SUBMISSION OF THE CENTER FOR REPRODUCTIVE RIGHTS REGARDING MATERNAL MORTALITY IN NIGERIA

Universal Periodic Review of Nigeria

August 29, 2008

The Center for Reproductive Rights ("CENTER") is a nonprofit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide. In accordance with Human Rights Council Resolution 5/1 of June 18, 2007, the Center presents this submission as a non-governmental stakeholder particularly concerned with Nigeria's compliance with its international obligations to reduce maternal mortality. The information in this letter is drawn from a recent report by the Center and Women Advocates Research and Documentation Centre (WARDC) entitled *Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria,* which is being submitted with this letter.

I. Introduction

International human right law requires states to ensure that women can achieve the highest attainable standard of health, including the fundamental right to survive pregnancy and childbirth, avoid preventable death, and obtain equal access to health care. Every year, more than half a million women worldwide lose their lives due to complications in pregnancy or childbirth and most of these deaths are preventable.[1] Ninety-nine percent of these women live in low-income countries and the vast majority die of preventable obstetric causes.[2] As Paul Hunt, the former Special Rapporteur on the Right to the Highest Attainable Standard of Health, informed this Council, "[m]aternal mortality is a human rights catastrophe on a scale that dwarfs other human rights issues such as disappearances and the death penalty."[3]

Nigeria has one of the highest numbers of maternal deaths in the world, despite its oil wealth. Nigeria's failure to address maternal mortality by implementing laws and policies that would ensure access to health care, including its availability and quality, and allocating adequate resources to the health care system, results in extraordinarily high levels of maternal deaths, particularly among low income women and women who live in rural areas. By failing to protect and ensure these women's lives and survival, Nigeria violates women's rights to life, health, non-discrimination and equality.

The CEDAW Committee has repeatedly expressed its concern over the high rates of maternal mortality in Nigeria. In 1998, the Committee, in its Concluding Observations, expressed concern at the high incidence of maternal death in Nigeria.[4] The Committee reiterated this concern in 2004 during Nigeria's fourth and fifth periodic reports.[5] In the most recent periodic review of Nigeria in July 2008 the Committee expressed great

concern at the precarious situation of the health system and "at the very high maternal mortality rate, the second highest in the world," and regret that "there has been no progress in reducing the maternal mortality rate since the consideration of the State party's combined fourth and fifth periodic report in 2004." The Committee urged Nigeria to "address, as a matter of priority, the high maternal mortality rate, including the allocation of adequate resources to increase women's access to affordable health services."[6]

Although the Nigerian government has recently stated that health – particularly maternal health – is a political priority that has been given increased attention,[7] maternal health care in the country has not improved, indicating that the government's actions have been inadequate.

The Center urges the Human Rights Council to closely examine the high incidence of maternal deaths and failure to guarantee the right to survive pregnancy and childbirth in Nigeria.

II. Key Issues

A. Failure to address high incidence of maternal deaths

Earlier this year, the World Health Organization (WHO) identified Nigeria as having the world's second-highest number of maternal deaths with approximately 59,000 maternal deaths taking place annually.[8] For every maternal death, 20 other women suffer serious and often permanent pregnancy-related complications and health problems.[9] Although Nigeria makes up 2% of the world's population, it accounts for 10% of its maternal deaths.[10] A woman in Nigeria has a 1-in-18 risk of dying in childbirth or from pregnancy-related causes during her lifetime,[11] which is higher than the overall 1-in-22 risk for women throughout sub-Saharan Africa.[12] The risks of maternal death are even greater for certain Nigerian women, such as those in the northern region of the country, rural women, low income women and women without formal education. The majority of these deaths are preventable – while there are multiple and complex causes of maternal mortality, governments must be held accountable when their actions or inaction contribute to the loss of women's lives.

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

A key structural issue that contributes to the high MMR is the division of health-care responsibilities among the three tiers of government: federal, state, and local. The Nigerian Constitution, which outlines the powers and responsibilities of each tier, is silent about their specific health-care responsibilities.[13] In the absence of a constitutional sharing of powers and outlining of responsibility for health care, the 1988 National Health Policy and Strategy to Achieve Health for All Nigerians (1988 National Health Policy) allocates the primary health sector to the local government, the secondary health sector to the state government, and the tertiary health sector to the federal government.[14]

However, being a federal system, the federal government has little control over both the state and local governments in the discharge of their duties. The absence of a constitutional or other legal prescription of health-care responsibilities has resulted in a dysfunctional system in which all three tiers of government have failed to prioritize their health-care duties. The problem is particularly visible at the primary health-care level and has had grave consequences for women seeking maternal care.

In its 2008 concluding observations the CEDAW Committee noted "that responsibility for the provision of health services is currently divided across the three tiers of government, with local governments responsible for the primary health-care system. It notes with concern that primary health-care services and facilities are often inadequate in quality, number and funding."[15]

2. 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.[16] 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,"[17] 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.[18] This pledge has not been fulfilled, 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.[19]

The CEDAW Committee has stated that the duty to fulfill rights "places an obligation on States parties to take appropriate legislative, judicial, administrative, budgetary, economic and other measures to the maximum extent of their available resources to ensure that women realize their rights to health care."[20] In 2004, during Nigeria's fourth and fifth periodic reports, the CEDAW Committee urged the government to "allocate adequate resources to improving the status of women's health, in particular with regard to maternal ...mortality." In 2008, in its concluding observations on Nigeria's 6th periodic report, the CEDAW Committee urged the government "to address, as a matter of priority, the high maternal mortality rate, including the allocation of adequate resources to increase women's access to affordable health services, particularly pre-natal, post-natal and obstetric services, as well as other medical and emergency assistance provided by trained personnel, particularly in rural areas."[21]

B. Barriers to Maternal Health Care

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

1. Financial barriers

User fees constitute serious barriers to obtaining quality maternal health care in Nigeria. For instance, an interviewee noted that: "Once you go to the hospital, before anyone attends to you, you have to drop some money … they [women] can't go to the hospital because they can't afford it. They are scared of the money they will have to pay and they don't have the money."[22]

The CEDAW Committee has stated that:

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

In addition, the United Nations Secretary General, in a 2008 report submitted to the Commission on the Status of Women, recommended that states "assess the gender impacts of revenue-raising measures, including user fees."[24] In the past, the CESCR Committee had observed that there was "gross underfunding and inadequate management of health services…."[25]

2. Infrastructural and institutional barriers

Many infrastructural and institutional barriers also hamper access to maternal health care. For instance, long waiting periods at health-care centers discourage women from seeking health care and even prevent access in cases where women are unable to put aside family or job responsibilities for long periods of time.[26] Malfunctioning or outdated hospital equipment also serves as a barrier to adequate maternal health care. A national study on the availability and quality of emergency obstetrics facilities found that only 4.2% of public facilities and 32.8 % of private facilities (and only 18.5% of both public and private facilities) met the internationally agreed-upon standards for emergency obstetrics care.[27] The study also found that less than one third of the public secondary and tertiary health centers met the international standards for comprehensive emergency obstetric care.[28] Frequent power outages that leave some health–care centers without alternative sources of power also constitute an infrastructural barrier with serious consequences for pregnant women. An obstetrician and gynecologist recalled being forced to continue a caesarean section with a flashlight when a power outage occurred.[29] The poor quality of maternal health–care facilities increases the risks of maternal morbidity and mortality and constitutes a violation of the government's obligations under the Convention. Rural women who require maternal health-care services face serious challenges in accessing these services due to long distances to heath facilities and unavailability of reliable and affordable transportation. An interviewee observed that in a particular local government, women who go into labour often climb onto "okadas" (motorcycles that are used as a form of public transportation) in order to access health services.[30]

In its 2005 concluding observations on Nigeria, the Committee on the Rights of the Child recommended that the "very high mortality rates" amongst mothers should be addressed "through improving ante- and post-natal care."[31] In 2008, in its concluding observations on Nigeria, the CEDAW Committee asked the government to "improve the country's health infrastructure, particularly at the primary level, and to integrate a gender perspective into all health sector reforms. It also urge[d] the State party to improve women's access to quality and affordable health-care and health-related services…."[32]

C. Lack of Availability of Family Planning Services and Information

The lack of adequate information and counseling on family planning and the resulting non-use of contraceptives is another major factor that contributes to the high rate of maternal mortality in Nigeria.[33] Access to family planning and contraceptives is an important strategy in reducing maternal mortality. In the absence of contraceptive services, women may experience unwanted pregnancies, possibly resulting in death or illness due to lack of adequate health care, or they may seek unsafe illegal abortions that can result in complications or death.

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."[34] In 2008, the CEDAW Committee reiterated this by asking the government to "to improve the availability and affordability of sexual and reproductive health services, including family planning information and services."[35] The CEDAW Committee also recommended "the adoption of measures to increase knowledge of and access to, affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children."[36] It further asked the Nigerian government to "implement awareness-raising campaigns to enhance women's knowledge of reproductive health issues and recommends that sex education be widely promoted and targeted at adolescent girls and boys."[37]

D. Unsafe Abortion

The Nigerian government has admitted in its sixth periodic report to the CEDAW Committee that "[o]f the main causes of maternal mortality, unsafe abortion is the single most preventable cause of death. Unsafe abortions remain frequent occurrences, killing over 34,000 Nigerian women annually."[38] Despite this affirmation, Nigeria's abortion law remains very restrictive. One study indicates that a majority of the abortions that are performed in Nigeria are unsafe,[39] partly because of the nation's restrictive legal context.[40] For example it has been estimated that 456,000 unsafe abortions take place annually in Nigeria.[41] The restrictive abortion law in Nigeria has not only contributed to the high numbers of unsafe abortion in the country, it has also had a discriminatory impact. Poor and low income women are disproportionately represented in the number of women who resort to – and die from – unsafe abortion in the country. The government has acknowledged in its sixth periodic report that "low income women and girls who cannot afford the high cost of abortion or who are ignorant of the dangers of unsafe procedures utilized by unqualified individuals, stand very high risks of loosing [sic] their

lives."[42] Despite this acknowledgement, no steps have been taken towards addressing the causes of these deaths.

The CEDAW Committee expressed concern at "the high rates of maternal mortality as a result of unsafe abortions" in the Concluding Observation on Nigeria's combined fourth and fifth periodic reports in 2004, and on this basis urged the government to "take measures to assess the impact of its abortion laws on women's health."[43] It reiterated this concern in its 2008 concluding observations and asked the government to "give consideration to its reform or modification."[44]

III. Questions

In light of the CEDAW Committee's recommendations in 1998, 2004 and 2008, we suggest that the States consider asking the following questions during the interactive dialogue with the Nigerian Government:

1. What measures are being put in place to reduce maternal mortality?
2. What steps have been taken to improve health infrastructure, and to improve access to quality and affordable health care services, particularly at the primary level?
3. What measures have been adopted to increase knowledge of, and access to, affordable contraceptive methods?
4. What assessments of the impact of Nigeria's abortion law on the maternal mortality rate of the country have been done?

IV. Recommendations

We suggest that the Human Rights Council consider making the following recommendations:

1. Nigeria should comply with the CEDAW Committee's recommendation in 2004 and 2008 to domesticate the Convention on the Elimination of all Forms of Discrimination against Women.
2. Nigeria should comply with the recommendation issued by the Committee on the Rights of the Child in 2005 to urgently address the very high maternal mortality rate. Nigeria should also comply with the recommendation of the CEDAW Committee in 2008 to address, as a matter of priority, the high maternal mortality rate, including by allocating adequate resources and improving the health infrastructure, particularly at the primary level.
3. The government should consider the impact of its abortion law on the country's maternal mortality rate as recommended by the CEDAW Committee in 2004 and 2008.
4. The government should take adequate measures to increase knowledge of, and access to contraceptive methods, as recommended by the CEDAW Committee in 2008.

We hope that this information is useful during the Universal Periodic Review of the Nigerian government's compliance with its human rights obligations.

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

Sincerely,

Onyema Afulukwe	Ximena Andión
Visiting Attorney	Advocacy Director
International Legal Program	International Legal Program

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[1] United Nations Population Fund (UNFPA), Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and The World Bank 1, available at http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf. [hereinafter Maternal Mortality in 2005].

[2] Id.

[3] Paul Hunt, Special Rapporteur on the Right to the Highest Attainable Standard of Health, Statement to the Human Rights Council, Mar. 28, 2007 [hereinafter Hunt, Statement to the Human Rights Council], available at www.ohchr.org/english/bodies/chr/special/docs/stat_health.doc.

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

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

[6] CEDAW Committee, *Concluding Observations on Nigeria* (2008), para. 33 & and 34.

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

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

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

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

[11] WHO et al., Maternal Mortality in 2005 at 25 (2007). The 2008 report of the 'Countdown to 2015: Maternal, Newborn and Child Health' confirms that these chances remain the same. 'Countdown to 2015' is a collaborative effort to track progress in maternal, newborn and child survival in high mortality countries by highlighting the progress, obstacles and solutions to achieving MDGs 4 (child survival) and 5

(maternal health). United Nations Children's Fund (UNICEF), Countdown to 2015: tracking Progress in Maternal, Newborn, and Child Survival 18 (2008), *available at* http://www.countdown2015mnch.org/documents/2008report/2008Countdown2015fullreport.pdf.

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

[13] Federal Ministry of Health (Nigeria), Health Sector Reform Programme 2004 at 1 (2005) [hereinafter Nigeria, Health Sector Reform Programme 2004 (2005)].

[14] Federal Ministry of Health (Nigeria), National Health Policy and Strategy to Achieve Health for All Nigerians 12-13, 53, sec. 5.5(a)-(c), Annex II (1988) [hereinafter Nigeria, National Health Policy and Strategy to Achieve Health for All Nigerians (1988)].

[15] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 31, CEDAW/C/NGA/CO/6 (2008).

[16] *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 [hereinafter *Abuja Declaration,* Abuja, Apr. 24-27, 2001].

[17] WORLD HEALTH ORGANIZATION (WHO) REGIONAL COMMITTEE FOR AFRICA RESOLUTION, HEALTH FINANCING: A STRATEGY FOR THE AFRICAN REGION, para. 2(c), AFR/RC56/R5 (2006), *available at* http://www.who.int/health_financing/documents/afrrc56-r5-healthfinancingstrategy.pdf.

[18] 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), para. 7 (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 [hereinafter Maputo Plan of Action].

[19] *See* Section Three of the report, which has been submitted with this letter.

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

[21] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 34, CEDAW/C/NGA/CO/6 (2008).

[22] Focus group discussion, Abuja, Feb. 11, 2008.

[23] CEDAW Committee, *General Recommendation No.* 24, para. 21.

[24] United Nations, Financing for gender equality and the empowerment of women, Report of the Secretary-General, para. 88(d), U.N. Doc. E/CN.6/2008/2 (2008).

[25] Committee on Economic, Social and Cultural Rights, *Concluding Observations: Nigeria,* para.28, E/C.12/1/Add.23 (1998).

[26] Focus group discussion with Kuti Folake, BAOBAB for Women's Human Rights, Lagos, Feb.13, 2008.

[27] A.O. Fatusi & K.T. Ijadunola, National Study on Essential Obstetric Care Facilities in Nigeria (Federal Ministry of Health [Nigeria] and UNFPA) at vii, 11 (2003), *available at,* http://nigeria.unfpa.org/documents/EOC.doc [hereinafter Fatusi & Ijadunola, National Study on Essential Obstetric Care Facilities in Nigeria (2003)].

[28] Id at 13. Lagos State was an exception with the majority of its secondary and tertiary health centers meeting the standard.

[29] Interview with Dr. Mairo Mandara, Obstetrician and Gynaecologist, Abuja, Feb. 11, 2008.

[30] Interview with Banke Akinrimisi, Centre for Women's Health and Information, Lagos, Feb. 14, 2008

[31] Committee on the Rights of the Child, *Concluding Observations: Nigeria,* para.49. CRC/C/15/Add.257.

[32] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 32, CEDAW/C/NGA/CO/6 (2008).

[33] Kaiser Network, Kaiser Daily HIV/AIDS Report, Mar. 31, 2008, http://www.kaisernetwork.org/daily_reports/rep_hiv_recent_rep.cfm?dr_cat=1&show=yes&dr_DateTime=31-MAR-08 (last visited May 27, 2008).

[34] CEDAW Committee, *Concluding Observations on Nigeria*, para. 308 (2004).

[35] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 34, CEDAW/C/NGA/CO/6 (2008).

[36] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 34, CEDAW/C/NGA/CO/6 (2008).
[37] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 34, CEDAW/C/NGA/CO/6 (2008).
[38] CEDAW consideration of reports, Nigeria 82 (2006).
[39] Stanley K. Henshaw et al., *Severity and Cost of Unsafe Abortion Complications Treated in Nigerian Hospitals*, International Family Planning Perspectives, Vol. 34, No. 1, at 40 (2008), available at http:// www.guttmacher.org/pubs/journals/3404008.pdf.
[40] Akinrinola Bankole et al., Guttmacher Institute, Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences 4 (2006), *available at* http:// www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA. pdf [hereinafter Guttmacher, Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences (2006)]; Gilda Sedgh et al., *Unwanted Pregnancy and Associated Factors Among Nigerian Women*, International Family Planning Perspectives, Vol. 32, No. 4, at 175 (2006), *available at* http://www. guttmacher.org/pubs/journals/3217506.pdf.
[41] Andrew Walker, *Saving Nigerians from risky abortions*, BBC News, Apr. 7, 2008, *available at* http://news.bbc.co.uk/2/hi/africa/7328830.stm.
[42] CEDAW consideration of reports, Nigeria 81 (2006).
[43] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 307, U.N. Doc. A/59/38 (2004), *available at* http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/ A.59.38,paras.282-316.En?Opendocument.
[44] Committee on the Elimination of Discrimination against Women, *Concluding Observations: Nigeria*, para. 34, CEDAW/C/NGA/CO/6 (2008).