Introduction

In 1994, the International Conference on Population and Development (the ICPD) which held in Cairo, Egypt, adopted a rights based approach to sexual and reproductive health which reflects a new global policy on the relationship between law, population, human rights, sexual and reproductive health, especially for women. This rights based approach is built on existing international human rights laws and agreements, and recognizes sexual and reproductive health and rights as important ends in human development. However, for any legal system to achieve its objectives in the aforementioned concepts and goals, it is essential that the political, economic and socio-cultural environments of the society, including religious and
traditional practices, health care delivery, policy framework, education and capacity building, constitutional guarantees and international and regional obligations are taken into consideration by the legal system, including the judiciary. The agendas and strategies for legislative and judicial activism in gender specific human rights are broad and interwoven, and violations of women’s rights relating to reproductive health appear only as a clearly visible tip of an iceberg.

The fundamental basis of reproductive ill health for women is often embedded in discriminatory social structures and stereotypes that can be reformed and remedied by judicial interpretation of enacted laws. Judicial decisions and case law, in particular, have the potential of advancing health and human rights protection for vulnerable groups, especially women. Law can be used by the judicial system to link abuses of reproductive health rights to actions or non actions for which the State or government is accountable. In cases involving inaccessible, unaffordable or lack of essential maternal or reproductive health care, the State agency involved can be held responsible by the judicial system and ordered to take steps towards effective remedies for victims. Remedies extend beyond compensation for past and present violations, to legislative, judicial and social reforms in order to prevent further or future abuse. The agenda for reproductive health care in Nigeria, therefore, goes beyond focus on health care policies and professional relations between doctors and patients. It involves legal and medical interventions that include public health promotion, for instance, to reduce the spread of sexually transmitted infections including HIV/AIDS, law reform to achieve women’s protection against domestic violence not limited to sexual violence, inheritance laws that accord women and widows an equitable share of resources, criminal laws that prohibit harmful traditional practices such as female genital mutilation, civil laws that protect women from discriminatory and abusive attitudes, etc. The road ahead is not easy but with activism and commitment by all stakeholders, the
goals of reproductive health and rights protection for women are achievable.

The standards contained in the International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995 have often been enumerated as factors or considerations for achieving a reproductive rights discourse within the Nigerian legal system. The need for the incorporation of these conference declarations into national legislation(s) on reproductive health and rights has been elaborated in some studies. This chapter identifies key considerations for enacting laws on reproductive health and advancing judicial reform in Nigeria. Considerations include the presence of constitutional obligations, recent policies and strategies, and health care delivery. Further factors range from existing legal and human rights frameworks, economic, social, cultural and political infrastructures, civil society participation, education and capacity training. The paper examines the potential and capacity for legislative and judicial activism in the areas of gender specific human rights obligations, and recommends strategies towards the enactment of a national Reproductive Health Law that would incorporate provisions of international instruments on gender, health and rights.

**Constitutional Obligations**

The Nigerian Constitution sets out the fundamental objectives and directive principles of State policy. While these objectives and principles do not grant legal rights to the nation’s citizens and cannot be ‘judicially’ enforced, all organs of government acting in good faith are required to apply them.¹ One of these objectives is to guarantee social justice, a term that includes reduction of maternal mortality under the Maputo Declaration.²

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Chapter II of the Constitution also establishes a State policy of ensuring the adequate provision of medical and health facilities for all. One of the State policies in Nigeria is to ensure distribution of material resources in a way that benefits all citizens.\textsuperscript{3} Evidence that maternal mortality affects some Nigerian women more than others because of their environments (rural vs. urban), location (north vs. south), level of education, or financial status directly contravenes the State’s stated principles.

The Nigerian Constitution specifically protects the right to life and recognizes the right to health, although in a non-justiciable context.\textsuperscript{4} The right to health encompasses physical, mental, and sexual health.\textsuperscript{5} The Economic, Social and Cultural Rights Covenant contains the most comprehensive provisions regarding the right to health under international human rights law.\textsuperscript{6} It guarantees the right to enjoyment of the highest attainable standard of physical and mental health, and identifies the steps that must be taken in order to achieve this right.\textsuperscript{7}

\begin{thebibliography}{9}
\bibitem{3} Ibid. Sec. 16(2).
\bibitem{4} Nigerian Constitution, Sections. 17(3)(d), 33(1).
\end{thebibliography}
including the reduction of still births, unsafe abortions, infant mortality, and the availability of medical services and health care to all. The Covenant also requires the government to ensure that special measures are taken to protect a mother during the period before and after child birth, and obligates the government to recognize the right to enjoy the benefits of scientific progress and its applications.

The Nigerian Constitution does not recognise the right to health as enforceable, even though some provisions of the Constitution can be interpreted as alluding to the right. Thus, it may not be wrong for one to infer recognition of the right to health as a basic human right. Section 14 recognises that the security and welfare of the people shall be the primary purpose of government. Section 17 obligates government to direct its policies to ensure adequate medical and health facilities for all persons. The Constitutional provisions clearly recognise that the right to life, sanctity of the human person and human dignity provided for in sections 17, 33 and 35 are clearly connected to the physical and mental health of persons. It can therefore be assumed that the Constitutional provision that guarantees the right to life can be construed as also guaranteeing the right to health, which includes the provision of adequate health facilities, especially for women and other vulnerable groups.

The absence of a right to health in the Nigerian Constitution does not release the government from its legal obligations to ensure that women get access to reproductive health services. Indeed, the right to health guaranteed in Article 16 of the African Charter has the force of law in Nigeria. The African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act states:

8. Ibid. art. 12(2)(d).
9. Ibid. art. 15(1)(b).
10. The African Charter was ratified by Nigeria in 1983 and incorporated as the African Charter on Human and Peoples Rights (Ratification and Enforcement)
As from the commencement of this Act, the provisions of the African Charter on Human and Peoples’ Rights shall have the force of law in Nigeria and shall be given full recognition and effect and be applied by all authorities and persons exercising legislative, executive or judicial powers in Nigeria.\(^{11}\)

Article 16 of the African Charter, which guarantees the right to health is therefore enforceable in Nigeria and should be applied by the government.\(^{12}\) It is worth noting that Nigerian courts have recently indicated that ‘jeopardizing’ health amounts to a violation of the right to life. In the case of *Gbemre v. Shell Petroleum Development Company and Others*, the plaintiff sought a declaration that the defendant’s activities in his community, which had endangered and impaired the health of the community’s residents, constituted a violation of their rights to life and dignity, as guaranteed by the Nigerian Constitution and the African Charter.\(^{13}\) The Federal High Court in Benin found in favour of the plaintiff.\(^{14}\) This case suggests

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11. Ibid. See also the African Charter on Human and Peoples Rights, 1981.


14. *Ibid*. This decision has been appealed before the Nigerian Court of Appeal, Benin City. See Gabriel Enogholase, Benin Court Registrar under
that the courts may be willing to construe the protection of the
right to life to include the protection of its underlying
determinants, such as health.

The Nigerian Constitution provides for ‘fundamental rights’
that are fully enforceable in the courts of law. These include the
right to life, the right to dignity, the right to personal
liberty, the right to private and family life and the right to
freedom from discrimination. The high incidence of maternal
deaths and ill health in Nigeria brings the non protection of
these rights into sharp focus, despite the presence of policies
and strategies that have been designed and developed to
supplement legal or Constitutional provisions.

Policies and Strategies
In recent times, the Nigerian government has developed
numerous policies and strategies that focus generally on health
and, specifically, on reproductive health. These policies
recognize maternal mortality as a national problem and
acknowledge the weaknesses of the health-care system in
addressing women’s health issues. In addition, they highlight
the extent to which the government has gone, or ought to go, to
reduce maternal deaths. They also serve as indicators of the
adequacy of the measures that have been taken. However, the
evidence of high maternal mortalities and reproductive ill health
in Nigeria show that most policy objectives have not be
attained.

The 1988 National Health Policy and Strategy to Achieve
Health for all Nigerians (1988 National Health Policy) was

15. Ibid. Sec. 33.
16. Ibid. Sec. 34.
17. Section 35, Nigerian Constitution, supra.
18. Section 37, Nigerian Constitution, supra.
19. Ibid, Sec. 42.
Nigeria’s first comprehensive health policy. It set a target of ‘health for all citizens by the year 2000’ and recognized primary health care as defined in the 1978 Declaration of Alma-Ata as an integral part of the 1988 National Health Policy. It also stated that the minimum level of primary health services must include ‘maternal and child health care, including family planning.’

Considering Nigeria’s three-tier system of governance, and noting that the Constitution places most health matters on the concurrent list, thereby authorizing the three tiers of government to share responsibilities on matters of health, the 1988 National Health Policy provided for a health-care system with three levels of care; primary, secondary, and tertiary. It assigned responsibility for providing primary health care to the local governments, ‘with the support of State Ministries of Health,’ secondary health care to the state governments, and tertiary health care to the federal government.

Under the 2004 Revised National Health Policy, which replaced the 1988 National Health Policy, the provision of three levels of care and division of responsibility for these levels among the three tiers of government, remains applicable. The new policy states that the maternal mortality rate in Nigeria is among the highest in the world and further notes that the government spends only USD 8 per capita on health, despite the

20. Nigeria’s National Health Policy and Strategy to Achieve Health for all Nigerians, at 7, Sec. 3.3 (1988).
22. Ibid.
23. Ibid at 12, Sec. 5.5.
24. Federal Ministry of Health (Nigeria), Revised National Health Policy, at 9-10, Sec. 4.6 (2004) [hereinafter Nigeria’s Revised National Health Policy (2004)]. The Maternal and Child Health Policy also provides for maternal and child health facilities. Other federal Agencies and parastatals associated with strengthening reproductive health are the National Primary Health Care Development Agency Act 1992 (NPHCDA), the Population Activities Fund Agency (PAFA), the Department of Community Development and Activities (DCDPA) and the National Health Insurance Scheme Act 1991.
international community’s recommendation of USD 34 per capita.\textsuperscript{25}

The 2004 Revised National Health Policy specifies national standards for reproductive health, and aims to ‘create an enabling environment for appropriate action and provide the necessary impetus and guidance to local initiatives in all areas of reproductive health.’\textsuperscript{26} Its objectives include reducing maternal morbidity, unwanted pregnancies, perinatal and neonatal morbidity and mortality; reducing gender imbalance in matters of sexual and reproductive health; and promoting research on reproductive health issues. In addition, it lists strategies for achieving these goals, such as ‘equitable access to quality reproductive health services, building the reproductive health capacity of providers, ensuring availability of appropriate materials for effective reproductive health services, and undertaking necessary research to address emerging issues in reproductive health.’\textsuperscript{27}

The Health Sector Reform Programme was developed to address priority health problems, including maternal mortality.\textsuperscript{28} It recognizes the deplorable health status of Nigeria’s citizens, and notes that the nation’s MMR is one of the highest in the world.\textsuperscript{29} It states that the absence of a clear constitutional mandate for health at the local-government level diminishes the local governments’ obligation to provide primary health care, and leaves uncertain the functions of the federal and state

\begin{itemize}
  \item \textsuperscript{25} \textit{Ibid} at Sec. 2.
  \item \textsuperscript{26} \textit{Ibid} at 32, Sec. 6.9(1).
  \item \textsuperscript{27} \textit{Ibid} at 32-33, Sec. 6.9(3). The Revised National Health Policy also provides for a national policy on adolescent health with the sole goal of meeting the special health needs of adolescents and call for promoting adolescent’s knowledge on health issues and creating an appropriate climate for policies and laws necessary for meeting adolescent health needs; \textit{Ibid}. at 33, Sec. 6.10.
  \item \textsuperscript{28} Federal Ministry of Health (Nigeria), Health Sector Reform Programme (2005).
  \item \textsuperscript{29} \textit{Ibid} at Section 1.
\end{itemize}
governments. The Programme also acknowledges the absence of dependable information on the government’s health expenditures and the failure of the people to scrutinize the budgetary allocations in this regard. It notes that constitutional gaps have obstructed the ability of the government to fulfil its responsibility to provide health care, and calls for the enactment of a national health Act that would remedy this loophole. In the meantime, the programme recognizes the need to establish primary health-care facilities and referral health facilities to ensure access to emergency obstetric care, stating that this would reduce maternal mortality and morbidity. While the 2004 Health Sector Reform Programme identified many of the problems of the Nigerian health sector and proffered solutions, challenges still persist.

Nigeria’s recent National Reproductive Health Policy and Strategy replaced the 1994 Maternal and Child Health Policy when it became clear that the existing policy placed greater emphasis on child health, rather than maternal health. The new policy was developed to address a number of concerns, including the ‘unacceptably high levels of maternal and neonatal morbidity and mortality.’ It was also to address ‘the current fragmentation of reproductive health activities and the limited impact of existing programmes in reducing sexual and reproductive ill-health,’ and the widespread lack of awareness and utilization of family planning services. The National Reproductive Health Policy and Strategy acknowledged the low

30. Ibid at Section 7 (h).
31. Ibid at Section 2.
32. Ibid at Section 15 (1) a.
33. Ibid at Section 22(2).
36. Ibid.
rate of access to reproductive health information and services at the primary, secondary, and tertiary health-care levels. In addition, it notes that while the 1998 National Health Policy, if strictly adhered to, could improve reproductive health services, such implementation has not taken place.

In order to meet its goals of reducing maternal morbidity and mortality and unwanted pregnancies by 50%, and raise the contraceptive prevalence rate from 21.6% to 40%, Nigeria’s National Reproductive Health Policy and Strategy provides for a number of actions for government to take. These measures include removing barriers to reproductive health care, improving access post-abortion services, strengthening reproductive health at the primary-care level, increasing training of health-care personnel in reproductive health, and promoting access to family planning information and services.

The Policy emphasizes the importance of providing:

- comprehensive (including referral), client-oriented, and good quality, equitably accessible, affordable and appropriate reproductive health services;
- developing a coherent and integrated framework of relevant policies, laws, strategies, and programmes that address reproductive health with particular attention to priority-setting, ensuring compliance by all tiers of government and individuals with all relevant treaties, policies and laws supporting the attainment of the highest level of reproductive health irrespective of age, sex, ethnicity, religion and socio-economic status and adequately funding reproductive health programmes through

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37. Ibid at 9.
38. Ibid at 12, 21.
39. Ibid at 22.
increased and timely financial contributions, [and] judicious and transparent use of funds available to the programmes.\textsuperscript{40}

In 2007, The Federal Ministry of Health also developed the Integrated Maternal, Newborn and Child Health Strategy.\textsuperscript{41} The strategy is composed of intervention packages, which address the main contributing factors to maternal, newborn, and child deaths.\textsuperscript{42} These packages shift the focus away from fragmented methods of implementing maternal and child health services to integrated methods. The strategy, which has three stages of implementation: 2007-2009, 2010-2012, and 2013-2015, uses primary health care as its main base.\textsuperscript{43} Its specific goals include ensuring that 70\% of deliveries occur in health facilities by 2015, and that at least 70\% of basic emergency obstetric care will be provided at primary health-care clinics and at general hospitals.\textsuperscript{44}

The IMNCH Strategy recognizes that poverty constitutes a barrier to accessing health care and aims to institute a Basic Health Insurance Scheme that would ensure free service to pregnant women, newborns and children under the age of five.\textsuperscript{45} It envisages specific roles for the executive, legislative and judicial arms of the three tiers of government in its implementation, and enjoins the First Lady of Nigeria to serve as the Goodwill Ambassador for women and children and to ensure the implementation of the strategy in the country.\textsuperscript{46}

\textsuperscript{40} Ibid at 19.
\textsuperscript{41} This is often referred to as the 2007 IMNCH Strategy, hereinafter called the IMNCH Strategy.
\textsuperscript{43} Ibid.
\textsuperscript{44} Ibid.
\textsuperscript{45} Ibid at 3.
\textsuperscript{46} Ibid at 4.
The present National Policy on Population for Sustainable Development, replaced the initial policy of 1988, and includes the specific goal of ‘improvement in the reproductive health of all Nigerians at every stage of the life cycle.’\(^{47}\) The policy outlines objectives that facilitate reaching this goal, including ‘expanding access and coverage and improving the quality of reproductive and sexual health care services, increasing and strengthening comprehensive family planning services and safe motherhood programmes, and addressing the reproductive health needs of adolescents.’\(^{48}\)

The 2007 National Policy on the Health & Development of Adolescents & Young People in Nigeria (the National Adolescent Health Policy), replaced the National Adolescent Health Policy of 1995, and recognizes the importance of ‘promoting and protecting the reproductive health of young people,’ defined as those between 10-24 years of age.\(^{49}\) The policy notes that married adolescents make up a large number of the young people in Nigeria, and are likely to have inadequate information regarding sexual and reproductive health.\(^{50}\) It also sets forth reproductive health targets for young girls and women to be met by the year 2015, including reducing the maternal mortality ratio by 75% and lowering the incidence of unwanted pregnancies by 50%.\(^{51}\) Moreover, it establishes strategies for reaching these targets, such as building the capacity of health-care workers who deal with young people and establishing an effective system for monitoring and evaluating the implementation of this policy.\(^{52}\)


\(^{48}\) Ibid at 21 - 22.


\(^{50}\) Ibid at 3.

\(^{51}\) Ibid at 12.

\(^{52}\) Ibid at 13.
The importance of catering to the maternal health-care needs of adolescents cannot be overemphasized. Nigeria’s latest demographic and health survey reveals that one quarter of Nigeria’s teenage women are either pregnant or have given birth. This statistic is not surprising, given the high number of married or cohabiting adolescents in the nation, particularly in the northern region. Research conducted by UNICEF found that Nigerian girls below the age of 18 died from maternal causes or suffered serious health issues at a rate four times higher than those aged between 20 and 24. The present National Gender Policy aims to eliminate discrimination on the grounds of sex and, among other things, protect the health of Nigerians as a means of achieving ‘equitable rapid economic growth.’ Its goals and targets include:

incorporating the principles of CEDAW and other global and regional frameworks that support gender equality and women empowerment in the country’s laws, judicial and administrative systems, reducing maternal mortality rates by at least 35%, improving reproductive health services and strengthening

56. Federal Ministry of Women Affairs and Social Development (Nigeria), National Gender Policy, at 6 (vii), 2006.
gender responsive, evidence-based health systems by 2015.57

Health Care Delivery
The most obvious level for reproductive health care is in the clinical setting where health care is delivered. Laws, however, govern the qualifications and skills that health care providers bring to their duties and responsibilities in clinical patient care. Qualifications and skills are products of education and training, and of professional registration and monitoring. Legal concerns at the health system level include the adequacy or otherwise of medical expertise, functions and structures through which clinical services are accessible or obstructed. The enforcement of governmental responsibilities to fund and provide equitable access to services that serve not just reproductive rights but human rights, of which reproductive rights are an important element, becomes paramount.

Legal and judicial reform can be advanced to increase and enhance the effectiveness of health systems through initiatives and the passage of health bills. Juridical and legislative reforms can also be done at government tribunals, courts and legislative houses. In Nigeria, where constitutional obligations do not explicitly protect the right to health, case law and court decisions have the potential of implementing and enforcing commitments made at international tribunals, regional and international human rights conventions. Reform strategies at all levels of the national health system will include:

- The comprehensive provision of reproductive and sexual health services that are of good quality, equitably

57. Ibid at 21.
accessible, affordable and appropriate to the needs of all members of the community.

- The delivery of reproductive and sexual health services as an integral part of primary health care, and of the health-care delivery system at all levels.
- Strengthening and improving referral system for reproductive health services.
- The review of all existing laws and policies in order to ensure the protection of the reproductive and sexual rights of individuals, including the right to make decisions concerning one’s reproductive health without coercion, violence, or discrimination.
- Requiring governments at all levels to ensure compliance with relevant treaties, policies and laws supporting the attainment of the highest standard of reproductive health services for all citizens.
- The development and implementation of a comprehensive plan for training and retraining of health care providers in integrated and reproductive health service delivery.
- Requiring all tiers of government to provide adequate funding for reproductive health programmes through creation of appropriate budget lines, increased and timely financial contributions, judicious and transparent use of available funds and the implementation of relevant health sector reforms.  

### Availability and Access to Contraceptives

Access to family planning or contraceptive methods is an important strategy in reducing maternal mortality.\textsuperscript{59} However, the Nigerian government does not ensure access to these methods, and many Nigerian women do not benefit from this critical option. While there is some variance in statistics, surveys show that the percentage of respondents who use any method of contraceptives ranges from 13.3\% to 15.6\% and the percentage of those who use modern methods of contraceptives range from 8.9\% to 11.6\%.\textsuperscript{60} 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.\textsuperscript{61}

Furthermore, one third of women of child bearing age have had an unwanted pregnancy, while 25\% of women between 15-49 years of age have an unmet need for family planning.\textsuperscript{62} The relevance of unplanned and unwanted pregnancies increases the likelihood of exposure to unsafe abortion and the risk of maternal morbidity or mortality.

According to the Nigerian Demographic and Health Survey (DHS), the rate of use of any method of contraception in 2003 was 13.3\%, while the rate of use of modern methods of contraception was 8.9\%.\textsuperscript{63} More recently, the 2010 National HIV/AIDS and Reproductive Health Survey (NARHS) found

\begin{itemize}
\item \textsuperscript{60} Nigeria’s National HIV/AIDS and Reproductive Health Survey 2005 at 117, tbl. 11.6 (2006).
\item \textsuperscript{62} Ibid. at 13.
\item \textsuperscript{63} NPC & ORC Macro, Nigeria Demographic and Health Survey 2003 at 67, tbl. 5.4 (2004).
\end{itemize}
that the rates of use were 25.6% and 11.6%, respectively.\textsuperscript{64} The predominant reasons for the low rate of contraceptive use - lack of access and lack of affordability - are directly attributable to the inaccessibility of family planning services and information, and partially as a result of inadequate funding of contraceptive services and information.

In failing to adequately ensure access to contraceptives and family planning services, the government neglects her duties under international human rights law; namely its obligation to ensure the right to health, the right to access family planning services and information, the right to decide on the number and spacing of children, and the right to equality and nondiscrimination. The State has also fallen short of fulfilling her obligations under regional laws, including the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the Maputo Protocol), which calls for states to ‘ensure that the right to health of women, including sexual and reproductive health is respected and promoted.’\textsuperscript{65} Under the Protocol, the right to health encompasses the following elements: the right to control fertility, the right to decide whether to have children as well as the number and spacing of children, the right to choose any method of contraception, and the right to family planning education.\textsuperscript{66} Additionally, the Maputo Plan of Action calls for the strengthening of ‘SRH [sexual and reproductive health] security with emphasis on family planning.’\textsuperscript{67}

\textsuperscript{64} National HIV/AIDS and Reproductive Health Survey in 2005, at 117, tbl. 11.6 (2010).
\textsuperscript{65} The Maputo Protocol, \textit{supra} at Art. 14(1).
\textsuperscript{67} Ibid.
Adequate family planning has a significant impact on reproductive health. According to Haruna, ‘by far the most important way of reducing maternal deaths is often by reducing the number of pregnancies a woman carries.’\(^6^8\) Similarly, an obstetrician and gynaecologist with the University College Hospital (UCH) in Ibadan has stated that family planning is ‘key’ to lowering Nigeria’s MMR.\(^6^9\) By preventing unintended pregnancies, access to family planning ‘could avert 20 to 35 per cent of maternal deaths’ and thus save more than 10,000 lives every year.\(^7^0\) In a recent article, the former national coordinator of the family planning unit of the Federal Ministry of Health stated that family planning could reduce maternal mortality by at least 20%.\(^7^1\) Interviewees testified to the strong correlation between the use of family planning and the reduction of maternal mortality rates in Nigeria.\(^7^2\) One doctor noted that ‘family planning is the first pillar in reducing maternal mortality.’\(^7^3\) An official at the State Ministry of Health, Ogun State, explained that the fact that his local government offers

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69. *Ibid*.


free family planning has been a factor in reducing the MMR in his state to 178 deaths per 100,000 live births (in comparison to the national rate of 1,100 per 100,000).  

Several other national and regional laws and policies obligate Nigeria to provide health services, including family planning services and maternal care, in a manner that is adequate, affordable and accessible. Some are enumerated below:

- Under the Maputo Protocol, Nigeria should take measures to ‘provide adequate, affordable and accessible health services, including information, education and communication programmes to women.’

- The 2001 National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians (Nigeria’s National Reproductive Health Policy and Strategy) calls for the government to ‘provide comprehensive (including referral), client-oriented reproductive health services that are of good quality, equitably accessible, affordable and appropriate to the needs of individual men and women, families and communities, especially underserved groups.’ The policy specifically calls for the removal of ‘all forms of barriers that limit access to comprehensive, integrated and qualitative reproductive health care.’

- The 2004 National Policy on Population for Sustainable Development aims to expand access to and coverage of reproductive and sexual health-care services as well as to

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76. Federal Ministry of Health (Nigeria), National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians, 17, supra.
77. Ibid. at 17.
improve the quality of these services.\textsuperscript{78} To achieve its goals, the Policy calls for ‘comprehensive reproductive and sexual health services that are of good quality, equitably accessible, affordable and appropriate to the needs of all members of the community.’\textsuperscript{79}

- The various strategies for achieving the goals that are laid out in the 2004 Revised National Health Policy include the provision of ‘equitable access to quality reproductive health services to assure availability of reproductive health issues in the community.’ In December 2010, the President launched the National Strategic Health Development Plan.

According to survey results, 60.5\% of women respondents either believed that family planning or child spacing methods were not easily available, or they did not know the answer to or response to the question.\textsuperscript{80} The figure for males was 55.5\%.\textsuperscript{81} Interviews revealed numerous factors for the lack of contraceptive availability; for instance, some contraceptives may have expired by the time they reach health facilities.\textsuperscript{82} As a result of these and other reasons, contraceptives are not available consistently or on a long-term basis.\textsuperscript{83} The general absence of health facilities, particularly in rural areas, is yet

\begin{itemize}
\item \textsuperscript{79} Ibid at 24.
\item \textsuperscript{80} Nigeria’s National HIV/AIDS and Reproductive Health Survey 2005 at 113, tbl. 11.3 (2006). Figures were obtained by adding percentage of females who ‘agree’ with statement and percentage off males who “don’t know/no response.”
\item \textsuperscript{81} Ibid. Figures were obtained by adding percentage of males who “agree” with statement and percentage of males who “don’t know” or have “no response.”
\item \textsuperscript{82} Interview with Mrs. L. A. Buba, President, PPF-Nigeria, Abuja, Feb. 8, 2008.
\item \textsuperscript{83} Ibid.
\end{itemize}
another barrier to access.\textsuperscript{84} By not ensuring that contraceptive goods and services are available in ‘sufficient quantity,’ the Nigerian government has failed to ensure accessibility.

Acceptability, as defined by the CESCR, requires that health goods and services be respectful and sensitive to gender and ‘designed to respect confidentiality.’\textsuperscript{85} Unfortunately, the government of Nigeria has neglected to ensure this element of the right to health. The attitude of health care professionals has been described as ‘nasty and inhumane’ by health care professionals.\textsuperscript{86} When healthcare providers are not ‘courteous’ to patients who seek information about family planning, these patients are unlikely to return to the facility. In addition, lack of confidentiality prevents women from seeking family planning at health-care centres; the fact that others will know why they are at the facility serves as a strong deterrent. By failing to ensure that women are able to receive health-care services in a manner that respects their confidentiality, women’s access to contraceptives is inhibited.

Both the CESCR and the CEDAW Committee have emphasized the importance of ensuring quality health goods and services, which includes skilled medical personnel.\textsuperscript{87} In addition, the CEDAW Committee has stressed that quality health-care services must be ‘acceptable to women’ in that they are ‘delivered in a way that . . . guarantees [their] confidentiality and is sensitive to [their] needs and perspectives.’\textsuperscript{88}

### Safe Abortion

\textsuperscript{84} Focus-group discussion with Kuti T. Folake, BAOBAB for Women’s Human Rights, Lagos, Feb. 13, 2008.

\textsuperscript{85} CESCR, General Comment No. 14, para. 12(c).

\textsuperscript{86} Interview with Dr. Mairo Mandara, Obstetrician and Gynaecologist, Abuja, Feb. 11, 2008.

\textsuperscript{87} CESCR, General Comment No. 14, para. 12(d).

\textsuperscript{88} CEDAW Committee, General Recommendation No. 24, para. 22.
Studies have shown that a majority of the abortions that are performed in Nigeria are unsafe partly because of the nation’s restrictive legal context. For example, it has been estimated that 456,000 unsafe abortions take place annually in Nigeria. Additionally, in the latest periodic report, the government states that unsafe abortions lead to about 34,000 deaths each year. A 2006 Federal Ministry of Health report estimated that for every unsafe abortion that results in death, a further thirty women suffer long-term injury and disability.

Lack of contraceptive access is thus a primary cause for the prevalence of unsafe abortions, with the usage rate of modern contraceptives estimated to be between 18.9% and 21.6%. A recent study found that 60% of women who have had abortions reported that they were not using family planning methods when they became pregnant. The direct connection between unsafe abortion and high mortality rates has led the Human Rights Committee, which interprets the Civil and Political Rights Covenant, to require that states issuing reports on the right to life must inform the Committee of ‘any measures taken by the State to help women prevent unwanted pregnancies, and

90. Ibid.
91. CEDAW, Consideration of Reports, Nigeria 82 (2006).
to ensure that they do not have to undergo life threatening clandestine abortions. 95

The CEDAW Committee has further noted the connection between lack of access to contraceptives, unsafe abortion and maternal mortality, and has clearly stated that high maternal mortality and morbidity rates and lack of access to contraceptives constitute important indications of governmental failure to ensure women’s access to health care. 96 The Committee has expressed concern about ‘the high rates of maternal mortality as a result of unsafe abortions,’ and on this basis has urged Nigeria to ‘take measures to assess the impact of its abortion laws on women’s health.’ 97

According to the Sixth Periodic Report of Nigeria to the CEDAW Committee: 98

*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.* 99

The African Charter, which has since been incorporated in Nigeria, prohibits any discrimination on the basis of ‘fortune’ or other status in the enjoyment of the rights that it guarantees, including the right to health. 100 Furthermore, the Maputo Protocol requires the nation’s government to ‘take corrective

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98. Supra at 81.
99. Ibid at 87.
100. African Charter, supra, Art. 16.
and positive actions in those areas where discrimination against women in law and in fact continues to exist.\textsuperscript{101} However, poor and low income women are disproportionately represented in the number who resort to, and die from complications arising from, unsafe abortion. Research shows that while 56\% of Nigerian women access abortion through qualified health professionals in private health centres, only 24\% of their poorer counterparts are able to do the same.\textsuperscript{102} Although one in four women who have abortions experience serious complications, only one third of these women seek treatment, largely due to stigma, shame and the high cost of such medical care.

**Conclusion**

Reproductive health and rights are indispensable to population and development, and the achievement of legal rights to reproductive health care sets the goal for achieving universal access to health information and services by the year 2015. Whilst it is crucial that an overall health strategy for any country must be ‘home grown’, Nigeria can certainly learn from and advance its realization of health rights through judicial implementation of international standards. The fulfilment of core health obligations will depend primarily on the enforcement of government policies in the health sector, and beyond that, on legislative and juridical measures to criminalise sexual violence in public and private spheres, female genital mutilation and other harmful traditional practices. Other obligations and duties include provision of maternal health care at all levels, safe abortions under prescribed circumstances, and HIV/AIDS related health care, especially for vulnerable groups such as women and children. More importantly, it will depend

\textsuperscript{101} Maputo Protocol, Art. 2(1)(d).
\textsuperscript{102} Guttmacher Institute, Facts on Unwanted Pregnancy and Induced Abortion in Nigeria 1 (Guttmacher, 2006).
on the domestication of international and regional human rights treaties and instruments in Nigerian law.

Furthermore, how men and women (especially political and public office holders, religious and community leaders, researchers, policy makers and stakeholders) perceive gender issues and women’s rights, and to what extent their decisions and actions reflect a concern over such rights, are questions that require continuing human rights education, aggressive public enlightenment and awareness campaigns, multidisciplinary research and a cross-cultural approach to the understanding, articulation and promotion of women’s rights as human rights in the civil, political, social, economic, cultural, environmental and developmental contexts of the State.

While the courts alone cannot ensure realisation of the right to health or healthcare, they may be able to provide a counterweight for the enforcement of core obligations related to internationally recognized human rights. At the same time, because legal and policy reforms and human rights can only provide a receptive context for changes in behaviour and do not by themselves produce these changes, it is important to recognise practical realities that may support or hinder these reforms. It is evident that efforts in the progressive realization of the goals, objectives and targets set out in the ICPD and subsequent international and regional documents have been made, as evident from the number of policies, laws and strategies to advance maternal and women’s health especially in the area(s) of reproductive capabilities. From all indications, this author believes that there is room for a national legislative framework on reproductive health rights, and judicial implementation of stated provisions. This is particularly evident when considering the appreciable windows of opportunity for legal enforcement in Nigeria examined in this paper, and the indications for capacity already existing within the Nigerian legal system. In the final analysis, judicial reform can only be advanced in this area if legislative provisions on the subject are
enacted and enforced, and international standards incorporated into domestic law(s).