CENTER FOR REPRODUCTIVE RIGHTS

June 30, 2008

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

Re: Supplementary Information on Nigeria Scheduled for Review during the 41st Session of the CEDAW Committee

Dear Committee Members:

This letter is intended to supplement the periodic report submitted by the government of Nigeria, which is scheduled to be reviewed by this Committee during its 41st session. The Center for Reproductive Rights (CRR), an independent non-governmental organization, hopes to further the work of the Committee by providing independent information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW or "the Convention").

We wish to bring to the Committee's attention specific areas of concern related to the status of women's reproductive health and rights: lack of access to maternal health care services, lack of access to family planning and contraceptive services, and a high number of unsafe abortions. The information in this letter is drawn from a recent report by CRR and Women Advocates Research and Documentation Centre (WARDC) entitled *Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria,* which is being submitted with this letter.

RIGHT TO REPRODUCTIVE HEALTH CARE AND INFORMATION (ARTICLES 10, 12, 14(2)(b) AND 16(1)(e))

Reproductive rights are fundamental to women's health and social equality and are an explicit part of the Committee's mandate under CEDAW. Accordingly, a state's commitment to respect, protect, and fulfill these rights should receive serious attention.
Specifically, the Convention commits states that have ratified it to "ensure... [a]ccess to specific educational information to help ensure the health and well-being of families, including information and advice on family planning" [Article 10(h)]; "take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health-care services, including those relating to family planning" [Article 12(1)]; "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary" [Article 12 (2)]; "take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure ... access to adequate health care facilities, including information, counselling, and services in family planning" [Article 14(2)(b)]; and to " ensure, on a basis of equality

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between men and women: ...[t]he same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights" [Article 16(1)(e)]. Despite these explicit protections in the Convention, the reproductive rights of women and girls in Nigeria continue to be neglected and violated.

A. FAILURE TO ADDRESS HIGH INCIDENCE OF MATERNAL DEATH AND MORBIDITY

The Committee's General Recommendation 24 on Women and Health has clearly stated that "high maternal mortality and morbidity rates worldwide ... provide an indication for States parties of possible breaches of their duties to ensure women's access to health care."[1]

In 1998, the Committee, in its Concluding Observations, expressed concern at the high incidence of maternal death in Nigeria.[2] The Committee reiterated this concern in 2004 during Nigeria's fourth and fifth periodic reports.[3] However, Nigeria continues to experience a very high rate of maternal death and morbidity. Although the government has recently stated that health – particularly maternal health – is a political priority that has been given increased attention,[4] maternal health care in the country has not improved, indicating that the government's actions have been inadequate.

Recently, the World Health Organization (WHO) identified Nigeria as having the world's second-highest number of maternal deaths with approximately 59,000 maternal deaths taking place annually.[5] For every maternal death, 20 other women suffer serious and often permanent pregnancy-related complications and health problems.[6] Although Nigeria makes up 2% of the world's population, it accounts for 10% of its maternal deaths.[7] A woman in Nigeria has a 1-in-18 risk of dying in childbirth or from pregnancy-related causes during her lifetime,[8] which is higher than the overall 1-in-22 risk for women throughout sub-Saharan Africa.[9] The risks of maternal death are even greater for certain Nigerian women, such as those in the northern region of the country, rural women, low income women and women without formal education. The MMR in the northern region is consistently over 1,000 per 100,000 live births, compared to the MMR in the southern region, which is frequently below 300 per 100,000 live births.[10] As of 2007, most northern states had MMRs of about 1,500 per 100,000 live births.[11] Meanwhile, some states in the southern region, such as Ogun, have MMRs that are consistently below 200 per 100,000 live births, and that are progressively decreasing.[12] The majority of these deaths are preventable – while there are multiple and complex causes of maternal mortality, governments must be held accountable when their actions or inaction contribute to the loss of women's lives.

1. Separation of Governmental Responsibility for Health Care in Nigeria's Three-Tier Federal System

A key structural issue that contributes to the high MMR is the division of health-care responsibilities among the three tiers of government: federal, state, and local. The

Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities.[13] In the absence of a constitutional sharing of powers and outlining of responsibility for health care, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates the primary health sector to the local government, the secondary health sector to the state government, and the tertiary health sector to the federal government.[14] However, being a federal system, the federal government has little control over both the state and local governments in the discharge of their duties.

In addition, the 1988 National Health Policy lacks legal force; unlike the constitution or other legislation, it cannot impose legal obligations. As a senior official at the Federal Ministry of Health explained:

> We [the federal government] can only appeal to the conscience of the local governments, because the health policies are not backed by law so the local governments do not see it [primary health-care provision] as their responsibility.[15]

The absence of a constitutional or other legal prescription of health-care responsibilities has resulted in a dysfunctional system in which all three tiers of government have failed to prioritize their health-care duties. The problem is particularly visible at the primary health-care level and has had grave consequences for women seeking maternal care.

2. Lack of Policy Implementation

While the government has developed a number of health policies, they have not been implemented. An example of the lack of policy implementation is the fact that the stated goal for 2001-2006 as articulated in the 2001 National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians, which is "to reduce maternal morbidity and mortality due to pregnancy and childbirth by 50%,"[16] is far from being achieved. Similarly, Nigeria has failed to meet the 2004 Revised National Health Policy's objectives of "reducing maternal morbidity due to pregnancy and childbirth by 50%" and "reducing perinatal and neonatal morbidity and mortality by 30%."[17]

3. Lack of Resource Allocation

The Committee has also stated that the duty to fulfill rights "places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care."[18] In 2004, during Nigeria's fourth and fifth periodic reports, the Committee urged the government to "allocate adequate resources to improving the status of women's health, in particular with regard to maternal ...mortality."[19] The government has stated in its response to the list of issues and questions with regard to the consideration of its sixth periodic report that maternal health has received increased budgetary allocations.[20] Yet, Nigeria continues to fail to provide

adequate resources in the field of health care. Nigeria's vast oil wealth has not translated into an improvement in the lives of Nigerians. In the 2001 Abuja Declaration on HIV and AIDS, Tuberculosis and other Infectious Diseases, the government willingly pledged to commit a minimum of 15% of its total annual budget to improving the health care-system.[21] This pledge has not been fulfilled.

4. Lack of Information and Transparency Regarding Resource Allocation and Expenditure

Even when resources are directed towards health care, the lack of transparency in how funds are spent and the prevalence of corruption mean that funds do not always fulfill their intended goals. This is partly because laws preventing public access to government information on grounds of security obscure the records that would enable the public to ascertain how well the government is meeting its responsibilities.[22] A law that grants the public access to information, particularly fiscal information, for example in the form of a freedom of information bill, would increase and enable the public to hold the leaders accountable.

B. BARRIERS TO MATERNAL HEALTH CARE

The government's failure to allocate adequate resources and to ensure accountability for resources that *are* allocated, has translated into financial, infrastructural, and institutional barriers to maternal health care, fuelling the high number of maternal deaths in the country.

This Committee has stated that:

> States parties should report on measures taken to eliminate barriers that women face in gaining access to health care services and what measures they have taken to ensure women timely and affordable access to such services. Barriers include requirements or conditions that prejudice women's access such as high fees for health care services, the requirement for preliminary authorization by spouse, parent or hospital authorities, distance from health facilities and absence of convenient and affordable public transport.[23]

In addition, the United Nations Secretary General, in a 2008 report submitted to the Commission on the Status of Women, recommended that states "assess the gender impacts of revenue-raising measures, including user fees."[24] User fees constitute serious barriers to obtaining quality maternal health care in Nigeria. For instance, an interviewee noted that: "Once you go to the hospital, before anyone attends to you, you have to drop some money ... they [women] can't go to the hospital because they can't afford it. They are scared of the money they will have to pay and they don't have the money."[25] Another devastating effect of user fees is the detention of women who cannot pay for the maternal health-care services they have received until they find the necessary funds. During a focus-group discussion that CRR and WARDC held with, among others, members of civil society organizations, one participant stated: "I have seen women who after delivery

had to come round the wards begging for money."[26] Yet another participant spoke of a woman who fled from the hospital after a caesarean section without waiting to have the stitches removed because she could not pay the fees: "In the night, while we were all sleeping, she sneaked away."[27] The fear of being detained discourages pregnant women from seeking skilled maternal care.

Exacting user fees from poor, and rural women—a majority of the female population in Nigeria—and thus severely limiting their ability to access maternal health care amounts to discrimination against women because only women need maternal health care.

While some local government areas and state governments have taken steps to reduce the negative impact of formal user fees on pregnant women by offering free maternal-health care services,[28] these efforts are crippled by serious limitations. A senior official of the Federal Ministry of Health confirmed that in most instances these health care facilities did not offer "total packages" where every aspect of health care – doctor's office visits, consultations, prescriptions and follow-up visits- was free.[29] Even when user fees have been waived, pregnant women are faced with informal levied costs, which have the potential to prevent low income and poor women from seeking maternal care. An additional cost stems from the requirement that patients purchase certain items such as antiseptics, bleach, cotton wool, plaster, gauze, syringes, flasks (for drinking), and sanitary pads.[30] These items are ones that adequately equipped health-care centers should provide. Lack of clarity regarding payments and lack of itemized billing are prevalent in many public hospitals and constitute additional financial barriers to access.[31]

Another financial barrier to accessing maternal health-care services is the compulsory requirement by public hospitals that partners of pregnant women donate blood. Focus group discussion participants stated that pregnant women who attempt to access maternal health-care services at many public or government hospitals are often required to bring their husbands to donate blood.[32] While patients may sometimes opt out by paying a fee, this option is not always made known. Compulsory spousal blood donation can potentially have multiple negative consequences for pregnant women who are unable or unwilling to compel their husbands to donate blood. One interviewee miscarried a pregnancy and could have lost her life because she was unable to comply with blood donation as a condition for accessing health care.[33] Moreover, the practice has a discriminatory impact on the poor, who may prefer to pay—but be unable to afford—a fee in lieu of blood donation.

Many infrastructural and institutional barriers also hamper access to maternal health care. For instance, long waiting periods at health-care centers discourage women from seeking health care and even prevent access in cases where women are unable to put aside family or job responsibilities for long periods of time.[34] Malfunctioning or outdated hospital equipment also serves as a barrier to adequate maternal health care. A national study on the availability and quality of emergency obstetrics facilities found that only 4.2% of public facilities and 32.8 % of private facilities (and only 18.5% of both public and private facilities) met the internationally agreed-upon standards for emergency obstetrics care.[35] The study also found that less than one third of the public secondary and tertiary

health centers met the international standards for comprehensive emergency obstetric care.[36]

Frequent power outages that leave some health–care centers without alternative sources of power also constitute an infrastructural barrier with serous consequences for pregnant women. An obstetrician and gynecologist recalled being forced to continue a caesarean section with a flashlight when a power outage occurred.[37] The poor quality of maternal health–care facilities increases the risks of maternal morbidity and mortality and constitutes a violation of the government's obligations under the Convention.

Rural women who require maternal health-care services face serious challenges in accessing these services due to long distances to heath facilities and unavailability of reliable and affordable transportation. A local government official noted that in his local government area, clinics were closed at night and on weekends. As a result, women who went into labor at these periods had no choice but to patronize traditional birth attendants. Explaining that some clinics have only one nurse due to understaffing, he said "if we had at least two nurses in a clinic, they could take shifts, but when there is just one person he is overworked, and if he is not around there is no access to health-care services."[38] An interviewee observed that in a particular local government, women who go into labour often climb onto "okadas" (motorcycles that are used as a form of public transportation) in order to access health services.[39]

C. ACCESS TO FAMILY PLANNING SERVICES AND INFORMATION

1. Inadequate Access to Family Planning Services and Information

Access to family planning and contraceptives is an important strategy in reducing maternal mortality. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate health care, or they may seek unsafe illegal abortions that can result in complications or death.

CEDAW obligates states to ensure that women have equal access to "specific educational information ...including information and advice on family planning"[40] and "access to health-care services, including those relating to family planning."[41] The Convention also affirms the right of women "to decide freely and responsibly on the number and spacing of their children, and requires states to ensure that women "have access to the information, education and means to enable them to exercise these rights."[42]

In 2004, the Committee urged the Nigerian government "to increase women's and adolescent girls' access to affordable health-care services, including reproductive health care, and to increase access to affordable means of family planning for women and men."[43] The CEDAW Committee made similar suggestions to Nigeria in 1998, when it encouraged the government "to increase its efforts to guarantee access to medical services and hospital medical facilities, particularly in the context of women's health needs," noting that "family planning programmes must be available to all" and that "free

access to health services should be a priority for Government . . ."[44] Ten years later, lack of access to contraception is pervasive, demonstrating that the government continues to fail in its obligations under international human rights law, at the expense of women's health and women's lives.

While there is some variance in statistics, surveys show that the percentage of respondents who use any method of contraceptives ranges from 13.3%[45] to 15.6%[46]; the percentage of those who use modern methods of contraceptives ranges from 8.9% [47] to 11.6%.[48] The consequences of this low usage of family planning methods include a high occurrence of unplanned and unwanted pregnancies: one in every five pregnancies in Nigeria is unplanned and half of these unplanned pregnancies are terminated.[49] Furthermore, one third of women of childbearing age have had an unwanted pregnancy,[50] while 25% of women between 15-49 years of age have an unmet need for family planning.[51] The prevalence of unplanned and unwanted pregnancies increases the likelihood of exposure to unsafe abortion and the risk of maternal morbidity or mortality.

The lack of correct information about contraceptives and the resulting non-use of contraceptives is a major factor that contributes to the high rate of maternal mortality in Nigeria.[52] The 2005 National HIV/AIDS and Reproductive Health Survey (NARHS) reveals that significantly fewer women have knowledge of modern methods of contraception than men (71.4% vs. 84.2%, respectively).[53] A similar discrepancy exists in rates of knowledge about modern methods of contraception (89.5% of men in contrast to 76.7% of women).[54] Thus, it is especially important that the government target educational and informational campaigns towards women.

The NARHS also reveals that both men and women hold potentially dangerous misconceptions about family planning. In response to survey questions, both men and women often stated that they did not know the answers to questions about family planning, indicating that the government has failed to provide them with education and information on this topic. Without an understanding of the facts regarding family planning, the ability of women to "decide freely and responsibly on the number and spacing of their children" [55] is deeply hindered.

According to the NARHS, almost a third of Nigerian women surveyed believe that family planning can lead to female infertility.[56] More than 40% of women answered this question by selecting "don't know/no response."[57] In response to whether family planning and child spacing methods cause cancer or other diseases, 16.5% of women agreed, 55% did not know or did not respond, and only 28.4% disagreed.[58] Not only must the government take steps to provide women and men with more information on contraceptive use, but it must also work to correct such "myths [and] misconceptions" about family planning methods.[59]

Interviews confirmed that "awareness is a major barrier to [contraceptive] use resulting in aversion towards it."[60] For example, interviewees indicated that women fear that contraceptive use will have adverse effects, including bleeding and permanent infertility.[61] Women also believe that contraception is an abortifacient,[62] and that it will

cause fatal diseases.[63] These fears play a significant role in preventing women from using contraceptives.[64]

2. Discriminatory Impact of Shortfalls in Contraceptive Access

Significant evidence exists of disparities in access to contraceptives based on age, region of residence, and level of wealth. Younger people, those residing in rural areas and the North, and the least wealthy have the lowest ability to access contraceptives, which demonstrates the government's failure to ensure access to contraceptives for all in a non-discriminatory manner. On the contrary, statistics reveal that the most vulnerable and marginalized members of society are least likely to have access to contraceptives.

Surveys reveal large discrepancies between those in rural and urban areas with regard to rates of contraceptive use, as well as knowledge of and perceptions regarding the accessibility and affordability of contraceptives. These discrepancies are contrary to the obligations in Article 14 (2)(b) of the Convention. Usage rates of contraceptives—both all methods and modern methods [65]—are significantly lower in rural populations than in urban populations. The rural rate of use of all methods is only 9.2%, in contrast to 20.2% in urban populations.[66] For modern methods, the rates are 5.7% and 13.9%, respectively.[67]

When statistics are gathered on the basis of wealth, the enormous differences in use between those of different socio-economic strata become obvious. The rate of use of any method of contraception is 6.9% among those in the lowest wealth quintile and 5.6% among those in the second wealth quintile.[68] The rate in the highest quintile is more than four to five times higher, at 30%.[69] For modern contraceptives, the usage rate among the lowest quintile is 3.6%; the rate in the second quintile is 2.9%.[70] This contrasts starkly with the 20.5% rate in the highest quintile.[71] These differences suggest that the cost of contraceptives prevents many women from using them. However, access to and use of contraceptives should not be dependent on economic ability. The government must ensure that cost does not prevent women from using the family planning method of their choice.

Regarding the funding of reproductive health programmes, a necessary component of which are family planning services, Nigeria's National Reproductive Health Policy and Strategy of 2001 calls for government funding towards reproductive health programmes.[72] An implementation strategy of the 2004 National Policy on Population for Sustainable Development similarly calls for funding for reproductive health programmes.[73] However, as of June 2005, the Federal Ministry of Health had not created a budget line towards the procurement of family planning commodities.[74] It is crucial that the government provide funding for family planning services in such a way that enables women to choose from a full range of contraceptive goods and decide which method best suits their needs. [75]

D. UNSAFE ABORTION

The Committee expressed concern at "the high rates of maternal mortality as a result of unsafe abortions" in the Concluding Observation on Nigeria's combined fourth and fifth periodic reports in 2004, and on this basis urged the government to "take measures to assess the impact of its abortion laws on women's health."[76] However, Nigeria's abortion law remains very restrictive, permitting abortion only to save a pregnant woman's life. [77] Even this limited exception is frequently unavailable. For instance, in Nigeria's sixth and latest periodic report to the Committee, which will be addressed during this 41st session, the government emphasizes that it has "one of the only national reproductive health policies in sub-Saharan Africa that recognizes that women have a legal right to abortion in certain circumstances," but admits that "few or no public health services yet offer such services."[78]

Many women have been seriously injured or died as a result of unsafe abortions. The Nigerian government has admitted in its sixth periodic report to the Committee that "[o]f the main causes of maternal mortality, unsafe abortion is the single most preventable cause of death. Unsafe abortions remain frequent occurrences, killing over 34,000 Nigerian women annually."[79] Despite this admission, Nigeria's abortion law remains very restrictive. One study indicates that a majority of the abortions that are performed in Nigeria are unsafe,[80] partly because of the nation's restrictive legal context.[81] For example it has been estimated that 456,000 unsafe abortions take place annually in Nigeria.[82]

The restrictive abortion law in Nigeria has not only contributed to the high numbers of unsafe abortion in the country, it has also had a discriminatory impact. Poor and low income women are disproportionately represented in the number of women who resort to – and die from – unsafe abortion in the country. For instance, one study shows that while 66% of Nigerian women who are not considered poor access abortion through medically trained professionals in health centres, only 44% of their poor counterparts are able to do the same.[83] Moreover, although one in four women who have abortions experience serious complications, only one third of these women seek treatment, largely due to the high cost of such care: about NGN 1,805 (approximately USD 115).[84]

The government has acknowledged in its sixth periodic report that "low income women and girls who cannot afford the high cost of abortion or who are ignorant of the dangers of unsafe procedures utilized by unqualified individuals, stand very high risks of loosing [sic] their lives."[85] Despite this acknowledgement, no steps have been taken towards addressing the causes of these deaths – including the restrictive abortion law.

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

1. What steps has the government taken to reduce maternal mortality, considering that current policies, such as Nigeria's National Reproductive Health Policy and Strategy of 2001 and the 2004 Revised National Health Policy, are not being implemented? In particular, what steps has the government taken to reduce in-country disparities that result

in greater susceptibility to maternal death among women in the northern regions of the country, rural areas and low-income women?

2. What is the government doing to ensure adequate resource allocation to the health sector? For instance, why has the government *not* met the commitment it made to allocate at least 15% of its national budget to health in the 2001 Abuja Declaration on HIV and AIDS, Tuberculosis and other Infectious Diseases?

3. What steps has the government taken to eliminate financial barriers that women face in accessing maternal health care? For example, in states and local government areas that have eliminated user fees, what is being done to ensure the long-term sustainability of such programs? What is the government doing to monitor and regulate hospital practices to ensure that unauthorized fees and other requirements are not imposed on women as a condition of treatment or discharge from hospitals (for example, requirements that their spouses donate blood and requirements that women purchase and provide their own medical supplies)?

4. Given the separation of responsibilities for health care provision between the three tiers of government, as a result of which local governments are responsible for the provision of primary health care, what is the federal government doing to ensure that local governments fulfil this obligation, especially given that local governments receive the smallest portion of the national budget?

5. What steps has the government taken to ensure adequate staffing – including recruitment, training, compensation, and retention – so as to eliminate barriers to care that women experience, such as long waiting periods before they are able to see their doctors and limited operating hours of hospitals? Similarly, what steps has the government taken to ensure that hospitals are supplied with necessary equipment, such as emergency obstetric care facilities, and to ensure that health care services, particularly emergency maternal health care services, are not interrupted during frequently occurring power outages?

6. What is the government doing to remove barriers that women face in accessing family planning and contraceptive services? For example, what is the government doing to ensure that sufficient supplies of contraceptives are available, that contraceptives are affordable, and that women and adolescent girls are provided with comprehensive and accurate information about contraceptives?

7. What specific steps has the government taken to reduce the high incidence of unsafe abortion which is one of the primary causes of maternal death in Nigeria, particularly among poor women upon whom the criminalization of abortion has a discriminatory effect?

We appreciate the active interest that the Committee has taken in women's reproductive health and rights and the strong Concluding Observations and General Recommendations the Committee has issued to governments in the past, stressing the need for governments

to take steps to ensure their realization. We hope that this information is useful during the Committee's review of the Nigerian government's compliance with the Convention.

If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,

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Ximena Andion
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[1] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, para. 17, U.N. Doc. A/54/38 (1999) [hereinafter CEDAW Committee, General Recommendation No. 24].

[2] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 170, U.N. Doc. A/53/38/Rev.1 (1998).

[3] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, paras. 307-308, U.N. Doc. A/59/38, (Supplement No. 38) (Part I) (2004). [hereinafter *CEDAW, Concluding Observations: Nigeria (2004)*

[4] *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, Responses to the list of issues and questions with regard to the consideration of the sixth periodic report, Nigeria*, 32, U.N. Doc. CEDAW/C/NGA/Q/6/Add. 1(2008). [hereinafter *CEDAW, responses to the list of questions and issues, Nigeria* (2008)].

[5] World Health Organization (WHO) et al., Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank 5 (2007), *available at* http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf [hereinafter WHO et al., Maternal Mortality in 2005 (2007)]. (India had the highest number of maternal deaths (117,000) based on the WHO's estimates).

[6] United Nations Population Fund (UNFPA), Maternal Morbidity, http://www.unfpa.org/mothers/morbidity.htm (last visited May 13, 2008).

[7] Federal Ministry of Health (Nigeria) & World Health Organization (WHO), Road Map for Accelerating the Attainment of the MDGs Related to Maternal and Newborn Health in Nigeria 1 (2005).

[8] WHO et al., Maternal Mortality in 2005 at 25 (2007). The 2008 report of the 'Countdown to 2015: Maternal, Newborn and Child Health' confirms that these chances remain the same. 'Countdown to 2015' is a collaborative effort to track progress in maternal, newborn and child survival in high mortality countries by highlighting the progress, obstacles and solutions to achieving MDGs 4 (child survival) and 5 (maternal health). United Nations Children's Fund (UNICEF), Countdown to 2015: tracking Progress in Maternal, Newborn, and Child Survival 18 (2008), *available at* http://www.countdown2015mnch.org/documents/2008report/2008Countdown2015fullreport.pdf.

[9] WHO et al., Maternal Mortality in 2005 at 16 (2007).

[10] Health Reform Foundation of Nigeria (HERFON), Nigerian Health Review 2006 at 105 (2006) (quoting Society of Gynaecology and Obstetrics of Nigeria (SOGON), 2004 Report on Status of Emergency Obstetrics Services in Nigeria).

[11] *Borno Records 1,500 Maternal Deaths Annually*, THE TIDE ONLINE Sept. 18, 2007.

[12] In 2004, Ogun State recorded an MMR of 178 per 100,000 live births, and an MMR of 173 per 100,000

live births in 2005. *See* Ogun State Ministry of Health, Department of Planning, Research and Statistics (Nigeria), Ogun State Health Bulletin, Vol. 2, at 17 (2005).
[13] Federal Ministry of Health (Nigeria), Health Sector Reform Programme 2004 at 1 (2005) [hereinafter Nigeria, Health Sector Reform Programme 2004 (2005)].
[14] Federal Ministry of Health (Nigeria), National Health Policy and Strategy to Achieve Health for All Nigerians 12-13, 53, sec. 5.5(a)-(c), Annex II (1988) [hereinafter Nigeria, National Health Policy and Strategy to Achieve Health for All Nigerians (1988)].
[15] Interview with a Federal Ministry of Health Official, Abuja, Feb. 6, 2008.
[16] Federal Ministry of Health (Nigeria), National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians 21 (2001).
[17] Federal Ministry of Health (Nigeria), Revised National Health Policy 32 (2004).
[18] Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, para. 17, U.N. Doc. A/54/38 (1999) [hereinafter CEDAW Committee, *General Recommendation No. 24*].
[19]*CEDAW, Concluding Observations: Nigeria para. 308, (2004),*
[20]*CEDAW, responses to the list of questions and issues, Nigeria* (2008)].
[21] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, African Summit onHIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, Apr. 24-27, 2001, para. 26, O.A.U. Doc. OAU/SPS/ABUJA/3, available at http://www. un.org/ga/aids/pdf/abuja_declaration.pdf [hereinafter Abuja Declaration, Abuja, Apr. 24-27, 2001].
[22] *FOI Bill and Professionalism of Journalism*, THE TIDE ONLINE, Mar. 18, 2008.
[23] CEDAW Committee, *General Recommendation No.* 24, para. 21.
[24] United Nations, Financing for gender equality and the empowerment of women, Report of the Secretary-General, para. 88(d), U.N. Doc. E/CN.6/2008/2 (2008).
[25] Focus group discussion, Abuja, Feb. 11, 2008.
[26] Focus group discussion with Kuti Folake, Lagos, Feb. 13, 2008.
[27] Focus group discussion with Grace, Lagos, Feb. 13, 2008.
[28] *Kaduna Warns Against Fee Collection in Hospitals*, DAILY TRUST, Mar. 21, 2008, *available at* http:// allafrica.com/stories/200803210434.html; Umar Yusuf, *Adamawa flags off free Medicare for mothers, infants*, VANGUARD, Nov. 29, 2007.
[29] Interview with a senior government official of the Federal Ministry of Health, Abuja, Feb. 7, 2008.
[30] Focus group discussion with Grace, Lagos, Feb. 13, 2008; interview with Joy Eke, Program Officer, Legal Research and Resource Development Center (LRRDC), Lagos, Feb. 15, 2008.
[31] Interview with Joy Eke, Program Officer, Legal Research and Resource Development Center (LRRDC), Lagos, Feb. 15, 2008.
[32] Focus group discussion with multiple participants, Lagos, Feb. 13, 2008.
[33] Interview with Hope, Lagos, Feb. 15, 2008 (name has been changed).
[34] Focus group discussion with Kuti Folake, BAOBAB for Women's Human Rights, Lagos, Feb.13, 2008.
[35] A.O. Fatusi & K.T. Ijadunola, National Study on Essential Obstetric Care Facilities in Nigeria (Federal Ministry of Health [Nigeria] and UNFPA) at vii, 11 (2003), *available at,* http://nigeria.unfpa.org/documents/EOC.doc [hereinafter Fatusi & Ijadunola, National Study on Essential Obstetric Care Facilities in Nigeria (2003)].
[36] Id at 13. Lagos State was an exception with the majority of its secondary and tertiary health centers meeting the standard.
[37] Interview with Dr. Mairo Mandara, Obstetrician and Gynaecologist, Abuja, Feb. 11, 2008.
[38] Interview with local government official, Lagos, Feb. 13, 2008.
[39] Interview with Banke Akinrimisi, Centre for Women's Health and Information, Lagos, Feb. 14, 2008
[40] CEDAW, art. 10(h).
[41]*Id.* at art. 12(1).
[42] *Id* at art. 16(1)(e).
[43] CEDAW Committee, *Concluding Observations on Nigeria*, para. 308 (2004).
[44] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 171, U.N. Doc. A/53/38/Rev.1 (1998).

[45] National Population Commission (NPC) (Nigeria) & ORC Macro, Nigeria Demographic and Health Survey 2003 at 67, tbl. 5.4 (2004) [hereinafter NPC & ORC Macro, Nigeria Demographic and Health Survey 2003 (2004)].
[46] Nigeria, National HIV/AIDS and Reproductive Health Survey 2005 at 117, tbl. 11.6 (2006).
[47] NPC & ORC Macro, Nigeria Demographic and Health Survey 2003 at 67, tbl. 5.4 (2004).
[48] Nigeria, National HIV/AIDS and Reproductive Health Survey 2005 at 117, tbl. 11.6 (2006).
[49] Akinrinola Bankole, et al., Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences 15 (2006), *available at* http://www.guttmacher. org/pubs/2006/08/08/Nigeria-UP-IA.pdf.
[50] *Id.* at 10.
[51] *Id.* at 13.

[52] *Kaiser Daily HIV/AIDS Report*, KAISER NETWORK, Mar. 31, 2008.
[53] Nigeria, National HIV/AIDS and Reproductive Health Survey 2005 at 112, tbl. 11.2 (2006).
[54] NPC & ORC Macro, Nigeria Demographic and Health Survey 2003 at 62, 63, tbls. 5.11, 5.12 (2004).
[55] CEDAW, art. 16 (1)(e).
[56] Nigeria, National HIV/AIDS and Reproductive Health Survey 2005 at 113, tbl. 11.3 (2006).
[57] *Id.*
[58] *Id.*
[59] Godwin Haruna, *How Ignorance of Contraceptive Use Fuels Maternal Mortality*, THIS DAY, May 5, 2008. [hereinafter Haruna, *How Ignorance of* Contraceptive Use Fuels Maternal Mortality, THIS DAY].
[60] Interview with Dr. Tope Ojo, Consultant in Pediatrics and Gynaecology, Lagos, Mar. 24, 2008
[61] Interview with Mrs. L. A. Buba, President, PPFNigeria, Abuja, Feb. 8, 2008; interview with nurse at Lagos Island Maternity Hospital, Lagos, Feb. 12, 2008; focus group discussion with Christie Adikwu, Damsel, Abuja, Feb. 11, 2008.
[62] Focus group discussion with Arubayi Olaide, Lagos University Teaching Hospital, Lagos, Feb. 13, 2008.
[63] Haruna, *How Ignorance of Contraceptive* Use Fuels Maternal Mortality, THIS DAY.
[64] Focus group discussion with Christie Adikwu, Damsel, Abuja, Feb. 11, 2008; interview with nurse at Lagos Island Maternity Hospital, Lagos, Feb. 12, 2008, Interview with Mrs. L. A. Buba, President, PPF-Nigeria, Abuja, Feb. 8, 2008.
[65] In this survey, the following methods are classified as "modern family planning methods": female and male sterilization, the pill, the IUD, injectables, implants, male and female condoms, the diaphragm, foam or jelly, the lactational amenorrhoea method (LAM), and emergency contraception. The following are classified as "traditional methods": periodic abstinence (safe period or rhythm method) and withdrawal. The survey also notes that "other traditional or "folk" methods mentioned by the respondents, such as herbs or amulets, were also recorded." NPC & ORC Macro, Nigeria Demographic and Health Survey 2003 at 61 (2004). Thus, when "all" methods are referred to, all of the above are included.
[66] *Id.* at 68.
[67] *Id.*
[68] *Id.* at 68, tbl.5.5.
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] Federal Ministry of Health (Nigeria), National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians 19 (2001) [hereinafter Nigeria, National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians (2001)].
[73] Federal Government of Nigeria, National Policy on Population for Sustainable Development 26 (2004) [hereinafter Nigeria, National Policy on Population for Sustainable Development (2004)].
[74] The ENHANSE Project, Reproductive Health in Nigeria: Situation, Response & Prospects 17 (2005).
[75] Haruna, *How Ignorance of Contraceptive Use Fuels Maternal Mortality*, THIS DAY.

[76] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 307, U.N. Doc. A/59/38 (2004), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/A.59.38,paras.282-316.En?Opendocument.

[77] *See* Criminal Code Act, ch. 25, art. 297, Cap. 77 of the Laws of the Federation of Nigeria (Revised ed. 1990), *available at* http://www.nigeria- law.org/Criminal%20 Code%20Act-PartV.htm#Chapter%2025 [hereinafter Nigeria Criminal Code]. Beyond this circumstance, anyone who aids or compels a woman to have an abortion; women who procure abortion; and those who supply any material that would be used for procuring abortion are considered to have committed criminal acts and are subject to fourteen years, seven years, and three years of imprisonment, respectively. *See* Nigeria Criminal Code, arts. 228-230; Penal Code (Northern States) Federal Provisions Act, art. 235, Cap. 345 of the Laws of the Federation of Nigeria (Revised ed. 1990). The Criminal Code and Penal Code apply in the Southern and Northern parts of the country respectively.

[78] *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women, Sixth periodic report of States parties, Nigeria* 81, U.N. Doc. CEDAW/C/NGA/6 (2006) [hereinafter *CEDAW consideration of reports, Nigeria* (2006)].

[79] CEDAW consideration of reports, Nigeria 82 (2006).

[80] Stanley K. Henshaw et al., *Severity and Cost of Unsafe Abortion Complications Treated in Nigerian Hospitals*, International Family Planning Perspectives, Vol. 34, No. 1, at 40 (2008), available at http:// www.guttmacher.org/pubs/journals/3404008.pdf.

[81] Akinrinola Bankole et al., Guttmacher Institute, Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences 4 (2006), *available at* http:// www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA. pdf [hereinafter Guttmacher, Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences (2006)]; Gilda Sedgh et al., *Unwanted Pregnancy and Associated Factors Among Nigerian Women*, International Family Planning Perspectives, Vol. 32, No. 4, at 175 (2006), *available at* http://www. guttmacher.org/pubs/journals/3217506.pdf.

[82] Andrew Walker, *Saving Nigerians from risky abortions*, BBC News, Apr. 7, 2008, *available at* http://news.bbc.co.uk/2/hi/africa/7328830.stm.

[83] Guttmacher, Facts on Unwanted Pregnancy and Induced Abortion in Nigeria 1 (2006).

[84] *Id.* at 2..

[85] CEDAW consideration of reports, Nigeria 81 (2006).