WOMEN AND REPRODUCTIVE HEALTH RIGHTS IN NIGERIA

Oluwakemi Amudat Ayanleye
Department of Business and Industrial Law, Faculty of Law,
Olabisi Onabanjo University, Ago-Iwoye, Ogun State, Nigeria.
Corresponding author: kemmyayanleye@gmail.com

 ISSN 1923-6654 (print)
ISSN 1923-6662 (online). Available at http://www.ssrn.com/link/OIDA-Intl-Journal-Sustainable-Dev.html

Abstract: While motherhood is a thing of joy, it is a source of sadness to many households as many women lose their life giving birth in Nigeria. Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age. Discussions on reproductive and sexual health rights which had hitherto been a 'taboo' in traditional African societies are on the increase amongst African scholars. While the right to health has been an internationally recognised human right, reproductive health rights gained formal acceptance only in 1993 and the need for women to have access to quality reproductive health services such as medical care, planned family, safe pregnancy, delivery care and treatment and prevention of sexually transmitted infections, such as HIV/AIDS is increasingly gaining recognition in Africa at large and Nigeria in particular. This article focuses on reproductive health as a human rights issue and discusses the right of women to reproductive health information, education and services. The paper also looks at the right of women to safe motherhood, choice of fertility, contraception, protection against rape, sexually transmitted disease and female genital mutilation. Nigeria ranks amongst countries with the highest rate of maternal mortality and morbidity and in spite of the global recognition of the right to health as a human right, Nigeria is yet to embrace the concept as there is no specific legislation on the right to health in Nigeria. Chapter IV of the 1999 Constitution which provides for the fundamental human rights makes no provisions for the right to health in spite of the fact that the right to life is only meaningful to a person who is healthy and the right to freedom of movement has no value for a person who is rendered immobile by a preventable disease. Provisions for healthcare are contained in Chapter II of the Constitution which embodies the economic and social policies of the country. Section 17 (3) (c) provides that the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons. However, the provisions of Chapter II have been excluded from adjudication by the courts, thus, no right of action can ensue from the breach of the provisions of the said chapter by the government. Further, there are statutory, cultural and religious factors militating against women's reproductive health rights and they have been a major cause of women's continued oppression. Issues in reproductive rights from the point of view of gender equality are also discussed. The paper concludes that promoting reproductive health and rights is indispensable for economic growth of and poverty reduction in the society.

Keywords: Access, Reproductive Health, Rights, Women

INTRODUCTION

While motherhood is a thing of joy, it is a source of sadness to many households as many women lose their life giving birth in Nigeria. Every single day, Nigeria loses about 2,300 under-five year olds and 145 women of childbearing age. This makes the country the second largest contributor to the under–five and maternal mortality rate in the world (UNICEF). What is more devastating is that these deaths could have been prevented by basic investment in primary healthcare and infrastructure by the government. The high rate of maternal mortality is a source of grave concern and the need to improve maternal health cannot be over emphasised. Academic discourse on reproductive health rights is a relatively novel phenomenon in Nigeria. While the right to health has been an internationally recognised human right, reproductive health rights gained formal acceptance only in 1993 (Atsenuwa et al, 2004). The International Conference on Population and Development (ICPD) held in Cairo in 1994, marked a paradigm shift in the focus of population programmes and underscored the need to

meet the reproductive health needs of individuals and couples as a key approach to improving quality of lives of people and stabilising the world population. As one of the countries that approved the historic Programme of Action that emanated from the ICPD, Nigeria committed herself to the implementation of the Reproductive Health concept and the achievement of the ICPD targets in the interest of the health and development of her citizenry (Nwoso, 2001). The African region, of which Nigeria is a foremost member, developed a regional strategy that would ensure the promotion of optimal reproductive health status and reduction of reproductive health morbidities and mortalities in member countries. Nigeria has since adopted this African strategy in spite of which access to reproductive health and reduction in maternal morbidity and mortality has been a mirage.

Until quite recently, reproductive and sexual rights were considered by most Africans as issues for discussion only by 'queers' and liberal feminist groups (Aniekwu, 2006). The typical traditional African values and societal norms view reproduction and sexual practices as very private issues not meant for public discussion. Thus, it was more or less a "sacrilege" to advocate for sexual rights, safe abortion and reproductive choice. Cultural practices like female genital mutilation (FGM) were accepted by many societies and the practice was not considered harmful or illegal by many. Many aspects of reproduction such as safe motherhood and family planning services were not regarded as 'rights' per se (Aniekwu, 2006). Safe motherhood means maternal health which includes the right of women to receive high-quality gynaecological, prenatal, delivery and postpartum care, in order to achieve optimal health for the mother, foetus and infant during pregnancy, childbirth and postpartum. The term "*reproductive rights*" was coined in 1984 during the International Meeting on Women and Health in Amsterdam (Choike Reports, n.d.). The event was seen as the starting point of the struggle to expand the scope of the concept of human rights to reproductive rights. This paper examines the nature and scope of reproductive health and also examines reproductive health as a human rights issue. This paper discusses access of women to reproductive health and analyses factors militating against the attainment of reproductive health rights in Nigeria.

CONCEPTUALISING REPRODUCTIVE HEALTH

There is no universal definition of reproductive health. According to the ICPD, reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes. The concept is centred on human needs and development throughout the entire life cycle, "*from the womb to the tomb"* (Federal Ministry of Health (FMOH), 2001). There is just not one reproductive right but a host of recognised human rights that have positive implications for the protection of reproductive health (Atsenuwa, et al, 2004). Reproductive rights consist of a number of separate human rights that "are already recognized in national laws, international laws and international human rights documents and other consensus documents," (Principle 7.3 ICPD, See CRLP,1998, Atsenuwa, et al, 2004, Gbadamosi, 2007).

Reproductive health implies that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. It includes access to voluntary, qualitative and sexual health information and education and services (Imasogie, 2004). Reproductive rights embrace the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice as well as other methods of their choice for regulation of fertility which are not against the law, the right to appropriate healthcare services which will enable women go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. Reproductive health is thus a constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive health problem (Atsenuwa et al, 2004, see also Gbadamosi, 2007). Reproductive health rights thus represent a paradigm shift from maternal and child health and family planning as it is broader and more comprehensive (Nwoso:2001).

Scope of Reproductive Health

Reproductive health care covers a wide range of services. These services are defined in the ICPD Programme of Action (PoA) as including family planning counselling, information, education,

communication and services, education and services for antenatal care, safe delivery and post-natal care, and infant and women's health care; prevention and treatment of infertility; prevention and treatment of infections, sexually transmitted diseases, including HIV/AIDS; breast cancer and cancers of the reproductive system, and other reproductive health conditions; and active discouragement of harmful traditional practices, such as female genital mutilation (FMOH: 2001). According to the ICPD, reproductive rights …embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. In the exercise of this right, they should take into account the needs of their living and future children and their responsibilities towards the community (Principle 7.3 of the ICPD PoA).

Thus the essential elements of a comprehensive reproductive health package are: comprehensive sexuality education, access to contraception, safe abortion, maternity care, and diagnosis and treatment of sexually transmitted infections (STIs), including HIV, diagnosis and treatment of breast and cervical cancers and other cancers that affect the reproductive system. This package of services enables girls and women to decide whether and when to get pregnant, to decide whether to carry a pregnancy to term, and to experience pregnancy and childbirth safely (IWHC, 2008).

Certain Aspects of Reproductive Health

Maternal Health

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period (WHO). It implies safe motherhood and reduction of maternal mortality and morbidity through the provision of maternal health services in the context of primary health care (Aniekwu), based on the concept of informed choice, including education, information and safe abortions. It also encompasses the health care dimensions of family planning, pre-conception, prenatal, and postnatal care in order to reduce maternal morbidity and mortality. Preconception care includes education, health promotion, screening and other interventions among women of reproductive age to reduce risk factors that might affect future pregnancies. Prenatal care aims at detecting any potential complication of pregnancy early, to prevent them if possible, and to direct the woman to appropriate specialist medical services as appropriate. Postnatal care issues include recovery from childbirth, concerns about newborn care, nutrition, breast-feeding and family planning. The Management Science for Health (MSH) lists the scope of maternal health as follows: (a) Prenatal care, safe delivery, and postpartum care (b) Treatment of infertility (c) Comprehensive family planning service delivery and post-abortion counselling (d) Diagnosis and treatment of complications of pregnancy, delivery, and abortion (e) Women's nutrition and gynaecologic health care, including cervical cancer screening (MSH:2006).

While motherhood is often a positive and fulfilling experience, for too many women in Nigeria, it is associated with suffering, ill health and even death. The major direct causes of maternal morbidity and mortality include haemorrhage, infection, high blood pressure, unsafe abortion, and obstructed labour. These are often caused by lack of adequate prenatal care and access to competent midwifery facility and personnel. The health situation of most women in Nigeria is often very precarious and receives very limited attention from the responsible health authorities. There are not enough health facilities especially in rural areas within the reach of the rural poor. Most women, particularly pregnant women, cannot afford health services (CRLP, 1998). Many of the local health centres and rural clinics are not functional and those that are open to the communities are poorly equipped and poorly staffed. Typically, in rural health centres, there is often not more than one nurse at any given time and there are no doctors.[1] The

[1] For instance in Odogbolu, which is the headquarters of a local government of same name in Ogun State, Nigeria where this researcher resides, there is only one health centre manned by Community Health Workers. The only doctor employed by the local government authority has his office in the local government secretariat outside the health centre. The doctor services all the towns and villages under the local government area and this covers more than 20 towns and villages. There are two private maternity clinics owned by retired midwives. The "nurses" in the clinics are trained on the job in the clinics. They have no formal medical training except as provided in the clinics. The Odogbolu scenario mirrors what

nurse or midwife in such an institution is usually forced to double as a doctor. In serious cases, patient referrals to bigger hospitals are delayed primarily because of the absence of a qualified doctor to do so (CRLP, 1998). Many women out of poverty are forced to attend traditional maternity centres that mostly do not have the required facilities to cater for the needs of the woman and unborn child. Even in urban centres, public health facilities are grossly inadequate with many being merely consulting clinics on account of lack of necessary infrastructure. Many private health institutions also do not have the requisite infrastructure and personnel and the few that have such infrastructure are out of the reach of the average woman.

The right to maternal health is one of the foremost reproductive rights. Though not specifically legislated in Nigeria, it may be inferred from the provisions of the 1999 Constitution. By virtue of section 17, the government is obliged to direct its policies to ensure adequate medical and health facilities for all persons; ensure that the health, safety and welfare of all persons in employment are not endangered or abused. The right to life is also entrenched in the 1999 Constitution. The emerging trend in international law is that governments, in protecting the right to life have to take positive measures that will include provision of adequate health facilities for all, especially women and children. It is therefore submitted that the constitutional provision that guarantees the right to life may be construed as guaranteeing also the right to health, which includes the provision of adequate health facilities accessible to all (Ladan;2006). This trend was recognised by the government in its report to the African Commission on Human and Peoples' Rights 2008-2011 (Federal Ministry of Justice, 2011). However, recognition and taking positive steps to ensure implementation are different things. Further, the Labour Act in section 54 recognises maternal health by making provisions for maternity leave before and after confinement. Article 13 (i) of the ACHPR protocol on Women's rights in Africa provides that state parties must adopt and enforce legislative and other measures to guarantee amongst others "*...adequate and paid pre and post natal maternity leave in both private and public sectors*".

obtains in most local governments across the country except in the few urban centres. In fact in some villages, they have to rely on traditional birth attendants as there are no hospitals or health facilities.

Only women in the organised labour sector enjoy the benefits of these provisions.

Protection against Rape and Assaults

The right to reject or accept a man's advances is the most fundamental right a woman can have (Tobi, 2004, Ayanleye, 2006). Rape is an unlawful carnal knowledge of a woman or girl without her consent, or with her consent if that is obtained by force or by means of threats or intimidation of any kind, or by fear of harm, or by means of false and fraudulent representation as to the nature of the act, or in the case of a woman, by impersonating her husband (Section 357 of the Criminal Code). Spousal rape is not recognized as a crime in Nigeria (S. 6 of the Criminal Code) as a woman is deemed to have given blanket consent to sexual intercourse by virtue of marriage. In ***R v. Mille (***[1954] 2 QB 282***),*** it was held that there is implied consent to intercourse which the wife gives at marriage which can only be revoked by order of court or by a separation agreement. However since a husband was not entitled to use force or violence for exercising his right of intercourse, he may be liable for assault. It was not until the 1992 case of ***Regina v. R (***[1992] 1 AC 599) that the House of Lords in a landmark decision overruled the previous common law position that a man could not rape his wife. However, until the amendment of S.6 of the Criminal Code, the applicability of this case in Nigeria is doubtful.

To ground a conviction in rape, the testimony of the victim must be corroborated. This can be quite frustrating and often the criminals/rapists get away with offences they have committed for lack of corroboration (Ladan:2006). For the female victims of rape, they become doubly jeopardised and traumatised. Also because of the secondary victimisation attached to it, rape cases often go unreported and the victim has to bear the burden for the rest of her life. It is therefore submitted that the need for corroboration should be expunged from the Criminal Code. A high number of women and girls suffer sexual assault, both within and outside marriage and in the context of sex work. Such rapes put them at risk of both HIV/STI infection and unwanted pregnancies. Much greater efforts are needed to expand access to post-exposure prophylaxis for rape survivors, as well as STI diagnosis and treatment and availability of emergency contraception for female survivors of assault (ICW, 2006).

Sections 360, 361, 362, and 363 of the Criminal Code also attempt to protect women and girls from indecent assault and abduction.

Protection from HIV/AIDS and Other Sexually Transmitted Infections and Other Reproductive Tract Infections

The right to health also includes protection from and treatment of sexually transmitted diseases and other reproductive tract infections. The incidence of HIV infection is steadily rising in Nigeria. It is particularly high among the youth. At least 80 percent of HIV infections in Nigeria are contracted through sexual intercourse. Other causes of infection are through unsterile injections and the inadvertent transfusion of unsafe blood and body piercing, scarification or cutting. The HIV situation in Nigeria is fuelled by a number of factors including ignorance, denial, stigmatisation of the infected people, inappropriate health care practices (including traditional ones); inadequate number of, and lack of access to voluntary testing and counselling facilities; lack of appropriate care for infected people; and, false claims about cure (FMOH, 2001). The low level of education among females and generally low social and economic status of women in the Nigerian society also play a part in the rising HIV rate as well as other reproductive problems. Urbanisation, unemployment and poverty have fuelled high-risk sexual behaviours including prostitution, thereby contributing to the increasing rate of HIV infection. Other health challenges facing women are cervical cancer, breast cancer and issues of menopause in the elderly. Although there have been recent efforts at raising awareness on breast and cervical cancer especially in the electronic media, these efforts would not amount to much without adequate facilities for early detection and treatment of both breast and cervical cancer.

Adolescent Reproductive Health

Another important feature of reproductive health rights is adolescent reproductive health. The reproductive health status of the Nigerian adolescent is poor. Paramount among the factors responsible for the current high levels of reproductive ill-health among adolescents is lack of sexuality education. Most adolescents do not have access to sexuality education. This is a result of the African attitude to discussions on sex. Discussions on sex are believed to be an adult preserve and children are shut out from such discussions. Facts about sexuality are usually shrouded in myths and misrepresented to the adolescents. They often have to find out on their own what sexuality is all about and often with dire consequences. The average age of first intercourse has declined and there is greater practice of unprotected sexual intercourse with multiple and casual partners by both boys and girls. It is not uncommon to find girls of 12 years who are sexually active. As such, there is a high rate of teenage pregnancy most of which end up in induced abortions, with majority being carried out by quacks and in unsafe environment. The high rate of teenage pregnancy also contributes to a high rate of school dropouts. As a result of increasing poverty and other adverse social conditions, there is an increasing rate of antisocial practices including drug abuse and violent crimes such as rape and armed robbery. Lack of parental care and monitoring also contribute to this menace. Many elite parents leave their children unattended to in the quest for wealth. On the other hand, the pervading poverty in the country also contributes to this problem. Many young girls have to help augment family income by hawking as a result of which they are often exposed to situations where they are sexually exploited. There is need to expose children to sex education appropriate to their age to reduce incidence of teenage pregnancies as well as sexually transmitted diseases. Cultural values that encourage sexual abstinence until marriage should be encouraged and promoted.

Harmful Practices and Reproductive Health

There are various harmful practices against women which contribute to reproductive ill health in Nigeria and constitute a violation of reproductive health rights. They include female genital mutilation (FGM), forced early marriage, traumatic puberty initiation rites, labour and delivery practices, wife inheritance and sexual hospitality practices. Some of these practices such as wife inheritance and group circumcision could facilitate the spread of HIV. Female genital mutilation/cutting is practised in many states in Nigeria in various forms from infancy to adulthood. The reason often cited for the practice of FGM is to reduce promiscuity among women. These practices cut across religious and cultural boundaries and the victims are unaware of the associated potential dangers such as haemorrhage, shock, and infections including Hepatitis B and HIV/AIDS. The long-term complications include psychological consequences, recurrent urinary tract infections, sexual dysfunction, chronic pelvic infection, infertility, prolonged obstructed labour, vesico-vaginal and recto-vaginal fistulae (VVF and RVF). Though there are several legislations against FGM in Nigeria, it is still prevalent because it is culturally rooted in the beliefs of the people. Further, Article 5 of the Protocol to ACHPR on Women's Rights in Africa enjoins state parties to take legislative and other measures to prohibit FGM in all its ramifications.

Early forced marriage is also another cultural practice with negative reproductive consequences. The Child Rights Act 2003 (CRA) prohibits the marriage of a girl under the age of 18 years, and it is an offence for the father/ guardian and the husband punishable with imprisonment. However, child marriage still abounds in the country, especially in the northern part of the country. Recently, a senator in the National Assembly got married to an under-aged girl. Though the marriage generated public outrage, the senator is yet to be arraigned before any law court. It brings to question the sincerity of our legislators and policymakers. If a senator who pledged to uphold the Constitution and the laws of the country could flout it with impunity without any reprisal, then, there really is a problem.

Gender-based violence is another harmful practice that is prevalent in Nigeria. Violence against women is defined as "any act that results in, or is likely to result in**,** physical, sexual and psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life". Most African cultures allow a man to chastise his wife by beating her. This is sometimes backed by law. For instance, the Penal Code (S. 55 (1)) claiming to be based on Shari'ah Legal system allows a man to chastise his wife as long as it does not amount to grievous hurt. This, it is submitted, is a misrepresentation of the Shari'ah. Violence has both short and long-term detrimental effects on women's health, thus violating the right to the enjoyment of the highest attainable standard of physical and mental health. There have been calls to legislate against this societal malaise which have not yielded much fruits. Out of the 36 states of the federation only Edo and Lagos States have legislated against domestic violence. Though the Lagos state law is not gender specific, it would still go a long way in protecting women against domestic violence. The law is also laudable in that it recognises economic abuse and deprivation as a form of domestic violence.

REPRODUCTIVE HEALTH RIGHT AS A FUNDAMENTAL RIGHT

It is a popular saying that health is wealth and a healthy nation is a wealthy nation. Thus, health is an issue of central concern to all countries and societies as it is a crucial cornerstone for socio-economic development and progress. The struggle to provide good health care to all in the society is epitomised by the Alma Ata declaration of 1978 which states that health *"is a fundamental human right" (*WHO) and its attainment is a "*most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector"* (Asangasi and Shaguy, 2009). The right to health is the right to an effective and integrated health system which is accessible to and affordable by all members of the society. Underpinned by the right to health, an effective health system is a core social institution, no less than a court system or a political system. However, in spite of the fact that the right to health is fundamental and indispensable for the enjoyment of other human rights, there is no specific legislation on the right to health in Nigeria. Chapter IV of the 1999 Constitution which provides for the fundamental human rights makes no provisions for the right to health in spite of the fact that the right to life is only meaningful to a person who is healthy and the right to freedom of movement has no value for a person who is rendered immobile by a preventable disease. Provisions for healthcare are contained in Chapter II of the Constitution which embodies the economic and social policies of the country. Section 17 (3) (c) provides that the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons. However, the provisions of Chapter II of the Constitution have been excluded from adjudication by the courts, thus, no right of action can ensue from the breach of the provisions of the said chapter by the government. The courts have consistently in a plethora of cases upheld the non justiciability of the provisions of the chapter (see generally *Okogie v. A.G. Lagos State* [1981] 2 NCLR, 337, *Adewole v. Jakande* [1981] 1NCLR, 262, *Ehimare v. Governor of Lagos State* [1981] 2, NCLR, 166).

The foregoing notwithstanding, the right to health has been recognised in numerous international instruments to which Nigeria is a State party. Article 25(1) of the Universal Declaration of Human Rights (UDHR) affirms that *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services*". (CESCR, 2000, Yamin, 2005, Kolawole, 2011). The International Covenant on Economic, Social and Cultural Rights (ICESCR) provides the most comprehensive article on the right to health in international human rights law. According to Article 12(1) of the ICESCR, state parties recognise "*the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*". Article 12(2) enumerates a number of steps to be taken by the States parties to achieve the full

realisation of this right. These include: (a) *Availability.* Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. (b) *Accessibility.* Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: (i) Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds. (ii) Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities. (iii) Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households. (iv) Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.
(c) *Acceptability.* All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. (d) *Quality.* As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation (CESCR, 2000).

The right to health is also recognised, *inter alia*, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, Articles 11(1) (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. CEDAW devotes a major attention to women's reproductive rights. The preamble stated that "*the role of women in procreation should not be a basis for discrimination*". The link between discrimination and women's reproductive role is a matter of recurrent concern in the Convention. It advocates, in article 5, "a proper understanding of maternity as a social function" and demands fully shared responsibility for child rearing by both sexes. Several provisions of CEDAW hinge on the reproductive health rights of women which include the right to maternity protection and child-care, access to adequate health care facilities, including information, counselling and services in family planning (Art 14(1)(f)), rights to decide freely and responsibly on the number and spacing of their children and to have access to information, education and means to enable them to exercise these rights" (Art 16(e)).

The right to health is also embodied in Article 16 of the African Charter on Human and Peoples' Rights which provides that every individual shall have the right to enjoy the best attainable state of physical and mental health. The ACHPR further provides that State Parties shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. The Protocol to the ACHPR on the Rights of Women in Africa in Articles 5 protects women from harmful cultural practices such as FGM. In article 12 (1) (c), the protocol enjoins state parties to protect women, especially the girl-child from all forms of abuse, including sexual harassment in schools and other educational institutions and provide for sanctions against the perpetrators of such practices. Article 14 specifically provides for the reproductive health rights of women.

Nigeria is a state party to these conventions. Nigeria ratified CEDAW without reservation. She has also domesticated the ACHPR by virtue of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act (the African Charter Act) of 1990. This makes the provisions of the ACHPR

enforceable in Nigeria. As recently as 2008, the ACHPR reiterated the commitment of the African Union to reproductive health rights. By resolution Res.135 (XXXXIIII) 08, the ACHPR declared that preventable maternal mortality in Africa is a violation of women's right to life, dignity and equality enshrined in the ACHPR and the Protocol to the ACHPR on the Rights of Women in Africa.

Nigerian Policy and Access to Reproductive Health

Nigeria has a number of policies in the health sector that are relevant to reproductive health. Foremost among these, is the National Health Policy and Strategy 1988 and 1998 (FMOH, 2001). The National Health Policy has a number of provisions which, if strictly implemented, could have led to improved access to basic health services including reproductive services for all population groups. However, the current level of access does not reflect strict adherence to this policy. Other relevant policies include the National Policy on Population for Development, Unity, Progress and Self Reliance (1988); Maternal and Child Health Policy (1994); National Adolescent Health Policy (1995); National Policy on HIV/AIDS/STIs Control (1997); National Policy on the Elimination of Female Genital Mutilation (1998); and Breastfeeding Policy (1994). The reproductive health policy is set within the framework of the Nigerian health policy, which upholds primary health care as the key to health development in Nigeria. This policy also recognises that the implementation of reproductive health should be in the context of primary health care, as stated at the ICPD. The Nigerian policy statement on reproductive health include among others (1) Protection of reproductive rights through the creation of an enabling legal environment by, the amendment and repeal of all laws contradicting reproductive rights principles and the enactment of appropriate legislation;

(2) Protection of the rights of all people to make and act on decisions about their own reproductive health free from coercion or violence, and based on full information within the framework of acceptable ethical standards; (3) Formulation and enforcement of legal instruments to support activities aimed at eliminating the practice of female genital mutilation and other forms of harmful practices such as gender-based violence especially sexual violence and rape, through intensified focus on public education and involvement of health care providers in the recognition and management of the problems. (4) Ensuring access of the public to scientifically proven preventive and curative reproductive health conditions including HIV/AIDS and protect them from unproven claims. (5) Removal of all forms of barriers that limit access to comprehensive, integrated and qualitative reproductive health care; (6) Adaptation of health facilities to the new concept of reproductive health as part of primary, health care through expansion and strengthening of outreach efforts at community level; (Establishment of appropriate mechanisms for the review of relevant curricula and training manuals of schools of medicine, nursing and health technology in order to incorporate reproductive health concepts, principles, strategies and methodologies. (FMOH, 2001)

The policy aims to serve as an effective national platform for strengthening reproductive health activities in Nigeria and facilitating the achievement of relevant global and regional goals in the interest of improved health, well-being, and overall quality of lives of all peoples in Nigeria (FMOH 2001). While the provisions of many of these policies are relevant to promotion of reproductive health, the existing relevant laws do not support some of the principles enunciated in this policies whilst some are non-committal. Despite the laudable provisions of the policies, reproductive health care in the country is still far below international standards. The state has failed to meet the basic standards set by Article 12 (2) of the ICESCR.

Impediments to Realisation of Reproductive health rights

A number of factors inhibit the provision and availability of maternal health and reproductive health care in Nigeria. Chief among this is the non-justiciability of the economic and social rights. Thus, the provisions of the facilities and infrastructure necessary for the enjoyment of reproductive health rights are left to the whims and caprices of the government. The 1999 Constitution makes good governance optional (Ayanleye, 2013), one of the indices of which is access to health care. The interdependence and indivisibility of economic, social, and cultural rights and civil and political rights has been broadly accepted since the end of the Cold War (Yamin: 2005). Under international law, states that are party to a variety of different treaties assume tripartite obligations: (1) to *respect* the right to health by refraining from direct violations, such as systemic discrimination within the health system; (2) to *protect* the right from interference by third parties, through such measures as environmental regulation of third parties; and (3) to *fulfil* the right by adopting deliberate measures aimed at achieving universal

access to care, as well as to preconditions for health (Yamin:2005). Mostly what the government in Nigeria is doing is mainly the first aspect which refraining from direct violations. The third aspect of the right which is fulfilment of the right by adoption of measures to achieve universal access to care has not enjoyed the necessary attention by the government.

Though the right to health does not mean a right to be *healthy* (CESCR: 2000), it contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health (CESCR:2000). The right to reproductive health in Nigeria seems to be a mirage. The inadequacy or lack of implementation of laws and policies, the prevalence of systemic corruption, weak infrastructure, ineffective health services, and the lack of access to skilled health-care providers worsened by separation of responsibilities for the provision of health care among the country's three tiers of government are among the factors militating against the enjoyment of the rights (Ogundipe and Obinna: 2009).

The vast scale of maternal death in Nigeria and the lack of necessary government commitment to effectively address the problem have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Fundamental human rights that the government of Nigeria is obligated to guarantee include the rights to life and health; the right to non-discrimination; the right to dignity; and the right to information (WARDC/CRR, 2008).

Although the ACHPR has been domesticated, Chapter II of the Constitution has overriding effect on the Act, thus no right of action can lie against the state for breach of the provisions of social economic rights. However, the courts are awakening to their responsibility as they have construed the right to life to extend to the right to a healthy environment (Gbemre v Shell Petroleum Development Company Nigeria Limited and Others (2005) AHRLR 151 (NgHC 2005). The decision in the case is a welcome development. The right to life can thus be construed to include the right to health and by extension the right to reproductive health. According to Bhagwati, "life means not only physical existence, it means the use of every limb or faculty through which life is enjoyed". (Bhagwati, 2009).

Another major constraint to the attainment of reproductive health in Nigeria is the poverty level of women. About 70% percent of the population live below the poverty line, majority of who are women. Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and largely preventable suffering and deaths. Many of the women and girls who die each year during pregnancy and childbirth could have been saved by relatively low-cost improvements in reproductive healthcare. Women's right to health, and reproductive health in particular, is essential to gender equality and female empowerment. The benefits of better reproductive health for both women and men can easily be demonstrated, from the point of view of society as well as the individual. In addition to saving lives and preventing infection and suffering, better reproductive health will lead to smaller families and slower population growth. An emphasis on human rights obligations is a tool in the battle to secure reproductive and sexual health. It reinforces the fundamental point that reproductive health programmes are essential to protect the dignity of men and women, something governments are obligated to do.

Unequal access of women to resources including healthcare is a major problem in Nigeria. Although women are economically active, their industry is poorly remunerated due to lack of education and formal training. Many poverty alleviation programmes aimed at improving the lives of women are often half-hearted. Many of such programmes are often used by politicians to canvass for votes and do not get to the targeted audience. The above inequalities severely constrain the ability of women and adolescent girls to acquire good health and women centred health services. At the household level, these disparities translate to a lack of autonomy and control over household resources. Women have little decision-making authority, and freedoms of movement, few women including working women have control over household economic resources (Jejeebhoy: 1997). In the Northern parts of the country, many women are in seclusion and require the permission of their husbands to go out.

Women's reproductive health is affected by a number of socio-cultural and biological factors. Underlying

the poor reproductive health of women is their poor economic status and inadequate delivery system.

Cultural and Religious Impediments

It is nearly impossible to consider sexual and reproductive health and rights without simultaneously considering the role of religion and culture. Religious teachings deeply influence personal conduct, especially in the areas of sexuality, marriage, gender, childbearing, and parental-children relationships. Moreover, secular notions of justice and rights draw upon interpretations of religious morality (CHSP:2005). Not only does religion shape the values of individuals and the cultures of societies, it has the power to influence government policy. It affects public policies through the involvement of religion in political processes and also through the religious beliefs of political leaders, policy makers, and civil servants. The influence of religion is pervasive, from the national government to small villages (CHSP:2005). Several practices that infringe on women's reproductive health rights are culturally acceptable. For instance, FGM is a practice that has defied attempts by government to eradicate because it is culturally etched in the society. Even the victims of FGM would rather suffer the pain than face societal disapproval and or ostracism.

Perhaps, the issue that has generated the most heated conflict between religion and reproductive health is the issue of abortion. In almost every part of the world, abortions have been the subject of religious, social, political and legal discourses. Under Nigerian law, interfering with pregnancy no matter how early in the course of the pregnancy is criminal unless such interference is undertaken to preserve the mother's life as prescribed by the Criminal and Penal Codes (Ladan:2006). The foetus is regarded as a human life from the moment the ovum is fertilized and one in which the society has an interest that must be protected by law. It is only when the mother's life is at risk that it is conceded that there is an overriding interest that allows abortion to be tolerated. The abortion debate train is also gaining ground in Nigeria. While some advocate for liberalising abortion laws, others fight for outright legalisation of abortion and others still want the status quo to remain. For those who want abortion legalised or the law liberalised, the argument is along two main lines – "the health argumentation and the rights argumentation" (Ladan:2006). While the former thinking contends that the existing abortion laws are too restrictive in the prescription of what constitutes therapeutic reasons, the latter thinking is that the existing abortion law reflect "*an unwarranted, unsupportable infringement of women's right to privacy*" and an attempt at legislating morality (Bauman).

The argument is that restrictive abortion law open up more people to the risk of unsafe abortion as a large number of abortions take place in spite of the law. Unsafe abortion is one of the greatest dangers to women's reproductive health and cause of the high rate of mortality in the female adolescent population. A report by the Federal Ministry of Health estimates that for every maternal death due to unsafe abortion, 30 more women suffered long-term injuries and disabilities due to unsafe abortion (Lawal:2012). The argument goes further that the restriction of the grounds upon which abortion may be performed to saving the woman's life is too narrow and may be insensitive to the difficulties posed by peculiar experiences of women. For example, a rape victim who becomes pregnant is not entitled to abortion even though this is clearly a case of unwanted and forced pregnancy. The trauma experienced by rape victims who find themselves pregnant should be sufficient to ground liberalisation of abortion laws so that they can have access to legal abortion. When it is appreciated that rape carries with it risk also of HIV infection, the least the law could do is be sensitive to the danger and consequent fears of the victims of rape. The ACHPR Protocol on Women's rights in Africa provides in Article 14 (2) (c) that state parties shall protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. It is submitted that the Nigerian law on abortion should be amended in line with the provisions of the ACHPR Protocol on women's rights.

It is submitted further that women's struggle should not be on legalising abortion but should be at reducing the incidence of unwanted pregnancies. Efforts should be made at inculcating moral values in our adolescents. In the struggle for their rights, women should also seek to maintain their dignity and womanhood. Sexual promiscuity should be discouraged and the root causes of sexual promiscuity amongst the adolescents addressed. Efforts at promoting abstinence and sexual discipline should be increased. This would not only reduce the risk of unwanted pregnancies, but also reduce the risk of STIs. Further, there should be increased access to family planning information and methods. Religious and cultural practices that enhance the dignity of women should be encouraged.

In addition, the traditional beliefs of many Nigerian affect their attitude to healthcare issues and with dire consequences. Many people still believe in witches, witchcraft and evil spirits as the causative agents of most diseases in Nigeria and thus would rather visit the herbalist or spiritual home rather than patronize orthodox hospitals and health centres.

Statutory impediments

Aside from the cultural forms of discrimination, there are also several discriminatory legislations against women's reproductive health rights (Ayanleye, 2006). For instance, the Nigeria Police Regulation[2] provides the qualification which must be possessed by a woman in order to be eligible for enlistment in the Nigerian Police Force as a recruit Constable. Subsection (g) provides that the woman must be unmarried. Thus, married women are precluded from enlistment. Meanwhile no similar provision is applicable to their male counterpart. Section 127 of the regulation provides that an unmarried woman police who becomes pregnant shall be discharged from the force and shall not be re-enlisted except with the approval of the Inspector General of Police. A woman Police desirous of marrying shall apply to the Commissioner of Police for the State Command in which she is serving requesting to marry and also supply the name, address and occupation of the spouse to be. Permission may be granted if the intended spouse is adjudged to be of character and the woman police has served for not less than three years. No similar provision is applicable to the male counterpart. (Nwazuoke, 2004) The 1999 Constitution in Section 42 (3) gives backing to what would otherwise be an unconstitutional provision. On the one hand Section 42 (1) provides that: A citizen of Nigeria of a particular community, ethnic group, place of origin, **sex**, religion or political opinion shall not by reason only that he is such a person (a) be subjected either expressly by, or in the practical application of, any law in force in Nigeria or any executive or administrative action of the government, to disabilities or restrictions to which citizen of Nigeria of other communities, ethnic groups, places of origin, **sex**, religions, or political opinion are not made subject. (Emphasis mine). However, what the Constitution gave with one hand, it took with the other by the provisions of subsection (3) which states that Nothing in subsection (1) of this section shall invalidate any law by reason only that the law imposes restrictions with respect to the appointment of any person to any office under the State or as a member of the armed forces of the Federation or a member of the Nigeria Police Force to any office in the service of a body corporate established directly by any law in force in Nigeria.

In another vein, the Criminal Code also contains discriminatory legislation against women. According to Section 353 *"Any person who unlawfully and indecently assaults any male person is guilty of a felony and is liable to imprisonment for three years"* while Section 360 on the other hand provides that "a*ny person who unlawfully and indecently assaults a woman or girl is guilty of a misdemeanour and is liable to imprisonment for two years"*.

One wonders at the rationale behind the distinction. It is thus advocated that the Criminal Code should be amended to remove the distinction.

CONCLUSION

The state of access to reproductive health in Nigeria is still below internationally acceptable standards and government efforts aimed at improving same is noncommittal. Achieving MDG 5 clearly requires that all women and men have ready access to contraceptive choices that are affordable and acceptable through services that are readily available and based on confidentiality and informed consent. Access to reproductive health rights is a major component of reducing maternal mortality and morbidity in Nigeria. When women have access to good information and health care, they are in a position to make sensible choices about marriage and the size of their family. Such individual decisions can add up to better lives for women and their families, a more robust job market, and, ultimately a stronger national economy. When young people are able to obtain reproductive health information and services, they increase their chances to make a successful transition to adulthood. Saving women's lives requires a functioning health system to deliver the package of sexual and reproductive health services. Health system investments in women's sexual and reproductive health services provide a strong foundation for health services for all. With accessibility to comprehensive reproductive health services, women are less likely to die in pregnancy, more likely to have healthier children and better able to balance their family and work life. Reproductive health is thus *sine qua non* to economic and social development.

SUGGESTIONS FOR REFORMS

Comprehensive sexuality education programs must be implemented in communities and schools,

[2] Section 118, Cap N359, Law of the Federation (L.F.N.) 2004.

beginning in the primary grades, of course at the level of their understanding. Comprehensive sexuality education should not just give young people biological information about their health, it must teach them about sex, contraception, and pregnancy, as well as communication and decision-making. It would help them learn how to establish equality in relationships, respect the right to consent in both sex and marriage, and end violence and sexual coercion.

Men play a key role in bringing about gender equality, thus, it is imperative to educate men on the need for reproductive health. It is essential to improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.

Government should take positive steps to implement the existing laws and treaties on women's rights in line with the suggestions made earlier. It is imperative to domesticate CEDAW in Nigeria. Laws that are discriminatory against women should be amended or repealed as the case may be in line with international standards. The National Assembly and the State Assemblies must enact laws prohibiting violence against women as a matter of urgency.

Breast and cervical cancer screening should be made available at all health centres, public hospitals, antenatal and postnatal clinics for ease of access, early detection and treatment.
The National Health Bill which has had a chequered history must be passed into law. This would further increase access to health rights. Most importantly, the 1999 Constitution must be amended to make socio-economic rights justiciable.

REFERENCES

[1] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act (the African Charter Act) of 1990.

[2] African Union, (2008), ACHPR/Res.135 (XXXXIIII).08: Resolution on maternal mortality in Africa, retrieved from http://www.achpr.org/english/resolutions/resolution135_en.htm accessed on 8/4/2012.

[3] Aniekwu, N.I., (2006), [En] gendering sexuality: Human rights issues in reproductive and Sexual health retrieved from http://arsrc.org/downloads/features/aniekwu.pdf accessed on 1/4/2012.

[4] Aniekwu, N.I., (n.d.) (a), The Convention on the elimination of all forms of discrimination against women and the status of implementation on the right to health care in Nigeria, retrieved from http://www.wcl.american.edu/hrbrief/13/3ijeoma.pdf?rd=1 accessed on 8/4/2012.

[5] Aniekwu, N, I., (n.d.) (b), The Development of reproductive health laws: Considerations for the Nigerian legal system, retrieved from http://www.nigerianlawguru.com/articles/general/THE%20DEVELOPMENT%20OF%20REPRODUCTIVE%20HEALTH%20LAWS,%20CONSIDERATIONS%20FOR%20THE%20NIGERIAN%20LEGAL%20SYSTEM.pdf accessed on 8/4/2012.

[6] Asangasi, I. and Shaguy, J., (2009), Complex Dynamics in the Socio-Technical Infrastructure: The Case of the Nigerian Health Management Information System retrieved from http://www.ifip.dsg.ae/Docs/FinalPDF/Work%20In%20Progress/ifip_71_%20asangasi%20&%20shaguy.pdf on 31/5/2010.

[7] Atsenuwa, A., et al, (2004), *Reproductive Health and Right Education, A Compilation of Resources*, Lagos,Legal Research and Resources Development Centre.

[8] Ayanleye, O. (2006), Gender Rights, in O. Oliyide and O. Awolowo (Eds.) *Rights*, (pp. 130-151) Lagos, Throne of Grace Publishers Limited.

[9] Ayanleye, O. A., (2013), Constitutional Engineering as a Strategy for Good Governance in Nigeria: Myth or Reality? *B.U.S.L.J*., 1(3), 57-77.

[10] Bauman, M. (n.d.), Law and morality dispelling false notions of the first amendment: The falsity, futility, and folly of separating morality from law, *Christian Research Journal*, 21(3) retrieved from http://www.equip.org/articles/law-and-morality on 27/3/2012.

[11] Centre for Reproductive Rights (CRR) and Women Advocates Research and Documentation Centre (WARDC) (2008), Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria, retrieved from http://www.who.int/pmnch/topics/maternal/crr_broken_promises.pdf on 27/3/2012.

[12] Choike Reports, (n.d.) Sexual and Reproductive Rights, retrieved from http://www.choike.org/nuevo_eng/informes/1197.html on 1/3/2012.

[13] Committee on Economic, Social and Cultural Rights, (CESCR) (2000), "Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights", Twenty-Second Session Geneva, 25 April-12 May 2000, retrieved from

http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En?OpenDocument on 8/4/2012.

[14] Fanton, J. F., (2005), Population and Reproductive Health, retrieved from http://www.macfound.org/site/c.lkLXJ8MQKrH/b.1142259/apps/nl/content3.asp?content_id={320C03B3-33E6-420E-B421-2C9487BBA587}&notoc=1 on 27/3/2012.

[15] Federal Ministry of Health (FMOH) (2001), *National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for All Nigerians*, Federal Ministry of Health, Abuja, Nigeria.

[16] Gbadamosi, Olaide, (2007), *Reproductive Health and Rights (African Perspectives and Legal Issues in Nigeria)*, Benin-City, Ethiope Publishing Corporation.

[17] ICW, (2006), Ensuring the Sexual and Reproductive Health & Rights of Women Affected by HIV retrieved from http://www.icw.org/node/169 on 27/3/2012.

[18] Imasogie, M.O., (2004), Reproductive Rights as Human Rights. In A. N. Nwazuoke, (Ed.) *Essay In Human Right Law*, (pp. 98-123) Department of Commercial and Industrial Law, Faculty of Law, Ebonyi State University.

[19] International Women's Health Coalition (IWHC) (2008), Five Sexual and Reproductive Health Services that Will Make Pregnancy Safer for All, retrieved from http://www.iwhc.org/index.php?option=com_content&task=view&id=3604&Itemid=1140 on 28/3/2012.

[20] Jejeebhoy, S.J., (1997), Addressing Women's Reproductive Health Needs: Priorities for the Family Welfare

[21] Program, *Economic and Political Weekly*, 32(9 & 10).p.475-484.

[22] Kolawole, A. K. A., (2011) The Right to Life and the Right to Health: Any Nexus?, *OIDA International Journal of Sustainable Development*, 2(5) pp. 95-106. Available at http://www.ssrn.com/link/OIDA-Intl-Journal-Sustainable-Dev.html

[23] Lawal, Sekinah, (2012), ACHPR faults Nigeria's Report, *National Mirror*, 15/02/2012 retrieved from http://nationalmirroronline.net/health/health-news/31359.html on 8/4/2012.

[24] Management Science for Health (MSH), (2006), Using National and Local Data to Guide Reproductive Health Programs, retrieved from http://erc.msh.org/mainpage.cfm?file=2.2.1c.htm&module=info&language=English accessed on 1/6/2010.

[25] Nigeria's 4th Periodic Country Report: - 2008 – 2010 on the Implementation of the African Charter on Human and Peoples' Rights in Nigeria, Report retrieved from http://www.achpr.org/files/sessions/50th/state-reports/4th-2008-2010/staterep4_nigeria_2011_eng.pdf on 22/8/2013.

[26] Nwazuoke, A.N., (2004), Equality and Discriminatory Legislation against Women in Nigeria. In A. N. Nwazuoke (Ed.), *Essays in Human Rights Law*, (pp. 142-157), Abakaliki, Department of Commercial and Industrial Law Faculty of Law, Ebonyi State University.

[27] Nwoso, A. B. C. (2001), Foreword to *National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for All Nigerians*, Abuja, Federal Ministry of Health.

[28] Ogundipe, S., Obinna, C., (2009), Maternal Death: Caging the Terror of Nigerian Women, retrieved from www.vanguardngr.com accessed on 5/3/2012.

[29] Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa retrieved from http://www.achpr.org/english/women/protocol-women.pdf on 8/4/2012.

[30] The 1999 Constitution of Nigeria.

[31] The Nigerian Criminal Code.

[32] Tobi, N., (2004), Woman and the Law: the Judicial Approach. In Y. Akinseye-George, and G. Gbadamosi, (Eds.), *The Pursuit of Justice and Development, Essays in Honour of Hon. Justice M. Omotayo Onalaja*, Lagos, Diamond Publishers.

[33] UNFPA, (2008), Negotiating culture: Promoting gender equality and empowering women, *The State of the World Population*, retrieved from www.unfpa.org on 2/3/2012.

[34] UNICEF, (n.d.), Maternal and Child Health, retrieved from http://www.unicef.org/nigeria/children_1926.html on 17/8/2013.

[35] World Bank (2010), Maternal mortality ratio (modeled estimate, per 100,000 live births), retrieved from http://data.worldbank.org/indicator/SH.STA.MMRT on 17/8/2013.

[36] World Health Organisation (WHO), (n.d.) Maternal Health, retrieved from

http://www.who.int/topics/maternal_health/en/ on 15/4/2012.

[37] World Health Organisation (WHO) (1978), Declaration of Alma Ata, retrieved from http://www.who.int/publications/almaata_declaration_en.pdf on 17/8/2013.

[38] Yamin, A. E., (2005), The Right to Health Under International Law and Its Relevance to the United States, *American Journal of Public Health*, 95(7): 1156–1161, doi: 10.2105/AJPH.2004.055111

About the authour

Oluwakemi Amudat Ayanleye, LL.B (Hons) (Ogun), LL.M (OOU), BL, lecturer Faculty of Law, Olabisi Onabanjo University, Ago-Iwoye, Nigeria. She is currently a doctoral student at Babcock University, Ilishan-Remo, Nigeria.