Lawyers Alert Sensitization Manual on HIV/Sexual & Reproductive Health & Rights SHRH

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Foreword

One of the key interventions of Lawyers Alert is free legal assistance to victims of Sexual and Reproductive Health and Rights violations. This service is rendered specifically to vulnerable groups. Vulnerable groups in this instance are women and girls suffering violence, persons infected with, affected by or most at risk of HIV which includes, females sex workers, persons who use drugs, persons with disability and the LGBTI community.

It is often assumed that being a lawyer is enough with regard to rendering legal assistance. This statement is true to the extent that the assistance being rendered is not SRHR specific. Even amongst lawyers, there are loads of misconceptions, prejudices and even outright discrimination. In several instances lawyers, human rights lawyers, have declined representing for instance, homosexuals and female sex workers, whose rights have been violated owing to culture, prejudices, and discrimination. This is basically because, they are not sensitised enough on SRHR to appreciate and understand that the violation of one right, is a violation of all rights. Human Rights are after all coexistent and interdependent. The arrest and detention of homosexuals, for instance does not only violate this right to self-expression, but also movement and in some instances, health (torture). We cannot therefore pick and choose which rights to protect or who to defend if we have full appreciation of what rights are.

This sensitization manual is a product of a project that seeks to sensitise lawyers on the rudiments of SRHR so as to enhance their understanding and ability to provide legal services to key populations It is by no means an exhaustive exposition on SRHR but basically seeks to introduce one to what the issues are, in a bid to turn an educated mind into an open one.

The manual, though meant for lawyers, can also be beneficial to anyone seeking an understanding of SRHR and attendant issues and could help whittle down prejudices, stigma, and discrimination against fellow humans.

Lawyers Alert is indebted to AmplifyChange for supporting this work. We appreciate all lawyers offering free legal services across Nigeria, especially our members and members of the Coalition of Lawyers for Human Rights, COLaHR.

We will continue to work with as many lawyers as possible towards enhancing access to justice and services for all those who are vulnerable especially victims of SRHR

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CHAPTER ONE

WHAT IS HIV?

OBJECTIVE

This chapter is aimed at enhancing general knowledge of HIV and AIDS.

DEFINITION

The abbreviation, HIV, stands for Human Immuno-deficiency Virus. Left untreated, it can degenerate into a condition known as AIDS, Acquired Immune Deficiency Syndrome. It is a life-long condition for which a cure is yet to be found though breakthroughs in research have yielded treatments which help people who have are HIV positive to live longer, healthier lives. HIV has no symptoms.

HISTORY

It is widely believed that HIV originated in Kinshasa, in the Democratic Republic of Congo around 1920 when HIV crossed species from chimpanzees to humans. This is debatable as other schools of thought have it that the virus came into existence as the bye product of attempts by military scientists to create a very potent biological weapon.

While infrequent cases of AIDS were documented prior to 1970, available facts indicate that the current epidemic started in the mid- to late 1970s. By 1980, HIV may have already spread to five continents (North America, South America, Europe, Africa and Australia). In this period, between 100,000 and 300,000 people could have already been infected. However, in Nigeria, the condition developed prominence in 1984 when a young girl was found to be living with the virus in Northern Nigeria.

TRANSMISSION

The transmission of HIV is effected through an exchange of bodily fluids. It should be noted here that while all the bodily fluids of an HIV positive person carry the virus, only the following fluids have been found to effectively transmit the virus: blood, semen, pre-seminal fluids, vaginal fluids, rectal fluids, and breast milk. Even so, these fluids must come in direct contact with the mucous membranes, damaged tissue, or injected directly into the blood stream for transmission to result. Mucous membranes are found in the vagina, penis, rectum and mouth.

From the above it can be seen that HIV transmission requires a certain degree of intimacy or invasion of the body to occur. As a result, all forms of unprotected sex, blood transfusions and or use of shared injectables, mother to child transmission, etc are fairly common ways through which the virus travels from one person to the next.

PREVENTION

While HIV transmission is possible through a variety of ways, as mentioned above, one of the major means of transmission is through unprotected sex. As a result of this knowledge, the ABC acronym was coined.

A – Abstinence

B – Be faithful

C – Condomise

Medications are also available to prevent mother to child transmission during birth and as a result of breastfeeding. Blood is also screened before transfusion to limit the spread via blood transfusions. People are discouraged from sharing any sharp objects whatsoever and also urged to carry out tests regularly to know early if they do get infected as the virus comes without any signs or symptoms whatsoever as earlier mentioned.

CONCLUSION

While it would seem as if all the hullabaloo surrounding HIV has died down, the virus is still very much alive and well and affecting many. There is a need therefore for people to continue practising safe sex and other preventive measures as outlined above to protect themselves from possible infection.

SUMMARY

HIV is a virus not a disease. It is still a global threat even if no longer of pandemic proportions. Owing to the fact that there is as yet no cure, the primary means of staying safe is adopting preventive measures and carrying out regular tests to detect the virus early in the event of contracting the virus.

EXERCISE

1) Find the meaning of PMTCT
2) Find the current prevalence rate in Nigeria

CHAPTER TWO

TERMINOLOGY

OBJECTIVE

Unlike most other health conditions, HIV has a language of its own which lawyers need to know. In this chapter, we get to know why there is need for a language of HIV and commonly used terms.

WHAT IS THE LANGUAGE OF HIV?

The language of HIV or HIV terminology refers to words universally used when talking about the HIV and or AIDS situation. One thing we must keep at the back of our minds as HIV experts is the need to use the right language when talking about those infected or affected by the virus and yes, there is a right way and a wrong way of talking about it as shown in the instances below:

	WRONG	RIGHT
1	AIDS carrier	HIV positive
2	AIDS test	HIV test
3	Commercial Sex Work(er)	Sex work, Commercial sex
4	Corrective rape	Homophobic rape
5	Intravenous Drug Users	People who inject drugs

I bet you were totally blind-sided by some of the language considered wrong, right? Well this is not all and a more exhaustive list can be sourced from http://www.unaids.org/sites/default/files/media_asset/2015_terminology_guidelines_en.pdf.

As professionals in the HIV sector, it is vital to keep abreast of such guides to enable us sound knowledgeable when we speak of current happenings in the sector.

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WHY DOES HIV HAVE A LANGUAGE?

Why should HIV have a special language when daily people die of diseases like malaria, diabetes and hypertension and yet those health conditions do not have a special language? In fact, why all the noise about HIV specifically when in Nigeria malaria affects far more people than HIV? These are some of the questions we are sometimes confronted with in the course of carrying out the task of educating people about HIV.

To answer the first, HIV has a global presence like no other health condition. Though a much bigger problem in developing nations like India, South Africa and Nigeria, the western world is equally affected. Due to this universal spread, there

is a need for a common platform of communication to facilitate discourse about the pandemic. Health and media practitioners, civil society actors, policy makers and politicians all need to be on the same page when talking about HIV issues. Of course, the easier the communication process, the less the confusion.

But in addition to the reason mentioned above, HIV is still a health condition shrouded in ignorance and myths. This has led to people being ostracised for being HIV positive. As a result, there is need for compassionate use of language when talking about HIV and those living with the virus. Additionally, a failure to be compassionate in our choice of language when talking about the virus facilitates spread. How? Well think about it. Let's say a neighbour of yours is living with the virus and in talking about it, innocently or not, you choose to refer to that person as an AIDS carrier (as we often do in Nigeria). How do you think that person feels hearing that? Chances are good that this person will immediately take steps to prevent other people from knowing his or her status so he or she does not have to contend with the embarrassment of being called "names."

Such steps might include relocating to an environment where people do not know their HIV status. In the course of hiding their status, such a person might be tempted to keep living as though they do not have the virus and wind up spreading it. Sounds extreme right? However, these assertions are based on research findings. For instance research indicates that there are more people living with the virus in rural areas than in urban centres in Nigeria. A careful evaluation of the situation shows that HIV numbers climbed because urban dwellers that were positive were relocating to villages to avoid being found out. Simply put, choice of language can fuel stigma and discrimination which in turn lead to the virus going underground and spreading.

A third reason for the use of appropriate terminology is that the wrong language is often inaccurate or misleading.

COMMON ERRORS

A commonly used expression when talking about HIV in Nigeria is "innocent victim," used to refer to people living positively. This expression is especially used when talking about children born with the virus, housewives presumably infected by their husbands and so on. The logic here is that they had no choice in the matter. Sex workers or single people are hardly ever given this appellation.

The use of the word "innocent" suggests a measure of judgement which as a media practitioner you really should not be doing. It is considered unprofessional. It also suggests that other people are guilty and the first question that comes to mind is, guilty of what? Sex? Sex is a physiological need most human beings will be driven to fill at some point in the course of their lives. It is natural. But people still get judged for this aspect of life because it is the chief means of spreading the virus.

CONCLUSION

The need for the use of the right language, especially by lawyers, when talking about HIV has been explained above. According to the United Nations program on HIV/AIDS (UNAIDS) there are about 33 million people living with HIV worldwide. Sub-Saharan Africa alone accounts for 22.5 million of those. The HIV population in Nigeria according to UNICEF stood at 3.3 million in 2009. This is a significant number and surely most of us are infected or affected. We must therefore strive to be more sensitive in acknowledging those who live with the virus to validate their humanity and not knowingly or unknowingly erode their self-esteem with the language we use when talking about their health status. Using the right language when talking to or about those who are HIV positive, is therefore the first step in the right direction.

SUMMARY

This chapter talks about what HIV terminology is, the need for it, and provides links to websites with information regarding the right language to use.

EXERCISE

See if you can spot what is wrong with any of the sentences below.

1. My father went for an AIDS test yesterday.
2. People treat HIV carriers very badly.
3. Innocent victims of HIV should have access to free medical care.
4. If prostitutes are registered and given adequate sexual health education, HIV numbers will decrease.
5. Homosexual men in bi-sexual relationships are at greater risk of infection.

CHAPTER THREE

GENDER and HIV

OBJECTIVE

In this chapter, the discussion centres on how gender issues could facilitate the spread of the virus.

DEFINITION

What is Gender? The common answer to this question is usually, "gender is one's sex." To a certain degree this answer is correct. The terms are often used interchangeably in everyday conversation. In the true sense however, gender has little to do with one's sex (biological make up), but everything to do with social, cultural and religious roles ascribed to both sexes. For instance, in many developing societies such as Nigeria, women are expected to take on housekeeping responsibilities while the man serves as the breadwinner. Even with the current trend where many women also work outside the home, they are still expected to fill these roles. Another example can be found in patrilineal societies where only the male child carries on the family name and so on.

These roles are all assigned to the individual sexes by culture, tradition, society and or religion. They are not biological functions. Biological roles would be those that come naturally to both sexes for instance, physical attributes (women grow bigger breasts than men, men tend to grow more facial and body hair than women do), and reproductive attributes (women get pregnant and give birth, men don't etc.).

RELEVANCE OF GENDER IN THE HIV CONTEXT

So, why are these social constructs given special consideration when talking about HIV?

According to the United Nations Development Fund for Women, UNIFEM, women constitute half the population of those living with HIV globally. However in places like Africa and other parts of the developing world, women outnumber men living with the virus. Indeed, research indicates that young women in these parts are 6 times more likely to be HIV positive than men.

Gender is an inextricable part of the HIV/AIDS equation. Young women are unduly vulnerable to infection; elderly women and young girls are also unduly affected by the burden of care in the epidemic's wake. Globally, females constitute up to 50% of People Living with HIV (PLHIV) while in sub-Saharan Africa, the figure is 60%. In low and middle-income countries worldwide, HIV is the leading cause of death and diseases in women of reproductive age.

Men and boys are affected by gender expectations that may encourage risk-taking behaviour, discourage accessing health care services and narrowly define their roles as partners and family members. Rates of HIV testing and treatment tend to

be lower among men compared to women. Gender inequality and poor respect for the human rights of women and girls are key factors in the HIV/AIDS epidemic: both from the point of view of effectiveness and from the point of view of social justice and or human rights.

GENDER BASED VIOLENCE

Sexual violence against women (i.e. rape) is a common and brutal violation of women's rights. This aids the spread of the virus. Studies have shown strong links between gender-based violence (GBV) and HIV infection with violence as a risk factor for HIV as well as a consequence of being HIV positive. About 35.6% of women across the world have experienced either non-partner sexual violence or physical or sexual violence by an intimate partner or both.

Though men could also be coerced or otherwise forced into sexual relations against their will, the figures for violence against women and girls remain much higher and should be acknowledged as such.

In Nigeria, for instance, women and girls abducted by insurgency groups are forced to marry, convert to another faith and endure physical and psychological abuse, forced labour, and rape in captivity. Hundreds of Nigerian women and girls have been abducted since 2009.

Forced sex increases the risk of HIV transmission among women due to lacerations. Women dreading or experiencing violence, can hardly negotiate safe sex, go for HIV testing, share their HIV status or access treatment. There is also the fear of stigma. Research shows that up to 45% of women who experienced physical or sexual violence did not seek help from any source or tell anyone about the violence.

Current gender roles also compromise men's health by encouraging them to equate risky sexual behaviours and violence with being manly and because in Nigeria masculinity norms impress on men to have more than one sexual partner, it is common for men to have unprotected sex with much younger women or even prepubescent girls, thereby ensuring the spread of the virus. According to UNIFEM, the factors that spur this spread include:

- Promiscuity - The percentage of women and men aged 15 – 49 with multiple sexual partners is higher amongst males than females, with more than 30% men ages 20 to 24 reporting multiple sex partners in 2012. This leads to three times higher infection rate among young women (15 – 24 years) compared to young men of the same age.
- Polygamy - One-third (33%) of married women in Nigeria are in polygamous relationships.
- Early sexual debut - 16% of girls are involved in sexual activity before age 15. Many are victims of GBV.

EFFECTS OF LACK OF EDUCATION

In Nigeria, there is sufficient evidence to show that lack of education can prevent women from accessing HIV information and services. Statistics provided by UNIFEM indicate that correct knowledge of HIV and its prevention among youth between the ages of 20 – 24, is low (24.4%), and generally higher in males at 27.0% than females, 22.3%. Contrary to societal fears, studies are said to show that sex education can delay sexual debut and actually increase condom or contraceptive use by sexually active adolescents.

However, women and girls have been found to generally be less informed about HIV and have fewer resources at their disposal to take preventive measures. They are often unable to negotiate safer sex due to economic dependency and unequal power relations.

Lack of education forces many women to adopt risky survival strategies, including sex work that increases their chances of contracting and spreading HIV. Child marriage is still common nationwide, with young girls often forced into marriage and sexual relations, causing health risks, including exposure to HIV. Research shows that up to 40% of girls are married by the age of 15. Harmful traditional practices such as Female Genital Mutilation (FGM), early and forced marriage, vaginal douching and women inheritance increase risk of HIV infection among women and girls. FGM is discussed in deeper detail in the chapter discussing SRHR.

BARRIERS TO CARE SEEKING BEHAVIOUR

In Nigeria it has been discovered that men might avoid seeking HIV services due to fear of stigma and discrimination with the attendant possibility of losing their jobs and therefore not being able to play their bread-winning role.

Similarly, women are likely to face barriers in accessing HIV prevention, treatment and care services due to their limited decision-making power, lack of control over financial resources, restricted mobility and child-care responsibilities.

Women and girls are often the primary caregivers in the family, including for those living with and affected by HIV, thereby hindering their economic opportunities. Many women lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. This

ACTIONS REQUIRED

HIV/AIDS and Other Sector Policy Makers should:

• Invest a good proportion of the HIV/AIDS budget to gender based programming to address specific gender and human rights issues to halt the spread of HIV.

• Equip gender desk officers with the requisite knowledge with regard to administering tools for gender and human rights based programming and gender responsive budgeting.

• Support the development of gender responsive costed state and national plans specifying strategies and interventions critical for the provision of gender and human rights based interventions.
• Ensure resource allocation/budgetary provision, approval and timely release for specific gender sensitive interventions.
• Monitor and track resources to ensure that gender and human rights specific interventions have budget lines and are executed appropriately.

THE GENDER DEBATE

Lawyers need to know the value of highlighting gender issues and how they are a potent factor in spreading the virus.
One way of doing this is by ensuring that both sides of the HIV story are adequately explored. For instance, it is important to make sure that there is an equal representation of both sexes when discussing gender related issues at any forum. Have a balanced number of men and women at workshops and or seminars. Even when it appears that the matter being discussed is of more relevance to one sex, it is important to know what the other sex thinks about the subject being explored and what role they play.
Another urgent thing to do is to highlight the peculiarities common to the gender situations mentioned and why they are a potent factor in the spread of the virus. Many people, including the educated, have no idea that these norms and practices play a strong role in driving the virus. HIV is no respecter of persons and as a result, if any significant in-roads are to be made towards its eradication, men and women must work together to ensure that it happens by knowing what the challenges are on either side of the divide.

GOVERNMENT'S EFFORTS

Several efforts have been made to tackle gender and HIV/AIDS related issues in Nigeria. These include:
• Scaling up of Prevention of Mother to Child Transmission (PMTCT)
• Accelerated PMTCT programmes at PHC & community levels, and giving attention to MARPs, women, young people, Vulnerable Children (VC).
• Mainstreaming gender issues, women empowerment and male involvement in all efforts of the national HIV response.
• Mobilization of strategic partnership with FBOs, women focused NGOs, traditional rulers, public and private organization through the office of First lady and wives of Governors and LGA Chairmen.
Integration of reproductive health and HIV services including comprehensive programmes that address gender inequality in a holistic way and cross-examine the socialization of boys and girls at home and school.
• Involvement of male and female gender focused networks including women and girls with disabilities who have been marginalized.
• Ongoing institutionalization of Gender Management System, which will enable a gender responsive functional system at national and sub-national levels and
• Gender responsive budgeting in HIV/AIDS programming.

CONCLUSION

Often considered inconsequential, the fact remains that gender issues play as big a role in the spread of HIV as risky behavior and as such, must be tackled in a combined effort involving men and women, the authorities and society as a whole.

SUMMARY

In this chapter, we have examined what gender is, how gender issues play a role in driving the virus and why gender balance is crucial when issues of HIV are being discussed.

EXERCISE

Within your immediate environment, what are those gender issues that you feel are potential drivers of the virus?

CHAPTER FOUR

SEXUAL AND REPRODUCTIVE HEALTH & RIGHTS

OBJECTIVE

In this chapter the subject SRHR, particularly with regard to women in Nigeria is explored and the implication of the general lack of knowledge of it pointed out.

DEFINITION

Women's Sexual and Reproductive Health and Rights speaks to a range of human rights issues including the right to life, freedom from torture, right to health, right to education, right to privacy, and so on. Various international charters have stipulated that women's health rights include their sexual and reproductive health. These international documents maintain that women should be availed of all reproductive health services, goods and facilities which should be adequately available, accessible both physically and economically, without discrimination, and be of good quality. This however, is not always the case. Religious, cultural and socio-economic factors frequently conspire to rob women of these rights particularly in developing countries such as Nigeria.

Some of these challenges include the need for women to get permission from third parties before receiving any kind of medical attention, inadequate and poor-quality services, financial challenges etc. Additional challenges include cultural practices and demands such as female genital mutilation and the pressure on married women to produce sons which sometimes leads women to have more children than they might ordinarily have intended to which sometimes takes a toll on the body.

SRHR IN NIGERIA

A shadow report on Women's Reproductive Rights in Nigeria paints a rather dismal picture of the health sector generally showing that only 40% of the population has access to healthcare facilities. In 1992, there was one doctor available for every 3,867 (three thousand eight hundred and sixty-seven) people and only a third of births were attended to by a doctor, nurse, trained midwife or traditional birth attendant. Current reports indicate that Nigeria's maternal mortality rate stands at 814 per 100,000 births (Index Mundi, 2016).

From the above statistics, it is quite obvious that there is a paucity of health facilities especially in rural areas where the majority of Nigeria's population is said to reside. However, in addition to the lack of these health facilities, most women who require their use are unable to afford these services even when they are available but in most instances, they are not.

According to the Centre for Reproductive Law and Policy, Family planning services are provided through the Primary Healthcare Centres (PHCs) to Maternal and Child Health (MCH) facilities yet owing to the challenges mentioned above those

who need them most are unable to access these services. Additionally, although health care providers have been trained to seek consent to provide these services, what many fail to do is ask for the previous health history of the patient frequently with bad consequences leading to a suspicion and or dislike of contraceptive devices and attendant negative word of mouth reports to fellow women.

Lack of adequate access to healthcare facilities also means an uphill battle against the continued spread of HIV as prevention of mother to child treatments would not be available to those in need along with the risks many birth attendants would still expose themselves to in the course of helping HIV positive mothers through the birth process.

In conclusion, the primary factors said to be mitigating against women seeking reproductive health services are poverty, poor transportation systems and lack of healthcare facilities and or personnel

ACCESS TO SRHR INFORMATION

Though in theory Nigeria's population policy includes an aggressive sensitization campaign, in fact there is very little if any serious awareness campaign by government agencies to ensure that women receive adequate knowledge about these services. What mostly happens is the distribution of heavily subsidised commodities to PHCs but the actual information is not available in the public domain. Classes are usually provided for women seeking pre-or ante natal care at many hospitals but we have mentioned earlier that there is also a serious lack of access to these facilities, even where they do exist.

Additionally, such information tends to be restricted to mostly to use of contraception, pregnancy and infant care with very little if any information on the need to space children for personal health reasons and or personal growth. Most of these women remain ignorant of the fact that they have right to make decisions where their bodies and sexuality are concerned deferring instead to cultural and religious teachings which appear to suggest that the men own their women completely including their right to healthcare and or sex.

FEMALE GENITAL MUTILATION

Statistics show that Nigeria, owing to her large population, has the highest number of Female Genital Mutilation (FGM) cases worldwide. According to Okeke, Anyaehie & Ezenyeaku (2012), Nigeria is said to account for ¼ of the total number of approximately 130 million victims of the practice That is a chilling 30-35 million women subjected to this inhuman practice in Nigeria. Though the prevalence rate in Nigeria is said to be about 41% in adult females, the practice is currently in decline most likely as a result of efforts to eradicate the practice, championed primarily by International Humanitarian organizations such as the World Health Organization (WHO), United Nations International Children Emergency Fund (UNICEF), the African Union (AU) to name a few.

But what then is FGM? FGM can be defined as any procedure which involves the partial or full removal of the external parts of the vagina either for, cultural, religious, or any non-therapeutic reasons. Though the practice is common across the world, Nigeria, Egypt, Mali, Eritrea, Sudan, Central African Republic and Northern Ghana. Somalia and Djibouti are said to have the highest prevalence rates in the entire world as the practice is almost universal in those parts. In Nigeria, the prevalence rate is highest in the deep South (77%), South East (68%), and the South West (65%). In the North, the prevalence rate is about 2% though those who do practice it ironically prefer the more extreme version of the practice which removes the entire external organs and stitching up the wound thereafter.
Though the origins of this practice remain vague, speculations suggest that it may have been part of initiation to womanhood, attempts at preserving virginity till marriage and curbing promiscuity, or possibly to maintain modesty and chastity. There are for known types: Type I or clitoridectomy (removal of all or part the clitoris only); type II or "Sunna" (removal of the clitoris along with all or parts of the labia); type III also known as infibulation (involves the removal of clitoris, the labia and stitching of the vagina leaving a hole the size of a pin only to allow for menstrual flow and urination); type IV is used to categorise a range of other such practice some of which include the use of herbs, cauterisation, the introduction of corrosive substances into the orifice, etc.
Unfortunately, while this practice is considered noble and perhaps even obligatory amongst the peoples who practice it, it frequently means dire health circumstances for the victim. These could include, haemorrhaging during the process, shock, infections, obstruction during childbirth, emotional/psychological trauma, and sexual dysfunction to name a few (Osuizigbo, 2016).
The Nigerian government is however not resting on its oars as the Violence Against Persons (Prohibition) Act could appropriately be deemed broad enough to cover such violations though not yet ratified in all the states. The Child's Rights Act, which focuses on the well-being of children is also another law which could come in handy for prosecuting FGM cases.

ABORTION

Marie Stopes UK (2017) defines abortion as the "deliberate medical process of ending a pregnancy…1 in 3 women will have an abortion in her life time." In Nigeria, while the process is not totally illegal, it is extremely restricted with only 3 grounds upon which it is permitted:

* To save the life of the woman
* To preserve mental health
* To preserve physical health

At least 2 physicians need to evaluate the case and agree that terminating the pregnancy would result in any of the above.
Despite this, it is reported that up to 1.25 million abortions were obtained in 2012 alone (Guttmacher Institute, 2015). Like any other law anywhere else, this one is

also regularly contravened with attendant and frequently horrific consequences for women, married and single who procure these services through clandestine means. For one thing, culturally and religiously, terminating a pregnancy is considered to be extremely taboo and even in instances where an abortion is legally procured, not many would admit to having one.
As a result, quack doctors whose specialty is abortion abound thereby contributing to the high levels of maternal mortality. The Guttmacher Institute (2015) reports that only 16% of women of reproductive age (15 – 49) avail themselves of contraceptives with only 11% using modern ones. According to the institute, these figures have remained unchanged since 2008.

CONCLUSION
SRHR especially for women are crucial throughout their reproductive years whether they have children or not. Women need to know what their sexual rights are and be able to take decisions about their sexuality, their health and their rights if more of them are to be saved the trauma of health challenges as a result of ignorance.

SUMMARY
More needs to be done in the health sector generally and particularly at the PHC levels that are designed to be the first port of call for those at the grassroots. Government needs to invest in producing more healthcare personnel, facilities and providing requisite informal education to the public targeting women of reproductive age. Custodians of culture particularly need to be made aware of the high mortality rates that attend the lack of rights to their bodies most Nigerian women are subjected to. They need to understand that a woman has the right to make decisions that impact her health and sexuality.

EXERCISE
What are the disadvantages of inadequate or lack of SRHR education particularly for women?

CHAPTER FIVE

SEXUAL DIVERSITY – AN OVERVIEW

OBJECTIVE

In this chapter, we explore a topic that is relatively taboo especially in conservative societies such as Nigeria: sex. But in this instance, we won't examine the issue broadly but instead narrow it down to the rather controversial subject of Sexual Diversity.

DEFINITION

The World Health Organization (2017) defines Sexual Diversity as a person's "…physical, romantic and or emotional attraction towards other people." It comprises 3 elements namely, sexual attraction, sexual behaviour and sexual identity. The 2 most common forms of orientation are heterosexuality, a term used to describe those who are attracted to members of the opposite sex and homosexuality, the term used for describing those who are sexually drawn to members of their own sex. Sexual behaviour on the other hand is defined as "the way in which an individual sexually engages with others." Sexual Identity, is frequently used interchangeably with Sexual Orientation.

TYPES OF SEXUAL ORIENTATION

While contemporary society recognises that there is a range of Sexual Orientations, some of the most commonly known are indicated below with explanations of what the different terms mean.

Heterosexual – This refers to people who are sexually attracted to people of the opposite sex.

Homosexual – People who are attracted to members of their own sex are called homosexual. Females are known as lesbians, while males are called gay.

Bi-sexual – People who are sexually attracted to both members of the opposite sex and people of their own sex are referred to as such.

Transgender – This is said to be an umbrella term used to identify those with a wide range of identities such as those who identify as third gender, and those whose sense of their own gender differs from their sex at birth. For instance, a man who was born with male genitalia might actually grow to identify himself as a member of the opposite sex (i.e. female) and vice versa.

Queer – This is also an umbrella term frequently used to identify people who are not heterosexually inclined. Once used derogatorily, it no longer is and has now been reclaimed by those in this community of persons as "an expression of pride and to reject narrow, reductive labels" (WHO, 2017).

Intersex – These are people whose biological sexual characteristics do no conform to traditional definitions and appearances of the male or female anatomy.

Pansexuality – Pansexuals are fluid enough in their sexuality to have no limitations on those they are sexually attracted to be they heterosexual, homosexual, transgender etc.

SEXUAL PRACTICES AND PARAPHERNALIA

Naturally, these different sexual orientations portend different sexual practices some of which are listed below in alphabetical order:

Anal sex – Also known as Sodomy. Sex through the anus. Though this might seem more like a gay act, the practice is gaining ground amongst other sexual identities including heterosexuals.

Auto eroticism – Self sexual stimulation and gratification also known as Masturbation

Bestiality – Sex with animals

Coprophilia – A sexual arousal triggered by or involving fecal matter or filth

Exhibitionism – A compulsion to display one's genitals in public

Fetishism – Sexual behavior wherein satisfaction is based to a very large extent on a particular object or body part

Froteurosexuality – Sexual satisfaction derived from rubbing of the genitals

Gerentosexuality – Sexual attraction to the elderly

Incest – Sexual activity between blood relations

Masturbation – Sexual self-gratification

Necrophilia – Sex with dead people

Nymphomania – Sexual unsatiety in a woman

Oral sex – Mouth to genital sexual gratification

Paedophilia – A situation where adults find children sexually attractive

Pederasty – Sexual attraction to pre-adolescent males

Rape – Forcefully having sex with an unwilling partner. "Force" here does not always refer to physical constraints but also coercion, threats and blackmail. Rape is the situation once the other party is being compelled against the persons will.

Sado-masochism – Sexual activity including infliction of pain in the process

Satyriasis – Unbridled sexual desire from a man

Serial Monogamy – People who are sexually involved with multiple sexual partners over a period of time but each time being involved with only one person

Sexual orgies – Group sex with multiple partners at the same time

Urophilia – Sexual pleasure derived from urination

Vaginal sex – Heterosexual sex where the penis and vagina are involved

Voyeurism – Sexual pleasure derived from watching others have sex

Some of the practices indicated above e.g. bestiality, paedophilia, necrophilia, etc. are against the law in many countries including Nigeria.

ASSOCIATED TERMS

Whilst discussing sexuality, there are certain terms we need to be familiar with. These include but are not limited to the following:

Heteronormativity – This term is used to describe the fallacy that everyone is heterosexually disposed and that heterosexuality is therefore the norm. It is blind to the fact that sexual minorities, represented by the Lesbian/Gay/Bi/Trans/Queer/& Intersex (LGBTQI) community, do exist and happen to share the same sexual space as everyone else.

Homophobia – This term is used to describe discrimination based on sexual orientation or gender identity and s frequently unleashed in the form of verbal abuse and or physical violence

Transphobia – Very similar to homophobia

SEXUAL DIVERSITY AND HIV

What then is the link, if any, between sexual diversity and HIV? Well for one thing, sex is one of the main modes of transmission of the virus. Exploring the different types of sexuality helps to open up the discussion on the different sexual communities and how the virus spreads through each. It is therefore important for lawyers to recognize that people have different sexual identities in order to know how best to approach each community with regard to meeting their legal needs especially with regard to HIV.

SEXUAL MINORITIES IN NIGERIA

To get a clear picture of the level of acceptance of sexual minorities, one need look only to the law criminalizing homosexuality. Known as the Same Sex Marriage (Prohibition) Act, 2013, it expressly forbids marriage or civil unions being entered into by people of the same sex. Though the law seems on the face of it to re affirm the nation's extremely conservative attitude to sex and such matters based primarily on strong religious leanings, it has led to a situation where the conversation around mitigating HIV amongst sexual minorities is being stifled. This will undoubtedly come with attendant negative consequences where people who are already HIV positive and therefore subjected to stigma and discrimination now have yet another reason to go underground and remain anonymous.

Since the law was made effective in 2013, data shows that there has been an increase in attacks on people based primarily on their sexual orientation. Most of these attacks have been carried out by government agencies who should ordinarily be the safe haven for those subjected to any form of attack. It is a situation which, if not soon checked, might actually end up being counterproductive with regard to progress in the HIV sector.

CONCLUSION

In conclusion, sexual orientation is a major aspect of the HIV conversation. It is a reality which must be accepted that the world is not made up only of heterosexuals and there is therefore a need to keep the conversation open and inclusive so that HIV mitigation efforts can gain traction.

SUMMARY

This chapter has examined what Sexual Orientation is, the different types of sexual orientation that exist as well as sexual practices. We have also examined the link between sexual orientation and the HIV situation and the need to ensure inclusiveness to keep making gains with regard to eliminating the virus completely.

EXERCISE

How would you feel or react, if someone really close to you, e.g. a family member identified as any sexuality other than that commonly accepted in your society?

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