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The Convention on the Elimination of All Forms of Discrimination Against Women and the Status of Implementation on the Right to Health Care in Nigeria

by Aniekwu Nkolika Ijeoma

THE CONVENTION ON the Elimination of All Forms of Discrimination against Women (CEDAW or Convention) is often described as an international bill of rights for women. As a tool for establishing and improving human rights protection, the Convention defines what constitutes discrimination against women and establishes legal obligations on States Parties to achieve their global, regional, and domestic commitments to gender equality. As an international instrument, it creates a treaty obligation on governments of States Parties to implement its provisions at a national level.

This article examines CEDAW and the status of its implementation with respect to access to health care for women in Nigeria. The first section gives a brief historical background and overview of the Convention with particular emphasis on Article 12, which specifically addresses discrimination against women in the field of health care. The second section assesses the status of women's health services in Nigeria and analyzes existing policies and legal guidelines on health related matters. It concludes that many of these policies are inconsistent with Nigeria's legal obligations under CEDAW and that certain provisions laid out in the Convention have yet to be implemented in the country. The final section details Nigeria's Reports to the CEDAW Committee and the Committee's Concluding Observations and Comments made with respect to the need for the state to fully recognize and protect women's right to health in accordance with the standards laid out by the Convention.

HISTORICAL BACKGROUND AND OVERVIEW OF CEDAW

CEDAW WAS ADOPTED on December 18, 1979, by the UN General Assembly, opened for signature on March 1, 1980, and entered into force on September 3, 1981.¹ The Convention begins with a definition of discrimination intentionally designed to prevent discrimination against women rather than sex-based discrimination generally.² It has the single paramount objective of prohibiting all forms of discrimination against women, which is defined as

Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on the basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.³

The standard of equality required by the Convention is not limited to formal equality but also provides the basis for realizing women's equal access to opportunities in their political, public, and private lives. The Convention addresses the particular disadvantages that women suffer by expanding the requirement of equal

treatment, usually measured by how men are treated, to recognize the distinctively gendered nature of discrimination against women.⁴ The Convention is therefore able to address the particular disadvantages that women suffer.

The Convention details three levels of government involvement: (1) formal recognition that all human rights and fundamental freedoms apply to women and men equally; (2) prohibition of discrimination in the enjoyment of those formally guaranteed rights and creation of equal opportunities for women to exercise all rights and freedoms; and (3) identification and elimination of gender-specific obstacles to the equal enjoyment of rights and freedoms.⁵ Because eliminating de facto discrimination is much more complex than enacting laws that recognize equal rights for all individuals,⁶ the Convention calls for special measures that are necessary to counter the history of extensive gender discrimination. Such structural measures have often been interpreted as discriminatory against men and remain controversial.

Under Article 12 of the Convention, States Parties are



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Improved adherence to CEDAW would support family planning services for Nigerian women.

required to take all appropriate measures to eliminate discrimination against women in the field of health care to ensure access to health care services.⁷ It states

(1) State Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

(2) Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.⁸

The examination of national reports submitted by States Parties pursuant to Article 18 of the Convention demonstrates that women's health is an issue that is recognized as a central concern in promoting women's well-being. For this reason the Committee on the Elimination of Discrimination Against Women determined at its 20th session to elaborate a general recommendation (No. 24) on Article 12 and to establish specific measures for eliminating discrimination against women in the area of health care. General Recommendation No. 24 affirms that access to health care, including reproductive health care, is a basic right under the Convention.

CEDAW IMPLEMENTATION IN NIGERIA AND ACCESS TO HEALTH CARE

NIGERIA'S FEDERAL GOVERNMENT ratified CEDAW in 1985 without reservation. The government signed the Optional Protocol to the Convention in 2000 and ratified it in 2004.⁹ As a State Party, Nigeria is obliged to implement the Convention by using all appropriate means to eliminate all forms of discrimination against women. Unfortunately, CEDAW does not enjoy automatic enforcement in Nigeria due to constitutional constraints. Section 12 of the Constitution of the Federal Republic of Nigeria specifically requires legislative domestication through the National Assembly of international conventions before they can be legally enforced.¹⁰ Nigeria has not passed any enabling legislation to domesticate the Convention, which has greatly hindered the observance and performance of its provisions.

With a population of approximately 132 million,¹¹ Nigeria is the tenth largest country in Africa and the most populous.¹² The country is made up of 36 states, including Abuja, the federal capital territory, and more than 780 local government councils.¹³ Maternal mortality and morbidity levels in Nigeria remain among some of the highest in the region and worldwide.¹⁴ Critical factors contributing to this situation include traditional and religious systems that support early and/or forced marriage, early and excessive child bearing, and different forms of gender based violence. Female genital mutilation, widowhood rites, and discriminatory customary practices directly and indirectly limit reproductive choices and seriously compromise women's health. Also relevant is the inadequate legal and policy framework for the protection of reproductive health and rights. For example, laws that criminalize abortion continue to constrain sexual and reproductive choices.¹⁵ The wide gap between policies and action and the absence of genuine political will remain challenges to the protection of women's health.¹⁶

Attention to women's health in Nigeria necessarily focuses on reproductive health because death, disability, and disease related to pregnancy, abortion, and childbirth remain some of the major health hazards for women. In societies where women are often still considered the property of their husbands and instruments for childbearing, unequal rights for women would appear to be sanctioned by Nigeria's customary laws. In many parts of the country, access to modern methods of family planning is often conditional upon the husband's authorization, thus denying women full and equal rights to planned parenthood.

With regard to women's health, culture, traditional beliefs and practices, and religion are factors that influence decision making. These factors also play important roles in access to health services and are cited as reasons for the non-usage of contraceptives, non-utilization of conventional health services, rigid insistence on the promotion of abstinence, and early marriage.¹⁷ In many parts of Nigeria, girl children are often withdrawn from their schools and

given out in marriage, resulting in high incidences of unsafe abortion, vesico-vaginal fistula, maternal morbidity, and mortality.¹⁸

CURRENT HEALTHCARE POLICY IN NIGERIA

Nigeria operates a three tier national health care system. Health issues falls under the concurrent legislative list of the national and state Houses of Assembly. The National Assembly has a bicameral structure consisting of the House of Representatives and the Senate. Additionally, there is a House of Assembly in each of the 36 states. Under the Constitution both the national and state Houses of Assembly have the authority to review and pass legislative bills on matters relating to health. Through these structures it is possible for various interest groups to penetrate the Assemblies and lobby for the passage of legislation of interest. All three tiers of government (fed-

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eral, state, and local) are involved in health service delivery. Primary health care is primarily the responsibility of the local government councils and communities, while the state and federal governments provide secondary and tertiary health care and facilities.

In 1988 Nigeria adopted the National Health Policy and Strategy to Achieve Health for all Nigerians (National Health Policy) with the proviso of “enabling all Nigerians to achieve productive social and economic lives.”¹⁹ The National Health Policy seeks to distribute health care and identifies health services as an

instrument for social justice and national security. In compliance with the National Health Policy, the federal government practices the primary health care (PHC) approach to facilitate access to health care. It provides for basic medical treatment (including maternal and child health care) and family planning services, which it defines to include education, counseling, provision of information on child spacing, and fertility treatment. Many government facilities, however, only distribute contraceptives and

improving living standards. The National Policy on Population states that “national family planning programmes shall make available a variety of methods of fertility to ensure free and conscious choice of all couples” but does not specify guidelines for the availability of safe contraceptives.²¹ Although there are no prohibitions on the advertising or distribution of contraceptives, the advertisement of materials concerning or relating to their use must not contravene laws prohibiting the publication or distribution of “obscene materials.” Materials that “tend to deprave and corrupt” may be deemed obscene and prohibited, thus limiting access to contraceptives.²²

In 2000 the government formulated the National Policy on Women to harmonize practices related to gender specific issues in the country.²³ The government launched a Reproductive Health Policy in 2001 and developed the National Reproductive Health Strategic Framework and Plan in 2002 to address maternal health, newborn mortality and morbidity, unwanted pregnancies, unsafe abortions, and sexually transmitted diseases.²⁴ The National Policy on Women and the Reproductive Health Policy indicate the capac-

“International human rights law establishes the minimum norms that ought to apply worldwide, and supervisory bodies such as the CEDAW Committee monitor how such global norms are implemented by States Parties to the Convention.”

antenatal classes and often do not address the need to space child bearing for reasons of personal development and health. Moreover, although family planning services are available at approximately 20-25 percent of all health facilities, there is often a shortage of contraceptives at health clinics and government hospitals.²⁰

The National Council of Health, chaired by the Minister of Health and comprised of the Minister of State for Health and all the state health commissioners is responsible for the development of national guidelines and the implementation of the National Health Policy. The federal government is largely responsible for policy guidance, planning and technical assistance, coordination of state level implementation of the National Health Policy, and establishment of health management information systems. The Ministries of Health, hospital management boards, and Local Government Areas share responsibility for health facilities and programs. Local Government Councils are directly responsible for the operation of health care facilities within their areas, including the provision of basic health services, community health, hygiene, and sanitation.

In addition to the National Health Policy, the government adopted the National Policy for Development, Unity, Progress and Self-Reliance (National Policy on Population) in 1988 to achieve the primary goals of decelerating the rate of population growth and

ity of states to mainstream issues of gender into social policies and were intended to show the Nigerian government’s commitment to promoting reproductive and sexual health and rights.

The federal government, pursuant to National AIDS and STI Control Programmes (NASCP), has specifically addressed HIV/AIDS by developing four strategic directives: prevention of HIV/AIDS infection, reduction of personal and social impact of HIV/AIDS on HIV-positive individuals and their families, reduction of the impact of HIV/AIDS on society, and the mobilization of efforts and resources to combat HIV/AIDS.²⁵ The implementation of these objectives, however, has not led to the desired goals. For example, the prevention of mother-to-child HIV/AIDS transmission has been largely unsuccessful and few women who live in urban areas have access to tertiary health facilities in cases of infection.

The fragmentation caused by the Nigerian government’s various policies — the National Health Policy, the Policy on



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Population, the Policy on Women, and NASCP — has resulted in a lack of integration of closely related health care services, considerable duplication of effort, and wasted resources. Little effort has been made to evaluate national projects and programs for overall impact and effectiveness. There is also a lack of effective monitoring mechanisms to track funds and resource allocation. This has led to the current limited understanding of the performances and impact of various programs, thereby resulting in a loss of control over program design and development.

LEGAL GUIDELINES AFFECTING HEALTHCARE IN NIGERIA

Section 17(3)(d) of the Constitution of the Federal Republic of Nigeria provides that the federal government “shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.”²⁶ This provision, however, lacks effective legal enforcement. Section 6(6) of the Constitution prevents the courts from looking into whether the fundamental objectives and

laws, up to 20,000 of Nigeria’s estimated annual maternal deaths have resulted from complications due to unsafe induced abortions.²⁹ Section 230 of the Criminal Code goes further to prohibit the supply of materials with the knowledge that they may be used unlawfully to “procure the miscarriage of a woman.” Section 233 of the Penal Code similarly states that “any person who with intent to cause a miscarriage and who undertakes any act that causes a woman’s death is subject to imprisonment for 14 years.”³⁰ These laws in particular contravene the purpose of CEDAW because they criminalize medical procedures that only women need.³¹

Despite these harmful laws, positive steps are being taken at the state level. Female genital mutilation has been outlawed in more than 25 states, including Cross River, Delta, Edo, Osun, Rivers, Bayelsa, and Ogun. More specifically, some states have enacted sexual and reproductive health related bills that aim to protect women’s sexual and reproductive health.³² A 1991 law passed in Bauchi prohibits the withdrawal of girls from school for the purpose of marriage.³³ The 1956 Age of Marriage Act sets the minimum age of marriage for both men and women at 16 years of age and is still in force in eastern Nigeria. Similarly, the states of Ogun and Ebonyi have incorporated the Child Rights Act of 2003, which sets the minimum age of marriage for both genders at 18 years of age.

The state of Edo has been particularly active in enacting laws that promote and protect women’s health. In 1999 the state House of Assembly passed the Female Circumcision and Genital Mutilation (Prohibition) Law and brought attention to the health implications of the practice. In addition, the state legislature enacted an edict against international sexual trafficking and prostitution, as well as a law for the monitoring of maternal mortality.³⁴ The legislature also raised the minimum age of marriage from 16 to 18 years of age. These enactments seem to indicate affirmative steps toward implementing those provisions of CEDAW designed to eliminate discrimination against women in access to health care.³⁵

NIGERIA’S REPORTS TO THE CEDAW COMMITTEE

ONE YEAR AFTER ITS RATIFICATION, Nigeria presented its first periodic report of CEDAW implementation to the Committee.³⁶ On July 2, 1998, the combined second and third reports were presented.³⁷ On January 20, 2004, the 23 member experts of the Committee heard Nigeria’s combined fourth and fifth reports. These reports marked the first time the government and NGOs worked together to produce the state report. In presenting the state report, which spanned 17 years (1987 to 2004), the Nigerian representatives detailed the progress the country had made in the promotion of equality between women and men.

The report detailed several laws that have been enacted by the National Assembly to address Article 12 concerns, including the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act in 2003, the Child Rights Act of 2003, the National Policy on Women in 2000, and the Reproductive Health Policy in 2002. State laws were also acknowledged, such as laws relating to widowhood practices and female genital mutilation, the prohibition of early marriage, trafficking in women and children, and the education of the girl child.³⁸ The report recognized the strong government commitment to implementing measures that eliminate all forms of discrimination against women by using the media and communications technology. The right to freedom from discrimination on the grounds of sex as contained in the Nigerian Constitution was specially noted as reflecting the com-



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A Nigerian mother and child.

directive principles of state policy have been implemented. Thus, it would appear that the provision for nondiscrimination in access to health care is not obligatory on the country’s 36 states.²⁷

Various laws directly affect Nigerian women’s health and the full enjoyment of their reproductive rights. Section 228 of the Criminal Code and Section 232 of the Penal Code prohibit abortions, regardless of the duration of the pregnancy, unless they are done “for the purpose of saving the life of the woman.”²⁸ The laws do not clearly distinguish between abortions performed by a registered medical practitioner and abortions performed by an unregistered medical practitioner, nor do they stipulate the kind of facilities in which abortions may take place. As a result of these restrictive

mitment of the country to protecting women's rights with a view to eliminating discriminatory practices.³⁹

CONCLUDING OBSERVATIONS OF THE CEDAW COMMITTEE

IN THE CEDAW COMMITTEE'S concluding comments on Nigeria's 2nd and 3rd Periodic Report, the Committee observed that notwithstanding ratification of the Convention without reservations the government did not "respect" the Convention in many regards. The Committee drew attention to "the lack of a legal and Constitutional framework to strengthen implementation of the Convention."⁴⁰ In 2004 the Committee noted that progress had been made in some areas and commended Nigeria for its combined 4th and 5th report. The Committee argued, however, that non-domestication of CEDAW reflected the non-primacy of the Convention over domestic law in Nigeria. The Committee also brought attention to Nigeria's slow pace of legislative reform to bring its laws into conformity with the provisions of the Convention; the persistence and social acceptability of harmful traditional practices; the continued prevalence of violence against women and girls including domestic violence; and the existence of restrictive criminal abortion laws.

The Committee recognized state efforts to combat trafficking in women by the adoption of the Trafficking in Persons (Prohibition) Law Enforcement and Administration Act 2003, but it expressed concern about the extent of this problem in Nigeria, the precarious situation of women's health, and inadequate health care facilities. The Committee also urged Nigeria to recognize that gender based violence constitutes a violation of the human rights of women under both CEDAW and General Recommendation No. 19, the latter of which was issued in 1992 and which defines discrimination in Article 1 to include gender-based violence, i.e., "violence that is directed against a woman because she is a woman or that affects women disproportionately." According to the Committee, Nigeria should take proactive and innovative measures to ensure that any conflict of law with regard to women's rights to equality and non-discrimination are resolved in full compliance with the provisions of the Convention and General Recommendation No. 21 on equality in marriage and family relations.

In summary the Committee noted the "patriarchal nature of the Nigerian society and the predominance of cultural stereotypes that were prejudicial to women which perpetuated a negative image of women and represented a real obstacle to implementation of the Convention. The coexistence of three systems: Islamic, civil and traditional, made it difficult to adopt laws which genuinely protected women's rights."⁴¹ The Committee also noted that a lack of awareness of human rights, fear to exercise rights and inadequate technical, and other resources were contributing factors to a lack of implementation in the country.⁴²

CONCLUSION

INTERNATIONAL HUMAN RIGHTS LAW establishes the minimum norms that ought to apply worldwide, and supervisory bodies such as the CEDAW Committee monitor how such global norms are implemented by States Parties to the Convention.⁴³ Governments therefore ought to incorporate universal human rights norms into their own rules of conduct. The core obligation is to adopt human rights norms as part of domestic law and apply them in policy and practice. Securing equal rights for women thus entails a wide range of obligations for public authorities, which reach far beyond a legal prohibition of discrimination.⁴⁴

In Nigeria the major challenge to the implementation of CEDAW lies in the Convention's continued non-domestication in Nigerian law and the country's fragmented, piecemeal approach in meeting its obligations to women's health care needs. Nigeria is a signatory to international human rights instruments that affirm the enhancement of health and rights; however, it has created an array of national policies that do not actively implement international standards on women's health. With the exception of some states, very little federal legislative action has been taken to protect women from harmful traditional practices that directly affect their sexual and reproductive health.⁴⁵ Further, the policy documents on reproductive health and rights serve merely as administrative guidelines and reflect a lack of serious political commitment to women's health in Nigeria. The result is a legal framework that remains incoherent and weak.

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ENDNOTES: CEDAW and the Status of Implementation on the Right to Health in Nigeria

¹ Convention on the Elimination of All Forms of Discrimination against Women, art. 1, *opened for signature* Dec. 18, 1979, *available at* <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm> (accessed Mar. 4, 2006) [hereinafter CEDAW].

² *Id.* at art. 1.

³ *Id.*

⁴ United Nations, *1989 World Survey on the Role of Women in Development*, U.N. Doc. ST/CSDHA/6, 7 (1989). *See also* *Women in a Changing Global Economy: 1994 Survey on the Role of Women in Development*, 3 (1995).

⁵ Katarina Tomasevski, *A handbook on CEDAW* (Sida June 2002).

⁶ Radhika Coomaraswamy, Commission on Human Rights, *Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences*, U.N. Doc. E/CN.4/1995/42, ¶ 51 (Nov. 22, 1994).

⁷ *Report of the Committee on the Elimination of Discrimination against Women*, 15th Sess., U.N. Doc. A/51/38, ¶ 286 (1996).

⁸ CEDAW at art. 12.

⁹ Division for the Advancement of Women, Department of Economic and Social Affairs, *Signatures and Accessions/Ratifications to the Optional Protocol*,

<http://www.un.org/womenwatch/daw/cedaw/protocol/sigop.htm> (last updated Mar. 15, 2006).

¹⁰ Constitution of the Federal Republic of Nigeria 1999, section 12, *available at* http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.htm#Powers_of_Federal_Republic_of_Nigeria (accessed Apr. 10, 2006).

¹¹ This is the July 2006 estimated population. CIA, *The World Factbook*, "Nigeria," <http://www.cia.gov/cia/publications/factbook/geos/ni.html> (last updated Jan. 10, 2006).

¹² United Nations, *Technical Cooperation*, "Demographic and health data collection in Nigeria," <http://esa.un.org/techcoop/flagship.asp?Code=NIR98P40> (accessed Apr. 10, 2006).

¹³ Motherland Nigeria, "Geography," <http://www.motherlandnigeria.com/geography.html> (accessed Apr. 10, 2006).

¹⁴ *See generally* UNFPA, *State of the World Population 2005*, "Reproductive Health Fact Sheet," http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm (accessed Apr. 4, 2006). It is estimated that one in 48 women in developing countries and one in 16 women in Africa are at risk of dying from pregnancy and childbirth. Safe Motherhood Initiative, "Maternal Mortality,"

http://www.safemotherhood.org/facts_and_figures/maternal_mortality.htm (2002). The maternal mortality rate in Nigeria was approximately 800 per 100,000 births in 2000, which is one of the highest figures in the world. World Health Organization, *Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, UNFPA* (World Health Organization 2004), available at http://www.who.int/reproductive-health/publications/maternal_mortality_2000/mme.pdf (accessed Apr. 4, 2006).

¹⁵ See Criminal Code, Laws of the Federation of Nigeria 2004, § 228; Penal Code, Laws of the Federation of Nigeria 2004, § 232.

¹⁶ Aniekwu Nkolika Ijeoma and Olowu F., World Bank Institute Program on MDGS and Reproductive Health, Special Publication of the Nigerian Network on Poverty Reduction, *The Legal Framework and Policy Environment for Health Sector Reform in Nigeria* (Apr. 2004).

¹⁷ Women's Health and Action Research Center in Benin City, Nigeria, *Strategic Plan 2005-2009*, 11.

¹⁸ On a positive note, a large number of policies have been adopted to support the implementation of various health programs. Some examples are the National Population Policy for Sustainable Development 1988 (revised in 2003), the National Reproductive Health Policy and Strategic Framework, the National Policy on HIV/AIDS, the National Youth Policy, the National Adolescent Reproductive Health Policy, the HIV Emergency Action Plan, the National Policy on VVF, the National Economic Empowerment and Development Strategy (NEEDS), and the anticipated State Economic Empowerment Development Scheme (SEEDS).

¹⁹ Federal Ministry of Health, *National Policy*.

²⁰ Helen Chapin Metz, ed., Library of Congress, Federal Research Division, *Nigeria: A Country Study* (1992).

²¹ Federal Ministry of Health, *National Policy*.

²² Criminal Code (Amendment) Law, Edo State (2000).

²³ Section 6.2.7 of the National Policy on Women calls for "action to discourage or forbid withdrawal of girls under eighteen from schools for marriage through legal sanctions."

²⁴ POLICY Project, *Youth Reproductive Health Policy Country Brief Series No. 2*, "Nigeria: Advocacy and Strategic Planning for Youth Reproductive Health in Edo State," available at http://www.policyproject.com/pubs/YRHCBS/Nig_YRH.pdf (Oct. 2004). The Reproductive Health Policy and the National Reproductive Health Strategic Framework and Plan are set within the framework of the National Health Policy. They recognize that the implementation of reproductive health should be in the context of Primary Health Care as stated in the program of action of the International Conference on Population and Development 1994.

²⁵ Women's Aid Collective (WACOL), *Status of CEDAW Implementation in Nigeria: A Shadow Report*, 28 (2004).

²⁶ Constitution of the Federal Republic of Nigeria 1999 at section 17(3)(d).

²⁷ *Id.*

²⁸ "Any person who, with intent to procure miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony, and is liable to imprisonment for fourteen years." Criminal Code at § 228, available at <http://annualreview.law.harvard.edu/population/abortion/NIGERIA.abo.htm> (accessed Apr. 10, 2006). "Whoever voluntarily causes a woman with child to miscarry shall, if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment for a term which may extend to fourteen years or with fine or with both." Penal Code at § 232, available at <http://annualreview.law.harvard.edu/population/abortion/NIGERIA.abo.htm>

(accessed Apr. 10, 2006). These laws are in direct contrast with Article 12 and General Recommendation 24 of CEDAW because they criminalize medical procedures that only women need.

²⁹ Population Council Report, *Prevention of Morbidity and Mortality for Unsafe Abortion in Nigeria* (Population Council 1991).

³⁰ Criminal Code at § 228; Penal Code at § 232.

³¹ Penal Code, Laws of the Federation of Nigeria, CAP 84 (1990).

³² Examples of state laws on health related issues are the Enugu state law on Prohibition of Infringement of a Widow's and Widower's Fundamental Human Rights Law (Mar. 8, 2001); the Edo state law on Female Genital Mutilation (2000); the Rivers state law on Reproductive health; and the Cross River state law on Early or Forced Marriage. Other states such as Benue, Cross River, Delta, Ogun, and Bayelsa have similar legislation. These laws criminalize unsafe practices like female genital mutilation, widowhood rites, early or forced marriage, and sexual trafficking, and stipulate fines and sanctions for offenders. It is important to note the poor enforcement of most laws and the persistence of unsafe practices that are directly detrimental to women's health.

³³ Prohibition of Withdrawal of Girls from School for Marriage law, Bauchi State (1991).

³⁴ Criminal Code (Amendment law) Edo State (2000); Edo State Maternal Mortality Monitoring Law (2001).

³⁵ NGO partnerships and collaborations in service delivery are also gaining ground. The integration of post-abortion care (PAC) services into health services (public and private), the training of service providers in PAC, and the introduction of providers to the use of manual vacuum aspiration are recent advances by a few NGOs in health care delivery.

³⁶ CEDAW, *General Recommendation No. 24 on Women and Health*, ¶ 29, U.N. Doc. A/54/38, (Feb. 2, 1999).

³⁷ *Concluding Comment of the CEDAW Committee on Nigeria*, 396th and 397th Meetings, CEDAW/C/NGA/2-3, (July 2, 1998). See also Nigerian NGO Coalition, *NGOs CEDAW Report For Nigeria* (1999).

³⁸ Enugu state law on Prohibition of Infringement of a Widow's and Widower's Fundamental Human Rights Law (Mar. 8, 2001); Edo state law on Female Genital Mutilation (2000); Rivers state law on Reproductive health; Cross River state law on Early or Forced Marriage.

³⁹ *Concluding Comment*, CEDAW/C/NGA/4-5.

⁴⁰ *Concluding Comment*, CEDAW/C/NGA/2-3.

⁴¹ *Concluding Comment*, CEDAW/C/NGA/4-5.

⁴² *Id.*

⁴³ United Nations, *Multilateral Treaties Deposited with the Secretary-General*, Status as of Dec. 31, 1995, 685-690, U.N. Doc. ST/LEG/SER.E/14 (1996).

⁴⁴ *Report of the Committee on the Elimination of Discrimination against Women*, 11th Sess., ¶ 412, U.N. Doc. A/47/38 (June 24, 1992). See also Halima Embarek Warzazi, Sub-Commission on Prevention of Discrimination and Protection of Minorities, *Final report of the Special Rapporteur on traditional practices affecting the health of women and children*, ¶ 72, U.N. Doc. E/CN.4/SUB.2/1996/6 (June 14, 1996).

⁴⁵ Enugu state law on Prohibition of Infringement of a Widow's and Widower's Fundamental Human Rights Law (Mar. 8, 2001); Edo state law on Female Genital Mutilation (2000); Rivers state law on Reproductive health; Cross River state law on Early or Forced Marriage.