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Report on Nigeria's Compliance with its Human Rights Obligations around Sexual and Reproductive Health and Rights

Submitted by:

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INTRODUCTION

In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center for Reproductive Rights (the "Center"), Legal Defence and Assistance Project (LEDAP), and Women Advocates Research & Documentation Centre (WARDC) jointly submit this letter to supplement the report of the government of Nigeria, scheduled for review by the Human Rights Council during its 31st session of the Universal Periodic Review Working Group (2018). The Center for Reproductive Rights (the Center) is a nonprofit legal advocacy organization dedicated to promoting and defending reproductive rights worldwide. The Center uses the law at the national, regional, and international levels to advance reproductive freedom as a fundamental right that all governments are legally obligated to protect, respect and fulfill. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in 45 nations in Africa, Asia, Europe, Latin American and the Caribbean, the United States, and through in-depth engagement with UN and regional human rights bodies. LEDAP is a non-governmental organization of lawyers and law professionals engaged in the promotion and protection of human rights, the rule of law, and good governance in Nigeria. WARDC is a nonprofit civil rights organization established in the year 2000 to promote respect for human rights, gender equality, equity, rule of law, accountability and social justice in Nigeria.

Nigeria is a party to multiple international and regional human rights treaties that require state parties to ensure the sexual and reproductive rights of women and girls.[1] At the national level, Nigeria has enacted various laws and put in place policies that guarantee sexual and reproductive rights of women and girls.[2] Preliminary findings from interviews and focus group discussions conducted by the Center and LEDAP in February 2018 among women and girls who have become internally displaced persons (IDPs) due to the conflict in north east Nigeria indicate a wide range of inadequacies with the provision of sexual and reproductive health services.[3] Women and girls shared experiences of sexual violence and exploitation to access food, water, and medicine. [4]

While some women in IDP camps had access to free maternal healthcare services during pregnancy, they were required to pay out-of-pocket for medications and did not have adequate food to sustain nursing, and in their own words "there is no overnight stay in the clinic after labor unless you give birth at night."[5] One woman who gave birth during the day and could not remain in the clinic overnight died in her tent during the night.

Focus group discussion participants also raised concerns about increased levels of child and forced marriage among IDPs as a survival measure.[6] An adolescent girl whose parents had forced her to marry a much older man spoke about being abandoned with two children and living in a host community without adequate shelter. There were also disparities in access to healthcare services including reproductive healthcare services between IDPs in formal camps and those in host communities or in camps where relocation efforts were previously ordered. IDPs in Damare camp indicated that there was no health clinic or water source in the camp.[7]

Despite the existence of a strong legal framework, women and girls continue to face numerous reproductive rights violations. This letter highlights the various reproductive health and rights issues that the Center, LEDAP and WARDC hope the Human Rights Council will take into account during its review of Nigeria: (i) violations of women's and girls' reproductive rights in situations of conflict; (ii) high maternal mortality and lack of access to maternal health care; (iii) lack of access to contraceptives and family planning information and services; (iv) high rate of unsafe abortions & lack of post-abortion care; and (v) sexual and gender-based violence against women and girls.

A. Violations of Women's and Girls' Reproductive Rights in Situations of Conflict

1. Conflict worsens peoples' health status partly because it destroys health infrastructure and disrupts services. On many occasions, vulnerable populations including women, people with disabilities and children bear the greatest brunt.[8] Essential services such as basic health care, including reproductive health care and counseling, are often disrupted or become inaccessible during conflict situations.[9]
2. Since 2009, more than 2.2 million people have been internally displaced, 20,000 civilians killed, and as many as 7,000 women and girls abducted as result of the Boko Haram conflict.[10] 1.17 million of the internally displaced persons are female and among them are 510,555 women of reproductive age.[11] Women and girls in conflict zones in Nigeria continue to face numerous reproductive rights violations. These include child and forced marriage, sexual and gender based violence, unsafe abortions and lack of access to family planning information and services.
3. Systematic sexual and gender-based violence has been a well-documented feature of Boko Haram's treatment of the women and girls it abducts. According to a recent study by the African Committee of Experts on Rights and Welfare of the Child (ACERWC), gender-based violence and child marriages in Nigerian camps for displaced people were confirmed by both State and non-State actors.[12] Rape cases involving girls as young as 3 years were also reported.[13] In one case, the perpetrator was released after handing a bribe.[14] Similarly in 2016, the report of the UN Secretary General indicated that four girls were pregnant as a result of sexual violence during their captivity and that all 68 mothers of the 112 children under 5 years of age in captivity had been either raped and/or were wives of Boko Haram members.[15]
4. In 2017, the CEDAW Committee raised concerns that a significant number of girls who were abducted by Boko Haram from Chibok and Damasak in Borno State in April and November 2014, respectively, had not been rescued and that they continue to be subjected to rape, sexual slavery, forced marriage and impregnation by insurgents.[16] The CEDAW Committee further expressed their concern on sexual exploitation in camps, especially in Maiduguri, and that girls and children born as a result of rape and sexual slavery committed by Boko Haram insurgents are subject to stigma and social isolation.[17] The CEDAW Committee urged Nigeria to 'protect women and girls who are disproportionately affected by conflicts and attacks by Fulani herders and ensure that perpetrators of such attacks, including gender-based violence, are arrested, prosecuted and punished with appropriate sanctions'.[18] Despite these calls, approximately 110 school girls were abducted in Dapchi, Yobe State on February 19, 2018 and while most of them were subsequently recovered, it is unclear what condition they are in.[19]
5. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), to which Nigeria is a state party provides that abortion should be permitted in situations of rape, incest and sexual assault, among other grounds.[20] However, survivors of sex slavery, rape, forced pregnancy and forced marriage lack access to safe legal abortion services. Nigeria has very restrictive abortion laws, permitting abortion only when the life of the woman is in danger.[21] In the absence of an enabling legal framework, these survivors are forced to carry the pregnancy or seek an unsafe abortion. For instance, more than 200 women and girls rescued by the Nigerian Army from Boko Haram in 2015 were reported to have been pregnant as a result of serial rape or forced marriage; none were offered access to safe abortion, leading some of them to seek out illegal, unsafe abortions.[22]
6. Family planning remains out of reach for millions of women and girls affected by crisis. Unsafe, restrictive, or repressive environments; prohibitive costs; lack of information in a language they understand; and fear of further violence or stigmatization for seeking care make it difficult for women and girls to access family planning information and services.[23] According to the most recent Demographic and Health Survey (DHS), contraceptive use is as low as 3% among married women in the North East of the country,[24] a part of the country which is in a state of humanitarian crisis due to

ongoing conflict and as low as 1% in five states in the North West.[25] For the vast majority of women and girls living in internally displaced persons (IDPs) camps, the poor sanitation and hygiene they face makes it extremely difficult to manage menstrual hygiene. Research indicates that 90% of IDPs are poor and cannot afford off-the-shelf sanitary pads and instead improvise with materials such as cloth, newspaper, and even dried grasses. Menstrual hygiene if not properly managed is a risk factor for reproductive tract infections.

B. High Maternal Mortality and Lack of Access to Maternal Health Care

7. The maternal mortality rate remains high in Nigeria. According to the World Health Organization's latest report on maternal mortality, Nigeria had the highest numbers of all maternal deaths worldwide in 2015, with an approximate 58,000 maternal deaths (19%).[26] One Nigerian woman dies every 13 minutes – that is 109 women dying each day - from preventable causes related to pregnancy and childbirth. For each death, there are an estimated 30 to 50 women who will experience life-long conditions and disabilities such as obstetric fistula.[27]
8. Several barriers continue to impede accessibility, availability and quality of maternal health care in Nigeria. According to a recent study, cost of services, distance to health facilities, and inadequate and long waiting times for those seeking care at public health facilities are key barriers to quality maternal health care.[28] Further, there is disparity in access based on women's geographical location, age and socio-economic status. Adolescent girls, uneducated women, and women in rural areas and from the northern part of Nigeria are at higher risk of maternal death compared to those in urban areas and from the south of the country.[29] These at-risk women are less likely to use skilled providers and formal health facilities at delivery, tend to deliver at home without a skilled attendant, and are more likely to turn to unsafe termination of pregnancies.[30] In 2013, 78% and 75% of women in the south-east and south-west, respectively, reported delivering their babies in a health facility, compared to only 20% and 11% in the north-east and north-west.[31] In 2013 the DHS showed that 8% of women did not deliver in a health facility because of unaffordable cost and as many as 56% of women could not afford the cost of antenatal care. [32] Pregnancy-related complications are the leading cause of death among young women aged 15-19 years.[33]
9. In 2017, the CEDAW Committee highlighted maternal mortality, high incidence of obstetric fistula and the limited access to antenatal, delivery, and postnatal care owing to physical and economic barriers as issues of concern.[34] The CEDAW Committee recommended to Nigeria to take steps to 'reduce the incidence of maternal mortality, including through the training of midwives and the effective implementation of the national midwives' service scheme, especially in rural areas, to ensure that all births are attended by skilled health personnel, in line with Sustainable Development Goals 3.1 and 3.7'.[35]
10. Abuse and mistreatment of care-seekers by health care providers at public health facilities is also widespread.[36] In a recent study, 36% of the women interviewed reported to have been physically abused during childbirth, others reported discrimination, lack of non-confidential care, poor unfriendly provider attitude, abandonment, and neglect.[37] Further, 22% of women interviewed reported detention in health facilities for failure to pay their bills. [38] The ongoing case, Women Advocates Research and Documentation Centre v. Attorney General of the Federation (2015), regarding the detention, mistreatment and maternal death of Folake Oduyoye filed before the Federal High Court of Nigeria, by WARDC with technical support from the Center, is illustrative of these systematic failures of the government to ensure access to maternal health care.

11. Maternal health remains underfunded. Since the Abuja Declaration in 2001, Nigeria has not attained the pledged funding benchmark of 15% of the annual budget. In 2018 only N340.45 billion, representing 3.9 percent of the N8.6 trillion expenditure plans were allocated to health sector, which is less than the 4.16 percent and 4.23 percent made to the health sector in 2017 and 2016 budgets respectively.[39]

C. High Rate of Unsafe Abortions & Lack of Post-Abortion Care

12. In its last Universal Periodic review in 2013, several states in their recommendations urged Nigeria to intensify its efforts to guarantee access to health care including enhanced reproductive health measures.[40] In 2017, the CEDAW Committee raised concern on the high rate of maternal mortality in Nigeria due to high numbers of unsafe abortions[41] and high incidence of unsafe abortion due to the restrictive laws. [42] At the regional level, the African Commission on Human and Peoples' Rights launched a continental campaign on decriminalization of abortion.[43] Nigeria has signed and ratified the Maputo Protocol and therefore has legal obligations to decriminalize abortion. Despite the emphasis by different human rights bodies, access to safe legal abortion and post-abortion care remains lacking in Nigeria.
13. Abortion laws in Nigeria remain very restrictive, permitting abortion only to save a pregnant woman's life.[44] 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.[45] 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 lobbying by the religious opposition.[46]
14. Consequently, the majority of abortions performed in the country are clandestine and unsafe; that is, terminated either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.[47] 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.[48] In 2012, fifty-six percent of unintended pregnancies ended in abortion, amounting to 14% of all pregnancies in Nigeria.[49] The restrictive abortion law means that numerous abortions are clandestine and unsafe, performed by providers that are untrained and unqualified "quacks." For instance, a study of 497 women with induced abortion complications found that over 41% of abortions had been performed by people who were not medical practitioners[50] in unhygienic environments and with dangerous methods.[51] 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.[52] Even where a woman obtains a legal abortion at a health care facility, inadequate staffing, training and equipment expose women to unnecessary risks.[53] Among those who have had 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.[54] Few general practitioners receive proper training to perform abortions.[55]
15. As a result, unsafe abortions account for 20-40% of maternal deaths in Nigeria, and many more women suffer serious injuries.[56] Of the 1.25 million induced abortions in Nigeria in 2012, 40% resulted in complications serious enough to require treatment in a facility.[57] About 212,000 women were treated in health facilities for complications of induced abortion that year, while 285,000 additional women suffered serious health complications but were not treated in medical facilities.[58] Many women who suffer from complications are unable to pay for PAC.[59] Further, many doctors refuse to operate on post-abortion patients for fear of criminal consequences.[60] Although the Nursing and Midwifery Council of Nigeria incorporated PAC into the training curriculum of midwifery[61], 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 aspiration to treat incomplete abortions, the recommended method for PAC.[62] Another study of health care professionals in the same area found that only 40.1% had been trained on PAC counseling.[63]

D. Lack of access to contraceptives and family planning information and services

16. 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 DHS, the use of any family planning method among currently married women increased only moderately between 2003 and 2013, from 13% to 15%.[64] Only 10% of women use a modern contraceptive method.[65] This figure represents a very small improvement from the 2003 rate of 8%.[66] This low contraceptive usage is the leading contributory factor to high rates of unwanted and unplanned pregnancy in Nigeria.[67] More than 60% of women with unplanned pregnancies did not use contraception.[68] 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.[69]According to the 2013 DHS, the unmet need was higher, at 19%, among women with primary education only.[70] 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.[71]
17. 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. 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.[72] 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.[73]
18. 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 DHS 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.[74] These women represent a significant population which family planning programs are not reaching. 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.[75] 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.[76] 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.[77] According to the 2013 DHS, only 56% of sexually active unmarried women and 30% of all women know about EC.[78] 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 knowledge about EC.[79]

E. Sexual and gender based violence against women and girls

19. In its last universal periodic review, several states urged Nigeria to take appropriate measures to eliminate violence against women including by enacting appropriate laws and improving public policies to combat violence.[80] 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.[81] The Act however applies in Federal capital only.[82] There are several states that do not have specific laws prohibiting sexual and gender based violence. Currently, there is no legislation at the federal level prohibiting FGM, and one-third of the country has no laws in place to protect women against any form of violence.[83] 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.[84] Numerous studies demonstrate that violence against women continues to be endemic in Nigeria.

20. According to the latest DHS, nearly three in ten women have experienced physical violence since age 15, mostly at the hands of their partners, with one-quarter of ever-married women having suffered from spousal physical, emotional, or sexual abuse at some point in their lives. [85] 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.[86] Where victims have attempted to bring charges, the perpetrators faced penal laws that are inadequate and outdated.[87] Only 2% of women who report violence go to the police; most women, of the 31% who seek help, turn to family.[88] As of 2015, only 18 people in Nigeria had ever been convicted for rape[89] despite the fact that between 2012 and 2013, the Lagos State Police Command alone recorded 678 cases of rape in the state. [90]

QUESTIONS

We hope that the Human Rights Council will consider addressing the following questions to the government of Nigeria:

i. What measures is Nigeria taking to ensure that women and girls in conflict-affected areas of the country have access to sexual and reproductive health services and information, quality maternal health care and safe abortion services?
ii. What measures is Nigeria taking to investigate and prosecute perpetrators of sexual and gender-based violations against women and girls affected by conflict, including effective mechanisms for accountability and redress?
iii. What steps are being taken to allocate the resources necessary to improve maternal healthcare services through ensuring that healthcare facilities are adequately equipped and, to increase the number of skilled healthcare providers in hard to reach populations, specifically women and girls in conflict-affected areas of the country?
iv. What measures is Nigeria taking to ensure that there are sufficient resources to properly implement the 2015 Violence against Persons (Prohibition) Act?
v. What concrete measures is the government going to take to improve the training of healthcare providers about patients' rights and eliminate the abuse and neglect of women by medical and hospital staff? What steps are being taken to protect women and girls from gender-based violence and abuse in healthcare facilities? How does the government propose to ensure that women are able to report and seek redress for such abuses?
vi. What measures is the government undertaking to clarify its laws on abortion and ensure that women have access to legal, safe abortion and post-abortion services?
vii. What measures does the government plan to undertake to remove the barrier women and girls face in accessing contraceptive services including by ensuring that they have access to comprehensive reproductive health information and services?

RECOMMENDATIONS

We hope the Council will consider the following recommendations to the Republic of Nigeria.

i. The government should take steps to increase access to sexual and reproductive health services for women and girls who are affected by the conflict including access to quality maternal health care, guarantee access to safe abortion services, and provide appropriate redress to victims of sexual and gender-based violence.
ii. 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 resources and infrastructure for delivering reproductive health services and information, and by providing these women and girls with medical treatment and psychosocial support.
iii. 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.
iv. 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.
v. 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, and risks to the health of the woman, 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.
vi. The government should take concrete actions to address violence against women, including by ensuring that all states adopt and enforce the 2015 Violence against Persons (Prohibition) Act, 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.

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

Sincerely,

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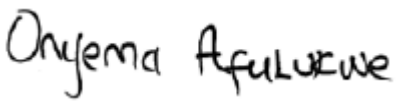

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[1] These include: Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1980), U.N.T.S. 13 (*entered into force* Sept. 3, 1981) [hereinafter CEDAW]; International Covenant on Economic, Social and Cultural Rights, *adopted* Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966) (*entered into force* Jan. 3, 1976) [hereinafter ICESCR]; Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (*entered into force* Sept. 2, 1990) [hereinafter CRC]; Convention on the Rights of Persons with Disabilities, *adopted* Dec. 13, 2006, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/611 (1980) (*entered into force* May 3, 2008) [hereinafter CRPD]; African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, O.A.U. Doc. CAB/LEG/67/3, rev. 5, 21 I.L.M. 58 (1982) (*entered into force* Oct. 21, 1986) [hereinafter Banjul Charter]; 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, CAB/LEG/66.6 (2000) (*entered into force* Nov. 25, 2005) [hereinafter Maputo Protocol].

[2] *See e.g.* the Violence against Persons (Prohibition) Act (2015) (Nigeria).

[3] Interviews were conducted in Yola, Adamawa State.

[4] Interviews and focus group discussions with women and girls at IDP camps in Yola, February 24 & 25, 2018.

[5] Interviews conducted on Feb 24, 2018 at Fufore IDP camp.

[6] FGD with NGOs and their clients who were women and girls affected by the conflict and living in IDP host communities, conducted in Yola on February 24, 2018.

[7] Interviews and FGDs in Damare IDP camp.

[8] UNICEF, THE IMPACT OF CONFLICT ON WOMEN AND GIRLS IN WEST AND CENTRAL AFRICA AND THE UNICEF RESPONSE 3 (2005); *People with Disabilities at Risk in Conflict Disaster*, HUMAN RIGHTS WATCH (May 19, 2016), https://www.hrw.org/news/2016/05/19/people-disabilities-risk-conflict-disaster.

[9] UNFPA, THE IMPACT OF ARMED CONFLICT ON WOMEN AND GIRLS: A CONSULTATIVE MEETING ON MAINSTREAMING GENDER IN AREAS OF CONFLICT AND RECONSTRUCTION 3 (2001), *available at* https://www.unfpa.org/sites/default/files/pub-pdf/impact_conflict_women.pdf.

[10] UNFPA, ADOLESCENT GIRLS IN DISASTER & CONFLICT: INTERVENTIONS FOR IMPROVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES 42 (2016), *available at* https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-Adolescent_Girls_in_Disaster_Conflict-Web.pdf.

[11] *Id.*

[12] AFRICAN COMMITTEE OF EXPERTS ON THE RIGHTS AND WELFARE OF CHILD, CONTINENTAL STUDY ON THE IMPACT OF CONFLICT AND CRISES ON CHILDREN IN AFRICA 69 (2016), *available at* http://www.acerwc.org/the-committee-releases-its-study-on-children-and-armed-conflicts/.

[13] *Id.*

[14] *Id.*

[15] U.N. Secretary-General, *Children and Armed Conflict: Rep. of the Secretary-General*, ¶ 192, U.N. Doc A/70/836-S/2016/360 (Apr. 20, 2016), *available at* https://www.un.org/ga/search/view_doc.asp?symbol=S/2016/360.

[16] CEDAW Committee, *Concluding Observations: Nigeria*, para. 15(a), U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017).

[17] *Id.* para. 15(c).

[18] *Id.*, para 16(e).

[19] Stephanie Busari and Bukola Adebayo, *More Than 100 Girls Missing After Raid on Nigerian School*, CNN (Feb. 26, 2018), https://edition.cnn.com/2018/02/25/africa/nigeria-boko-haram-father/index.html.

[20] Maputo Protocol, *supra* note 1, art. 14 (2)(c).

[21] *See* Criminal Code Act, Chapter 77 of the Laws of the Federation of Nigeria (Revised ed. 1990), Articles 228-230, 297, 309, 328.

[22] Laura Basset, *Instruments of Oppression*, THE HUFFINGTON POST, http://highline.huffingtonpost.com/articles/en/kenya-abortion/.

[23] CENTER FOR REPRODUCTIVE RIGHTS, HIDDEN CASUALTIES: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND SEXUAL VIOLENCE IN CONFLICT 1 (2016), *available at* https://www.awid.org/sites/default/files/atoms/files/sexual_reproductive_rights_sexual_violence_in_conflict.pdf.

[24] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY: KEY FINDINGS 5 (2013) [hereinafter NDHS 2013 KEY FINDINGS].

[25] NIGERIA NATIONAL POPULATION COMMISSION AND ICF INTERNATIONAL, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 95 (2013) [hereinafter NDHS 2013].

[26] WHO, UNICEF, UNFPA, WORLD BANK GROUP, UNPD, TRENDS IN MATERNAL MORTALITY: 1990 TO 201 xi (2015), *available at* http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1.

[27] AFRICAN POPULATION HEALTH AND RESEARCH CENTER, MATERNAL HEALTH IN NIGERIA: FACTS AND FIGURES 1 (2017), *available at* http://aphrc.org/wp-content/uploads/2017/06/APHRC-2017-fact-sheet-Maternal-Health-in-Nigeria-Facts-and-Figures.pdf.

[28] AFRICAN POPULATION AND HEALTH RESEARCH CENTER, MATERNAL HEALTH IN NIGERIA: SITUATION UPDATE 24 (2017) [hereinafter APHRC SITUATION UPDATE 2017].

[29] *Id.*, at xi.

[30] *Id.*

[31] *Id*., at 7.
[32] *Id*. at 24; NDHS 2013, *supra* note 25 at 137.
[33] APHRC SITUATION UPDATE 2017, *supra* note 28, at 14.
[34] CEDAW Committee, *Concluding Observations: Nigeria*, para. 37(a) and (d), U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017).
[35] *Id.*, para. 38(a).
[36] Foluso Ishola, Onikepe Owolabi & Veronique Filippi, *Disrespect and Abuse of Women During Childbirth in Nigeria: A Systematic Review*, 12 PLoS ONE 3 (2017).
[37] *Id.*
[38] *Id.*
[39] Ebuka Onyeji, *2018 Budget: Again, Nigeria Falls Short of AU Health Funding Commitment*, PREMIUM TIMES (Nov. 10, 2017), https://www.premiumtimesng.com/news/headlines/248909-2018-budget-nigeria-falls-short-au-health-funding-commitment.html; Kingsley Obiejesi, 2018 Budget Maintains Abysmal Allocation to Health Sector, INTL CENTRE FOR INVESTIGATIVE REP. (Nov. 8, 2017), https://www.icirnigeria.org/2018-budget-maintains-abysmal-allocation-health-sector.
[40] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Nigeria*, para. 135.58, U.N. Doc. A/HRC/25/6 (2013).
[41] CEDAW Committee, *Concluding Observations: Nigeria*, para. 37(a), U.N. Doc. CEDAW/C/NGA/CO/7-8 (2017).
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