND MDG ON HEALTH FOR ALL BY 2010

In spite of its obligations, Nigeria has not yet modernized its legal frame work for the protection of women and children, due to a number of constraining factors. The first, is a federal constitutional arrangement that does not situate issues concerning children and women within the legislative purview of the National Assembly but with State legislatures, thereby making it difficult to establish an adequate legal framework applicable throughout the country. A second factor is the overbearing influence of cultural tradition, which tends to treat women as appendages of men and also fail to recognize the individuality of children beyond seeing them as gift from God. Poverty, illiteracy and ignorance tend to perpetuate discriminatory practices in Nigerian's traditionally patriarchal society. In this condition, it has proven difficult for Government to introduce laws, policies and programmes to uphold the rights of children and women. Consequently, the broad picture is one of tokenistic legal and policy programmes that lack uniformity or real impact. Actual practice is driven more by cultural sentiments than constitutional, legal or international obligations.[2]

The Millennium Development Goals 5 & 6 and in Nigeria goals 4 & 5 on improvement on Maternal Mortality and Combating HIV/AIDS respectively are centred on the following issues:-

Maternal Mortality:- Universal access to reproductive health by basic antenatal care which provides women with a package of preventive interventions, including nutritional advice. Women are also alerted to danger signs that may threaten their pregnancy and given support in planning a safe delivery. Moreover, in countries where malaria is endemic, they may be provided with intermittent preventive treatment. Women who are HIV-positive receive help in avoiding transmission of the virus to their babies.[3] Very early childbearing brings with it heightened risks of complications or even death. In almost all regions, the adolescent birth rate (the number of births per 1,000 women aged 15 to 19) decreased between 1990 and 2000 and then slowed its decline or even increased in the subsequent eight years. Sub-Saharan Africa has the highest birth rate among adolescents (122 births per 1,000 women), which has changed little since 1990. Also, contraception use have shown that throughout the world, increased access to safe, affordable and effective methods of contraception has provided individuals with greater opportunities for choice and responsible decision-making in matters of reproduction. Contraceptive use has also contributed to improvements in maternal and infant health by preventing unintended or closely spaced pregnancies and pregnancy in very young women, which can be risky. Reaching adolescent is critical to improving reproductive health on maternal mortality and achieving the Millennium Development Goals; in sub-Saharan Africa, contraceptive use among adolescents is substantially lower than that of all women of reproductive age, though they have similar levels of unmet need (25%). This was the conclusion drawn from data available for 22 countries, which looked at contraceptive use among women aged 15 to 19 who were married or in a union. Thus, the percentage of adolescents who have their demand for contraception satisfied is much lower than that of all women aged 15 to 49. This disparity in access has changed little according to data from the same sources for earlier periods, pointing to scant progress in improving access to reproductive health care for adolescents. Lastly, the aid for family planning have over the decades, demand for family planning is likely to increase, based on substantial unmet need and the expected rise in the number of women and men of reproductive age. Yet funding for family planning services and supplies has not risen commensurately.

Combating HIV/AIDS:- Between 2001 and 2009, the HIV incidence rate declined steadily, by nearly 25% worldwide. However, this global progress masks substantial regional differences. With antiretroviral drugs, progress has been achieved in combating HIV/AIDS. The number of people receiving antiretroviral treatment for HIV or AIDS increased 13-fold from 2004 to 2009. As a result, the number of AIDS-related deaths declined by 19 per cent over the same period. Although new infections are waning, the number of people living with HIV has grown. Women and young people are especially vulnerable. Globally, nearly 23% of all people living with HIV are under the age of 25.[4] And young people (aged 15 to 24) account for 41 per cent of new infections among

[1] Protocol to the African Charter on Human & People's Rights on the Rights of Women in Africa. 2nd Ordinary Session, Assembly of the Union, adopted, July, 2003 (herein Protocol on the Rights of Women in Africa)
[2] See Ladan Opsit, Supra note 57 at p. 31-32.
[3] United Nations Millennium Development Goals Report, 2011. We can End Poverty by 2015, Millennium Development Goals. New York, 2011.
[4] Ibid

those aged 15 or older. In 2009, women represented a slight majority (about 51%) of people living with HIV. Understanding how HIV spreads is the first step to avoiding infection. On average, only 33% of young men and 20% of young women in developing regions have a comprehensive and correct knowledge of HIV.[1] Condom use is encouraged to reduce the spread of the virus. Condom use during higher-risk sex is still low among young people in developing regions. On average, less than half of young men and just over a third of young women used condoms during their last high-risk sexual activity in sub-Saharan African countries. In 2009, the World Health Organization (WHO) revised its guidelines for treatment of adults and adolescents with HIV, including pregnant women. As a result, the number of people defined as needing antiretroviral therapy grew—from 10.1 million to 14.6 million at the end of 2009. In the medium term, the higher initial investments required to conform to these guidelines are expected to be fully compensated for by fewer hospitalizations and lower morbidity and mortality rates. Based on the new 2009 guidelines, coverage of antiretroviral therapy increased from 28% in December 2008 to 36% at the end of 2009. Under the previous 2006 guidelines, global coverage would have reached 52% in 2009. Antiretroviral therapy coverage varies by sex and age. In 2009, coverage was higher among women (39%) than among men (31%). Also, overall coverage among children in low- and middle-income countries was lower than that among adults. About 356,400 children under age 15 were receiving antiretroviral therapy at the end of 2009, up from 275,300 at the end of 2008.[2] These children represented an estimated 28% of all children under 15 who needed treatment in low- and middle income countries, up from 22% in 2008.

As at 2012, only 37.1% of reduction in maternal mortality had been achieved and only 8% of the GDP was disbursed towards the realization of the MDG. However it is hoped that by 2015, 56.1% reduction in maternal mortality is hoped to be achieved with a 10% of the budget of the country transferred to MGD for the realization of its goals.[3] This is not adequate.

CONCLUSION

Sexuality rights is worthy of rights protection. Global discussions over sexuality often use terms such as sexual identity, sexual orientation, sexual preference and sexual minority interchangeably to refer to aspect of sexual identity, behaviour, or association that should attract right protection. However, in Nigeria the influence of culture and religion would not allow the realization of the protection of those sexuality rights especially for women.

[1] China is not included in the calculation.
[2] Opsit, supra note 76.
[3] Achieving the MDGs in Nigeria. Harmonization for Health in Africa (HHA) Kakamono Prepared in Close Collaboration with CESAG – UNICEF (2012).