CENTER FOR REPRODUCTIVE RIGHTS

AND DOCUMENTATION CENTRE

September 28, 2016

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information on Nigeria Scheduled for Review during the Pre-Session Working Group of the 67th Session of the CEDAW Committee

Honorable Committee Members:

This letter is intended to supplement the combined seventh and eighth periodic report of the government of Nigeria, which is scheduled to be reviewed by this Committee during its pre-sessional working group of the 67th Session. The Center for Reproductive Rights (the Center), a global advocacy organization and Women Advocates Research and Documentation Center (WARDC), a national non-governmental organization based in Nigeria, hope to further the work of the Committee by providing independent information on Nigeria concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[1]

This letter highlights the following issues of concern regarding the sexual and reproductive rights of Nigerian women and adolescent girls: high maternal mortality and lack of access to maternal health care services; lack of access to family planning information and services; high rate of unsafe abortion and lack of post-abortion care; sexual and physical violence against women and girls; child marriage; and lack of access to sexual and reproductive health services in conflict areas.

I. LACK OF ACCESS TO MATERNAL HEALTH CARE SERVICES

This Committee and other treaty monitoring bodies have framed the issue of maternal mortality as a violation of women's and girls' right to health and life.[2] Particularly, this Committee has confirmed that ensuring equality of health results, including by lowering the maternal mortality rate, is an important indicator of a state's success in overcoming rights violations.[3] Particularly on Nigeria, this Committee has repeatedly drawn attention to the high incidence of maternal death in the country[4] and has urged the government to address the issue, as a matter of priority, including through the allocation of "adequate resources to increase women's access to affordable health services, particularly pre-natal, post-natal, and obstetric services, as well as other medical and emergency assistance provided by trained personnel, particularly in rural areas."[5] During the 2013 Universal Periodic Review (UPR), it was again recommended that Nigeria implement measures to reduce the high maternal mortality rate.[6] Similarly, in 2015, the African Commission on Human and Peoples' Rights (African Commission) condemned the country's high rate of maternal mortality[7] and urged the state to strengthen ongoing initiatives to reduce the high rate of maternal mortality by "eliminating all barriers to maternal health services in the country, increasing budgetary allocation to the health sector in line with the Abuja Declaration, and promoting human rights-based private-sector investment in the health sector."[8]

However, while the government, in its current report to the Committee has acknowledged the high maternal mortality as a "key challenge,"[9] and has highlighted several measures it has undertaken to address the issue, including free maternal health services for pregnant women; the mobilization and deployment of midwives to increase skilled birth attendance; and the construction of facilities specifically equipped to treat obstetric fistula,[10]evidence shows that these efforts have been ineffective in improving maternal health care. For instance, Midwives Services Scheme (MSS), which was launched in December 2009 to mobilize midwives in rural communities, has faced challenges with navigating between federal, state and local authorities, insufficient government commitment and maintaining qualified personnel.[11] Recent reports indicate that, in many states, midwives go many months without receiving their salaries and allowances and have to work in conditions where basic facilities such as electricity and water are not available.[12] As a result, the maternal mortality rate remains exceedingly high, and obstacles to accessing maternal health services persist.

In 2015, the World Health Organization (WHO) identified Nigeria as having the world's fourth-highest maternal mortality rate.[13] According to the report, there are 814 deaths for every 100,000 live births,[14] a figure which has hardly changed since 2008, when Nigeria had 829 deaths for 100,000 live births.[15] This is approximately 58,000 maternal deaths annually,[16] indicating that approximately 159 women die every day due to pregnancy related complications. Although Nigeria makes up just over 2% of the world's population, it accounts for approximately 19% of the world's maternal deaths.[17] However, the government, in its Millennium Development Goal End-Point Report indicated that the maternal mortality ratio was 243 per 100,000 live births in 2014 and claimed that the country had achieved the Millennium Development Goal of reducing the maternal mortality ratio by three-quarters between 1990 and 2015.[18] However, this is contrary to the findings of the WHO report which indicated that Nigeria had failed to meet the goal.[19] As such, if Nigeria is to achieve the Sustainable Development Goals target of reducing the global maternal mortality ratio by 2030 to less than 70 for 100,000 live births,[20] it must significantly increase its efforts.

Antenatal, delivery and postnatal care

While ensuring access to antenatal, delivery and postnatal care is crucial in reducing the high maternal mortality, Nigerian women and adolescent girls often have limited access to such services. According to the 2013 Nigeria Demographic and Health Survey (2013 NDHS) one-third of women do not attend antenatal care, putting them at a heightened risk of maternal mortality.[21] While 61% of women received ANC from a skilled provider, only 51% had attended four antenatal visits as recommended by the WHO.[22] The number of women attending antenatal care has shown a mere 3% increase from the 2008 rate when 58% of women received ANC from a skilled provider.[23] Further, there is disparity in access based on women's geographical location: 75% of those living in urban areas had the WHO-recommended number of visits as compared to only 38% of those living in rural areas.[24] Forty-seven percent of rural women age 15-49 did not receive any antenatal care while 86% of urban women were able to access to service.[25]

Increasing the percentage of births delivered in health facilities and increasing assistance during childbirth can help reduce deaths arising from complications of pregnancy.[26] However, in Nigeria, between 2008 and 2013, the number of deliveries in a health facility increased just slightly from 35% to 36%.[27] Seventy-seven percent of women in rural areas give birth at home, as compared with 37% of their urban counterparts.[28] Moreover, only 6% of women in the lowest wealth quintile deliver in health facilities, as compared to 80% of births among women in the

highest wealth quintile.[29] In 2015, the Nigerian National Strategic Framework for Fistula Prevention and Control estimated that anywhere between 400,000 and 800,000 women had obstetric fistula, the result of prolonged labor without prompt medical intervention.[30] Almost 50% of the fistula cases in the world occur in Nigeria, with between 50,000 to 100,000 new cases each year.[31] The indirect cause for most of these cases is early marriage,[32] which as discussed below, is highly prevalent in Nigeria.

In addition, the survival and well-being of a woman depends substantially on the care received during the postnatal period, as a large number of maternal deaths occur during the first 24 hours after delivery.[33] It is estimated that two-third of deaths resulting from complications from pregnancy and childbirth occur in the postnatal period, which includes the six weeks following delivery.[34] The WHO recommends that women have four postnatal checkups: one within the first twenty-four hours, another three days after delivery, the third between one to two weeks after delivery, and a fourth checkup six weeks after delivery.[35] However, the 2013 NDHS showed that 58% of women in Nigeria did not attend any postnatal checkup.[36] Only 36% of women had a postnatal checkup within the first twenty-four hours of delivery, and only 6% had a checkup between one and forty-one days after childbirth.[37] Further, there is disparity in access based on geographical location: 69% of rural women received no postnatal care while the rate is 38% for women living in urban areas.[38] Eighty-two percent of women living in the North West of the country, one of the lowest-income regions in Nigeria,[39] had no postnatal checkup.[40]

Barriers to access to maternal health care

Aside the effect of poverty on the health-seeking behavior of much of the population, delayed access in emergency obstetric care in many health facilities accounts for a great percentage of maternal deaths in Nigeria. The low antenatal, delivery and postnatal care attendance rate is indicative of the numerous barriers women and adolescent girls encounter in accessing the services. A 2008 fact-finding report published by the Center and WARDC documented the financial, infrastructural, and institutional obstacles that prevent Nigerian women's access to maternal healthcare needed to prevent maternal deaths. [41] One such barrier is a compulsory spousal blood donation requirement—the widespread practice of requiring spouses to donate blood or pay a fee in lieu before a woman can access antenatal care.[42] Despite the Nigerian law that blood donation be voluntary, many public health care facilities require husbands of antenatal patients to donate blood.[43] Compulsory spousal blood donation can have multiple negative consequences, including discriminatory impacts on pregnant women who are unable or unwilling to compel their husbands to donate blood.[44] Husbands may refuse to permit their wives to access antenatal, intra-partum, and postnatal services and can potential expose women to domestic violence if they attempt to compel their husbands to donate blood.[45] The blood-donation requirement also disadvantages pregnant women who are unmarried, including those who may have become pregnant due to sexual violence, or whose husbands become ill, abandon them, or pass away during the course of the pregnancy.[46]

For example, in 2012 Queeneth was denied ANC at the Igando General Hospital, a public hospital in Lagos State, where hospital management insisted that she bring her husband to donate blood as a pre-condition for receiving ANC.[47] When she was seven-months pregnant, Queeneth had quarreled with her husband, who severely beat her, stripped her naked, and threw her out of the house; she could not ask her husband or another close male relative to donate blood on her behalf. Maureen, a student who became pregnant in 2010 at age 16, was abandoned by her boyfriend and subsequently denied ANC at the General Hospital in Gbagada, Lagos State,

although she had a higher risk of pregnancy-related complications due to her age and did not have the means to pay a fee in lieu of blood donations, even if it had been an option. The discriminatory impact of the fee on poor and single women includes diminished access to reproductive health services, inferior care, and worse health outcomes.[48] In a 2013 article, women recounted that their spouses had to donate one pint of blood or pay up to N6,000 before the women could register for ANC with Ayinke House, a maternity government hospital in Lagos State.[49] Another article from 2013 reported that the Mother and Child Centre of the Ifako Ijaiye General Hospital in Lagos State required women to fulfil a mandatory spousal blood donation before being eligible to register for ANC.[50]

Another major obstacle Nigerian women who attempt to access maternal health facilities is the cost of services. As of 2013, the National Health Insurance Scheme (NHIS) covered only around 3% of the entire population,[51] indicating that majority of women in Nigeria have to pay user fees in order to receive maternal health care. In 2013, the government of Nigeria launched the Maternal and Child Health Initiative—Conditional Cash Transfer (CCT) program, which aimed to provide up to N5,000, or approximately $30 USD, to women who access maternal health services.[52] However, lack of financial means continue to be a barrier to women's access. When unable to pay the hospital fees, many women are detained in health care facilities without due process and refused medical treatment, often leading to grave consequences to their life and health, which can discourage others from seeking skilled maternal care to avoid detention.[53]

The recent case of Folake Oduyoye, which was filed in the Federal High Court of Nigeria by the WARDC and the Center, is illustrative of the systematic failures of the government to ensure access to maternal healthcare. In 2014 Oduyoye was referred and admitted to the Lagos University Teaching Hospital for complications that arose after she gave birth through a caesarean operation at the Midas Touch private clinic in Lagos.[54] She was treated successfully and discharged, but subsequently detained without due process when her family was unable to pay the medical bill in full.[55] Despite her husband's numerous pleas and attempt to partially pay the hospital fees, she was detained for six weeks in a heavily guarded ward that lacked a toilet, electricity, or mosquito netting. She was denied medical treatment when she started having serious health complications.[56] As a result, she died from puerperal sepsis and pneumonia before she could be released.[57] The Center and WARDC have filed a case before the Federal High Court of Nigeria, seeking the government accountability for failure to ensure Oduyoye's access to maternal health services. Particularly, the case is seeking financial reparations, a public apology, and a declaration that the detention of Oduyoye was illegal, unconstitutional, and in violation of her rights to life, health, liberty, freedom from arbitrary detention, non-discrimination, dignity, and freedom from cruel, inhuman and degrading treatment.[58]

The detention of women who cannot pay their medical bills is widespread. For example, in a study of 446 women who had given birth at Enugu State University Teaching Hospital in 2012, 98 reported having been detained because they could not pay their medical bills.[59] Women like the 23-year-old Amarachi Amadi, who as of July 2016 had been stuck with her child in a hospital in Abia State for four months with no foreseeable way to pay her bills, are known as Awaiting Bill Settlement patients.[60] They must look after themselves and their new-borns while they are prohibited from leaving the hospital until they settle their bills; while some married women can rely on their husbands to bring them food, single mothers may receive no outside support.[61] In some instances the health facilities release the women but detain their babies for lack of

payment. The women then have to come every day to breastfeed and take care of their new born until they are able to settle the bills.

However, in 2012, Nigeria spent only 6.5% of its annual budget on health which means that individual households had to cover 75 percent of health costs.[62] This rate has not shown much improvement: in 2016, Nigeria only dedicated 8.2% of its total budget to health[63] and in 2015, 69% of health costs were covered by individual households.[64] Although an examination of the government's budget for 2014 and 2015 show an increase in projected spending on maternal for Nigeria,[65] reports demonstrate that in 2015, the Nigerian government dramatically cut spending on women's health. In 2015 the National Primary Healthcare Development Agency faced cuts in allocations for maternal, newborn, and child health by up to 42% compared to its 2014 provisions.[66] NHIS allocations for maternal and child health insurance were cut by 77%.[67] The Federal Ministry of Health allocations for maternal, newborn, and child health was cut by 37%, with no funds allocated to antenatal care, newborn care, nutrition, or fistula repair services in 2015.[68] In addition, in 2012, the government launched the Saving One Million Lives program to scale up access to essential primary health services and supplies for maternal and child health in order to save one million lives by 2015.[69] The initiative aimed to deliver an "integrated package of interventions at thousands of primary health care clinics with referral links, including access to a skilled healthcare provider."[70] However, the government has not released data indicating whether or not this program has been successful or describing any challenges to implementation. While the government received a $500 million USD grant from the World Bank in 2015 to continue the initiative until 2019,[71] as of 2016 there had been no disbursements of funds "due to the novelty of the program for results approach in Nigeria, the delay in appointing a cabinet, and difficult budget discussions that have distracted attention from other priorities."[72]

Another key structural issue that contributes to the high rate of maternal mortality and the limited access to ANC and PNC is the division of health-care responsibilities among the three tiers of government: federal, state, and local. The Center's 2008 report on maternal death drew attention to this structural problem,[73] which according to recent reports continues to pose obstacles to women's accessing maternal health care. The Federal Government provides the overall policy framework and set standards for quality assurance and training.[74] The States handle the policy-making process and personnel financing as well as provide capital investment for tertiary and secondary facilities within their jurisdictions.[75] Primary health care facilities are managed by the local government.[76] Coordination and close collaboration between the various tiers and function are often lacking, which results in a poor and disorganized health care system.[77] The three tiers of government must harmonize their health care priorities and agendas in order to ensure increased health care access for women.

II. LACK OF ACCESS TO CONTRACEPTION AND FAMILY PLANNING SERVICES

In 2004, the Committee urged the Nigerian government to "increase women's and adolescent girls' access to affordable health-care services, including reproductive health care, and to increase access to affordable means of family planning for women and men."[78] Again, at the conclusion of its 2008 review, this Committee drew attention to the low rates of contraceptive usage as a significant factor leading to unwanted and unplanned pregnancies in Nigeria and called upon Nigeria to improve the availability and affordability of family planning information and services, as well as to adopt "measures to increase knowledge of, and access to, affordable contraceptive methods so that women and men can make informed choices about the number and spacing of children."[79] In 2015, the African Commission also urged Nigeria to take steps to

improve access to contraceptives and family planning options.[80] However, while in its current report, the government acknowledged the extremely low rate of contraceptive use in Nigeria, it did not highlight any efforts made to improve the situation.[81]

Lack of access to contraception remains pervasive, demonstrating that the government continues to fail in its obligations. The vast majority of women in Nigeria do not use any form of contraception. The use of any family planning method among currently married women increased only moderately between 2003 and 2013, from 13% to 15%.[82] Only 11% of women use a modern contraceptive method. This figure represents a very small improvement from the 2003 rate of 9%.[83] This low contraceptive usage is the leading contributory factor to high unwanted and unplanned pregnancy in Nigeria.[84] The most recent data available shows that in 2012 roughly one quarter of Nigeria's 9.2 million pregnancies were unintended.[85] More than 60% of women with unplanned pregnancies did not use contraception.[86] Surveys showed that in 2013 16% of married women had an unmet need for family planning, meaning they wished to space their next birth or stop bearing children but did not use contraception.[87] According to the 2013 NDHS, unmet need was higher, at 19%, among women with only primary education.[88] Nigerian women have on average one child more than the number they want, meaning that the total fertility rate is 15% higher than it would be if all unwanted births were avoided.[89]

Moreover, significant evidence exists of disparities in access to contraceptives based on levels of wealth, education, and geographical location. Low income women, women with low educational level, and those residing in rural areas have limited access contraceptives, which demonstrates the government's failure to ensure access to contraceptives for all in a non-discriminatory manner. Contraceptive use is as low as 3% among married women in the North East of the country,[90] a low-income region in a state of humanitarian crisis due to the conflict since 2009,[91] and as low as 1% in six states in the North West,[92] another low-income region.[93] The use of any family planning method increases with educational attainment. Contraceptive use is only 3% among women with no education compared to 37% among women who have more than a secondary education.[94] In rural areas, only 9% of women use any family planning method and 6% use a modern method, as compared with 27% of women in urban areas who use any method and 17% who use a modern method.[95] The discrepancies between rates of contraceptive use in urban and rural areas are contrary to the obligations in Article 14 of CEDAW, which requires States to ensure that women in rural areas have access to adequate health care facilities, including information, counseling, and services in family planning.[96]

Barriers to access to contraceptive information and services

The low contraceptive use and the high level of unmet demand is indicative of the number of barriers Nigerian women and adolescent girls encounter in accessing these services. For instance, family planning outreach programs are not reaching the vast majority of women in Nigeria. A study of almost three-thousand women who sought abortions at eighteen urban and fourteen rural private hospitals and clinics in Ogun State revealed that 70% had not used contraception because of fear of side effects and lack of adequate information or misinformation about contraception.[97] The 2013 NDHS found that over 90% of women who do not use any form of contraception had never discussed family planning with a fieldworker or a staff member at a health facility.[98] These women represent a significant population which family planning programs are not reaching.[99] A separate study of 407 health care providers at clinics and hospitals in Kaduna and Abuja States, in Northern West and Central Nigeria, found that only 31% had been trained in family planning counseling.[100]

Lack of stable and constant supply of all family planning methods throughout the country is also an impediment to access. Clinics report difficulty maintaining supplies of the preferred forms of contraceptives.[101] Clinic in rural areas, where women have to travel great distances to the nearest health care facility, report shortages of the contraceptive injection, the most preferred contraceptive method as its effects last for several months.[102] Health workers in the villages of Jigawa have reported shortages of the injection due to medical suppliers' own deficiency and lack of trained staff administrators.[103] In a study published in 2013, respondents from rural areas reported having to travel 20 to 50 kilometers to obtain certain contraceptive methods such as the pill.[104]

Studies have also demonstrated a connection between women's empowerment and use of contraception. In Nigeria, decisions around family size and fertility fall outside a women's domain and are made by husbands,[105] and the majority of women play no part in decisions regarding their health.[106] Measures to improve women's empowerment, especially with reference to their own health, would increase women's uptake of contraception.[107]

Low contraceptive use and the resulting prevalence of unplanned and unwanted pregnancies increases the likelihood of exposure to unsafe abortion and the risk of maternal mortality and morbidity.[108] Despite commitments by the government of Nigeria to increase family planning services, the federal health budget showed that in 2014 the government spent just over N11 per capita on family planning, as opposed to the recommended per capita spending of N750.[109] Spending on family planning, which was less than 1% of the total health budget, dropped by N96 million between 2013 and 2014.[110] Although Nigeria's Family Planning Blueprint costed plan indicates that USD 21M and USD 28.1 was needed in 2014 and 2015, respectively, to meet the contraceptive need, only 0.01% of this budget was allocated in those years, making the country heavily dependent on aid to fill the funding gap.[111] In addition, even when the federal government does provide contraceptives at no cost, state governments, which are responsible for getting the products to the clinics, pharmacies, and other health facilities where women can access them, have not dedicated funds to transport the contraceptives to those points of access.[112] Various studies have also shown that to increase access to contraception, cost barriers must be removed so that contraception is available to women in all levels of society.[113]

Emergency contraception

Emergency contraception (EC) is an essential tool to prevent unwanted and unplanned pregnancy and is a critical component of care for survivors of sexual violence. In Nigeria, although EC is not included in the Essential Medicine List, the National Family Planning/Reproductive Health Service Protocol provides guidance on the use of the method. [114] Further, while EC is available over the counter, the method is not available in majority of public facilities.[115]

Many women also have no knowledge of emergency contraception (EC). According to the 2013 NDHS, only 56% of sexually active unmarried women and 30% of all women know about EC.[116] A study of female undergraduates at a private university in Southwest Nigeria revealed that although 61% of the students were aware of EC, 20% had erroneously used certain medications as EC, and only 20% knew the correct timing of EC usage.[117] A study of health care providers in Kaduna and Abuja States found that while 57% of the providers had been trained in EC counseling, only 12% were considered to have comprehensive EC knowledge.[118] Only three-quarters of the providers could correctly describe how EC works, and only 29% of providers knew that all women are eligible for EC.[119] Most of the providers acquired knowledge about EC

from brochures and other forms of information provided by EC marketing representatives and not from the government.[120]

III. HIGH RATE OF UNSAFE ABORTION AND LACK OF POST-ABORTION CARE

This Committee has repeatedly expressed concern regarding the high rate of unsafe abortion and resulting maternal mortality and has recommended that the State implement measures to address the issue.[121] Particularly, during its most recent review of the country, the Committee called upon Nigeria to reform or modify its abortion laws and to assess their impact on the maternal mortality rate.[122] However, Nigeria did not mention any progress made with respect to abortion law reform in its current report to the Committee.[123]

The laws on abortion in Nigeria remain very restrictive, permitting abortion only to save a pregnant woman's life.[124] Outside of this narrow exception, women who procure an abortion, persons who aid an abortion, and persons who supply any material used to procure an abortion are subject to up to fourteen years imprisonment.[125] The Nigerian federal abortion laws do not provide exceptions for when the pregnancy resulted from rape, incest, or when the pregnancy threatens the women's health.[126] In 2013, when Imo State passed a law permitting abortion in cases of rape, incest, or mental or physical health consequences, the state assembly repealed the law in face of intense opposition.[127] By failing to revise its laws on abortion, the Nigerian government is failing in its obligations under the Protocol of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which it has ratified without reservations, to ensure women's access to abortion in cases of sexual assault, rape, incest, severe fetal anomaly, and where the continued pregnancy endangers the mental or physical health or life of the pregnant woman.[128]

According to the latest available study, in 2012 alone, in Nigeria, 1.25 million induced abortions occurred, which amounts to 33 abortions per 1,000 women aged 15–49.[129] It is estimated that most, and at least over half a million of those abortions were unsafe.[130] Another study estimates that one in seven Nigerian women aged 15 to 49 have tried to obtain an unsafe abortion, either from "unqualified practitioners or qualified ones working under substandard medical conditions."[131] Fifty-six percent of unintended pregnancies ended in abortion,[132] amounting to 14% of all pregnancies in Nigeria.[133] There is a direct link between the low rate of contraceptive use in Nigeria and the high rate of abortions. Sixteen percent of pregnancies ended in induced abortion in the North East zone, where women have the country's lowest rate of any method of contraceptive use at only 3%.[134] A 2012 study from Ogun State in Western Nigeria showed that of 2,934 women seeking an abortion, 78.5% of the pregnancies were associated with non-contraceptive use.[135] Many adolescents rely on abortion due to different misconceptions regarding the side effects of contraceptives, including fear of future infertility, , while abortion is regarded as an immediate solution.[136] To reduce the rate of unsafe abortion, the government must take steps to provide more information on contraceptive use as well as to correct myths and misconceptions about family planning methods.

The restrictive abortion law means that most abortions are clandestine and unsafe,[137] performed by providers that are untrained and unqualified "quacks."[138] For instance, a study of 528 women with induced abortion complications found that 79% of the abortions had been performed by people who were not medical practitioners[139] in unhygienic environments and with dangerous methods.[140] Even in situations where the procedure was performed by medically-qualified

persons, it may be done in places where aseptic rules may not be followed such as their homes and private clinics.[141] Even where a woman obtains a legal abortion at a health care facility, inadequate staffing, training and equipment expose women to unnecessary risks.[142] Among those who have an abortion performed by a physician, a large number developed complications and sought post-abortion care, indicating that the performing physician was not well-trained in abortion services.[143] Few general practitioners receive proper training to perform abortions.[144]

Unsafe abortions account for 20-40% percent of maternal deaths in Nigeria, and many more suffer serious injuries.[145] Of the 1.25 million induced abortions in Nigeria in 2012, 40% resulted in complications serious enough to require treatment in a facility.[146] About 212,000 women were treated in health facilities for complications of induced abortion that year, while an estimated 285,000 additional women suffered serious health complications but were not treated in medical facilities.[147] This severe deficiency in adequate health care is attributed to several factors. Many women who suffer from complications are unable to pay for post-abortion care (PAC).[148] Further, many doctors refuse to operate on post-abortion patients for fear of criminal consequences.[149] Although the Nursing and Midwifery Council of Nigeria incorporated PAC into the training curriculum of midwifery,[150] a survey of 437 medical health practitioners in southeastern Nigeria found that 24.5% of the respondents were not aware of PAC services and only 35.5% used manual vacuum aspirator to treat incomplete abortions, the recommended method for PAC.[151] Another study of health care professionals in the same area found that only 41% had been trained on PAC counseling.[152] Other sources indicate that the theory and practice of PAC is often not included in undergraduate and postgraduate medical training curricula.[153] The lack of access to PAC contributes significantly to the high levels of maternal mortality and morbidity in Nigeria.

IV. ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH RIGHTS

In developing countries, pregnancy and childbirth-related complications are the leading cause of death for adolescent girls aged 15–19.[154] Besides the health implications, early childbearing has adverse social and economic consequences on adolescent girls. However, while 54% of girls in Nigeria are sexually active by age 18,[155] only 6% of those age 15-19 use any contraceptive method[156] and just under 5% of girls use a modern contraceptive method.[157] Only 39% of girls ages 15-19 know where they can obtain condoms.[158] As a result, pregnancy rate among adolescent girls is very high. It is estimated that 23% of girls ages 15 to 19 have begun childbearing[159] and the national adolescent fertility rate is 122 births per 1,000 girls.[160] In the states in the North West of the country, one of the lowest-income areas, that rate is as high as 171 births per 1,000 girls.[161] Thirty-two percent of adolescents in rural areas have begun childbearing, as opposed to only 10% in urban areas.[162] Childbearing rates for adolescent girls are over 50% in some areas of the North West region.[163] Additionally, the low rates of contraception use have led to high rates of unsafe abortion among adolescents in Nigeria. Numerous studies show that the majority of women who seek PAC at hospitals and clinics for complications arising from unsafe abortions are unmarried adolescent girls.[164] For example, a 2011 study found that 38% of patients admitted to the Niger Delta University Teaching Hospital for complications from unsafe abortions were under twenty years old.[165] Forty-eight percent of those abortions were performed by people who were not doctors, or "quacks," and 30% were self-induced.[166] Another 2014 study of adolescent girls aged 13- 20 in South West Nigeria found that a quarter had been pregnant at least once, and all who had ever become pregnant had tried to terminate the pregnancy.[167]

Adolescents often encounter barriers in accessing sexual and reproductive health information and services. Parents and other stakeholders frequently withhold information on reproductive health and sexuality from adolescents due to traditional and socio-cultural beliefs.[168] Since 2007, Nigeria has implemented the national Family Life and HIV Education (FLHE) curriculum in all junior secondary schools in Lagos State.[169] The curriculum consists of 27 lessons over the course of three years, and excludes discussion of contraception and sexual behavior.[170] Also, studies suggest that FLHE curriculum has reached only 13% of in-school adolescents in Nigeria.[171] In order to address the issue, the government must scale-up the implementation of this curriculum in schools in other States, and ensure that the curriculum covers comprehensive, scientifically accurate information on sexual and reproductive health.

V. SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

In its concluding observations to Nigeria in 2008, the Committee highlighted the continuing prevalence of violence against women, including domestic violence, as well as the absence of a comprehensive national law, strategy, or program to combat violence against women.[172] At that time, several pieces of legislation to address gender-based violence remained pending before the National Assembly. The Committee also noted with concern that the majority of services for victims, including shelters, were provided by non-governmental organizations with limited support from the Nigerian government.[173] In 2015, after a ten-year-long legislative process, the pending laws on gender-based violence were consolidated and entered into law as the Violence against Persons Prohibition (VAPP) Act, which broadly covers physical, psychological, economic, and sexual violence, including rape, as well as harmful traditional practices.[174] Despite its initial gender-based dimension, the final bill does not focus on violence against women specifically, but instead addresses violence against all persons.[175] It also broadens the list of punishable offenses, becoming the first federal legislation prohibiting female genital mutilation (FGM),[176] sexual harassment, and domestic violence.[177] It includes new prohibitions of and punishments for battery, stalking, substance attacks, incestuous conduct, forceful ejection from the home, and the abandonment of spouses and children.[178] Moreover, the VAPP Act establishes protective orders for victims, provides for a sex offender registry,[179] and establishes a special trust fund to provide victims legal assistance, shelter, and rehabilitation.[180]

However, it is unclear whether the VAPP Act applies outside the Federal Capital Territory, or if it needs to be passed in each of the 36 States of the Federation, as Nigeria has a three-tier government system. Currently, 10 States do not have laws prohibiting FGM, and one-third of the country has no laws in place to protect women against any form of violence.[181] Section 55 of Nigeria's penal code, in force in the North, specifically allows husbands to discipline their wives, just as it allows parents and teachers to discipline children, as long as they do not inflict "grievous" harm.[182] In its current report to the Committee, the government has not provided information on the measures taken to enforce the VAPP Act as well as data showing whether the Act has helped reduce the incidence of and protect women from violence.

Numerous studies demonstrate that violence against women is endemic in Nigeria.[183] According to the latest NDHS, nearly three in ten women have experienced physical violence since age 15, with one-quarter of ever-married women having suffered from spousal physical, emotional, or sexual abuse at some point in their lives.[184] Most who have experienced physical violence did so at the hands of their partners.[185] Fifty one percent of women who were married during the survey reported that their husband or partners have inflicted physical violence on them.[186] Fifty eight percent of these women have also suffered sexual violence perpetuated by their husbands.[187] A

2013 study of 373 women in a fertility clinic in Northwest Nigeria showed that about 36% of the women had experienced at least one form of intimate partner violence in the preceding year.[188] Most of those women (83%) had experienced sexual violence.[189] This is probably an underestimation since rape and sexual violence often go unreported by victims and unpunished because of shame and social stigma placed on the victim.[190] Indeed, in 2012 a research revealed that one in five women has experienced some form of physical violence.[191] Where victims have attempted to bring charges against their aggressor, they faced penal laws that are inadequate and outdated.[192] Only 31% of women who have suffered violence have sought help.[193] Only 2% of women who report violence go to the police; most women who seek help turn to family.[194] As of 2015, only 18 people in Nigeria had ever been convicted for rape.[195] Between 2012 and 2013, however, the Lagos State Police Command recorded 678 cases of rape in the State[196] indicating even in situations where the incidence that do get reported, hardly any lead to convictions.

Adolescent girls throughout Nigeria also experience high rates of violence. For instance, a study from 2015 showed that 85% of 480 out-of-school girls aged 10 to 19 years from Lagos state had experienced at least one form of physical, psychological, or sexual domestic violence in the twelve months preceding the study.[197] About 71% of the respondents experienced at least one form of physical abuse.[198] Most girls also believed that intimate partner violence could be justified, as 78% of the girls believed in at least one justification for wife battering.[199] A separate study from 2015 of public high school girls in Osun State showed that 56% experienced sexual harassment, 24% experienced sexual exploitation, and 21% experienced rape.[200] Teachers and peers were primary perpetrators of sexual abuse.[201] The opportunity for sexual favors is regarded by male teachers as "a privilege of their position."[202] Reports have indicated that violence becomes normalized in training environments, where student teachers witness sexual violence against girls and assume such behavior is acceptable.[203]

VI. EARLY MARRIAGE

In 2008, this Committee noted that only 18 of Nigeria's 36 States had adopted the Child Rights Act, which sets the minimum age of marriage at 18 years,[204] and urged the remaining States to adopt and implement this legislation.[205] The Committee also urged Nigeria to repeal Section 29(4)(b) of the Nigerian Constitution, "which states that a woman is considered of full upon marriage thereby lending support to early marriages."[206] The Committee also highlighted "contradictions and inconsistencies created by the application of statutory, customary and sharia laws in the State party's tripartite legal system, particularly in the areas of marriage and family law," noting with concern the system's continued discrimination against women.[207] Following its 2010 review of Nigeria, the Committee on the Rights of the Child also raised similar concerns regarding the inconsistent laws on marriage [208] and the extremely high prevalence of early marriages among girls in the northern states.[209] During the 2013 UPR, it was repeatedly recommended that Nigeria take steps to eliminate and protect girls from child marriage.[210] Again, the African Commission in 2015 urged Nigeria to ensure that all states adopt the Child Rights Act and set marriage to eighteen years.[211]

However, in its current report to this Committee, Nigeria has not indicated what steps, if any, it has taken to eliminate and protect girls from child marriage including revising the contradicting laws.[212] Nigeria's Constitution still does not establish a minimum age of marriage, and only 23 of the 36 States have adopted the Child Rights Act.[213] The 13 States that have not adopted the Act have no laws prohibiting child marriage. Many of those states have a penal code based on Shari'a law, which does not set an age for adulthood but rather determines age in relation to

puberty.[214] Nigeria has tripartite legal systems, that is civil, customary, and Islamic laws, working concurrently, and the federal government has control over only civil marriages and not Islamic marriages.[215] As such, under the current Constitution, if a person marries a child under Islamic law, that person is immune from prosecution the federal government does not have the mandate to interfere with Islamic marriage.[216]

Consequently, early marriage remains rampant in Nigeria. Almost half of women in Nigeria are married by age 18.[217] Approximately 23% of women are married by age 15.[218] These numbers are significantly higher in some areas, such as the North West region, where the median age at marriage for girls is 15.[219] In rural areas, the median age at marriage is 16 years.[220]

Married girls are often pressured into having early and repeated pregnancies, which have serious, harmful consequences for their life and health and that of their children. Girls who become pregnant before age 15 have double the risk of maternal death and obstetric fistula than older women, and up to five times the risk in sub-Saharan Africa.[221] Moreover, child marriage increases girls' vulnerability to sexually transmitted infections (STIs). For instance, a study of girls from Adamawa State who had been married before the age of 16 showed that 62% were diagnosed with at least one type of STI, and only 25% of the girls ever discussed the need to use condoms with their husbands, even when they were at risk.[222]

In 2015, the government took the commendable initiative to establish a Technical Working Group on Ending Child Marriage within the Ministry of Women Affairs and Social Development.[223] However, it is unclear what the TWG's mandate is and how the TWG plans to carry out this mandate. The government must provide information on the programs or policies that this body has initiated and on the ways they have been effective to reduce the rate of child marriage.

VII. LACK OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN CONFLICT AREAS

As this Committee consistently has noted, State party obligations under the Convention are non-derogable and continue to apply during conflict situations.[224] Moreover, in line with General Recommendation No. 30, the Committee has emphasized States' obligations to ensure equal access to comprehensive health information and services, including sexual and reproductive health care, to internally displaced and refugee women and girls[225] and particularly for women and girls who are victims of sexual violence.[226] However, security issues compound infrastructural barriers and have severely limited access to maternal health care in portions of northern Nigeria affected by the conflict with Boko Haram,[227] which has displaced more than 2.1 million people.[228] While maternal mortality and morbidity rates have long remained disproportionately higher in northern Nigeria due to the lack of access to quality maternal health care, the insecurity in the region since 2011 has exacerbated the problem.[229] The existing level of poor maternal health outcomes and access to sexual and reproductive health services heightens the challenges of addressing the gendered nature of Boko Haram's violations, which include the kidnapping of women and girls, sexual violence, and forced marriage and pregnancy.[230] More recently, human rights experts have raised concerns of sexual violence and early marriage in camps for internally displaced peoples.[231]

Displaced women, as well as the hundreds of women and girls who were kidnapped by Boko Haram and have become pregnant through rape,[232] are in particularly urgent need of reproductive health services, including maternal health care, which remains largely inaccessible throughout

the affected region.[233] A 2014 article reported that fewer than 30 trained midwives were available in all of Jigawa State, which has a population of 5 million people.[234] According to the Internal Displacement Monitoring Centre, Boko Haram has stolen medical supplies from health facilities and has displaced, kidnapped, and killed health workers.[235] Violence in areas under a state of emergency has caused at least 37% of health facilities to close, leaving those that remain open overwhelmed by patients.[236] As a result, essential reproductive and maternal health care remains inaccessible to tens of thousands of women, which has worsened the already disproportionately high rates of maternal mortality and morbidity in the northern regions.

VIII. QUESTIONS

1. Given the extremely high rate of maternal mortality, what steps has the government taken to strengthen the implementation and effectiveness of its many initiatives to reduce maternal mortality and to increase access to maternal health care? What steps has the government taken to reduce in-country disparities that result in greater susceptibility to maternal death among women living in rural areas and low-income women? What is the federal government doing to ensure that local governments fulfil their obligation to provide health care?
2. What steps has the government taken to implement the National Health Law 2014 in regards to maternal health care which was intended to provide National Health Insurance Scheme (NHIS) for vulnerable groups including women? Can the government provide data on the number of pregnant women who have accessed NHIS?
3. What steps is the government taking to remove barriers that women face in accessing family planning and contraceptive information and services? What measures is the government undertaking to ensure that sufficient supplies of contraceptives, including emergency contraceptives, are available and affordable, and that women and girls are provided with comprehensive and accurate information about contraceptives and family planning?
4. What steps is the government taking to revise the law on abortion, to bring it in line with the Maputo Protocol and international human rights standards, given the high level of maternal deaths due to unsafe abortion and inadequate post-abortion care, particularly among adolescents, low income and rural women, and those without any formal education?
5. What measures has the government taken to reduce unwanted and unplanned pregnancies among adolescents including by addressing the barriers to access to reproductive health services? What concrete actions has the government taken to ensure that all adolescents in Nigeria receive comprehensive and scientifically accurate sexual and reproductive health education?
6. What concrete actions has the government taken to implement and enforce the Violence against Persons Prohibition (VAPP) Act 2015 to protect women and girls from gender-based violence throughout Nigeria including by ensuring that States adopt the Act? In addition to passing the VAPP Act, what specific steps has the government taken to address violence against women and adolescent girls including violence in schools?

7. What steps are being taken to implement the Child Rights Act in the 13 states where it has not been enacted, and ensure that child marriage is prevented and prohibited in the 23 states that have passed the Child Rights Act?

8. Given the limited access to sexual and reproductive health care, and particularly maternal health care, in regions affected by the conflict with Boko Haram and in camps for internally displaced persons, what steps is the government taking to (a) ensure equal access to comprehensive sexual and reproductive health care services for women and girls affected by the conflict and (b) strengthen health systems so as to meet the needs of affected communities, in particular those of girls and women survivors of sexual violence?

---

[1] *See* Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46, U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

[2] Committee on Economic, Social and Cultural Rights (ESCR Committee), *General Comment No. 14*: The right to the highest attainable standard of health (Art. 12), (22nd Sess., 2000), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter ESCR Committee, *Gen. Comment No. 14*]; *see, e.g.*, CEDAW, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38/Rev.1 (1999); *Colombia*, para. 393, U.N, Doc A/54/38/Rev.1 (1999); *Dominican Republic*, para. 337, U.N. Doc A/53/38/Rev.1 (1998); *Madagascar*, para. 244, U.N. Doc A/49/38, (1994).

[3] *See generally* Committee on the Elimination of Discrimination against Women (CEDAW Committee), *General Recommendation No. 24: Article 12 of the Convention (women and health)*, (20th Sess., 1999), *in* Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008) [hereinafter CEDAW Committee, *Gen. Recommendation No. 24*].

[4] *See* CEDAW Committee, *Concluding Observations: Nigeria*, para. 170, U.N. Doc. A/59/38/Rev. 1 (1998); CEDAW Committee, *Concluding Observations: Nigeria*, paras. 307–08, U.N. Doc. A/59/38, (Supplement No. 38) (Part I) (2004); CEDAW Committee, *Concluding Observations: Nigeria*, para. 33, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).

[5] CEDAW, *Concluding Observations: Nigeria*, para. 34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).

[6] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Nigeria*, para. 135.105, U.N. Doc. A/HRC/25/6 (2013) [Hereinafter *2013 UPR Nigeria*].

[7] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014)*, African Union, para. 76 (2015).

[8] *Id.*, para. 117.

[9] CEDAW Committee, *Consideration of reports submitted by States parties under article 18 of the Convention: Combined seventh and eighth periodic reports of States parties due in 2014: Nigeria*, para. 10.1, U.N. Doc. CEDAW/C/NGA/7-8 (2015) [hereinafter *Periodic Report of State Parties: Nigeria*].

[10] *Id.*, para. 10.2.

[11] WORLD HEALTH ORGANIZATION (WHO), NIGERIA MIDWIFES SERVICE SCHEME, *available at* http://www.who.int/workforcealliance/forum/2011/hrhawardscs26/en/index.html; Seye Abimbola, et. al., *The Midwives Service Scheme in Nigeria*, 9 PLoS Med., (2012), *available at* http://journals.plos.org/plosmedicine/article/asset?id=10.1371/journal.pmed.1001211.PDF.

[12] Halima Musa, *State of midwives service scheme in Kano*, DAILY TRUST, Feb. 1, 2016, *available at* http://www.dailytrust.com.ng/news/health/state-of-midwives-service-scheme-in-kano/131761.html; Nnenna Ibeh, *How Nigerian govt ruins midwives scheme, fails to fight maternal deaths*, PREMIUM TIMES, Apr. 27, 2015, http://www.premiumtimesng.com/news/headlines/182131-how-nigerian-govt-ruins-midwives-scheme-fails-to-fight-maternal-deaths.html.

[13] ESTIMATES BY WHO, UNICEF, UNFPA, WORLD BANK GROUP AND THE UNITED NATIONS POPULATION DIVISION, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, 19 (2015), *available at*

http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1 [hereinafter WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015].
[14] *Id.*
[15] In 2008, Nigeria reported 829 deaths for 100,000 live births. THE WORLD BANK, *Maternal mortality ratio* (modeled estimate, per 100,000 live births), *available at* http://data.worldbank.org/indicator/SH.STA.MMRT?locations=NG
[16] WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, *supra* note 13.
[17] *Id.*
[18] Nigeria Office of the Senior Special Assistant to the President on the Millennium Development Goals, 2015 Millennium Goals End-Point Report 7, 17 (2015), *available at* http://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/Nigeria/Nigeria_MDGs_Abridged_Sept30.pdf?download.
[19] WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, *supra* note 13, at 74.
[20] Sustainable Development Knowledge Platform, *Goal 3: Ensure healthy lives and promote well-being for all at all ages*, *available at* https://sustainabledevelopment.un.org/sdg3.
[21] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS, 8 (2013), *available at* https://dhsprogram.com/pubs/pdf/SR213/SR213.pdf [hereinafter NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013].
[22] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 128, 130 (2013), *available at* http://dhsprogram.com/pubs/pdf/FR293/FR293.pdf [hereinafter NIGERIA DHS 2013].
[23] *Id.*, at 128.
[24] *Id.*, at 130.
[25] *Id.*, at 128.
[26] *Id.*, at 135.
[27] *Id.*
[28] *Id.*, at 136.
[29] *Id.*
[30] US Agency for International Development (USAID), *Repairing Obstetric Fistula in Nigeria*, Dec. 17, 2015, *available at* https://www.usaid.gov/results-data/success-stories/repairing-obstetric-fistula-nigeria.
[31] *Id.*
[32] UKWUOMA ARMSTRONG, CHILD MARRIAGE IN NIGERIA: THE HEALTH HAZARDS AND SOCIO-LEGAL IMPLICATIONS 28-29 (2014).
[33] Oluwaseyi Dolapo Somefun and Latifat Ibisomi, *Determinants of postnatal care non-utilization among women in Nigeria*, 9(21) BMC RES. NOTES 1, 1–2 (2016).
[34] Joseph O. Ugboaja et al., *Barriers to Postnatal Care and Exclusive Breastfeeding among Urban Women in Southeastern Nigeria* 54(1) NIGERIAN. MED. J. 45, 45 (2013).
[35] WHO, *Postnatal Care for Mothers and Newborns, Highlights from the World Health Organization 2013 Guidelines*2 (2015), *available at* http://www.who.int/maternal_child_adolescent/publications/WHO-MCA-PNC-2014-Briefer_A4.pdf.
[36] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013, *supra* note 21, at 8; NIGERIA DHS 2013, *supra* note 22, at 143.
[37] NIGERIA DHS 2013, *supra* note 22, at 142-143.
[38] *Id.*, at 142.
[39] *Id.*, at 16.
[40] *Id.*, at 142.
[41] *See*, in general, CENTER FOR REPRODUCTIVE RIGHTS ET AL., BROKEN PROMISES: HUMAN RIGHTS, ACCOUNTABILITY AND MATERNAL DEATH IN NIGERIA 39–49 (2008) [hereinafter BROKEN PROMISES].
[42] *Id.*, at 39–49.
[43] Abdulwahab Abdulah, *Is compulsory blood donation breach of fundamental right?*, VANGUARD, June 14, 2012, http://www.vanguardngr.com/2012/06/is-compulsory-blood-donation-breach-of-fundamental-right/ (noting a 2012 petition submitted by WARDC to end the policy of compulsory spousal blood donation); Fabomwo AO & Okonofua FE, *An Assessment of Policies and Programs for Reducing Maternal Mortality in Lagos State, Nigeria*,

14 AFRICAN J. REPRODUCTIVE HEALTH 55, 58 (2010), *available at* http://www.ajrh.info/vol14_no3_Special/14_3_article_7.pdf
[44] BROKEN PROMISES, *supra* note 41, at 44.
[45] *Id.*
[46] *Id.*, at 45.
[47] Interviews conducted by the Center and WARDC: firsthand accounts from women.
[48] BROKEN PROMISES, *supra* note 41, at 44-45.
[49] Taiwo Akinlami, *Maternity Practices in Government Hospitals in Lagos State: The Must-Read and Instructive story of a patient*, SOCIAL WORKS WATCH (Feb. 5, 2013), http://taiwoakinlami.wordpress.com/2013/02/05/maternity-practices-in-government-hospitals-in-lagos-state-the-must-read-and-instructive-story-of-a-patient/
[50] Oyeyemi Gbenga Mustapha, *Hospital under pressure over huge patients' traffic*, THE NATION, July 23, 2013, http://thenationonlineng.net/hospital-under-pressure-over-huge-patients-traffic/.
[51] Arin Dutta and Charles Hongoro, *Scaling Up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand*, FUTURES GROUP: HEALTH POLICY PROJECT 1 (2013).
[52] *Periodic Report of State Parties: Nigeria*, *supra* note 9, para. 10.2; *See also* Ugo Okoli et al., *Conditional Cash Transfer Schemes in Nigeria: Potential Gains for Maternal and Child Health Service Uptake in a National Pilot Program* 14(408) BMC PREGNANCY & CHILDBIRTH 1, 1 (2014), *available at* http://www.biomedcentral.com/1471-2393/14/408.
[53] BROKEN PROMISES, *supra* note 41, at 41.
[54] *Women Advocates Research and Documentation Center v. Attorney General of the Federation*, [2015] Originating Summons, Federal High Court (Nigeria).
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] *Id.*
[59] Innocent I. Okafor et al., *Disrespect and Abuse during Facility-Based Childbirth in a Low-Income Country*, 128 INT'L. J. GYNECOLOGY & OBSTETRICS 110, 112 (2015).
[60] Adaobi Tricia Nwaubani, *Sky-High Bills Leave Nigerian Mothers and Newborns Trapped in Hospitals*, THOMSON REUTERS FOUNDATION, July 12, 2016, *available at* http://news.trust.org/item/20160712104512-b6xji/.
[61] *Id.*
[62] BRITISH COUNCIL, GENDER IN NIGERIA REPORT 2012: IMPROVING THE LIVES OF GIRLS AND WOMEN IN NIGERIA 40 (2nd ed. 2012), *available at* http://www.dfid.gov.uk/Documents/publications1/Gender-Nigeria2012.pdf [hereinafter BRITISH COUNCIL].
[63] Vinayak Bhardwaj, *Does Nigeria have the lowest health budget in Africa?*, AFRICA CHECK, May 16, 2016, *available at* https://africacheck.org/reports/does-nigeria-have-the-lowest-health-budget-in-africa/.
[64] MAMAYE! AND AFRICA HEALTH BUDGET NETWORK, FACTSHEET ON HEALTH FINANCING IN NIGERIA IN 2015, 2 (2015), *available at* http://www.mamaye.org/sites/default/files/evidence/NG%20HF%20Factsheet%202015.pdf [hereinafter FACTSHEET ON HEALTH FINANCING IN NIGERIA IN 2015].
[65] Agbojo Adewale, *Analysis of Gender Responsivness of the 2014 and 2015 Annual Budget of Lagos and Kwara States, and the Federal Government* (Unpublished).
[66] FACTSHEET ON HEALTH FINANCING IN NIGERIA IN 2015, *supra* note 64.
[67] *Id.*
[68] *Id.*
[69] Global Health Workforce Alliance, *Nigeria launches 'Saving One Million Lives' by 2015 initiative* (2012), http://www.who.int/workforcealliance/media/news/2012/1mlives/en/; UNICEF, *Nigeria launches initiative to save one million lives by 2015*, Oct. 16, 2012, http://www.unicef.org/media/media_66201.html; FEDERAL REPUBLIC OF NIGERIA, NIGERIA'S 5TH PERIODIC COUNTRY REPORT: 2011– 2014 ON THE IMPLEMENTATION OF THE AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS IN NIGERIA, 19 (2014), *available at* http://www.achpr.org/files/sessions/14th-eo/state-reports/5th-2011-2014/staterep5_nigeria_2013_eng.pdf [hereinafter NIGERIA'S 5TH PERIODIC COUNTRY REPORT: 2011– 2014]
[70] NIGERIA'S 5TH PERIODIC COUNTRY REPORT: 2011– 2014, *supra* note 69, at 19
[71] Press Release, WORLD BANK, NIGERIA: WORLD BANK APPROVES US$500 MILLION TO IMPROVE MATERNAL AND CHILD HEALTH, ACHIEVE THE 'SAVING ONE MILLION LIVES' GOAL (Apr. 23, 2015), *available at*

http://www.worldbank.org/en/news/press-release/2015/04/23/nigeria-world-bank-approves-us500-million-to-improve-maternal-and-child-health-achieve-the-saving-one-million-lives-goal.
[72] WORLD BANK, NIGERIA – PROGRAM TO SUPPORT SAVING ONE MILLION LIVES: IMPLEMENTATION AND STATUS REPORT 1 (Mar. 31, 2016), *available at* http://documents.worldbank.org/curated/en/2016/03/26159229/nigeria-nigeria-program-support-saving-one-million-lives-p146583-implementation-status-results-report-sequence-02.
[73] BROKEN PROMISES, *supra* note 41, at 7.
[74] Godwin Unumeri and Salisu Ishaku, *Review of Postpartum and Postnatal Care Programs in Nigeria*, POPULATION COUNCIL, 6 (2015), http://www.popcouncil.org/uploads/pdfs/2015RH_NigeriaPPFP.pdf
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] CEDAW, *Concluding Comments: Nigeria Combined fourth and fifth periodic report,* para. 308, U.N. Doc. A/59/38, Excerpted from Supplement No. 38 (2004).
[79] CEDAW, *Concluding Observations: Nigeria*, paras. 336-337, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).
[80] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014),* African Union, para. 118 (2015).
[81] *Periodic Report of State Parties: Nigeria*, *supra* note 9, para. 10.5.
[82] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013, *supra* note 21, at 5.
[83] NIGERIA DHS 2013, *supra* note 22, at 67.
[84] Mustafa Adelaja Lamina, *Prevalence of Abortion and Contraceptive Practice among Women Seeking Repeat Induced Abortion in Western Nigeria*, JOURNAL OF PREGNANCY 1, 1 (2015) [hereinafter *Prevalence of Abortion*].
[85] Akinrinola Bankole et al., *The Incidence of Abortion in Nigeria*, 41(4) INTERNATIONAL PERSPECTIVES ON SEXUAL AND REPRODUCTIVE HEALTH 170, 175 (2015) [hereinafter *The Incidence of Abortion in Nigeria*].
[86] *Prevalence of Abortion*, *supra* note 84, at 1-2.
[87] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 201, *supra* note 21, at 6.
[88] *Id.*
[89] NIGERIA DHS 2013, *supra* note 22, at 81.
[90] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013, *supra* note 21, at 5.
[91] UNITED NATIONS OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS, *UN emergency fund allocates $13 million to help people in north-eastern Nigeria*, (Jun. 27, 2016), available at http://www.unocha.org/top-stories/all-stories/un-emergency-fund-allocates-13-million-help-people-north-eastern-nigeria.
[92] The states are Jigawa, Kano, Katsina, Kebbi, Sokoto, and Yob. NIGERIA DHS 2013, *supra* note 22, at 94.
[93] *Id.*, at 16.
[94] *Id.*, at 94.
[95] *Id.*, at 95.
[96] CEDAW, *supra* note 1, art. 14(2)(b).
[97] *Prevalence of Abortion*, *supra* note 84, at 3.
[98] NIGERIA DHS 2013, *supra* note 22, at 114.
[99] The states are Jigawa, Kano, Katsina, Kebbi, Sokoto, and Yob. NIGERIA DHS 2013, *supra* note 22, at 114.
[100] Babatybde Ahonsi et al., *Providers' and Key Opinion Leaders' Attitudes, Beliefs, and Practices Regarding Emergency Contraception in Nigeria*, POPULATION COUNCIL, 6 (2012) *available at* http://www.popcouncil.org/uploads/pdfs/2012RH_ECNigeria_FinalSurvRep.pdf [hereinafter Ahonsi, *Providers' and Key Opinion Leaders' Attitudes*].
[101] Jane Dreaper, *Contraception: Rural Nigeria's family-planning challenge*, BBC NEWS, July 11, 2012, http://www.bbc.co.uk/news/health-18763614.
[102] *Id.*
[103] *Id.*
[104] Augustine Ankomah et al., *Barriers to Contraceptives Use among Married Young Adults in Nigeria: A Qualitative Study*, 3 INT'L JOURNAL OF TROPICAL DISEASE & HEALTH 268, 278 (2013).
[105] Anne Austin, *Unmet contraceptive need among married Nigerian women: an examination of trends and drivers*, 91 CONTRACEPTION 31, 37 (2015).
[106] *Id.*, at 32.
[107] *Id.*, at 37.

[108] *See generally*, Saifuddin Ahmed et al., Matern*al Deaths Averted by Contraceptive Use: An Analysis of 172 countries*, 380(9837) LANCET 111–25 (2012).
[109] Judd-Leonard Okafor, *Govt spending for family planning drops*, THE DAILY TRUST, Oct. 10, 2015. http://www.dailytrust.com.ng/news/general/govt-spending-for-family-planning-drops/114361.html; *See also*, Association for the Advancement of Family Planning (AAFP), *Report of the Budget Tracking of the 2014 National Family Planning Budget*, 1–2 (April 2015) http://aafpng.org/wp-content/uploads/2015/09/Report-of-the-Budget-Tracking-final.pdf [hereinafter AAFP, *Report of the Budget Tracking*].
[110] Okafor, *supra* note 109. *See also*, AAFP, *Report of the Budget* Tracking, *supra* note 109, at 1.
[111] PUBLIC HEALTH INSTITUTE, ANALYZING HEALTH FUNDING COMMITMENTS IN THE 2014 AND 2015 APPROPRIATION ACTS 3 (2015).
[112] USAID, *Ensuring Access to Family Planning in Nigeria* (Mar. 2015), available at https://www.usaid.gov/results-data/success-stories/ensuring-sustainable-access-family-planning-cross-river-state-nigeria.
[113] NIGERIA DHS 2013, *supra* note 22, at 89.
[114] International Consortium for Emergency Contraception, *Counting What Counts: Tracking Access to Emergency Contraception* (2014), *available at* http://www.cecinfo.org/custom-content/uploads/2014/10/ICEC_Nigeria-factsheet_2014-update.pdf.
[115] *Id*.
[116] NIGERIA DHS 2013, *supra* note 22, at 90.
[117] Jacob Olumuyiwa Awoleke et al., *Awareness and practice of emergency contraception at a private university in Nigeria*, 8 BMC RESEARCH NOTES 1,5 (2015).
[118] Ahonsi, *Providers' and Key Opinion Leaders'* Attitudes, *supra* note 100.
[119] *Id*.
[120] *Id*.
[121] *See e.g*. CEDAW Committee, *Concluding Observations: Nigeria*, paras. 307-308, U.N. Doc. A/59/38 (Supplement No. 38) (2004); CEDAW, *Concluding Observations: Nigeria*, paras. 33-34, U.N. Doc A/59/38 (Supplement No. 38) (2008).
[122] CEDAW, *Concluding Observations: Nigeria*, para. 34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).
[123] *See generally*, *Periodic Report of State Parties: Nigeria*, *supra* note 9.
[124] Penal Code (Northern States) Federal Provisions Act, Chapter 345 of the Laws of the Federation of Nigeria (Revised ed. 1990), Articles 232-236; Criminal Code Act, Chapter 77 of the Laws of the Federation of Nigeria (Revised ed. 1990), Articles 228-230, 297, 309, 328. *See* CENTER FOR REPRODUCTIVE RIGHTS, *Nigeria's Abortion Provisions*, *available at* http://www.reproductiverights.org/world-abortion-laws/nigerias-abortion-provisions.
[125] *Id*.
[126] U.N. POPULATION DIVISION, DEPARTMENT OF ECONOMIC & SOCIAL AFFAIRS, *Nigeria, in* ABORTION POLICIES: A GLOBAL REVIEW, 169 (2002), *available at* http://www.un.org/esa/population/publications/abortion/.
[127] Allyn Gaestel, *Abortions in Nigeria are legally restricted, unsafe – and common*, ALJAZEERA AMERICA, Dec. 10, 2013, http://america.aljazeera.com/articles/2013/12/10/abortions-in-nigeriaareillegalunsafeaandcommon.html.
[128] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, 2nd Ordinary Sess., Assembly of the Union, *adopted* July 11, 2003, art. 14, para. 2(c), CAB/LEG/66.6 (*entered into force* Nov. 25, 2005) (ratified December 16, 2004).
[129] *The Incidence of Abortion in Nigeria*, *supra* note 85, at 170.
[130] *Id*.
[131] AKINRINOLA BANKOLE ET AL., BARRIERS TO SAFE MOTHERHOOD IN NIGERIA, GUTTMACHER INSTITUTE, 9 (2009).
[132] *The Incidence of Abortion in Nigeria*, *supra* note 85, at 170.
[133] *Id*., at 175.
[134] GUTTMACHER INSTITUTE, ABORTION IN NIGERIA, OCTOBER 2015 FACT SHEET, *available at* https://www.guttmacher.org/fact-sheet/abortion-nigeria; *The Incidence of Abortion in Nigeria*, *supra* note 85, at 176.
[135] *Prevalence of Abortion*, *supra* note 84, at 1-2.
[136] *Id*., at 2.
[137] Stanley K. Henshaw, et al., *Severity and Cost of Unsafe Abortion Complications Treated in Nigerian* Hospitals, 34 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 40, 49 (2008).
[138] Cajethan Ife Emechebe et al., Com*plications of induced abortion: Contribution to maternal mortality in a tertiary center of a low resource setting*, 5 SAUDI J. HEALTH SCI. 34, 34 (2016).
[139] *Id*.

[140] *Id.*, at 37.
[141] *Id.*
[142] SUSHEELA SINGH, ET AL., ABORTION WORLDWIDE: A DECADE OF UNEVEN PROGRESS, GUTTMACHER INSTITUTE, 28 (2009).
[143] *Id.*
[144] *Id.*; Rosemary Ogu, *Outcome of an intervention to improve the quality of private sector provision of postabortion care in northern Nigeria*, 118 INT'L J. GYNECOLOGY & OBSTETRICS 57 (2012) [hereinafter Ogu, *Outcome of an intervention*].
[145] *Prevalence of Abortion*, *supra* note 84.
[146] *The Incidence of Abortion in Nigeria*, *supra* note 85, at 174.
[147] *Id.*, at 173, 176.
[148] Bosede O Awoyemi and Jacob Novignon, *Demand for abortion and post abortion care in Ibadan, Nigeria*, 4 HEALTH ECONOMICS REVIEW, 5–6 (2014).
[149] Elizabeth Dwyer, *How Nigeria's Police Are Becoming Allies For Safe Abortion*, THE WORLD POST, June 29, 2016.
[150] Echendu Dolly Adinma, *Post Abortion Care Services in Nigeria*, *in* Dr. Stavros Sifakis (Ed.), From Preconception to Postpartum, 130 (2012), *available at* http://www.intechopen.com/books/from-preconception-to-postpartum/post-abortion-care-services.
[151] Adinma, JIB et al, *Awareness and practice of post abortion care services among health care professionals in southeastern Nigeria*, 41 SOUTHEAST ASIAN J OF TROP MED PUBLIC HEALTH 696-704, 696 (2010).
[152] Adinma, JIB et al., *Post abortion care counseling practiced by health professionals in southeastern Nigeria*, 111 INT'L J. OF GYNECOLOGY AND OBSTETRICS 53-56, 53 (2010).
[153] Ogu, *Outcome of an intervention*, *supra* note 144.
[154] Press Release, UN WOMEN, *Child Marriages: 39,000 Every Day – More than 140 million girls will marry between 2011 and 2020* (Mar. 7, 2013), *available at* http://www.unwomen.org/en/news/stories/2013/3/child-marriages-39000-every-day-more-than-140-million-girls-will-marry-between-2011-and-2020/.
[155] NIGERIA DHS 2013, *supra* note 22, at 59.
[156] *Id.*, at 94.
[157] *Id.*, at 93.
[158] *Id.*, at 261.
[159] *Id.*, at 78.
[160] Rafael Cortez et al., *Adolescent Sexual and Reproductive Health in Nigeria*, WORLD BANK GROUP, 1 (2015) [hereinafter Cortez, *Adolescent Sexual and Reproductive Health*].
[161] *Id.*
[162] NIGERIA DHS 2013, *supra* note 22, at 78.
[163] *Id.*, at 79.
[164] Isa Ayuba Ibrahim et al., *Pattern of Complicated Unsafe Abortions in Niger Delta University Teaching Hospital Okolobiri, Nigeria: A 4 Year Review*, 11(4) NIGERIAN HEALTH J. 112, 114 (2011).
[165] *Id.*
[166] *Id.*, at 113.
[167] Mary Olufunke Obiyan and Ojo Melvin Agunbiade, *Paradox of Parental Involvement in Sexual Health and Induced Abortions Among In-school Female Adolescents in Southwest Nigeria*, 18(4) SEXUALITY & CULTURE, 847 (2014).
[168] Isonguyo, et al. *Adolescents and Utilization of Family Planning Services in Rural Community of Nigeria*, 3 Research on Humanities and Soc. Sciences, 3 (2013).
[169] U.N. EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION, SCHOOL-BASED SEXUALITY EDUCATION PROGRAMMES: A COST AND COST-EFFECTIVENESS ANALYSIS IN SIX COUNTRIES, EXECUTIVE SUMMARY 8 (2011), *available at* http://www.unesco.org/new/fileadmin/MULTIMEDIA/HQ/ED/pdf/CostingStudy.pdf.
[170] *Id.*, at 18.
[171] Cortez, *Adolescent Sexual and Reproductive Health*, *supra* note 160, at 4 (noting that there has been no large scale impact evaluation of the FLHE program).
[172] CEDAW, *Concluding Observations: Nigeria*, para. 23, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).
[173] *Id.*

[174] Cheluchi Onyemelukwe and Ifeoma Okekeogbu, *The Violence against Persons (Prohibition) Act: A CHELD Brief*, CENTRE FOR HEALTH ETHICS LAW AND DEVELOPMENT (CHELD) (2015), available at http://cheld.org/wp-content/uploads/2012/04/Violence-Against-Persons-Prohibition-Act-2015-A-CHELD-Brief.pdf [hereinafter Onyemelukwe and Okekeogbu, *The Violence against Persons (Prohibition) Act*].
[175] *Id.*
[176] *Id.*; Alexandra Topping, *Nigeria's female genital mutilation ban is important precedent, say campaigners*, THE GUARDIAN, May 29, 2015, *available at* https://www.theguardian.com/society/2015/may/29/outlawing-fgm-nigeria-hugely-important-precedent-say-campaigners.
[177] Chinedu Anarado, *Why Nigeria's New Violence against Persons (Prohibition) Act is Only the Beginning*, VENTURES AFRICA, June 15, 2015, *available at* http://venturesafrica.com/why-nigerias-new-violence-against-persons-prohibition-act-is-only-the-beginning/.
[178] Women's Aid Collective Initiative, *Synopsis: Violence against Persons (Prohibition) Act, 2015, Nigeria*, *available at* http://www.law.utoronto.ca/utfl_file/count/documents/reprohealth/ls_088vapp_act_2015_nigeria_synopsis.pdf.
[179] *Id.*
[180] Onyemelukwe and Okekeogbu, *The Violence against Persons (Prohibition) Act*, *supra* note 174.
[181] *See Periodic Report of State Parties: Nigeria*, *supra* note 9, at para. 3.11.
[182] Penal Code of Northern Nigeria Section 55(1), EQUALITY NOW, http://www.equalitynow.org/content/penal-code-northern-nigeria; *See also* Sharon Lafraniere, *Entrenched Epidemic: Wife-Beating in Africa*, N.Y. TIMES, Aug. 11, 2005, http://www.nytimes.com/2005/08/11/world/africa/entrenched-epidemic-wifebeatings-in-africa.html.
[183] *See generally* Morenike O. Folayan et al., *Rape in Nigeria: A Silent Epidemic among Adolescents with Implications for HIV Infection*, 7 GLOBAL HEALTH ACTION (2014); NIGERIA DHS 2013, *supra* note 22, at 301, 303-304.
[184] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013, *supra* note 21, at 15.
[185] NIGERIA DHS 2013, *supra* note 22, at 301.
[186] *Id.*, at 306.
[187] *Id.*, at 309.
[188] Zubairu Iliyasu, *Phenotypes of Intimate Partner Violence among Women Experiencing Infertility in Kano, Northwest Nigeria*, 133 INT'L. J. GYNECOLOGY & OBSTETRICS 32, 34 (2016).
[189] *Id.*
[190] BRITISH COUNCIL, *supra* note 62, at 47.
[191] *Id.*, at 48.
[192] AMNESTY INTERNATIONAL, NIGERIA: RAPE – THE SILENT WEAPON 22 (2006).
[193] NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013, *supra* note 21, at 15.
[194] NIGERIA DHS 2013, *supra* note 22, at 327.
[195] *Only 18 Rape Convictions Recorded In Nigeria's Legal History – Lawyer*, PREMIUM TIMES, Nov. 9, 2015, http://www.premiumtimesng.com/news/top-news/192895-only-18-rape-convictions-recorded-in-nigerias-legal-history-lawyer.html.
[196] Patience Obgo, *Lagos Records 678 Rape Cases in One Year*, THE EAGLE ONLINE, Apr. 15, 2013, http://theeagleonline.com.ng/lagos-records-678-rape-cases-in-one-year/
[197] Michael O. N. Kunnuji, *Experience of Domestic Violence and Acceptance of Intimate Partner Violence Among Out-of-School Adolescent Girls in Iwaya Community, Lagos State*, 30(4) JOURNAL OF INTERPERSONAL VIOLENCE 543, 552 (2015).
[198] *Id.*
[199] *Id.*, at 554.
[200] A.A. Ogunfowokan and BR Fajemilehin, *Experiences of sexual abuse by adolescent girls in Ife/Ijesa zone, Nigeria*, 15 NIGERIAN. J. HEALTH SCI. 89–97 (2015).
[201] *Id.*
[202] BRITISH COUNCIL, *supra* note 62, at 49-50, citing S. BAKARI & F. LEACH, *I invited her to my office: Normalising sexual violence in a Nigerian college of education, in* Dunne, M., ed., Gender, Sexuality and Development, (2008).
[203] *Id.*
[204] CEDAW, *Concluding Observations: Nigeria*, para. 15, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).
[205] *Id.*, para. 16.
[206] *Id*, paras. 15-16.

[207] *Id*., para. 17.
[208] Committee on the Rights of the Child, *Concluding Observations: Nigeria*, para. 26, U.N. Doc. CRC/C/NGA/CO/3-4 (2010).
[209] *Id*., para. 65.
[210] UN Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Nigeria*, U.N.Doc. A/HRC/25/6, paras. 135.12, 135.89, 135.100, and 137.27 (2013).
[211] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011 – 2014)*, para. 120 (Nov. 14–18, 2015).
[212] *Periodic Report of State Parties: Nigeria*, *supra* note 9, para 3.3.iv.
[213] GIRLS NOT BRIDES, *Child marriage around the world: Nigeria*, http://www.girlsnotbrides.org/child-marriage/nigeria/; *See also* Kenneth Ofoma, *23 States Pass Child Rights Act in Nigeria – UNICEF*, NEW TELEGRAPH, http://newtelegraphonline.com/23-states-pass-child-rights-act-nigeria-unicef/.
[214] 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(2) AFR. HUM. RIGHTS L. J. 474, 477 (2013).
[215] *Id*., at 485.
[216] *Id*.
[217] NIGERIA DHS 2013, *supra* note 22, at 57.
[218] *Id*.
[219] *Id*.
[220] *Id*., at 58.
[221] UN SECRETARY GENERAL, FRAMEWORK OF ACTIONS FOR THE FOLLOW-UP TO THE PROGRAMME OF ACTION OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT BEYOND 2014, U.N. Doc A/69/62, 82 (2014).
[222] E. O. Adeyemi, *Child Marriage and Sexually Transmitted Infections: Implications For HIV Prevention Among Young Mothers in Adamawa State Nigeria*, 89 SEX TRANSM INFECT A297 (2013).
[223] GIRLS NOT BRIDES, *supra* note 213.
[224] CEDAW, *General Recommendation No. 28: on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, (47th Sess.), para. 11, U.N. Doc. CEDAW/C/2010/47/GC.2 (2010); CEDAW Committee, *Concluding observations on the combined initial and second to fifth periodic reports of the Central African Republic*, para. 13, U.N. Doc. CEDAW/C/CAF/CO/1-5 (2014).
[225] CEDAW, *General Recommendation No. 30 on women in conflict prevention, conflict, and post-conflict situations*, paras. 52(c) and 57(d), U.N. Doc. CEDAW/C/GC/30 (2013).
[226] *Id*., at paras. 38(e) and 57(g); CEDAW, Concluding observations on the second periodic report of the Syrian Arab Republic, paras. 27(f) and 39(f), U.N. Doc. CEDAW/C/SYR/CO/2 (2014).
[227] Toyin Ojora-Saraki, *Health Care Workers Need Security in Northern Nigeria*, HUFFINGTON POST, Aug. 20, 2014, http://www.huffingtonpost.com/toyin-ojorasaraki/health-care-workers-nigeria_b_5692218.html.
[228] INTERNAL DISPLACEMENT MONITORING CENTRE, 2016 GLOBAL REPORT ON INTERNAL DISPLACEMENT, 102 (May 2016), *available at* http://www.internal-displacement.org/assets/publications/2016/2016-global-report-internal-displacement-IDMC.pdf.
[229] Ojora-Saraki, *supra* note 227.
[230] Human Rights Council, *Report of the United Nations High Commissioner for Human Rights on violations and abuses committed by Boko Haram and the impact on human rights in the affected countries*, paras. 38-43, U.N. Doc. A/HRC/30/67 (2015); Human Rights Council, *Report of the Special Rapporteurs on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, on the sale of children, child prostitution and child pornography and on contemporary forms of slavery, including its causes and consequences on their joint visit to Nigeria*, paras. 35 and 38, U.N. Doc. A/HRC/32/32/Add.2 (2016).
[231] UN Office of the High Commissioner on Human Rights, *Nigeria: huge displacement and humanitarian crisis require urgent life-saving and protection measures*, Aug. 29, 2016.
[232] Adam Nossiter, *Boko Haram Militants Raped Hundreds of Female Captives in Nigeria*, N.Y. TIMES,May 18, 2015, http://www.nytimes.com/2015/05/19/world/africa/boko-haram-militants-raped-hundreds-of-female-captives-in-nigeria.html?_r=0.
[233] Ojora-Saraki, *supra* note 227.

[234] *Id.*
[235] INTERNAL DISPLACEMENT MONITORING CENTRE, BRIEFING PAPER: NIGERIA: FLEEING BOKO HARAM'S RELENTLESS TERROR, 3 (June 5, 2014), http://www.internal-displacement.org/assets/publications/2014/201406-af-nigeria-boko-haram-brief-en.pdf.
[236] *Id.*