COMMUNICATION 564/15 BEFORE THE AFRICAN COMMISSION ON HUMAN AND PEOPLES' RIGHTS

IN THE MATTER BETWEEN COMMUNITY LAW CENTRE (DULLAH OMAR INSTITUTE), ALLIANCE FOR AFRICA, WOMEN ADVOCATE RESEARCH AND DOCUMENTATION CENTRE AND THE CENTER FOR REPRODUCTIVE RIGHTS (ON BEHALF OF THOUSANDS OF WOMEN)

AND

THE FEDERAL REPUBLIC OF NIGERIA (THE RESPONDENT)

ARGUMENT ON MERITS

- **Facts**

1. Nigeria has for over a decade accounted for one of the world's highest numbers of maternal deaths.[1] According to the World Health Organization (WHO), nearly 20% of all maternal deaths in the world occur in Nigeria.[2] An estimated 600 000, deaths and 900 000 near-miss cases occurred between 2005-2015.[3] The maternal mortality ratio for Nigeria in 2015 was 800 deaths per 100 000 live births compared to 12 deaths per 100 000 live births in developed countries.[4] The possibility of a woman dying from pregnancy, childbirth or postpartum complications in Nigeria is 1 in 22 compared to 1 in 4900 in developed countries.[5]

2. The victims are thousands of women who die every day due to preventable reasons. They include the women whose names the Complainants provided to the Commission on its request. Most of these injuries and deaths are avoidable as has been documented through studies and reports including by the Women Advocacy Research and Documentation Centre (WARDC) and the Center for Reproductive Rights, as well as the Allan Guttmacher Institute.[6] Those in vulnerable conditions, such as women with no formal education, a low-income, or living in rural settings, adolescent girls, unmarried women, and women in the northern region of Nigeria, where there is ongoing conflict, bear a disproportionate risk of poor maternal health outcomes due to inadequate provision of maternal healthcare services.

3. These women are more likely to experience denials of access to antenatal care due to wide-spread mandatory blood donation practices, delayed access to and poor-quality maternity services, and arbitrary detentions and ill-treatment following childbirth for the inability to pay medical bills. These are unfortunate outcomes of the inadequate national political commitment to develop and implement health programs and policies that can address significant financial, infrastructural, and institutional barriers in the health system. Infrastructural weaknesses in Nigeria such as lack of ambulances, and very limited number of facilities with appropriate equipment for emergency obstetric care, increase pregnant women's susceptibility to injury or death.[7]

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[1] World Health Organization *et al Trends in maternal mortality: 2000 to 2017: estimates* Geneva (2019).

[2] World Health Organization (WHO) 'Maternal health in Nigeria: Generating information for action' available at https://www.who.int/reproductivehealth/maternal-health-nigeria/en/ (accessed on 28 April 2020).

[3] Ibid.

[4] Ibid.

[5] Ibid.

[6] Center for Reproductive Rights and Women Advocacy, Research and Documentation Centre *Broken Promises: Human Rights, Accountability, and Maternal Death in Nigeria* (2008) available at https://www.reproductiverights.org/document/broken-promises-human-rights-accountability-and-maternal-death-in-nigeria (accessed on 23 May 2020).

[7] Ibid.

4. Women who could overcome these infrastructural challenges still encounter financial barriers such as high out-of-pocket or user fees for vaginal or C-section deliveries. Women who can pay the required deposit may risk being detained if they cannot pay their full bill when it is time to be discharged. Those who are detained are typically subjected to mistreatment and denied even life-saving care. Despite the availability of Nigeria's National Health Insurance Scheme which was established in 2005, the number of people who have coverage is very low. The number of women with coverage is even lower with research showing that the Scheme applies in a manner that excludes low income women and those working in the informal sector from benefiting from coverage.[8] As such, these already vulnerable women are more likely to be faced with unaffordable out-of-pocket costs for healthcare services and are more likely to experience detention and mistreatment.

5. Women must also navigate the challenges posed by institutional gaps such as disruptions in access to maternity care, brought on by recurrent power outages or industrial action by healthcare providers in the country. They are also susceptible to being beaten, slapped and verbally abused for failing to comply with instructions during labour. These issues have worked in concert with typically preventable or treatable medical factors, such as post-partum haemorrhage, pre-eclampsia, eclampsia, and complications from unsafe abortion, to sustain high levels of preventable maternal injuries and deaths in Nigeria.

6. The protracted insurgency in north-east Nigeria has further exacerbated the maternal health situation due to the mass abduction, rape, and forced pregnancy of adolescent girls and women, and the devastation of healthcare facilities in the affected areas, resulting in an unprecedented deficit in maternal healthcare services.[9] Without adequate measures in place, Nigeria's maternal deaths and injuries will remain on an upward trajectory, making it improbable that it will achieve Sustainable Development Goal 3, ensuring good health and wellbeing, by reducing the global maternal mortality ratio to less than 70 per 100, 000 live births by 2030.

7. These preventable deaths amount to an unnecessary loss of life, violating a range of Nigeria's human rights obligations under constitutional, regional and international human rights law. The government, which is the primary duty bearer of human rights obligations under these laws has a three-fold legal obligation to "respect, fulfil and protect" all constitutional and human rights provisions. Its obligation to *"respect"* rights entails refraining from doing anything

[8] National Health Scheme *Predictors of Enrolment in the National Health Insurance Scheme among Women of Reproductive Age in Nigeria* (2018) available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6326643/ (accessed on 23 May 2020).

[9] O Afulukwe 'Accountability for Maternal Healthcare Services in Nigeria' (2017) 137 (2) *International Journal of Gynecology and Obstetrics* 220-226.

that would interfere with their existence and enjoyment. The obligation to *"fulfil"* requires the adoption of all necessary measures, including legislative, administrative, and judicial measures. The obligation to *"protect"* requires taking all necessary action to prevent violations of the rights of citizens by private actors, exercising due diligence in investigating any violations, and bringing perpetrators to justice.

- **Violation of the Right to Life**

8. The failure of the Nigerian government to reduce the high levels of preventable maternal death and injury amounts to a violation of the right to life. The right to life is enshrined in Article 4 of the African Charter on Human and Peoples' Rights (African Charter);[10] Article 4 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol);[11] and in Article 5 of the African Charter on the Rights and Welfare of the Child (African Children's Charter).[12]

9. The African Commission on Human and Peoples' Rights (the Commission), interpreting Article 4 of the African Charter in a General Comment on the Right to Life, has stated that a state must take positive steps and measures to prevent a loss of life.[13] It also categorically confirmed that States are to address preventable maternal deaths in particular as part of their Article 4 obligations.[14] The Commission specifically noted that States have a responsibility to address chronic but pervasive threats to life such as preventable maternal deaths by establishing functioning health systems and eliminating discriminatory laws and practices that restrict access to healthcare services.[15]

10. In Resolution 135 on maternal mortality in Africa, the Commission declared that "preventable maternal mortality is a violation of the rights to life, health and dignity of women in Africa."[16] The Commission has also expressed concern about the high levels of maternal deaths in Nigeria specifically and recommended the adoption and enforcement of necessary measures to reduce

[10] African Charter on Human and Peoples' Rights, *adopted* June 27, 1981, art. 16, O.A.U. Doc. CAB/LEG/67/3 rev.5, 21 I.L.M 58 (1982) (*entered into force* Oct. 21, 1986) (*ratified by Uganda* May 10, 1986),

[11] The Protocol to the African Charter on the Rights of Women in Africa adopted by the African Union (AU) in 2003 entered into force on 27 November 2005.

[12] African Charter on the Rights and Welfare of the Child adopted by the Organisation of African Union (OAU) in 1990 entered into force 29 November 1999.

[13] See African Commission on Human and Peoples' Rights, General Comment No. 3 on the African Charter on Human and Peoples' Rights: The Right to Life (Article 4), 2015.

[14] Ibid para. 42.

[15] Ibid para. 3 and 42.

[16] African Commission on Human and Peoples' Rights, Resolution 135 on maternal mortality in Africa, 44th Ordinary Sess. (2008), available at http://www.achpr.org/sessions/44th/resolutions/135/ (accessed on 23 May 2020).

these deaths.[17] The Commission has consistently noted the alarming rate of maternal mortality in Nigeria, highlighting that according to the United Nations Children's Fund (UNICEF), the country currently has the second highest rate of maternal deaths in the world – and they continue to occur at a very high rate.[18]

11. The Commission, in some of its jurisprudence, has made the link between the protection of the rights to health and life.[19] For instance, in the *Pen International* case,[20] it affirmed that the denial of health care services to a prisoner undermines his right to life, as guaranteed in the African Charter.[21] It clarified that the right to life also extends to preventing loss of life and is interrelated to the right to health of individuals. Also, in the *SERAC* case[22], the African Commission adopted a purposive interpretation of rights guaranteed in the African Charter by holding that failure to prevent the pollution of water and resources of the Ogoni people amounted to a violation of the rights to health and life as guaranteed in the African Charter.[23]

12. The right to life is also enshrined in Section 33 (1) of the Nigerian Constitution and in international human rights instruments which Nigeria has ratified. They include Article 6(1) of the International Covenant on Civil and Political Rights (ICCPR),[24] Article 6(1) & (2) of the Convention on the Rights of the Child (CRC),[25] and Article 10 of the International Convention on the Rights of People with Disabilities (CRPD).[26]

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[17] Ibid, para. 36.

[18] African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014), (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020).

[19] See E Durojaye 'The Approaches of the African Commission to the right to health under the African Charter' (2013) 17*Law Democracy and Development*. 393-416.

[20] *International Pen and Others*. on *Behalf of Saro Wiwa v. Nigeria*. AHRLR 212 (ACHPR 1998); Communication No. 137/94, 139/94, 154/96 and 161/97.

[21] See O Afulukwe-Eruchalu & E Durojaye 'Developing norms and standards on maternal mortality in Africa: lessons from UN human rights bodies' (2017) 1 *African Human Rights Yearbook* 82-106; see also, R Cook *et al Reproductive health and human rights: Integrating medicines, ethics and Law* (2003) *161*.

[22] *Social and Economic Rights Action Center (SERAC) and Another v Government of Nigeria* Communication 155/96 decided at the 30th Ordinary Session of the African Commission held from 13 to 27 October 2001, Banjul, The Gambia.

[23] Ibid.

[24] International Covenant on Civil and Political Rights adopted Dec. 16, 1966, G.A. Res. 2200A (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).

[25] Convention on the Rights of the Child (CRC), adopted 20 Nov. 1989, G.A. Res. 44/25, annex, U.N. GAOR 44th Sess., Supp. No. 49, U.N. Doc. A/44/49 (1989) (entered into force Sept. 2, 1990), art. 6(1).

[26] Convention on the Rights of Persons with Disabilities adopted Dec. 13, 2006, art. 10, G.A. Res. A/RES/61/106, U.N. GAOR, 61st Sess., U.N. Doc. A/61/6111, (entered into force May 3, 2008).

13. Interpreting Article 6 of the ICCPR which guarantees the right to life, the Human Rights Committee, the treaty monitoring body charged with its interpretation, has stated in its General Comments No. 6 and No. 36 that the right to life requires States to take measures to safeguard individuals from arbitrary and preventable losses of life[27] and that the right should not be narrowly interpreted.[28] The Committee affirmed that this obligation includes taking steps to protect women against the unnecessary loss of life related to pregnancy and childbirth[29] by ensuring that reproductive health services are accessible.[30] It has urged States to exercise due diligence to protect the lives of individuals from violations attributable to private or non-state actors.[31]

14. Significantly, the Committee has emphasized that States' obligation to ensure the right to life also applies to "reasonably foreseeable threats and life-threatening situations that can result in loss of life" and notes that a violation of Article 6 may be found "even if such threats and situations do not result in loss of life."[32]

15. The Human Rights Committee as well as other treaty monitoring bodies have confirmed that lack of access to emergency obstetric care and other reproductive health services escalate the risk of maternal death.[33] They have also reiterated that barriers to access to reproductive healthcare, including costly treatment expenses with regard to pregnancy,[34] and poor access to antenatal services,[35] increase women's risk of maternal death and disability. They have mandated States to reduce maternal death rates,[36] by providing

[27] Human Rights Committee, General Comment No. 6: Article 6 Right to life, (16th Sess. 1982), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 176, paras. 3, 5, U.N. Doc. HRI/GEN/I/Rev.9 (Vol. I) (2008) [hereafter General Comment No. 6].; Human Rights Committee, General Comment 36 on article 6 of the International Covenant on Civil and Political Rights, on the right to life adopted 30 0ctober UN Doc CCPR/C/GC/36 2018.

[28] See General Comment No. 6 para. 5 and General. Comment No. 36 para. 3.

[29] Human Rights Committee, General Comment No. 28: Article 3 The equality of rights between men and women, (68th Sess. 2000), in Compilation of General Comments and Recommendations Adopted by Human Rights Treaty Bodies, at 228, para. 10, U.N. Doc. HRI/ GEN/1/Rev.9 (Vol. I) (2008).

[30] Human Rights Committee, Concluding Observations: Mali, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003).

[31] See General Comment No. 36, para. 7

[32] Ibid, para. 7.

[33] See Concluding 0bservations of the Human Rights Committee on Mali, para. 14, U.N. Doc. CCPR/CO/77/MLI (2003), Concluding Observations of the CEDAW Committee on Burundi, para. 36, U.N. Doc. CEDAW/C/BDI/CO/4 (2008).

[34] See Concluding Observations of the Children's Rights Committee on Central African Republic, para. 54, U.N. Doc. CRC/C/15/Add.138 (2000).

[35] Ibid.

[36] See Concluding Observations of the Children's Rights Committee on Niger, para. 47(b), U.N. Doc. CRC/C/15/Add.197 (2002).

sufficient resource allocation,[37] enhancing women's access to maternal healthcare services,[38] and skilled attendants during delivery,[39] and developing awareness-raising campaigns on the importance of antenatal care.[40]

16. The Committee on the Elimination of Discrimination against Women (CEDAW Committee) in the landmark case of *Alyne v. Brazil*, [41] a pregnant Afro-Brazilian woman who died while delivering at a hospital, determined that in order to protect women's human rights to life, health, and freedom from discrimination, States are responsible for the timely access to quality maternal health care to all women, regardless of their socio-economic status.[42] In this case, she was denied a minimum level of maternal health care due to systemic failures of the health care system. The CEDAW Committee determined that Alyne had not been "ensured appropriate services in connection with her pregnancy,"[43] concluding that systemic problems with access to timely, quality health care services violated her right to health under CEDAW Article 12(2).[44] Further, Alyne was denied maternal health care due to "professional negligence, inadequate infrastructure and lack of professional preparedness," which resulted in her being "left largely unattended in a makeshift area in the hallway of the hospital . . . ."[45]

17. In a decision issued by comparative regional human rights mechanisms, the Inter-American Commission and Court of Human Rights, in *Xákmok Kásek Indigenous Community v. Paraguay*,[46] the Inter-American Court of Human Rights found a violation of the right to life for the preventable maternal death of a woman who died following labor complications, during which she received no medical attention. The Court found that Paraguay failed to take positive measures that reasonably could have been expected to prevent or avoid the risk to life, and that "states must design appropriate health-care policies that

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[37] See Concluding Observations of the Children's Rights Committee on Djibouti, para. 42, U.N. Doc. CRC/C/15/Add.131 (2000).

[38] See Concluding Observations of the Children's Rights Committee on Mozambique, para. 51(b), U.N. Doc. CRC/C/15/Add.172 (2002).

[39]See Concluding Observations of the Children's Rights Committee on Botswana, para. 49, U.N. Doc. CRC/C/15/Add.242 (2004).

[40] Ibid.

[41] *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Communication No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

[42] *Alyne da Silva Pimentel Teixeira v. Brazil*, CEDAW Committee, Communication No. 17/2008, U.N. Doc. CEDAW/C/49/D/17/2008 (2011).

[43] Ibid para. 7.4.

[44] Convention on the Elimination of All Forms of Discrimination against Women adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979 entry into force 3 September 1981, in accordance with article 27(1), art. 12, para. 2.

[45] *Alyne case p*ara. 7.4.

[46] *Xákmok Kásek Indigenous Community v. Paraguay*, Merits, Reparations, and Costs, Judgment, Inter-Am. Ct. H.R. para. 232 (2010), http://www.corteidh.or.cr/docs/casos/articulos/seriec_214_ing.pdf (accessed on 23 May 2020).

permit assistance to be provided by personnel who are adequately trained to attend to births, policies to prevent maternal mortality with adequate prenatal and post-partum care, and legal and administrative instruments for healthcare policies that permit cases of maternal mortality to be documented adequately."[47]

- **Violation of the Right to Health and sexual and reproductive health**

18. The right to health is "a fundamental human right indispensable for the exercise of other human rights."[48] Nigeria's per capita expenditure on health is $ 72 USD, one of the lowest in the world.[49] Despite the commitments made by Nigeria under the 2001 Abuja Declaration to allocate at least 15% of its annual budget to improve the health sector,[50] the Nigerian government has failed woefully to meet this commitment. Rather, budgetary allocation to the health sector has continued to hover around 5% to 6%.[51] For a country endowed with so many natural resources, the shoestring spending on health, including maternal health is not only unacceptable, the resulting failure of the Nigerian government to reduce preventable maternal injuries and deaths amounts to a violation of the right to health.

19. The right to health is adequately guaranteed in Article 16 of the African Charter which obligates States to guarantee to every individual, the right to health.[52] Nigeria has fully domesticated the Charter. The right requires States to undertake "the necessary measures to protect the health of their people." [53] It also mandates States to ensure that this includes access to medical attention during sickness.[54] The Commission has explained that access to sexual and reproductive health services constitutes an integral part of the right to health.[55] It has further called on African governments to ensure the provision of adequate health care services for all women, particularly poor women and women living in rural areas.

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[47] Ibid para. 33.

[48] ESCR Committee, General Comment No. 14, para.1.

[49] See World Data Atlas 'Nigeria - current health expenditure per capita' available at https://knoema.com/atlas/Nigeria/Health-expenditure-per-capita (accessed on 30 April 2020).

[50] World Health Organization, The Abuja Declaration: Ten Years On 1 (2011), available at http://www.who.int/healthsystems/publications/Abuja10.pdf (accessed on 23 May 2020); see also Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, Abuja, Nigeria, para. 26, OAU/SPS/ABUJA/3 (2001), available at http://www.un.org/ga/aids/pdf/abuja_declaration.pdf. (accessed on 23 May 2020).

[51] R Hafez 'Nigeria Health Financing System Assessment' World Bank (2016) 22-26.

[52] African Charter on Human and Peoples' Rights.

[53] Ibid.

[54] Ibid.

[55] See Resolution on Reproductive Health of Women reproduced in E Durojaye and G Mirugi-Mukundi 'Compendium of Documents and Cases on the Right to Health under the African Human Rights System' (2013).

20. Also, the African Commission has called on States to adopt a rights-based approach to maternal health care including the provision of well-trained staff, employment and retention of skilled health care personnel.[56] In its Principles and Guidelines for the Implementation of Economic, Social and Cultural Rights in the African Charter, the Commission noted that health care services, including maternal health care must be available, accessible, acceptable and of good quality.[57]

21. The Commission, in its concluding observations, has recommended that Nigeria urgently strengthen ongoing initiatives to reduce the high rate of maternal mortality by; eliminating all barriers to maternal health services in the country; increasing budgetary allocation to the health sector; and promoting human rights-based investments in the health sector.[58] The Commission has also expressed concern regarding the lack of a legal framework for health in Nigeria that clearly defines the roles and responsibilities of healthcare professionals, as well as the oversight responsibilities of government across the health sector.[59] Thus, recommending that a comprehensive legal framework be put in place to address these issues.[60]

22. In some of its case law, the African Commission has explained the nature of obligations imposed by Article 16. For instance, in the *Purohit* case the African Commission has explained that the enjoyment of the right to health is crucial for the existence of an individual and intersects with other human rights. The Commission further notes that the right to health includes 'the right to health services, access to goods and services to be guaranteed to all without discrimination.'[61] In the *Free Legal Assistance* case, the African Commission held that the failure of the government to provide basic services such as safe

[56] See Ibid; see also Human Rights Council's Resolution on 'Technical Guidance on the Application of a rights-based Approach to the Implementation of Policies and Programmes to reduce Preventable Maternal mortality and Morbidity' A/HRC/21/22.

[57] The Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights adopted by the African Commission on Human and Peoples' Rights in November 2010 during its 48th Ordinary Session.

[58] African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014), (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020].

[59] African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014), (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020).

[60] Ibid, para 133.

[61] *Purohit and Moore v. The Gambia,* cited as: Communication No. 241/2001, Sixteenth Activity report 2002-2003, Annex VII.

drinking water and electricity and the shortage of medicine constituted a violation of the right to enjoy the best state of physical and mental health (protected in Article 16).[62] Implicit in this decision is that failure by the Nigerian government to provide adequate maternal health goods and services for women is a violation of Article 16 of the African Charter and Article 14 of the Maputo Protocol.

23. Article 14 of the Maputo Protocol also guarantees the right to health, including sexual and reproductive health.[63] Article 14 (2) (a) provides that States must ensure the right to adequate, affordable and accessible health care services for all women, especially those in rural areas.[64] In light of the poor spending on the health sector by the Nigerian government, the provision of Article 14 (2) (a) must be read together with Article 10 (h) of the Maputo Protocol, which requires States to reduce military expenditure in order to free more resources for women's development.[65] Article 14 (2) (b) expressly obligates States to provide new or strengthen existing pre-natal, delivery, and post-natal health services.[66]

24. In General Comments No.1 on Article 14 (1) (d) and (e) of the Maputo Protocol and No.2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Maputo Protocol, the African Commission highlights that States must ensure access to sexual and reproductive health services to women, especially disadvantaged women.[67] The Commission further urges States to commit adequate resources towards the realization of the health needs of women.[68] It has explained that it is crucial that States ensure availability, financial and geographical accessibility to quality sexual and reproductive health services.[69] Furthermore, the Commission has observed that maternal mortality is a serious public health emergency in Africa that requires decisive actions and measures from African governments.[70] The right to health is similarly protected by Article 14 of the African Children's Charter.

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[62] *Free Legal Assistance Group and Others v. Zaire,* Communication. No. 25/89, 47/90, 56/91, 100/93.

[63] The Protocol to the African Charter on the Rights of Women in Africa.

[64] Ibid.

[65] Ibid.

[66] Ibid, Article 14 (2) (b).

[67] General Comment No.1 on Article 14 (1) (d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Commission on Human and Peoples' Rights during its 52nd Ordinary Session in November 2012; General Comment No. 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Commission on Human and Peoples' Rights during its 54th Ordinary Session in November 2014.

[68] See African Commission, General Comment No. 2.

[69] Ibid, para 29.

[70] See African Commission's Resolution on Maternal Mortality.

25. Nigeria has fully domesticated the African Charter and is obligated to guarantee the right to health as provided for in the Charter. Further, it has developed several legislation containing standards and policies on health which it is bound by. The National Health Policy identifies the reduction of maternal mortality and morbidity as one of its main objectives and provides strategies to achieve this which includes improving equitable access to reproductive health services and ensuring that materials required to provide such services are available.[71] The National Health Act provides that no citizen can be deprived of emergency treatment and, in Section 20, prescribes a fine and imprisonment for non-compliance.[72] However, the reality is that pregnant women are denied emergency obstetrics care frequently, especially low income and rural women.

26. The right to health is also enshrined in international human rights instruments which Nigeria has ratified, including in Article 24 of the CRC which urges States to ensure that no child is deprived of their right of access to such healthcare services. The Right to health is further guaranteed in Articles 12 and 14 of the CEDAW Convention, which obligates States to ensure that women access adequate services in connection with pregnancy, confinement and the post-natal period.[73] The CEDAW Convention offers legal protection against discrimination in the enjoyment of women's right to health, including non-discrimination in access to health care.[74]

27. CEDAW General Recommendation 24 further clarifies that the CEDAW Convention "does not allow for any delayed or purposely chosen incremental manner in the implementation of the obligations," including on account of economic or resource constraints. Accordingly, the CEDAW Committee has asked governments to implement appropriate budgetary measures to ensure that women can realize their right to health care, and affirmed that high fees are a barrier that can violate this right.[75] The CEDAW Committee during its past periodic reviews of Nigeria, has consistently expressed concern about the "very high maternal mortality rate" and insufficient access to health care services for women. It recommended that the government strengthen access to affordable healthcare services.[76]

[71] Federal Ministry of Health (FMOH) *National Health Policy of Nigeria* 1998, 2004 and 2016.
[72] National Health Act of 2014, sections 20, 24 and 30.
[73] Convention on the Elimination of all Forms of Discrimination against Women.
[74] Ibid articles 2(c), 12(1).
[75] See CEDAW Committee, General Recommendation No. 24: Article 12 of the Convention (women and health).
[76] See CEDAW Committee, Concluding Observations: Nigeria, para. 170, U.N. Doc. A/53/38/Rev.1 (1998); paras. 307-308, U.N. Doc. A/59/38 (Supplement No. 38) (Part 1) (2004); and paras. 33-34, U.N. Doc. CEDAW/C/NGA/CO/6 (2008).

28. The right to health is also guaranteed comprehensively in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[77] The UN Committee on Economic, Social and Cultural Rights (ESCR Committee), which oversees States' implementation of the ICESCR, has elaborated in General Comment No. 14, that "[e]very human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life with dignity."[78] It has confirmed that this includes a right to maternal, child, and reproductive health, and has asked States to improve maternal and reproductive health services, including access to family planning, pre - and post-natal care, and emergency obstetric care.[79]

29. The ESCR Committee established that the right to health consists of both freedoms and entitlements. Entitlements include "the right to a system of health protection" which facilitates the highest attainable level of health.[80] This entitlement is recognized as a crucial component of a life with dignity.[81] It includes the entitlement to "unhindered access to a whole range of health facilities, goods, services and information, which ensure all people full enjoyment of the right to sexual and reproductive health."[82] Realization of this right requires ensuring the enjoyment of "facilities, goods, services and conditions" necessary to attain the highest standard of health.[83]

30. The ESCR Committee has further stated that fulfilling the right to health requires that governments guarantee, to all, its availability, accessibility, acceptability and quality.[84] *Availability* means providing public health facilities, trained medical personnel, goods, services, and programs in sufficient quantity.[85] The ECSR has interpreted availability broadly to require the adequate provision of "underlying determinants of health"[86] that affect women's health, such as sexual and reproductive health information, clean water, literacy, nutrition, gender equality, and participation in health-related decision-making.[87] These underlying determinants of health directly affect women's

[77] International Covenant on Economic, Social and Cultural Rights.
[78] Ibid.
[79] Ibid, para 14.
[80] Ibid.
[81] Ibid. para. 1.
[82] See ESCR Committee, General Comment No. 22, para. 5.
[83] Ibid, para. 9.
[84] Ibid para. 12; see also P Hunt and J Bueno De Mesquita, 'Reducing maternal mortality: The contribution of the right to the highest attainable standard of health,' Human Rights Center, University of Essex, at page 6.
[85] Ibid, para. 12(a).
[86] Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Rep. of the Special Rapporteur on the right to of everyone to the enjoyment of the highest attainable standard of physical and mental health, U.N. General Assembly (61st Sess.), para. 14, U.N. Doc. A/61/338 (Sept. 13, 2006) (by Paul Hunt) [hereinafter SRRH, The right to health (2006)].
[87] Ibid; See also ESCR Committee, General. Comment No. 14, paras. 3–4, 11, 12(a).

ability to survive pregnancy and childbirth,[88] as well as the well-being of vulnerable groups such as women living with HIV, those with disabilities, and those of a low socioeconomic status. Availability encompasses access to trained medical personnel and skilled providers who are trained to perform the full range of maternal health services.[89] Availability also includes adequate provision of essential drugs as defined by the World Health Organization (WHO),[90] including misoprostol for the management of miscarriage and incomplete abortion, and the prevention of postpartum hemorrhage.[91]

31. *Accessibility* includes four dimensions: (1) non-discrimination in services, particularly to the most marginalized sections of the population, (2) physical accessibility of health services and the underlying determinants of health, (3) economic accessibility (affordability) of health facilities, goods and services, including underlying determinants of health for all, and (4) information accessibility, which includes the right to receive information relating to health.[92] Additionally, accessibility entails timely provision of health services and information.[93] Ensuring accessibility requires that States take measures to address discriminatory laws, policies, practices, and gender inequalities that prevent women from seeking good quality services.[94] Fulfilling the element of accessibility requires ensuring women's access to reproductive health services without discrimination. The CEDAW Committee has emphasized that women should be free from discrimination in access to health care and information, particularly with regard to pregnancy-related services, among others.[95] It is considered discriminatory when States lack adequate health services to prevent and treat illnesses unique to women.[96]

32. *Accessibility* also requires that publicly available or privately provided sexual and reproductive health services be affordable for everyone.[97] To ensure that women are not disproportionately burdened by the costs of health, essential goods and services that relate to the underlying determinants of sexual and reproductive health must be provided at no cost or based on the principle of equality.[98] The ESCR Committee notes that "[p]eople without sufficient means should be provided with the necessary support to … access [] health facilities providing sexual and reproductive health information, goods and services."[99]

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[88] Ibid, para. 18.
[89] See ESCR Committee, General Comment No. 22, para. 13.
[90] Ibid.
[91] Ibid.
[92] See ESCR Committee, General Comment No. 14, para. 12(b).
[93] Ibid, para. 16.
[94] Ibid para. 17(c).
[95] See CEDAW Committee, General. Recommendation No. 24, para. 2.
[96] Ibid, para. 11.
[97] See ESCR Committee, General. Comment No. 22, para. 17.
[98] Ibid.
[99] Ibid.

33. *Acceptability* means health services should be sensitive to culture and gender and should respect confidentiality in a manner consistent with medical ethics.[100] The CEDAW Committee has stated that "[a]cceptable services are those that 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."[101] As such, States have an obligation to provide tailored facilities, goods, information and services to specific groups.[102] For example, States must ensure the availability of female health providers where their absence may deter women from seeking health care.[103]

34. *Quality* health care means that "[h]ealth facilities, goods and services must also be scientifically and medically appropriate and of good quality."[104] States must provide "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[105] States must also ensure that health care facilities provide reproductive health information and services that are scientifically accurate[106] and reflect modern advances.[107] The failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, undermines the quality of care.[108]

Core Principles Applicable to State Responsibility for Right to Health Obligations:

35. The African Commission's Principles and Guidelines on the Implementation of the Socioeconomic Rights in African Charter and ICESCR General Comment 14 on the right to health, address certain significant principles including that there are *minimum core obligations* that States must guarantee, which are not subject to resource availability requirements and are non-derogable.[109] This means that States are required to prioritize the immediate realization of these obligations and satisfy, at the very least, minimum essential levels of each. The immediate and non-derogable nature requires that even the poorest of countries, with the least resources, fulfil these obligations instantaneously, and at all times even during emergency situations or conflict, particularly for the most vulnerable amongst them.

[100] See ESCR Committee, General. Comment No. *14*, para. 12(c).
[101] See CEDAW Committee, General. Recommendation No. 24, para. 22.
[102] See ESCR Committee, General. Comment No. 22, para. 20.
[103] See CEDAW Committee, Concluding Observations: Nepal, para. 32(a), U.N. Doc. CEDAW/C/NPL/CO/4-5 (2011).
[104] See Principles and Guidelines on the Implementation of the ESCR in the African Charter para. 67; ESCR Committee, General. Comment No. 14, para. 12(d).
[105] Ibid.
[106] See OHCHR & WHO, Fact Sheet No. 31, at page 4.
[107] Center for Reproductive Rights, *Gaining Ground: A Tool for Advancing Reproductive Rights Law Reforms* 35 (2006).
[108] ESCR Committee, General. Comment No. 22, para. 21.
[109] See ESCR Committee, General. Comment No. 14.

36. The Committee has further clarified that States also have an obligation to take steps "individually and through international assistance and co-operation" to meet their minimum core obligations. This further reconfirms that States cannot rely on lack of resources as a reason for non-compliance as they have a corresponding obligation to seek international assistance or cooperation to ensure the minimum core obligations are met.

37. The ESCR Committee has underscored that it is a "core obligation" for States to "ensure, at the very least, minimum essential levels of satisfaction of the right to sexual and reproductive health."[110] The Committee has specifically declared that the obligation to ensure reproductive and maternal health is an obligation of comparable priority to a minimum core or minimum essential obligation under the right to health with which States must comply with at all times.[111] As such, provision of maternal health services, including pre-natal and post-natal care, is one of the minimum essential elements of the right to health which is not subject to progressive realization or availability of resources and which, instead, States have an immediate obligation to ensure. This entails that they "adopt and implement a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health, which is devised, periodically reviewed and monitored through a participatory and transparent process, disaggregated by prohibited ground of discrimination."[112]

38. It further entails that they "guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services,

[110] Ibid, para. 49 (States are required at a minimum "(a) To repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information; (b) To adopt and implement a national strategy and action plan, with adequate budget allocation, on sexual and reproductive health, which is devised, periodically reviewed and monitored through a participatory and transparent process, disaggregated by prohibited ground of discrimination; (c) To guarantee universal and equitable access to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and disadvantaged and marginalized groups; (d) To enact and enforce the legal prohibition of harmful practices and gender-based violence, including female genital mutilation, child and forced marriage and domestic and sexual violence, including marital rape, while ensuring privacy, confidentiality and free, informed and responsible decision-making, without coercion, discrimination or fear of violence, in relation to the sexual and reproductive needs and behaviours of individuals; (e) To take measures to prevent unsafe abortions and to provide post-abortion care and counselling for those in need; (f) To ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health that are non-discriminatory, non-biased, evidence-based, and that take into account the evolving capacities of children and adolescents; (g) To provide medicines, equipment and technologies essential to sexual and reproductive health, including based on the WHO Model List of Essential Medicines; (h) To ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health.".

[111] See ESCR Committee, General Comment No. 14.

[112] Ibid.

goods and facilities, in particular for women and disadvantaged and marginalized groups."[113] This right is not subject to "progressive realization"—meaning that States have an immediate obligation to take deliberate, concrete, and targeted steps towards ensuring equitable and affordable access.[114] For obligations that do no fall within the minimum core, it notes that while a State may be permitted to engage in the *progressive realization* of the right to health in recognition of its resource limitations, such a State but must continue to devote the "*maximum of its available resources*" to improve health care over time.[115] It further clarifies that progressive realization is never a justification for non-compliance with the core obligations.

39. The Committee has further identified the right to non-discrimination as a minimum core obligation and confirmed that accordingly the obligations imposed by the right to non-discrimination are immediate. The immediate nature requires that even the poorest of countries, with the least resources, fulfil this right instantaneously, particularly for the most vulnerable amongst them. Also, the far-reaching nature of obligations under the right to non-discrimination means that all other rights must be guaranteed on an equal basis to all without any discrimination. Accordingly, barriers that prevent women from accessing maternal healthcare services, which only women need, violate not only their right to health, but also their rights to non-discrimination on the basis of sex, and socio-economic status.

40. States' obligations and responsibility extend to maternal health violations in private healthcare facilities as several of the treaty monitoring bodies have affirmed. The CESCR Committee in its General Comment No. 14 provides that health care services must be affordable to all no matter whether they are provided by public or private facilities.[116] It requires States to ensure that private providers of health care services understand the importance of the right to health in the pursuit of their activities.[117] It explicitly clarifies that States' obligation to *protect* entails ensuring that the privatization of public goods such as health services does not impede the obligations to ensure the availability, accessibility, acceptability and quality of healthcare services.[118]

[113] Ibid.

[114] See ESCR Committee, General. Comment No. 3: Article 3, the nature of States parties' obligations, (5th Sess. 1990), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, paras. 1–2, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[115] Ibid.

[116] See ESCR Committee, General. Comment No. 14, para. 12.

[117] Ibid, para. 55.

[118] See ESCR Committee, General. Comment No. 14, para. 35.

41. In General Recommendation No. 24, the CEDAW Committee expressly confirms that States cannot absolve themselves of responsibility for women's poor health outcomes in health facilities by delegating or transferring their powers to private sector providers. The Committee reiterated this position in *Alyne v Brazil* where it decided that Alyne died principally due to the low-quality maternity care she received.[119] Responding to the government's assertion that it could not be held responsible for the actions of a private health institution, the Committee emphasized that governments could not relinquish their responsibilities by outsourcing medical services. Instead they must supervise and regulate the health practices and policies of private health facilities.[120] The CRC in General Comment No. 15 has also observed that States remain responsible for health rights violations even where it has delegated the provision of heath care services to private actors.[121] The Nigerian government, as such, remains accountable for violations occurring in both public and private health facilities in the country.

- **Violation of the Right to Dignity and Freedom from Torture, Cruel, Inhuman and Degrading Treatment**

42. Dignity serves as the basis of all human rights,[122] and, as a result, the right to life has been broadly interpreted by courts as the right to live with dignity. The fundamental principle of human dignity obligates States to protect women from maternal deaths caused by gender-based violence and the denial of access to reproductive health care and information. The freedom from torture, cruel, inhuman and degrading treatment (Ill-treatment) is closely connected to the right to dignity.

43. Some of the victims of maternal morbidity and mortality in Nigeria are women who experienced unnecessary delays in receiving maternity care at health facilities or were detained in healthcare facilities for their inability to pay their full medical bills, and who then experienced abuse and mistreatment by healthcare providers resulting in debilitating injuries or death.[123] The instances of abuse and mistreatment experienced include being denied access to post-delivery care, inadequate access to food and clean water, being required to sleep on the bare floor so that beds can be made available to patients with the ability to pay, sleep deprivation as a result, and denial of access to their new

[119] Ibid, para. 7.3-7.5.
[120] Ibid, para. 7.5.
[121] Ibid, para. 7.5.
[122] Universal Declaration of Human Rights adopted Dec. 10, 1948, Article 1, G.A. Res. 217A (III), U.N. Doc. A/810 (1948); ICCPR, *supra note* 3, Preamble; International Covenant on Economic, Social and Cultural Rights, adopted Dec. 16, 1966, preamble, G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, U.N. Doc A/6316 (1966) (entered into force Sept 2, 1990).
[123] F Oduyoye 'Nigeria Hospital Detention' available at https://www.vice.com/en_us/article/59xxkd/nigeria-hospital-detention-folake-oduyoye (accessed on 23 May 2020).

born which caused them severe mental anguish. Indeed, such was the experience of one of the women whose name the Complainants provided to the Commission.

44. Health care services, including maternal health care should be provided with respect for the dignity of women and their freedom from ill-treatment. Where women face ill-treatment in the reproductive rights sphere, the State's responsibility is often engaged by the application of restrictive and discriminatory laws or policies, actions by medical professionals who fail to meet ethical standards, by the failure to appropriately regulate private healthcare settings, or the failure to sanction violence by private individuals.[124]

45. Article 5 of the African Charter combines a wide range of rights including the protection of the right to dignity and freedom from ill-treatment. [125] In some of its decisions, including *Curtis Doebbler v Sudan, and Egyptian Initiative for Personal Rights and INTERIGHTS v Arab Republic of Egypt***,** the African Commission has explained that this provision is violated when an individual is exposed to suffering or treated in an undignified manner.[126] More recently, the Commission has explained that coercive acts, including denial of reproductive health services, will amount to cruel, inhuman and degrading treatment in violation of Article 5 of the Charter.[127] The African Commission further enjoins States to take measures with a view to ensuring redress for victims of such human rights violations.[128]

46. Article 4 of the Maputo Protocol guarantees women's right to be treated with dignity. While the African Commission has not clarified the scope and content of this provision, it has noted that States must ensure that women are not treated in an inhuman, cruel and degrading manner while seeking sexual and reproductive health services, addressing the detention of pregnant women in health facilities.[129] Therefore, the high maternal deaths in Nigeria, mainly due to lack of access to quality health care services coupled with the detention,

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[124] K Mayall, O Afulukwe, and K Thomasen *Reproductive Rights Violations as Torture or Ill-Treatment in Gender Perspectives on Torture: Law and Practice*, Washington, D.C., Center for Human Rights & Humanitarian Law, American University Washington College of Law (2018).

[125] African Charter on Human and Peoples' Rights.

[126] See for instance *Curtis Doebbler v Sudan* (Communication No. 235/2000) [2009] ACHPR 103; (25 November 2009); *Egyptian Initiative for Personal Rights and INTERIGHTS v Arab Republic of Egypt* (Communication No. 323/2006) [2011] ACHPR 85; (16 December 2011).

[127] See General Comment No. 4 on the African Charter on Human and Peoples' Rights: The Right to Redress for Victims of Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment (Article 5) paras. 56-57, adopted at the 21st Extra-Ordinary Session of the African Commission on Human and Peoples' Rights, held from 23 February to 4 March 2017 in Banjul, The Gambia.

[128] Ibid. para. 58.

[129] See African Commission, General Comment No. 2, para. 36.

mistreatment and abuse of women in health care facilities for their inability to pay the full maternity bills, constitute a violation of the right to dignity and to be free from cruel, inhuman and degrading treatment. In their latest concluding observations, the Commission expressed concern regarding violence against women multiple times, recommending that Nigeria should build operational and institutional capacities to combat violence against women by ensuring that cases of violence are properly investigated and prosecuted, as well as raising awareness among the public.[130] The Committee on the Prevention of Torture in Africa (CPTA) has recognised that the denial of abortion and post-abortion care can also amount to torture or other cruel, inhuman or degrading punishment or treatment.[131]

47. The right to dignity and freedom from ill-treatment is protected under Section 34 1(a) of the Nigerian Constitution.[132] National courts in Africa have specifically determined that the detention and mistreatment of women in healthcare facilities following child birth violate the rights of women. The High Court of Kenya in *Maimuna v. The AG* found that such detention violated the right to health, dignity and freedom from torture, cruel, inhuman and degrading treatment.[133]

48. The right to dignity and freedom from ill-treatment is likewise enshrined in a number of international human rights instruments all of which Nigeria has ratified. These include Articles 1 and 16 (1) of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT),[134] Articles 7 and 10(1) of the ICCPR.[135] The right to dignity is also specifically recognized in the preambles of the ICESCR, CAT, and CEDAW.

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[130] African Commission on Human and Peoples' Rights, *Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014)*, (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020).

[131] Commissioner Lawrence M. Mute, Chairperson, Committee for the Prevention of Torture in Africa, Inter-Session Activity Rep. (May 2017 to November 2017) and Thematic Rep. on Denial of Abortion and Post-Abortion Care as Torture and Other Cruel, Inhuman or Degrading Punishment or Treatment, Presentation at the 61st Ordinary Session of the ACHPR (Nov. 1-15, 2017), available at http://www.achpr.org/files/sessions/61st/inter-act-reps/299/comm_mute_cpta_61_act_report_eng.pdf. (accessed on 14 May 2020).

[132] Constitution of the Federal Public of Nigeria, 1999.

[133] *Milicent Awuor Omuya alias Maimuna Awuor & Anor vs. The AG & 4 Others*, Petition No. 562 of 2012, Mumbi, J in the High Court of Kenya, para. 178, available at http://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Judgment%20Petition%20No562%20of%202012%20Kenya%20detention%20case.pdf [hereinafter *Maimuna v. AG 2012*]. (accessed on 23 May 2020).

[134] 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, U.N. Doc. A/39/51 (1984), 1465 U.N.T.S. 85 (entered into force June 26, 1987).

[135] International Covenant on Civil and Political Rights.

49. States parties to these instruments have the obligation to refrain from committing acts of ill-treatment as well as to take effective judicial and other measures to prevent, punish, and redress these acts.[136] When there is evidence that shows that ill-treatment has been committed, States are generally required to conduct a prompt and impartial investigation, to prosecute and take action against the perpetrators, and, in some cases, to provide civil remedies to the victims.[137] Further, States are responsible for acts of ill-treatment that are committed by State agents as well as private individuals who acted in an official capacity, on behalf of the State, or in conjunction with the state.[138] The State is also responsible for human rights violations committed by non-state actors if the state failed to take the necessary measures to prevent the violation or punish and redress such harms.[139]

50. The Committee Against Torture (CAT Committee) has repeatedly stated that the right to be free from ill-treatment is absolute and cannot be diminished under any circumstance.[140] It has affirmed that women are vulnerable to ill-treatment in the context of "deprivation of liberty, medical treatment, particularly involving reproductive decisions, and violence by private actors in communities and homes."[141] The CAT Committee as well as the Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment have also recognized physical, verbal, and mental abuse of women in the context of maternal health care as a form of ill-treatment – a widespread human rights violation that has been documented globally, and can include the detention of women unable to pay their medical bills, the denial of anaesthesia, and prolonged delays in administering care.[142]

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[136] Convention Against Torture, arts. 2(1), 12, 14; ICCPR, art. 2(2); Human Rights Committee, General Comment No. 20: Article 7 (Prohibition of torture, or other cruel, inhuman or degrading treatment or punishment), (44th Sess. 1992), in Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, at 200, para. 8, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[137] Convention Against Torture, art. 12; see also *Godínez-Cruz v. Honduras*, Judgment and Merits, Inter-Am. Ct. H.R. (ser. C) No. 5, para. 175 (Jan. 20, 1989); *Velásquez-Rodríguez v. Honduras*, Judgment, Inter-Am. Ct. H.R. (ser. C) No. 4, para. 166 (July 28, 1988); *M.C. v. Bulgaria*, No. 39272/98 Eur. Ct. H.R., paras. 149–53 (2004).

[138] [10] CAT Committee, General Comment No. 2, *supra note* 1, at 376, para. 15.

[139] See *Ximenes Lopes v. Brazil*, Merits, Reparations and Costs Judgment, Inter-Am. Ct. H.R. (ser. C) No. 149, paras. 85–86 (July 4, 2006); CAT Committee, General Comment No. 2, *supra note* 1, para. 18; Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development, para. 53, U.N. Doc. A/HRC/7/3 (Jan. 15, 2008) (by Manfred Nowak); Committee on Economic, Social and Cultural Rights, General Comment No. 14:.

[140] CAT Committee, General Comment No. 2, para. 5; see also CAT, Article 2(2).

[141] Ibid, para 22.

[142] CAT Committee, Concluding observations on the third to fifth periodic reports of United States, para. 21, U.N. Doc. CAT/C/USA/CO/3-5 (2014); see also CAT Committee, Consideration of Reports Submitted by States Parties under Article 19 of the Convention, Conclusions and recommendations of the Committee against Torture: United States of America, para. 33, U.N. Doc CAT/C/USA/CO/2 (2006). See also J Méndez, Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Report of the Special Rapporteur on torture and other

51. For example, the CAT Committee expressed concern about "the on-going practice [in Kenya] of post-delivery detention of women unable to pay their medical bills,"[143] during which women and their infants are neglected and abused by health workers.[144] The UN Special Rapporteur on Torture has also affirmed that the abuse and mistreatment that women face when seeking reproductive health services can "cause tremendous and lasting physical and emotional suffering."[145] The Special Rapporteur further noted that women face numerous violations, including "abusive treatment and humiliation in institutional settings."[146] The CAT Committee has found State responsibility where the State knew or should have known about acts of ill-treatment by non-State actors and failed to exercise due diligence in addressing and remedying these violations.[147] It has further confirmed that indifference or inaction provides a form of encouragement and/or de facto permission, for individuals committing acts of ill-treatment, which may include acts of gender-based violence.[148]

52. The recognition of reproductive rights violations as rising to the level of ill-treatment in certain circumstances, such as maternity care, makes clear the urgent and inviolable nature of Nigeria's legal obligations to ensure that denial of antenatal care, detention, abuse and mistreatment of women seeking maternal health services are prevented, addressed, and remedied effectively. The widespread nature of these actions in both private and public health facilities in Nigeria and the attention drawn to them in human rights reports, shadow letter submissions to the African Commission and other treaty monitoring bodies and human rights mechanisms, and by investigative journalists, clearly establishes knowledge of the violations on the part of the Nigerian government, even where they occurred in private facilities.

- **Violation of the Right to Equality and Non- Discrimination**

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cruel inhuman or degrading treatment or punishment, Human Rights Council, para. 46, U.N. Doc. A/HRC/31/57 (Jan. 2, 2016)

[143] CAT Committee, Concluding Observations: Kenya, para. 27, U.N. Doc. CAT/C/KEN/CO/2 (2013).

[144] See Center for Reproductive Rights & Federation of Women Lawyers-Kenya, 'Failure to Deliver: Violations of Women's Human Rights in Kenyan Health Facilities' (2007) 56-59, available at http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bo_failuretodeliver.pdf (accessed on 23 May 2020); Focus group discussion participant, in Nairobi, Kenya (Mar. 1, 2012) (on file with the Center for Reproductive Rights).

[145] J Méndez (2016),, para. 42; Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Rep. of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, para. 46, U.N. Doc. A/HRC/22/53 (Feb. 1, 2013).

[146] Ibid. para. 46.

[147] CAT Committee, General Comment No. 2: Implementation of Article 2 by States parties, para. 18, U.N. Doc. CAT/C/GC/2 (2008).

[148] CAT Committee, General Comment No. 2: Implementation of Article 2 by States parties, para. 18, U.N. Doc. CAT/C/GC/2 (2008).

53. Due to patriarchy and adherence to cultural practices, women are often subjected to daily discriminatory practices and human rights violations.[149] This and several contributory factors such as low-income, lack of formal education, location in a rural area, early marriage, and low status of women combined with the corruption and mismanagement of resources, poor infrastructure and poor funding of the health sector to exacerbate the poor maternal health situation in Nigeria.[150]

54. These factors have sustained the seemingly insurmountable financial barriers which include a system of user fees that prevents impoverished women from accessing antenatal and intra-partum care in Nigeria.[151] Women who do receive maternity-related healthcare risk being detained in healthcare facilities if they are unable to pay later.[152] This practice leads women to avoid care if they are unable to afford it, or to endanger themselves by leaving the hospital before treatment has ended to avoid the hospital fees.[153]

55. Another financial barrier relates to the practice of compulsory spousal blood donation.[154] Although the Nigerian policy on blood donation requires that all donations be voluntary, human rights report findings confirm that pregnant women who attempt to access maternal healthcare services at many public or government hospitals, as well as private facilities, are often required to bring their husbands to donate blood.[155] While patients may sometimes opt out of this wide spread practice of blood donation requirement by paying a fee, this option is not always made known and has a discriminatory impact on the poor who may prefer to pay—but be unable to afford—a fee in lieu of blood donation.[156]

56. Compulsory spousal blood donation can have multiple negative consequences

[149] For detailed discussion on some of these practices, see U Ewelukwa 'Pre-colonialism, Gender, Customary Injustices: Widows in African Societies' (2002) 24 *Human Rights Quarterly* 425-484; see also, E Durojaye 'Woman but not human' Widowhood practices and human rights violations in Nigeria' (2013) 27, 2 *International Journal of Law, Policy and the Family* 176-196; AU Iwobi 'No Cause for Merriment: The Position of Widows under Nigerian Law' (2008) 20 *Canadian Journal of Women and Law* 37-86.

[150] See O Olonade et al 'Maternal Mortality and Maternal Health Care in Nigeria: Implications for Socio-Economic Development' *Open Access Macedonian Journal of Medical Sciences* available at https://www.ncbi.nlm.nih.gov/pmc/Articles/PMC6447322/ (accessed on 30 April 2020).

[151] Center for Reproductive Rights and Women Advocate Research and Documentation Centre (2008).

[152] Ibid, at 41.

[153] Ibid.

[154] Ibid, at 44-45.

[155] Ibid.

[156] Ibid.

on pregnant women who are unable or unwilling to compel their husbands to donate blood, including husbands' refusal to permit their wives to access antenatal, intra-partum, and postnatal services and women's exposure to domestic violence if they attempt to compel their husbands to donate blood. The blood-donation requirement also disadvantages pregnant women who are unmarried, including those who may have become pregnant due to sexual violence, 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 unaffordable for many. The discriminatory impact of this fee on poor and single women includes diminished access to reproductive health services, inferior care, and worse health outcomes.[157]

57. It has long been recognized that the obligation to ensure the rights to equality and non-discrimination underlies all human rights. The rights to equality and non-discrimination effectively demonstrate the scope of harm suffered by women through the denial of reproductive rights—including as a result of cultural and ideological opposition—and the corresponding obligation of governments to ensure that discrimination does not expose women to the risk of pregnancy-related injuries and death.

58. The right to non-discrimination and equality before the law is guaranteed in Articles 2 and 3 of the African Charter.[158] The African Commission, in the case of *Legal Resource Foundation v Zambia*, has explained the relevance of Articles 2 and 3 of the African Charter dealing with non-discrimination and equal protection of the law.[159] According to the African Commission:

> *The right to equality is very important. It means that citizens should be expected to be treated fairly and justly within the legal system and be assured of equal treatment before the law and equal enjoyments of all the rights available to all other citizens. The right to equality is important for a second reason. Equality or lack of it affects the capacity of one to enjoy many other rights*.[160]

59. This clearly speaks to the discriminatory practices women are subjected in Nigeria which often limit their access to sexual and reproductive health services, including maternal health care. The African Commission has further clarified *in Good vs Republic of Botswana* that the right to non-discrimination is

[157] Ibid. at 44-45.
[158] African Charter on Human and Peoples' Rights.
[159] *Legal Resource Foundation v Zambia* (2001) AHLR84 (ACHPR 2001).
[160] Ibid paras. 65-68.

violated when: “a) equal cases are treated in a different manner; b) a difference in treatment does not have an objective and reasonable justification; and c) if there is no proportionality between the aim sought and the means employed.”[161] This view of equality highlights that differential treatment is not discriminatory if it has a legitimate purpose, such as achieving gender equality.

60. The provisions of Articles 2 and 3 must be read together with Article 18 (3) of the African Charter which prohibits discrimination against women and protects the right to family. Allowing preventable maternal deaths to go unaddressed undermines the right to found a family as envisaged under Article 18 (3) of the Charter. To this end, African governments have agreed to address discriminatory practices against women in all spheres of life and ensure the provision of social services, including maternal health services, are available to all women, especially women in rural areas.[162]

61. Article 1 of the Maputo Protocol prohibits discriminatory practices both in private and public spheres. It requires States to eliminate all forms of discrimination against women. Article 2 also calls on States to adopt a holistic approach to address root causes of discrimination against women. The Maputo Protocol adopts a substantive equality approach to discrimination against women like its international counterpart, the CEDAW. It emphasizes that States are required to combat both de jure and de facto discrimination against women by undertaking the necessary legislative and institutional reforms.[163] As such, States should include the principle of equality in the constitution and other relevant laws, implement legislative measures to address all forms of discrimination, and take other positive actions to remedy factual discrimination.[164] Thus, in order for women to enjoy their right to maternal care, States must address cultural and religious practices that perpetuate the low status of women.

62. In addition, Article 5 of the Maputo Protocol requires States to eradicate harmful practices that may undermine the human rights of women. The African Commission has noted that States are obligated to create an enabling legal environment that will address harmful practices against women and guarantee

[161] *Good v. Republic of Botswana,* African Commission on Human and Peoples’ Rights, Communication No. 313/05, para. 219 (2010), available at http://www.achpr.org/files/sessions/47th/comunications/313.05/achpr47_313_05_eng.pdf (accessed on 23 May 2020).
[162] See Solemn Declaration on Gender Equality in Africa adopted by the African Union Assembly of Heads of State and Government in Addis Ababa, Ethiopia 2004.
[163] See Maputo Protocol, Article 2.
[164] Ibid.

access to sexual and reproductive health services without discrimination.[165] It has further noted that the "right to health care without discrimination requires States to remove impediments to the health services reserved for women, including ideological or belief based barriers."[166] More importantly, States are to remove all administrative, legal, cultural and religious barriers that promote and perpetuate gender-based inequality and may impede access to sexual and reproductive health care services for women.[167] In its latest concluding observations, the Commission expressed concern over the harmful practices which continue to restrict women from fully enjoying their rights and recommended that Nigeria put measures in place to better achieve gender equality.[168]

63. The right to equality and non-discrimination is also enshrined in Section 42 of the Nigerian Constitution. It is also guaranteed in international human rights instruments, including the ICCPR, ICESCR, CRC and CEDAW.[169] In a recent decision in *S.F.M v Spain*,[170] regarding "obstetric violence" the CEDAW Committee determined that the mistreatment a woman experienced during childbirth caused her lasting physical and mental trauma and violated her rights to non-discrimination and to health and other rights guaranteed under Articles 2 b), c), d) and f), 3, 5 and 12 of the Convention. The Committee urged the State to take measures, including by adopting policies, to prevent such treatment in future, and to provide reparations for the damage to her physical and psychological health.

64. As a state party to these instruments, the Nigerian government has the obligation to adopt and implement all necessary laws and policies to ensure the protection of women's rights to equality and non-discrimination.[171]

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[165] See Joint general comment of the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) on ending child marriage adopted by the African Commission on Human and Peoples' Rights (ACHPR) and the African Committee of Experts on the Rights and Welfare of the Child (ACERWC) 2017.

[166] African Commission, General Comment No. 2, para. 25.

[167] Ibid.

[168] African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014), (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020).

[169] International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights, Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Rights of the Child, Convention on the Elimination of All Forms of Discrimination against Women.

[170] See CEDAW Committee available at file:///D:/CEDAW/SFM%20V%20Spain--CEDAW%20decision%20on%20obstetric%20violence.pdf (accessed on 23 May 2020).

[171] CEDAW, Articles 2, 3, 24; ICESCR, Article 2(1); ICCPR, Article 2(2); Human Rights Committee, General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant, (18th Sess. 2004), in

Formal v Substantive Equality:

65. Ensuring equality means addressing not only formal *(de jure)* inequality, which is discrimination based on law, but also substantive *(de facto)* inequality or discrimination based on practice.[172] Formal equality requires ensuring that laws and policies treat all persons alike.[173] In particular, formal equality provides a basis through which States can protect individuals from State and private intrusions into their liberty.[174] However, formal equality is not sufficient to preclude discrimination; often this approach presumes that equality requires treating groups identically without taking into account their differences, which may actually put certain groups at a disadvantage.[175] In the context of sexual and reproductive rights, substantive equality requires that the distinct sexual and reproductive health needs of particular groups are addressed with tailored attention.[176]

66. Substantive equality provides a more comprehensive understanding of equality, requiring the equality of results and opportunities.[177] At its core, substantive equality requires States to identify the root causes of discrimination, such as power structures and social and economic systems reinforced by gender stereotypes and socialized gender roles, which lead to inequalities. Cultural and religious practices such as child marriage and spousal permission to seek healthcare services in Nigeria tend to exacerbate maternal death.[178] Also, the practices of mandatory spousal blood donation and detention of women in health care facilities for their inability to pay their maternity bills in full, because they are based on wide-spread practice and not law, fall within the scope of violations that ensuring formal equality alone will not sufficiently address.

Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 243, para. 4, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008).

[172] See CEDAW Committee, General Recommendation No. 25: Article 4, para. 1, of the Convention (temporary special measures), (13th Sess. 2004), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 365, paras. 7–10, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008); ESCR Committee, General Comment No. 16: The equal right of men and women to the enjoyment of all economic, social and cultural rights (art. 3), 34th Sess., 2005, in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 113-115, para. 7, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[173] CEDAW Committee, General Recommendation No. 25, paras. 7–8.

[174] S Fredman, 'Providing Equality: Substantive Equality and the Positive Duty to Provide' (2005) *South African Journal on Human Rights* 21, 166.

[175] CEDAW Committee, General Recommendation No. 25, para. 8.

[176] ESCR Committee, General Comment No. 22 on the Right to Sexual and Reproductive Health.

[177] Ibid, paras. 8–10.

[178] See E Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism and Unofficial Law* 103-132.

67. Substantive equality also requires States to acknowledge that people experience inequality differently not only because of who they are as individuals but also because of the groups to which they belong. It recognizes that discrimination can be compounded for women based on their gender and other identities. Substantive equality requires that States measure progress on addressing inequalities by looking at outcomes of results for all persons, including the most marginalized, and ensuring equality of results, which may require enacting practices and policies targeting particular marginalized groups. It further means that women may experience intersectional discrimination that requires States to undertake additional measures to meet their distinctive health needs and overcome barriers to their access to reproductive health services, such as maternal health.

68. This substantive equality approach is also reflected in the ICCPR and CEDAW, as well as in the CESCR.[179] The Human Rights Committee has noted that States are required to address both *de jure* and *de facto* discrimination in private and public spheres.[180] They are further required to not only remove barriers but also take positive measures "to achieve the effective and equal empowerment of women."[181] To this end, they should 'adopt whatever legislation is necessary to give full effect to the principle of equality between men and women,"[182] develop policies that promote gender equality,[183] take efforts to eliminate gender stereotypes about women in the family and society,[184] and address practices that disproportionally impact women.[185]

69. Similarly, the CEDAW Committee has affirmed that to fulfill women's human rights, States must use all appropriate means to promote substantive equality, including by adopting temporary special measures.[186] To this end, the

[179] CEDAW, arts. 1–4; Human Rights Committee, General Comment No. 28: The equality of rights between men and women, art. 3, (68th Sess. 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 228, paras. 2, 4, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008); ESCR Committee, General Comment No. 16, paras. 6, 8.

[180] Human Rights Committee, Concluding Observations: Jordan, para. 7, U.N. Doc. CCPR/C/JOR/CO/4 (2010).

[181] Human Rights Committee, General Comment No. 28: Article 3 (The equality of rights between men and women), (68th Sess. 2000), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 3, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. I) (2008).

[182] Human Rights Committee, Concluding Observations: Dominican Republic, para. 10, U.N. Doc. CCPR/C/DOM/CO/5 (2012).

[183] Human Rights Committee, Concluding Observations: Guatemala, para. 8, U.N. Doc. CCPR/C/GTM/CO/3 (2012).

[184] Human Rights Committee, Concluding Observations: Cape Verde, para. 8, U.N. Doc. CCPR/C/CPV/CO/1 (2012).

[185] Human Rights Committee, Concluding Observations: Canada, para. 20, U.N. Doc. CCPR/C/79/Add.105 (1999).

[186] Committee on the Elimination of Discrimination against Women (CEDAW Committee), General Recommendation No. 28: The Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women, (47th Sess. 2010), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, para. 20, U.N. Doc. CEDAW/C/GC/28 (2010).

Committee has noted that "women be given an equal start and that they be empowered by an enabling environment to achieve equality of results" and that "[t]he position of women will not be improved as long as the underlying causes of discrimination against women, and of their inequality, are not effectively addressed."[187]

70. The CEDAW Committee has emphasized that while significant progress has been achieved in repealing or modifying discriminatory laws, there is still a need for more action to promote substantive equality between men and women.[188] To ensure substantive equality, the CEDAW Committee and other treaty monitoring bodies urge States to "make more use of temporary special measures such as positive action, preferential treatment or quota systems. . . ."[189] Recognizing that women's role in procreation exposes them to discrimination, CEDAW calls on States specifically to introduce special measures to protect women during pregnancy.[190] While States are required to reduce their maternal mortality rates through safe motherhood services and prenatal assistance,[191] simply reducing their overall maternal mortality rates does not fulfill their obligations to ensure substantive equality under CEDAW. States are required to provide adequate interventions to prevent maternal mortality, including appropriate health services that meet the distinct needs of women and are inclusive of marginalized sectors of society.[192]

71. These above standards as discussed require Nigeria to fully account for the high the levels of preventable maternal deaths by addressing the roles both formal and substantive inequality on the basis of sex play in women's susceptibility to dying or suffering debilitating injuries; as well as the different maternal health outcomes that women experience based on their socio-economic status.

- **Violation of the Right to Information**

[187] CEDAW Committee, General Recommendation No. 25.

[188] CEDAW Committee, General Recommendation No. 5: Temporary Special Measures, (7th Sess. 1998), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 320, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) (2008).

[189] Ibid; see also Human Rights Committee, General Comment No. 18: Non-discrimination, (37th Sess. 1989), in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 195, para. 10, U.N. Doc. HIR/GEN/1/Rev.9 (Vol. I) (2008); CEDAW Committee, Gen. Recommendation No. 25, *supra note* 9, para. 14; ESCR Committee, General. Comment No. 16, *supra note* 9, para. 15.

[190] CEDAW, art. 11(2).

[191] CEDAW Committee, General Recommendation No. *24*, para. 31(c).

[192] *Alyne case*.

72. Access to comprehensive sexual and reproductive health information is crucial to preventing ill-health and ensuring the well-being of all individuals. Further, access to sexual and reproductive health information can help in preventing unplanned pregnancies, unsafe abortion and minimizing incidence of maternal deaths and morbidities. Evidence abounds to show that many of the maternal deaths in Nigeria could easily be avoided if women and girls have adequate access to information about their health. The right to information is guaranteed in Article 9 of the African Charter.[193] The right to information acts as a gateway right for the rights to health, life. Dignity, and equality. The right to obtain information is necessary to realize other fundamental rights such as the rights to health, life, equality and dignity. Specifically in relation to health, Article 14 (2) of the Maputo Protocol recognizes the right to health-related information as a vital component of the right to health, emphasizing the importance of information, education and communication services in the provision of adequate, affordable and accessible health care services.

71. The African Commission, in a number of cases, has clarified the scope of the provision on the right to information. For instance, in the *Media Rights Agenda* case[194], the Commission explains that States are obligated to ensure access to information to all and must not be seen to hinder such access. In other words, the state obligation in this regard is both negative and positive.

72. Article 14 (1) (f) of the Maputo Protocol guarantees the right to family planning education. This provision is important for a country like Nigeria where the rate of adolescent pregnancy and women's fertility rate is very high. The African Commission has explained that States are required to ensure available, accessible, acceptable and reliable information on access to contraceptive services to women and girls.[195] In their latest concluding observations, the Commission recommended that Nigeria revise its law on abortion and takes steps to improve access to contraceptives and family planning.[196] Also, the Commission has enjoined States to take appropriate measures with a view to providing comprehensive sexuality education for girls in schools.[197]

73. The right to information is further guaranteed under international human rights instruments. The CESCR in General Comment 14 clarifies that the right to

[193] African Charter on Human and Peoples' Rights.

[194] *Media Rights Agenda and Others v Nigeria*, Cited as Communication No. 105/93, 128/94, 130/94 and 152/96 (1998).

[195] See African Commission, General Comment No. 2, para. 28.

[196] African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on the 5th Periodic Report of the Federal Republic of Nigeria on the Implementation of the African Charter on Human and Peoples' Rights (2011-2014), (57th Ordinary Sess. 2015), available at https://www.achpr.org/sessions/concludingobservation?id=93 (accessed on 14 May 2020).

[197] See General Comment No. 1 of the African Commission.

health requires States to *"improve … maternal health, [and] sexual and reproductive health services, including … emergency obstetric services and access to information, as well as to resources necessary to act on that information."*[198] Further, it has stated that the right to health extends not only to access to healthcare but also to the underlying determinants of health, such as ... 'access to health-related education and information, including information relating to sexual and reproductive health.'[199] The Committee has also provided as part of the minimum core obligations under the right to health that States are: " *To ensure all individuals and groups have access to comprehensive education and information on sexual and reproductive health that are non-discriminatory, non-biased, evidence-based, and that take into account the evolving capacities of children and adolescents."*[200]

74. The CEDAW Committee in its General Comment 24 on women and health asserts that women's "access to health services, education and information, including in the area of sexual and reproductive health" (para. 31(b)-(c))[201] is a requisite aspect of the right to health and to information.

- **Right to Enjoy the Benefits of Scientific Progress**

75. Women in Nigeria have a right to benefit from scientific progress including advancements in access to quality maternal health care services. The high levels of preventable maternal injuries and deaths in the country, particularly when compared with other countries in the region and globally, indicate that women receiving maternal healthcare services do not enjoy this right. By failing to mitigate the high levels of preventable maternal injuries and deaths in Nigeria through ensuring quality maternal healthcare services, a reproductive health service that only women need, women are deprived of the opportunity and the right to access up-to-date maternity services like their counterparts in countries with similar resources and capabilities as Nigeria. This failure amounts to a violation of women's right to enjoy the benefits of scientific progress, as envisaged.

76. While there is no specific provision on the right to the benefits of scientific progress in the African Charter or the Maputo Protocol, it can be argued that this right is imbedded in the enjoyment of the right to health guaranteed in Article 16 of the African Charter and 14 of the Maputo Protocol. Indeed, in General Comment 2 on Article 14 of the Maputo Protocol, the African

[198] See ESCR Committee General Comment No. 14, para. 14.
[199] Ibid para. 11.
[200] Ibid para. 49.
[201] See CEDAW Committee, General Recommendation No.24, para. 31(b)-(c).

Commission recognizes that when women are denied access to reproductive and maternal health services they are also denied the benefit of scientific progress as articulated in the ICESCR.[202]

77. The African Commission has also observed that States parties are obligated to ensure "availability, accessibility and acceptability of procedures, technologies and comprehensive and good quality services, using technologies based on clinical findings."[203] This implies that States must ensure the availability of relevant progressive technologies, including modern forms of contraceptives methods to prevent unwanted pregnancy and meet the reproductive health needs of women. Depriving women access to the benefits of scientific progress amounts to a violation of their rights under the African Charter and Maputo Protocol.

78. The ICESCR, in Article 15(1)(b) & (3), also specifically protects the right of everyone to enjoy the benefits of scientific progress and its applications.[204] The ESCR Committee, as discussed in a prior section, has explained that *Quality* health care means that "[h]ealth facilities, goods and services must also be scientifically and medically appropriate and of good quality,"[205] and that States must provide "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment. . . ."[206] It has underscored that the failure or refusal to incorporate technological advances and innovations in the provision of sexual and reproductive health services, undermines the quality of care.[207]

79. The Human Rights Committee has asked States to develop plans to advance the right to life which should include, among others, detailed plans to improve access to medical examinations and treatments to reduce maternal mortality.[208]

80. The Nigerian government must ensure an enabling legal and financial environment that allows the benefits of scientific progress to permeate the health sector and make it accessible to all categories of women without discrimination. Without such measures to in place, Nigeria will likely maintain its position as a country with one of the highest levels of maternal deaths in the world.

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[202] The African Commission General Comment No. 2 on Article 14 (1) (a), (b), (c), and (f) and Article 14 (2) (a) and (c) of the Maputo Protocol, at para. 33.
[203] Ibid, para. 55.
[204] See ICESCR Article 15 (1).
[205] See ESCR Committee, General Comment No. 14, para. 12(d).
[206] Ibid.
[207] See ESCR Committee, General Comment No. 22, para. 21.
[208] See Human Rights Committee General. Comment No. 36, para. 26.

- **Violation of the Right to an Effective Remedy**

81. The high levels of preventable maternal injuries and deaths in Nigeria have gone on for well over a decade with hundreds of thousands of women dead but there is still not one instance of admissibility, judicial or administrative, or remedy provided to the victims or their families. Ensuring redress for victims requires investigating violations, prosecuting perpetrators and providing reparation including compensation.[209]

82. At the regional level, Article 7 of the African Charter states that every individual shall have the right to have their case heard. Article 7 (1) (a) highlighting that this comprises "the right to an appeal to competent national organs against acts of violating…fundamental rights as recognised and guaranteed by conventions, laws, regulations and customs in force. . . ."[210] The Maputo Protocol specifically protects the right to remedies in Article 25 noting that States are obligated to (a) "provide for appropriate remedies to any woman whose rights or freedoms, as herein recognised, have been violated; (b) ensure that such remedies are determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by law."[211]

83. The right to an effective remedy is guaranteed in Article 15(1)(b) & (3) of the ICESCR. The CESCR Committee has clarified in General Comment 22 that as part of the core or immediate obligations government have with respect to the right to health, they should " ensure access to effective and transparent remedies and redress, including administrative and judicial ones, for violations of the right to sexual and reproductive health." Further in General Comment No. 36, the Human Rights Committee has noted that in order to fulfil their obligation to respect and ensure the right to life, States must put in place legislative and other measures, and "provide effective remedies and reparation to all victims of violations of the right to life."[212]

84. The Human Rights Committee has noted the obligation of States to respect and to ensure the right to life, to give effect to it through legislative and other

[209] Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; pages 18-20; available at http://www2.ohchr.org/english/bodies/hrcouncil/docs/14session/A.HRC.14.39_AEV-2.pdf (accessed on 23 May 2020).
[210] See Article 7 (1) (a) African Charter.
[211] See Article 25 Maputo Protocol.
[212] See Human Rights Committee General Comment No. 36, para. 4.

measures, and to provide effective remedies and reparation to all victims of violations of the right to life.

85. In *Xákmok Kásek Indigenous Community v. Paraguay*, The Commission discussed the importance of the obligation to provide reparations,[213] stressing that they are "crucial to ensuring that justice is done."[214] It further emphasized that reparation called for full restitution,[215] and that in situations where it was impossible to provide this remedy, it was the Court's role to impose measures to, among other things, "ensure that the violated rights are respected."[216] It declared that preventing future violations constituted a crucial reason for providing reparations.[217] It urged the Court to mandate the state to immediately provide, among other things, healthcare services to the Community;[218] and take appropriate steps to prevent future violations.[219]

- **Reliefs**

86. The Complainants request the following reliefs:

    a. A declaration that the continued high levels of preventable maternal mortality and morbidity in Nigeria constitute a violation of Articles 2, 3,4,5 and 16 of the African Charter on Human and Peoples' Rights and Articles 1,2,4,5 and 10(h) and 14 (1) (a) (b), (c), (f), and (2) (a) and (c) of the Maputo Protocol

    b. A declaration that the continued high levels of preventable maternal mortality and morbidity in Nigeria also constitute a violation of the corresponding provisions under the Nigerian Constitution, and in the ICCPR, ICESCR; CEDAW; and CRC.

    c. A declaration that the Respondent state should make access to antenatal care and maternal care services for all women, especially those in rural areas, free and establish adequate numbers of health care centres in rural areas across the country.

[213] Ibid, para. 252-258.
[214] Ibid, para. 257.
[215] Ibid.
[216] Ibid, para. 258.
[217] Ibid.
[218] Ibid, para. 291 (d).
[219] Ibid, para. 291 (i).

d. A recommendation that in line with the Abuja Declaration the Nigerian government should invest more of its resources in improving the health care sector as a whole.

e. A recommendation that the Respondent state provide adequate professional training to healthcare providers on the reproductive health and rights of women and adolescent girls.

f. A recommendation that the Respondent state establish a Health Ombudsman to entertain complaints in relation to violation of human rights, including preventable maternal mortality and morbidity.

g. A declaration that the Respondent state establish administrative, legislative and policy measures to require an end to the practice of detaining women who cannot pay their full maternity care bills.

h. A declaration that the Respondent state address impunity for preventable maternal deaths and ensure effective remedies for violations.

i. An award of the sum of N5 billion as damages or compensation to the women and their families that have suffered physical and psychological loss, including debilitating injuries, due to complications arising from pregnancy and childbirth in the country.

j. A declaration that the African Commission will retain monitoring jurisdiction over the complaint and the implementation of the decision.

k. A declaration that the Respondent state set up an administrative unit or appoint an experts committee to track and report on the status of compliance with the decision.