



BROKEN PROMISES

HUMAN RIGHTS, ACCOUNTABILITY, AND MATERNAL DEATH IN NIGERIA

CENTER
FOR
REPRODUCTIVE
RIGHTS



WOMEN ADVOCATES RESEARCH
AND DOCUMENTATION CENTRE

The Center for Reproductive Rights

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The Center for Reproductive Rights uses the law to advance the position that reproductive freedom is a fundamental right all governments are legally obligated to protect, respect and fulfill.

Our Vision

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WARDC Vision

A peaceful society free from all forms of discrimination against women and the girl child, with structures to protect fundamental human rights of all, where everybody works vigorously in unity towards a true democracy and development.

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Definitions of Key Terms¹

Maternal Death: *the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.*²

Late Maternal Death: *the death of a woman from direct or indirect obstetric causes more than 42 days but less than one year after termination of pregnancy.*³

Pregnancy-Related Death: *death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.*⁴

Maternal Morbidity describes pregnancy- and childbirth-related illness and injury.⁵

Maternal Mortality Ratio (MMR): *Number of maternal deaths during a given time period per 100,000 live births during the same time-period.*⁶

Maternal Mortality Rate: *Number of maternal deaths in a given period per 100,000 women of reproductive age during the same time-period.*⁷

Adolescents are those between 10 and 19 years of age.⁸

Executive Summary

The number of maternal deaths in Nigeria is second only to that of India. The majority of these maternal deaths, as in the rest of the world, are preventable, and while the causal factors can be multiple and complex, governments must be held accountable when their actions or inaction contribute to this ongoing loss of women's lives. To that end, this report from Women Advocates Research and Documentation Centre (WARDC) and the Center for Reproductive Rights (CRR) focuses specifically on the Nigerian government's responsibility for the dire state of maternal health in the country. Although this report highlights these issues in the context of maternal health, many of the problems discussed here have repercussions for the health system overall and the general health of all Nigerians.

While the Nigerian government has repeatedly identified maternal mortality and morbidity as a pressing problem and developed laws and policies in response, these actions have not translated into a significant improvement in maternal health throughout the country. A number of factors inhibit the provision and availability of maternal health care in the country, including: 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. The separation of responsibilities for the provision of health care among the country's three tiers of government both contributes to and exacerbates the harmful impact of these various factors.

The failure of the government to adequately regulate and fund the health system manifests itself in a variety of ways. One key structural issue is the division of health-care responsibilities among the three tiers of government: federal, state, and local. The Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities. In the absence of a constitutional sharing of powers and outlining of responsibility for health care, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates the primary health sector to the local government, the secondary health sector to the state government, and the tertiary health sector to the federal government. The federal government has little control over both the state and local governments in the discharge of their duties. In addition, the 1988 National Health Policy lacks legal force; unlike the constitution or other legislation, it cannot impose legal obligations. As a senior official at the Federal Ministry of Health explained: "We [the federal government] can only appeal to the conscience of the local governments, because the health policies are not backed by law so the local governments do not see it [primary health-care provision] as their responsibility."

The absence of a constitutional or other legal prescription of health-care responsibilities has resulted in a dysfunctional health-care system in which all three tiers of government have failed to prioritize their health-care duties, and have faced no political or legal repercussions for doing so. The problem is particularly visible at the primary health-care level, which constitutes the first point of contact with the health-care system, and has particularly deleterious effects for women seeking maternal care.

Issues around resource allocation for health care also abound. Nigeria's vast oil wealth has not translated into an improvement in the lives of ordinary Nigerians. Although the Nigerian government willingly pledged to commit 15% of its total annual budget to improving the health-care system in the

2001 Abuja Declaration on HIV and AIDS, Tuberculosis and other Infectious Diseases, it has fallen far short of this commitment, instead allocating slightly over 5% of its 2008 budget to health care. Even when resources are directed towards health care, the lack of transparency in how funds are spent and the prevalence of corruption mean that funds do not always fill their intended goals. In 2006, the government's failure to meet targets on transparency was a core reason for the suspension of a USD 50 million grant awarded by Global Fund to prevent mother-to-child HIV transmission and broaden access to antiretroviral drugs. Transparency and freedom of information are integral to curbing corruption and determining the allocation and adequacy of released funds—both of which are important factors in establishing the extent of political will to reduce maternal mortality and promote safe motherhood. The consideration of these factors, however, is difficult in Nigeria's current political environment. Laws preventing public access to government information on grounds of security obscure the records that would enable the public to ascertain how well the government is meeting its responsibilities. The secrecy around budgetary allocations to health, including reproductive and maternal health, and the public's inability to access such information, shields the government from accountability for expenditures on health care. A local government official from Abeokuta South Local Government Area admitted to not knowing the percentage of the state's budget that went to health care, since this figure was dependent on the discretion of the chairman and other executive members.

Financial, infrastructural, and institutional barriers to maternal health care also fuel the high rate of maternal death in the country. Each obstacle reflects the gross inadequacy of essential building blocks of a health system. User fees in both public and private facilities constitute serious barriers to obtaining quality maternal health care, resulting in women either not seeking care or being denied essential services when they are unable to pay the accompanying fees. Another unfortunate outgrowth of user fees is the detention of women who cannot pay for the maternal health-care services they have received until they find the necessary funds. The fear of being detained could discourage pregnant women from seeking skilled maternal care. Even those that do have the courage to seek professional treatment during delivery may risk foregoing postnatal care in order to escape detention.

Some Nigerian states and local government areas (LGAs) have taken steps to reduce the negative impact of formal user fees on pregnant women by offering free maternal health-care services. These efforts, however, are crippled by serious limitations. A senior official of the Federal Ministry of Health confirmed that while some state governments were providing free maternal health-care services, in most instances they did not offer "total packages" where every aspect of health care was free (doctor's office visits, consultations, prescriptions, and follow-up visits). The introduction of free services has also been undermined by the lack of systemic capacity to sustain free services, including inadequate staffing and supplies of medication. One obstetrician/gynaecologist described the difficulty with handling the increased influx of women that accompanied free services in Kano State, noting that the region did not have enough nurses and midwives to handle the increased demand for maternal health care due in part to the limitations placed by the Federal Ministry of Health and the Nursing and Midwifery Council on the number of midwives and nurses that may graduate each year. She noted, "I love free maternity services; I think it is a good strategy but it must be done with our eyes wide open, knowing there will be lessons of implementation learned within the first year."

Pregnant women who access maternal health-care services face uncertain, informally levied costs, even when user fees have been waived, which has the potential to dissuade a poor or financially struggling woman from seeking maternal care. Pregnant women in Nigeria often find that health-care

facilities have a list of items that they must pay for out of pocket. The content of these lists varies from one hospital to the next, but usually includes antiseptics, bleach, cotton wool, plaster, gauze, syringes, flasks (for drinking), and sanitary pads. Most of these items should be available in adequately equipped health-care centres. Furthermore, these lists demand specific brands, forcing pregnant women to re-purchase items that they already own in a different brand. An interviewee explained that nurses justify brand demands by stating that they must ensure the use of high-quality products. Yet patients, the interviewee explained, named a different rationale: the demands allowed the nurses to stock up on leftover supplies from previous patients and to sell these products to the new patients. Such conduct points to corruption and to an unregulated or unmonitored health system that allows its occurrence.

Health facility policies requiring the partners of pregnant women to donate blood can further hinder women's access to services. Although the Nigerian policy on blood donation requires that all donations be voluntary, social norms and the screening and administrative charges levied on blood recipients lead voluntary donors to think their blood is being sold. This has led to "family replacement donation" as a principal means of blood collection. Focus-group discussion (FGD) participants stated that pregnant women who attempt to access maternal health-care services at many public or government hospitals are often required to bring their husbands to donate blood. While patients may sometimes opt out by paying a fee, this option is not always made known. Compulsory spousal blood donation can potentially have multiple negative consequences on pregnant women who are unable or unwilling to compel their husbands to donate blood. Moreover, the practice has a discriminatory impact on the poor, who may prefer to pay—but be unable to afford—a fee in lieu of blood donation.

Infrastructural and institutional barriers to accessing maternal health care are also plentiful. After scaling the hurdles of locating and reaching a health-care centre, which can be a particular challenge in rural areas, women may encounter long waits and the negative attitudes of many health-care providers, particularly at public hospitals. Long waiting periods at health-care centres are widely acknowledged and lamented in Nigeria. A participant in an FGD noted that the distant location of health centres and the large number of people waiting to be attended to usually forces patients to spend the entire day there. In fact, they may not even see the doctor at the end of the day. She observed, "When I go to the teaching hospital, I know I'll spend the whole day there. I could get there by 7:30 am and pick number 100." There is evidence that women do not seek maternal health care at hospitals and clinics due to prior embarrassing experiences or the fear of being humiliated by the health-care staff. A six-month-pregnant interviewee who had registered at a private hospital explained that the discouraging attitude of health-care workers at public/government hospitals had influenced her decision. The negative attitude of health-care staff can be attributed in part to being understaffed, overworked, and underpaid. Regarding understaffing, one local government official explained that clinics were closed at night and on weekends in his local government area, and women who went into labour at these periods had no choice but to patronize traditional birth attendants. He further observed that some clinics had only one nurse running them and noted that understaffing limited access: "If we had at least two nurses in a clinic, they could take shifts, but when there is just one person he is overworked, and if he is not around there is no access to health-care services."

The use of malfunctioning or outdated hospital equipment and problems with power supply are also commonplace in Nigeria. A national study on the availability and quality of the nation's EOC facilities found that only 4.2% of public facilities and 32.8% of private facilities (and only 18.5% of both public

and private facilities) met the internationally agreed-upon standards for emergency obstetric care. While secondary and tertiary health systems consist of referral institutions and should have more advanced facilities and the ability to tackle more difficult cases than primary health centres, the study found that less than one third of the public secondary and tertiary health centres met the international standards for comprehensive emergency obstetric care. Power outages are also common and constitute serious problems at health centres, since the Power Holding Company of Nigeria (formerly the National Electric Power Authority)—the sole body in charge of power supply in the country—operates well below standards. As a result, health centres must acquire power generators to provide electricity when a power outage occurs. When a health centre is unable to purchase or maintain a generator, medical personnel are stretched to the limits of their skills. A doctor at a hospital in Lagos identified constant power failure as a barrier to quality care at the hospital. The issue of poor power supply, like most other problems in Nigeria, owes much to the corruption that stems from the nation's overwhelming lack of accountability and political will to implement effective changes.

Access to family planning or contraceptive methods is also an important strategy in reducing maternal mortality. However, the government has failed to take steps to ensure access and, as such, many Nigerian women are not benefiting from this necessary strategy. While there is some variance in statistics, surveys such as the Demographic and Health Survey show that the percentage of Nigerians who use any method of contraceptives ranges from 13.3% to 15.6%, while the percentage of Nigerians who use modern methods of contraceptives ranges from 8.9% to 11.6%. The consequences of this low rate of use of family planning methods include a high occurrence of unplanned and unwanted pregnancies: 1 in 5 pregnancies in Nigeria is unplanned and half of these unplanned pregnancies are terminated. Furthermore, one third of women of childbearing age have had an unwanted pregnancy while 25% of women aged 15-49 years old have an unmet need for family planning. The prevalence of unplanned and unwanted pregnancies increases the likelihood of exposure to unsafe abortion and to maternal morbidity or mortality. The Nigerian government has recognized that unsafe abortion is one of the most easily preventable causes of maternal death.

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. The dismal state of maternal health in the country also implicates key issues involving good governance, accountability, and transparency in resource allocation.

WARD/CRR urge the Nigerian government to back its stated commitment to reducing maternal deaths with the necessary actions, including: strengthening Nigeria's human rights framework; establishing effective accountability mechanisms to ensure that, when appropriate, public officials are subject to investigation and liability for corruption; improving access to information within the health-care system; improving access to family planning services, including a full range of contraceptive methods; removing financial barriers that result in the denial of or delays in receiving necessary health-care services; developing a comprehensive strategy to address infrastructural problems, including equipment and supply shortages; and reducing incidents of unsafe abortion, which is one of the primary causes of maternal mortality for women.

This report is based on desk and field research conducted between October 2007 and May 2008. The desk research involved a literature review of research publications such as books, journals, newspaper articles, and documentary analysis, as well as a synthesis of policies, legislation, and national demographic and health surveys published by the federal and state governments of Nigeria. In addition, it included reviews of civil society and non-governmental organisation surveys and publications on health and reproductive health care.

The field research involved two fact-finding trips to Nigeria by CRR in collaboration with WARDC and continuous fact finding by WARDC. Over sixty people were interviewed, including federal, state, and local government officials, women's empowerment groups, non-governmental organisations, and advocacy groups, whose interests focus on health reform, human rights, and the protection of reproductive health and rights. Health-care providers such as medical practitioners, nurses, traditional birth attendants, and a faith-based birth attendant, as well as pregnant women and women who had been affected directly or indirectly by the poor state of maternal health care, were also interviewed. All interviewees were informed about the object of the interview and the subject matter of the report. The consent of those whose names are mentioned was duly obtained and the names of those who did not consent to their names being used have been withheld or changed.

Introduction

... Nigeria, on a percentage basis, leads the world in maternal mortality statistics. This is an unacceptable state of affairs which is largely traceable to the leadership problem in the country. In a country where funds that are meant for equipping hospitals and employment of doctors, especially at the tertiary level, are routinely fraudulently misappropriated and shared by politicians, the population, especially the women, cannot but pay dearly for lack of, and inadequate medical facilities, during pregnancy and childbirth.

– Daily Sun, Voice of the Nation, “Worrisome Maternal Death Records.”⁹

MATERNAL MORTALITY IN NIGERIA

In its most recent report, the World Health Organization (WHO) identifies Nigeria as having the world's second-highest number of maternal deaths with approximately 59,000 of such deaths taking place annually.¹⁰ Nigeria's maternal mortality ratio (MMR) is 1,100 maternal deaths per 100,000 live births.¹¹ For every maternal death, 20 other women suffer serious and often permanent pregnancy-related complications and health problems.¹²

Although Nigeria makes up 2% of the world's population, it accounts for 10% of its maternal deaths.¹³ A woman in Nigeria has a 1-in-18 risk of dying in childbirth or from pregnancy-related causes during her lifetime,¹⁴ which is higher than the overall 1-in-22 risk for women throughout sub-Saharan Africa.¹⁵ The risks of maternal death are even greater for certain Nigerian women, such as those in the northern region of the country, rural women, and low income women without formal education. The MMR in the northern region is consistently over 1,000 per 100,000 live births, compared to the MMR in the southern region, which is frequently below 300 per 100,000 live births.¹⁶ As of 2007, most northern states had MMRs of about 1,500 per 100,000 live births.¹⁷ Meanwhile, some states in the southern region, such as Ogun, have MMRs that are consistently below 200 per 100,000 live births, and that are progressively decreasing.¹⁸

The scale of worldwide maternal death is shocking: one woman dies in childbirth every minute,¹⁹ with over half a million women dying per year.²⁰ Most of these deaths can be prevented.²¹ Preventable maternal death and disability are increasingly recognized as pressing human rights issues, encompassing questions of resource allocation and political commitment, for which governments must be held accountable.²² The situation in Nigeria illustrates the importance of government accountability in effectively reducing maternal death.

With a population of over 140 million,²³ Nigeria is the most populous country in Africa and the tenth most populous in the world.²⁴ It is also the biggest oil exporter in Africa, with oil revenues accounting for over 80% of government revenue.²⁵ Despite Nigeria's oil wealth, its incidence of maternal death is one of the worst in the world. Resources alone do not automatically translate into a reduction in maternal death; the WHO has identified long-term political will or commitment as an indispensable factor for the reduction of maternal death.²⁶ This means that governments and decision makers must develop adequate laws, policies, and measures,²⁷ and must ensure their execution by making the

necessary funds available. Likewise, they must implement international and regional laws and policies that impact maternal health. While the Nigerian government has ratified most relevant international and regional treaties and has developed policies aimed at improving reproductive health, including maternal health, these actions have not translated into effective implementation and resource allocation. This report highlights a number of factors that inhibit the provision and availability of maternal health care in the country, which include: 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. The separation of responsibilities for the provision of health care among the country's three tiers of government both contributes to and exacerbates the harmful impact of these various factors.

Objectives of this Report

The high incidence of maternal mortality in Nigeria has medical, political, social, cultural, economic, and human rights implications. However, the goal of this report is to present a focused analysis of the political and economic reasons for the very poor maternal health outcomes in Nigeria and the susceptibility of Nigerian women to maternal death. This report seeks to show that the causes of maternal death are not solely medical or socio-cultural, but also clearly linked to inept governance and violations of rights that are guaranteed by international, regional, and national laws—rights that governments should prioritize and implement. Thus, the report looks beyond the medical factors and emergencies that form the most commonly cited causes of maternal mortality, and that often mask the role of the government in maternal deaths. It instead focuses on the political and economic factors that are the core responsibilities of the government, such as the political will to implement laws and policies and strengthen budgeting processes, and how these factors impact the risk and incidence of maternal death. The report also seeks to highlight the negative effects that the division of health-care responsibilities among the three tiers of government have had on maternal health.

Methodology and Scope

This report is based on desk and field research conducted between October 2007 and May 2008. The desk research involved a literature review of research publications such as books, journals, newspaper articles, and documentary analysis, as well as a synthesis of policies, legislation, and national demographic and health surveys published by the federal and state governments of Nigeria. In addition, it included reviews of civil-society and non-governmental-organisation surveys and publications on health and reproductive health care.

The field research involved two fact-finding trips to Nigeria by CRR in collaboration with WARDC and continuous fact finding by WARDC. Over sixty people were interviewed, including federal, state, and local government officials, women's empowerment groups, non-governmental organisations, and advocacy groups, whose interests focus on health reform, human rights, and the protection of reproductive health and rights. Health-care providers such as medical practitioners, nurses, traditional birth attendants, and a faith-based birth attendant, as well as pregnant women and women who had been affected directly or indirectly by the poor state of maternal health care, were also interviewed. All interviewees were informed about the object of the interview and the subject matter of the report. The consent of those whose names are mentioned was duly obtained and the names of those who did not consent to their names being used have been withheld or changed.

Structure of this Report

This report provides an analysis of some of the key factors that contribute to Nigeria's high maternal mortality rate and their human rights and legal implications. Section One focuses on failures in government leadership, including issues involving health-care financing and corruption. Section Two is a short inset discussing how the nation's lack of contraceptive access and funding contributes to its high maternal death rate. Section Three examines some of the financial and structural barriers that prevent women from accessing necessary maternal health care, followed by Section Four, which is a brief inset on how Nigeria's restrictive abortion law fuels maternal mortality and morbidity. Section Five outlines the national legal and policy framework and the regional and international human rights framework addressing maternal mortality, and examines some of the human rights implications of Nigeria's high MMR. Recommendations to key stakeholders, based on input from the women, medical providers, non-governmental organisations, and officials with whom WARDC/CRR spoke, are included at the end of this report.

Failures in Health-Care Financing, Leadership, and Governance

While social and cultural factors contribute to the high MMR in Nigeria, the problem is also a political and economic one. The failure of the government to adequately regulate and fund the health system has sustained the prevalence of maternal death in the country.

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

Nigeria's national government is divided into three distinct tiers: the federal, the state, and the local governments.²⁸ The Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities.²⁹ This omission³⁰ has resulted in overlaps and uncertainty regarding the division of these obligations, which has enabled each level of government—particularly the local tier—to shirk its duties in this regard.³¹

In the absence of a constitutional sharing of powers and outlining of responsibility for health care, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates the primary health sector to the local government, the secondary health sector to the state government, and the tertiary health sector to the federal government.³² As a result, the three tiers of government are chiefly responsible for three different levels of health care, with the federal government having little control over both the state and local governments in the discharge of their duties. In addition, the 1988 National Health Policy lacks legal force; unlike the constitution or other legislation, it cannot impose legal obligations. The absence of a constitutional or other legal prescription of health-care responsibilities has resulted in a dysfunctional health-care system in which all three tiers of government have failed to prioritize their health-care duties,³³ and have faced no political or legal repercussions for doing so.

The problem is particularly visible at the primary health-care level, which constitutes the first point of contact with the health-care system, and for which the local governments are chiefly responsible. While the 1988 National Health Policy, in accordance with the Declaration of Alma-Ata,³⁴ states that the provision of primary health care is indispensable if the health of Nigerians is to be improved,³⁵ the collapse of this level of care is well acknowledged.³⁶ Results of other fact findings on some local governments have detailed both the availability of huge financial allocations and the extensive corruption that depletes substantial funds that would have otherwise improved the health sector.³⁷ But corruption permeates all three tiers of government with adverse consequences for all three levels of health care, as this report explains below.

The consequences of the separation of governmental responsibility for health care, such as the inability of the federal government to compel the other levels of government—particularly the local level—to fulfil their policy obligations, can be grave. A senior official of the Federal Ministry of Health, Abuja remarked:

We [the federal government] can only appeal to the conscience of the local governments, because the health policies are not backed by law so the local governments do not see it [primary health-care provision] as their responsibility.³⁸

CORRUPTION
permeates all three tiers of government with adverse consequences for all three levels of health care.

According to this official, the nation's health-care problems do not stem from the federal government, but from the local governments, which consistently refuse to improve primary health care in the country and cannot be compelled to do so.

In the Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007 (2004 Health Sector Reform Programme) the Federal Ministry of Health (FMOH) calls for the passing of a National Health Act that would address this gap in the constitution.³⁹ Along these lines, a bill on the National Health Act was introduced before the National Assembly of Nigeria about two years ago. The Executive Secretary of the Health Reform Foundation of Nigeria (HERFON), a non-governmental organisation that has pushed for the passage of the bill, identified some of the crucial aspects of the proposed act.⁴⁰ They include a provision on health-care funding that mandates that the federal government provide 2% of the financing for primary health care, a provision that requires local governments to ensure minimum health care to all citizens, including primary health care, and a provision that obligates state and local governments to contribute specified funds to health care.

The upper house of the National Assembly (the Senate) had initially suspended the bill,⁴¹ but subsequently passed it in May 2008.⁴² The bill, which must also be passed by the lower house (the House of Representatives) and receive the president's assent before becoming law, does not resolve the uncertainty over each tier's responsibility for health-care provision. While there is hope that ongoing moves for constitutional reform will eventually resolve the issue, enacting such change is often a painstaking and lengthy process.

Lack of Political Will to Address Maternal Mortality

The WHO has identified long-term political will or commitment as an indispensable factor in reducing maternal death.⁴³ This means that governments and decision makers must develop adequate policies and measures on this issue, and must ensure their implementation by making the necessary funds available.⁴⁴

Lack of Policy Implementation

Violations of the obligation to fulfil occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include the failure to adopt or implement a national health policy designed to ensure the right to health for everyone.

– Committee on Economic, Social and Cultural Rights⁴⁵

The depth of maternal-health issues that are covered by laws and policies, some of which are identified in Section Five of this report, indicates that the Nigerian government has recognized maternal mortality as a pressing issue and identified concrete steps that need to be taken to address the problem. However, the lack of implementation of these laws and policies demonstrates insufficient political commitment to effectively reduce maternal death. Other studies on maternal mortality in Nigeria have concluded that there is currently a low level of political will regarding this problem.⁴⁶ While government officials and others with whom WARD/CRR spoke for this report stated that many policies exist on maternal health care, they all agreed that these policies have been inadequately implemented—if at all.⁴⁷

Certain aspects of maternal health are yet to be regulated in Nigeria. For instance, no policies or laws require the compulsory and confidential reporting and documentation of maternal deaths.⁴⁸ Additionally, an interviewee identified the need for a law that obligates all levels of government to ensure that all health facilities are equipped to provide emergency obstetric care (EOC) and free antenatal care services.⁴⁹

Striking evidence of the lack of policy implementation is found in the Reproductive Health Policy of 2001. Its stated goal for 2001-2006—“to reduce maternal morbidity and mortality due to pregnancy and childbirth by 50%”⁵⁰—is far from being attained. Similarly, Nigeria has failed to meet the 2004 Revised National Health Policy’s objectives of “reducing maternal morbidity due to pregnancy and childbirth by 50%” and “reducing perinatal and neonatal morbidity and mortality by 30%.”⁵¹

Lack of Resource Allocation

In 2001, the Nigerian government willingly pledged to allocate a minimum of 15% of its annual budget to improving the health sector.⁵² It was reminded of and urged to fulfil this commitment in the 2006 WHO Regional Committee for Africa resolution “Health Financing: A Strategy for the African Region,”⁵³ and again during the Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010 (Maputo Plan of Action).⁵⁴ Yet the pledge remains unfulfilled, resulting in an insufficiently funded maternal health-care sector. This inadequacy of funds has contributed to the nation’s high rates of maternal mortality and morbidity and to violations of the rights of pregnant women.⁵⁵

NIGERIA’S HEALTH EXPENDITURE

Nigeria’s THE [Total Health Expenditure] as a proportion of GDP varied between the least value of 4.39% in 2000 and the highest value of 5.45% in 1998, with an average ratio of 4.78% over the period 1998-2002. This does not compare favourably with the average ratio of 7.2% of THE/GDP for the Eastern and Southern Africa NHA Network In fact it is poorer than the performance in less-endowed African countries like Rwanda (5.0%); Kenya (5.3%); Zambia (6.2%); Tanzania (6.8%) and Malawi (7.2%) while it is much lower than what obtains in South Africa (7.5%).

– **Soyibo Adedoyin**⁵⁶

Nigeria’s public-health expenditure as a percentage of GDP was 1.3 % in 2006⁵⁷ and 1.4% in 2007,⁵⁸ placing it on the 2006 and 2007 lists of countries that spent the lowest percentage on health. Currently (2008), the total budget allocation to health⁵⁹ constitutes slightly more than 5% of the total budget of Nigerian Naira (NGN) 2.748 trillion.⁶⁰ While this figure represents an increase in budget allocation compared to the previous years, it falls far short of the 15% minimum allocation that the government committed itself to in the 2001 Abuja Declaration.⁶¹

THE FACT THAT

Nigeria's oil wealth has not been used to improve the lives of its citizens and to decrease the number of maternal deaths points in part to a failure of political will on the part of the government.

The Devastating Effects of Corruption on Nigeria's Health-Care System

Corruption hurts the poor disproportionately by diverting funds intended for development, undermining a government's ability to provide basic services, feeding inequality and injustice, and discouraging foreign investment and aid.

*– Kofi Annan, former United Nations Secretary-General*⁶²

The stakes are high and the resources precious: money lost to corruption could be used to buy medicine, equip hospitals or hire badly needed medical staff.

*– Transparency International*⁶³

The government's failure to adequately address corruption within the health-care system and to ensure that what resources Nigeria does have are properly allocated and reach their intended targets contributes to the weakness of the health-care sector and the persistence of poor maternal health.⁶⁴ The fact that Nigeria's oil wealth has not been used to improve the lives of its citizens and to decrease the number of maternal deaths points in part to a failure of political will on the part of the government.

Corruption is defined as the "misuse of entrusted power for private gain."⁶⁵ It is a worldwide phenomenon that occurs at the political, social, and economic levels,⁶⁶ with negative effects on every aspect of a country's development.⁶⁷ Corruption in the health sector originates from public and private actors and takes many forms, including the diversion of public funds for private use by high-level government officials, the marketing of fake drugs by pharmaceutical companies, and demands for informal payments by health-care providers.⁶⁸ Governments have a responsibility to stop all corruption, regardless of its source, for it hugely impacts their ability to protect and fulfil the rights of their citizens.⁶⁹

Corruption in Nigeria

Although corruption is not peculiar to the Nigerian context, both its extremely vast scale and the prevailing culture of impunity set the country apart.⁷⁰ Nigeria is perceived as one of the most corrupt nations in the world and consistently receives a poor ranking on the list of corrupt countries published by Transparency International.⁷¹ In 2007, the latest list ranked Nigeria at 147 out of 180 corrupt countries.⁷² Evidence gathered during the fact-finding and desk-research processes of this report attest to the systemic nature of corruption in the oil-rich country, and its impact on the health sector in general and maternal health care in particular. Identifying Nigeria as an oil-rich country is significant because the nature and incidence of corruption in the country cannot be separated from its vast oil revenue.

- Oil export is the main source of Nigeria's revenue, and in 2003 accounted for over two thirds of the gross domestic product (GDP) and over 80% of total government revenue.⁷³ Currently, the revenue from oil production and export constitutes over 90% of the country's gross earnings.⁷⁴
- Between 1965 and 1995, Nigeria earned approximately USD 350 billion in oil revenue.⁷⁵ With the increase in oil prices in recent times, the revenue from oil has risen dramatically. As a member of the Organization of the Petroleum Exporting Countries (OPEC), Nigeria earned USD 56 billion in net oil-export revenues in 2007 alone.⁷⁶ This constitutes almost one quarter of the nation's USD 223 billion in revenues from 1999 to 2007.⁷⁷
- Despite revenue boosts, the health-care system remains dysfunctional and the financial, infrastructural, and institutional barriers continue to contribute to the high MMR in Nigeria.

As the main source of revenue, oil has proved to be a fertile ground for corruption.⁷⁸ The World Bank estimates that 80% of Nigeria's energy revenues benefit only 1% of the population.⁷⁹ However, corrupt practices transcend the oil sector and news about corruption amongst the nation's public officials is a recurring and widespread occurrence in the national and international media.⁸⁰

In fact, the government has acknowledged the high incidence of corruption. In 2004, it developed the National Economic Empowerment and Development Strategy (NEEDS), which admits to the institutionalization of corruption in the country.⁸¹ Established as a strategy for achieving economic-development reform in the country, NEEDS states that Nigeria's lack of economic growth and development stems mainly from its legacy of corruption.⁸² It identifies the eradication of corruption as one of its goals⁸³ and recommends the establishment of special anti-corruption agencies, such as the Independent Corrupt Practices and Other Related Crimes Commission (ICPC)⁸⁴ and the Economic and Financial Crimes Commission (EFCC),⁸⁵ as strategies for meeting this objective.⁸⁶ In fact, the EFCC, which has become the face of the anti-corruption fight, claims to have recovered USD 5 billion and prosecuted 82 people between 2004 and 2006,⁸⁷ noting that the records of the Nigerian Central Bank and Ministry of Finance show that over USD 380 billion has been mismanaged since 1960.⁸⁸ It estimates that USD 14 billion out of the USD 20 billion in oil revenue generated in 2003 was lost to corruption—a full 70% of the revenue for that year.⁸⁹ Although the EFCC states that it has brought the percentage of stolen oil revenue down from 70% to 40% by 2004,⁹⁰ its independence has currently come into question. Claims of selective investigation and prosecution of people suspected of corruption have arisen;⁹¹ if established, this would constitute a violation of Article 6 of the United Nations Convention against Corruption (UNCAC), which requires anti-corruption bodies to be independent.⁹² Such actions would constitute a crime under Article 17 of the UNCAC, which criminalizes corruption⁹³ without allowing for exemptions.

A report by the World Bank has noted the inadequacy of the country's anti-corruption fight, and has recommended other complementary measures, including expanding the capacity of the offices of the accountant general and the auditor general and reforming the civil service.⁹⁴ Similarly, civil-society organisations such as Human Rights Watch have published reports regarding corruption in Nigeria, and have noted the absence of transparency and accountability and a pervasive difficulty in obtaining information that could help reduce corruption.⁹⁵ This state of affairs if established contravenes Article 13 of the UNCAC, which requires the government to promote the participation of non-governmental organisations and civil society in fighting corruption, and to grant the public access to information.⁹⁶

NIGERIA IS PERCEIVED as one of the most corrupt nations in the world.

In fact, one of the legal barriers to maternal health care identified in this report is the lack of transparency on resource allocation due to the absence of legislation ensuring freedom of information.

Corruption in Nigeria's Health-Care Sector

We need the political will to execute and implement laws enacted. We as legislators also have to increase our oversight function so that monies allocated to the health sector do not end up misapplied or misappropriated.

– Senator Olurunimbe Momoora⁹⁷

Politicians are buying jeeps at six million Naira but this [amount] can equip a centre with emergency obstetric care services. They buy jeeps and drive them on pothole ridden roads and drive past deserted primary health care centres.

– Hajiya Bilkisu Yusuf, Director of Advocacy Nigeria⁹⁸

Perhaps nowhere is the negative impact of corruption more pronounced than in the health sector of many countries, not least Nigeria, where the consequences go beyond loss of revenue to the loss of many lives.⁹⁹ As a result, focus has been placed on researching corruption in the health sector,¹⁰⁰ which has revealed that the concentration of large funds and the multiplicity of key players in this area make it vulnerable to corrupt activities.¹⁰¹

Whatever the reason, corruption has hurt and continues to hurt the health of Nigerians. For example, corruption by public officials enabled the marketing of fake medicines in the country,¹⁰² earning those involved about USD 60 million each year.¹⁰³ The use of these medicines, which at some point constituted 70% of the medicines available in the country,¹⁰⁴ resulted in many serious sicknesses and deaths.¹⁰⁵ In 2006, the government's failure to meet targets on transparency was a core reason for the suspension of a USD 50 million grant awarded by Global Fund to prevent mother-to-child HIV transmission and broaden access to antiretroviral drugs.¹⁰⁶

An ongoing investigation of why the Federal Ministry of Health failed to return about NGN 300 million in unspent funds to the national treasury as mandated¹⁰⁷ indicates that portions of the money were distributed between some officials of the health ministry and some members of the Senate Committee on Health without valid authorization.¹⁰⁸

Sadly, many cases of maternal death in Nigeria would not occur in a different political and economic environment, even in the developing world. A global study that measured corruption in Nigeria's health sector found that 42% of health-care staff had experienced salary delays exceeding six months, even though adequate funds had been delivered to the local government.¹⁰⁹ Research has shown that failure to adequately remunerate health-care providers encourages them to "demand contributions from patients."¹¹⁰ Section Three of this report discusses how such informal contributions constitute financial barriers to maternal health care.

The Legal Framework of Corruption in Nigeria

A number of regional, national, and international laws seek to prevent, prohibit, criminalize, and punish corruption in Nigeria. Section 98 of the Nigerian Criminal Code criminalizes corruption as a felony punishable by a seven-year prison sentence.¹¹¹ In addition, the Fifth Schedule of the 1979 Nigerian

Constitution established a code of conduct for public officials,¹¹² including the prohibition of foreign bank accounts,¹¹³ the prohibition of acceptance of personal gifts received in the course of their public duties,¹¹⁴ and the duty to declare their assets.¹¹⁵ It also established a Code of Conduct Bureau that would ensure compliance with this code¹¹⁶ and receive complaints of non-compliance.¹¹⁷ In addition, it created a Code of Conduct Tribunal¹¹⁸ to which the bureau could refer such complaints,¹¹⁹ and which had the power to try and punish violators.¹²⁰ The current constitution (the 1999 Constitution) retained these provisions in its third and fifth schedules.¹²¹

At the regional level, Nigeria ratified the African Union Convention on Preventing and Combating Corruption on 26 September 2006.¹²² This convention, which expresses concern at the negative and devastating effects of corruption on political, economic, social, and cultural stability,¹²³ guarantees the right of access to information required to help fight corruption.¹²⁴ Article 12 mandates that the government create an environment that allows civil society and the media to hold it to the highest levels of transparency and accountability.¹²⁵

Certain international laws and regulations also govern corruption in Nigeria. The United Nations Convention against Corruption (UNCAC),¹²⁶ which Nigeria ratified on 14 December 2004,¹²⁷ expresses concern that corruption jeopardizes the rule of law.¹²⁸ Accordingly, Article 5 of the UNCAC requires states to adopt preventive anti-corruption policies and practices, while Article 6 obligates them to ensure that independent bodies implement these policies and practices.¹²⁹ Article 13 mandates that the Nigerian government grant the public access to information and promote the participation of non-governmental organisations and civil society in fighting corruption.¹³⁰ In addition, Article 17 of the UNCAC criminalizes corruption, while Article 34 requires the government to take measures to address the consequences of corruption.¹³¹

Despite the existence of such laws, from the regional level to the international, corruption continues to be a major problem in Nigeria, with devastating results in the area of health care.

Lack of Information and Transparency Regarding Resource Allocation and Expenditure

Access to health information is an essential feature of an effective health system as well as the right to the highest attainable standard of health. Health information enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realization, expose corruption, hold those accountable to account, and so on.

– Paul Hunt, the United Nations Special Rapporteur on the right to the highest attainable standard of health¹³²

Transparency and freedom of information are integral to curbing corruption. The allocation and adequacy of released funds can demonstrate the extent of political will to reduce maternal mortality and promote safe motherhood.¹³³ The consideration of these factors, however, is difficult in Nigeria's current political environment. Laws preventing public access to government information on grounds of security obscure the records that would enable the public to ascertain how well the government is meeting its responsibilities.¹³⁴

THE SECRECY around budgetary allocations to health, including reproductive and maternal health, and the public's inability to access such information, shields the government from accountability for expenditures on health care.

In 1999, the Freedom of Information Bill, which sought to make public records and information available to the public, was brought before the Nigerian National Assembly.¹³⁵ After years of delays, the senate passed the bill in 2007 and presented it to President Olusegun Obasanjo, whose tenure was almost ending at the time, to sign into law.¹³⁶ The president had espoused a personal commitment to such legislation during the 2004 National Economic Empowerment and Development Strategy, identifying an act ensuring the public's right to information as a strategy for ending corruption.¹³⁷ However, he declined to sign the bill, asking for modifications for reasons that included the grave implications of the law on Nigeria's security.¹³⁸ At the moment, no Nigerian law imposes a legal obligation on the government to collect fiscal information and disseminate it to the public. The resulting absence of accountability and lack of information are discussed below.

The secrecy around budgetary allocations to health, including reproductive and maternal health, and the public's inability to access such information, shields the government from accountability for expenditures on health care. For instance, an interviewee at the Centre for Women's Health and Information (CEWHIN) described the challenges that the organisation faced in obtaining information about the Ibeju-Lekki Local Government Area's health budget while working in Lagos State.¹³⁹ She noted that the officials with whom they were scheduled to meet either departed before or postponed their meetings. A local government official from Abeokuta South Local Government Area admitted to not knowing the percentage of the state's budget that went to health care, since this figure was dependent on the discretion of the chairman and other executive members.¹⁴⁰

Lack of transparency and access to information enables public officials to remain unaccountable to the health needs of the people. For instance, a general hospital (a secondary health-care service) in Maiduguri, which was built, well-equipped, and "ready for patients in 2006," was locked up by the governor pending the president's attendance of its opening ceremony.¹⁴¹ It remained locked and unused until it was burnt down in 2008, allegedly by arsonists whom the governor claimed wanted to ruin his political reputation.¹⁴² It is worth mentioning that some interviewees noted that the government has a tendency to build health centres that it neither equips nor staffs.¹⁴³ These interviews revealed a number of reasons for this phenomenon, including the politicization of health and widespread diversion of funds, which allow politicians to take pride in building structures that the people can see, as well as the fact that the intended beneficiaries of health services lack the means to hold public officials accountable.¹⁴⁴ Consequently, the need for transparency and access to information cannot be overstated since it would allow the people to stay informed and demand that the government be accountable for any decisions that impact their health.

The Health Sector Reform Programme, which was published by the FMOH, acknowledges the problems of uniform decision making and priority setting caused by the absence of information about budgetary allocations:

*The real cost of health services is not known, as there is no system for National Health Accounts (NHA). There are no reliable data or information on the combined Federal, State and LGA [Local Government Area] expenditures, nor on expenditures from private and donor sources.*¹⁴⁵

Lack of knowledge of the cost of health-care provision makes it difficult to determine the adequacy of governmental allocations to health care and the potential need to increase allocations to a specific region or vulnerable group, or to make other special considerations. For instance, women who

are at higher risk of maternal death, such as adolescents and those living in rural areas and the northern region, may benefit from increased allocation to meet their needs. Without access to such resource-allocation information, strategies for reducing maternal death amongst these groups may be misinformed. Furthermore, transparency in budgetary allocation would ensure the re-allocation of available resources from less urgent concerns to efforts to reduce maternal mortality and morbidity when necessary.

The absence of transparency regarding health-care budgetary allocation makes it difficult to hold the government accountable for unfulfilled obligations. A law that grants the public access to information would increase transparency and enable the people to hold their leaders accountable. Moreover, such a law could serve as an early warning sign of misplaced priorities and could reduce the widespread mismanagement and corruption in Nigeria.

WHY THE RIGHT TO INFORMATION IS CENTRAL TO PROTECTING THE RIGHT TO HEALTH

Legislators recognize that a regime of freedom of information would subject them to greater public scrutiny.

– **Edetaen Ojo**¹⁴⁶

The right to information is a fundamental human right; its realization is also central to fulfilling other fundamental human rights. Access to information is necessary to ensure good governance through transparency and accountability. Article 19 of the International Covenant on Civil and Political Rights (Civil and Political Rights Covenant)¹⁴⁷ and Article 9 of the African Charter on Human and Peoples' Rights (African Charter)—both of which Nigeria has ratified—recognize the right to information.¹⁴⁸ This right is reaffirmed in the Declaration of Principles on Freedom of Expression in Africa, which was adopted by the African Commission on Human and Peoples' Rights. The declaration states that “everyone has the right to access information held by public bodies,” as well as “the right to access information held by private bodies which is necessary for the exercise or protection of any right.”¹⁴⁹ Refusals to disclose such information “shall be subject to appeal to an independent body and/or the courts,” and public bodies are required to publish “important information of significant public interest,” even absent a request to do so.¹⁵⁰ Furthermore, the declaration provides that those who release “in good faith information on wrongdoing, or that which would disclose a serious threat to health, safety or the environment” shall not be subject to sanctions.¹⁵¹

Absence of Gender-Responsive Budgeting

State parties shall combat all forms of discrimination against women through appropriate legislative, institutional and other measures. In this regard, they shall: integrate a gender perspective in their policy decisions, legislation, development plans, programmes and activities and in all other spheres of life.

– **Article 2(1)(c), Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)**¹⁵²

Gender-responsive budgeting has been described as a process of budgeting that is gender sensitive and considers the disparate impact of budget decisions on women, men, and different social groups, such as rural and urban groups.¹⁵³ It does not, however, require a separate budget for each group.¹⁵⁴

THE SECRETARY GENERAL of Women's Rights Advancement and Protection Alternative ... has noted that adequate financing for women's needs would reduce the nation's maternal mortality rate.

The United Nations General Assembly has noted,¹⁵⁵ and the Commission on the Status of Women has recently reiterated,¹⁵⁶ the importance of governments incorporating a gender perspective into their budgetary processes¹⁵⁷ and initiating gender-sensitive expenditure reviews.¹⁵⁸ Furthermore, in its General Recommendation 24, the Committee on the Elimination of all Forms of Discrimination against Women notes that states are obligated to take appropriate measures, including relevant budgetary allocations, to fulfil women's right to health care.¹⁵⁹

Interviewees identified the absence of gender-responsive budgeting on health issues as a core missing consideration in the budgetary allocations of each level of Nigeria's government. The Secretary General of Women's Rights Advancement and Protection Alternative (WRAPA), pointed out that the lack of a gender perspective in these budgets had left the key concerns of women unaddressed in public expenditures.¹⁶⁰ She also noted that adequate financing for women's needs would reduce the nation's maternal mortality rate.

Ahaoma Okoro, a consultant at WARDC, commented on the effect of the absence of gender-responsive budgeting and proposed a role for non-governmental organisations (NGOs):¹⁶¹

We have enormous resources in this country so civil society cannot be satisfied with the fact that the government is giving billions of Naira. [For instance], if two billion Naira is budgeted to health, we ask ourselves, how much of this money will go into issues around reproductive health. It deserves major attention—I get upset when people say that [the] Government is trying. For instance, there is news that the Government wants to build primary health care centres in all 774 local government areas. My question is have we conducted a needs assessment [to determine what is needed and should be prioritized]?¹⁶²

Although gender-responsive budgeting trainings and initiatives have occurred in Nigeria,¹⁶³ the absence of and lack of implementation of gender-responsive budgeting on health issues means that the health needs of women remain neglected.

THE LOW RATE OF CONTRACEPTIVE USE IN NIGERIA AS A MAJOR CONTRIBUTING FACTOR TO HIGH RATES OF MATERNAL MORTALITY

High maternal mortality and morbidity rates worldwide and the large numbers of couples who would like to limit their family size but lack access to or do not use any form of contraception provide an important indication for States parties of possible breaches of their duties to ensure women's access to health care.

– **Committee on the Elimination of All Forms of Discrimination against Women**¹⁶⁴

The number of maternal deaths in a population is essentially the product of two factors: the risk of mortality associated with a single pregnancy or a single live birth, and the number of pregnancies or births that are experienced by women of reproductive age.

– **WHO, “Maternal Mortality in 2005”**¹⁶⁵

As long as women cannot determine how many children they want, and when to stop, they will continue to die. We need to look at the remote social and economic variables that compound this.

– **Dr. Mairo Mandara, obstetrician and gynaecologist**¹⁶⁶

Family planning is the first pillar in reducing maternal mortality.

– **Senior Official of the Federal Ministry of Health**¹⁶⁷

Access to family planning or contraceptive methods is an important strategy in reducing maternal mortality.¹⁶⁸ However, the Nigerian government has failed to take steps to ensure access to these methods; many Nigerian women therefore 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%¹⁶⁹ to 15.6%;¹⁷⁰ the percentage of those who use modern methods of contraceptives ranges from 8.9%¹⁷¹ to 11.6%.¹⁷² 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.¹⁷³ Furthermore, one third of women of childbearing age have had an unwanted pregnancy,¹⁷⁴ while 25% of women between 15-49 years of age have an unmet need for family planning.¹⁷⁵ The prevalence of unplanned and unwanted pregnancies increases the likelihood of exposure to unsafe abortion and the risk of maternal morbidity or mortality.

According to the 2003 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%.¹⁷⁶ More recently, the 2005 National HIV/AIDS and Reproductive Health Survey (NARHS) found that the rates of use were 15.6% and 11.6%, respectively, in 2005.¹⁷⁷ The predominant reasons for the low rate of contraceptive use—lack of access and lack of affordability, which will be

FAMILY PLANNING
*is key to lowering
Nigeria's maternal
mortality rate.*

discussed in greater detail below—are directly attributable to the failure of the Nigerian government to ensure that women can obtain family planning services and information, partially as a result of its inadequate funding of contraceptive services and information.

In failing to ensure access, the government violates its 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 non-discrimination. The government also falls short of fulfilling its obligations under regional laws, including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which calls for states to “ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”¹⁷⁸ Under this 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.¹⁷⁹ Additionally, the Maputo Plan of Action calls for the strengthening of “SRH [sexual and reproductive health] commodity security with emphasis on family planning.”¹⁸⁰

The Right to Health

The government of Nigeria is violating women's right to health by failing to ensure that they have access to contraceptives. Adequate family planning has a significant impact on reproductive health: “By far the most important way of reducing maternal deaths is simply by reducing the number of pregnancies.”¹⁸¹ Similarly, an obstetrician and gynaecologist with the University College Hospital (UCH) in Ibadan recently stated that family planning is “key” to lowering Nigeria's MMR.¹⁸² By preventing unintended pregnancies, access to family planning “could avert 20 to 35 per cent of maternal deaths” and thus save more than 100,000 lives every year.¹⁸³ In a recent article, the 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%.¹⁸⁴

Interviewees testified to the strong correlation between the use of family planning and the reduction of maternal mortality rates in Nigeria.¹⁸⁵ One doctor noted that “family planning is the first pillar in reducing maternal mortality.”¹⁸⁶ An official at the State Ministry of Health, Ogun explained that the fact that his local government offers 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).¹⁸⁷

Nigeria's International Legal Obligations

Under international law, as an element of the right to health, the government must make certain that a woman has “the right to control one's health and body, including sexual and reproductive freedom. . . .”¹⁸⁸ When a government does not ensure that a woman has access to contraceptives, her right to control her health and body is severely restricted; thus, the government fails in its duty to safeguard her rights and fails to abide by its own legal obligations.

As recently as 2004, the Committee on the Elimination of All Forms of Discrimination against Women (CEDAW Committee), in its Concluding Observations to Nigeria, noted its concern about the nation's "insufficient and inadequate health-care facilities and family planning services and the lack of access to such facilities and services."¹⁸⁹

The **Committee on Economic, Social and Cultural Rights** (CESCR) has elaborated upon the meaning of the right to health by outlining the following "interrelated and essential elements" of this right: availability, accessibility, acceptability, and quality.¹⁹⁰

In explaining the different components of the right to health, the CESCR has stated that in order to ensure availability, a "sufficient quantity" of public health-care facilities, programmes, and goods and services must be available.¹⁹¹ Such goods must include "essential drugs, as defined by the WHO Action Programme on Essential Drugs."¹⁹² The 2007 Model List of Essential Medicines includes contraceptives among the core "minimum medicine needs for a basic health system."¹⁹³

Secondly, the CESCR explains that health facilities, goods, and services must be accessible in a non-discriminatory manner: they must be available to all, especially to the most vulnerable or marginalized sectors of society; they must be physically accessible, again particularly by vulnerable and marginalized groups such as women and those living in rural areas; they must be affordable; and people must be able to "seek, receive and impart information and ideas concerning health issues."¹⁹⁴

Third, to ensure acceptability, health facilities, goods, and services must be, among other factors, "sensitive to gender."¹⁹⁵

Finally, health facilities, goods, and services must be of good quality.¹⁹⁶

Nigeria's failure to ensure access to contraception contravenes each of the elements of the right to health delineated by the CESCR.

National and Regional Laws

Several national and regional laws and policies obligate Nigeria to provide health services in a manner that is adequate, affordable, and accessible.

- Under the Maputo Protocol, Nigeria should take measures to "provide adequate, affordable and accessible health services, including information, education and communication programmes to women."¹⁹⁷
- 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 of 2001) 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."¹⁹⁸ The policy specifically calls for the removal of "all forms of barriers that limit access to comprehensive, integrated and qualitative reproductive health care."¹⁹⁹

SIGNIFICANT EVIDENCE exists of disparities in access to contraceptives based on age, region of residence, and level of wealth.

- 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 improve the quality of these services.²⁰⁰ 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.”²⁰¹
- 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.”²⁰²

Lack of Availability of Contraceptives

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 respond to this question.²⁰³ The figure for males was 55.5%.²⁰⁴ Interviews revealed numerous factors for the lack of contraceptive availability; for instance, they are often held up at ports or have expired by the time they reach health facilities.²⁰⁵ As a result of these and other reasons, contraceptives are not available consistently or on a long-term basis.²⁰⁶ The general absence of health facilities, particularly in rural areas, is yet another barrier to access.²⁰⁷ By not ensuring that contraceptive goods and services are available in “sufficient quantity,” the Nigerian government fails to ensure availability.

Lack of Access to Contraceptives: Non-Discrimination; Physical Accessibility; Affordability; Information

Survey results show that the only method of modern contraception found to be accessible by more than half of those surveyed is the condom, which 56.5% of men and women said was accessible (although the figure for females was only 48.2%).²⁰⁸ In general, condoms were perceived as being the most accessible (56.5%), followed by the pill (31.6%), injectables (28.4%), and the IUD/Coil (13.6%).²⁰⁹

Non-Discrimination

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

Disparities Based on Rural vs. Urban Residence

Surveys reveal large discrepancies between those in rural and urban areas with regard to rates of contraceptive use, as well as knowledge of and perceptions regarding the accessibility and affordability of contraceptives. These discrepancies are ones that the state is obligated to

address under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).²¹⁰

To begin with, usage rates of contraceptives—both all methods and modern methods²¹¹—are significantly lower in rural populations than in urban populations. The rural rate of use of all methods is only 9.2%, in contrast to 20.2% in urban populations.²¹² For modern methods, the rates are 5.7% and 13.9%, respectively.²¹³

The perception of accessibility also varies widely between rural and urban areas. For example, 76.3% of those in urban areas found the condom to be accessible; less than half (45.2%) of those in rural areas agreed.²¹⁴

Regarding affordability, large discrepancies exist yet again between those in rural and urban areas: there is a difference of almost 30% between those in urban areas (73.4%) and those in rural areas (43.8%) who think the condom is affordable.²¹⁵ In the case of the pill, the difference is close to 20% (41.7% in urban areas vs. 21.9% in rural areas).²¹⁶

Rural and urban regions also have varying levels of knowledge of contraceptives. According to the NARHS, the percentage of women in urban areas who have knowledge of any method of contraception is 90.5%, as compared to only 69.8% of women in rural areas; the rates of knowledge in regard to modern methods of contraception are 89.7% and 61.1%, respectively.²¹⁷ Similarly, the DHS revealed that 91% of urban women have knowledge of any method of contraception, as compared to 72.9% of rural women.²¹⁸ Comparable differences exist in the knowledge of modern methods of contraception: 90.7% in urban areas vs. 69.8% in rural areas.²¹⁹

Moreover, among those using modern methods of contraceptives, those in rural areas were less informed about the side effects or problems of their particular methods. For example, 35.7% of rural users of modern contraceptives, compared to 49.6% of their urban counterparts, were informed of such side effects or problems.²²⁰ Similarly, only 31.6% of those in rural areas, compared to 47.2% of those in urban areas, were informed about what to do if they experienced side effects.²²¹ This discrepancy has a marked impact on the ability of men and women to make informed choices about which method of contraception best suits their needs.

Disparities Based on Region

The rates of use for both all methods of contraception and modern methods of contraception are lowest in the North East and North West regions of Nigeria. For example, in the North East, the rate of use of any method of contraception is 4.2% and the rate of use of modern methods of contraception is 3.0%.²²² These figures are in stark contrast to rates in the South West (32.7% for all methods and 23.1% for modern methods).²²³ Similarly, those in the North East and the North West are least likely to find contraceptives accessible.²²⁴

Large regional discrepancies also exist in knowledge about contraception. According to the DHS, the rates of knowledge of both any method of contraception and modern methods are lowest in

the North East (63.5% and 60.8%, respectively), in contrast to rates higher than 95% in the South West.²²⁵ The NARHS also demonstrates that the rates of knowledge of any method are lowest in the North West and the North East (only slightly higher than 60%).²²⁶ The knowledge rate for modern methods of contraception is similarly low in these two regions (slightly higher than 50%).²²⁷ Finally, those in the North East and the North West are least likely to find modern contraceptives affordable.²²⁸

Discrepancies Based on Wealth

When statistics are gathered on the basis of wealth, the enormous differences in use between those of different socio-economic strata becomes obvious. The rate of use of any method of contraception is 6.9% among those in the lowest wealth quintile and 5.6% among those in the second wealth quintile.²²⁹ The rate in the highest quintile is more than four to five times higher, at 30.0%.²³⁰ For modern contraceptives, the usage rate among the lowest quintile is 3.6%; the rate in the second quintile is 2.9%.²³¹ This contrasts starkly with the 20.5% rate in the highest quintile.²³² These differences suggest that the cost of contraceptives prevents many women from being able to use them. However, access to and use of contraceptives should not be dependent on economic ability. The government must ensure that cost does not prevent women from using this family planning method.

Physical Accessibility

Physical accessibility can play a significant role in contraceptive use; interviews revealed that many women lack a means of transport to health facilities.²³³ Thus, by failing to provide adequate transportation that enables women to reach facilities where they can obtain contraceptives, the Nigerian government fails in its obligation to ensure that contraception, a basic health good, is accessible to all.

Affordability

According to the CESCR, health goods and services must be “affordable for all, including socially disadvantaged groups.”²³⁴ Similarly, the CEDAW Committee has called upon states to eliminate barriers that women face in gaining access to health care—one such barrier being “high fees for health care services.”²³⁵ In 2004, the CEDAW Committee urged the Nigerian government “to increase women’s and adolescent girls’ access to affordable health-care services, including reproductive health care, and to increase access to affordable means of family planning for women and men.”²³⁶ The CEDAW Committee made similar suggestions to Nigeria in 1998, when it encouraged the government “to increase its efforts to guarantee access to medical services and hospital medical facilities, particularly in the context of women’s health needs,” noting that “family planning programmes must be available to all” and that “free access to health services should be a priority for Government . . .”²³⁷ The fact that, ten years later, cost continues to serve as a barrier for women demonstrates that the government continues to fail in its obligations under international human rights law, at the expense of women’s health and women’s lives. Finally, the ICPD Programme of Action also stresses that it is vital for leaders to “translate their public support for reproductive health, including family planning, into adequate allocations of budgetary

. . . resources to help meet the needs of all those who cannot pay the full cost of services.”²³⁸

This language emphasizes that appropriate budgeting is a central element of ensuring access to contraceptives.

Regarding the funding of reproductive health programmes, a necessary component of which are family planning services, Nigeria’s National Reproductive Health Policy and Strategy of 2001 calls for government funding towards reproductive health programmes.²³⁹ An implementation strategy of the 2004 National Policy on Population for Sustainable Development similarly calls for funding for reproductive health programmes.²⁴⁰ However, as of June 2005, the Federal Ministry of Health had not created a budget line towards the procurement of family planning commodities.²⁴¹ It is crucial that the government provide funding for family planning services in such a way that enables women to choose from a full range of contraceptive goods and decide which method best suits their needs.²⁴²

Both the NARHS and interviews reveal that the cost of contraceptives is a significant barrier to access. According to the NARHS, 61.8% of females either agreed or “don’t know/didn’t respond” when asked if it is expensive to practice family planning and child spacing.²⁴³ The figure for males is 56.3%.²⁴⁴ Regarding specific types of contraception, the only contraceptive method that more than 50% of all respondents found to be affordable is the condom.²⁴⁵ The affordability figures for all other types of contraceptives—the pill, injectables and the IUD/coil—were less than 30%.²⁴⁶

The information collected in interviews confirmed that the unaffordability of contraceptives contributes to low usage rates.²⁴⁷ One health-care practitioner at Lagos Island Maternity Hospital explained that while family planning methods were once provided free of charge, they are currently available at subsidized rates.²⁴⁸ In addition, one interviewee countered the perception that Nigerian women do not want to space their children; in fact, they lack the ability to do so because they cannot afford the cost of family planning methods.²⁴⁹ Cost was also identified as a barrier to contraceptive access during a focus-group discussion with civil society groups; participants explained that while contraceptives were previously free, the fact that they now cost something “discouraged use.”²⁵⁰

Information about Contraceptives

The lack of correct information about contraceptives and the resulting non-use of contraceptives is a major factor that contributes to the high rate of maternal mortality in Nigeria.²⁵¹ It is the government’s duty to ensure that the Nigerian people receive information about family planning methods, as increased awareness would contribute to a reduction in maternal mortality rates.

The NARHS reveals that significantly fewer women have knowledge of modern methods of contraception than men (71.4% vs. 84.2%, respectively).²⁵² According to the DHS, while approximately 90% of men have knowledge of any method of contraception, only 78.5% of women possess such information.²⁵³ A similar discrepancy exists in rates of knowledge about modern methods of contraception (89.5% of men in contrast to 76.7% of women).²⁵⁴ Thus, it is especially important that the government target educational and informational campaigns towards women.

WOMEN ALSO BELIEVE that *contraception is an abortifacient, and that it will cause fatal diseases. These fears play a significant role in preventing women from using contraceptives.*

Moreover, the NARHS shows that the knowledge rate among married women is significantly lower than the rate among unmarried women who are sexually active (75.7% of married women, in contrast to 88.2% of unmarried women).²⁵⁵ The DHS findings confirm this trend: while only 78.4% of married women know about contraception methods, 91.2% of unmarried, sexually active women are similarly informed.²⁵⁶ The same discrepancy exists regarding modern methods of contraception: 76.2% of currently married women have such information, in contrast to 91.2% of unmarried, sexually active women.²⁵⁷

Similar differences are found in the rates of contraceptive use: the rate among married women is only 12.6%, while the rate among sexually active, unmarried women is significantly higher, at 49.9%.²⁵⁸ Furthermore, 8.2% of married women use modern contraceptives, in contrast to 38.6% of sexually active, unmarried women.²⁵⁹

The NARHS also reveals that both men and women hold potentially dangerous misconceptions about family planning. In response to survey questions, both men and women often stated that they did not know the answers to questions about family planning, indicating that the government has failed to provide them with education and information on this topic. Without an understanding of the facts regarding family planning, the ability of women to “decide freely and responsibly on the number and spacing of their children” is deeply hindered and their right to make these decisions is violated.²⁶⁰

According to the NARHS, almost a third of Nigerian women surveyed believe that family planning can lead to female infertility.²⁶¹ More than 40% of women answered this question by selecting “don’t know/no response.”²⁶² In response to whether family planning and child spacing methods cause cancer or other diseases, 16.5% of women agreed, 55% did not know or did not respond, and only 28.4% disagreed.²⁶³ In response to the statement that “being sterilized for a man is equal to being castrated,” 27.1% of females and 32.4% of males agreed and almost half of the females and 37% of the males did not know or did not respond.²⁶⁴ Not only must the government take steps to provide women and men with more information on contraceptive use, but it must also work to correct such “myths [and] misconceptions” about family planning methods.²⁶⁵

Interviews confirmed that “awareness is a major barrier to [contraceptive] use resulting in aversion towards it.”²⁶⁶ For example, interviewees indicated that women fear that contraceptive use will have adverse effects, including bleeding and permanent infertility.²⁶⁷ Women also believe that contraception is an abortifacient,²⁶⁸ and that it will cause fatal diseases.²⁶⁹ These fears play a significant role in preventing women from using contraceptives.²⁷⁰

Statistics also reveal that health-care providers are failing to provide comprehensive information about contraceptives to patients. The results of the DHS confirmed that less than half (42.4%) of those who are currently using modern methods of contraceptives were informed about the side effects or problems of the method.²⁷¹ An even smaller percentage of individuals (39.1%) were informed what to do if they were to experience side effects.²⁷²

Both men and women strongly associated the use of contraceptives with “moral” or other consequences. For example, according to NARHS, 46.7% of females and more than 50% of males agreed that family planning encourages young people to be “loose.”²⁷³ Only about a quarter of both men and women disagreed with this statement.²⁷⁴ In addition, 35% of females and close to half of men agreed that family planning and child spacing methods encourage women to be promiscuous.²⁷⁵ Finally, when asked whether condoms “encourage” male infidelity, 31.2% of females and almost 40% of males agreed.²⁷⁶ Considering the devastating consequences of non-use of contraceptives on women’s lives, it is crucial that factual information regarding contraceptives be provided so that fears about such “moral” consequences do not prevent their use.

NIGERIA’S INTERNATIONAL OBLIGATIONS WITH RESPECT TO PROVIDING INFORMATION ABOUT CONTRACEPTIVES

The CEDAW Committee has stressed the critical importance of states providing education and counselling on family planning.

The Committee has emphasized the relationship between CEDAW Article 12 and other treaty provisions, including those related to education. For example, states are obligated to ensure “access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning,” as well as to ensure that women “have access to the information, education and means to enable them to exercise” the right “to decide freely and responsibly on the number and spacing of their children.”²⁷⁷

CEDAW Article 10(h) obligates the Nigerian government to take steps to eliminate discrimination against women and to ensure their equal access to “specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.”²⁷⁸

CEDAW Article 12(1) requires the government to take measures to eliminate discrimination against women in the field of health care and to ensure equality between men and women in access to family planning services.²⁷⁹ The government is thus obligated to address the discrepancies in knowledge of contraceptives between men and women.

The ICPD Programme of Action also calls upon states to “ensure that women and men have information and access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and informed choice.”²⁸⁰ The information that states provide about family planning methods must be “accessible, complete and accurate.”²⁸¹ Specifically, it should discuss the “health risks and benefits [and] possible side effects” of family planning methods.²⁸² It is particularly important that accurate information about the possible side effects of contraceptives be provided, given the misconceptions that so many men and women in Nigeria possess about this issue.

WHEN HEALTH-CARE PROVIDERS ARE NOT

“COURTEOUS” to patients who seek information about family planning, these patients are unlikely to return to the facility.

Lack of Acceptability and Quality of Contraceptive Goods and Services

Acceptability, as defined by the CESC, requires that health goods and services be respectful and sensitive to gender and “designed to respect confidentiality.”²⁸³ Yet again, the government of Nigeria has neglected to ensure this element of the right to health. For example, interviews revealed that the attitude of health-care personnel presented a barrier to accessing contraceptives.²⁸⁴ This attitude was described as “nasty and inhumane” at times.²⁸⁵ When health-care providers are not “courteous” to patients who seek information about family planning, these patients are unlikely to return to the facility.²⁸⁶ 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.²⁸⁷ By failing to ensure that women are able to receive health-care services in a manner that respects their confidentiality, Nigeria inhibits women’s access to contraceptives.

Finally, both the CESC and the CEDAW Committee have emphasized the importance of ensuring quality health goods and services, which, the CESC notes, includes skilled medical personnel.²⁸⁸ 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.”²⁸⁹

Lack of Access to Contraception and Unsafe Abortion

Unsafe abortions are a major cause of maternal deaths in Nigeria. Both the Human Rights Committee²⁹⁰ and the CEDAW Committee²⁹¹ have expressed concerns about this link generally, and the CEDAW Committee has specifically expressed concern and issued recommendations about it in regard to Nigeria.²⁹² Further information on the connection between lack of access to contraception, unsafe abortion, and maternal mortality can be found in the Section “Unsafe Abortion: A Major Contributor to the High Rate of Maternal Mortality in Nigeria.”

Ensuring Access to Condoms as a Means to Prevent HIV Infection and Transmission

In order to prevent the spread of HIV/AIDS and other sexually transmitted infections, it is vital that the Nigerian government ensure the full accessibility of family planning services and information. The CEDAW Committee has noted the link between access to sexual health information and services and the prevalence of HIV/AIDS, emphasizing that states should “ensure, without prejudice and discrimination, the right to sexual health information, education and services for all women and girls.”²⁹³ It is particularly imperative that the government take steps to guarantee that women can access contraceptives, particularly condoms, given that girls and women comprise approximately 61% of new HIV cases in Nigeria.²⁹⁴ The director-general of the National Agency for the Control of AIDS has emphasized that in order to prevent the further spread of HIV, women must be able to negotiate safe sex with their partners.²⁹⁵ A central component of safe sex is the use of contraception, particularly condoms. Thus, to curb the spread of HIV, the government must make certain that women can easily access condoms. The failure to guarantee such access violates women’s right to health.

It is also necessary for the Nigerian government to ensure that girls receive information regarding HIV/AIDS. The Committee on the Rights of the Child (Children's Rights Committee), in its General Comments, has called upon states to ensure that "children . . . have the right to access adequate information related to HIV/AIDS prevention and care. . . ." ²⁹⁶ The same Comment emphasizes the importance of providing "free or low-cost contraceptive methods and services." ²⁹⁷ The Committee also reiterates that states must take measures to ensure both the availability and accessibility of goods, services, and information to prevent and treat HIV/AIDS. ²⁹⁸ Specifically, the Committee calls for states to remove barriers to accessing preventive measures, such as condoms. ²⁹⁹

Importance of Efforts Aimed at Adolescents ³⁰⁰

Knowledge of Contraceptives Among Adolescents

- This age group possesses the lowest level of awareness (64.2%) regarding contraceptives. ³⁰¹
- Adolescents of both sexes have the least knowledge of both any method of contraception and modern methods of contraception. Merely 64.9% of adolescents have knowledge of any method of contraception, in contrast to 85.9% among those between 25-29 years of age. ³⁰² With regard to modern methods of contraception, 61.6% of adolescents have such knowledge, as compared to 83.4% of those between 25-29 years of age. ³⁰³

Use of Contraceptives Among Adolescents

- The usage rate of any method of contraception among adolescents is lowest among all age groups at 6.6%. ³⁰⁴
- Only 4.7% of adolescents use modern methods of contraception, again the lowest among all age groups. ³⁰⁵
- Merely 4.3% of currently married adolescents use any method of contraception, and just 3.8% use modern methods of contraception. ³⁰⁶

Considering the high number of maternal deaths due to unsafe abortion among adolescents, it is critical that the government focus its efforts to increase both knowledge about and access to family planning and contraceptives for this age group. ³⁰⁷ In the National Policy on the Health & Development of Adolescents & Young People in Nigeria, 2007, the government set a goal of reducing the incidence of unwanted pregnancies among young females by 50%. ³⁰⁸ However, as of June 2005, the Federal Ministry of Health had not created a budget line for programmes that would directly target adolescents and youth, indicating that the government has not adequately focused on this group. ³⁰⁹

The CEDAW Committee has highlighted the importance of educational efforts targeted at this age group, stressing that these programmes should include "information and counselling on all methods of family planning." ³¹⁰ The Children's Rights Committee has similarly emphasized the importance of providing adolescents with "access to sexual and reproductive information, including on family planning and contraceptives. . . ." ³¹¹ Remarking on the high rates of maternal mortality among adolescents, the Children's Rights Committee has recommended that states take measures to reduce this figure linking high MMRs among this population to unsafe abortion practices. ³¹²

CONSIDERING THE HIGH NUMBER OF MATERNAL DEATHS due to unsafe abortion among adolescents, it is critical that the government focus its efforts to increase both knowledge about and access to family planning and contraceptives for this age group.

The Purported Impact of Culture and Religion on Low Rates of Contraceptive Prevalence

When asked who should make decisions regarding the use of family planning, almost one quarter of all respondents to the NARHS named the husband.³¹³ Among males, this rate was close to 30%.³¹⁴ Less than half of all respondents answered that both the husband and wife should make this decision.³¹⁵ Interviews confirmed that this belief is played out in practice; some women are required (for religious and other reasons) to seek permission from their husbands before they can obtain health-care services or use family planning.³¹⁶ One government representative explained that men often make decisions and that their views on contraceptives determine whether or not women can use them.³¹⁷ NGO representatives agreed that the attitude of many men towards contraception is poor, stating that they should become “enlightened.”³¹⁸ One NGO representative commented that women who are economically empowered are able to access family planning even without the consent of their husbands.³¹⁹ The pre-requisite of consent is related to the broader issue of the extent to which women are able to make decisions regarding their own lives.³²⁰ Barriers to access that extend beyond the personal relationship between a husband and a wife must be eliminated to ensure women’s access to and use of contraceptives.

The 1995 Beijing Declaration and Platform for Action emphasizes that women’s “limited power” with regard to their sexual and reproductive lives can adversely affect their health.³²¹ The limited power of many women in Nigeria to make decisions about whether to use family planning has adverse consequences on their health. They even place their own health and lives at risk by becoming pregnant because they lack the power to make decisions about contraceptive use.

Some interviewees cited religion, culture, and traditional beliefs as reasons for both the lack of discussion regarding contraception and the low rate of contraceptive use in Nigeria.³²² However, the government cannot use this reasoning to excuse its lack of efforts to promote better understanding about and use of family planning methods. International human rights law obligates the Nigerian government to make certain that such perspectives are not used to validate certain practices. For example, the Human Rights Committee has called on states to “ensure that traditional, historical, religious or cultural attitudes are not used to justify violations of women’s right to equality before the law and to equal enjoyment of all Covenant rights.”³²³

Barriers to Maternal Health Care

Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures.

– **Declaration of Alma Ata, 1978**³²⁴

The current section highlights the existing barriers to maternal health care in Nigeria and how these barriers create or contribute to the nation's violations of the rights of women. It combines both primary and secondary research and the results of fact finding conducted around issues that are relevant to the reduction of maternal mortality and morbidity in Nigeria. The barriers to maternal health care in Nigeria are classified under three broad sub-sections: financial, infrastructural, and institutional. Each obstacle reflects the gross inadequacy of essential building blocks of a health system, such as the provision of health services and the development of a health workforce, as identified by the World Health Organization (WHO)³²⁵ and recently reiterated by Paul Hunt, the United Nations Special Rapporteur on the right to the highest attainable standard of health.

Whereas the right to health allows for progressive realization due to limitations in available resources, it prescribes certain core and immediate obligations that must be fulfilled. The Committee on Economic, Social and Cultural Rights (CESCR) has confirmed in its General Comment 14 that reproductive and maternal health-care provisions are obligations of comparable priority to the core obligations,³²⁶ which means that the Nigerian government's responsibilities in this regard are immediate. Accordingly, to the extent that the issues identified below limit reproductive and maternal health care in Nigeria, they represent the government's failure to fulfil immediate duties under the right to health.

Financial Barriers

Out-of-pocket payment for health-care services in Nigeria can be very high, ranging from 70% to 85%.³²⁷ These payments, such as user fees, drug costs, and other informal costs, are common in Nigeria and have adverse consequences on health care, including constituting a barrier to access amongst vulnerable groups, such as poor women.

The Impact of User Fees

Once you go to the hospital, before anyone attends to you, you have to drop some money so they tell me they can't go to the hospital because they can't afford it.

They are scared of the money they will have to pay and they don't have the money.

– **Christie, an interviewee from DAMSEL**³²⁸

I do not see why the military will have free medical services and pregnant women will not, so I think as a matter of policy there is a huge deficit in terms of political action to promote maternal health in Nigeria.

– **Tijah Bolton-Akpan, Innovations for Change, a Nigerian NGO**³²⁹

IN NIGERIA, there is evidence that maternal deaths increased by 56% and hospital deliveries fell by 46% after user fees were introduced.

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OUTLINES *instances of maternal deaths occurring, in one case in a hospital, because life-saving care was delayed pending the payment of fees and in another case on the way to the hospital, because the woman was reluctant to incur hospital costs and had stayed at home until it was too late.*

User fees were introduced in Nigeria's health care system in the 1980s, when the country was undergoing a structural adjustment programme (SAP).³³⁰ However, the negative impact of user fees on access to health-care services in developing countries is public knowledge. In Nigeria, there is evidence that maternal deaths increased by 56% and hospital deliveries fell by 46% after user fees were introduced.³³¹

User fees constitute health risks and lead to many deaths in poor populations, where they limit the people's financial ability to access health-care services. As most of the world's 1.5 billion poor are female,³³² user fees have particularly damaging gendered effects, some of which play out in women's ability to obtain maternal health-care services. Both the United Nations Population Fund (UNFPA) and the United Nations Development Fund for Women (UNIFEM) have acknowledged that poor women often lack access to essential maternal health-care services, such as antenatal checkups.³³³ With over 70% of the Nigerian population living below the poverty line,³³⁴ many Nigerian women are unable to pay the user fees that accompany necessary maternal services. These fees range from NGN 15,000 to NGN 20,000 (approximately USD 130 to 170) at public/government hospitals and can be as high as NGN 50,000 (over USD 400) at private hospitals.³³⁵ One media publication outlines instances of maternal deaths occurring, in one case in a hospital, because life-saving care was delayed pending the payment of fees and in another case on the way to the hospital, because the woman was reluctant to incur hospital costs and had stayed at home until it was too late.³³⁶

In Nigeria, place of residence and level of education are some of the factors that influence poverty, and thus limit access to maternal health care when user fees are imposed. Research shows that two thirds of Nigerians reside in rural areas.³³⁷ This is significant given that a 2004 study found that maternal death is considerably higher in rural areas, which had an MMR of 828 per 100,000 live births, compared to 351 per 100,000 live births in urban areas.³³⁸ There is an unmistakable connection between limited access to maternal health care and a higher MMR amongst uneducated women and women who reside in rural areas. The low percentage of rural and uneducated women who receive antenatal and intra-partum care is illustrated in the National HIV/AIDS and Reproductive Health Survey, 2005 (NARHS).³³⁹ The study found that of the 2,171 survey participants who had given birth in the preceding five years, only 47.2% of those from rural areas received antenatal care, compared to 85% of their urban counterparts.³⁴⁰ Likewise, only 32.2% of those who never attended school received antenatal care, as opposed to 95.5% of those with higher education.³⁴¹ Furthermore, just 31% of the rural women in the survey received intra-partum care, compared to 70% of their urban counterparts, while 17% of those who had never attended school received intra-partum care, compared to 95% of those with higher education.³⁴² While certain social, cultural, and religious factors contribute to the low rate of access by these groups, poverty stands out as a constant factor amongst these variables. It has driven women to give birth at home, with 17% of them delivering without any form of assistance,³⁴³ and another 20% relying on traditional birth attendants,³⁴⁴ some of whom lack the requisite skills.³⁴⁵ This trend has contributed greatly to the high mortality and morbidity ratios in the country. Recently, the Society of Gynaecology and Obstetrics of Nigeria (SOGON) attributed the country's high MMR to the fact that over 90% of deliveries were conducted by unskilled and improperly trained attendants since women could not afford the high costs of health-care services.³⁴⁶

User fees can also contribute to discriminatory attitudes among many health-care workers. One focus-group discussion (FGD) participant narrated his wife's experience when she sought maternal health-care services. She was treated in a hostile manner during her labour until the nurses discovered that

she was a lecturer at a university and started giving her better care. He concluded that health-care workers were more likely to treat indigent pregnant women badly.³⁴⁷

The United Nations Secretary General, in a 2008 report submitted to the Commission on the Status of Women, recommended that states “assess the gender impacts of revenue-raising measures, including user fees.”³⁴⁸ Exacting user fees from poor, uneducated, and rural women—a majority of the female population in Nigeria—and thus limiting their ability to access maternal health care amounts to discrimination against women because only women need maternal health care. This is evident in Article 12(1) of CEDAW,³⁴⁹ which requires states to “take all appropriate measures to eliminate discrimination against women in the field of health care,” and which the CEDAW Committee has interpreted to include a duty to eliminate such barriers, such as high fees that limit women’s access to health-care services.³⁵⁰

Furthermore, the Committee on Economic, Social and Cultural Rights (CESCR), in interpreting Article 12 of the International Covenant on Economic, Social and Cultural Rights (Economic, Social and Cultural Rights Covenant), which guarantees the right to health, has observed that “accessibility,” which is an essential element of this right, includes “economic accessibility or affordability.”³⁵¹ Thus, maternal deaths resulting from financial barriers to access constitute clear evidence that the Nigerian government is violating and failing to prevent the violation of the right to health, and indeed the right to life.

Detention of Patients Who Cannot Pay

I have seen women who after delivery had to come round the wards begging for money.

– **Kuti Folake, BAOBAB for Women’s Human Rights**³⁵²

An unfortunate outgrowth of user fees is the detention of women who are unable to pay for the maternal health-care services they have received until they find the necessary funds. The fear of being detained could discourage pregnant women from seeking skilled maternal care. Even those that do have the courage to seek professional treatment during delivery may risk foregoing postnatal care in order to escape detention. During an FGD, a participant stated that she knew of a woman who fled from the hospital after a caesarean section without waiting to have the stitches removed because she could not pay the fees: “In the night, while we were all sleeping, she sneaked away.”³⁵³

Not only do these detentions showcase the inadequate funding of the health sector by the government, but they also violate the right to dignity of the women who are affected.³⁵⁴ Moreover, this trend sets back the Government’s Integrated Maternal, Newborn and Child Health Strategy, 2007, the objective of which is to ensure that 70% of deliveries occur in health facilities by 2015.³⁵⁵

Existing Limitations in Cases Where User Fees Have Been Removed

Incomprehensive Waivers of User Fees

Some Nigerian states and local government areas (LGAs) have taken steps to reduce the negative impact of user fees on pregnant women by offering free maternal health-care services.³⁵⁶ These efforts, however, are crippled by serious limitations, and the experiences of pregnant women who seek care remains shaped by their financial ability, their level of education, and their place of residence.

These experiences also reflect the inadequacy of the nation's facilities and the gaps that exist in referral chains.

Regarding financial ability, many interviewees observed that the imposition of fees for services still constituted barriers to access. A senior official of the Federal Ministry of Health confirmed that while some state governments were providing free maternal health-care services, in most instances they did not offer "total packages" where every aspect of health care was free (doctor's office visits, consultations, prescriptions, and follow-up visits).³⁵⁷ This was reiterated by civil society members during a focus-group discussion.³⁵⁸ One participant noted that user-fee waivers often covered some but not all types of care. Thus antenatal, intra-partum and postnatal care were not all offered for free at all times.³⁵⁹ Another participant recalled a 2004 visit to a health centre in Abia State, where he saw a woman in labour who needed a caesarean section.³⁶⁰ She had not been transferred to a better-equipped hospital because she could only afford free services, which only her current facility offered. Initiating a conversation with the hospital staff about her plight, he asked about the cost of transferring her and whether it could be compared with how much her life was worth. Had he not stepped in, he noted, the woman probably would have died. He attributed this incident to the fact that while public hospitals are required to apply the government's user-fee waivers, private hospitals have no such obligation. This creates a gap in the referral chain. As a result, women who cannot afford to pay for services do not receive the quality of care that would reduce their susceptibility to serious harm or death.³⁶¹

In many cases, user-fee waivers cover visits to the doctor's office but not the related prescriptions. For instance, a 31-year-old mother of four who was visiting Massey Street Children's Hospital, Lagos State for a regular check-up for her 1-year-old son³⁶² lamented the limitations of free health-care services at the facility. Medical tests had to be paid for, and although medicines were to be given out free of charge, those medicines that cost over NGN 200 (approximately USD 2) were consistently out of stock. This is known as the "out of stock syndrome." Another pattern was for the staff at the hospital pharmacy to refer patients to other pharmacies where the medicines could be purchased; in many instances, they had an affiliation with these pharmacies and enjoyed personal gains from such referrals. Furthermore, a pharmacist at State Hospital, Ijaiye stated that there were no free or government-subsidized medicines for pregnant women.³⁶³

The fact-finding processes of this report revealed the co-existence of pharmacies where medicines were free and pharmacies where they were for sale in the same hospital. We also learned that the occurrence of the "out of stock syndrome" was significantly higher at the pharmacies where medicines were dispensed free of charge.

Inadequate Planning of the Introduction and Sustainability of User-Fee Waivers

Barriers to the introduction and sustainability of user-fee waivers include the need for systemic capacity-building and advocacy efforts by the government. A senior official of the Federal Ministry of Health stated that some of the states where user fees had been waived lacked the systemic capacity to sustain the waivers.³⁶⁴

Dr. Mairo Mandara, an obstetrician and gynaecologist who spoke with WARDC/CRR, stated that she had travelled throughout northern Nigeria to advocate for free maternity services.³⁶⁵ Although the response was frequently positive, she also encountered serious challenges to implementation. For instance, large amounts of drugs were being released and completely used up in 1.5 to 2 days, and the paperwork needed to account for the use and distribution of the medicines was overwhelming. In addition, small clinics that regularly saw three to five patients per day were seeing about fifty to sixty patients on days during which services were free. In Kaduna State, it became clear that removal of user fees was a first step that must be followed immediately with other services; once fees are waived, the use of hospitals becomes overwhelming and unsustainable without a backup plan.³⁶⁶

Another challenge is the provision of an adequate number of skilled health-care providers to handle the huge influx of women that accompanies free services. Dr. Mandara explained that while Kano State had responded to advocacy requesting the increase of the budget line for maternal health, the region did not have enough nurses and midwives to handle the increased demand for maternal health care. She explained that the government is accountable for the staffing shortage, for it stems from the limitations placed by the Federal Ministry of Health and the Nursing and Midwifery Council on the number of midwives and nurses that may graduate each year. As a result of these regulations, she noted, that two years ago, Bauchi State only produced seven nurses. She concluded, “I love free maternity services; I think it is a good strategy but it must be done with our eyes wide open, knowing there will be lessons of implementation learned within the first year.”³⁶⁷

Other Costs

Apart from user fees and incomprehensive user-fee waivers, Nigerian women face other costs and barriers while seeking access to maternal health-care services.

Lists of Out-of-Pocket Supplies

Pregnant women in Nigeria often find that health-care facilities have a list of items that they must pay for out of pocket, which constitutes a hidden cost that women bear even when user fees are waived. The content of these lists varies from one hospital to the next, but usually includes Dettol and Izal (antiseptics), bleach, cotton wool, plaster, gauze, syringes, flasks (for drinking), and sanitary pads.³⁶⁸ Most of these items should be available in adequately equipped health-care centres. Furthermore, these lists demand specific brands, forcing pregnant women to re-purchase items that they already own in a different brand. An interviewee described the experience of a pregnant woman who had bought a pair of gloves, as requested, but was refused admission and care until she purchased the brand specified by the hospital.³⁶⁹ The interviewee explained that nurses justify brand demands by stating that they must ensure the use of high-quality products. Yet patients, the interviewee explained, named a different rationale: the demands allowed the nurses to stock up on leftover supplies from previous patients and to sell these products to the new patients.³⁷⁰ Such conduct points to corruption and to an unregulated or unmonitored health system that allows its occurrence.

Requiring pregnant women to provide a list of items before accessing necessary and life-saving care has a disproportionate impact on poor women, who may be unable to afford some or all of the required items. Moreover, such lists only exist at public hospitals, which poor women are more likely to use because of the high cost of private facilities. The discriminatory impact of these lists contributes to the high number of maternal deaths and constitutes a violation of the rights of women.

REQUIRING PREGNANT WOMEN to provide a list of items before accessing necessary and life-saving care has a disproportionate impact on poor women.

COMPULSORY SPOUSAL BLOOD DONATION ... subjects the wellbeing of a pregnant woman to her husband's decision to donate or withhold his blood.

Lack of Clarity Regarding Payments and the Absence of Itemized Billing

Pregnant women who access maternal health-care services face uncertain costs, even when user fees have been waived, which has the potential to dissuade a poor or financially struggling woman from seeking maternal care. The ambiguity stems from the absence of information needed to determine and plan the affordability of such costs. An interviewee bemoaned the billing practices at public hospitals, stating that bills for maternal health-care services are usually not itemized.³⁷¹ While it is possible to ask for an itemized bill, she explained, such a service is purely discretionary and one must plead with the nurses to obtain billing information from the doctors. The inability of women to ascertain which services they are paying for hides mistakes and encourages the use of corrupt billing practices. Section One of this report, which focuses on corruption in the health sector, further highlights its prevalence in the country.

Compulsory Spousal Blood Donation

Haemorrhage is the leading cause of maternal mortality in Africa and is responsible for 34% of maternal deaths in the continent.³⁷² It is also the leading cause of maternal death in Nigeria,³⁷³ where the weak referral systems, inadequately equipped health centres, bad roads, and scarce means of transportation impede access to emergency obstetric care (EOC). The Nigerian policy on blood donation requires that all donations be voluntary.³⁷⁴ However, social norms and the screening and administrative charges levied on blood recipients, which lead voluntary donors to think their blood is being sold, have led to a shortage of willing donors. Thus, “family replacement donation” is a principal means of blood collection.³⁷⁵ This has significant consequences for pregnant women.

Focus-group discussion participants stated that pregnant women who attempt to access maternal health-care services at many public or government hospitals are required to bring their husbands to donate blood.³⁷⁶ This is a compulsory requirement that is contrary to the policy on voluntary blood donation. While patients may sometimes opt out by paying a fee, this option is not always made known. A consultant in pediatrics and gynaecology stated that compulsory spousal blood donation was advantageous for pregnant women since it made blood available at a cheaper rate, noting that while private hospitals did not make this demand, they conducted blood transfusions at expensive rates.³⁷⁷ Indeed, to the extent that many cases of maternal mortality from haemorrhage would have been avoided if there was no shortage of blood for transfusion, this requirement may be viewed as a proactive step by health-care centres. However, there is evidence that hospitals are not always equipped to screen the blood they receive, which results in the prevalence of unsafe blood.³⁷⁸ The requirement also underscores the fact that the health sector is inadequately equipped and largely dysfunctional; pregnant women are required to supply blood that they may or may not need and are denied care if they cannot provide or pay for blood.

Compulsory spousal blood donation can potentially have multiple negative consequences on pregnant women who are unable or unwilling to compel their husbands to donate blood. These consequences include: husbands' refusal to permit their wives to access antenatal, intra-partum, and postnatal services; women's exposure to domestic violence if they attempt to compel their husbands to donate blood; and the effective imposition of a mandatory HIV/AIDS test for the husbands, who know that their blood will be screened for the virus. Moreover, the practice has a discriminatory impact on the poor, who may prefer to pay—but be unable to afford—a fee in lieu of blood donation. It also subjects the wellbeing of a pregnant woman to her husband's decision to donate or withhold his blood.

Hope's experiences reveal the barriers to care posed by compulsory spousal blood donation. When Hope was two months pregnant, she went to a public teaching hospital, where she felt she would get the best medical advice on how to manage her fibroids. She immediately encountered the blood-donation requirement: "I said I wanted to register and wanted to see a doctor. For them to even start attending to me the first [thing] I had to do was to get my husband to donate blood and then after that, the nurse starts a series of antenatal [tests]. I asked if my husband doesn't want to donate blood, what do they expect me to do? And they said he had to." For personal reasons, Hope's husband was not willing to donate blood, and she was told that no one else could donate in his stead. Hope then went to a Catholic hospital for pregnant women, where the staff told her that they would ask her husband to donate blood at a later stage. However, she was not confident about the quality of care she would receive there:

*Though I told them I had fibroids, I knew deep down in my heart that the teaching hospital had the experts [and] professionals. At the Catholic hospital they would have to invite a specialist [from a teaching hospital] to see me. Deep down I knew I wasn't getting all the care I wanted. [A]t about 5 months, I felt this pain and I rushed to the Catholic hospital. They didn't want to touch me because of the fibroids. They were afraid. . . .*³⁷⁹

Hope lost the pregnancy. She later learned that the teaching hospital allowed fees in lieu of blood donation; she was never told of that option during her visit there.³⁸⁰

The blood-donation requirement also disadvantages pregnant women who are unmarried, or whose husbands become ill, abandon them, or pass away during the course of the pregnancy. These women have no option but to pay the fee in lieu of blood donation, which can be as high as NGN 11,000 (over USD 90), according to an FGD participant who is a member of the nursing staff at Lagos University Teaching Hospital. This fee serves as yet another obstacle that prevents poor women from accessing maternal health-care services. The discriminatory effects that it has on poor and single women include diminished access to reproductive health services, inferior care, and worse health outcomes.

Infrastructural and Institutional Barriers

Unpredictable complications occur in about 15% of all deliveries. This statistic makes skilled attendance during delivery a critical necessity for all pregnant women, since it is difficult to predict who will develop a life-threatening complication.³⁸¹ Skilled attendance includes access to a qualified health-care provider for prenatal and delivery care, as well as operating in a health centre with adequate referral services to a more advanced facility if needed.³⁸² The UNFPA outlines the multifaceted nature of the term "skilled attendance":

*Skilled attendance denotes not only the presence of midwives and others with midwifery skills . . . but also the enabling environment . . . they need in order to perform capably. It also implies access to a more comprehensive level of obstetric care in case of complications requiring surgery or blood transfusions.*³⁸³

Thus, "skilled attendance" includes not only the presence of properly trained personnel, but also the existence of adequate infrastructure and institutional capacity for maternal health-care services. The lack of these necessities in Nigeria can have grave consequences for women.

Sub-Standard (Maternal) Health-Care Facilities and Services

When I was at ABU Zaria, routinely I had a torch-light in my bag because if the light goes off during a C-section, I would have to take it out and continue.

– Dr. Mairo Mandara, Obstetrician and Gynaecologist³⁸⁴

Before I had spent 2 hours in the hospital they gave me oxytocin. They wanted me to hurry up and go into labour so someone else could take over my bed.

– Kuti Folake, BAOBAB for Women's Human Rights³⁸⁵

The use of malfunctioning or outdated hospital equipment is commonplace in Nigeria.³⁸⁶ A national study on the availability and quality of the nation's EOC facilities found that private facilities were better equipped than public or government facilities. It found that only 4.2% of public facilities and 32.8% of private facilities (and only 18.5% of both public and private facilities) met the internationally agreed-upon standards for emergency obstetric care.³⁸⁷ As noted in the introduction, the three tiers of government are responsible for three levels of health care. Thus the local, state, and federal governments are mandated to provide primary, secondary, and tertiary health-care services, respectively. The secondary and tertiary health systems consist of referral institutions; thus, they should have more advanced facilities and the ability to tackle more difficult cases than primary health centres. However, the study found that less than one third of the public secondary and tertiary health centres met the international standards for comprehensive emergency obstetric care.³⁸⁸

Power outages are common and constitute serious problems at health centres, since the Power Holding Company of Nigeria (formerly the National Electric Power Authority)—the sole body in charge of power supply in the country—operates well below standards. As a result, health centres must acquire power generators to provide electricity when a power outage occurs. When a health centre is unable to purchase or maintain a generator, medical personnel are stretched to the limits of their skills. For example, Dr. Mairo Mandara, an obstetrician and gynaecologist, recalled being forced to continue a caesarean section with a flashlight when a power outage occurred.³⁸⁹ Likewise, a doctor at the Massey Street Children's Hospital, Lagos identified constant power failure as a barrier to quality care at the hospital.³⁹⁰ The issue of poor power supply, like most other problems in Nigeria, owes much to the corruption that stems from the nation's overwhelming lack of accountability and political will to implement effective changes.³⁹¹

The poor quality of maternal health-care facilities, particularly in public hospitals, increases the risks of maternal morbidity and mortality. Moreover, it constitutes a violation of the right to health by the government, particularly of its obligation to ensure the quality of health-care facilities and services as an essential element of the right to health.³⁹²

Shortages of Health-Care Staff and Negative Attitudes among Providers

Health workers' training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy.

– Paul Hunt, the United Nations Special Rapporteur on the right to the highest attainable standard of health³⁹³

The drip [IV] would finish, my blood will be flowing back into the [IV] pack, I would be shouting and there is no one to attend to me.

– **Kuti Folake, BAOBAB for Women's Human Rights**³⁹⁴

Women who have scaled the hurdles of locating and reaching a health-care centre, and who are prepared to endure the long wait, must also brave the negative attitudes of many health-care providers, particularly at public hospitals. For example, one FGD participant recounted her experience at the Lagos University Teaching Hospital during the delivery of her first child. Because there were two doctors and four nurses attending to eleven pregnant women at the time, she lacked proper assistance when the intravenous drip she was receiving finished. No one came to turn it off, and it began drawing her blood back into the packet. She screamed for help, but there was no one to attend to her. Afterwards, when she asked the doctors why they had allowed this to happen, they stated that there were too few of them treating too many people.³⁹⁵ Sadly, pain and neglect are not uncommon in the experiences of pregnant women at public health centres, as similar findings show.³⁹⁶

There is evidence that women do not seek maternal health care at hospitals and clinics due to prior embarrassing experiences or the fear of being humiliated by the health-care staff.³⁹⁷ A six-month pregnant interviewee³⁹⁸ who had registered at a private hospital explained that the discouraging attitude of health-care workers at public/government hospitals had influenced her decision. With dramatic differences between the costs of delivery in private hospitals (NGN 50,000, or approximately USD 400) and public hospitals (NGN 15,000 to 20,000, or approximately USD 130 to 150), or the cost of traditional birth attendants (TBAs) (NGN 5,000, or approximately USD 45), many women cannot afford private hospitals like this interviewee could. Accordingly, the negative attitude of health-care workers contributes to maternal mortality by discouraging women from seeking skilled attendance during delivery. Indeed, while the link between poverty and heightened patronage of TBAs is distinct, this report found that the added role of women's experiences at public hospitals was significant. Government officials, health professionals, and members of the public commonly assume that women prefer TBAs. However, upon further scrutinizing the issues during interviews and FGDs, it became evident that some women view using TBAs not as a preference but as a necessity due to lower and flexible modes of payment, as well as their constant availability and positive attitude. Validating these findings, a TBA who was interviewed for this report confirmed that women prefer to give birth in hospitals and that while she charged NGN 5,000 (approximately USD 45), she sometimes allowed women to pay this fee later.³⁹⁹

The negative attitude of health-care staff can be attributed in part to being understaffed, overworked, and underpaid.⁴⁰⁰ Regarding understaffing, one local government official explained that clinics were closed at night and on weekends in his local government area, and women who went into labour at these periods had no choice but to patronize TBAs. He further observed that some clinics had only one nurse running them and noted that understaffing limited access: "If we had at least two nurses in a clinic, they could take shifts, but when there is just one person he is overworked, and if he is not around there is no access to health-care services."⁴⁰¹

"Brain drain" in Nigeria's health sector is often cited as a core reason for understaffing, which helps obscure the government's responsibility in the matter. While brain drain has indeed contributed to the shortage, it is important to note that the dearth of adequately paying jobs in the country has influenced the decision of medical personnel to migrate.⁴⁰² Doctors also consider the government's inability to

DURING THE DELIVERY of her first child... she screamed for help, but there was no one to attend to her.

THESE LENGTHY WAITING PERIODS

are a consequence of inadequate health-care financing, which has led to a gross shortage of staff and a lack of equipment with which to administer necessary care to patients.

maintain the primary and secondary health-care sectors a major cause of brain drain.⁴⁰³ The lack of sufficient health staff and the overworking of the available few can be traced to the government's reluctance to hire more staff than it wants to pay. This has the effect of overworking what few doctors are available; already underpaid, they have no incentive to remain cordial under pressure.

A doctor at the Massey Street Children's Hospital, a public hospital in Lagos, indicated that he often saw about one hundred patients each day.⁴⁰⁴ When asked if he was adequately compensated, he responded that all health professionals were underpaid in Nigeria. Regarding the quality of care dispensed, he stated, "Considering the limitations, it's good." The limitations to which he was referring include lack of equipment and constant power outages. These factors are more likely to occur in the public health sector and not in the private sector, where patients pay much more for services.

As earlier noted, the CESCRC has interpreted the right to health to include the underlying determinants of health, such as "trained medical and professional personnel receiving domestically competitive salaries."⁴⁰⁵ Thus, by inadequately compensating what few doctors remain at public hospitals, the Nigerian government is failing in its obligation to guarantee the right to health.

Long Waiting Periods

Long waiting periods at health-care centres are widely acknowledged and lamented in Nigeria. A participant in an FGD noted that the distant location of health centres and the large number of people waiting to be attended to usually forces patients to spend the entire day there. In fact, they may not even see the doctor at the end of the day. She observed, "When I go to the teaching hospital, I know I'll spend the whole day there. I could get there by 7:30 am and pick number 100."⁴⁰⁶ She concluded by stating that most women could not afford to waste an entire day in that manner.⁴⁰⁷ A 31-year-old mother of four who had visited Massey Street Children's Hospital, Lagos State for a regular check-up for her 1-year-old son told us that she had been at the hospital from 7 am to 4 pm the previous day and had not been attended to.⁴⁰⁸ Although her residence was a two-and-a-half-hour drive from the hospital, she had returned to make another attempt to obtain care for her child.

In the Nigerian context, many women are wage earners and care givers who are unable to spend such long periods of time in order to access health care. These lengthy waiting periods are a consequence of inadequate health-care financing, which has led to a gross shortage of staff and a lack of equipment with which to administer necessary care to patients. A consultant in pediatrics and gynaecology lamented to CRR/WARDC the fact that the Island Maternity Hospital, which sees several hundred thousand pregnant women per month, had just five consultants.⁴⁰⁹ In addition, a local government official, while commenting on the causes of the high maternal mortality rate in Nigeria, observed that most local government areas, especially his own, lacked equipment and were short staffed.⁴¹⁰ He admitted that at times a single nurse might run an entire clinic, even though some of the available equipment must be manned by doctors, because of the low availability of physicians. He also noted that clinics were usually closed on weekends and that any emergency arising at these times would have to be dealt with elsewhere.

To the extent that long waiting periods contribute to maternal mortality and morbidity, the Nigerian government has violated its obligation to ensure the availability, accessibility, and quality of health-care services.⁴¹¹

Location of, Distance from, and Transportation to Health Centres

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

– **Committee on the Elimination of All Forms of Discrimination against Women**⁴¹²

I delivered my baby at Asokoro hospital—if you must be attended to, you have to be there before 5 am. You go from one table to another, up to five of them, before a doctor attends to you. If I had a hospital where I live, what would I be doing in Asokoro?

– **Christabel, Excellent Women International Forum, a Lagos-based NGO**⁴¹³

The location of and long distance to health-care centres, particularly primary health-care facilities, and the lack of reliable and affordable means of transportation in Nigeria constitute one of the major infrastructural barriers that pregnant women encounter in accessing health care. These factors are especially damaging for rural women, who are even further removed from essential maternal health-care centres and services than women in urban areas.⁴¹⁴ For instance, an interviewee noted that many rural women in Ibeju-Lekki LGA, Lagos State, who go into labour must climb onto “okadas” (motorbikes that have been transformed into public transportation) or find unreliable “kabu kabus” (private car owners who use their cars, which are often in states of disrepair, as public taxis when they need to make extra money).⁴¹⁵ Some of these rural women live in riverine areas that can only be accessed by jeep during the rainy seasons due to the difficult terrain. Furthermore, for these women, the nearest tertiary institution for referral is 40 km away.

Situations like the one in Ibeju-Lekki are common in the country, which constitutes a violation of the Nigerian government's obligation to ensure the availability and accessibility of health-care services as essential elements of the right to health. The Economic, Social and Cultural Rights Covenant has interpreted accessibility of health care to include physical accessibility and requires governments to ensure that medical services “are within safe physical reach, including in rural areas.”⁴¹⁶

UNSAFE ABORTION: A MAJOR CONTRIBUTOR TO THE HIGH RATE OF MATERNAL MORTALITY IN NIGERIA

Of the main causes of maternal mortality, unsafe abortion is the single most preventable cause of death.

– *Sixth Periodic Report of Nigeria to the CEDAW Committee*⁴¹⁷

ABORTION IN NIGERIA

Nigeria's abortion law is among the most restrictive in the world, permitting abortion⁴¹⁸ only to save the pregnant woman's life.⁴¹⁹ Even this limited exception is frequently unavailable. In Nigeria's latest periodic report to the CEDAW Committee, which will be addressed this year (2008), the government emphasizes that it has "one of the only national reproductive health policies in sub-Saharan Africa that recognizes that women have a legal right to abortion in certain circumstances," but admits that "few or no public health services yet offer such services."⁴²⁰

A majority of the abortions that are performed in Nigeria are unsafe,⁴²¹ partly because of the nation's restrictive legal context.⁴²² For example, it has been estimated that 456,000 unsafe abortions take place annually in Nigeria.⁴²³

Additionally, in the latest periodic report, the government states that unsafe abortions lead to about 34,000 deaths each year.⁴²⁴

A 2006 Federal Ministry of Health report estimated that for every unsafe abortion that results in death, another thirty women suffer long-term injury and disability.⁴²⁵

Lack of contraceptive access contributes to the prevalence of unsafe abortion, with the usage rate of modern contraceptives estimated to be between 8.9% and 11.6%.⁴²⁶ A recent study found that 60% of women who have had abortions reported that they were not using family planning techniques when they became pregnant.⁴²⁷

Unsafe Abortion Violates the Rights to Life and Health

The direct connection between unsafe abortion and high death rates has led the Human Rights Committee, which interprets the Civil and Political Rights Covenant,⁴²⁸ 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 to ensure that they do not have to undergo life-threatening clandestine abortions."⁴²⁹

Furthermore, the CEDAW Committee has 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.⁴³⁰ 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."⁴³¹

It is important to note that the Maputo Protocol provides in Article 14(2)(c) that a state's obligation to guarantee the right to health includes protecting "the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother."⁴³² Although Nigeria is a party to the protocol, the nation's laws do not yet uphold this commitment.

Unsafe Abortion Violates the Right to Non-Discrimination

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 losing [sic] their lives.

– *Sixth Periodic Report of Nigeria to the CEDAW Committee*⁴³³

The African Charter, which has been incorporated in Nigeria (see Section Five), prohibits any discrimination on the basis of "fortune" or other status in the enjoyment of the rights that it guarantees,⁴³⁴ including the right to health.⁴³⁵ Furthermore, the Maputo Protocol requires the nation's government to "take corrective and positive action in those areas where discrimination against women in law and in fact continues to exist."⁴³⁶

However, poor and low income women are disproportionately represented in the number who resort to—and die from—unsafe abortion. Research shows that while 66% of Nigerian women who are not considered poor access abortion through medically trained professionals in health centres, only 44% of their poor counterparts are able to do the same.⁴³⁷ Moreover, although one in four women who have abortions experience serious complications, only one third of these women seek treatment, largely due to the high cost of such care: NGN 1,805 (approximately USD 115).⁴³⁸

Human Rights, Legal, and Policy Framework

The Nigerian government has undertaken international and regional obligations to take concrete and immediate steps to reduce and eventually eliminate preventable maternal deaths. These commitments stem from international laws and treaties that the government has ratified, as well as international guidelines or policies towards effectively implementing these laws. The government has also assumed such obligations by ratifying regional laws and the guidelines and policies that promote their implementation. In addition, various constitutional and national laws impose similar duties and responsibilities.

The international and regional policies described in this report convey the standard of action that the participating states have committed themselves to undertake in order to protect the human rights of each individual. At the national level, Nigeria has developed various policies to guide its standard of health-care provision for all segments of the population, including those specifically geared towards the provision of reproductive health care. While these policies are not legally enforceable, they serve as guidelines for conscientious governments, and as concrete measuring tools for holding inefficient governments accountable. Most of the relevant policies are identified in this section and analyzed in subsequent sections of this report. This section addresses rights related to maternal health in general. Rights relating specifically to family planning and abortion are discussed in greater detail in Sections Two and Four.

International and Regional Standards

Several regional treaties—the African Charter,⁴³⁹ the African Charter on the Rights and Welfare of the Child (Children’s Charter),⁴⁴⁰ and the Maputo Protocol—provide important protections for the reproductive health of women and girls in Nigeria. Nigeria domesticated the African Charter in 1983.⁴⁴¹ As a result, its provisions have the force of law in Nigeria and must be implemented by the legislative, executive, and judicial arms of government.⁴⁴²

Nigeria has also confirmed its commitment to upholding international human rights standards by becoming a party to several major global treaties, including the Civil and Political Rights Covenant,⁴⁴³ the Economic, Social and Cultural Rights Covenant,⁴⁴⁴ CEDAW,⁴⁴⁵ the Convention on the Rights of the Child (Children’s Rights Convention),⁴⁴⁶ and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.⁴⁴⁷ A state that ratifies or accedes to an international convention “establishes on the international plane its consent to be bound by a treaty.”⁴⁴⁸ The government of Nigeria is therefore obligated under international law to protect the rights guaranteed by these instruments. However, with the exception of the Children’s Rights Convention, Nigeria has failed to domesticate the provisions of these international treaties through national-level laws.⁴⁴⁹ Nigeria has also ratified the Optional Protocols to the Civil and Political Rights Covenant and CEDAW, which permit individuals to submit claims of rights violations directly to the relevant monitoring body, as established by each treaty, after exhausting domestic remedies.

SEVERAL REGIONAL TREATIES—the African Charter on Human and Peoples’ Rights, the African Charter on the Rights and Welfare of the Child, and the African Charter’s Protocol on the Rights of Women in Africa—provide important protections for the reproductive health of women and girls in Nigeria.

Protected Rights

The government of Nigeria is legally bound to respect, protect, and fulfil the following rights pursuant to the international and regional conventions it has ratified.

The Rights to Life and Health

International and regional conventions repeatedly recognize the fundamental rights to life and to the highest attainable standard of health, and impose an obligation on states to enforce these rights.⁴⁵⁰ The African Charter, for example, states: “Every individual shall have the right to enjoy the best attainable standard of physical and mental health. States Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”⁴⁵¹ The Maputo Protocol specifically calls upon states to “ensure that the right to health of women, including sexual and reproductive health is respected and promoted.”⁴⁵² In addition, the Nigerian constitution specifically protects the right to life and recognizes the right to health, although in a non-justiciable context.⁴⁵³

As indicated above, the right to health encompasses physical, mental, and sexual health.⁴⁵⁴ The Economic, Social and Cultural Rights Covenant contains the most comprehensive provisions regarding the right to health under international human rights law.⁴⁵⁵ 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,⁴⁵⁶ including the reduction of still birth and infant mortality⁴⁵⁷ and guaranteeing that medical services and medical attention are available to all.⁴⁵⁸ The covenant also requires the government to ensure that special measures are taken to protect a mother during a reasonable period before and after childbirth⁴⁵⁹ and obligates the government to recognize the right to enjoy the benefits of scientific progress and its applications.⁴⁶⁰

Expounding on governmental obligations in the reproductive health context, the Committee on Economic, Social and Cultural Rights (CESCR) has explained that Article 12(2)(a) requires states to take

*measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.*⁴⁶¹

In addition, the Committee has stated that the right to health envisaged in Article 12 encompasses access to health-related education and information, including education on sexual and reproductive health.⁴⁶² The CESCR has further stated that an essential component of the right to health is the availability, accessibility, acceptability, and quality of health facilities, goods, and services.⁴⁶³

The Maputo Protocol calls upon states to provide adequate, affordable, and accessible health services to women and to establish and strengthen prenatal, delivery, and postnatal health and nutritional services for women during pregnancy and breast-feeding.⁴⁶⁴ Similarly, CEDAW requires states to “ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary,” and to empower women to “decide freely and responsibly on the number and spacing of their children, and to have access to the information, education and means to enable them to exercise these rights.”⁴⁶⁵ The CEDAW Committee has also

emphasized the need for governments to monitor the quality of their nations' health services⁴⁶⁶ and to make sure that such services are “delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.”⁴⁶⁷ Moreover, the Children's Rights Convention affirms the right to “necessary medical assistance and health care,” “appropriate pre-natal and post-natal health care for mothers,” and “family planning education and services,”⁴⁶⁸ while the Children's Charter protects the reproductive health of women by requiring the government to “ensure appropriate health care for expectant and nursing mothers.”⁴⁶⁹

The CESCR interprets a State's obligation to *respect* the right to health, guaranteed in Article 12 of the Economic, Social and Cultural Rights Covenant as an obligation to refrain from interfering directly or indirectly with its enjoyment.⁴⁷⁰ Corruption by public officials interferes with pregnant women's enjoyment of the right to health by depleting the limited resources that would have built, equipped, and staffed health centres and ensured adequate provision of and access to services.

The CESCR also interprets a state's obligation to *protect* the right to health as a duty to take measures that stop third parties from interfering with the right.⁴⁷¹ The imposition of informal fees by health-care providers, as well as the distribution of fake drugs by pharmaceutical companies, interferes with the accessibility and quality of maternal health services. These issues show that the government has not appropriately ensured the observance of ethical codes of conduct by health-care providers, nor has it controlled the marketing of medicine by third parties, both of which are components of the obligation to protect the right to health.⁴⁷²

Likewise, a state's obligation to *fulfil* the right to health requires the adoption of appropriate legislative, administrative, budgetary, judicial, promotional, and other measures.⁴⁷³ By failing to enact laws that would foster accountability and transparency, particularly on the disbursement and use of funds, and by not providing the minimum budgetary allocation required for the provision of an adequate number of maternal health-care centres, the Nigerian government fails in this obligation.⁴⁷⁴ Consequently, it is in violation of various international and regional treaties and national laws that have been developed to obligate states to prevent and criminalize corruption and to punish offenders.

The Right to Non-Discrimination

The rights to equality and non-discrimination—regardless of gender, age, or financial resources—are bedrocks of human rights doctrine and fundamental principles of international and regional law.⁴⁷⁵ Every human right discussed in this section must be exercised without discrimination.⁴⁷⁶

The African Charter not only declares that all individuals are “equal before the law,” but also specifically requires states to “ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.”⁴⁷⁷ Similarly, the Maputo Protocol calls upon states to reform laws and practices that discriminate against women.⁴⁷⁸

International standards emphasize the need for equality in “access to health care services, including those related to family planning.”⁴⁷⁹ The right to health is subject to progressive realization and resource availability,⁴⁸⁰ but states must take “deliberate, concrete and targeted” steps towards the realization of this right, and some obligations are immediate and not subject to resource availability.⁴⁸¹

The minimum core government obligations that the CESCRC has recognised include the duty to “ensure reproductive, maternal (pre-natal as well as post-natal), and child health care.”⁴⁸² Similarly, in its 2007 Concluding Observations, the Children’s Rights Committee recommended that another African government give all pregnant women health and social services free of charge.⁴⁸³

With regard to economic access, the CESCRC has stated that “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.”⁴⁸⁴ Thus, the governmental duty to protect health includes taking measures to ensure that private health-care facilities provide services that meet the state’s human rights obligations.⁴⁸⁵ Nigeria must “ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services” for all women.⁴⁸⁶

CEDAW obligates the government to take steps to eliminate discrimination against women and to ensure that they have equal access to “specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.”⁴⁸⁷ In addition, it requires that the government take steps to ensure that women do not face inequality as they access health-care services.⁴⁸⁸

The needs of rural women also receive special attention under CEDAW, which obligates governments to address their specific needs and to guarantee rural women freedom from discrimination and equal access to adequate health-care facilities.⁴⁸⁹

The Right to Dignity

Detention in health facilities and mistreatment by health-care providers infringe upon the right to dignity.

The right to dignity is recognized in the Nigerian Constitution⁴⁹⁰ and protected by international and regional instruments.⁴⁹¹ The African Charter states, “Every individual shall have the right to the respect of the dignity inherent in a human being.”⁴⁹² The Maputo Protocol also calls upon states to “adopt and implement appropriate measures to ensure the protection of every woman’s right to respect for her dignity.”⁴⁹³ Similarly, the Children’s Charter makes several references to the governmental obligation to protect dignity.⁴⁹⁴

The Right to Information

Please see Section One, text box: “Why the Right to Information is Central to Protecting the Right to Health.”

Policies and Declarations on Maternal Mortality Reduction

The legally binding provisions of the major human rights conventions are complemented by international consensus documents and development goals that support a globally recognized rights framework regarding maternal health.

International Declarations and Policies

At the United Nations Millennium Summit in 2000, the United Nations member states, including Nigeria,⁴⁹⁵ developed the Millennium Development Goals (MDGs), which were designed to enable the poorest countries to improve the quality of life of their citizens, and resolved to achieve these goals by 2015.⁴⁹⁶ The fifth MDG requires all member states to improve maternal health. In order to achieve this goal, a number of targets were set, including reducing maternal mortality by three quarters (75%) between 1990 and 2015.⁴⁹⁷ The National Millennium Development Goals Report published by the Nigerian government in 2004 assessed the nation's successes and challenges in taking steps to achieve the MDGs.⁴⁹⁸ It identified teenage pregnancy as a major challenge,⁴⁹⁹ and recommended establishing "a fully functional referral system between all levels of [health] care, including provision of Emergency Obstetrics Care (EOC)."⁵⁰⁰

In 2005, world leaders convened again to assess progress toward attaining the MDGs, and issued an outcome document in which they reaffirmed their commitment to the MDGs. The member states resolved to implement national development strategies to achieve the goals⁵⁰¹ and to make effective and transparent use of public funds.⁵⁰² Furthermore, they pledged to prioritize the fight against corruption at national, regional, and international levels by adopting policies that emphasize accountability and transparent public-sector management.⁵⁰³ Additionally, they committed themselves to improving health systems in developing countries in order to provide sufficient health workers, infrastructure, management systems, and supplies to achieve the health-related MDGs by 2015.⁵⁰⁴ The member states also resolved to achieve universal access to reproductive health by 2015,⁵⁰⁵ and to integrate this goal into strategies aimed at achieving the MDGs, including reducing maternal mortality and improving maternal health.⁵⁰⁶

Other international declarations and policies, such as those contained in the 1993 Vienna Declaration,⁵⁰⁷ the 1994 Programme of Action of the Cairo International Conference on Population and Development,⁵⁰⁸ and the 1995 Beijing Declaration and the Platform for Action, Fourth World Conference on Women,⁵⁰⁹ call on states to ensure the provision of maternal health-care services as part of a woman's right to health.

Regional Policies

Several recent regional policies and declarations affirm a political and financial commitment to reducing maternal mortality. In the 2001 Abuja Declaration on HIV and AIDS, Tuberculosis and other Infectious Diseases, the Heads of State and Government of the Organisation of African Unity (OAU), now the African Union (AU),⁵¹⁰ pledged to allocate at least 15% of their annual budgets towards improving the health sector.⁵¹¹ In 2006, the World Health Organization Regional Committee for Africa urged its member states to fulfil this pledge in a resolution entitled "Health Financing: A Strategy for the African Region."⁵¹² This commitment has become an integral part of Africa's health-financing strategy.

THE ABSENCE of an enforceable right to health can increase the difficulty of holding the government accountable for its failure to provide life-saving health-care services.

In the 2004 “Maputo Declaration: Together Shaping our Future,” leaders from the African, Caribbean and Pacific Group of States expressed deep concern about the high rates of maternal death in developing countries.⁵¹³ They made the commitment to reduce maternal mortality, acknowledging that doing so was a matter of social justice and human rights.⁵¹⁴

The Maputo Plan of Action was decided upon in 2006 at a Special Session of the Conference of the African Union Ministers of Health in Maputo, Mozambique.⁵¹⁵ The Maputo Plan of Action acknowledges the devastating effects of poor reproductive health in Africa, including the high maternal mortality rate, and provides a guide to escalating measures to ensure the attainment of universal access to reproductive health services by 2015.⁵¹⁶ Recognizing that sexual and reproductive health will remain inaccessible without a robust health-care system, the Maputo Plan of Action calls on governments to comply with their 2001 Abuja pledge to allocate at least 15% of their annual budgets towards improving the health sector.⁵¹⁷ It also provides for implementation strategies, which include strengthening sexual and reproductive health access, particularly in family planning, emergency obstetric care, referral services, and service-delivery equity between rural and urban regions.⁵¹⁸

National Law and Policy

The Constitution

The 1999 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 thus cannot be judicially enforced, all organs of government acting in good faith are required to apply them.⁵¹⁹ One of these objectives is to guarantee social justice—a term that includes reduction of maternal mortality under the Maputo Declaration—in Nigeria.⁵²⁰ It is also the policy of the state to ensure distribution of material resources in a way that benefits all citizens.⁵²¹ Evidence that maternal mortality affects some Nigerian women more than others because of their residence (rural vs. urban), location (north vs. south), level of education, or financial status directly contravenes this principle. Chapter II of the constitution also establishes a state policy of ensuring the adequate provision of medical and health facilities for all.⁵²²

ABSENCE OF A CONSTITUTIONAL RIGHT TO HEALTH

The tendency of states to place rights in hierarchies, construing civil and political rights as those which impose immediate obligations on the state, while viewing socio-economic rights as mere aspirations, is entrenched in the Nigerian Constitution. Consequently, the right to health is not included in chapter IV of the constitution, in which fundamental human rights guarantees are set forth. Instead, chapter II, which contains the fundamental (albeit unenforceable) objectives and directive principles of state policy, provides for the adequate provision of medical and health services for all persons under section 17(3)(d).⁵²⁶

The absence of an enforceable right to health can increase the difficulty of holding the government accountable for its failure to provide life-saving health-care services, such as antenatal, intra-partum, and postnatal care, as well as emergency obstetric care, to pregnant women. It is important to note that provision of these services would have prevented many maternal deaths in the country;⁵²⁷ skilled attendance at all births and timely

emergency obstetric care constitute two of the three best strategies for reducing maternal mortality.⁵²⁸ Nigeria has one of the world's highest incidences of maternal mortality, yet according to a seventeen-year study of the factors that contribute to maternal mortality in north-central Nigeria, most of these deaths were preventable.⁵²⁹ Other studies have reached similar conclusions.⁵³⁰

This lack of a right to health and the resulting high number of maternal deaths should be a matter of concern to the government. The United Nations Special Rapporteur on the right to the highest attainable standard of health has stated that “preventable maternal mortality also often represents a violation of a woman’s right to life.”⁵³¹ The right to life is guaranteed in section 33 of the Nigerian Constitution,⁵³² yet the government has not been called upon to account for the nation’s high number of maternal deaths, many of which are preventable. Interviewees acknowledged the close link between the right to life and the right to health. For example, one interviewee⁵³³ noted that chapter IV of the constitution makes the right to life justiciable but is silent on the issue of quality of life. She concluded that chapter IV gives life while chapter II takes it away, since the government cannot be held accountable for stating that it can only provide health care within available resources. Likewise, a senior official of the Federal Ministry of Health (FMOH) stated that while the constitution does not reflect health as a right, “health is a fundamental right and without it we are saying we have no right to live.”⁵³⁴

Observing that a constitutional review to include a justiciable right to health, even if agreed upon, would be a lengthy process, the senior official explained that the FMOH has sought a different means of ensuring the provision of health-care services: the National Health Act, a new law that focuses on the responsibilities of the different tiers of government. A bill proposing the passing of the National Health Act into law has been before the Nigerian National Assembly for over two years and is yet to be passed. The FMOH official noted that the nation’s senators, being politicians, do not necessarily appreciate the urgency and importance of the act—hence, the delay. “NGOs need to push for the Health Act to be passed,” she added, stressing that civil society should make the delay a public discourse. In May 2008, the upper house of the National Assembly of Nigeria (the Senate) passed a ‘National Health Bill 2008,’⁵³⁵ which “seeks to provide a framework for the development and management of a health system within the Federal Republic of Nigeria.”⁵³⁶ The Bill, which must also be passed by the lower house (the House of Representatives) and signed by the President before becoming law, provides for access to health-care services, but does not provide for the right to health.⁵³⁷

The absence of a right to health in the Nigerian Constitution does not release the government from its legal obligations to ensure that preventable maternal deaths do not occur. Indeed, the right to health guaranteed in Article 16 of the African Charter has the force of law in Nigeria. The 1983 African Charter on Human and Peoples’ Rights Ratification and Enforcement Act states:⁵³⁸

As from the commencement of this Act, the provisions of the African Charter on Human and Peoples’ Rights which are set out in the Schedule to this Act shall, subject as thereunder provided, have force of law in Nigeria and shall

THE UNITED NATIONS SPECIAL RAPPORTEUR

on the Right to Health has stated that “preventable maternal mortality also often represents a violation of a woman’s right to life.” The right to life is guaranteed in the Nigerian Constitution, yet the government has not been called upon to account for the nation’s high number of maternal deaths, many of which are preventable.

be given full recognition and effect and be applied by all authorities and persons exercising legislative, executive or judicial powers in Nigeria.

Thus, Article 16 of the African Charter, which guarantees the right to health,⁵³⁹ is enforceable in Nigeria and should be applied by the government.⁵⁴⁰ It is worth noting that Nigerian courts have recently indicated that jeopardizing health amounts to a violation of the right to life. In the 2005 case *Gbemre vs. Shell Petroleum Development Company and Others*,⁵⁴¹ the plaintiff sought a declaration that the defendant’s activities in his community, which had endangered and impaired the community’s residents, constituted a violation of their rights to life and dignity, as guaranteed by the Nigerian Constitution and the African Charter. The Federal High Court in Benin found in favour of the plaintiff.⁵⁴² Although this case is currently being appealed, it suggests 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.

Furthermore, the Nigerian Constitution provides for guarantees of “fundamental rights” that are fully enforceable in the courts of law. These guarantees include the right to life,⁵²³ the right to dignity,⁵²⁴ and the right to freedom from discrimination.⁵²⁵ The high incidence of maternal death in Nigeria brings these rights into focus.

National Policies and Strategies

The government has also developed policies and strategies that focus generally on health and specifically on reproductive health. These policies recognize maternal mortality as a pressing problem and acknowledge the weaknesses of the health-care system. In addition, they highlight the extent to which the government has gone—or ought to go—to reduce maternal deaths. These policies also serve as indicators of the adequacy of the measures that have been taken. However, evidence shows that they have not been effectively implemented and that their objectives have not been attained. These findings and their consequences are addressed in Section Three of this report.

Health Sector Policies

The 1988 National Health Policy and Strategy to Achieve Health for all Nigerians (1988 National Health Policy) was Nigeria’s first comprehensive health policy.⁵⁴³ It set a target of “health for all citizens by the year 2000”⁵⁴⁴ and recognized primary health care as defined⁵⁴⁵ in the 1978 Declaration of Alma-Ata as an integral part of the 1988 National Health Policy.⁵⁴⁶ It also stated that the minimum level of primary health services must include “maternal and child health care, including family planning.”⁵⁴⁷

Considering Nigeria’s three-tier system of governance, and noting that the 1979 Constitution placed most health matters on the concurrent list of responsibilities, thereby authorizing the three tiers of government to share responsibilities on matters of health,⁵⁴⁸ the 1988 National Health Policy provided for a health-care system with three levels of care: primary, secondary, and tertiary.⁵⁴⁹ 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.⁵⁵⁰

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.⁵⁵¹ The new policy states that the maternal mortality rate in Nigeria is among the highest in the world⁵⁵² and further notes that the government spends only USD 8 per capita on health, despite the international community's recommendation of USD 34 per capita.⁵⁵³

The 2004 Revised National Health Policy specifically delineates national standards for reproductive health⁵⁵⁴ 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.”⁵⁵⁵ Its objectives include reducing maternal morbidity, unwanted pregnancies, and 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.”⁵⁵⁶

The Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and Plans of Action, 2004-2007⁵⁵⁷ (2004 Health Sector Reform Programme) was developed to address priority health problems, including maternal mortality. 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.⁵⁵⁸ Moreover, 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 care⁵⁵⁹ and leaves uncertain the functions of the federal and state governments.⁵⁶⁰ 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.⁵⁶¹ It notes that the constitutional gaps have obstructed the ability of the government to fulfil its responsibility to provide health care,⁵⁶² and calls for the enactment of a national health act that would remedy this loophole.⁵⁶³ In the meantime, the programme recognizes the need to establish primary health-care facilities that are connected to secondary, referral health facilities to ensure access to emergency obstetric care, stating that this would reduce maternal mortality and morbidity.⁵⁶⁴ While the 2004 Health Sector Reform Programme identifies many of the problems of the Nigerian health sector and proffers accurate solutions, these problems still persist.

Reproductive Health Policies

The federal government has developed a number of policies and strategies on reproductive health, all of which recognize the importance of addressing maternal mortality.

Nigeria's National Reproductive Health Policy and Strategy of 2001 replaced the 1994 Maternal and Child Health Policy when it became clear that the existing policy placed greater emphasis on child health than maternal health.⁵⁶⁵ The new policy was developed to address a number of concerns, including the “unacceptably high levels of maternal and neonatal morbidity and mortality,”⁵⁶⁶ “the current fragmentation of reproductive health activities and the limited impact of existing programmes in reducing sexual and reproductive ill-health,”⁵⁶⁷ and the widespread lack of awareness and utilization of family planning services.⁵⁶⁸ The National Reproductive Health Policy and Strategy of 2001 acknowledges the low rate of access to reproductive health information and services at the primary, secondary, and tertiary health-care levels.⁵⁶⁹ In addition, it notes that while the 1998 National Health

THE 2004 REVISED NATIONAL HEALTH 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 international community's recommendation of USD 34 per capita.

Policy, if strictly adhered to, could improve reproductive health services, such implementation has not taken place.⁵⁷⁰

In order to meet its goals of reducing maternal morbidity and mortality and unwanted pregnancies by 50%⁵⁷¹ and raising the contraceptive prevalence rate from 8.6% to 20%,⁵⁷² Nigeria's National Reproductive Health Policy and Strategy of 2001 lays out a number of actions for the government to take. These measures include removing barriers to reproductive health care,⁵⁷³ improving access to EOC and post-abortion services,⁵⁷⁴ strengthening reproductive health at the primary-care level,⁵⁷⁵ increasing training of health-care personnel in reproductive health,⁵⁷⁶ and promoting access to family planning information and services.⁵⁷⁷ The policy also emphasizes the importance of providing "comprehensive (including referral), client-oriented," and "good quality, equitably accessible, affordable and appropriate" reproductive health services;⁵⁷⁸ developing a "coherent and integrated" framework of relevant policies, laws, strategies, and programmes that address reproductive health "with particular attention to priority-setting";⁵⁷⁹ 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";⁵⁸⁰ and adequately funding "reproductive health programmes through increased and timely financial contributions, [and] judicious and transparent use of funds available to the programmes."⁵⁸¹

In addition, the Federal Ministry of Health developed the Integrated Maternal, Newborn and Child Health Strategy in 2007 (2007 IMNCH Strategy). The strategy is composed of intervention packages, which address the main contributing factors to maternal, newborn, and child deaths.⁵⁸² 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.⁵⁸³ Its specific goals include ensuring that 70% of deliveries occur in health facilities by 2015,⁵⁸⁴ and that at least 70% of basic emergency obstetric care will be provided at primary health-care clinics and at general hospitals.⁵⁸⁵

The 2007 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.⁵⁸⁶ It envisages specific roles for the executive, legislative, and judicial arms of the three tiers of government in its implementation,⁵⁸⁷ 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.⁵⁸⁸

Finally, the 2004 National Policy on Population for Sustainable Development, which replaced the initial policy of 1988, includes the specific goal of "improvement in the reproductive health of all Nigerians at every stage of the life cycle."⁵⁸⁹ 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.⁵⁹⁰

Implementation strategies at all levels of the national health system include:⁵⁹¹

- The comprehensive provision of "reproductive and sexual health services that are of good quality, equitably 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.
- A strengthened and improved 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.”

Other Relevant Policies

The 2007 National Policy on the Health & Development of Adolescents & Young People in Nigeria (2007 National Adolescent Health Policy), which replaced the National Adolescent Health Policy of 1995, recognizes the importance of “promoting and protecting the reproductive health of young people,” defined as those between 10-24 years of age.⁵⁹² 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.⁵⁹³ 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%.⁵⁹⁴ 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.⁵⁹⁵

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.⁵⁹⁶ This statistic is not surprising, given the high number of married adolescents in the nation, particularly in the northern region.⁵⁹⁷ Research conducted by UNICEF found that Nigerian girls below the age of 16 succumbed to maternal death at a rate six times higher than those aged between 20 and 24.⁵⁹⁸

The National Gender Policy was developed in 2006 and aims to eliminate discrimination on the grounds of sex and, among other things, to protect the health of Nigerians as a means of achieving “equitable rapid economic growth.”⁵⁹⁹ 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,”⁶⁰⁰ reducing maternal mortality rates by at least 35%, improving reproductive health services and strengthening “gender responsive, evidence-based health systems” by 2015.⁶⁰¹

Recommendations

TO THE GOVERNMENT OF NIGERIA

- **Strengthen Nigeria’s human rights framework.**
 - Domesticating international and regional human rights treaties, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the African Charter’s Protocol on the Rights of Women in Africa (Maputo Protocol) and implement them at the national level.
 - Guarantee the right to the highest attainable standard of physical and mental health and adopt a rights-based approach to the provision of health-care services.
 - Fulfil the pledge made by the government to allocate at least 15% of the national budget to health.
 - Develop a law that clearly defines the responsibilities of the federal, state, and local governments for tertiary, secondary, and primary health care, and that accounts for the unequal resources that are available to each tier of government for the implementation of their responsibilities.
 - Develop programmes and policies to address the underlying determinants of health that are essential to prevent maternal mortality, such as participation in health-related decision-making processes, information on sexual and reproductive health, literacy, nutrition, and gender equality.
- **Establish effective accountability mechanisms to ensure that, when appropriate, public officials are subject to investigation and liability for corruption.**
- **Establish community-based health audits as a component of monitoring and accountability mechanisms.**
- **Develop disaggregated data as well as indicators and benchmarks to measure progress in guaranteeing access to reproductive health care.**
- **Improve access to information within the health-care system.**
 - Enact a comprehensive freedom of information bill that includes whistleblower protections and encourages public employees to report incidences of wrongdoing.
 - Make public the operating guidelines, standards, and procedures that govern public health facilities.
 - Develop a policy to ensure that patients can easily obtain their comprehensive medical records from private and public health facilities.
- **Ensure the design and implementation of gender-responsive health budgeting.**

- **Improve access to family planning services, including a full range of contraceptive methods. Ensure that barriers to access, such as the requirement of spousal authorization, do not hinder women’s right to use family planning services.**
- **Undertake informational and educational efforts aimed at both men and women to provide accurate, evidence-based, and comprehensive information about contraceptives and to correct commonly held misconceptions. Such efforts should include sexuality education aimed at adolescents, given high teenage pregnancy and maternal death rates.**
- **Remove financial barriers that result in the denial of or delays in receiving necessary health-care services.**
 - Publicize which services are cost exempt and ensure that they are actually free in practice.
 - Where local and state governments have committed to offer free maternity services in public facilities, provide the finances and staffing necessary to make this a reality and define explicitly which services are included. Consider developing a reimbursement strategy with private health facilities to enable them to provide free maternity services, as well.
 - Monitor practices in facilities to make certain that informal and inappropriate fees are not levied.
 - Ensure that women in need of delivery services are not turned away because they cannot pay a fee or deposit.
 - Explicitly outlaw at all health facilities the practice of detaining patients who cannot pay their medical bills.
- **Improve the waiver system (the system of removing user fees, such as payments for doctors’ visits, prescriptions, and maternal care services, instituted by some state and local governments) in public health facilities.**
 - Develop adequate, sustainable plans for the waiver system.
 - Establish clear guidelines and procedures for implementing the waiver system.
 - Publicize the existence of a waiver system and its eligibility criteria; institute protections so that determining waiver status does not delay access to care.
 - Reimburse public facilities for administering and granting waivers.
- **Develop a comprehensive strategy to address infrastructural problems, such as equipment and supply shortages, that includes:**
 - Providing ambulances or other safe, comfortable, and speedy means of transportation to health-care centres.
 - Mandating that all local and state governments equip and staff health-care centres, as opposed to continuing the practice of locking them up after they have been built.
 - Equipping health centres with alternative sources of power in case of power outages.

- **Reduce the high incidence of unsafe abortion, which is one of the primary causes of maternal mortality for women.**
 - Review and update current reproductive health policies and guidelines, including those regarding training and equipment for health providers, to guarantee access to safe abortion services within the existing law.
 - Ensure that women who develop abortion-related complications are not doubly victimized by both the health-care and the criminal-justice systems.
 - Take measures to make certain that medical professionals who provide or advocate for safe abortion are not harassed or unjustly targeted for criminal prosecutions.
- **Involve women and the community in the design and implementation of health policies aimed at improving maternal health.**
- **Distribute government guidelines addressing reproductive health services to all facilities, to women, and to the community at large and encourage their use; emphasize the importance of informed consent in these guidelines.**
- **Institutionalize continuous and permanent training programs for reproductive health-care providers in both public and private facilities. Such training programs should focus on women's reproductive rights as well as patients' rights.**
- **Address in-country differences in susceptibility to maternal death.**
 - In efforts aimed at reducing maternal death rates, ensure that heightened attention and effort is placed on those who are particularly vulnerable based on age, region of residence, level of wealth, and education.
- **Maintain an official list of existing traditional birth attendants [TBAs] and provide all TBAs with training on the importance of skilled attendance during delivery and the need to refer patients to health-care centres.**

TO ALL PUBLIC AND PRIVATE HEALTH-CARE FACILITIES

- **Protect patients' rights and promote accountability.**
 - Conduct trainings for all staff members on protecting the rights and dignity of patients; encourage health-care staff to report rights violations.
 - Post patients' rights prominently and provide complaint boxes; develop clear processes for lodging and redressing complaints and make this information readily available to patients.
 - Ensure that all health-care staff wear badges with their names and positions prominently displayed.
- **Establish payment policies that are fair and transparent and that safeguard patients' health.**
 - Do not turn away women seeking delivery care because they cannot pay a fee or deposit.

- Immediately stop the practice of detaining patients who cannot pay their medical bills; release all patients who are currently being detained.
- Ensure that women and their families are not required to bring supplies for delivery or other reproductive health services. Post the fee schedule for services in a prominent location and make certain that patients understand these fees.
- Stop requiring compulsory spousal blood donation before women can receive maternal health-care services.

TO THE WORLD BANK AND INTERNATIONAL MONETARY FUND

- **Examine the human rights consequences of conditions placed on funding and take the necessary steps to ensure that these conditions do not result in rights violations, such as detention for inability to pay medical bills. Make certain that these conditions do not weaken the health-care system in other ways, such as by making it impossible to hire sufficient numbers of qualified medical staff.**

TO THE INTERNATIONAL DONOR COMMUNITY

- **Monitor the expenditure of grants and demand transparency and accountability in their use.**

TO INTERNATIONAL AND AFRICAN HUMAN RIGHTS BODIES

- **Use the occasion of Nigeria’s periodic reports to the treaty-monitoring bodies to issue strong Concluding Observations and Recommendations in order to reinforce Nigeria’s obligations to protect women’s rights when seeking reproductive health-care services and to provide redress and remedies for violations of these rights.**

TO CIVIL SOCIETY ORGANISATIONS

- **Heighten advocacy efforts aimed at maternal mortality and identify opportunities to bring cases to the courts to determine whether human rights violations have occurred.**
- **Canvass for an open, transparent, and engendered budget.**
- **Design strategies to hold the government accountable to its international and regional commitments.**

Endnotes

- ¹ Please note that all definitions in italics are lifted verbatim from the footnoted sources.
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- ⁴⁴³ International Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (*entered into force* Mar. 23, 1976) (acceded to by Nigeria July 29, 1993) [hereinafter Civil and Political Rights Covenant].
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- ⁴⁴⁵ Convention on the Elimination of All Forms of Discrimination against Women, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) (ratified by Nigeria June 13, 1985) [hereinafter CEDAW].
- ⁴⁴⁶ Convention on the Rights of the Child, *adopted* Nov. 20, 1989, G.A. Res. 44/25, annex, U.N. GAOR, 44th Sess., Supp. No. 49, at 166, U.N. Doc. A/44/49 (1989), *reprinted in* 28 I.L.M. 1448 (*entered into force* Sept. 2, 1990) (ratified by Nigeria Apr. 19, 1991) [hereinafter Children's Rights Convention].
- ⁴⁴⁷ Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *adopted* Dec. 10, 1984, G.A. Res. 39/46, U.N. GAOR, 39th Sess., Supp. No. 51, at 197, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (*entered into force* June 26, 1987) (ratified by Nigeria June 28, 2001) [hereinafter Convention against Torture].
- ⁴⁴⁸ Vienna Convention on the Law of Treaties, art. 2(1)(b), May 23, 1969, 1155 U.N.T.S. 331 (*entered into force* Jan. 27, 1980), *available at* http://untreaty.un.org/ilc/texts/instruments/english/conventions/1_1_1969.pdf. See also *Vienna Declaration and Programme of Action, World Conference on Human Rights*, Vienna, Austria, June 14-25, 1993, U.N. Doc. A/CONF.157/23, para. 1 (1993) [hereinafter *Vienna Declaration and Programme of Action*] (reaffirming "the solemn commitment of all States to fulfil their obligations to promote universal respect for, and observance and protection of, all human rights and fundamental freedoms for all in accordance with the Charter of the United Nations, other instruments relating to human rights, and international law").
- ⁴⁴⁹ See Edwin Egede, *Bringing Human Rights Home: An Examination of the Domestication of Human Rights Treaties in Nigeria*, *JOURNAL OF AFRICAN LAW*, Vol. 51, No. 2, at 273 (2007), *available at* http://works.bepress.com/cgi/viewcontent.cgi?article=1006&context=edwin_egede.
- ⁴⁵⁰ See, e.g., Universal Declaration of Human Rights, arts. 3, 25, *adopted* Dec. 10, 1948, G.A. Res. 217A (III), U.N. Doc. A/810, at 71 (1948) [hereinafter Universal Declaration]; CEDAW, arts. 10(h), 12, 14.2(b); Economic, Social and Cultural Rights Covenant, art. 12; Civil and Political Rights Covenant, art. 6(1); Children's Rights Convention, arts. 6(1), 24(1); Banjul Charter, arts. 4, 16; African Charter on Children, arts. 5(1), 14; Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, arts. 4(1), 14, *adopted* July 11, 2003, 2nd African Union Assembly, Maputo, Mozambique [hereinafter Maputo Protocol].
- ⁴⁵¹ Banjul Charter, art. 16.
- ⁴⁵² Maputo Protocol, art. 14.
- ⁴⁵³ Constitution, secs. 17(3)(d), 33(1) (1999) (Nigeria).
- ⁴⁵⁴ Economic, Social and Cultural Rights Covenant, art. 12(1); Maputo Protocol, art. 14. The UN Declaration on Violence against Women defines violence as including "physical, sexual and psychological violence." Declaration on the Elimination of Violence against Women, G.A. Res. 48/104, art. 2(c), U.N. Doc. A/RES/48/104 (1993).
- ⁴⁵⁵ Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health*, para. 2, U.N. Doc. E/C.12/2000/4 (2000) [hereinafter CESCR, *General Comment No. 14*].
- ⁴⁵⁶ Economic, Social and Cultural Rights Covenant, art. 12(1).
- ⁴⁵⁷ *Id.* art. 12(2)(a).
- ⁴⁵⁸ *Id.* art. 12(2)(d).
- ⁴⁵⁹ *Id.* art. 10(2).
- ⁴⁶⁰ *Id.* art. 15(1)(b).
- ⁴⁶¹ CESCR, *General Comment No. 14*, para. 14.
- ⁴⁶² *Id.* para. 11.
- ⁴⁶³ *Id.* para. 12 (adding further that accessibility consists of non-discrimination, physical accessibility, affordability, and access to information). The UN Special Rapporteur on the right to health has recently affirmed these necessary components of the right to health. Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council"*, paras. 68, 71, U.N. Doc. A/HRC/4/28 (Jan. 17, 2007) [hereinafter Special Rapporteur Report, *Implementation of Resolution 60/251* (2007)].
- ⁴⁶⁴ Maputo Protocol, art. 14.
- ⁴⁶⁵ CEDAW, arts. 12(2), 16(1)(e). The CEDAW Committee has further urged governments to take measures "to prevent coercion in regard to fertility and reproduction, and to ensure that women are not forced to seek unsafe medical procedures...because of lack of appropriate services in regard to fertility control." Committee on the Elimination of Discrimination against Women, *General Recommendation 19: Violence against women*,

- para. 24(m), U.N. Doc. A/47/38 (Jan. 29, 1992).
- ⁴⁶⁶ Committee on the Elimination of Discrimination against Women, *General Recommendation 24: Women and health*, para.31(d), U.N. Doc. A/54/38 (1999).
- ⁴⁶⁷ *Id.* para. 22.
- ⁴⁶⁸ Children's Rights Convention, art. 24(2).
- ⁴⁶⁹ African Charter on Children, art. 14(2)(e).
- ⁴⁷⁰ CESCR, *General Comment No. 14*, para. 33.
- ⁴⁷¹ *Id.*
- ⁴⁷² *Id.* paras. 33, 35.
- ⁴⁷³ *Id.* para. 33.
- ⁴⁷⁴ *Id.* paras. 33, 36.
- ⁴⁷⁵ Civil and Political Rights Covenant, arts. 2, 3; Economic, Social and Cultural Rights Covenant, arts. 2, 3; Banjul Charter, arts. 2, 3, 18(3); Committee on Economic Social and Cultural Rights, *General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights*, para. 1, U.N. Doc. E/C.12/2005/4 (2004).
- ⁴⁷⁶ See, e.g., Universal Declaration, art. 2; Civil and Political Rights Covenant, art. 2(1); Economic, Social and Cultural Rights Covenant, art. 2(2); Banjul Charter, art. 2.
- ⁴⁷⁷ Banjul Charter, arts. 3, 18(3).
- ⁴⁷⁸ Maputo Protocol, art. 2.
- ⁴⁷⁹ CEDAW, art. 12(1). See also Children's Rights Convention, art. 24(2)(f).
- ⁴⁸⁰ Economic, Social and Cultural Rights Covenant, art. 2(1); Children's Rights Convention, art. 4.
- ⁴⁸¹ Committee on Economic, Social and Cultural Rights, *General Comment No. 3: The nature of States parties obligations*, para. 2, U.N. Doc. E/1991/23 (1990) [hereinafter CESCR, *General Comment No. 3*]; Special Rapporteur Report, *Implementation of Resolution 60/251*, para. 63 (2007).
- ⁴⁸² CESCR, *General Comment No. 14*, para. 44; see also CESCR, *General Comment No. 3*, para. 29.
- ⁴⁸³ Committee on the Rights of the Child, *Concluding Observations: Kenya*, paras. 48, 52, U.N. Doc. CRC/C/KEN/CO/2 (2007).
- ⁴⁸⁴ CESCR, *General Comment No. 14*, para. 12 (emphasis added).
- ⁴⁸⁵ *Id.* para. 35.
- ⁴⁸⁶ *Id.* para. 35.
- ⁴⁸⁷ CEDAW, art. 10(h).
- ⁴⁸⁸ *Id.* arts. 12(1).
- ⁴⁸⁹ *Id.* art. 14.
- ⁴⁹⁰ Constitution, sec. 34 (1999) (Nigeria).
- ⁴⁹¹ Universal Declaration, art. 1; Civil and Political Rights Covenant, at preamble; Banjul Charter, art. 5; African Charter on Children, art. 11(5).
- ⁴⁹² Banjul Charter, art. 5.
- ⁴⁹³ Maputo Protocol, art. 3.
- ⁴⁹⁴ African Charter on Children, arts. 11, 17, 20.
- ⁴⁹⁵ Nigeria became a member of the United Nations on Oct. 7, 1960. See United Nations List of Member States, <http://www.un.org/members/list.shtml#n> (last visited May 23, 2008).
- ⁴⁹⁶ United Nations Millennium Development Goals, <http://www.un.org/millenniumgoals/> (last visited May 23, 2008).
- ⁴⁹⁷ Millennium Development Goals..
- ⁴⁹⁸ UNITED NATIONS DEVELOPMENT GROUP, NIGERIA MILLENNIUM DEVELOPMENT GOALS REPORT (2004), available at <http://www.undg.org/index.cfm?P=87&f=N>.
- ⁴⁹⁹ *Id.* at 40.
- ⁵⁰⁰ *Id.* at 65.
- ⁵⁰¹ United Nations General Assembly, 2005 World Summit Outcome, 60th Sess., para. 22(a), U.N. Doc. A/RES/60/1 (2005).
- ⁵⁰² *Id.* para. 22(b).
- ⁵⁰³ *Id.* para. 24(c).
- ⁵⁰⁴ *Id.* para. 57(a).
- ⁵⁰⁵ *Id.* para. 57(g).
- ⁵⁰⁶ *Id.*, para. 57(g).
- ⁵⁰⁷ *Vienna Declaration and Programme of Action*.
- ⁵⁰⁸ *Programme of Action of the International Conference on Population and Development*, Cairo, Egypt, Sept. 5-13, 1994, paras. 8.20-8.26, U.N. Doc. A/CONF.171/13/Rev.1 (1995).
- ⁵⁰⁹ *Beijing Declaration and the Platform for Action, Fourth World Conference on Women*, Beijing, China, Sept. 4-5, 1995, U.N. Doc. A/CONF.177/20 (1996).
- ⁵¹⁰ The African Union replaced the OAU on July 9, 2002. See Report of the Special Session of the Council of Ministers on the African Union, Durban, South Africa, Jul. 8, 2002, O.A.U. Doc. AHG/232 (XXXVIII)-b, available at http://www.au2002.gov.za/docs/summit_council/minsprep.htm; Agenda of the First Session of the Assembly of the African Union, Durban, South Africa, Jul. 9-10, 2002, A.U. Doc Ass/AU/1(1), available at <http://www.au2002.gov.za/docs/dbnsummit/agenda9-10jul.htm>.
- ⁵¹¹ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*, Abuja, Nigeria, Apr. 24-27, 2001, para. 26, O.A.U. Doc. OAU/SPS/ABUJA/3, available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf.
- ⁵¹² WORLD HEALTH ORGANIZATION (WHO) REGIONAL COMMITTEE FOR AFRICA RESOLUTION, HEALTH FINANCING: A STRATEGY FOR THE AFRICAN REGION, AFR/RC56/R5, para. 2(c) (2006), available at http://www.who.int/health_financing/documents/afrrc56-r5-healthfinancingstrategy.pdf.
- ⁵¹³ Maputo Declaration: Together Shaping Our Future, 4th Summit of ACP Heads of State and Government, Maputo, Mozambique, June 23-24, 2004, para. 30, O.A.U. Doc. ACP/28/010/04, available at http://www.acpsec.org/summits/maputo/maputo_declaration_en.html.
- ⁵¹⁴ *Id.* para. 30.
- ⁵¹⁵ African Union Conference of Ministers of Health, Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights 2007-2010, Sp/MIN/CAMH/5(1) (2006) available at http://www.africa-union.org/root/AU/Conferences/Past/2006/September/SA/Maputo/doc/en/Working_en/SRHR_%20Plan_of_Action_2007_Final.pdf.

- ⁵¹⁶ *Id.* paras. 5, 10.
- ⁵¹⁷ *Id.* para. 7.
- ⁵¹⁸ *Id.* para. 18.
- ⁵¹⁹ Constitution, sec. 13 (1999) (Nigeria).
- ⁵²⁰ *Id.* sec. 14(1).
- ⁵²¹ *Id.* sec. 16(2).
- ⁵²² *Id.* sec. 17(3)(d).
- ⁵²³ *Id.* sec. 33.
- ⁵²⁴ *Id.* sec. 34.
- ⁵²⁵ *Id.* sec. 42.
- ⁵²⁶ *Id.* ch. 2, sec. 17(3)(d).
- ⁵²⁷ See Editorial, *Country's Alarming Maternal Deaths*, THIS DAY, Oct. 30, 2007, available at <http://allafrica.com/stories/200710310436.html>.
- ⁵²⁸ UNITED NATIONS POPULATION FUND (UNFPA), STATE OF WORLD POPULATION 2005: THE PROMISE OF EQUALITY: GENDER EQUITY, REPRODUCTIVE HEALTH AND THE MILLENNIUM DEVELOPMENT GOALS 36 (2005), available at http://www.unfpa.org/upload/lib_pub_file/493_filename_en_swp05.pdf. (The third strategy is family planning.)
- ⁵²⁹ I.A.O. Ujah et al., *Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-year Review*, AFRICAN JOURNAL OF REPRODUCTIVE HEALTH, Vol. 9, No. 3, at abstract (2005).
- ⁵³⁰ Olufemi T. Oladapo et al., *Maternal Deaths in Sagamu in the New Millennium: a Facility-based Retrospective Analysis*, BMC PREGNANCY & CHILDBIRTH, Vol. 6, No. 6 (2006), available at <http://www.biomedcentral.com/1471-2393/6/6>.
- ⁵³¹ PAUL HUNT & JUDITH BUENO DE MESQUITA, UNIVERSITY OF ESSEX HUMAN RIGHTS CENTER, REDUCING MATERNAL MORTALITY: THE CONTRIBUTION OF THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH (2007), available at http://www.unfpa.org/upload/lib_pub_file/750_filename_reducing_mm.pdf.
- ⁵³² Constitution, sec. 33 (1999) (Nigeria).
- ⁵³³ Interview with Saudatu Shehu Mahdi, Secretary General, Women's Rights Advancement and Protection Alternative (WRAPA), Abuja, Feb. 8, 2008.
- ⁵³⁴ Interview with a senior government official of the Federal Ministry of Health, Abuja, Feb. 7, 2008.
- ⁵³⁵ SENATE (NIGERIA), NATIONAL HEALTH BILL 2008 (SB.50), available at <http://www.nphnet.org/docs/NATIONAL.doc>.
- ⁵³⁶ *Id.* at 28.
- ⁵³⁷ Though Section 1(e) of the National Health Bill seeks to "protect, promote and fulfill the rights of the people of Nigeria to have access to health care services," this focuses merely on entitlement to health services. It falls short of a right to health guarantee as provided in international and regional human rights laws such as the Economic, Social and Cultural Rights Covenant and the Banjul Charter. The contents of the Right to Health under regional and international laws have already been discussed in this section of the report.
- ⁵³⁸ Banjul Charter Enforcement Act (Nigeria).
- ⁵³⁹ Banjul Charter, art. 16.
- ⁵⁴⁰ The African Commission on Human and Peoples' Rights held that the Nigerian government violated the right to health (Article 16) of the Banjul Charter in the case *Social & Economic Rights Action Center v. Nigeria*, Communication No. 155/96, African Commission on Human Rights (2001), available at <http://www1.umn.edu/humanrts/africa/comcases/155-96.html> (finding government oil exploration activities had caused a number of negative health impacts including reproductive problems).
- ⁵⁴¹ *Gbemre v. Shell Petroleum Dev. Co.*, Suit No. FHC/B/CS/53/05, Nigeria F.H.C. (unreported), Nov. 14, 2005, available at <http://www.climatelaw.org/cases/case-documents/nigeria/ni-shell-nov05-judgment.pdf> (last visited Apr. 16, 2008).
- ⁵⁴² *Id.* This decision has been appealed before the Nigerian Court of Appeal, Benin City. See *Gabriel Enoghlose, Benin Court Registrar Under Investigation*, VANGUARD, Sept. 27, 2006, available at <http://www.climatelaw.org/cases/country/nigeria/gasflares/2006Sept25>.
- ⁵⁴³ FEDERAL MINISTRY OF HEALTH (NIGERIA), NATIONAL HEALTH POLICY AND STRATEGY TO ACHIEVE HEALTH FOR ALL NIGERIANS, at i (1988) [hereinafter NIGERIA, NATIONAL HEALTH POLICY AND STRATEGY TO ACHIEVE HEALTH FOR ALL NIGERIANS (1988)].
- ⁵⁴⁴ *Id.* at 1, sec. 1.1.
- ⁵⁴⁵ *Declaration of Alma-Ata; International Conference on Primary Health Care*, Alma-Ata, USSR, Sept. 6-12, 1978, at 1, paras. VI, VII. available at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.
- ⁵⁴⁶ NIGERIA, NATIONAL HEALTH POLICY AND STRATEGY TO ACHIEVE HEALTH FOR ALL NIGERIANS, at 7, sec. 3.3 (1988).
- ⁵⁴⁷ *Id.* at 9, sec. 4.3(d).
- ⁵⁴⁸ *Id.* at 11, sec. 5.1.
- ⁵⁴⁹ *Id.* at 12, sec. 5.5.
- ⁵⁵⁰ *Id.* at 12-13, sec. 5.5(a)-(c) .
- ⁵⁵¹ FEDERAL MINISTRY OF HEALTH (NIGERIA), REVISED NATIONAL HEALTH POLICY, at 9-10, sec. 4.6 (2004) [hereinafter NIGERIA, REVISED NATIONAL HEALTH POLICY (2004)].
- ⁵⁵² *Id.* at 2, sec. 2.
- ⁵⁵³ *Id.*
- ⁵⁵⁴ *Id.* at 32-33, sec. 6.9.
- ⁵⁵⁵ *Id.* at 32, sec. 6.9(1).
- ⁵⁵⁶ *Id.* 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. *Id.* at 33, sec. 6.10.
- ⁵⁵⁷ FEDERAL MINISTRY OF HEALTH (NIGERIA), HEALTH SECTOR REFORM PROGRAMME (2005).
- ⁵⁵⁸ *Id.* at 1.
- ⁵⁵⁹ *Id.*
- ⁵⁶⁰ *Id.* at 7.
- ⁵⁶¹ *Id.* at 2.
- ⁵⁶² *Id.* at 14.
- ⁵⁶³ *Id.* at 15.
- ⁵⁶⁴ *Id.* at 22.
- ⁵⁶⁵ Interview with a senior government official of the Federal Ministry of Health, Abuja, Feb. 7, 2008.
- ⁵⁶⁶ FEDERAL MINISTRY OF HEALTH (NIGERIA), NATIONAL REPRODUCTIVE HEALTH POLICY AND STRATEGY TO ACHIEVE QUALITY REPRODUCTIVE AND SEXUAL HEALTH FOR ALL NIGERIANS 12 (2001).

- ⁵⁶⁷ *Id.* at 13.
- ⁵⁶⁸ *Id.*
- ⁵⁶⁹ *Id.* at 9.
- ⁵⁷⁰ *Id.* at 12, 21.
- ⁵⁷¹ *Id.* at 21.
- ⁵⁷² *Id.* at 22.
- ⁵⁷³ *Id.* at 17.
- ⁵⁷⁴ *Id.* at 18.
- ⁵⁷⁵ *Id.* at 17.
- ⁵⁷⁶ *Id.*
- ⁵⁷⁷ *Id.*
- ⁵⁷⁸ *Id.*
- ⁵⁷⁹ *Id.* at 16.
- ⁵⁸⁰ *Id.*
- ⁵⁸¹ *Id.* at 19.
- ⁵⁸² FEDERAL MINISTRY OF HEALTH (NIGERIA), INTEGRATED MATERNAL, NEWBORN AND CHILD HEALTH STRATEGY 2 (2007).
- ⁵⁸³ *Id.*
- ⁵⁸⁴ *Id.*
- ⁵⁸⁵ *Id.*
- ⁵⁸⁶ *Id.* at 3.
- ⁵⁸⁷ *Id.*
- ⁵⁸⁸ *Id.* at 4.
- ⁵⁸⁹ FEDERAL GOVERNMENT OF NIGERIA, NATIONAL POLICY ON POPULATION FOR SUSTAINABLE DEVELOPMENT 20 (2004).
- ⁵⁹⁰ *Id.* at 21-22.
- ⁵⁹¹ *Id.* at 24-26.
- ⁵⁹² FEDERAL MINISTRY OF HEALTH (NIGERIA), NATIONAL POLICY ON THE HEALTH & DEVELOPMENT OF ADOLESCENTS & YOUNG PEOPLE IN NIGERIA, at i (2007).
- ⁵⁹³ *Id.* at 3.
- ⁵⁹⁴ *Id.* at 12.
- ⁵⁹⁵ *Id.* at 13.
- ⁵⁹⁶ NATIONAL POPULATION COMMISSION (NPC) (NIGERIA) & ORC MACRO, NIGERIA DEMOGRAPHIC AND HEALTH SURVEY 2003, at xxiii (2004).
- ⁵⁹⁷ Dennis Ityavar & Inuwa Bakari Jalingo, *The State of Married Adolescents in Northern Nigeria* 6 (Action Health, Inc., Working Paper, May 2006), available at <http://www.actionhealthinc.org/publications/downloads/married.pdf> (citing studies that indicate that, nationally, 20% of Nigerian women are married by the age of 15 and 40% by 18, and, in Northern Nigeria, 45% of women are married by 15 and 73% by 18).
- ⁵⁹⁸ Innocenti Research Centre, UNICEF, *Early Marriage: Child Spouses*, INNOCENTI DIGEST, No. 7, at 11 (2001), available at <http://www.unicef-irc.org/publications/pdf/digest7e.pdf>.
- ⁵⁹⁹ FEDERAL MINISTRY OF WOMEN AFFAIRS AND SOCIAL DEVELOPMENT (NIGERIA), NATIONAL GENDER POLICY, at vii (2006).
- ⁶⁰⁰ *Id.* at 18.
- ⁶⁰¹ *Id.* at 21.

Reducing preventable maternal deaths and improving the dire state of maternal health are key obligations of the government of Nigeria. While multiple causes of maternal mortality exist, this report focuses on the relevant political and economic factors and the manner in which the Nigerian government's lack of accountability, its failure to implement its laws and policies, and its inadequate funding of its health system contributes to the country's shockingly high number of maternal deaths. The report also addresses the many financial and institutional barriers to obtaining quality maternal care that stem from the government's failure to adequately allocate resources to the health sector and to eliminate obstacles to obtaining family-planning and contraceptive methods, as well as the impact of systemic corruption and the separation of responsibilities for the provision of health care among Nigeria's three tiers of government. While these issues are highlighted in the context of maternal health, many of this report's findings have repercussions for the entire health system and the general health of all Nigerians.

Broken Promises: Human Rights, Accountability, and Maternal Death in Nigeria, produced by Women Advocates Research and Documentation Centre and the Center for Reproductive Rights, demonstrates the pressing need for the Nigerian government to fulfil its commitment to saving women's lives by implementing systematic changes that will improve maternal health throughout the country.

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