1 REALISING THE SEXUAL AND REPRODUCTIVE HEALTH NEEDS OF WOMEN AFFECTED BY THE BOKO HARAM INSURGENCY IN NIGERIA

by **Aisosa Jennifer Isokpan**

Introduction

The need to secure women's reproductive health was recognised as far back as 1993 at the Vienna Conference on Human Rights, the International Conference on Population and Development (ICPD), Cairo in 1994 and the Fourth World Conference on Women in Beijing in 1995. The consensus documents from the ICPD and Beijing conference also articulated the need for women to have access to reproductive health services highlighting the special needs of refugees and internally displaced women. During armed conflict, in addition to other challenges, women are exposed to random acts of sexual violence which includes mass rape, sexual slavery, forced prostitution, forced marriages and pregnancy as well as engaging in transactional sex for survival (UNFPA Adolescent Girls and Armed Conflict, 2016).

This reality makes women and girls amongst the world's most vulnerable and requiring timely access to reproductive health services. Unfortunately, in situations of conflict, existing health services are usually overstretched and at best operate at rudimentary levels. In addition, they are forced to cope with injuries because of widespread violence, shortage of food, water, shelter as well as other socio-economic deprivations. As such, in giving humanitarian assistance, there is a possibility that food and shelter and other emergency health issues could be prioritized over the sexual and reproductive health needs of women and girls. No doubt, efforts have been made by various international bodies and States in providing sexual and reproductive health care services to those affected by armed conflict but not to the extent of adequately meeting the needs of a substantial number of those in need.

This contribution takes particular note of the unmet sexual and reproductive health needs of women affected by the Boko Haram insurgency especially, among the internally displaced populations. The reference to women in this paper includes adolescent girls as they face similar sexual and reproductive health challenges. This paper shows that the Nigerian government has not made the delivery of sexual and reproductive health services a priority and has largely abdicated its duties to international support agencies. It is noted that the sexual and reproductive health consequences of the Boko Haram insurgency could be minimised at least among the displaced populations if the underlying causes of sexual violence against women are addressed. Also of importance is the need for the measures adopted to be the outcome of a participatory process involving the affected women.

The Boko Haram insurgency in Nigeria and its impact on women

The group Jama'atu Ahlis Sunna Lidda'awati wal-jihad (people committed to the propagation of the prophet's teachings and jihad) popularly known as Boko Haram, has unleashed terror on the Northeast of Nigeria since 2009 through series of bombings, assassinations and abductions in furtherance of its aim of creating an Islamic State governed by Sharia law. The insurgency has led to loss of lives, properties and a huge displacement of people including women and children. Across the six states of the Northeast Nigeria, the on-going crisis is estimated to directly affect 26 million people, with 14 million in need of humanitarian assistance. Borno, Adamawa and Yobe States are the most directly affected by the conflict and Bauchi, Gombe and Taraba are equally affected as they host most of the internally displaced populations. This has led to a huge strain on basic infrastructure and services including healthcare (Humanitarian Crisis Overview, 2017).

The insurgency has negatively affected women as they face grave human rights abuses including death, torture, sexual and gender-based violence in addition to other socio-economic deprivations. A notable feature of the Boko Haram insurgency in Nigeria is the widespread sexual violence used as a weapon of war against abducted women and girls by the insurgents for several reasons including torture; humiliation; domination; forced conversion, an attempt to discourage western education as well as to produce a new generation of extremists in Nigeria. As a result of exposure to sexual violence, some return with pregnancies or with babies fathered by the boko haram extremists. Women are sometimes forced to marry their captors, and to give birth without medical assistance. Some have also tested positive for HIV and other sexually transmitted infections. This raises serious concerns for the sexual and reproductive health of a whole generation of women and girls who have endured sexual violence in the hands of their captors. The Boko haram sect has abducted thousands of women and girls since the start of the conflict in 2009. The height of this was the abduction of over 250 Chibok girls in April 2014 which ignited an international outcry and lead to the popular '#BringBackOurGirls' campaign (UNICEF,2015). Though the Chibok girls' abduction represented the largest single incident of abduction attributable to the Boko Haram, it is one among a series of abductions of women and girls by the sect.

The internal displacement resulting from

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the insurgency has equally had a heavy toll on women. They make up 54 per cent of the displaced population with a large number living in deplorable conditions in often over-crowded camps with limited sanitary facilities, and weak protection and security measures in place. There is also a lack of adequate reproductive health care services including timely clinical management of rape (Humanitarian Crisis Overview, 2017). The displacement situation has increased the rate of violence against women in IDP camps including rape, early/forced marriages as well as engagement in transactional sex. Transactional sex (sexual exchange for material gain) has been reported in many IDP camps in Borno, for several reasons including in exchange for food assistance and to gain freedom of movement in and out of temporary IDP sites (Humanitarian Crisis Overview, 2017). There have equally been reported cases of harassment of women in IDP camps and host communities, often in the course of conducting daily activities such as food distribution and water collection. This risky coping mechanism predisposes these women and girls to reproductive health complications.

The burden appears worse for pregnant women or lactating mothers, elderly women and female headed households. This situation is rooted in gender-based discrimination, social norms and gender stereotypes and can be exacerbated in humanitarian settings of which women and girls are at the receiving end (UNFPA, 2016).

The unmet reproductive health needs of women affected by the boko haram insurgency

During armed conflict, the resulting disruption of protection services leads to an increase in sexual violence exacerbating threats to the health and survival of women and girls. This has significant sexual and reproductive health consequences including forced and unwanted pregnancies, unsafe abortions, risk of sexually transmitted infections (STI) including HIV, chronic pelvic pain and other gynaecological problems. They also suffer mental and emotional health problems such as anxiety, depression, loss of self-esteem, eating disorders amongst others (UNFPA, 2017). Access to sexual and reproductive health services during armed conflict is important to curb the spread of infectious diseases as well as control the rate of maternal and child mortality. Victims of sexual violence require specialised health care including timely clinical management of rape, psychological and psychosocial support, and access to justice, safety and security as a minimum requirement.

Sexual and reproductive health is an essential component of the universal right to the highest attainable standard of physical and mental health. Implicit in this right is access to effective, affordable and safe healthcare services to enable women go safely through pregnancy, childbirth and have a healthy infant. It involves the availability of affordable pre-natal care, safe motherhood services, assisted childbirth from a trained attendant, comprehensive infant health care, and access to information regarding contraception. It includes the right of women to enjoy a satisfying and safe sexual life free from coercion, discrimination and violence as well as the prevention of sexually transmitted infections including HIV (UNFPA, 2014). States have an obligation to within available resources and progressively achieve the full realization of the right to sexual and reproductive health which must be available, accessible, and affordable and of good quality (Committee on Economic Social and Cultural Rights ESCR General Comment 22 (2016) paras 11-21, 33). This obligation also includes the duty to ensure its existence even in situations of armed conflict.

The realisation of this right is largely dependent on the achievement of gender quality and non-discrimination. The CEDAW committee considers violence against women and girls as a form of discrimination and a manifestation of gender inequalities which during armed conflict place them at a heightened risk of various forms of gender-based violence (Committee on the Elimination of All forms of Discrimination against Women, General Recommendation 30, (2013) para 34). This is largely due to the fact that women are disproportionately affected by poverty, violence, socio-economic deprivations, discrimination in decision making at various levels amongst others.

Women have a right to be protected from all forms of violence whether in public or private settings and definitely during armed conflict. Article 4 of the African Women's Protocol emphasises the need for a woman to enjoy respect for her integrity and the security of her person. States must give effect to this by taking appropriate measures to protect women from violence including unwanted or forced sex whether such takes place in private or public (Article 4(2) (a) African Women's Protocol).

This means that women affected by armed conflict especially the refugees and internally displaced sheltered in camps have a right to be protected from sexual violence. The United Nations Security Council Resolution 1325 calls on all parties to armed conflict to take special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict (UN Security Council Resolution 1325, (2000) para 10).

The escalation of the conflict in 2014 has resulted in a severe deterioration of living conditions and has significantly disrupted the health system with a rise in outbreaks of preventable communicable diseases, restricted access to essential medicines and care for non-communicable diseases and a lack of services for pregnant and lactating women. Among the most vulnerable populations are reproductive age females below poverty line who are sheltered in IPD camps as a result of the insurgency. Access to adequate healthcare has been highly constrained due to the destruction of over 450 health facilities in Borno, Adamawa, Yobe and Gombe, with 334 in Borno alone (Humanitarian Needs Overview, 2017). In addition to the insufficient number of skilled health care workers, the limited availability of medicines and medical equipment together with a non-functioning referral system hampers humanitarian response (Humanitarian Crisis Overview, 2017). It is estimated that over 1 million women of reproductive age do not have adequate family planning, ante-natal care and post-natal care, safe delivery, emergency obstetric care, prevention and treatment of STIs and HIV, rape treatment and other life-saving reproductive health services (Humanitarian Crisis Overview, 2017). UNFPA is working to reach people affected by the insurgency through support to 155 health facilities and clinics in Adamawa, Borno and Yobe states, reaching 1.2 million people.

Some 300,000 people were reached in October and November of 2016 alone. UNFPA supplies these facilities with comprehensive reproductive health kits containing contraceptives; equipment for pre-natal care, safe childbirth and post-natal care; supplies to treat sexually transmitted diseases and to prevent HIV; and supplies to support the clinical management of rape. These efforts are part of a broader plan to restore access to essential reproductive health services to people affected by the crisis (UNFPA, 2017). The UNFPA has also created safe spaces in some IDP camps reaching thousands of women (UNFPA Adolescent Girls (2016). These safe spaces in camps provide an entry point for reproductive health information and services including family planning and psychosocial counselling for gender-based violence. It equally offers women and girls opportunities to acquire livelihood skills and engage with others to rebuild community networks.

These efforts though laudable have not been able to meet the needs of a large number of affected women and girls. As said earlier, the Nigerian government had performed less than expected in its assistance to the IDPs as it appears to have abdicated its responsibility to international support agencies. A State has the primary role in the provision of humanitarian assistance to IDPs within its territory (UN Guiding Principles on Internal Displacement, principle 25, United Nations Resolution 46/182 of 1991, para 4). The support of international bodies cannot override that responsibility as it is only limited to some camps reaching just a fraction of the IDPs. The major burden lies with the Nigerian government. However, the government has not been able to meet the humanitarian needs of the IDPs probably because their needs outweigh its current capacity to address them and also the limited understanding of the needs of IDPs. National efforts to respond to the challenges of IDPs and mitigate the long-term effects remain inadequate as shown by the 2017 Humanitarian Needs Overview which demonstrates that the needs of IDPs remain largely unmet.

It is not in doubt that the worsening Nigerian economy and state finances are affecting the ability of the response at the Federal and State level, as Nigeria is currently battling with economic recession. The recent establishment of an Inter-Ministerial Task Force in 2016 under the Minister of Budget and Planning and an Emergency Coordination Centre as its operational arm are very positive steps in fostering greater partnership and more efficient coordination between the Government and the humanitarian community. It shows government's readiness to effectively lead the humanitarian response. The impact of these efforts is yet to be seen just as other previous results. Addressing the needs of the affected women and girls goes way beyond setting up committees. Rather, it turns on adequate implementation of strategies to meet the needs of the people.

Conclusion and recommendations

The reproductive health needs of women and girls affected by armed conflict are similar to their counterparts in stable environments except that the consequences of armed conflict make them more vulnerable to sexual and reproductive ill health.

Efforts at addressing the sexual and reproductive health challenges of women have to be holistic in approach and aimed at addressing the root causes of sexual violence and its attendant consequences such as transmission of STIs and unwanted pregnancies which puts a strain on already limited healthcare services.

It also involves ensuring access to contraceptive alternatives in order to control the rate of unwanted pregnancies. The underlying cause of this sexual exploitation is the dependence of women on male partners for survival due to the deplorable living conditions including shortage of food, limited security and lack of economic opportunities. Food insecurity happens to be the greatest concern among the internally displaced people which predisposes women to engage in transactional sex for their survival and that of their dependants (OCHA 'Nigeria-Northeast: Humanitarian Emergency 2017). Women should be given opportunities to be empowered in order to prevent dependence on a male partner placing them at risk of sexual exploitation.

It should be borne in mind that in all conflicts, women are faced with challenges in ways specific to women. This does not necessarily make them a homogenous group as different women will have varying needs, vulnerabilities and coping mechanisms. For a fact, it is important to spot the general needs of women, but it is equally necessary to respond to their different needs. The challenges faced by adolescent girls could in some way differ from those of older women with dependants. Same applies to lactating women, elderly and female headed households. The intervention programmes need to be borne out of a participatory process where women can be involved and engaged with on what services would adequately meet their needs. The CEDAW Committee has expressed concern that while women often take on leadership roles during conflict as heads of households, peacemakers, political leaders and combatants, their voices are silenced and marginalized in post conflict and transition periods and recovery processes (CEDAW, General Recommendation 30, (2013) para 42). The UN Security Council in its Resolution 1325 requires that measures adopted in camps and settlements take into consideration the peculiar needs of women and girls (UN Security Council Resolution 1325 para 12). It has equally stressed the need for women to be part of the decision-making processes at all stages including conflict prevention, management and resolution (UN Security Council Resolution 2106 (2013) para 7). It will amount to an exercise in futility to attempt to address the root causes of sexual violence among displaced women and girls without engaging with them in a bid to know their peculiar challenges and how best to deal with it.

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2 SOME RECENT DEVELOPMENTS ON JUSTICIBILITY OF ECONOMIC,SOCIAL AND CULTURAL RIGHTS by **Eric AyemereOkojie and Peace O. Folorunsho**

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Introduction

On 16 November 1966, the United Nations General Assembly adopted as well as opened for signature, ratification,and accession, via Resolution 2200A (XXI), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its sister covenant, the International Covenant Civil,and Political Rights (ICCPR). The ICESCR entered into force on 3 January 1976 in accordance with Article 27.

Whilst the ICESCR deals with economic,social and cultural rights (ESCR) such as work, health, education, social security and social insurance, and an adequate standard of living including adequate food, clothing and housing and the continuous improvement of the standard of living, the ICCPR is concerned with civil and political rights. Among these are the right to life, the right to liberty and security of person, the right to marry and found a family with the full consent of both parties, the right to fair trial, the right to privacy, and the prohibition of slavery and servitude, torture or cruel, inhuman or degrading treatment or punishment.

A good number of these rights (ESCR and civil and political rights) have been incorporated into the constitutions of countries that are state parties to these covenants, including Nigeria (a focus of this paper). According to Trispiotis (2010:1), these two sets of rights were developed after the 1950s during the Cold War. It should be noted that it was at the time of the adoption of the two covenants that ESCR started playing second fiddle to civil and political rights, a status they have retained into the present day.

Historically, issues pertaining to food, health, education, shelter, and work have troubled the human race (Udu: 28).

The aforesaid have been argued to have been responsible for the Tonghat Peasant Revolution in Korea in 1894, in which, in response to exploitation by local magistrates, peasants occupied the country office, seized weapons and distributed illegally collected tax rice to the poor (Abelmann: 27).

In China, peasants also resisted taxes which they perceived as inequitable (Hanagana, Moch,and Blake: 158). The issue of food, particularly bread, was the major cause of the French Revolution of 1789 in which the monarch was deposed. According to Udu (28), those who experienced the greatest violation of ESCR were slaves, who suffered from hunger, lived in miserable conditions, had ill-health resulting from poor food and lack of medical care, and had little or no access to formal education.

The establishment of the United Nations (UN) in 1945 after the end of the Second World War was a turning point in the international concern for the protection human rights generally (both civil and political rights as well as ESCR). Article 55 of the UN Charter states amongst others that the UN shall promote a higher standard of living, full employment, and conditions of economic and social progress and development.

It is worth noting that the rights above have been part of the language of international human rights since the adoption of the Universal Declaration on Human Rights (UDHR) 1948 (International Commission of Jurists: 2). These rights are replicated in Articles 22-27 of the UDHR. It should be noted that the UDHR was a non-binding instrument: it was a mere declaration that had a no legal force whatsoever in holding states accountable for the non-implementation of those rights.