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Sexual and Reproductive Health Rights: How Far have the Yoruba Women of Nigeria Gone

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I. Introduction and Statement of Problem

The roots of gender based discrimination run deep and lie buried in culture, customs, beliefs and superstitions. The issues relating to what has come to be known as the women question or why women are relegated to the background has become very prominent in the last few decades. The four core coordinates of human existence - culture, society, religion and family, have continued in locating women and men in specific social contexts, defined their roles, designed their activities and created processes of centrality- marginalization, visibility- invisibility and rooting- uprooting and rerouting (Aluko, 2009). This discrimination is reflected in our daily lives, be it areas of health, education, job opportunities or rights. The complexity and multi-layered realities of gender in our society need to be deconstructed for us to be able to work towards creating an equitable future.

Specifically, women's subordinate position has been linked intimately with the institution of marriage. The traditional form of marriage across cultures placed women at a disadvantage position (Aina, Aransiola and Osezua, 2006). With limited choices in sexual and health decisions, and the inability to abstain from sexual intercourse, women are forced to endure domination by their husbands in marital relationships. Thus, a link has been found between gender inequality and the sexual health conditions in any society. It is also a truism that the general neglect of women's health is a major hindrance to women's full participation in the development process. Any serious attempt at transforming the quality of life (most especially health) at the household level must necessarily have a better understanding of sexuality dynamics at this level, and much more importantly an appraisal of the marriage contracts as these exist in our society today.

A recent global study revealed that over 35 percent of women worldwide have experienced physical or sexual partner violence or non-partner sexual violence (World Health Organization, 2013). That is 818 million women (United Nations, 2013) – almost the total population of Sub-Saharan Africa. The most common form is abuse by an intimate partner, which has profound consequences on the health and well-being of women and their families, as well as effects on wider communities and development outcomes (WHO, 2013). In Nigeria, the 2013 NDHS reported that overall, 25 percent of ever-married women age 15-49 report ever having experienced emotional, physical, or sexual violence from their spouse, and 19 percent report having experienced one or more of these forms of violence in the past 12 months.

It is against this backdrop that this paper examines the extent to which Yoruba women have been able to exercise their sexual and reproductive health rights focusing on rights to make responsible reproductive choices; rights to sexual autonomy; rights to sexual expression; and rights to sexual freedom, going beyond the focus on ideological aspects of masculinity. This is because it is generally assumed among the Yoruba of southwest Nigeria that women do not have personal choices to make when it comes to sexuality (Harcourt, 1993). This assumption makes it difficult for women to face the reality of lack of decision making power within the family. As husbands and household heads, men control the sexuality of their wives (Isiugo-Abanihe, 1994). Wives are bound to comply with their husband's sexual demands as refusal is a major source of strife, the taking of other wives or the keeping of "outside wives" (Karanja, 1987). However, the irony of the Yoruba women's situation and position is that, unlike others they are known to have a

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relatively high social status derived from a high level of economic independence whereby they can on their own engage in paid job or engage in trading activities and earn income. The ability to keep and control the income that accrues from their trading activities (Odebode 2004; van Staveren and Odebode 2007) are important issues that give women in the region some leverage over their African sisters elsewhere. This implies that sexual decision-making among the Yoruba is characterised by certain specific structural and cultural problems which needs to be investigated and examined. The major question addressed in the study therefore is, do Yoruba women actually or in any way have any control over their sexuality despite improved socio-economic status?

II. Clarifying Concepts and Definitions: Sexuality, Sexual Health and Sexual Rights

Sexuality according to WHO (2004) is "a central aspect of being a human throughout life and encompasses sex, gender, identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction". Jemiriye (2006) also defined sexuality as "the condition of having interpersonal behaviour or relationship between male and female which may be associated with, leading up to, substituting for or resulting to or from genital union. It is the phenomena of sexual instincts and their manifestations especially within the two human organic divisions called male and female".

Sexual Rights according to the 14th World Congress of Sexology (1999) "are universal human rights, based on inherent freedom, dignity and equality of all human beings". Since health is a fundamental human right, so is the result of an environment which recognizes, promotes and defends sexual rights.

Sexual health therefore, is "a state of physical, emotional, mental and social being in relation to sexuality: it is not merely the absence of disease, dysfunction or infirmity" (WHO 2002). Sexual health is that enabling environment wherein the sexual rights of an individual are protected. As a result, sexual health can be said to be in place in the context of a marriage where the following sexual rights are expressed:

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

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

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

Africa, especially the sub-Saharan Africa has the worst indicators of women's health especially with regards to reproductive health (Aina, et al., 2006). This is an indication that there is still a pervasive violation of women's rights especially their sexual rights, due to prevailing cultural practices in this part of the world. Sexual violence has its roots in cultural discrimination

against women, which supports the subordination of women in marriage and marital relations. Hence, women in most of the Nigerian cultures are meant to endure, rather than enjoy marriage. The discriminatory practices against women are often used to explain the social placement of women in most African societies – 'poor, powerless, and pregnant'. No doubt, the social placement of women in our society has implications for their sexual health, while the denial of power to exercise sexual rights continues to violate the rights of women to sexual health. According to WILDAF (2005), the overt emphasis on traditional values and lack of respect of women's consent in a marital union has impeded marital relations in many parts of Africa. Furthermore, failure to define discrimination of women as an issue of concern has further worsened the status of women and led to the violation of their sexual rights as espoused by the declaration of sexual rights.

III. The Status of Women among the Yoruba

Yoruba women are both autonomous and subordinate to men. Autonomy arises through a fairly rigid sexual division of labour, which excludes women from most agricultural work, and means that traditional women work independently of their husbands and not jointly or cooperatively with them (Lloyd 1974). Despite women's autonomy, however, many aspects of the social system give men greater seniority and control than women. Men are permitted several wives, but women may have only one husband (Aderinto, 2001; Alaba, 2004; Dopamu and Alana 2004). Double standards of sexual morality for husbands and wives with the risks of infection and diseases such as HIV/AIDS limit women's life choices concerning their health, happiness and career. Whereas husbands maintain the right to control their spouses' desires for extramarital sexual activity, most wives do not try to exercise such control over their spouses (Orubuloye, Caldwell and Caldwell, 1992).

Infact, the literature is replete with assertions that because African society is largely patriarchal, men dominate family decision-making. The extension of this reality to sexuality appears to fuel some discord in the literature on who really determines timing and the frequency of sex between heterosexual married partners. Some studies report that men controls sexuality in conjugal unions than their female counterparts (Isiugo-Abanihe 1994; Oyekanmi 1999), and that women cannot resist sexual advances from their husbands even when they perceive their health is at risk (possibility of contacting STIs) (Bammeke 1999; Adewuyi 1999). In essence the position established by scholars indicates that women are at a disadvantage in sexual negotiation or control relative to their husbands' privileged and stronger position in African culture. On the other hand, some other studies have indicated that women exact considerable influence in negotiating sex in marriage (Orubuloye (1995: 231; Orubuloye, Caldwell and Caldwell, 1991; Orubuloye et. al.1997; Ogunjuyigbe and Adeyemi, 2005; Wusu and Isiugo-Abanihe, 2008). In view of these discordant voices on the subject matter, this present study is very germane. The question now is: If Yoruba women do have control over their sexuality at all, to what level?

IV. Theoretical Perspective

This study is based on the feminist social rights perspective on women's sexual and reproductive/health rights, which defined the terrain of reproductive and sexual rights in terms of power and resources: power to make informed decisions about one's own fertility, childbearing, child-rearing, gynaecologic health, and sexual activity; and resources to carry out such decisions safely and effectively. This terrain necessarily involves some core notion of "bodily integrity", or "control over one's body". However, it also involves one's relationships to one's children, sexual partners, family members, community, and society at large; in other words, the body exists in a socially mediated universe.

Critics have raised several fundamental problems about rights discourse: its indeterminate language, its individualist bias, its presumption of universality, and its dichotomization of "public" and "private" spheres (Correa & Petchesky, 1994). However, rather than abandoning rights discourse it can be reconstructed so that it specifies both gender, class, cultural, and other differences and recognizes social needs. The point is, sexual and reproductive/ health (or any other) rights understood as private "liberties" or "choices", are meaningless, especially for the marginalised, without enabling conditions through which they can be realised. These conditions constitute social rights and involve social welfare, personal security, and political freedom. Their provision is essential to the democratic transformation of societies to abolish gender, class, racial and ethnic injustice.

By implication this perspective has linked reproductive/health and sexual rights to development, and has challenged all legalistic notions of civil and political rights that still dominate the human rights field. Democracy movements in most societies easily invoke rights when it comes to voting, or forming political parties or trade unions. Why should concepts like "reproductive rights," "bodily integrity," and women's right to sexual self- determination be any less adaptable? The construction of a legal and normative boundary between "public" and "private" insulates the daily, routine practices of gender subordination especially in the home (Dixon-Muller, 1993). Feminist writings (Bunch 1990; Elias 1991; Cook 1993; Copelon

1994) and actions in defence of women's rights build on these critiques to challenge the customary reluctance of states and international agencies to intervene in traditionally defined "family matters".

There is need to develop analytical frameworks that respect the integrity of women's reproductive and sexual decisions, however constrained, while also condemning social, economic, and cultural conditions that may force women to "choose" one course over another. Such conditions prevail in a range of situations, curtailing reproductive/health choices and creating dilemmas for women's health activists. For reproductive decisions to be in any real sense "free", rather than compelled by circumstances or desperation, requires the presence of certain enabling conditions as mentioned earlier. These conditions constitute the foundation of reproductive and sexual rights and are what feminists mean when they speak of women's "empowerment".

Such enabling conditions or social rights are integral to reproductive /health and sexual rights and directly entail the responsibility of states and mediating institutions for their implementation. Rights involve not only personal liberties (domain where governments should leave people alone), but also social entitlements (domains where affirmative publication is required to ensure that rights are attainable by everyone). They thus necessarily imply public responsibilities and a renewed emphasis on the linkages between personal well-being and social good, including the good of public support for gender equality in all domains of life.

The issue therefore is, when are reproductive and sexual decisions freely made and when coerced? Bodily integrity includes both "a woman's right not to be alienated from her sexual and reproductive/health capacity (e.g., through coerced sex or marriage, denial of access to birth control) and her right to the integrity of her physical person (e.g., freedom form sexual violence, from unwanted pregnancies, from sexually transmitted diseases)" (Dixon-Mueller 1993). It also implies affirmative rights to enjoy the full potential of one's body- for health, procreation, and sexuality. What therefore do we say of women suffering the consequences of sexually transmitted diseases, who find themselves in a social circumstance that further increases their risk of exposure to sexually transmitted infections and their complications? This shows women's lack of sexual self-determination. This shows that the individual (liberty) and the social (justice) dimensions of rights can never be separated, as long as resources and power remain unequally distributed in most societies. Thus the affirmative obligations of states become paramount, since the ability of individuals (women in particular) to exercise reproductive and sexual rights depends on a range of conditions not yet available to many people and impossible to access without public support.

V. Methods

Study area: The study location was carried out in Ibadan, the capital city of Oyo State. Located in south-western Nigeria, 78 miles inland from Lagos, it is a prominent transit point between the coastal region and the areas to the north. The population of Ibadan was 2,550,593 according to 2006 census results (National Population Commission 2010). The principal inhabitants of the city are the Yoruba People. The abundance of women who were economically empowered or with improved socio-economic status in Ibadan metropolis made it a choice place for the study.

Data collection procedure: The analysis presented in this paper is based on qualitative data collected in the study population, which are purposively selected for this research. Twelve focus group discussion sessions, comprising about six to ten people per group, giving a total of 114 participants of mainly Yoruba tribe living in Ibadan metropolis, were conducted to generate qualitative data. As a result, four criteria were applied in forming the discussion groups: level of education, occupation, age and ethnic background. The discussions were taped, after obtaining permission from participants. The tapes were transcribed, sorted and analyzed by manual content analysis, which is a systematic, replicable technique for compressing many words of text into fewer content categories based on explicit rules of coding and identifying themes or patterns.

Research instrument- Focus Group Discussion (FGD) guide: The aim of the FGDs was to examine the extent to which Yoruba women can exercise their sexual and reproductive health rights. The key interview questions fell into four main categories:

- Background information: Respondents were asked questions on age, marital status, level of education, religion, type of occupational group they belong to.
- Family structure and communication level: respondents were asked questions on areas of spousal communication and decision making process.
- Gender roles in sexuality and sexual behaviour within the marriage: respondents were asked questions on rights to sexual expression, sexual freedom and sexual autonomy.
- Rights to make responsible reproductive choices: respondents were asked questions the use of contraception.

VI. Findings and Discussions

a) Background Information

Majority of the participants in the FGD were below 40yrs of age and in the sexually active, reproductive stage of the life-span. The mean age of the

women was 30yrs. Also majority have post-secondary education. The least occupational group was trading/business activities, while others were involved in other different professions like banking, lecturing, teaching, medical doctors, nursing etc.

b) Family Structure and Communication Level

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

> We never used to talk much to each other. Where do I have the time? Is it me that I have to leave home early to go to the market to sell my wares, or him that has his business to face? We hardly go out together……

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

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

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

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

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

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

c) Gender roles in sexuality and sexual behaviour within the marriage: rights to sexual expression, sexual freedom and sexual autonomy

Some of the respondents reported non-consensual sexual relation with their husband. In the words of a primary school teacher:

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

A large share of the women are constrained in exercising agency over these domains. Such experiences heightened marital dissatisfaction. While the productive and reproductive functions of marriage were fulfilled, neither intimacies nor the marital bond were strengthened. Most of these women viewed such interactions as only satisfying the husband's lust and reported the absence of the desire for sex or sexual pleasure. In the words of another woman, a university lecturer:

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

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

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

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

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

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

Yet another said:

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

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

Several other women like this banker, talked about not being physically and psychologically prepared for engaging in sex on some occasions or responding to their husbands' demands by saying:

> When he forces himself, I am dry and it hurts a lot. If he cared for me and my feelings, he will wait till I am ready. But he never bothers, he his interested only in getting what he wants.

Meanwhile, coercive sex carries an inherent threat of tissue damage due to the absence of lubrication, and poses the risk of STIs and HIV. Husbands indulging in coercive sex used threat of taking a second wife or extra-marital affair to get their wives comply with their wishes. The threat of physical force and coercive sex is effectively used by husbands to ensure a woman's submission to their sexual demands. Social norms and institutions- both formal and informal – perpetuates such violence through norms and expectations that reinforce inequality and place women's decision-making about their bodies outside their realm of control. Meanwhile, the ability to choose when to have sex and on what terms is a critical indicator of agency.

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

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

To this group of women, sexual rights for women are designed to undermine culture, tradition and dignity. Refusing sex with your husband is prompting him to involve in extramarital affair. So it is believed that even when negotiation is attempted the women reported that they are usually unable to prevent a forced sexual encounter. It is therefore, believed that it is impossible for a woman to reject sexual advances from her husband.

Lastly, the general view among this group of women when asked who initiates sex among spouses is that: '*Men initiate sex because women don't reveal their desires, even when they are interested they would never initiate sexual demand….'* Members of the group also chorused that it is inappropriate and bad manners for women to initiate sex. Other ways women send out erotic messages is through preparing delicious dishes for their husbands, dressing elegantly and being extra-nice to their husbands. Older women however believed that they could reject their husbands' sexual advances if they are not willing or are not favourably disposed.

d) Rights to make responsible reproductive choices

Very few of the women had ever used or suggest condom with their husbands. For women who suspect their husbands of infidelity, suggesting condom

use for marital sex poses multiple problems. As one of the respondents puts it: '*Her request may be interpreted as indicating that she suspects not only that her husband is cheating but that the type of extramarital sex he is having is risky and, by implication is immoral'.* Moreover, the meaning of her request may be twisted and misinterpreted by her spouse and turned against her with an accusation that it is she who is being unfaithful. In the words of a banker:

A woman asking her husband to use a condom is putting,

herself in the position of a whore. What does she need a,

condom with her man for, unless she is flirting around,

outside the married house?

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

Findings also revealed by the respondents that Yoruba men do not like to use condoms with their wives. The main reason been that *"it just doesn't feel natural……prefer flesh to flesh……..It hinders actual contact…"* Even some of the women said they do not really the idea of using condoms. In the words of one of the respondents *"I prefer to feel him in me",* However, the logic that follows from this is the fact that men, presumably, are granted the unconditional sexual access to their wives, and could exercise power to enforce this (Sen, 1999; Jegede & Odumosu, 2003). Women generally lack sexual autonomy in many cultures of the world, thus, unwanted pregnancies as a result of powerlessness over contraception usage are the end results.

e) Implications of the study

The findings of this study show that women bear most of the health burden in marital relations. There is relativity of power between men and women in sexual intercourse among married couples no matter the level of the woman's socio-economic status. Cultural expectations, when backed by a conservative religious and political framework, largely outweigh the ability of individuals to challenge them. Underpinning women's difficulty in refusing sex is the common assumption that consenting to sex at any point in the relationship, establishes consent for the rest of the relationship, which also creates barriers to recognising marital rape. The ability to refuse sex and to ask partner to use a condom are closely related. Findings reflect attitudes that associate condom use with illicit sex and promiscuity, and to religious prohibitions.

VII. Conclusions

The foregoing shows that regular spousal communication enhances the right of a woman over her sexuality. At the moment it is replaced by force and violence, which is instigated by the social conditioning of men to be more sexually expressive than women, and therefore more likely to initiate sexual advances. There appears to be lack of full understanding of the nature and meanings of sexual rights and sexual right abuse in the area. The sexual health needs of women especially should be given adequate attention in any intervention programmes to curb the incessant menace of sexual coercion. This will empower women and increase their control over their sexual lives. At the moment, freedom to make decision on when to have sex and when not to, which is an essential domain of agency for asserting fundamental human rights and in promoting gender equality is still lacking. Social norms and laws are important drivers of agency, and this is especially true in the context of sexual and reproductive decisions. These two mediates through the household, impact agency and other gender-equality outcomes. Interventions and policies that seek to change norms around women's sexuality roles will be critical for increasing women's sexual and reproductive agency. Women's agency cannot increase in isolation from the wider community hence, the need to engage men and other gate-keepers in sexual and reproductive health issues may be promising. Although they need to be carefully designed to avoid unintended consequences like reinforcing traditional power dynamics or to produce only modest behavioural change.

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