

June 3, 2019

**The Human Rights Committee**

RE: Supplementary information for review of the Federal Republic of Nigeria in the absence of the second periodic report, scheduled by the Human Rights Committee during its 126th Session, July 01-26, 2019

Honourable Committee Members:

The Center for Reproductive Rights (the Center) Women Advocates Research & Documentation Centre (WARDC) and Legal Defence and Assistance Project ( LEDAP) jointly submit this letter to the Human Rights Committee (the Committee) ahead of the review of the Federal Republic of Nigeria, in the absence of the second periodic report scheduled by the Committee during its 126th session. The Center for Reproductive Rights (the Center) is a non-profit 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 fulfil. The Center has strengthened reproductive health laws and policies across the globe by working with more than 100 organizations in fifty 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. WARDC is a non-profit 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. Since its inception, WARDC has filed over 450 cases in court, instituted four class actions and receives an average of six women every week for legal and social counselling on gender-based violence and other civil matters that affect women. 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. Founded in 1997 by a group of pro bono lawyers working to protect and support political prisoners, the organization has grown to 1700 members across Nigeria. LEDAP provides free legal representation to poor and vulnerable victims of human rights violations. It also works to promote and protect rights of women under its domestic violence and reproductive health programmes.

This letter provides information in line with the Committee’s 2018 list of issues to the government of Nigeria and the 2019 replies to the list of issues by the government of Nigeria. The letter highlights various reproductive health and rights issues and recommendations that the Center hopes the Committee will consider during the review. These issues include: (i) violations of women’s and girls’ reproductive rights in situations of conflict; (ii) 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 and lack of post-abortion care; and (v) sexual and gender-based violence against women and girls.

# **Violations of Women’s and Girls’ Reproductive Rights in Situations of Conflict**

The Committee recognizes the vulnerability of women during periods of internal or international armed conflicts and has highlighted the importance of taking measures during such situations to protect women from all forms of gender-based violence, including sexual violence.[[1]](#footnote-1) The Committee in its 2018 list of issues to Nigeria, requested the government to *‘explain measures taken to address sexual violence, rescue all of the “Chibok girls” kidnapped in 2014 , to assist and rehabilitate abductees, in particular survivors of sexual violence perpetrated by terrorist groups; and ensure that survivors of sexual violence are not stigmatized and measures taken hold perpetrators accountable’*.[[2]](#footnote-2) The Committee further requested Nigeria *‘to provide information on legislative, policy and institutional measures taken to protect internally displaced and especially women and children from sexual abuse*’. [[3]](#footnote-3) However, the government of Nigeria in its 2019 list of replies to the Committee failed to demonstrate measures taken to address sexual violence and protect women and girls in internally displaced camps (IDP camps) in Nigeria. Yet women and girls in conflict zones in Nigeria and those in IDP camps continue to face multiple reproductive rights violations and lack access to essential reproductive health services. Namely: child and forced marriage, sexual and gender-based violence, unsafe abortions, maternal deaths and injuries and lack access to family planning information and services.

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 a result of the Boko Haram conflict.[[4]](#footnote-4) 1.17 million of the internally displaced persons are women, and 510,555 are of reproductive age.[[5]](#footnote-5) Preliminary findings from interviews and focus group discussions conducted by the Center and LEDAP in February 2018 among women and girls who have been internally displaced due to the conflict in North East Nigeria indicate a wide range of inadequacies with the provision of sexual and reproductive health services.[[6]](#footnote-6) Women and girls shared experiences of systemic and widespread sexual violence and exploitation to access food, water, and medicine.[[7]](#footnote-7)

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 labour unless you give birth at night. One woman who gave birth during the day and could not remain in the clinic overnight died in her tent during the night”.[[8]](#footnote-8)

Focus group discussion participants also raised concerns about increased levels of child and forced marriage among IDPs as a survival measure.[[9]](#footnote-9) 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.[[10]](#footnote-10) 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.[[11]](#footnote-11) IDPs in Damare camp indicated that there was no health clinic or water source in the camp.[[12]](#footnote-12)

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 the 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.”[[13]](#footnote-13) Rape cases involving girls as young as 3 years were also reported.[[14]](#footnote-14) In one case, the perpetrator was released after handing a bribe.[[15]](#footnote-15) Similarly in 2016, a 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 [forced into marriage by] Boko Haram members.”[[16]](#footnote-16) In 2018, WARDC conducted a mapping exercise on gender based violence in Borno State. According to the report, cases of sexual and gender-based violence remain high in IDP camps. There are several allegations of sexual exploitation and abuse in exchange for resources (money, assets, food among others) by IDP security officers , influential community members and humanitarian workers.[[17]](#footnote-17) The report also confirms that majority of sexual and gender based violence cases are still solved through traditional conflict resolution mechanisms and alternative dispute resolution process which may place limitations on women’s access to justice.[[18]](#footnote-18) This is further exacerbated by a fragmented justice system due to the absence of mobile courts, limited presence of police personnel, who have responsibilities to arrest, investigate and prosecute crimes and offences perpetrated in the communities and state at large.[[19]](#footnote-19) While there have been efforts to address existing gender based issues, most of the interventions have been carried out by non-governmental organizations. [[20]](#footnote-20)

# **Maternal Mortality and Lack of Access to Maternal Health Care**

The Committee, as well as other treaty-monitoring bodies (TMBs), has framed the issue of maternal mortality as a violation of women’s and girls’ rights to health and to life.[[21]](#footnote-21) In its 2018 list of issues to Nigeria, the Committee requested the government of Nigeria to *‘provide information on measures taken to improve access to health services for pregnant women and respond to whether women seeking maternal health services are detained in hospitals post-delivery or denied access to services for failure to pay bill’*.[[22]](#footnote-22) In response, in its 2019 list of replies to the Committee, the government of Nigeria reported that various policy and legislative reforms had been put in place including enactment of National Health Act, 2014, National Health Policy 2016, National Strategic Health Development Plan (2010–2015) and 2018–2022.[[23]](#footnote-23) Further the government reports that in April 2019, it declared a state of emergency on maternal and infant mortality to be able to eradicate the high rates of maternal and infant mortality.[[24]](#footnote-24) In its April 2019 statement, the government of Nigeria acknowledges that “*in the last 25 years, Nigeria made the 5th worst progress among 20 countries that had the worst maternal mortality ratios by 1990 worse than war-challenged countries with wide-scale humanitarian crisis such as Afghanistan, Liberia, Sierra Leone and South Sudan who made better progress”.*[[25]](#footnote-25)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]](#footnote-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]](#footnote-27)

High 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 in Nigeria.[[28]](#footnote-28) These challenges are further exacerbated by disparities in access based on women’s geographical location,[[29]](#footnote-29) age[[30]](#footnote-30) and socio-economic status.[[31]](#footnote-31) Adolescent girls, women without any formal education, 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.[[32]](#footnote-32) 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.[[33]](#footnote-33) In 2013, 78% and 75% of women in the South East Zone and South West Zone, respectively, reported delivering their babies in a health facility, compared to only 20% and 11% in the North East and North West Zones.[[34]](#footnote-34) 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. [[35]](#footnote-35) Pregnancy-related complications are the leading cause of death among young women aged 15-19 years.[[36]](#footnote-36)

Despite admitting the high maternal mortality rates, the government of Nigeria in its 2019 list of replies to the Committee does not explicitly specify measures taken to address detention of women post-delivery due to inability to pay medical fees or denial of services for failure to pay bill.

Detention of women post delivery due to inability to pay medical fees is widespread.[[37]](#footnote-37) The case below demonstrates the ripple effects of detention of women post-delivery due to inability to pay medical bills.

***Women Advocates Research and Documentation Centre v. The Attorney General of the Federation & 3 others***

*In September 2014, Folake Oduyoye was admitted to Lagos University Teaching Hospital on due to complications from a caesarean delivery at another hospital on August 30. After receiving treatment and being discharged in October 2014, she and her husband received an outstanding bill of N 1,382,700, an equivalent of USD 3,840. He paid N 300,000, an equivalent of USD 830 but that was not sufficient for the hospital and they detained Folake—keeping her in a heavily guarded ward that lacked a toilet, electricity or mosquito netting.*

*She was denied any medical attention because the hospital claimed she had been discharged yet was locked in a ward against her will and needed post-surgical care for her caesarean. Her husband made multiple pleas for her release, assuring the hospital that they would pay the remaining balance monthly. But weeks went by, and she started having serious health complications. Their cries for help were ignored and Folake died in the hospital on December 13, 2014 from puerperal sepsis and pneumonia.*

*In 2015, with technical support from the Center, WARDC filed a lawsuit at the Federal High Court of Nigeria challenging the government for failing to ensure access to the highest attainable standard of health and the right to be free from torture in-humane and degrading treatment. In 2018, the federal high court of Nigeria dismissed the case on irregularities. WARDC, with technical support from the Center filed a leave to appeal and this was granted in March 2019. The first appeal hearing held in May 2019.*

# **High Rate of Unsafe Abortions & Lack of Post-Abortion Care**

The Committee has recognized that states ‘duty to protect and ensure the right to life includes a duty to protect women who terminate their pregnancies’.[[38]](#footnote-38) In its 2018 list of issues to Nigeria, the Committee requested the government of Nigeria to provide statistics on *‘ number of clandestine termination of pregnancies per year and indicate government’s intention to amend its legislation in order to ensure safe and legal access to abortion where carrying the pregnancy to term could cause the pregnant woman or girl substantial harm or suffering, especially in cases where the pregnancy is the result of rape or incest or when it is non-viable’.*[[39]](#footnote-39) However, in its 2019 list of replies to the Committee, government of Nigeria did not provide statistics of clandestine abortions or explicitly report on any legal reforms to ensure women and girls access to safe legal abortion.

Abortion laws in Nigeria remain very restrictive, permitting access only to save a pregnant woman’s life.[[40]](#footnote-40) 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.[[41]](#footnote-41) According to the latest available study, in 2012, 1.25 million induced abortions occurred in Nigeria, which amounts to 33 abortions per 1,000 women aged 15-49.[[42]](#footnote-42)

Of the 1.25 million induced abortions in Nigeria in 2012, 40% resulted in complications serious enough to require treatment in a facility.[[43]](#footnote-43) 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.[[44]](#footnote-44) Many women who suffer from complications are unable to pay for Post Abortion Care (PAC).[[45]](#footnote-45) Furthermore, many doctors refuse to operate on post-abortion patients for fear of criminal consequences.[[46]](#footnote-46) Although the Nursing and Midwifery Council of Nigeria incorporated PAC into the midwifery training curriculum,[[47]](#footnote-47) a survey of 437 medical health practitioners in South East 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 in such cases.[[48]](#footnote-48) Another study of health care professionals in the same area found that only 40.1% of them had been trained in PAC counselling.[[49]](#footnote-49)

# **Lack of access to contraceptives and family planning information and services**

The Committee has recognized that the right to contraception is rooted in the right to life, rights related to family, and the right to equality and non-discrimination.[[50]](#footnote-50) To this end, the Committee has consistently urged state parties to ensure access to appropriate and affordable contraception and modern methods of contraceptive, and dissemination of information on effective modern methods of contraceptives to all, in particular to those in rural and remote areas.[[51]](#footnote-51) In its 2018 list of issues to Nigeria, the Committee requested the government to *‘describe efforts to ensure access to safe and affordable contraceptive methods, as well as to prevent teen pregnancies*.’[[52]](#footnote-52) In response, in the 2019 list of replies to the Committee, Nigeria reported that it had increased its funding on family planning by 300% since 2013 and this covers family planning programme, child survival programme and an action plan for reducing child mortality in Nigeria to at most 20/1000 live birth by the year 2035.[[53]](#footnote-53)

Despite the increase in budget allocation, statistics show that contraceptive use remain incredibly low among women and girls in Nigeria. According to the latest National Demographic Health Survey ( DHS), the use of any family planning method among currently married women increased only moderately between 2003 and 2013, from 13% to 15%.[[54]](#footnote-54) This figure represents minimal improvement from the 2003 rate of 13%.[[55]](#footnote-55) More than 60% of women who have had unplanned pregnancies had not used contraception.[[56]](#footnote-56) The unmet needs for contraceptives varies with level of education, geographical location and levels of income. Only 3% of women with no education use contraception, compared to 37% of women who have completed more than a secondary education.[[57]](#footnote-57) In rural areas, only 9% of women use any family planning method, and only 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.[[58]](#footnote-58) The largest contributors to the low uptake has been a lack of knowledge about the various available options, misconceptions about the use of contraceptives, patriarchal nature of the society and lack of commodities.[[59]](#footnote-59) For instance, 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.[[60]](#footnote-60)

# **Sexual and gender-based violence against women and girls**

The right to be free from discrimination includes the right to be free from gender-based violence and harmful practices. In its 2018 list of issues to Nigeria, the Committee requested for information on ‘*implementation of 2015 Violence Against Persons (Prohibition) Act, measures taken to eradicate impunity for sexual violence, assist women victims of violence, in particular availability of shelters and care facilities’*.[[61]](#footnote-61) The Committee further requested for information on ‘*capacity building of police, hospital staff and legal professionals on issues related to sexual violence and measures taken to prohibit harmful practices* *including child marriage’.* [[62]](#footnote-62) In its 2019 list of replies to the Committee, Nigeria states that there are ongoing efforts in all the states of the Federation to ensure the adoption of the Violence Against Persons (Prohibition) Act and that Anambra, Ekiti, Lagos, Imo, Edo, Rivers, Cross River. These are just 5 states out of 36 states in Nigeria.

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.[[63]](#footnote-63) 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 twelve months leading up to the study.[[64]](#footnote-64) Where victims have attempted to bring charges, the perpetrators faced penal laws that are inadequate and outdated.[[65]](#footnote-65) Only 2% of women who report violence go to the police.[[66]](#footnote-66) Most of the 31% of women who actually seek help, turn to family.[[67]](#footnote-67) As of 2015, only eighteen people in Nigeria had ever been convicted of rape,[[68]](#footnote-68) despite the fact that, between 2012 and 2013, the Lagos State Police Command alone recorded 678 cases of rape in the state.[[69]](#footnote-69)

# **Questions**

**We hope that the Committee will consider addressing the following questions to government of Nigeria**

1. What measures is Nigeria taking to ensure that women and girls in conflict zones have access to reproductive health services and information?
2. What measures is Nigeria taking to investigate SRHR violations against women and girls affected by conflict, including effective mechanisms for redress?
3. 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?
4. What measures is Nigeria taking to ensure that there are sufficient resources to properly implement the VAPP Act?
5. 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 in healthcare facilities?
6. 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?
7. What measures is the government undertaking to revise its laws on abortion in accordance with regional and international human rights standards and ensure that women have access to legal, safe abortion and post-abortion services?
8. 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?
9. What measures is the government taking to ensure that women and girls seeking maternal health services are not detained in hospitals post-delivery or are not denied services due to inability to pay?

# **Recommendations**

We hope the Committee will consider the following recommendations to the Federal Republic of Nigeria

1. 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 and legal abortion services, and provide appropriate redress to victims of sexual and gender-based violence.
2. The government should take concrete measures to ensure quality of care during delivery including through training health professionals on dignity and a human rights-based approach to maternal health services.
3. The government should allocate adequate resources to ensure access to SRHR services by women and girls including maternal health care, safe and legal abortion and family planning services.
4. 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
5. The government should take concrete measures to ensure access to family planning and contraceptive information and services including by ensuring adequate supplies of contraceptives.
6. The government should decriminalize abortion and review the law on abortion in line with international human rights standards.
7. 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 girls, as well as ensure access, by victims of violence, to medical treatment and psychosocial support.
8. The government should prohibit the detention of women post delivery due to inability to pay medical fees.

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.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Evelyne Opondo  Senior Regional Director for Africa  Center for Reproductive Rights | Onyema Afulukwe  Senior Counsel for Africa  Center for Reproductive Rights | Chino Obiagwu  Founding Director and National Coordinator  Legal Defence and Assistance Project | Abiola Akiyode-Afolabi  Founding Director  Women Advocates Research and Documentation Centre |

1. Human Rights Committee, *General Comment No. 28: Article 3* *(The equality of rights between men and women)*, (68th Sess., 2000), para. 3, at 228, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008) [hereinafter Human Rights Committee, *Gen. Comment No. 28*]. [↑](#footnote-ref-1)
2. Human Rights Committee, List of Issues in the absence of the second periodic report of Nigeria, CCPR/C/NGA/Q/2 (28November 2018) [*hereinafter List of Issues*), para 12. [↑](#footnote-ref-2)
3. List of Issues, *supra* note 2, para 14. [↑](#footnote-ref-3)
4. 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>. [↑](#footnote-ref-4)
5. *Id.* [↑](#footnote-ref-5)
6. Interviews and Focus Group Discussions with internally displaced women and girls, in Yola, Adamawa State, Nigeria [Feb.24, 2018]. [↑](#footnote-ref-6)
7. Interviews and Focus Group Discussions with women and girls at camps hosting internally displaced persons (IDPs), in Yola, Adamawa State, Nigeria (Feb. 24, 25, 2018). [↑](#footnote-ref-7)
8. Interviews with women and girls, in Fufore IDP Camp, Yola, Adamawa State, Nigeria (Feb. 24, 2018). [↑](#footnote-ref-8)
9. Focus Group Discussions with NGOs and their clients, in Yola, Adamawa State, Nigeria (Feb. 24, 2018). The clients were women and girls affected by the conflict and living in IDP host communities. [↑](#footnote-ref-9)
10. *Id.* [↑](#footnote-ref-10)
11. *Id.* [↑](#footnote-ref-11)
12. Interviews and Focus Group Discussions with women and girls, in Damare IDP Camp, Yola, Adamawa State, Nigeria (Feb.24, 2018). [↑](#footnote-ref-12)
13. African Committee of Experts on the Rights and Welfare of the 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/>. [↑](#footnote-ref-13)
14. *Id.*  [↑](#footnote-ref-14)
15. *Id.* [↑](#footnote-ref-15)
16. U.N. Secretary-General, *Children and Armed Conflict: Rep. of the Secretary-General*, para. 192, U.N. Doc A/70/836-S/2016/360 (Apr. 20, 2016). [↑](#footnote-ref-16)
17. Women advocates research and documentation center, ‘Borno State GBV Mapping Report ( 2018). [↑](#footnote-ref-17)
18. *Id.*  [↑](#footnote-ref-18)
19. *Id.* [↑](#footnote-ref-19)
20. *Id.*  [↑](#footnote-ref-20)
21. *See, e.g.*, Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003); *see also* Human Rights Committee, *Concluding Observations:* *Ecuador*, para. 11, U.N. Doc. CCPR/C/79/Add.92 (1998) (“[T]he Committee regrets the State party’s failure to address the resulting problems [of the prohibition of abortion] faced by adolescent girls, in particular rape victims, who suffer the consequences of such acts for the rest of their lives. Such situations are . . . incompatible with articles 3, 6 and 7 of the Covenant, and with article 24 when female minors are involved.”); ESCR Committee, *General Comment No. 14: The right to the highest attainable standard of health (Art. 12)*, (22nd Sess., 2000), para. 14, at 81, para. 52, U.N. Doc. E/C.12/2000/ (2000) 4[hereinafter ESCR Committee, *Gen. Comment No. 14*]; CEDAW Committee, *Concluding Observations: Belize*, para. 56, U.N. Doc. A/54/38 (1999); CEDAW Committee, *Concluding Observations:* *Colombia*, para. 393, U.N. Doc A/54/38 (1999); CEDAW Committee, *Concluding Observations:* *Dominican Republic*, para. 337, U.N. Doc A/53/38 (1998); CEDAW Committee, *Concluding Observations:* *Madagascar*, para. 244, U.N. Doc A/49/38 (1994). [↑](#footnote-ref-21)
22. List of Issues, supra note 2, Para 7. [↑](#footnote-ref-22)
23. Human Rights Committee, list of issues in the absence of the second periodic report of Nigeria: Replies of Nigeria to the list of issues, CCPR/C/NGA/Q/2/Add.1 ( 9 May 2019) [ hereinafter *Replies to the List of Issues*], para 29. [↑](#footnote-ref-23)
24. Response to List of Issues, supra note 19, para 30; see also Nigeria declares state of emergency on maternal and child health at < <https://nphcda.gov.ng/nigeria-declares-state-of-emergency-on-maternal-and-child-health/>> [↑](#footnote-ref-24)
25. *Id.*  [↑](#footnote-ref-25)
26. World Health Org. [WHO], UNICEF, UNFPA, World Bank Group, U.N. Development Program [UNDP], Trends in Maternal Mortality: 1990 to 2015, xi (2015), *available at* <http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1>. [↑](#footnote-ref-26)
27. African Population Health and Research Center [APHRC], 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>. [↑](#footnote-ref-27)
28. APHRC, Maternal Health in Nigeria: Situation Update 24 (2016), *available at* <http://aphrc.org/wp-content/uploads/2016/05/Maternal-Health-in-Nigeria_Final-Report.pdf> [hereinafter APHRC, Situation Update 2016]. [↑](#footnote-ref-28)
29. *Id.* at 16–17. [↑](#footnote-ref-29)
30. *Id.* at 14–15. [↑](#footnote-ref-30)
31. *Id.* at 17–20. [↑](#footnote-ref-31)
32. *Id.* at xi. [↑](#footnote-ref-32)
33. *Id.* [↑](#footnote-ref-33)
34. *Id.* at 7. [↑](#footnote-ref-34)
35. *Id.* at 24; NDHS 2013, *supra* note 52, at 137. [↑](#footnote-ref-35)
36. APHRC, Situation Update 2016, *supra* note 60, at 14. [↑](#footnote-ref-36)
37. *See generally* Foluso Ishola, Onikepe Owolabi & Veronique Filippi, *Disrespect and Abuse of Women During Childbirth in Nigeria: A Systematic Review*, 12 PLoS ONE (2017). [↑](#footnote-ref-37)
38. Human Rights Committee, *Concluding Observations: Chile*, para. 15, U.N. Doc. CPR/C/79/Add.104 (1999); Human Rights Committee, *General Comment No. 36 on article 6 of the International Covenant on Civil and Political Rights on the right to life, revised draft prepared by the Rapporteur*, para. 9 (July 2017) (by Yuval Shany), *available at* <https://www.ohchr.org/Documents/HRBodies/CCPR/GCArticle6/GCArticle6_EN.pdf> (adopted at 120th session). [↑](#footnote-ref-38)
39. List of Issues, *supra* note 2, Para 8. [↑](#footnote-ref-39)
40. Criminal Code Act Cap. (77), Laws of the Federation of Nigeria (revised edition 1990), sec. 228–230, 297, 309, 328. [↑](#footnote-ref-40)
41. *Id.* [↑](#footnote-ref-41)
42. GUTTMACHER Institute, Fact Sheet: Abortion in Nigeria (2015), *available at* <https://www.guttmacher.org/sites/default/files/factsheet/fb-nigeria.pdf>. [↑](#footnote-ref-42)
43. Bankole, *supra* note 49, 170 and 174. [↑](#footnote-ref-43)
44. *Id.* at 170. [↑](#footnote-ref-44)
45. *Id.* at 173, 176. [↑](#footnote-ref-45)
46. *See* Elizabeth Dwyer, *How Nigeria’s Police Are Becoming Allies for Safe Abortion*, The World Post (June 29, 2016), <https://www.huffingtonpost.com/entry/nigeria-police-abortions_us_5773ef93e4b0eb90355d0822>. [↑](#footnote-ref-46)
47. Echendu Dolly Adinma, *Post Abortion Care Services in Nigeria*, available at <. <https://www.researchgate.net/publication/221921718_Post_Abortion_Care_Services_in_Nigeria>> [↑](#footnote-ref-47)
48. JIB Adinma et al., *Awareness and Practice of Post Abortion Care Services Among Health Care Professionals in Southeastern Nigeria*, 41 Se. Asian J. Tropical Med. & Pub. Health 3, 696 (2010). [↑](#footnote-ref-48)
49. JIB Adinma et al., *Post Abortion Care Counseling Practiced by Health professionals in Southeastern Nigeria*, 111 Int’l J. Gynecology & Obstetrics 1, 53 (2010). [↑](#footnote-ref-49)
50. Human Rights Committee, *Concluding Observations: Albania*, para. 14, U.N. Doc. CCPR/CO/82/ALB (2004); Human Rights Committee, *Concluding Observations:* *Hungary*, para. 11, U.N. Doc. CCPR/CO/74/HUN (2003); Human Rights Committee, *Concluding Observations: Mali*, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003); Vietnam, para. 15, U.N. Doc. CCPR/CO/75/VNM (2002). [↑](#footnote-ref-50)
51. Human Rights Committee, *Concluding observations on the fifth periodic report of Cameroon*, para. 22(d), U.N. Doc. CCPR/C/CMR/CO/5 (2017); Human Rights Committee, *Concluding observations on the third periodic report of Lebanon*, para. 26, U.N. Doc. CCPR/C/LBN/CO/3 (2018); Human Rights Committee, *Concluding observations on the fifth periodic report of Romania*, para. 26, U.N. Doc. CCPR/C/ROU/CO/5 (2017). [↑](#footnote-ref-51)
52. List of Issues, *supra* note 2, Para 8. [↑](#footnote-ref-52)
53. Reply to List of Issues, *supra* note 20, Para 30. [↑](#footnote-ref-53)
54. NDHS 2013 Key Findings, *supra* note 51, at 5. [↑](#footnote-ref-54)
55. NDHS 2013, *supra* note 52, at 97. [↑](#footnote-ref-55)
56. *Id.*  [↑](#footnote-ref-56)
57. *Id.* [↑](#footnote-ref-57)
58. *Id.* [↑](#footnote-ref-58)
59. DHS 105-106. [↑](#footnote-ref-59)
60. *See* Int’l Consortium for Emergency Contraception, Counting What Counts: Tracking Access to Emergency Contraception (2013), *available at* <http://www.cecinfo.org/custom-content/uploads/2013/05/ICEC-Nigeria-Fact-Sheet-2013.pdf>. [↑](#footnote-ref-60)
61. List of Issues, *Supra* note 2, para 7. [↑](#footnote-ref-61)
62. Id. [↑](#footnote-ref-62)
63. NDHS 2013, *supra* note 52, at 301. [↑](#footnote-ref-63)
64. NDHS 2013 Key Findings, *supra* note 51, at 15. [↑](#footnote-ref-64)
65. Amnesty Int’l, Nigeria: Rape – the Silent Weapon 22, AI Index AFR 44/020/2006 (2006), *available at* <https://www.amnesty.org/download/Documents/68000/afr440202006en.pdf>. [↑](#footnote-ref-65)
66. NDHS 2013, *supra* note 52, at 327. [↑](#footnote-ref-66)
67. *Id.* [↑](#footnote-ref-67)
68. *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-historylawyer.html>. [↑](#footnote-ref-68)
69. Patience Obgo, *Lagos Records 678 Rape Cases in One Year*, Eagle Online (Apr. 15, 2013), <https://theeagleonline.com.ng/lagos-records-678-rape-cases-in-one-year>. [↑](#footnote-ref-69)