William & Mary Journal of Women and the Law

Volume 22 | Issue 3 Article 6

Intersections of Violence Against Women and Health: Implications for Health Law and Policy in Nigeria

Cheluchi Onyemelukwe

INTERSECTIONS OF VIOLENCE AGAINST WOMEN AND HEALTH: IMPLICATIONS FOR HEALTH LAW AND POLICY IN NIGERIA

CHELUCHI ONYEMELUKWE*

INTRODUCTION
I. THE HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN
  A. *Reproductive Health*
    1. *General Reproductive Health Concerns*
    2. *Child Marriage*
    3. *Rape*
    4. *Female Genital Mutilation*
    5. *Domestic Violence*
    6. *Policy Development and Application*
    7. *Recommendations*
  B. *Mental Health*
II. RESPONSIBILITY OF HEALTH CARE PROVIDERS
  A. *Role of Health Care Providers*
  B. *National Legislation and Professional Codes*
  C. *Violence Against Persons (Prohibition) Act*
  D. *State Gender-Based Violence Laws*
  E. *Protocol of Health Care Workers*
  F. *Recommendations*
III. ACCESS TO HEALTH SERVICES
CONCLUSION

INTRODUCTION

Violence against women is both a human rights violation[1] and a public health hazard.[2] Men, women, and children alike can be

* J.S.D., Dalhousie University, Canada. LL.M., Dalhousie University, Canada. LL.B., University of Nigeria. Dr. Onyemelukwe serves as the Founder and Executive Director of the Centre for Health Ethics Law and Development (CHELD, http://www.cheld.org), a non-profit dedicated to promoting health in Nigeria through law, education, research and advocacy; she will reference her advocacy through her position at CHELD anecdotally throughout this Article.

1. *See*, *e.g.*, Dorothy Q. Thomas & Michele E. Beasley, *Domestic Violence as a Human Rights Issue*, 15 HUM. RTS. Q. 36, 62 (1993) (arguing for a human rights approach to domestic violence); U.N. Women, Handbook for Legislation on Violence Against Women 10 (2012), http://www.unwomen.org/~/media/headquarters/attachments/sections/library/publications/2012/12/unw_legislation-handbook%20pdf [http://perma.cc/6PXD-5EWS].

2. *See* Claudia Garcia-Moreno & Charlotte Watts, *Violence Against Women: An Urgent Public Health Priority*, 89 BULL. WORLD HEALTH ORG. [WHO] 1, 2 (2011), http://

violated by the violent acts of others. However, violence against women is violence meted out to women on account of their gender.[3] Violence against women is increasingly being recognized as a global public health problem that demands solutions within both global and local public health policies.[4] However, in many developing countries, including Nigeria, violence against women has not received much attention or support in the health arena, specifically within health law and policy.[5] The aim of this Article is to begin the conversation in the context of Nigeria, with the hope that it will galvanize efforts to recognize and implement preventative and restorative interventions in the arena of health.

For reasons of convenience, in this Article I use the terms "violence against women" and "gender-based violence" interchangeably. Gender-based violence has been defined by the United Nations' Declaration on the Elimination of Violence Against Women as "any act . . . that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."[6] Violence against women cuts across all income groups, races, ethnicities, ages, and other social bounds; it is found in all kinds of settings, including in peacetime and in armed conflict situations.[7] The primary targets of gender-based violence tend to be women, who also tend to suffer significant physical and other types of negative consequences as a result, yet have fewer resources at their disposal to deal with such violence.[8] The situation

---

www.who.int/bulletin/volumes/89/1/10-085217.pdf [http://perma.cc/DE78-PF49] ("When the cumulative impacts on mortality and morbidity are assessed, the health burden is often higher than for other, more commonly accepted, public health priorities."); *see also* Linda L. Dahlberg & James A. Mercy, *The History of Violence as a Public Health Issue*, 11 AMA VIRTUAL MENTOR 167, 167 (2009) (providing a history of violence as a public health issue).

3. WORLD HEALTH ORG. [WHO], *Promoting Gender Equality to Prevent Violence Against Women*, *in* VIOLENCE PREVENTION: THE EVIDENCE 3 (2009), http://www.who.int/violence_injury_prevention/violence/gender.pdf [http://perma.cc/V2NT-WDVW].

4. G. Krantz, *Violence Against Women: A Global Public Health Issue!*, 56 J. EPIDEMIOLOGY & COMMUNITY HEALTH 242, 242 (2002).

5. *See* Lori L. Heise et al., *Violence Against Women: A Neglected Public Health Issue in Less Developed Countries*, 39 SOC. SCI. & MED. 1165, 1165 (1994).

6. G.A. Res. 48/104, art. 1, Declaration on the Elimination of Violence Against Women, (Dec. 20, 1993).

7. U.N. Econ. Comm'n for Afr. [UNECA], Violence Against Women in Africa: A Situational Analysis (2010), http://www.uneca.org/Portals/awro/Publications/21VAW%20in%20Africa-A%20situational%20analysis.pdf [http://perma.cc/8FDC-53AF]; *see* WHO, *Violence Against Women: In Situations of Armed Conflict and Displacement* (July 1997), http://www.who.int/gender/violence/v7.pdf [http://perma.cc/PUU7-MYE8].

8. U.N. Population Fund [UNFPA], UNFPA Strategy and Framework for Action to Addressing Gender-Based Violence 2008–2011, at 7 (2009), http://www.unfpa.org/sites/default/files/pub-pdf/2009_add_gen_vio.pdf [http://perma.cc/P97U-M9KD].

is not helped by the fact that violence against women is tolerated by many societies and cultures.[9]

In Nigeria, several accounts describe a raging epidemic of violence against women with about one in three females having experienced physical violence at one time or another in their lifetime.[10] Women suffer various types of violence and accompanying harm, including rape, sexual harassment, domestic violence/intimate partner violence, trafficking, and harmful traditional practices, such as female genital mutilation, childhood marriage, and widowhood practices.[11] Each type of violence causes harm and has serious implications for health. While the criminal justice system is clearly implicated in acts of violence against women with regard to delineation of offenses, penalties, and criminal law procedures,[12] the health consequences of violence against women also implicate other aspects of law and policy, specifically health law and policy.[13]

The links between health and gender-based violence have received much consideration, including by organizations like the World Health Organization (WHO)[14] and various United Nations agencies, some of which I refer to throughout the Article. Certain conclusions drawn in such literature inform my analyses in the context of Nigeria. For one thing, the health sector has much to offer victims of violence against women, being often the first (and sometimes only) point of contact for these victims.[15] Health care facilities are frequently the one place in which a woman receives support even when she will not report abuse to law enforcement authorities.[16] Indeed, as has been noted,

> it is probable that no other sector has a greater opportunity to aid women survivors of violence than the health sector. The

9. *See* UNECA, *supra* note 7.

10. NAT'L POPULATION COMM'N & ICF INT'L, NIGERIA: DEMOGRAPHIC AND HEALTH SURVEY 2013, at 303–05 (2014), http://www.population.gov.ng/images/ndhs_data/ndhs_2013/2013_ndhs_final_report.pdf [http://perma.cc/N6WJ-RB7R] [hereinafter HEALTH SURVEY 2013].

11. WHO, GLOBAL AND REGIONAL ESTIMATES OF VIOLENCE AGAINST WOMEN: PREVALENCE AND HEALTH EFFECTS OF INTIMATE PARTNER VIOLENCE AND NON-PARTNER SEXUAL VIOLENCE 4 (2013), http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf [http://www.perma.cc/6JQS-3JVY]; Joseph Olukayode Akinbi, *Widowhood Practices in Some Nigerian Societies: A Retrospective Examination*, 5 INT'L J. HUMAN. & SOC. SCI., Apr. 2015, at 67, 72.

12. *See* U.N. Women, *supra* note 1, at 50.

13. *See* Garcia-Moreno & Watts, *supra* note 2.

14. *See, e.g.*, WHO, *supra* note 11, at 1.

15. UNFPA, Health Sector Response to Gender-Based Violence: An Assessment of the Asia Pacific Region 7 (2010), http://asiapacific.unfpa.org/sites/asiapacific/files/pub-pdf/Assessment.pdf [http://perma.cc/GZ9V-3VAN].

16. *Id.*

> institutionalised health care system is probably the only institution that interacts with every woman at some point in her life. For many women, a visit to a health facility may be her first effort to seek help and the only chance to receive support and care, as well as to escape a situation of abuse.[17]

Furthermore, research has shown that abused women are more likely to seek medical attention than other women.[18]

In essence, then, violence against women has certain consequences for health, health systems and, accordingly, for health law and policy-making. Academic examination of gender-based violence continues to grow in Nigeria.[19] However, much less, if any, discussion has been undertaken about the impact that such violence has or should have on health law and policy-making. Certainly, some types of violence against women have received attention in the health arena, in particular reproductive health related violence issues, such as female genital mutilation for its role in maternal morbidity,[20] and child marriage for its role in maternal and infant mortality.[21] Yet in terms of framing health policy and law around this important public health concern, much room remains for identification of issues, analysis, and evidence-based policy-making. Women activists and groups have typically focused on other aspects of violence against women, including access to justice, law reform, human rights, the need for awareness creation and the need for material resources.

The reasons are not hard to decipher. Health and medical law in Nigeria is only just being recognized as a relevant field of study.[22] For purposes of this Article, the term "health law" comprises, broadly speaking, laws and legal provisions that specifically address health (including, but not limited to, constitutional provisions, public health laws, reproductive health laws, mental health laws, health insurance laws, and laws regulating medical practitioners) as well as

---

17. *Id.*

18. *Id.* at 17.

19. *See, e.g.*, Ine Nnadi, *An Insight into Violence Against Women as Human Rights Violation in Nigeria: A Critique*, J. POL. & L., Sept. 2012, at 48.

20. WHO, *Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries*, 367 LANCET 1835, 1839 (2006).

21. UNFPA, Marrying Too Young: End Child Marriage 13 (2012), http://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf [http://perma.cc/ANM8-8RC5]; WHO, *Global Plan of Action to Strengthen the Role of the Health System Within a National Multisectoral Response to Address Interpersonal Violence, in Particular Against Women and Girls, and Against Children, Building on Existing Relevant WHO Work* 4 (Mar. 20, 2015), http://www.who.int/topics/violence/UNFPA-GAP2-violence.pdf [http://perma.cc/5945-HE4M].

22. Very few universities in Nigeria have a course in health or medical law. I am one of the pioneer teachers of this course to law students in Nigeria.

legal provisions that are relevant to health matters, such as health provisions found in domestic violence laws. Nigeria's National Health Act, which provides a legal framework for Nigeria's health system, was finally signed into law in December 2014 after more than a decade's delay.[23] Prior to this time, Nigeria's health system was governed by an inchoate combination of an array of issue-specific legislation,[24] legislation at the state level in several states, government policies, and self-regulation by professionals. It is likely that the new National Health Act will provide an impetus for more exploration and analyses of health from a legal perspective.

Until recently, health policy has been more entrenched than health law, being the tool most used by government to achieve set objectives in Nigeria's health sector.[25] However, health policies may come and go with governments, and do not possess the attribute of legal enforceability that legislation and other types of law have.[26] In any event, women encounter Nigerian health policy most often through reproductive health services, including maternal health, abortion, and sexual health.[27] Again, this is not surprising given the high statistics of maternal mortality in Nigeria.[28] Nigeria's current National Health Policy,[29] refers to women in a number of areas, in

---

23. Paul Adepoju, *Nigeria's New National Health Bill—The Beginning of Another Era in Healthcare Delivery*, AFR. HEALTH: NIGERIA 5, 5 (2015), http://africa-health.com/wp-content/uploads/2015/10/AH-Nigeria-edition-Jan-15.pdf [http://perma.cc/NE87-2MQZ].

24. *See* Felix Abrahams Obi, *The National Health Bill: After Ten Years in the Making is an End in Sight?*, NIGERIA HEALTH WATCH (Nov. 4, 2014), http://nigeriahealthwatch.com/the-national-health-bill-after-ten-years-in-the-making-is-an-end-in-sight [http://perma.cc/92XC-UY7A]. Examples of issue-specific legislation include the National Health Insurance Scheme Act and the Marketing (Breast Milk Substitutes) Act. *See, e.g.*, National Health Insurance Scheme Decree No. (35) (1999); Breast Milk Substitutes Act (1990) Cap. (M5).

25. WHO, *Country Cooperation Strategy at a Glance: Nigeria*, WHO Doc. WHO/CCU/14.03/Nigeria (May 2014); *see also* Abubakar Jimoh, *Understanding the National Health Act*, CIV. SOC'Y LEGIS. ADVOC. CTR. (Dec. 28, 2014), http://www.cislacnigeria.net/2014/12/understanding-the-national-health-act [http://perma.cc/E6VB-2E43].

26. *See* B. Obinna Okere, *Fundamental Objective and Directive Principles of State Policy Under the Nigerian Constitution*, 32 INT'L & COMP. L.Q. 214, 223 (1983).

27. Asikia Ige, *Women and the Right to Health in Nigeria: The Intersections*, 5 BRIT. J. ARTS & SOC. SCIS. 177, 184 (2012); *see also* CTR. REPROD. L. & POL'Y, WOMEN'S REPRODUCTIVE RIGHTS IN NIGERIA: A SHADOW REPORT (1998), http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Nigeria%20CEDAW%201998.pdf [http://perma.cc/RHP2-3JHV].

28. Nigeria is one of the countries with the highest maternal mortality rates in the world. WHO, *Maternal Health: Maternal Mortality Ratio, Interactive Chart* (2015), http://gamapserver.who.int/gho/interactive_charts/mdg5_mm/atlas.html (last visited Mar. 23, 2016). According to a Nigerian population survey published in 2014, about 576 out of every 100,000 women die in pregnancy or during child birth each year. HEALTH SURVEY 2013, *supra* note 10, at 273–74, 277–78.

29. FED. MINISTRY OF HEALTH, REVISED NATIONAL HEALTH POLICY (2004) (The author is a member of the Technical Working Group charged with preparation of a new National Health Policy to replace the 2004 edition).

particular reproductive health, control of malaria, and immunization during pregnancy.[30] However, it also pays specific attention to female genital mutilation (FGM).[31] Beyond FGM, all other types of violence against women receive no mention or goal-setting in the current National Health Policy.

Moreover, even within legislation focused on violence against women in Nigeria, the health aspects are not emphasized. For instance, the recently enacted Violence Against Persons (Prohibition) Act is a federal law that provides an overarching framework for all matters to do with violence in the Federal Capital Territory.[32] The Act states that victims are entitled to be informed of the availability of health services.[33] However, it does not specify what these health services are, nor does it specifically identify the role of health care providers.

What this means, in sum, is that the health implications of violence against women have not received the kind of attention that they should, either in health law or in health policy. Much of the attention devoted to violence against women is in the realm of criminal law or, as I describe hereunder, in peripheral legal provisions that do not delve beyond surface provisions on the duties of medical professionals or the delivery of health services. Yet women who are victims of gender-based violence suffer severe, sometimes chronic, other times life-threatening and permanent health consequences.[34] Although it is well accepted that law enforcement institutions are crucial in responding to issues relating to violence against women, focusing all attention on criminal law interventions does not take into consideration other possible areas of intervention. This includes the probability that women who are victims of gender-based violence are more likely, in my experience, to seek the help of health providers than law enforcement.

The result is that there has been little attempt to develop specific health interventions, which entail identifying health challenges, including them in health law and policy, budgeting, and conducting analysis by policymakers, as well as subjecting them to academic scrutiny. A consideration of interventions on, and responses to,

30. *Id.* at ch. 6.3–6.4.

31. *Id.* at ch. 6.8. I discuss this further in Part I.A.4, *infra.*

32. Violence Against Persons (Prohibition) Act (2015) [hereinafter VAPP Act]. The Act was assented to on May 25, 2015, after protracted advocacy lasting over a decade. *VAPP ACT Signed into Law; May 25, 2015*, VOICES4CHANGE (May 28, 2015), http://www.v4c-nigeria.com/vapp-act-signed-into-law-may-25th-2015 [http://perma.cc/HMY8-HWRP].

33. VAPP Act, § 32(1)(c) (providing that "[a] police officer, at the scene of an incident of violence or as soon thereafter as reasonably possible . . . shall have the duty of . . . providing or arranging transportation for the victim to the nearest hospital or medical facility for treatment of injuries where such treatment is needed").

34. *See* UNFPA, *supra* note 15, at 17.

violence against women as they intersect with health law and policy would provide an understanding of the possibilities of developing and institutionalizing effective health interventions by using the tools of law and policy. This does not limit the roles of criminal law and other aspects that have received more attention in the Nigerian context. Instead, it enhances our understanding of the health aspects and makes provisions for the health issues to be addressed. For instance, where legislation states that medical care will be provided where a woman is violated by rape, what kind of medical care is anticipated? Who is required to provide this care? Who undertakes the expense? And can all the answers to these questions be interpreted as being contained in a legal provision that merely states, without more, that medical care shall be provided?

Moreover, reframing and expanding the definition of violence against women as a health problem—in addition to a criminal matter, a human rights violation, an economic burden and a developmental challenge—has the potential to break the silence that often surrounds this issue, and encourage a change in societal mores and attitudes.[35] This Article intends, therefore, to identify the intersections of violence against women and women's health, analyze them in the context of existing law and policy, and draw out the implications that these have for health law and policy-making in Nigeria. I do this, not only as an academic exercise, but in a bid to draw attention to an important, and currently missing component, of the desirable interventions in this public health issue in Nigeria. Health law and policy are critical components of the efforts that can assist women transitioning from victim to survivor. Gaps in the legal obligations of health care providers or in mental health need to be addressed and provided for.

Engaging in this exercise of identifying intersections will necessarily require an examination of some of the legislation on gender-based violence, including recent domestic violence legislation in Nigeria. I will seek to identify the gaps, and underscore the inadequacies of implementation of these pieces of health-related legislation. I will recommend solutions that take into account the links between gender-based violence and health, in order to provide victims and survivors of gender-based violence with the health interventions needed. This examination will also provide policymakers and influencers with an understanding of some of the important elements that must be taken into account to address public health needs beyond the immediate needs of victims and survivors.

---

35. Lori Ashford & Charlotte Feldman-Jacobs, *The Crucial Role of Health Services in Responding to Gender-Based Violence*, USAID 1, 2–3 (2010), http://www.prb.org/igwg_media/crucial-role-hlth-srvices.pdf [http://perma.cc/W5UP-43A2].

I begin this examination with a review of the health consequences of violence against women. Several of these have been identified in the literature and very little attempt is made here to reinvent these. However, I situate them within the context of Nigeria in an attempt to demonstrate other links with the health system and health issues. I then consider other links and investigate the impact of health law and policy, the absence of such law and policy, the implications of such absence in Nigeria, and some recommendations. I conclude with some thoughts on how the understanding of these links would improve the health law and policy response and ultimately benefit women who are victimized by gender-based violence in Nigeria.

I. THE HEALTH CONSEQUENCES OF VIOLENCE AGAINST WOMEN

There are many negative consequences of violence against women, including destabilization of family units, labor and productivity costs, financial hardships for families, and adverse effects on economies and development.[36] However, I focus here on the health costs of gender-based violence. Violence against women, whether manifested by domestic violence, sexual assault, sexual harassment in the workplace, or harmful traditional practices, constitutes a significant health challenge with considerable rates of mortality and morbidity.[37] The gravity of the health consequences of violence against women is underscored by research that has shown that "it is a more common cause of ill-health among women than traffic accidents and malaria combined" and is as serious a cause of death as cancer.[38] Its public health impact is thus enormous and demands a serious response from all angles, including law and policy.

Health problems that are a direct or indirect result of gender-based violence have been identified elsewhere.[39] Physical wounds, stabbings, bites, lacerations, swelling, black eyes, concussions, broken bones and fractures, burns and scarring, and other physical disfigurement are a common result of physical violence.[40] Somatic problems also tend to accompany gender-based violence, including

36. OFFICE ON WOMEN'S HEALTH, U.S. DEP'T HEALTH & HUMAN SERVS., THE HEALTHY WOMAN: A COMPLETE GUIDE FOR ALL AGES 237 (2008) (ebook).

37. For a discussion on the global issues related to gender-based violence, *see* Charlotte Watts & Cathy Zimmerman, *Violence Against Women: Global Scope and Magnitude*, 359 LANCET 1232 (2002).

38. UNFPA, *supra* note 15, at 16 (internal quotations omitted).

39. *See, e.g.*, *id.* at 19; Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 LANCET 1331 (2002).

40. Ctrs. for Disease Control & Prevention [CDC], *Intimate Partner Violence: Definitions*, http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html [http://perma.cc/YJD3-VH2K]; UNFPA, *supra* note 15, at 19.

chronic headaches, abdominal and pelvic pains, and muscle aches.[41] But the health outcomes of gender-based violence go beyond the direct result of physical violence. The World Health Organization and researchers working on gender-based violence, including domestic violence, identify several of the non-fatal health consequences of gender-based violence.[42] These may be physical or psychological in nature. Physical outcomes include such adverse effects as unwanted pregnancies, sexually transmitted infections (STIs) including HIV/AIDS, miscarriage, irritable bowel syndrome, asthma, chronic pains, headaches, and temporary or permanent physical disabilities.[43] Mental health outcomes include post-traumatic stress disorders, low self-esteem, anxiety, depression, sexual dysfunction, and obsessive compulsive disorders.[44] Women may also indulge in self-destructive behaviors as a result of violence, including unhealthy behaviors such as drinking excessively, smoking, and engaging in unprotected sexual intercourse.[45] It is important to note that certain health consequences of gender-based violence linger for a long time, and may become permanent disabilities or chronic illnesses.[46]

Beyond illnesses and disabilities, violence against women can also have fatal consequences for women and their children. These include suicide, homicide, maternal mortality, infant mortality, and death resulting from untreated STIs such as AIDS.[47] In Nigeria, several of the incidents that make it to frontline news reporting are reports of homicides committed by intimate partners: the case of Titilayo Omozoje, the banker who was killed by her husband in 2011, is a prominent example.[48] Another is Mercy Nnadi, which included the homicide of Ms. Nnadi's one year old boy and grievous harm to Ms. Nnadi herself, caused when her husband burned her with a hot pressing iron, leaving permanent physical scarring.[49]

---

41. UNFPA, *supra* note 15, at 17.

42. WHO, *Violence Against Women: WHO Consultation, Geneva, 5–7 February, 1996*, at 11, WHO Doc. FRH/WHD/96.27 (1996), http://apps.who.int/iris/bitstream/10665/63277/1/FRH_WHD_96.27.pdf [http://perma.cc/R75U-UFVU].

43. *Id.*

44. *Id.*

45. *Id.*; Cynthia Grant Bowman, *Domestic Violence: Does the African Context Demand a Different Approach?*, 26 INT'L J.L. & PSYCHIATRY 473, 473 (2003).

46. WHO, WORLD REPORT ON VIOLENCE AND HEALTH 100–02 (Etienne G. Krug et al. eds., 2002).

47. UNFPA, *supra* note 15, at 19.

48. Abdulwahab Abdulah, *Wife Murder: Evidence that Sent Arowolo to Hangman's Noose*, VANGUARD (Feb. 27, 2014, 1:24 AM), http://www.vanguardngr.com/2014/02/wife-murder-evidence-sent-arowolo-hangmans-noose [http://perma.cc/LZ4Y-KEQW].

49. Evelyn Usman, *I Forgive My Husband but . . . Says Woman Whose Hubby Killed Only Son, Burnt Her with Hot Pressing Iron*, VANGUARD (Dec. 8, 2012, 12:50 AM), http://www.vanguardngr.com/2012/02/i-forgive-my-husband-but-says-woman-whose-hubby-killed-only-son-burnt-her-with-hot-pressing-iron [http://perma.cc/37XB-Z9ZE].

Other cases that have garnered prominent attention include women killing in apparent response to abuse: for instance, an ongoing case involves a fourteen-year-old girl who killed her husband and his friends as part of her resistance to a forced marriage.[50]

Outside of the direct consequences to women, violence against women also affects the health of their children. The Nigeria Demographic and Health Survey 2013 points out that the rate of infant mortality and mortality for children under five increases significantly where a woman is unable to make decisions about her marriage and family, and where the woman believes abuse, such as wife-beating, can be justified on grounds such as burning the food, arguing with a husband, going out without telling a husband, neglecting the children, or refusing to have sexual intercourse.[51]

I consider some of these consequences, other links to the health sector and health law and policy implications in more detail below.

A. Reproductive Health

One of the key areas gravely affected by gender-based violence is women's reproductive health. The consequences of violence against women in the area of reproductive health are well-recognized around the world.[52] The types of gender-based violence that impinge on reproductive health are wide and varied. They range from virginity testing, forced pregnancy, forced abortion, early/child marriage, rape, forced prostitution, and harmful traditional practices such as FGM.[53] Each of these is experienced in Nigeria, some more widely or more societally accepted than others.[54]

1. General Reproductive Health Concerns

Sexual and reproductive problems are a significant cause of women's ill health and death globally, by some accounts second only to communicable diseases.[55] The effects of gender-based violence in

50. Heather Saul, *Nigeria Child Bride 'Poisons Husband' Twice Her Age and His Friends*, INDEPENDENT (Apr. 14, 2014), http://www.independent.co.uk/news/world/africa/nigeria-child-bride-poisons-husband-twice-her-age-and-his-friends-9256380.html [http://perma.cc/PE6T-JPCF].

51. HEALTH SURVEY 2013, *supra* note 10, at 300.

52. WHO, *supra* note 46, at 101–02.

53. *Id.* at 149–50.

54. *See, e.g.*, U.S. Dep't of State, Bureau of Democracy, H.R. and Lab., Country Reports on Human Rights Practices: Nigeria 31–33, 36–37 (2014).

55. *See* SUSHEELA SINGH ET AL., ALAN GUTTMACHER INST., ADDING IT UP: THE BENEFITS OF INVESTING IN SEXUAL AND REPRODUCTIVE HEALTHCARE 11 (2003), http://www.unfpa.org/sites/default/files/pub-pdf/addingitup.pdf [http://perma.cc/XNL7-53N3].

this regard include increased risk of STIs and HIV infection, maternal mortality, infant mortality, heavy bleeding at child birth, anemia, obstetric fistula, and vesico-vaginal fistula.[56] FGM may result in bleeding, infections if done in unsanitary conditions, a limited ability or complete inability to enjoy sexual relations, pain during sexual intercourse, painful menstruation, vesico-vaginal fistula, recto-vaginal fistula, pelvic inflammatory disease, and obstructed labor.[57] A United States study found that women who experienced domestic violence were three times more likely to have gynecological problems than women who had not experienced similar abuse.[58] These medical conditions included "chronic pelvic pain, vaginal bleeding or discharge, vaginal infection, painful menstruation, sexual dysfunction, fibroids, pelvic inflammatory disease, painful intercourse, urinary tract infection and infertility."[59] Violence during pregnancy is connected with an increased risk of miscarriage, premature delivery, and low birth weight.[60] For children and women in forced marriages, use of contraception may be limited as a result of the lack of power to insist on a specific number of children or when pregnancy should occur.[61] This, in turn, can impact child mortality and low birth weight.[62] In cases of forced prostitution, early marriage, rape, and trafficking, a higher degree of complications are reported, including infertility as a result of untreated STIs.[63]

Nigeria has some of the world's highest rates of maternal mortality.[64] Gender-based violence constitutes one cause of this grave reproductive health challenge via gender-based violence such as child marriage, domestic violence, and FGM. Law and policy have intervened in the area of reproductive health much more than any

---

56. WHO, *Understanding and Addressing Violence Against Women: Health Consequences*, at 2, WHO Doc. WHO/RHR/12.43 (2012), http://apps.who.int/iris/bitstream/10665/77431/1/WHO_RHR_12.43_eng.pdf [http://perma.cc/3AEL-4YZY].

57. *See* UNICEF, *Nigeria: Female Genital Mutilation*, http://www.unicef.org/nigeria/FGM_.pdf [http://perma.cc/7CCB-66Q6]; WHO, *Understanding and Addressing Violence Against Women: Female Genital Mutilation*, at 2–3, WHO Doc. WHO/RHR/12.41 (2012), http://apps.who.int/iris/bitstream/10665/77428/1/WHO_RHR_12.41_eng.pdf [http://perma.cc/8NJ2-U9RR].

58. Barbara Shane & Mary Ellsberg, *Violence Against Women: Effects on Reproductive Health*, OUTLOOK, Sept. 2002, at 3.

59. *Id.*

60. Claire C. Murphy et al., *Abuse: A Risk Factor for Low Birth Weight? A Systematic Review and Meta-Analysis*, 164 CAN. MED. ASS'N J. 1567, 1570–71 (2001).

61. WOMEN LIVING UNDER MUSLIM LAWS, CHILD, EARLY AND FORCED MARRIAGE: A MULTI-COUNTRY STUDY 18 (2013), http://www.wluml.org/sites/wluml.org/files/UN%20report%20final.pdf [http://perma.cc/CDL7-ECL3].

62. *Id.*

63. Shane & Ellsberg, *supra* note 58, at 6.

64. WHO, *supra* note 28.

other health consequence of violence against women. Some of the interventions have not been completely fruitful as current statistics on reproductive health in Nigeria indicate. I discuss several of these areas of legal and policy interventions below.

2. Child Marriage

Child marriage has recently received much attention in Nigerian news as a result of state leaders allegedly marrying minor females,[65] or appearing to legitimize child marriage by recognition of the marriage of others below the age of eighteen.[66] The health consequences of child marriage are well established. They include death at childbirth, complications during childbirth which include obstetric fistula, vagino-vesico fistula, heightened risks of STIs, and increased risk of cervical cancer.[67] Apart from health risks to the child bride, there are also risks to the children that they bear, which include increased morbidity and mortality.[68]

How has the law intervened? In Nigeria, the Child Rights Act,[69] a domestication of the Convention on the Rights of the Child,[70] explicitly prohibits child marriage.[71] It states that no person under the age of eighteen can marry.[72] It further goes on to state that a person below the age of eighteen cannot be betrothed.[73] Each of these offenses—child marriage or betrothal—carries a significant punishment by Nigerian standards: a fine of 500,000 naira and up to five years' imprisonment.[74] However, as of 2015, no one has ever been convicted of the offense even though this Act was enacted in 2003, and a significant number of children continue to be married off in parts of Nigeria.[75]

---

65. Afua Hirsch, *Nigerian Senator Who 'Married Girl of 13' Accused of Breaking Child Rights Act*, THE GUARDIAN (July 25, 2013, 2:25 PM), http://www.theguardian.com/world/2013/jul/25/nigeria-senator-accused-child-bride [http://perma.cc/7HCG-M4SH].

66. Cheluchi Onyemelukwe, *The Brouhaha . . . And Why It Should Continue*, THIS DAY LIVE (July 30, 2013), http://www.thisdaylive.com/articles/the-brouhaha-and-why-it-should-continue/154877 [http://perma.cc/L9E6-AP32].

67. Nawal M. Nour, *Health Consequences of Child Marriage in Africa*, 12 EMERGING INFECTIOUS DISEASES 1644, 1645–47 (2006).

68. *Id.* at 1647.

69. Child Rights Act (2003).

70. G.A. Res. 44/25, Convention on the Rights of the Child (Sept. 2, 1990).

71. Child Rights Act, § 21.

72. *Id.*

73. *Id.* § 22.

74. *Id.* § 23 (The fine is approximately 2,500 U.S. dollars.).

75. *Child Marriage Around the World: Nigeria*, GIRLS NOT BRIDES, http://www.girlsnotbrides.org/child-marriage/nigeria [http://perma.cc/9Y5P-GUN7] (estimating that 43% of females in Nigeria are married before turning 18).

Most importantly, the Act is not law in all the states of Nigeria. Only twenty-four states, out of the country's thirty-six states, have adopted this legislation.[76] Adoption by states is important because child matters are on the residual list in the Constitution, which gives states the exclusive power to make laws relating to children.[77] Although marriage is on the exclusive list over which the federal government has power to make law, marriage in Nigeria is governed by statutory law (over which the federal government has exclusive powers), customary law, and Islamic law.[78] Child marriages are typically conducted under customary and Islamic laws, leaving the federal government seemingly out of the loop in this matter.[79] In the twenty-four states that have adopted the Child Rights Act, child marriage is prohibited. However, some of these states have modified the definition of a child, lowering it from the federal law's stipulation of eighteen years: Akwa Ibom and Cross River States define a child as a person of sixteen and below,[80] while Jigawa State defines a child for purposes of marriage not by age but by puberty.[81] In effect, any child above these stated ages can be married in those states.

More troubling than states' modification of the age stipulation is the fact that twelve states, eleven of them in the North, have not passed the Child Rights Act.[82] The implication is that children of any age in those states can be married legally under Islamic and customary law. Unfortunately, these Northern states also have the highest number of child marriages,[83] and these marriages are often justified by resort to culture and religious interpretations.[84] It is further disturbing that these are the same states that tend to have the highest maternal and infant mortality rates, some of them due to child marriages and early pregnancies.[85]

---

76. U.N. Children's Fund [UNICEF], UNICEF Nigeria—Fact Sheet: Child Rights Legislation in Nigeria 2 (Apr. 2011), http://www.unicef.org/nigeria/Child_rights_legislation_in_Nigeria.pdf [http://perma.cc/VCN9-JW4Q].

77. *Id.*

78. Tim S. Braimah, *Child Marriage in Northern Nigeria: Section 61 of Part I of the 1999 Constitution and the Protection of Children Against Child Marriage*, 14 AFR. HUM. RTS. L.J. 474, 483–85 (2014).

79. *Id.*

80. Commission on the Rights of the Child, *Consideration of Reports Submitted by States Parties Under Article 44 of the Convention*, ¶ 26, U.N. Doc. CRC/C/NGA/CO/3–4 (June 11, 2010) (indicating Akwa Ibom's legislation sets the age of a child at 16); CHARLES MWALIMU, THE NIGERIA LEGAL SYSTEM 703 (2005) (indicating the Age of Marriage Act in Cross River State prohibits marriage under customary law before the age of 16).

81. Commission on the Rights of the Child, *supra* note 80, ¶ 26.

82. UNICEF, *supra* note 76, at 2.

83. WOMEN LIVING UNDER MUSLIM LAWS, *supra* note 61, at 29–31.

84. *See Child Marriage Around the World*, *supra* note 75.

85. Henry V. Doctor et al., *Northern Nigeria Maternal, Newborn and Child Health Programme: Selected Analyses from Population-Based Baseline Survey*, 4 OPEN DEMOGRAPHY

3. Rape

Another type of violence against women that has grave consequences for reproductive health is rape. Rape is a criminal offense; it is prohibited under Nigeria's Criminal Code that governs the South,[86] and the Penal Code that regulates criminal matters in the Northern parts of the country.[87] These statutes apply throughout the Federation except in the Federal Capital Territory, which is currently governed by the recent VAPP Act.[88] Unfortunately, the utilization of the rape provisions in both statutes remains unsatisfactory due to the limited definitions provided in the law. For example, the Criminal Code's requirements of corroboration and penetration[89] in order to successfully prove rape has limited its utilization and therefore precludes justice for many women. Moreover, the definition of rape is problematic—marital rape is explicitly excluded from the definitions of rape under Nigeria's Criminal Code and Penal

---

J. 11, 11, 20 (2011); Gilles Guerrier et al., *High Maternal and Neonatal Mortality Rates in Northern Nigeria: An 8-Month Observational Study*, 5 INT'L J. WOMEN'S HEALTH 495, 496–98 (2013); FED. MINISTRY OF HEALTH, MOTHER, NEWBORN AND CHILD HEALTH AND MORTALITY IN NIGERIA—GENERAL FACTS (2008), http://www.unicef.org/nigeria/ng_publications_advocacybrochure.pdf [http://perma.cc/Q3DB-DJUU].

86. The Criminal Code defines rape as:

> Any person who has unlawful carnal knowledge of a woman or girl, without her consent, or with her consent, if the consent is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or, in the case of a married woman, by personating her husband, is guilty of an offence which is called rape.

Criminal Code Act (2004) Cap. (C38), § 357.

87. The Penal Code defines rape thus:

> (1) A man is said to commit rape who, except in the case referred to in subsection (2) of this section, has sexual intercourse with a woman in any of the following circumstances:
>
> (a) against her will;
>
> (b) without her consent;
>
> (c) with her consent, when her consent has been obtained by putting her in fear of death or of hurt;
>
> (d) with her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married;
>
> (e) with or without her consent, when she is under fourteen years of age or of unsound mind.
>
> (2) Sexual intercourse by a man with his own wife is not rape, if she has attained to puberty.

Penal Code (Northern States) Federal Provisions Act (2004) Cap. (89), § 282.

88. VAPP Act, § 47.

89. The requirement reads in part: "When the term 'carnal knowledge' or the term 'carnal connection' is used in defining an offence, it is implied that the offence, so far as regards that element of it, is complete upon penetration." Criminal Code Act, § 6.

Code.[90] Attempts to change this law, championed by civil society organizations, have consistently been rebuffed by Nigeria's mostly male legislators.[91] The law has often been justified by cultural reasons, where women are not traditionally permitted to say no to men they are married to.[92] This argument is sometimes bolstered by excuses that women may take liberties to accuse their husbands of a crime in the event of a dispute between the two parties, and a general defensiveness that does not acknowledge that marital rape is a human rights violation, as well as a health hazard.

Given my experience in domestic violence, I am aware that marital or spousal rape occurs frequently as part of domestic violence. Yet because of the exclusion of marital rape from the definition of rape under the Criminal Code, there often has been no specific interventions developed in health policy for married victims.[93] Married women, therefore, have not been able to seek any health interventions available to rape victims, even in the event of physical and psychological injury. Further, by defining rape as only vaginal penetration, no matter how slight, with a part of the body,[94] the law, as it stands currently, fails to protect those who are sexually abused with instruments other than a penis. There are many reports of instruments like hands, knives, bottles, and sticks being employed in assaulting women, and pictures of horrific attacks with these instruments can be found on social media.[95] In such circumstances, or where anal rape occurs, the abuser may be convicted of indecent assault or indecent treatment, which has the significantly lower punishment of two to three years,[96] as opposed to rape for which a

90. Tolulope Monisola Ola & Johnson Olusegun Ajayi, *Values Clarifications in Marital Rape: A Nigerian Situation*, EUR. SCI. J., Dec. 2013, at 291, 296–98.

91. *See* Chineze J. Onyejekwe, *Nigeria: The Dominance of Rape*, J. INT'L WOMEN'S STUD., Oct. 2008, at 48, 53 (noting the government's failure to enact specific laws against rape); Nse Etim Akpan, *Men Without Women: An Analysis of the 2015 General Elections in Nigeria* 1 (2015) (unpublished manuscript), http://www.inecnigeria.org/wp-content/uploads/2015/07/Conference-Paper-by-Nse-Etim-Akpan.pdf [http://perma.cc/GEA2-QLT8].

92. Ola & Ajayi, *supra* note 90, at 293.

93. *See id.* at 296–98 (indicating that the Criminal Code Act and Penal Code Act draw on the assumption that the "institution of marriage presupposes the presence of consent" and further finding that because of difficulty proving marital rape "there is a culture of silence on marital rape which means that many cases are unreported").

94. Criminal Code (2004) Cap. (C38), § 6.

95. *See, e.g.*, *'My Horror'—Woman Sexually Assaulted by Ejigbo Mob Speaks (VIDEO Included)*, AFR. SPOTLIGHT (Jan. 11, 2014), http://africanspotlight.com/2014/01/11/horror-woman-sexually-assaulted-ejigbo-mob-speaks-video-included [http://perma.cc/S7YP-GLGH].

96. Criminal Code (2004) Cap. (C38), § 360 ("Any person who unlawfully and indecently assaults a woman or girl is guilty of a misdemeanour, and is liable to imprisonment for two years.").

convicted offender may be sentenced for life.[97] The trivialization of assault with instruments, some of which have led to the death of the victims,[98] unfortunately means that the health consequences are also minimized and little or no specific interventions are provided in such situations. Photography and videography of rape scenes, including gang rapes, have gained increased currency in the milieu of wider internet access.[99] This is not currently covered in law, despite the huge psychological and long-term mental health impact that this may have on victims.

The VAPP Act, which provides a comprehensive framework for all issues relating to violence in Nigeria, adopts a more general definition of rape and has the potential to revolutionize the treatment of rape in Nigeria's courts. It defines rape as penetration of the vagina, anus, or mouth with any part of the body, or foreign object, without consent.[100] This definition captures categories of rape not previously criminalized, such as the rape of men or boys, or marital rape.[101] It includes a sentence of life imprisonment in certain circumstances.[102] The VAPP Act does not, however, address photography and videography of rapes. The definition of rape under the VAPP Act is broader, a significant improvement over previous law, and more in keeping with modern realities. Its provisions, including those pertaining to rape, supersede those of the Criminal Code and the Penal Code.[103] However, as stated under section 47 of the Act, it currently applies to the Federal Capital Territory only, being federal legislation enacted in regard to criminal law.[104] The reason for this

97. *Id.* § 358 ("Any person who commits the offence of rape is liable to imprisonment for life, with or without caning.").

98. *See, e.g.*, AFR. SPOTLIGHT, *supra* note 95.

99. *See, e.g.*, Anayo Okoli, *Abia Gang-Rape Case: Suspects Are Husband's Cousins—Police*, VANGUARD (Mar. 23, 2013, 10:21 AM), http://www.vanguardngr.com/2013/03/abia-gang-rape-case-suspects-are-husbands-cousins-police [http://perma.cc/X7YN-87PL] (explaining that a young woman was gang-raped by men who took a video and circulated it on the internet).

100. The VAPP Act defines rape thus:

> (1) A person commits the offence of rape if—
>
> (a) he or she intentionally penetrates the vagina, anus or mouth of another person with any other part of his or her body or anything else;
>
> (b) the other person does not consent to the penetration; or
>
> (c) the consent is obtained by force or means of threat or intimidation of any kind or by fear of harm or by means of false and fraudulent representation as to the nature of the act or the use of any substance or additive capable of taking away the will of such person or in the case of a married person by impersonating his or her spouse.

§ 1.

101. *Id.*

102. *Id.* § 2.

103. *Id.* § 45.

104. *Id.* § 47.

restriction is apparent: criminal law is a matter on the residual list of the Constitution.[105] Thus, states have to adopt the VAPP Act for it to become law in those states, and the VAPP Act does not redefine the offense of rape in a state until that state adopts it as law.

With the VAPP Act providing a significant improvement on the law on rape in the Federal Capital Territory, it becomes clear that obsolete laws still govern other states in Nigeria. Further, it is important to acknowledge that beyond the archaic provisions enshrined in the Criminal Code and the Penal Code, important gaps remain and practical challenges subsist. One such practical challenge is that women are often socialized to consider acts such as rape acceptable, especially in light of the Health Survey data reporting that young women justify a husband's domestic violence against her on grounds of a wife's refusal to have sex with her husband.[106] Furthermore, in practice, the physical and mental health challenges of rape, whether within or outside marital relations, remain largely unrecognized and not sufficiently provided for. Rape centers are virtually non-existent.[107] Rape centers are crucial, specialized avenues for survivors to receive information that will be vital for criminal prosecution of perpetrators of rape. Rape centers are also vital for providing free medical treatment to victims, which includes preventive care for STIs including HIV, emergency contraception, and counseling services. It is important that the government have a key role in establishing these centers both as a symbolic and practical gesture. The services of such centers should ideally be offered freely to women to ensure that cost does not deter women from accessing beneficial services. In Lagos—a forward-looking state in terms of gender-based violence issues—the Mirabel Centre was established in 2013 as a joint effort of the state government, several civil society groups, and foreign institutions.[108] It provides a service center for victims of sexual abuse, including emergency medical treatment, forensic medical examinations, and counseling.[109] It reportedly sees

105. T. Naidike, *Doctrine of Covering-The-Field in Federal Constitutional Theory*, T. NAIDIKE'S BLOG (Oct. 1, 2011), http://tnaidike.wordpress.com/doctrine-of-covering-the-field-in-federal-constitutional-theory-2 [http://perma.cc/8JHZ-KQKA].

106. HEALTH SURVEY 2013, *supra* note 10, at 293.

107. IMMIGR. & REFUGEE BD. OF CAN., NIGERIA: DOMESTIC VIOLENCE, INCLUDING LAGOS STATE; LEGISLATION RECOURSE, STATE PROTECTION AND SERVICES AVAILABLE TO VICTIMS, (2011-OCTOBER 2014) [NGA104908.E] (2014), http://www.refworld.org/docid/548168e14.html [http://perma.cc/YM7Q-ZY5A].

108. Sola Ogundipe, *Mirabel Centre Confronts Sexual Assault in Lagos*, VANGUARD (Dec. 17, 2013, 12:11 AM), http://www.vanguardngr.com/2013/12/mirabel-centre-confronts-sexual-assault-lagos [http://perma.cc/9CSR-WGCG].

109. *Mirabel News Oct 2013: Our Mirabel Centre*, PARTNERSHIP FOR JUST. (Oct. 15, 2013), http://www.pjnnigeria.org/mirabel-news-oct-2013-our-mirabel-centre.pjn [http://perma.cc/WZ2M-JSM5].

an average of twenty-five clients per month.[110] Unfortunately, there does not appear to be similar centers in other parts of the country. Due to this vacuum, post-exposure prophylaxis is not yet widely available to prevent the contraction of HIV in the aftermath of rape.

The VAPP Act, regrettably, does not require the government to establish such centers in the Federal Capital Territory, although previous versions of the Bill had originally contained this provision.[111] It has been observed that,

> [d]espite pressure on the government from international and local NGOs to provide emergency contraception and post-exposure prophylaxis (PEP) drugs as a public service to rape victims, laws and policies in many sub-Saharan African countries . . . do not explicitly obligate health care providers to provide rape victims with treatment for sexually transmitted diseases, emergency contraception to prevent possible pregnancy, or medical treatment for injuries sustained as a result of the rape.[112]

For Nigeria, lack of specific law or policy requiring the establishment of rape centers throughout the country is a significant challenge, given the high rates of HIV infection in the country.[113] Providing a legal foundation by legislating for the establishment of such centers would have ensured greater possibility of sustainability and provided an advocacy tool for civil society organizations focused on women's and health rights. Alternatively, given resource constraints, developing an integrated strategy for equipping primary health care centers and other health facilities around the country with the necessary education and resources may be a more sustainable approach. Either way, the need for sexual violence management in health care remains a palpable need that must be addressed. The VAPP Act should also have stated clearly the legal obligations of health care providers to provide rape victims with treatment for sexually transmitted diseases and emergency contraception. Thus, I recommended that these gaps be considered and addressed in a future amendment of the VAPP Act.

---

110. IMMIGR. & REFUGEE BD. OF CAN., *supra* note 107.

111. ENIKŐ HORVÁTH ET AL., GENDER-BASED VIOLENCE LAWS IN SUB-SAHARAN AFRICA 45 (2007), http://www.nycbar.org/pdf/report/GBVReportFinal2.pdf [http://perma.cc/B5RC-DRNB].

112. *Id.*

113. Joint U.N. Program on HIV/AIDS [UNAIDS], Nigeria: HIV and AIDS Estimates (2014), http://www.unaids.org/en/regionscountries/countries/nigeria [http://perma.cc/32VU-M229] (reporting that as of 2014, about 3.4 million people in Nigeria were estimated to be living with HIV; the prevalence rate for individuals aged 15–49 was 3.2%).

4. Female Genital Mutilation

As earlier highlighted, FGM is another type of gender-based violence that adversely affects reproductive health. Nigerian women account for approximately one-quarter of all women who have been subjected to FGM worldwide—the highest absolute number from any single country.[114] The long awaited VAPP Act aims to prohibit FGM in Nigeria.[115] However, as stated earlier, this Act currently applies to the Federal Capital Territory only, and thus, the VAPP Act does not prohibit FGM in a state until that state adopts it as law.

The Nigerian Constitution can arguably provide a legal basis for prohibition of FGM. In this regard, the Constitution states, "no person shall be subject to torture or to inhuman or degrading treatment."[116] Even prior to this, several states—Edo, Cross River, Ogun, Osun, Rivers, and Bayelsa—had banned FGM by law.[117] Unfortunately, there has been limited awareness and enforcement of these laws. From a health standpoint, health care providers need to be trained to manage cases of FGM, provide awareness of the health consequences, and engage in health education.[118] Developing a message that focuses on the health consequences of FGM may also be more effective in reaching the areas where FGM remains in practice than emphasizing the rights of children and women to sexual enjoyment. There is little in existing policy or law that addresses these needs.

5. Domestic Violence

The VAPP Act also addresses domestic/intimate partner violence: it contains offenses such as spousal battery.[119] In addition to this, it

---

114. TC Okeke, USB Anyaehie & CCK Ezenyeaku, *An Overview of Female Genital Mutilation in Nigeria*, 2 ANNALS MED. & HEALTH SCIS. RES. 70, 70 (2012) (reporting Nigerian women "account[ ] for about one-quarter of the estimated 115–130 million circumcised women worldwide").

115. VAPP Act, § 6.

116. CONSTITUTION OF NIGERIA (1999), § 34(1)(a).

117. IMMIGR. & REFUGEE BD. OF CAN., PREVALENCE OF FEMALE GENITAL MUTILATION (FGM), INCLUDING ETHNIC GROUPS IN WHICH FGM IS PREVALENT; AVAILABLE STATE PROTECTION [NGA103520.E] (2010), http://www.ecoi.net/local_link/144821/245688_en.html [http://perma.cc/PQD5-EJD3].

118. The National Association of Nigerian Nurses and Midwives' Campaign for Eradication of FGM was one of such projects. *See* Sarah Eckinger, *Nigeria: Female Genital Cutting—The 20th Century's Attempt to Ban a Harmful Traditional Practice*, YALE GLOBAL HEALTH REV. (2014), http://yaleglobalhealthreview.com/2014/04/30/nigeria-female-genital-cutting-the-20th-century-attempt-to-ban-a-harmful-traditional-practice [http://perma.cc/6GVX-VFAN] (explaining how Nigeria educated communities on the harms of FGM to build support against the practice).

119. VAPP Act, § 46 (defining spousal battery as "the intentional and unlawful use of force or violence upon a person, including the unlawful touching, beating or striking of

defines domestic violence separately as "any act perpetrated on any person in a domestic relationship where such act causes harm or may cause imminent harm to the safety, health or well-being of any person."[120] Such act includes physical abuse, sexual abuse, emotional or psychological abuse, economic abuse, intimidation, harassment, stalking, damage to property, forced isolation from family and friends, and abandonment.[121] Some of these acts may impact reproductive health adversely.

Prior to the VAPP Act, legislation on domestic violence was available only in a few states—Lagos, Cross River, Ekiti, Jigawa, and Ebonyi.[122] The VAPP Act and several states' legislation establishes the requirement to provide medical care to those affected by violence in the domestic context.[123] These pieces of legislation do not often draw a distinction between the kinds of injuries to be treated but address medical care generally. It is left to the medical facility to decide which types of care to provide in the aftermath of domestic violence, whether or not this will include emergency contraception, antibiotics to prevent STIs, PEP to prevent HIV, or merely pain medication. The National Health Act of 2014, however, provides that health care providers must provide emergency care.[124] Again, emergency care is not defined although it may be surmised that it must include that which would save lives.

6. Policy Development and Application

Outside of legislation, there are several policies that have been developed at the national level that deal with reproductive health issues in Nigeria. These are the National Gender Policy,[125] the National Policy on Reproductive Health,[126] National Policy on the Elimination of Female Genital Mutilation,[127] and the National Policy on HIV/AIDS.[128] The National Gender Policy lists the eradication of HIV/AIDS as a major policy goal and recognizes the vulnerability of

another person against his or her will with the intention of causing bodily harm to that person").

120. *Id.*

121. *Id.*

122. IMMIGR. & REFUGEE BD. OF CAN., *supra* note 107.

123. *Id.*; VAPP Act, § 38(1)(a)–(b).

124. National Health Act (2014), § 20(1).

125. FED. MINISTRY OF WOMEN AFFAIRS & SOC. DEV., NATIONAL GENDER POLICY (2006).

126. FED. MINISTRY OF HEALTH, NATIONAL REPRODUCTIVE HEALTH POLICY AND STRATEGY TO ACHIEVE QUALITY REPRODUCTIVE AND SEXUAL HEALTH FOR ALL NIGERIANS (2001) [hereinafter NATIONAL REPRODUCTIVE HEALTH POLICY].

127. FED. MINISTRY OF HEALTH, NATIONAL POLICY ON THE ELIMINATION OF FEMALE GENITAL MUTILATION (1998).

128. NAT'L AGENCY FOR THE CONTROL OF AIDS, NATIONAL POLICY ON HIV/AIDS (2009) [hereinafter NATIONAL POLICY ON HIV].

women to HIV as a result of gender-based violence that often leads to a woman having less power of choice over sexual relations and protection.[129] In even more strongly worded terms, the National Policy on Reproductive Health recognizes that gender-based violence in its myriad forms negatively impacts the reproductive health of women.[130] It reiterates the government's commitment to eliminate all forms of gender-based violence against women, including sexual violence and domestic violence.[131] It states specific targets that the government plans to meet in order to ensure the elimination of all forms of violence against women.[132] Specifically regarding the health sector, this includes, as already discussed, ensuring adequate training for obstetrics, gynecology surgeons, and other relevant health professionals in the management of fistula and other FGM related complications; providing appropriate care and support, including counseling for victims of violence, including sexual violence; and ensuring appropriate training for health care providers.[133] It also states that "[t]he Federal Ministry of Health shall establish guidelines for planning, organising, conducting and supervising training of all health personnel at all levels. It will provide appropriate technical support for curriculum development, training, and continuing education."[134] It is not clear that these targets have received adequate attention. Inquiries made to the Federal Ministry of Health indicate that the guidelines for reproductive health education for health care providers have yet to be produced since 2001 when this Policy was developed. The National HIV/AIDS Policy addresses violence against women and its relationship to HIV/AIDS, though not in great detail. It recognizes that women are vulnerable to physical and sexual abuse.[135] On the interface of HIV/AIDS and violence against women, the relationship between the two concerns is particularly obvious in cases of rape. The Policy calls for enforcing legal measures to prevent rape, sexual harassment of women, and harmful traditional practices against women.[136] The Policy contains provisions on orphans and other vulnerable children who may be affected by HIV/AIDS, calling for a gender-sensitive approach in dealing with these children.[137] It also recognizes the need to protect the human rights of persons living with HIV/AIDS, which may include abused women, and also the

129. NATIONAL GENDER POLICY, *supra* note 125, art. 4.3.9.
130. NATIONAL REPRODUCTIVE HEALTH POLICY, *supra* note 126, art. 3.2.5.
131. *Id.* art. 1.2.2.
132. *Id.* art. 4.2.
133. *Id.* art. 3.2.5.
134. *Id.* art. 4.2.1.2.
135. NATIONAL POLICY ON HIV, *supra* note 128, art. 7.4(B).
136. *Id.*
137. *Id.*

human rights of widows who may be affected by HIV/AIDS.[138] It does not, however, specifically address post exposure prophylaxis in cases of rape, except in the context of sexual violence within prisons.[139] This is a gross oversight that needs to be remedied.

In Nigeria, gender-based violence often acts as a cause of HIV infection through forced sexual relations within and outside marriage relationships, and through deliberate and often torturing experiences of adultery by intimate partners, which increases risks of getting and transmitting STIs.[140] My experience dealing with victims of gender-based violence who have become infected with HIV also indicates that the health system has not provided room for these women to be detected and for any appropriate care to be provided. Revisions of the Policy, going forward, must take into greater account the connections that exist between HIV/AIDS and violence against women, and stipulate specific steps to provide care in cases of sexual violence against women.

7. Recommendations

Overall it is clear that while reproductive health issues have received attention in the context of violence against women in Nigeria, more remains to be done. High rates of child marriage, FGM, and domestic violence emphasize this need. Much of the existing law, developed many years before, are in need of urgent revision to address current concerns such as the need to clarify the definition of rape, enhance provisions that address health concerns, and provide legal foundations for necessary interventions. Existing law and policy, for instance on rape, child marriage, and FGM, need to be enforced and implemented respectively. Gaps also need to be remedied—enhancing legal provisions to include the provision of rape crisis centers, clearly identifying the roles of health care providers, and the provision of necessities such as PEP need to be enhanced. It would also be appropriate to update the National Reproductive Health Policy, incorporating more recent international guidelines, such as those promulgated in 2013 by the World Health Organization regarding responses to intimate partner violence and sexual violence against women.[141]

---

138. *Id.* art. 7.1.

139. *Id.* art. 7.4(B).

140. NATIONAL REPRODUCTIVE HEALTH POLICY, *supra* note 126, art. 1.2.2.

141. *See* WHO, RESPONDING TO INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE AGAINST WOMEN: WHO CLINICAL AND POLICY GUIDELINES 3–9 (2013), http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf?ua=1 [http://perma.cc/6VAR-BWKF] [hereinafter WHO, RESPONDING TO INTIMATE PARTNER VIOLENCE].

B. Mental Health

Several connections exist between violence against women and mental health concerns in Nigeria. The first link has already been identified under the section on the health consequences of violence against women: mental illness can and frequently results from experiencing violence. These include substance abuse disorders, mood disorders, depression, post-traumatic stress disorder, generalized anxiety disorder, and increased risk of suicide.[142] Gender-based violence can cause mental illness, predispose victims to mental disorders, and further increase vulnerability to additional experiences of gender-based violence.[143]

I offer here a caveat that permeates my analysis in the rest of this section: while it is crucial to recognize the impact of gender-based violence on mental health, it is also very important to avoid pathologizing women who have experienced violence. Such pathologizing may have short term and direct benefits for the woman in question, for instance, in criminal matters where the woman is accused of a crime. However, it may have long term consequences. Such pathologizing may harm women, particularly by sticking them with labels of helplessness, and with huge emotional costs, such as rendering it difficult to obtain child custody.[144]

Even so, we must recognize that there are mental health consequences or harms originating from gender-based violence like rape, forced marriage, and domestic violence. To refuse to acknowledge this would be to deprive many women of the benefit of any health services that may be available to support them and provide them a better quality of life. Instead a nuanced approach is called for. For instance, mental illness in criminal cases may need to be separated from temporary breaks from reality under the pressure of gender-based violence, actions taken in self-defense, or mental health challenges that do not affect a woman's decision-making. But these distinctions draw from recognition of all the possible consequences of gender-based violence.

Beyond the direct effects on women, the mental health effects of violence on children within the family context have been documented.[145] Further, as Bowman rightly points out, cultural and

142. WHO, *supra* note 46, at 100–02.

143. Susan Rees et al., *Lifetime Prevalence of Gender-Based Violence in Women and the Relationship with Mental Disorders and Psychosocial Function*, 306 JAMA 513, 518, 520 (2011).

144. *See* LAW COMMISSION, PARTIAL DEFENCES TO MURDER 89 (2004) (U.K.).

145. *See, e.g.*, Gayla Margolin et al., *Youth Exposed to Violence: Stability, Co-occurrence, and Context,* 12 CLINICAL CHILD & FAM. PSYCHOL. REV. 39, 39 (2009).

religious norms that insist on and enforce women's subordinate status in marriage, society, and public life, inflict damage on women's psyche and self-esteem.[146] This may call for some kind of mental health intervention in extreme cases.[147] Depression is not an unusual diagnosis for women who have lived in abusive situations or who have been harmed by rape;[148] it is a diagnosis that may lead to a poor quality of life if left untreated.[149] In my work through the Center for Health Ethics Law and Development (CHELD), some of the women we have helped have been diagnosed with depression.

Unfortunately, in Nigeria, mental health concerns remain a taboo issue, resulting in high levels of stigma and poor treatment uptake.[150] The upshot is that many women who have been adversely affected by violence, including in their homes, may be reluctant to access any treatment available. This may in turn worsen their prognosis and prolong recovery. For women in intimate relationships, this may have several negative consequences. For instance, issues such as mental health status may be taken into account in determining child custody.[151] Failing to deal with mental health concerns may render a woman unfit to take care of children. A vicious cycle may then ensue. A denial of custody to a woman, who in the Nigerian context where gender roles remain conservatively circumscribed is likely to have been the primary caregiver of the child, is likely to worsen her mental health status, and cases confirm this.[152] Many women require but may not receive counseling in the immediate aftermath of trauma, which may lead to long-term problems.[153]

Given that violence against women may predispose them to mental issues, the question that arises would then be: how do law and policy in Nigeria tackle mental health matters, particularly in respect to women and girls who experience violence on account of

146. Bowman, *supra* note 45, at 489.

147. *Id.*

148. Kelsey Hegarty et al., *Association Between Depression and Abuse by Partners of Women Attending General Practice: Descriptive, Cross Sectional Survey*, 328 BMJ 621, 623 (2004).

149. *Id.*

150. MENTAL HEALTH LEADERSHIP & ADVOCACY PROGRAMME, UNIV. IBADAN, MENTAL HEALTH SITUATION ANALYSIS IN NIGERIA 4–5 (2012).

151. *See, e.g.*, M.F. Tunde-Ayinmode, *Family Characteristics of Nigeria Women with Severe Mental Illness Attending a Psychiatric Outpatient Clinic*, 88 E. AFR. MED. J. 183, 187–88.

152. *Id.*

153. *Cf.* Eleni Michalopoulou et al., *Stress Management and Intimate Partner Violence: A Randomized Controlled Trial*, 30 J. FAM. VIOLENCE 795, 795–96 (2015) (detailing impacts of gender-based violence and finding that stress management techniques might reduce perceived stress but do not alleviate other psychological symptoms of victims, indicating the necessity of alternate intervention mechanisms such as counseling).

their gender? Unfortunately, mental health matters have remained relegated to the back burner in the provision of mental health services and in health policy making in Nigeria. A WHO-AIMS Report noted that mental health matters have been grossly neglected.[154] There is a dearth of psychiatrists, but medical practitioners who practice in primary health are permitted to prescribe psychotropic drugs.[155] For women who live in rural areas, there is very little access to mental health services.[156] The situation is more grim for women in conflict-ridden areas, as there is often little or no psychosocial support.[157]

Non-governmental organizations and faith-based organizations fill an important gap with respect to supporting women who are experiencing or have experienced violence.[158] Many of these organizations provide ongoing emotional support to victims of gender-based violence.[159] Many also provide some form of counseling services, even though they do not have the capacity or the requisite expertise.[160] There is limited room for appropriate referrals to specialized services for counseling and therapy, since these services are mostly non-existent outside psychiatric hospitals.[161] Rape centers may provide psychological support services, but as mentioned earlier, are scarce. Some organizations, like the Centre for Health Ethics Law and Development, provides some counseling which include tips on how to detect domestic abuse and manage the situation and referrals to counselors and psychiatrists as appropriate.[162]

---

154. WHO & NIGERIA MINISTRY OF HEALTH, WHO-AIMS REPORT ON MENTAL HEALTH SYSTEM IN NIGERIA 5–6 (2006), http://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf [http://perma.cc/4HRX-8VJ7].

155. *Id.* at 25.

156. *Id.* at 24.

157. *See, e.g*, INT'L ORG. FOR MIGRATION, AN ASSESSMENT OF PSYCHOSOCIAL NEEDS AND RESOURCES IN YOLA IDP CAMPS: NORTH EAST NIGERIA 4 (2015), http://nigeria.iom.int/sites/default/files/newsletter/Yola%20Assessment%20 Report%20MHPSS%202015.pdf [http://perma.cc/XH8A-CGCA] (describing the necessity of, and difficulty in, providing mental health and psychosocial services to displaced persons in northern Nigeria based on continued instability there).

158. *See* MENTAL HEALTH LEADERSHIP & ADVOCACY PROGRAMME, *supra* note 150, at 15.

159. *See* CLEEN FOUND. & PROJECT ALERT ON VIOLENCE AGAINST WOMEN, RESPONDING TO GENDER BASED VIOLENCE: A TOOL BOOK 17 (2006) (recognizing the role non-state actors play in responding to victims of violence, and providing best practices for those organizations).

160. *See id.* at 18.

161. Oye Gureje & Victor O. Lasebikan, *Use of Mental Health Services in a Developing Country: Results From the Nigerian Survey of Mental Health and Well-Being*, 41 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 44, 44 (2006).

162. *See* CENTRE HEALTH ETHICS L. & DEV. (CHELD), THE RED DIARY: TIPS FOR SURVIVING DOMESTIC VIOLENCE AND ABUSEAND A DIRECTORY FOR HELP IN NIGERIA 5 (2014), http://domesticviolence.com.ng/wp-content/uploads/2014/11/Red-Diary.pdf [http://perma.cc/Y4F5-J87H].

We have found that more in-depth psychological counseling may be necessary, especially when the abuse is longstanding, but is often unavailable outside a psychiatric setting that many women object to because of longstanding attitudes against mental health. What may be available and acceptable to women in Nigeria, however, may be informal support systems like family, churches, and other religious organizations. There is a clear role for law in discouraging discrimination through specific legal provisions. There is an important part for law to play in encouraging mental health services development through requiring governments to provide requisite basic services, and in imposing screening and reporting obligations on mental health providers, amongst other things.

How then have mental health law and policy in Nigeria managed this issue? Unfortunately, the role of law has been severely circumscribed due to the delay in legal reforms. Currently, no legislation exists to regulate mental health procedures and to protect the human rights of patients. The Lunacy Act was enacted in 1958 and is the current extant legislation on mental health issues.[163] The Act is outdated, does not include basic and internationally accepted standards for mental health care, and is long overdue for a replacement.[164]

As a result, a Mental Health Bill has been proposed to provide a legislative foundation for the provision of mental health services in Nigeria.[165] Even so, this bill does not specifically address issues surrounding violence or women in particular, or reporting and screening obligations. This bill has been in the National Assembly for over a decade.[166] It was not passed before the new administration took over at the end of May 2015, leaving the bill to begin the cycle of enactment processes afresh when the National Assembly is sworn in for another term. The VAPP Act makes some attempt to provide relief, though in a cursory manner. The Act provides that victims are entitled to receive psychological care, amongst other types of care.[167] No organization is specifically required by law to provide this; the section notes that victims may receive such care through government and non-governmental organizations that provide them.[168]

---

163. Lunacy Act (1958) Cap. (112).

164. Paula Ugochukwu Ude, *Policy Analysis on Nigerian Lunacy Act (1958): The Need for a New Legislation*, J. PSYCHIATRY, Dec. 22, 2015, art. 343, at 2.

165. Mental Health Bill (2008).

166. *See* Ude, *supra* note 164, at 2.

167. VAPP Act, § 38(1). ("[E]very victim of violence . . . is entitled to the following rights . . . (a) to receive the necessary materials, medical, psychological, social and legal assistance through governmental agencies and/or non-governmental agencies providing such assistance; (b) . . . to be informed of the availability of legal, health and social services and other relevant assistance and be readily afforded access to them . . . .").

168. *Id.* Moreover, this Act is only operative in the Federal Capital Territory. *Id.* § 47.

In terms of mental health policy, in 2013, the National Policy for Mental Health Services Delivery was developed.[169] The Policy observes that hitherto mental health services in Nigeria have focused on "[h]ospital rather than on primary care; [t]reatment rather than prevention, promotion or rehabilitation; [s]pecialist expertise rather than family physicians; [d]octors at the expense of other disciplines and [c]oncentrating health services in the major cities with little decentralisation across . . . communities."[170] Further, the Policy recognizes that it would be practically impossible to ensure that everyone who requires mental health care receives this from mental health specialists, given the paucity of such specialists.[171] It therefore encourages the integration of basic mental health care needs within the primary health care system, which is the cornerstone of health delivery in Nigeria.[172] The result would be that those who require basic mental health services, including counseling, would receive this from primary health care centers throughout the country. The Policy further recognizes the need to enact legislation that protects the rights of patients.[173]

The Policy specifically addresses mental health issues in women and children. It notes that women (and children) are especially vulnerable to mental health challenges and should therefore receive special attention.[174] It highlights the issue of postpartum depression, noting that women may suffer from mental health challenges around childbirth.[175] These challenges, it states, should be addressed immediately to prevent mental health challenges in children who may develop mental health challenges of their own as a result of their mothers' illness.[176]

Unfortunately, violence against women and its consequent impact on the mental health of women does not receive any attention in the Policy. This is a serious omission, given that the Nigeria Demographic and Health Survey has consistently recognized violence against women as a health issue with mental health consequences.[177] This omission does not take into account recent issues such as terrorist attacks in Nigeria that have affected women and girls,

169. FED. MINISTRY OF HEALTH, NATIONAL POLICY FOR MENTAL HEALTH SERVICES DELIVERY (2013) [hereinafter NATIONAL POLICY FOR MENTAL HEALTH SERVICES DELIVERY].
170. *Id.* at 13.
171. *See id.* at 5.
172. *Id.* at 6, 13.
173. *Id.* at 9.
174. *Id.* at 10.
175. *Id.*
176. *Id.*
177. NAT'L POPULATION COMM'N & ICF MACRO, NIGERIA: DEMOGRAPHIC AND HEALTH SURVEY 2008, at 261 (2009); HEALTH SURVEY 2013, *supra* note 10.

disproportionately, including the use of young girls as suicide bombers, with the possible effect on the mental health of mothers or other women in conflict situations.[178] The effect of the narrow couching on the Policy's provisions on women and the important omissions contained therein is to maintain the status quo—where the mental health needs of victims of gender-based violence continue to remain hidden and unattended.

Moreover, the VAPP Act provides in Section 38 that victims are entitled to receive psychological care, which can be interpreted as including counseling.[179] This is only operative in the Federal Capital Territory; there is no legal or policy requirement to refer victims to counseling in any other parts of Nigeria. Further, although it is now clear that violence and abuse are implicated in mental health problems, women who present for mental treatment are often not screened for gender-based violence in jurisdictions around the world.[180] This situation is likely to be similar in Nigeria, given that the Policy does not clearly recognize gender-based violence as a potential source of mental health challenges or explicitly require specialists or primary health care givers to screen women for this.

Some of the general recommendations of the Policy would benefit women who are experiencing mental health challenges as a result of gender-based violence, including recommendations on inter-sectoral collaboration. For instance, the recommendations on integrating mental health care into primary health to ensure, that regardless of the scarcity of specialists and specialist hospitals and services, mental health care can be provided to those who need it throughout the country. Any screening for gender-based violence, including history of domestic violence or sexual abuse, would thus be conducted by primary health care providers. To be effective, education on issues around violence against women would have to be provided to these caregivers.

Unfortunately, the Policy, with its non-recognition of this potential source of mental health challenges, leaves little room for such awareness creation or for primary health care providers to identify and address these issues. Further, the Policy recommends liaisons with other sectors and ministries such as the Ministry of Social Affairs, Ministry of Internal Affairs, Ministry of Defence, the police,

178. *See, e.g.*, *Young Female Suicide Bombers Kill 15 in Nigeria Market Attack*, THE GUARDIAN (Nov. 18, 2015, 3:37 PM), http://www.theguardian.com/world/2015/nov/18/young-female-suicide-bombers-kill-15-in-nigeria-market-attack [http://perma.cc/CX89-K775].

179. VAPP Act, § 38(1)(a).

180. Kelsey Hegarty, *Domestic Violence: The Hidden Epidemic Associated with Mental Illness*, 198 BRIT. J. PSYCHIATRY 169, 169 (2011).

prisons, schools and universities, religious leaders, and so on.[181] Little mention is made of women; in this case, the Ministry of Women's Affairs would have been a good addition.[182] The Policy includes civil society organizations, but does not specify those focused on gender issues. What these gaps suggest is not only that gender issues, including gender-based violence, are not yet recognized and understood as being a major problem with attendant mental health consequences. Because of this, there is little room within the Policy to bring these issues to the fore and provide opportunities for them to be effectively addressed.

In sum, it is clear that greater attention needs to be paid to the mental health concerns that arise as a consequence of violence against women in Nigeria. Current law and policy remain grossly inadequate in this respect. For women experiencing mental health concerns as a result of trauma of violence within or outside the home in Nigeria, the situation appears bleak. The stigma attached to mental health issues, combined with high rates of under-reporting and the lack of effective legislation, allow very little support for women experiencing mental health challenges. There is no legal or policy mandate to refer victims to counseling. Yet counseling is crucial because it helps to destroy dangerous myths that abound in regard to the place of women and the benefits of mental health care. Counseling also provides an avenue to address well-founded and groundless, yet very real, fears that often prevent women from recognizing, reporting, seeking help for, or getting out of abusive relationships.

The solution for addressing mental health challenges faced by victims of violence against women here lies in broad and particular avenues for mental health care development in Nigeria. In terms of broad or general avenues to improve mental health care in the country, it is important that greater political commitment be devoted to tackling mental health care in the country. This will encourage prioritization in resource distribution, efforts to improve awareness of mental health issues, the promotion of human rights, and the improvement of existing medical facilities. Greater political commitment would also lead to enacting the Mental Health Bill and accompanying legal protections. Greater political commitment would also be necessary to implement the recent policy on mental health. These broad efforts would encourage provision of services directed towards

181. NATIONAL POLICY FOR MENTAL HEALTH SERVICES DELIVERY, *supra* note 169, at 17–19.

182. Interestingly, at this time there is no Federal Ministry of Social Affairs. It is not clear if this is a typo and the Policy meant to refer to the Ministry of Women Affairs and Social Development instead.

improvement of mental health care in Nigeria, reduction of discrimination, a higher profile for mental health issues, greater awareness, reduced stigma and, very likely, increased uptake of mental health services.

More specific interventions would reflect a considered, nuanced, view of gender issues. These interventions should include a revision of the Policy to address specific mental health challenges that arise as a result of gender-based violence. Appropriate interventions would also include legal requirements for screening for gender-based violence in any legislation to be developed, accompanied by requirements for counseling, and specific instructions within the Policy about the manner of eliciting information, what to do with information obtained, and the welfare of victims. Amongst other things, the legislation and revised Policy could require universities to establish and maintain counseling offices where women who have suffered violence have the freedom to seek counseling and an avenue for justice. All of these would benefit women suffering the mental health effects of gender-based violence in Nigeria.

II. RESPONSIBILITY OF HEALTH CARE PROVIDERS

A. Role of Health Care Providers

The role of health care providers in a public health challenge of epidemic proportions in Nigeria is a very important one. They can provide health services to manage physical injuries. Beyond that, however, they are often the first professionals that a victim will have access to.[183] Further, they can provide other support such as counseling, information on support available, and assistance with law enforcement officials, with prosecution, and with ongoing support and empowerment.[184] Moreover, as the United Nations Handbook for Legislation on Violence Against Women proposes, the health sector (that would include health providers) should be a part of developing legislation, guidelines, protocols and regulations on violence against women.[185] In this way, health care providers can bring their own peculiar perspective based on experiences and expertise to bear on the regulatory framework. More directly, through routine

183. Elaine Hewins, Brittany DiBella & Juhi Mawla, *Domestic Violence and the Role of the Healthcare Provider*, VERIZON FOUND. 4 (2013), https://www.verizon.com/about/sites/default/files/WhitePaper_DomesticViolence.pdf [http://perma.cc/4ZBX-Z9XD].

184. *See* Karuna S. Chibber & Suneeta Krishnan, *Confronting Intimate Partner Violence: A Global Health Priority,* 78 MOUNT SINAI J. MED. 449, 453 (2011).

185. U.N. Women, *supra* note 1, at 20.

examination and screening, health care providers can detect women who are being abused in domestic violence situations and other types of violence against women. They can assist in reframing the issue of gender-based violence as a health issue, helping to lift the silence around it.

Yet preliminary research conducted by CHELD and more authoritative sources, such as the Nigeria Demographic and Health Survey, suggests that the role of health care providers in detecting, preventing, managing, and providing assistance for victims is a neglected area in Nigerian health law and policy.[186] In this respect, some crucial issues come up for consideration in relation to health care providers and violence against women in Nigeria. How do health care providers engage women to detect, prevent, and manage situations of domestic violence? Do women seek help from health care providers in Nigeria in the event of violence? What kinds of care are, and should be, provided by health care providers? What are the reporting obligations of health care providers under the law? Are there screening obligations? What resources does the law provide to enhance the capacity of health care providers to detect and support women who are victims and survivors of gender-based violence?

In terms of help-seeking behavior in regard to violence against women, the Nigeria Demographic and Health Survey has some information that provokes concern: about half of abused women—possibly up to fifty-seven percent—have never sought help from any source, including help from health care providers.[187] Forty-five percent of such women have not told anyone—including family, health providers, or law enforcement—that they have been abused.[188] In essence, many abused women in Nigeria do not seek help from health care providers for violence and are unlikely to receive any health care they need. These figures reflect my experience working with abused women.

The fact that many women do not seek help from health care providers may stem from little understanding, both by health care providers and women in Nigeria, that the health care centers may provide an appropriate forum to discuss their problems and seek support. Out of all the women surveyed in the Nigeria Demographic and Health Survey, only around three percent of women who reported experiencing physical violence sought help from a doctor or medical personnel.[189] Only ten percent of women who experienced

186. *See* HEALTH SURVEY 2013, *supra* note 10, at 5.
187. *Id.* at 326–27.
188. *Id.* at 325.
189. *Id.* at 327.

sexual violence reported seeking assistance from a medical doctor or other health provider.[190] My own relations with women as the Executive Director of a non-profit that provides support for victims of gender-based violence suggests that HIV infection and other kinds of STIs are issues affecting violated women, including women in marriages. My work further indicates that there is reticence by women to share their experience with violence and that health care providers do not often make the relevant inquiries. In my experience, women who have been raped often do not speak up because of the possibility of not being believed, not receiving justice, and feelings of misplaced guilt and shame. In addition to the psychological burden, they do not receive the care needed to combat any infections contracted or counseling for the mental and psychological trauma experienced. Lack of health care-seeking behavior also reflects problems with access to health care.[191]

For the three percent who have sought assistance from health care providers, it is important to ask: what support is provided by health care providers? How adequate is that support? Unfortunately, very little information in this regard is publicly available. My research for this Article did not indicate that this issue has been addressed by the researchers or health care providers, which suggests that this is an area that requires more research in Nigeria.

B. National Legislation and Professional Codes

What does the law provide in regard to the obligations of health care providers in cases of gender-based violence? The National Health Act, while it does not address gender-based violence specifically, contains certain relevant provisions. For instance, it provides that all health care providers (that is, health facilities) must provide emergency treatment.[192] Thus, a woman who has been raped, beaten, and attacked and comes into a health facility must be given emergency care.[193] It also provides that a patient's privacy and confidentiality must be maintained by the health care provider.[194] This is particularly relevant for women who are victims of gender-based violence.

In addition to the general provisions of the National Health Act, the Codes of Ethics of the various health professions—such as the

190. *Id.*
191. *See supra* Part III.
192. National Health Act (2014), § 20(1).
193. *See id.*
194. *Id.* §§ 26–29.

Medical and Dental Council of Nigeria's Code of Medical Ethics[195] and the Nursing and Midwifery Council of Nigeria's Code of Professional Conduct[196]—articulate the duties and obligations of health professionals. These Codes of Ethics are subsidiary legislation, having indirect force of law, as they are made under the umbrella and with the mandate of the legislation establishing the professional councils that regulate the health professions. The Medical and Dental Council of Nigeria's Code of Medical Ethics made under the Medical and Dental Practitioners Act[197] for example, provides that the failure to provide care as speedily as needed to a patient constitutes professional negligence.[198] Another omission that may constitute professional negligence, and that may be relevant to gender-based violence, is:

> [f]ailure to see a patient as often as his [or her] medical condition warrants or to make proper notes of the practitioner's observations and prescribed treatment during such visits or to communicate with the patient or his relation as may be necessary with regards to any developments, progress or prognosis in the patient's condition.[199]

Making proper notes enables a medical doctor to determine if observations would assist such doctor in determining if there is a continuing threat to the well-being of the woman, and how long abuse has been going on.

Neither the Codes of Ethics nor the National Health Act make specific provisions for gender-based violence. Indeed, while other health conditions are named in the Medical and Dental Council of Nigeria's Code of Medical Ethics, gender-based violence is not specifically mentioned.[200] I now turn to laws that address gender-based violence specifically to determine if health care providers (including health facilities and health professionals) have any obligations with respect to providing care to victims of violence against women.

---

195. Code of Medical Ethics in Nigeria (2004).

196. Nursing & Midwifery Council of Nigeria, *Code of Professional Conduct*, http://www.nmcn.gov.ng/portal/index.php/2014-05-21-12-19-46/2014-05-21-12-20-27 [http://perma.cc/4AKH-F9WS].

197. Medical and Dental Practitioners Act (2004) Cap. (M8), § 1(2)(c).

198. Code of Medical Ethics in Nigeria (2004), art. 28(A).

199. *Id.* art. 28(I).

200. *See, e.g.*, *id.* arts. 23–24 (providing considerations regarding, for example, assisted reproduction and HIV/AIDS management, but with no reference to sensitivities related to gender-based violence).

C. Violence Against Persons (Prohibition) Act

The VAPP Act provides little with respect to the obligations of health care providers. As discussed earlier, it does state that victims are entitled to receive medical and psychological care from governmental and non-governmental bodies.[201] However, it does not impose a mandatory obligation on these organizations to provide such care.[202] It also states that a health worker can be a complainant who may bring an application for a protection order.[203]

D. State Gender-Based Violence Laws

Legislation on gender-based violence, including domestic violence, passed by six out of thirty-six states in Nigeria, provides room for health providers to interface with victims of such violence. The obligations placed on health providers, for the most part, deal with providing medical care or assistance with obtaining medical care for victims of domestic violence. For instance, Lagos State legislation on domestic violence provides that a health worker who is present at the scene of an incidence of domestic violence shall render assistance, to include assisting or making arrangements for the complainant to find suitable shelter and to obtain medical treatment.[204] This provision imposes a mandatory obligation on health providers at the scene of domestic violence to assist a victim in obtaining medical care. In Ebonyi State, the domestic violence law requires that any social worker (or police officer) present at the scene of any incident of domestic violence shall

> (a) render such assistance to the victim as may be required in the circumstance, including:
>
> i. using reasonable force to rescue
> ii. making arrangement for victim to find suitable shelter
> iii. directing victims to obtain medical treatment; and
> iv. arresting the offender, provided that in the case of a social worker, report shall be made to the nearest police formation for such arrest.[205]

"Social workers," under the law, include health workers.[206]

---

201. VAPP Act, § 38(1)(a).
202. *Id.* § 38.
203. *Id.* § 28(4).
204. A Law to Provide Protection Against Domestic Violence and for Connected Purposes (2007), § 3(1) (Lagos, Nigeria) [hereinafter Lagos Domestic Violence Law].
205. Protection Against Domestic Violence and Relation Matters Law (2005), § 5(1) (Ebonyi, Nigeria).
206. *Id.* § 3 (defining social worker as "a person trained, qualified and employed as

In Ekiti State, legislation requires a police officer who receives a complaint about gender-based violence to take (not merely refer) the victim to a medical practitioner.[207] This is different from the VAPP Act provision that requires a police officer to provide or arrange transportation for the victim to the nearest hospital or medical facility for treatment of injuries.[208] The medical practitioner is, in turn, required to help the victim "(i) [b]y screening for domestic violence; (ii) [b]y documenting abuse in the medical record; (iii) [b]y safeguarding evidence; (iv) [b]y providing counseling services; [and] (v) [b]y making referrals to appropriate social and legal services . . . ."[209] The medical practitioner is also required to provide the victim "information about the full spectrum of intervention and option[s] available," and support the woman in adopting the options best suited to the victim's particular case.[210] These duties are wider than those contained in other legislation on domestic violence in other states. The medical practitioner's screening obligation, however, does not include a reporting requirement.[211] In this respect, it is clearly left for the woman to consider, after information on options is provided, whether to proceed with these options.

It is clear, therefore, that health care providers in a few states have responsibilities to refer and, in Ekiti State, to actually deliver the victim, to a facility for medical treatment. This obligation, however, is limited to an immediate situation where the health provider is at the scene or immediately thereafter. Thus, the obligation does not extend long term—such as when a woman is already in the hospital for another procedure, say, antenatal services. Yet, in many instances, a health provider would usually not be at the scene of a rape, the scene of a FGM rite, or as these laws intend, a domestic violence situation. This raises the question: what are the wider obligations of health providers? Are there, for instance, any obligations in respect of assisting with protection orders? Are there any reporting obligations?

A health provider may have an obligation or a discretionary power to apply for a protection order on behalf of an abused woman.[212] A protection order is an order by the court prohibiting the abuser

---

such and includes a health worker, human rights personnel and officer of any group whose object includes providing support for victims of domestic violence").

207. Ekiti State Gender-Based Violence (Prohibition) Law (2011), § 8(A)(a) (Ekiti, Nigeria) [hereinafter Ekiti Gender-Based Violence Law].

208. VAPP Act, § 32(1)(c).

209. Ekiti Gender-Based Violence Law §§ 8(A)(a)(i)–(v).

210. *Id.* § 8(A)(b).

211. *Id.* § 8(A).

212. *Id.* § 12(B).

from committing any further acts of domestic violence, enlisting another to commit such acts;[213] it may contain other conditions that the court deems essential for the protection of the victim.[214] It may or may not prohibit the abuser from entering into the residence or the work place of the abused if the court considers this to be in the best interests of the abused.[215] Under the VAPP Act, Lagos' domestic violence law, and Jigawa's law, a health service provider can bring an application for a protection order for a victim of domestic violence.[216] This allows a health service provider, to intervene, where she or he has knowledge of abuse, and take concrete action that will help the victim. Further, the law in Lagos State goes on to state that the health service provider can bring such an application for a protective order, without the consent of the victim where such victim is "(a) a minor; (b) mentally retarded; (c) unconscious; (d) incapable to consent for fear of refusal; or (e) a person whom the court is satisfied [is] unable to provide the required consent."[217] Unfortunately, from my current research, it appears that health professionals, and the wider public, have a very limited knowledge of these laws and this particular legal provision, thus leaving the provision without its potentially beneficial effect.

Apart from protection orders, a health care provider may have reporting obligations under the law. Reporting requirements or obligations, generally speaking, are legal requirements mandating health care providers or other social workers to report to law enforcement authorities where they have treated injuries that result from gender-based violence, including domestic violence. In some countries, the health care provider might be required to inform women that they are obligated by law to make a report of any detected domestic abuse or other gender-based violence to the relevant authorities. In Nigeria, there are provisions extant in certain pieces of legislation requiring health care providers, such as doctors, nurses, and midwives, to report to police or other law enforcement authorities. For example, the VAPP Act allows voluntary organizations working to help victims to record a violence incident report, and forward it to the police or to the magistrate.[218] In Ekiti State, the law provides that "[a] protection officer, a social worker, or health care giver shall

213. *Id.* § 13.
214. *Id.* § 17(b)(i)–(xvii) (listing behaviors that the court may prohibit).
215. *Id.*
216. Lagos Domestic Violence Law § 2(3); Domestic Violence and Other Related Matters Law (2006), § 3 (Jigawa, Nigeria); VAPP Act, § 28(4).
217. Lagos Domestic Violence Law § 2(3)(a)–(e).
218. VAPP Act, § 40(3)(a).

lodge a complaint about any form of gender-based violence where the intervention is in the interest of the victim."[219] In essence, the health care giver is mandated to register a complaint only when she or he has judged that it is in the interest of the victim. As a result, this is not a mandatory reporting obligation but a discretionary choice or power. Arguably, this provision is reasonable given the circumstances, but it also leaves a lot of room for non-reporting for reasons that may include the health care provider's unwillingness to become entangled in a potentially messy situation. Although I am not focused here on children, I note that there is also no mandatory reporting requirement if the victim of violence—physical or sexual—is a child (including a female child),[220] a serious oversight in a country where the rate of child abuse, including gender-based child abuse, is high. In Lagos State, there are no clear reporting obligations, although it does allow the health provider to apply for a protection order for certain victims.[221]

E. Protocol of Health Care Workers

Nigerian legislation clearly avoids mandating a report and goes ahead to require the woman's consent. Codes of ethics, which usually have indirect legal force as subsidiary legislation, do not prescribe requirements for gender-based violence, nor do they contain reporting requirements.[222] Several possible reasons for a lack of mandatory reporting can be speculated upon. Reasons might include that it is traditionally not considered the place of health care workers to interfere where it is a domestic violence situation; there may be time and resource constraints on health care workers; law enforcement has not ordinarily been viewed as particularly helpful in situations of gender-based violence, including in domestic violence situation that are typically considered "private" matters; law enforcement may not have the capacity to deal with the report; things might become a lot worse for the woman should she find it necessary to return to the situation in which the abuse occurred; the woman may not want any intervention and her wishes must be respected; and confidentiality may be compromised, which may in turn limit a woman's desire to disclose abuse. It could be one or any combination of these reasons. These are all good reasons. Unfortunately, many

219. Ekiti Gender-Based Violence Law § 6(c).
220. *Id.* § 8(A).
221. *See* Lagos Domestic Violence Law, § 2(3).
222. *See, e.g.*, Code of Medical Ethics in Nigeria (2004).

women continue to suffer and are revictimized after seeing health professionals, while perpetrators go scot-free, even with the full knowledge of third parties like health care providers. Mandatory reporting thus remains a matter that should receive attention and consideration in Nigeria's context.

A great need exists to increase awareness amongst health care providers about violence against women, its impact, and measures that can and should be taken to provide support for victims and survivors. None of the extant pieces of legislation require training and capacity development in the area of violence against women for health care providers. However, support needs to be provided to health care providers to develop their capacity in this area. Such resources could include education towards becoming a health professional, training as part of continuing education and professional development, and materials and publications that can be consulted by professionals while in consultation. Such publications could include an articulation of the legal obligations of the health care providers under various laws, indicators that might suggest that a woman is living in an abusive situation, the health consequences of gender-based violence, questions that should be asked in screening, referral resources, law enforcement sources, and other relevant material.

Although not provided for in the extant legislation, the need for training health care providers has received attention in the National Reproductive Health Policy.[223] Unfortunately, training targets remain to be accomplished, with the result that many health care providers do not receive training in issues of gender-based violence and reproductive health.

Health care providers themselves can be avenues to create awareness amongst women of the health consequences of gender-based violence and the resources available to assist them. Suggestions have also been made that health care providers and health facilities can provide posters that show situations of domestic violence and provide information to create awareness.[224] These posters would indicate to a woman that she can speak up about an abusive situation, and a welcoming attitude by health care providers can help a woman begin her journey to health, freedom, and justice.

It is important, also, to note that health care providers themselves are human beings existing in the same society that victims of violence against women live in. They are subject to the societal and

223. For a discussion of the training proposed in the National Reproductive Health Policy, see *supra* notes 126, 130–34, & 140, and accompanying text.

224. Bonnie M. McClure, *Domestic Violence: The Role of the Health Care Professional*, MICH. FAM. REV., Spring 1996, at 63.

cultural biases and notions that give rise to, excuse, and promote violence against women. Many health care providers in Nigeria are themselves women, who may have personal experience of gender-based violence. Studies in other countries like South Africa have shown that nurses may experience the same or a higher level of gender-based violence as their patients,[225] and such violence may be within the health sector. In some cases, this may result in health care providers becoming abusive to their patients. What this means is that health care providers themselves, like other women, stand to benefit from any intervention in this area, including legal and policy interventions. Further, research and training programs must be targeted at health professionals to identify any peculiar issues and provide adequate responses.

F. Recommendations

As a matter of law and policy, safe, non-judgmental, confidential environments must be provided in health facilities and by health providers for women to feel safe to disclose gender-based violence. As has been suggested earlier, posters and informational material should be available in private and public facilities that detail what violence against woman is, what it may look like, and how to get help.[226] Health providers must be provided with the training they need both while undergoing professional training and continuing education after graduation with information on violence against women, how best to screen for it, and what resources are available to provide help. These suggestions are also identified in the World Health Organization's policy guidelines, which enunciate, amongst other things, the importance of training all levels of health workers to recognize when women may be at risk of domestic violence and to provide appropriate responses.[227] The guidelines also recognize that health care settings like antenatal services and HIV testing may offer potential avenues for providing assistance to survivors of violence.[228]

Amending existing law and policy to include these suggestions is recommended, in particular requiring standardized training of health care providers to ensure an understanding of the meaningful

225. Julia Kim & Mmatshilo Motsei, *"Women Enjoy Punishment:" Attitudes and Experiences of Gender-Based Violence Among PHC Nurses in Rural South Africa*, 54 SOC. SCI. & MED. 1243, 1243 (2002).

226. *See, e.g.*, Shane & Ellsberg, *supra* note 58, at 5.

227. WHO, RESPONDING TO INTIMATE PARTNER VIOLENCE, *supra* note 141, at 36.

228. *Id.*

contribution they can make to recognizing, detecting, managing, and eliminating violence against women. Provision of safe places and increasing women's awareness of the fact that they can seek help from health care providers who are themselves willing to provide that avenue of assistance must be encouraged by law and policy.

III. ACCESS TO HEALTH SERVICES

Women's access to health services is a critical component of any consideration of health law and policy in relation to violence against women. Denial of needed health care services can be considered another manifestation of gender-based violence. In many cases, perpetrators like intimate partners and abusive spouses prevent their partners from accessing health services, and limit their ability to independently determine what kind of health care services they require.[229] Often through the avenues of intimidation and threats, preventing access may take the form of ordering a pregnant woman not to attend antenatal treatment on pain of severe beating or denial of financial support. It may take the form of denying the victim of the violence access to health care services to treat injuries arising from the violence either to further punish the victim through exercising domination or to prevent others from having knowledge of the abuse. The victim may deny herself health care services out of shame. The result may be further damage to the health of the woman, or if she is pregnant, cause pregnancy complications that harm her and her baby's health.

I have addressed particular aspects of access in my analyses of other issues such as reproductive health, mental health, and the obligations of health care professionals. But a broader approach to access to health services is also necessary. Determinants of access such as affordability and availability play a significant role in the extent to which victims of gender-based violence are able to access necessary and appropriate health services. Moreover, the Nigeria Demographic and Health Survey 2013, discussed earlier, noted that women do not often seek health services in relation to gender-based violence.[230] While some victims may have difficulty trusting health care providers, or even realize that health facilities are a potential source of assistance, there are broader issues around access that transverse all matters of health in Nigeria. Can women afford to pay for health care? Does the state offer free health care services?

229. CDC, *Intimate Partner Violence: Consequences*, http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html [http://perma.cc/9UQ9-P6W4].

230. HEALTH SURVEY 2013, *supra* note 10, at 325–27.

Is there wide coverage of women in terms of health insurance in Nigeria? What are the provisions made for emergency situations?

Recently, there has been much talk about universal health coverage, defined by the World Health Organization as the goal of "ensur[ing] that all people obtain the health services they need without suffering financial hardship when paying for them."[231] This concept of universal health coverage has been adopted by the government as an important goal for Nigeria;[232] indeed, the Presidential Summit on Universal Health Coverage in 2014 affirmed health as a fundamental right of Nigerians.[233] Universal health coverage is concerned in large part with the affordability and the effects of financial hardship endured by many as they pay out of pocket for unforeseen medical services.[234] Thus, how health services are paid for is an integral part of access. In Nigeria, health care is funded by a combination of mechanisms: public financing through government budgeting, private financing through private insurance, and private financing through out-of-pocket payments.[235] Those in the formal sector often benefit from private health insurance schemes put in place by employers. Also, until very recently, the National Health Insurance Scheme has focused on the formal sector covering only a meager eight percent of the population.[236] Over seventy percent of Nigeria's 170 million people work in the formal sector and for the most part pay out of pocket for health care.[237] Many attempts are being made by the government and some development partners to change this narrative.[238] It remains to be seen how successful they will be. Presently, however, out-of-pocket expenditures remain the bulk of health care expenditures.[239] For many women who work in

231. WHO, *What is Universal Coverage?* (Dec. 2014), http://www.who.int/features/qa/universal_health_coverage/en [http://perma.cc/USN4-RDT7].

232. I am a member of the NHIS Technical Working Group for developing this initiative—Health Insurance Schemes (SHIS) in Nigeria.

233. WHO, *Presidential Summit on Universal Health Coverage Ends in Nigeria*, http://www.afro.who.int/en/nigeria/press-materials/item/6376-presidential-summit-on-universal-health-coverage-ends-in-nigeria.html [http://perma.cc/B7GH-NNL3].

234. *See* WHO, *What is Universal Coverage?*, *supra* note 231.

235. ADEDOYIN SOYIBO, NHA ESTIMATION GROUP, NATIONAL HEALTH ACCOUNTS OF NIGERIA, 1998–2002, at 28 (2005).

236. Abiodun Awosusi, Temitope Folaranmi & Robert Yates, *Nigeria's New Government and Public Financing for Universal Health Coverage*, 3 LANCET GLOBAL HEALTH 514, 514 (2015).

237. Lawumi Adekola, *Health Insurance in Nigeria*, MED. WORLD NIGERIA (Feb. 19, 2015), http://www.medicalworldnigeria.com/2015/02/health-insurance-in-nigeria-by-dr-lawumi-adekola [http://perma.cc/BT9N-V56J].

238. WHO, *Presidential Summit on Universal Health Coverage Ends in Nigeria*, *supra* note 233.

239. SOYIBO, *supra* note 235, at tbl.16 (demonstrating that household out-of-pocket expenditures make up about two-thirds of total health care expenditures in Nigeria).

the informal sector, they have to pay out of pocket for health services, including services needed for treating health issues arising from gender-based violence. Women, as acknowledged in various national policies, tend to be the poorest people in the country.[240] In domestic violence situations, women are often prevented from working; the effect is that they often have no money of their own to pay for, amongst other things, necessary health services. Further, even where health services are denoted by states as free, in practice payment is often required.[241] Issues of equity are also raised in the disparity between access to health care facilities in rural and urban areas: there are typically more health care facilities in urban than in rural areas.[242] Consequently, women largely suffer from lack of access to health services on economic grounds, which may be exacerbated if they are in rural areas. In this regard, physical inaccessibility is also a serious challenge. In many rural areas, primary health care centers may be few and far away. With limited public transportation facilities, geographical inaccessibility becomes problematic. These are obviously challenges that go beyond gender-based violence but that have a significant impact on health-seeking behavior and health outcomes of victims.

To tackle the challenge of financial constraints that limit access to health facilities and other resources, Ekiti's domestic violence prohibition provides for a fund designated specifically for victims of gender-based violence,[243] to be used (amongst other things) for the rehabilitation of victims.[244] The VAPP Act unfortunately does not provide for such a fund, although earlier versions of the Bill had included a provision for one.

Specific provisions within health legislation may also help with regard to access to medical care. The National Health Act makes certain provisions that may help to minimize lack of access, including a prohibition against requiring payment before emergency services are provided.[245] Other provisions, such as that which entitles every

240. *See, e.g.*, Oduwole Tajudeen A. & Fadeyi Abedayo O., *Gender, Economic Activities and Poverty in Nigeria*, 2 J. RES. PEACE GENDER & DEV. 106, 108–09 (2013).

241. K. T. Ijadunola, *Free Health Services in Nigeria: How Beneficial to the Poor?*, OBAFEMI AWOLOWO UNIV., http://www.oauife.edu/ng/wp-content/uploads/2013/05/Dr.-K.-T.-Ijadunola-Free-Health-Services-in-Nigeria.doc [html version at http://perma.cc/A4AH-FCSP].

242. Hodo Bassey Riman & Emmanuel Sebastian Akpan, *Healthcare Financing and Health Outcomes in Nigeria: A State Level Study Using Multivariate Analysis*, 2 INT'L. J. HUMAN. & SOC. SCI. 296, 304 (2012).

243. Ekiti Gender-Based Violence Law § 32.

244. *Id.* §§ 32–33.

245. National Health Act § 20(1) ("A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason whatsoever.").

Nigerian a minimum benefit package of care[246] will help provide universal health coverage. Again, enforcement remains fundamental. Further, efforts are currently being made to develop health insurance schemes at the state level in order to widen and deepen health insurance in Nigeria.[247] Whether these steps will be effectively implemented so that they assist women affected by gender-based violence remains to be seen.

Legal and policy requirements for the establishment of gender-based violence centers within state-run facilities where many services, including for rape, other sexual violence, and domestic violence, can be provided at government expense must be considered as one of the avenues through which the government can provide comprehensive services, including referral services, to assist victims of gender-based violence. Services provided must be guided by "principles of accessibility, confidentiality, respect and self-determination"[248] to ensure that women receive the full value of such services in a manner that will preserve fundamental human rights and guarantee a good health outcome.

CONCLUSION

This Article has identified several intersections of gender-based violence and women's health to draw out the implications that these have for health law and policy-making in Nigeria. The aim, as stated at the outset, is not only to add to the literature on violence against women in Nigeria but to draw to a crucial yet missing component in interventions for gender-based violence: the health aspects. Establishing, institutionalizing and enforcing health laws, policies, and protocols that identify, recognize, make provisions for, and establish interventions for dealing with violence against women are vital. The various aspects of health care discussed in this Article clearly underscore the need for this. Gaps and inadequacies must be addressed with respect to reproductive health laws and policies, mental health law and policy, health provider obligations, and access to health care. I have made some recommendations under each linkage examined. In addition, implementing the recent World Health Organization guidelines on responding to intimate partner violence,[249] would prove helpful in improving current health law and

246. *Id.* § 3.

247. These efforts are the responsibility of the Taskforce for the National Health Insurance Commission, of which I am a member.

248. ENIKŐ HORVÁTH ET AL., *supra* note 111, at 78.

249. WHO, RESPONDING TO INTIMATE PARTNER VIOLENCE, *supra* note 141.

policy to address issues of gender-based violence in Nigeria. These guidelines include recommendations designed to improve health professionals understand the impacts of gender-based violence, teach methods to detect violence, and use the health care setting as an opportunity to reach victims to provide assistance.[250]

Having dealt with the inadequacies of legislation and policies within the text of this Article, what remains here are concluding remarks that address broader issues of health law and policy development and implementation in Nigeria. I dwell here on the broader issue of making sure these legislation and policies that address the health linkages of violence against women actually work to serve Nigerian women. The first matter is inter-sector relationships. While the focus of this Article has been on health law and policy development and enforcement in the context of gender-based violence, it is important to emphasize the need for linking the health sector to other sectors. The suggestions made on improving our understanding of and engagement with the health intersections of violence against women will be much more effective when other sectors implicated in violence against women are developed and effectively coordinated. These include the criminal justice sector, the planning and budgeting sectors, and sectors involved in promoting gender equality. Again, it is important to reiterate that inter-sector collaboration will be effective only when the intersections of violence against women and health and different sectors are fully recognized.

A seamless and effective system could look this way: a victim of sexual violence who has injuries knows that she can access help from a health provider. The health personnel provide medical care, including post-exposure prophylaxis and counseling services by trained professionals, where necessary. Health care providers are legally mandated to refer such an issue to the police, and do so. The police then take up the matter, and expeditiously charge the matter to court. Health care providers give expert witness testimony with an informed perspective and expert technical knowledge. Judges who have been trained in matters of violence against women approach the matter with sensitivity and the required speed, guided by reformed laws. Such a coordinated system would provide fluid, effective support to the needs of women who suffer gender-based violence. Unfortunately, this is currently not the reality in Nigeria.

There must be commitment to enforce laws, implement policies, through setting practical targets and meeting them, and budgeting for these targets. These have not often been present, or when present

250. *See id*. at 16–40.

are only partially so. As has been noted elsewhere, policies and legislation are viewed largely as statements of good intent, but often without the requisite commitment.[251] Resources, in terms of funding, technical expertise, and requisite commodities, are required. Given resource constraints, effective use must be made of aid provided by development partners in terms of planning so that efforts are not duplicated. There must be proper budgeting and oversight. The VAPP Act—finally enacted after over a decade of advocacy[252]—must now be implemented.

Further, much of the existing policies discussed here are established and operate on the national level. Nigeria's federation consists of semi-autonomous states and local governments. While it is the federal government's responsibility to set policy directions in health matters through the Federal Ministry of Health, a principle that is now clearly articulated in the National Health Act, implementation often takes place at the level of states and local governments. This must be taken into account in developing policies on gender-based violence. There is a need to deepen engagement to the states and local governments on these policies, especially as they relate to violence against women. There is a need to liaise with these levels of governments to communicate the urgency of the problem and provide necessary technical and financial support, with appropriate oversight.

The epidemic of violence against women in Nigeria requires that all possible interventions be employed to prevent, mitigate and provide assistance to victims and survivors. Recognizing the health links and intersections is a crucial part of any such endeavor. The serious health consequences of violence against women require that governments, civil society organizations, academics, and health providers begin the important task of proposing, developing, advocating for, and implementing improved health law and policy pertaining to violence against women.

---

251. CHRIS ALISON, PARTNERSHIP FOR TRANSFORMING HEALTH SYSTEMS, FILLING THE GAPS IN HEALTH POLICY AND LEGISLATION 5 (2008).

252. WOMEN'S AID COLLECTIVE (WACOL), Synopsis: Violence Against Persons (Prohibition) Act, 2015, Nigeria, http://www.law.utoronto.ca/utfl_file/count/documents/reprohealth/ls_088vapp_act_2015_nigeria_synopsis.pdf [http://perma.cc/6M3S-DXPY].