CENTER FOR REPRODUCTIVE RIGHTS

WOMEN ADVOCATES RESEARCH AND DOCUMENTATION CENTRE

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Supplementary information on Nigeria scheduled for review by the Committee on the Elimination of Discrimination against Women during its 67th Session

Honorable Committee Members:

The Center for Reproductive Rights (the Center)[1] and Women Advocates Research and Documentation Centre (WARDC)[2] hope to further the work of the Committee on the Elimination of Discrimination against Women (the Committee) by providing independent information on Nigeria. This letter is intended to supplement the combined seventh and eighth periodic report of the government of Nigeria. It is also intended to supplement the Center's and WARDC's pre-session letter of September 28, 2016 addressed to the Committee, attached herewith and containing detailed information, including on the lack of access to reproductive health services in conflict areas in Nigeria. This submission highlights: 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; adolescents' sexual and reproductive health rights; sexual and physical violence against women and girls; and early marriage. The letter also addresses the list of issues (LOIs)[3] and questions raised by the Committee during its 67th pre-sessional working group.

I. HIGH MATERNAL MORTALITY AND 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' rights to health and life.[4] Particularly on Nigeria, this Committee has repeatedly drawn attention to the high incidence of maternal deaths in the country[5] 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."[6] In the current LOIs, the Committee also asked the government to **provide information on concrete steps it has taken to reduce the high maternal mortality rate.**[7]

While Nigeria is yet to respond to the LOIs, in its current report to the Committee the government has acknowledged the high maternal mortality as a "key challenge,"[8] 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.[9] However, evidence shows that these efforts have been ineffective in improving maternal health care, and 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.[10] According to the report, there are 814 deaths for every 100,000 live births,[11] a figure which has hardly changed since 2008, when Nigeria had 829 deaths for every 100,000 live births.[12] This is approximately 58,000 maternal deaths annually,[13] 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.[14] However, in its Millennium Development Goal End-Point Report, the government 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.[15] This is contrary to the findings of the WHO report which indicated that Nigeria had failed to meet the goal.[16] As such, if Nigeria is to achieve the Sustainable Development Goals target of reducing the maternal mortality ratio to less than 70 per 100,000 live births by 2030,[17] it must significantly increase its efforts.

Antenatal, delivery and postnatal care

In its most recent LOIs, the Committee asked the government to **state the measures in place to address limited access to antenatal care, delivery and postnatal care and to eliminate obstetric fistula.**[18] While the government is yet to respond to the LOIs, evidence shows that Nigerian women and adolescent girls often have limited access to such services.

According the latest Nigeria Demographic Health Survey (2013 NDHS), the number of women attending antenatal care (ANC) has only increased by 3% from 2008 when 58% of women received ANC from a skilled provider.[19] Despite the slight increase, more than one-third of women do not attend ANC, putting them at a heightened risk of death.[20] While 61% of women received ANC from a skilled provider, only 51% had attended four antenatal visits as recommended by the WHO.[21] 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.[22] Forty-seven percent of rural women ages 15-49 did not receive any ANC while 86% of urban women were able to access the service.[23]

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.[24] Almost 50% of the fistula cases in the world occur in Nigeria, with between 50,000 to 100,000 new cases each year.[25] The indirect cause for most of these cases is early marriage,[26] which, as discussed below, is highly prevalent in Nigeria.

In Nigeria, access to postnatal services that would help to address complications from pregnancy is very limited. The 2013 NDHS showed that 58% of women in Nigeria did not attend any postnatal checkup.[27] 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.[28] Further, there is disparity in access based on geographical location: 69% of rural women received no postnatal care (PNC) while the rate is 38% for women living in urban areas.[29] Eighty-two percent

of women living in the North West of the country, one of the lowest-income regions in Nigeria,[30] had no postnatal checkup.[31]

Barriers to access to maternal health care

Aside from 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 ANC, delivery and PNC 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 health care needed to prevent maternal deaths. [32] 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 ANC.[33] Despite the Nigerian law that blood donation be voluntary, many public health care facilities require husbands of antenatal patients to donate blood.[34] 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.[35] Husbands may refuse to permit their wives to access antenatal, intra-partum, and postnatal services and can potentially expose women to domestic violence if they attempt to compel their husbands to donate blood.[36] The blood-donation requirement is also disadvantageous to pregnant women who are unmarried, and 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.[37]

Another major obstacle to Nigerian women who attempt to access maternal health facilities is the cost of services. As of 2016, it was reported that the National Health Insurance Scheme (NHIS) covered only around 3-4% of the entire population,[38] indicating that majority of women in Nigeria have to pay user fees in order to receive maternal health care. In addition, although in 2014 Nigeria passed the National Health Act[39] which provides for grounds of exemption for some people, including women and children, from paying for health care services in public facilities,[40] these provisions have rarely been used to offer women free maternity care. As a result, lack of financial means continues 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.[41]

In its most recent LOIs, the Committee requested that the government state the measures in place to prevent **the refusal to provide medical treatment, and the detention of babies and women when they cannot pay their medical bills at maternal health facilities**.[42] Despite the government's lack of response to this issue the detention of women who cannot pay their medical bills is widespread.

The recent case of Folake Oduyoye, which was filed in the Federal High Court of Nigeria by WARDC and the Center, is illustrative of these systematic failures of the government to ensure access to maternal health care. 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.[43] She was treated successfully and discharged, but subsequently detained without due process when her family was unable to pay the medical bill in full.[44] 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.[45] As a result, she died from puerperal sepsis and pneumonia before she could be released.[46] The case before the Federal High Court seeks that the government take 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.[47]

In its current report, the government highlighted its commitment "of a minimum budgetary allocation of 15% to health care in accordance with the Abuja Declaration of 2001 to "implement free health services for the vulnerable groups of the population especially women during pregnancy, childbirth and puerperal conditions and children under five years."[48] In 2016, Nigeria only dedicated 4.13% of its total budget to health and this has not shown much improvement in 2017 when the proposed budget is still less than 5%.[49]

II. Lack of Access to Contraception and Family Planning Information and Services

The Committee, drawing attention to the low rates of contraceptive usage as a significant factor leading to unwanted and unplanned pregnancies in Nigeria, has repeatedly urged the Nigerian government to improve the availability and affordability of family planning information and services.[50] In the current LOIs the Committee also asked the government **to provide information on concrete measures to address low rates of contraceptive use**.[51] While the government is yet to respond to the LOIs, it reported extremely low rates of contraceptive use in Nigeria, but did not highlight any efforts made to improve the situation.[52]

Lack of access to contraception remains pervasive, demonstrating that the government continues to fail in its obligations to address the low rates of contraceptive use. According to the latest Demographic Health Survey, the use of any family planning method among currently married women increased only moderately between 2003 and 2013, from 13% to 15%.[53] Only 10% of women use a modern contraceptive method.[54] This figure represents a very small improvement from the 2003 rate of 8%.[55] This low contraceptive usage is the leading contributory factor to high rates of unwanted and unplanned pregnancy in Nigeria.[56] More than 60% of women with unplanned pregnancies did not use contraception.[57] 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.[58] According to the 2013 NDHS, the unmet need was higher, at 19%, among women with primary education only.[59] 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.[60]

Low income women, women with low educational level, and those residing in rural areas have limited access to contraceptives, which demonstrates the government's failure to ensure access to contraceptives for all. Contraceptive use is as low as 3% among married women in the North East of the country,[61] a part of the country which is in a state of humanitarian crisis due to ongoing conflict,[62] and as low as 1% in five states in the North West,[63] another low-income region with a large population of women in vulnerable situations.[64] 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.[65] 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.[66]

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. 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.[67] These women represent a significant population which family planning programs are not reaching.[68]

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.[69] Clinics 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 effect lasts for several months.[70]

In addition, emergency contraception (EC), an essential tool to prevent unwanted and unplanned pregnancy and a critical component of care for survivors of sexual violence, is not available in many public facilities.[71] According to the 2013 NDHS, only 56% of sexually active unmarried women and 30% of all women know about EC.[72] 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.[73]

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 in Nigeria and resulting maternal mortality and has recommended that the state implement measures to address the issue.[74] 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.[75] In addition, in its current LOIs, the Committee asked the government to **indicate whether it is "considering the decriminalization of abortion and whether there are plans to expand the grounds for legal abortion to include cases of rape, incest, severe fetal impairment and where the health of the pregnant woman is at risk**."[76]

Although Nigeria did not address the issue in its current report to the Committee or respond to the LOIs, the laws on abortion in Nigeria remain very restrictive, permitting abortion only to save a pregnant woman's life.[77] 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.[78] 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 as a result of intense opposition.[79]

According to the latest available study, in 2012 alone, 1.25 million induced abortions occurred in Nigeria, which amounts to 33 abortions per 1,000 women aged 15–49.[80] It is estimated that most of those abortions were unsafe.[81] 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."[82] In 2012, fifty-six percent of unintended pregnancies ended in abortion,[83] amounting to 14% of all pregnancies in Nigeria.[84]

The restrictive abortion law means that numerous abortions are clandestine and unsafe,[85] performed by providers that are untrained and unqualified "quacks."[86] For instance, a study of 497 women with induced abortion complications found that over 41.45% of the abortions had been performed by people who were not medical practitioners.[87] in unhygienic environments and with dangerous methods.[88] Even in situations where the procedures were performed by medically-qualified persons, they may be done in places where aseptic rules may not be followed such as their homes and private clinics.[89] Even where a woman obtains a legal abortion at a health care facility, inadequate staffing, training and equipment expose women to unnecessary risks.[90] Among those who have an abortion performed by a physician, a large number developed complications and sought post-abortion care (PAC), indicating that the performing physician was not well-trained in abortion services.[91] Few general practitioners receive proper training to perform abortions.[92]

As a result, unsafe abortions account for 20-40% of maternal deaths in Nigeria, and many more women suffer serious injuries.[93] Of the 1.25 million induced abortions in Nigeria in 2012, 40% resulted in complications serious enough to require treatment in a facility.[94] 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.[95] Many women who suffer from complications are unable to pay for PAC.[96] Further, many doctors refuse to operate on post-abortion patients for fear of criminal consequences.[97] Although the Nursing and Midwifery Council of Nigeria incorporated PAC into the training curriculum of midwifery,[98] 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.[99] Another study of health care professionals in the same area found that only 41% had been trained on PAC counseling.[100]

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.[101] 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,[102] only 6% of those ages 15-19 use any contraceptive method[103] and just under 5% of girls use a modern contraceptive method.[104] Only 39% of girls ages 15-19 know where they can obtain condoms.[105] As a result, it is estimated that 23% of girls ages 15-19 have begun childbearing[106] and the national adolescent fertility rate is 122 births per 1,000 girls.[107] 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.[108] Thirty-two percent of adolescents in rural areas have begun childbearing, as opposed to only 10% in urban areas.[109] Childbearing rates for adolescent girls are over 50% in some areas of the North West region.[110] Additionally, the low rates of contraceptive 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.[111]

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.[112] The Family Life and HIV Education (FLHE) curriculum, which is delivered in all junior secondary schools in Lagos

State,[113] excludes discussion on contraception and sexual behavior.[114] Also, studies suggest that the FLHE curriculum has reached only 13% of in-school adolescents in Nigeria.[115]

V. SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

In 2015, after a ten-year-long legislative process, the laws on gender-based violence were consolidated and entered into law as the Violence against Persons (Prohibition) Act, 2015 (VAPP Act), which broadly covers physical, psychological, economic, and sexual violence, including rape, as well as harmful traditional practices.[116] In the Committee's LOIs to which Nigeria is yet to respond, the Committee requested that Nigeria **provide information on whether the VAPP Act applies outside the Federal capital and whether the Act is supported through targeted budget allocations and includes a monitoring system**.[117] **The Committee also requested that the government provide data on the number of (a) investigations, prosecutions and convictions related to gender-based violence against women, including domestic violence; and (b) protection orders obtained by women and girls, and the rate of their compliance.**[118]

However, it remains 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.[119] 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.[120] In its current report to the Committee, the government has neither provided information on the measures taken to enforce the VAPP Act, nor data showing whether the Act has helped reduce the incidence of and protect women from violence.

Numerous studies demonstrate that violence against women continues to be endemic in Nigeria.[121] According to the latest NDHS, nearly three in ten women have experienced physical violence since age 15, mostly at the hands of their partners,[122] with one-quarter of married women having suffered from spousal physical, emotional, or sexual abuse at some point in their lives.[123] A study from 2015 showed that 85% of 480 out-of-school girls aged 10 - 19 from Lagos State had experienced at least one form of physical, psychological, or sexual domestic violence in the 12 months preceding the study.[124] Where victims have attempted to bring charges, the perpetrators faced penal laws that are inadequate and outdated.[125] Only 2% of women who report violence go to the police; most women, of the 31% who seek help, turn to family.[126] As of 2015, only 18 people in Nigeria had ever been convicted for rape[127] despite the fact that between 2012 and 2013, the Lagos State Police Command alone, recorded 678 cases of rape in the State.[128]

VI. EARLY MARRIAGE

This Committee and other treaty monitoring bodies have repeatedly expressed concern regarding the "contradictions and inconsistencies created by the application of statutory, customary and sharia laws"[129] on marriage in Nigeria and recommended that the country address the high rate of early marriage.[130]

In the current LOIs, to which the government is yet to respond, the Committee requested that Nigeria **provide an update on the practical measures taken to eliminate harmful practices, particularly…child marriage**, as well as repeal provisions that allow for the same.[131] 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.[132] 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.[133] The states that have not adopted the Act have no laws prohibiting child marriage. Many of them 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.[134]

Almost half of women in Nigeria are married by age 18.[135] Approximately 24% of women are married by age 15.[136] These numbers are significantly higher in some areas, such as the North West region, where the median age at marriage for girls is 15.[137] In rural areas, the median age at marriage is 16 years.[138]

Married girls are often pressured into having early and repeated pregnancies, which have serious, harmful consequences for their life and health and those 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.[139] 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 had ever discussed the need to use condoms with their husbands, even when they were at risk.[140]

VII. RECOMMENDATIONS

1. The government should strengthen the implementation and effectiveness of its many initiatives to reduce maternal mortality and increase access to maternal health care services. This should include ensuring that women in need are exempted from paying hospital fees when accessing maternal health services; taking steps to reduce in-country disparities that result in greater susceptibility to maternal death among women living in rural areas and low-income women; as well as ensuring that local governments fulfil their obligation to provide health care.
2. The government should take steps to remove barriers that women and adolescent girls face in accessing family planning and contraceptive information and services including undertaking measures to ensure that sufficient supplies of contraceptives, including emergency contraceptives, are available, accessible and affordable, and that women and girls are provided with comprehensive and accurate information about contraceptives and family planning.
3. The government should decriminalize abortion and review the law on abortion to bring it in line with international human rights standards providing, at minimum, for abortion in cases of rape, incest, risks to the health of the mother and severe fetal impairment, 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.
4. The government should undertake measures to reduce unwanted and unplanned pregnancies among adolescents by addressing the barriers they encounter in accessing reproductive health services including by ensuring that they receive comprehensive and scientifically accurate sexual and reproductive health education.

5. The government should take concrete actions to address violence against women, including by ensuring that all States adopt and enforce the Violence against Persons (Prohibition) Act, 2015, and that they take specific steps to investigate and prosecute violence against women and adolescent girls even in schools, as well as ensure access, by victims of violence, to medical treatment and psychosocial support.
6. The government should take concrete actions to eliminate and protect girls from child marriage including by revising all contradictory laws on the minimum age of marriage and ensuring that the Child Rights Act, 2003, is adopted in the states where it has not been recognized and that it is implemented in all states.
7. The government should take specific steps to ensure universal access to comprehensive sexual and reproductive health care for women and girls affected by the conflict and sexual violence in that context, including by strengthening the human resource and infrastructure for delivering reproductive health services and information, and by providing these women and girls with medical treatment and psychosocial support.

We hope that this information is useful during the Committee's review of the Government of Nigeria. If you would like further information, please do not hesitate to contact us.

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[1] The Center for Reproductive Rights is a global organization, with headquarters in New York and regional offices in Nairobi, Nepal, Bogota, Geneva and Washington D.C. that uses the law to advance reproductive freedom as a fundamental human right that governments are obligated to respect, protect and fulfill.
[2] Women Advocates Research and Documentation Centre is a national non-governmental organization established to promote respect for human rights, gender equality, equity, rule of law, accountability and social justice in Nigeria.
[3] Committee on the Elimination of Discrimination Against Women (CEDAW Committee), *List of issues in relation to the combined seventh and eighth periodic reports of Nigeria*, U.N. Doc. CEDAW/C/NGA/Q/7-8 (2016) [hereinafter CEDAW Committee, *List of issues Nigeria*].
[4] *See* CEDAW Committee, *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); 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, para. 21, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).
[5] *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).
[6] CEDAW, *Concluding Observations: Nigeria*, para. 34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).
[7] CEDAW Committee, *List of issues Nigeria*, *supra* note 3, para. 16.
[8] 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*].
[9] *Id.*, para. 10.2.
[10] WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, 19 (2015), http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1 [hereinafter TRENDS IN MATERNAL MORTALITY: 1990 TO 2015].
[11] *Id.*
[12] 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.
[13] WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, *supra* note 10.
[14] *Id.*
[15] 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.
[16] WHO, TRENDS IN MATERNAL MORTALITY: 1990 TO 2015, *supra* note 10, at 74.
[17] 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 under "Targets& Indicators".

[18] CEDAW Committee, *List of issues Nigeria*, *supra* note 3, para. 17.
[19] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 128 (2013), *available at* http://dhsprogram.com/pubs/pdf/FR293/FR293.pdf [hereinafter NIGERIA DHS 2013].
[20] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS, 128, 130 (2013), *available at* https://dhsprogram.com/pubs/pdf/SR213/SR213.pdf [hereinafter NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 2013].
[21] NIGERIA DHS 2013, *supra* note 19., at 130.
[22] *Id.*
[23] *Id.*
[24] 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.
[25] *Id.*
[26] UKWUOMA ARMSTRONG, CHILD MARRIAGE IN NIGERIA: THE HEALTH HAZARDS AND SOCIO-LEGAL IMPLICATIONS 28-29 (2014).
[27] NIGERIA DHS 2013, *supra* note 19, at 142-143.
[28] *Id.*
[29] *Id.*, at 142.
[30] *Id.*, at 16.
[31] *Id.*, at 142.
[32] *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].
[33] *ID.*, at 39–49.
[34] 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.
[35] BROKEN PROMISES, *supra* note 32, at 44.
[36] *Id.*
[37] *Id.*, at 45.
[38] Peter Duru, *Only 4% of Nigerians covered by NHIS*, VANGUARD, Dec. 2, 2016, http://www.vanguardngr.com/2016/12/4-nigerians-covered-nhis/.
[39] National Health Act (2014) *available at* http://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/1189__2014_Official-Gazette-of-the-National-Health-Act-,_FGN_1272.pdf.
[40] Id., Section 3.
[41] BROKEN PROMISES, *supra* note 32 at 41.
[42] CEDAW Committee, *List of issues Nigeria*, *supra* note 3, para. 17.
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