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# The Application of the International Right to Health Framework for the Reduction of Maternal Mortality in Nigeria: Prospects and Challenges

A thesis submitted by Oluseyi Funke Olayanju for the award of the Degree of

Doctor of Philosophy

Durham Law School, Durham University

2023

## Abstract

This thesis is concerned with the application of the right to health approach to achieve the reduction of maternal mortality in Nigeria. Existing literature has primarily focused on recommending that Nigeria adopt and implement international right to health standards in order to reduce its extremely high maternal mortality ratio. These recommendations are often preceded by a catalogue of Nigeria's various failings to conform with the standards of the framework. The inherent shortcomings of the framework, as well as the challenges associated with its implementation are usually overlooked. Invariably, there has hitherto been a one-sided consideration of the prospects of the framework. Therefore, this study provides a holistic presentation of the prospects and challenges of the framework. To provide a nuanced understanding of the viability of the framework in the Nigerian context, as well as to fill a gap in knowledge, an empirical study focusing on Lagos state in Nigeria, explored the experiences of the implementers of some of the aspects of the framework.

Overall, the research reveals that although the right to health approach is potentially useful, adopting and implementing all or any part of it, without taking account of the problems of the framework and how to adapt the framework to fit the peculiarities of the Nigerian context, would result in nominal gains and, or unintended consequences. This study thus contributes to a more balanced and informed discussion on the feasibility of the right to health approach in relation to maternal mortality reduction in Nigeria.

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## LIST OF ABBREVIATIONS

| | |
|---|---|
| AAAQ | Availability, Accessibility, Acceptability, and Quality of healthcare |
| ACRWC | African Charter on the Rights and Welfare of the Child |
| ACERWC | African Committee of Experts on the Rights and Welfare of the Child |
| African Charter | African Charter on Human and Peoples' Rights |
| African Charter Act | African Charter on Human and Peoples Rights (Ratification and Enforcement) Act |
| African Commission | African Commission on Human and Peoples' Rights |
| AHRLR | African Human Rights Law Report |
| AU | African Union |
| CS | Caesarean Section |
| CFRN | The Constitution of the Federal Republic of Nigeria,1999 CAP C4 LFN 2004, |
| CEDAW | Convention on the Elimination of Discrimination Against Women |
| CESCR | Committee On Economic Social and Cultural Rights |
| CCPR | Committee on Civil and Political Rights |
| CPR | Civil and Political Rights |
| CRC | Convention on the Rights of the Child |
| CRC Committee | Committee on the Rights of the Child |
| ESCR | Economic, Social and Cultural Rights |
| EmOC | Emergency Obstetric Care |
| EPMM | Ending Preventable Maternal Mortality |
| FCCPC | Federal Competition & Consumer Protection Commission |
| FGM | Female Genital Mutilation |
| FMOH | Federal Ministry of Health |
| GC3 | CESCR, General Comment No. 3: The Nature of States Parties Obligations |
| GC14 | CESCR General Comment 14 |
| GC15 | CRC General Comment 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health |

| | |
|---|---|
| GC22 | UN CESCR General Comment No. 22 (2016) of the CESCR (GC22) |
| GR24 | UN CEDAW Committee General Recommendation 24 |
| HEFAMAA | Health Facility Monitoring and Accreditation Agency |
| HRBA | Human Rights Based Approach |
| HRC | Human Rights Council |
| HSC | Health Service Commission |
| ICPD | International Conference on Population and Development |
| KI | Key informant |
| KIA | Key Informant Agency |
| KIH | Key Informant Hospital |
| KIM | Key Informant Ministry |
| LASHMA | Lagos State Health Management Agency |
| LSBTS | Lagos State Blood Transfusion Service |
| LSTMB | Lagos State Traditional Medicine Board |
| LMOH | Lagos State Ministry of Health |
| MDPA | Medical and Dental Practitioners Act 1988, Cap M8 LFN 2004 |
| MDPDC | Medical and Dental Practitioners Disciplinary Committee |
| MDG | Millennium Development Goals |
| MH | Maternal Health |
| MM | Maternal Mortality |
| MMM | Maternal Mortality and Morbidity |
| MPDSR | Maternal and Perinatal Death Surveillance and Response |
| NCHRE | National Code of Health Research Ethics |
| NHREC | National Health Research Ethics Committee |
| NGO | Non-Governmental Organisation |
| NHA | National Health Act |
| NHP | National Health Policy |
| NMA | Nigeria Medical Association |
| NWLR | Nigerian Weekly Law Reports |
| OHCHR | the Office of the High Commissioner for Human Rights |
| PHC | Primary Health Care |
| PPMV | Proprietary and Patent Medicine Vendors |
| RH | Right to Health |
| RMNCAH | Reproductive Maternal, Newborn Children and Adolescent Health |

| SBA | Skilled Birth Attendants |
|---|---|
| SDG | Sustainable  Development Goals |
| SRH | Sexual and Reproductive Health |
| SRHR | Sexual and Reproductive Health Rights |
| TBA | Traditional Birth Attendants |
| TMB | Treaty Monitoring Bodies |
| UDHR | Universal Declaration of Human Rights |
| UHC | Universal Health Coverage |
| UPR | Universal Periodic Review |
| UN | United Nations |
| VAPP Act | Violence Against Persons Prohibition Act |
| WHO | World Health Organisation |

## Table of Legislation and Treaties

### Nigerian Legislation

African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap A 9 LFN 2004

Child Rights Act 2003 Cap C50 LFN 2004

Constitution of the Federal Republic of Nigeria 1999 CAP C4 LFN 2004

Corrupt Practices and other Related Offences Act, 2001 Cap C 31 LFN 2004.

Criminal Code Act, Cap C 39, LFN 2004.

Criminal Law of Lagos State 2015

Ekiti State Gender Based Violence (Prohibition) Law 2011

Health Sector Reform Law Lagos 2006 Part 5,

Interpretation Act Cap I 23 LFN 2004

Jigawa State Child Rights Law 2021

Lagos State Blood Transfusion Committee Law no. 10 2004.

Lagos State Health Scheme Law 2015.

Lagos State Protection Against Domestic Violence Law 2007

Medical and Dental Practitioners Act Cap M8 LFN 2004 (MPDA)

National Health Act 2014

National Health Insurance Authority Act 2021

National Health Insurance Scheme (NHIS) Act Cap N42 LFN 2004

Nursing and Midwifery (Registration Etc.) Act. Cap N143 LFN 200

Penal Code (Northern States) Federal Provisions Act (No. 25 of 1960)

Violence Against Persons Prohibition Act 2015

**Legislation of Other Countries**

**India**

Constitution of India 1950

**Sierra Leone**
Constitution of Sierra Leone 1991

**Ghana**
Constitution of the Republic of Ghana 1996.

**Kenya**
Kenya Health Act No.21 of 2017

**United Kingdom**

Magna Carta (1215)

English Bill of Rights (1689)

**United States of America**

American Declaration of Independence (1776)

**International**

Charter of the United Nations 1945

Constitution of the World Health Organisation 1947

Convention on the Rights of the Child 1989

Covenant of the League of Nations 1919

Declaration of Alma- Ata 1978

International Convention on the Elimination of Discrimination Against Women 1979

International Covenant on Civil and Political Rights 1966

International Covenant on Economic, Social and Cultural Rights 1966

Optional Protocol to International Covenant Economic, Social and Cultural Rights, Resolution 2009

Optional Protocol to International Convention on the Elimination of Discrimination Against Women 1999

Universal Declaration of Human Rights 1948

**Regional**

**Africa**
African Charter on Human and Peoples' Right 1981

African Charter on the Rights and Welfare of the Child OAU Doc. CAB/LEG/24.9/49 (1990)

Pretoria Declaration on Economic Social and Cultural Rights 2004

Protocol to the African Charter on Human and Peoples' Right on the Rights of Women in Africa 2003

**Europe**

European Convention on Human Rights and Biomedicine, 1997.

European Social Charter 1961

**South America**

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 1988

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**Nigeria**

Attorney General Ondo State v Attorney General Federation (2002) 9 NWLR (pt. 772) 222.

Femi Falana v FRN (unreported suit no: FHC/IKJ/CS/M59/10).

Festus Odafe & ors v Attorney General Federation (unreported suit no: FHC/PH/CS/680/2003)

Mojekwu v Ejikeme (2000)5 NWLR (pt. 657) 403.

Mojekwu v Mojekwu (1997) 7 NWLR (pt 283) 1

Nkwocha v Ofurum (2002) 5 NWLR (pt 761) 506.

Onyirioha v. IGP (2009) NWLR (pt.1128) 342.

SERAP v Attorney General Lagos. (LHC Unreported Suit No. ID 2759GCM/2018).

Togun v Oputa (2001) 16 NWLR (pt740)597@644.

**Canada**

Eldridge v British Columbia [1997] 3 SCR 624.

**India**

Paschim Banag Khet Samity v State of West Bengal (1996) 4 SCC 37.

Mandal v Deen Dayal Harinagar Hospital and others, W.P (c) Nos. 8853 of 2008.

Jaitun v Maternal Home MCD, Jangpura and others W.P No. 10700/2009.

**New Zealand**

Shortland v Northland Health Ltd [1998] 1 NZLR 433.

**United Kingdom**

R v Bourne (1938) All E.R 315.

**Kenya**

Joseph Majani v Att Gen of Kenya & Ors. Petition No. 5 of 2014 of the High Court of Kenya

**African Commission or Court**

APDF & IHRDA V Rep of Mali (046/2016) (2018) AfCHPR 15

Jonah Gbemre v Shell Petroleum Development Company of Nigeria and others (2005) AHRLR 251.

Ken Saro Wiwa v Nigeria, Communications 13/94-139/94-154-96-161/97; AHRLR 212 (ACHPR 1998).

Kwoyelo v Uganda, Communication 431/12, African Commission on Human and Peoples Rights 129 (2018).

Media Rights Agenda et al v Nigeria (2000) AHRLR 200 (ACHPR 1998).

SERAC and CESR v Nigeria (2001) AHRLR 60 (ACHPR 2001).

**The ECOWAS Court**

Dorothy Njemanze & 3 others v FRN (ECW/CJ/APP/17/14).

**The European Court of Human Rights**

PS v Poland (ECtHR) Application No.57375/08. 30 OCT 2012.

**International Human Rights Bodies**

Alyne da Silva Pimentel v Brazil CEDAW/C/49/D/17/2008.

KL v Peru CCPR/C/85/D/1153/2003.

LC v Peru CEDAW/C/50/D/22/2009 (2011).

Statement of Copyright

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## Chapter 1

## General Introduction

### 1.1 Introductory Remark

A maternal death is a personal tragedy, an unquantifiable loss to families and nations, yet Nigeria holds the unenviable record of being the largest contributor to maternal mortality (MM) numbers in the world.[1] A woman's lifetime risk of dying from a maternal cause in Nigeria is 1 in 29 compared to the global average of 1 in 180 or that of developed countries,[2] 1 in 3800.[3] However, the burden of MM is unequally borne by some geopolitical regions in the country and specific categories of women. It is less prevalent among women who are educated, economically empowered, and resident in urban areas. Despite the intensified campaigns generated by the Millenium Development Goals (MDGs), Nigeria did not achieve the MDG 5a target of attaining a 75% reduction in maternal mortality ratio by 2015.[4] Although some progress was recorded,[5] economic, socio-cultural, legal and political factors militate against significant improvement. With the launch of the SDGs (Sustainable Development Goals )[6] and goal 3.1, in particular, to reduce the global MM ratio by 2030; Nigeria's persistently high MM ratio continues to generate discussions from relevant fields, including human rights.

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[1] The three other heavy contributors are India, Congo, and Ethiopia. Max Roser and Hannah Ritchie, 'Maternal Mortality 2020, OurWorldInData.org' (2013) <https://ourworldindata.org/maternal-mortality> accessed 30 December 2023.

[2] Although there is no universally agreed definition of the terms 'developing or developed' countries, the criteria by which independent countries are grouped into either category include the human development index, standard of living, income per capita, level of industrialisation, Gross Domestic Product, Gross National Product and political stability. Developed countries are countries which achieve these standards on a high spectrum, while in developing countries, they are below average. There are 152 developing countries in the world, covering the whole of Africa, Central and South America and almost all Asian countries. World Data, ' Developing Countries' <List of 152 developing countries (worlddata.info)> accessed 30 December 2023.

[3] WHO, 'Maternal Mortality Fact sheet no 348' ( WHO, 22 February 2023) <Maternal mortality (who.int)> accessed 30 December 2023.

[4] In 2015, the MDG cut-off year, Nigeria had 58,000 maternal deaths, which was the highest in the world. Max Roser and Hannah Ritchie (n 1).

[5] Of all the MDGs, the goal related to maternal mortality was reportedly the least achieved. According to the UN, the maternal rate in sub-Saharan Africa was the least reduced though Nigeria claims the maternal mortality rate reduced from 1000 deaths per 100,000 live births in 1990 to 243 per 100,000 live births in 2014. UN, 'The Millennium Development Goal Report 2015' <https://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf > accessed 30 December 2023. . Also, Nigeria, 2015 End Point Report on MDGs <https://www.undp.org/content/dam/undp/library/MDG/english/MDG%20Country%20Reports/Nigeria/Nigeria_MDGs_Abridged_Sept30.pdf> accessed 30 December 2023.

[6] The Sustainable Development Goals are 17 goals which subscribing states aim to achieve by 2030. Goal no 3 focuses on health. UN Department of Economic and Social Affairs, 'The 17 Goals' <https://sustainabledevelopment.un.org/?menu=1300> accessed 30 December 2023.

Human rights attention on MM is premised on the basis that MM is a product of injustice[7] and a manifestation of inequality.[8] Firstly, among men between the ages of 15 and 44, there is no cause of death and disability that is comparable with the rate of death for women of the same age due to MM.[9] Secondly, most of the deaths occur in developing countries. Thirdly, in most countries, the victims are disadvantaged women such as indigenous women, those living in poverty and of ethnic or racial minorities. The struggle to right the wrongs caused by injustice is the foundation on which modern human rights are built.[10] Thus, invoking the language of human rights makes it possible to advocate for justice for vulnerable women and prevent the wrongs that promote MM.

Maternal mortality is largely preventable through the provision of well-known healthcare interventions and other sexual and reproductive health needs, which states are obliged to provide for women under national and various international human rights laws. Therefore, recognising MM as a human rights issue creates the opportunity to bring the paraphernalia of human rights, such as the legal framework, advocacy tools, accountability mechanisms and processes, to bear on policy-making, programming, and the implementation of MM reduction efforts.[11] The protection of women's rights to life, equality, education, information, the benefits of scientific progress, freedom from discrimination, and the highest attainable standard of physical and mental health, including sexual and reproductive health, amongst others, individually or in conjunction with other rights (multi-rights) have been recognised as beneficial for preventing MM.[12]

The RH approach, or a human rights-based approach (HRBA) to health, with the right to health occupying a central position, is the most frequently named as important for preventing maternal deaths. As an approach, it is a legal framework useful for action and for programming both with respect to healthcare services as well as the unfavourable conditions that act as the

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[7] WHO, 'Advancing Safe Motherhood Through Human Rights' (2001) 8 <https://iris.who.int/handle/10665/66810 > accessed 30 December 2023.
[8] Ebenezer Durojaye, 'Substantive Equality and Maternal Mortality in Nigeria' (2012) 44 (65) Journal of Unofficial Law and Pluralism 103, 104.
[9] Alicia Ely Yamin and Deborah Maine, 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations' (1999)21 (3) Human Rights Quarterly 563,564.
[10] WHO (n 7) 6.
[11] Judith Bueno de Mesquita, 'Maternal Mortality and Human Rights: From Theory to Practice', in Michael Freeman and Sarah Hawkes, and Belinda Bennett (eds), *Law and Global Health: Current Legal Issues* ( online edn, Oxford Academic 2014) < https://doi.org/10.1093/acprof:oso/9780199688999.003.0015 >accessed 30 December 2023.
[12] UN Human Rights Council, Preventable Maternal Mortality and Morbidity and Human Rights Resolution adopted by the Human Rights Council on 17 June [2009] A/HRC/RES/11/8, para 2 (HRC Resolution on MM).

underlying determinants of maternal ill-health or even death.[13] Nigeria's high maternal death ratio has been described as the product of violations of women's human rights and their right to health in particular.[14] It is argued that as the main duty bearers, states have the obligation to carry out recommended right to health measures relevant for guaranteeing women's right to the highest attainable standard of health and thereby protecting their lives.[15] These measures are not restricted to providing healthcare facilities or goods but also include addressing social, cultural, and other factors militating against realising the rights. Additionally, it involves the application of human rights principles to ensure that the equitable distribution of health goods and services, and that the formulation of participatory policies.

Nevertheless, unreservedly endorsing the human rights approach for reducing MM in Nigeria or any other country may be unbalanced. In the same vein, pressuring Nigeria to comply with the dictates of RH without a thorough consideration of the challenges of applying the framework may be questionable**.** For example, the right to health as well as the broader HRBA, are the subject of various unresolved criticisms which may impact the capacity and willingness of states to adopt their standards. In many countries, there also exist complex legal, political, economic, and social situations that are seemingly incompatible with the standards of a human rights approach relevant for achieving MM reduction.

Consequently, this thesis posits that, in light of these concerns, the actual utility of the framework regarding Nigeria's MM problem remains uncertain. Therefore, a realistic and critical assessment of the framework, as well as all the pertinent factors related to the Nigerian MM situation must be conducted. Through this assessment, the potential of the framework to influence or enhance the effectiveness of the current measures in place can be clarified**.** The current measures include interventions based on public health and medical practice. Public health and medicine (including medical ethics) are complementary frameworks that are closely related to the right to health approach and within which actions to prevent maternal deaths have been carried out.

Over the years, public health has acted as a means of assessing the prevalence of MM, establishing the causes and determinant factors, identifying appropriate interventions and

[13] Sofia Gruskin, 'Right based Approaches to Health: Something for Everyone' (2008) 10(1) *Health and Human Rights* 65.
[14] Ebenezer Durojaye (n 8).
[15] Obadina Ibrahim, 'Adopting a Rights Based Approach to Maternal Health in Nigeria: A Comparative Overview from South Africa and India' (2019) 1(1) Adeleke University Law Journal 72.

implementing them.[16] In England, for instance, it is argued that public health investigations into the causes of maternal deaths led to actions such as the improvement of standards of obstetric care, the introduction of antibiotics, and the institution and continuation of confidential enquiries into maternal deaths, which contributed to the decline of MM rates.[17] Similarly, China, which attained the millennium development goal of reducing MM in 2014, employed public health preventive healthcare services, free prenatal examinations, prenatal visits and post-natal visits to all women in the reproductive age range irrespective of age, socio-economic status or household registration.[18] The comprehensive and practical three-delays model of identifying the determinants of maternal mortality was also a contribution of public health.[19] The global Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategy and the MM monitoring component of it, the EPMM (Ending Preventable Maternal Mortality), also have a public health basis.[20]

These achievements and many others prove that public health, when it lives up to its mission of 'ensuring the conditions in which people can be healthy,'[21] can make significant contributions to preserving women's health and lives. However, the failure of public health to adequately and promptly address societal conditions in their efforts to eradicate the AIDS pandemic greatly revealed its weakness[22] in respect of health issues underlaid by societal conditions which MM exemplifies. This failure was in spite of public health's longstanding recognition of and attempts to engage with the societal dimensions of health. Apart from efforts

[16] Sanjay Rai and others, 'Public Health Approach to Address Maternal Mortality'(2012) Indian Journal of Public Health <Public health approach to address maternal mortality - Document - Gale Academic OneFile> accessed 30 December 2023; Sonia Shirin and Shamsun Nahar, 'Maternal Mortality is a Public health Problem' (2013) 6(2) Ibrahim Medical College <http://dx.doi.org/10.3329/imcj.v6i2.14735 > accessed 30 December 2023.

[17] Geoffrey Chamberlain, 'British Maternal Mortality in the 19th and Early 20th Century' [2005] 99 Journal of the Royal Society of Medicine<559 559..563 (nih.gov)> accessed 30 December 2023; Irvine Loudon, 'Maternal Mortality in the Past and its Relevance to Developing Countries Today' (2000) 72(1)The American Journal of Clinical Nutrition 241S <https://doi.org/10.1093/ajcn/72.1.241St> accessed 30 December 2023.

[18] Pengyu Zhao, 'The Influence of Basic Public Health Service Project on Maternal Health Services: An Interrupted Time Series Study' (2019) 19 (824) BMC Public Health < https://doi.org/10.1186/s12889-019-7207-1 > accessed 30 December 2023.

[19] Tim Thomas, 'Maternal Health from 1985-2013: Hopeful Progress and Enduring Challenges' (2013) <mhretrospective_final.pdf (macfound.org)> accessed 30 December 2023.

[20] The RMNCAH refers to an integrated range of services, interventions and programs targeted towards improving the health and well-being of individuals at various stages of life, from newborn to adolescence as well as reproductive and maternal. WHO, Committing to Implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (2023)< Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (who.int)> accessed 30 December 2023.

[21] Jonathan M Mann, 'Promoting Human Rights is Essential for Protecting Health' (1996) 312(924) BMJ Health and Human Rights <Health and human rights | The BMJ> accessed 30 December 2023.

[22] ibid.

going as far back as the 19th century,[23] the most prominent attempt before the AIDS pandemic was through the 1978 Alma Ata Declaration.[24] In the 1986 Ottawa Charter on Health Promotion, prominence was also given to social determinants which were described therein as 'prerequisites'.[25] However, as Mann and other scholars observed, the integration of the social approach into public health programs has not always been a priority.[26]

Medicine or medical ethics has also been beneficial in providing an opportunity to assess individual patient-provider interactions in the context of reproductive and maternal health. This approach is basically clinical and involves adhering to professional or legal principles to provide humane and respectful care to women seeking childbirth or other reproductive health services at health facilities.[27] Early MM interventions in developed countries prioritised the supervision of healthcare personnel as coercive treatments, mistreatment and undue interference in childbirth were associated with high MM rates in those countries at the time.[28] However, the fact that the causes of MM are a combination of individual and societal factors means that a biomedical system is of limited effect in the prevention or reduction of complex or chronic health issues.[29]

Human rights, on the other hand, are social based in that they are grounded on the relationship between the individual and their society, immediate or global. Moreover, a rights-based approach, on the other hand, is described as enabling focus on more 'distal, non-clinical risk factors or social determinants.'[30] The earliest recognitions of the right clearly made the connection between health and determinants.[31] Thus, it involves developing interventions that

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[23] John W Frank and J. Fraser Mustard, 'The Determinants of Health from a Historical Perspective' (1994) 123(4) Health & Wealth 1.

[24] WHO, World Health Organization. Regional Office for Europe. (1978). Declaration of Alma-Ata< https://iris.who.int/handle/10665/347879> accessed 30 December 2023

[25] WHO Regional Office for Europe Ottawa Charter for Health Promotion, 1986 < https://iris.who.int/handle/10665/349652> accessed 30 December 2023.

[26] Jonathan Mann, 'Aids and Human Rights, Where Do We Go From Here?' (1998) 3(1) Health and Human Rights 143; Orielle Solar and Alec Irwin, 'Social Determinants, Political Contexts and Civil Society Action: A Historical Perspective on the Commission On Social Determinants Of Health (2006)17 (3) Health Promotion Journal of Australia 180, 181.

[27] Joanna N Erdman, 'Commentary, Bioethics, Human Rights and Childbirth' (2015) 17(1)Health and Human Rights <Commentary: Bioethics, Human Rights, and Childbirth – Health and Human Rights Journal (hhrjournal.org) > accessed 30 December 2023.

[28] Irvine Loudon (n 17) 242, 243S.

[29] L O Gostin and others, 'Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being' (2011) 159(6) University of Pennsylvania Law Review 1777.

[30] Tabassum Firoz and others, 'A Framework for Healthcare Interventions to Address maternal morbidity' (2018) 141 (Suppl, Suppl 1) International Journal of Gynaecology and Obstetrics 61, 66 <https://doi.org/10.1002%2Fijgo.12469)> accessed 30 December 2023.

[31] For instance, according to Article 25 of the Universal Declaration of Human Rights, an adequate standard of living encompassing food, clothing, social care and so on, is essential for health and wellbeing. Universal

take cognisance of the effect of social vulnerability on MM[32] giving it a scope as broad as public health. Furthermore, the right to health also provides a legal framework within which individuals and groups can enforce their access to medical and public health interventions.[33]

However as observed above, there are arguments against human rights as the better framework to address public health problems.[34] Apart from the reasons mentioned earlier, scholars who perceive human rights as being unable to address a collective right to health have opposed the recommendation.[35] It is also believed that human rights aspire to protect individual rights even at the expense of public health.[36] This situation was said to be the case in the AIDS pandemic, which is often described as the beginning of the contemporary application of human rights to public health issues.[37] Critics contended that in the case of Africa, stigma was the underlying factor engendering transmission as well as treatment-seeking behaviour. Thus, the human rights goal to protect individuals from stigma was detrimental to collective interests. In response, it has, however, been argued that rather than pursuing individual or collective interests, human rights strive to apply policies that are based on scientific evidence and decided on after transparent public discourse.[38] For instance, the initial AIDS policy was based on the effect of discrimination on HIV-infected people and people living with AIDS.[39] The sustained analysis of HIV-AIDS transmission from a human rights lens eventually led to the recognition of and development of actions to address the societal factors that contributed to vulnerability to HIV.[40] This development also meant that the agitation of critics for the societal sensitivity of human rights when pursuing public health goals was addressed. More importantly, it

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Declaration of Human Rights Adopted by General Assembly Resolution 217 A (III) of 10 December 1948 Preamble

[32] ibid.

[33] Paul Hunt and Gunilla Backman, 'Health systems and the Right to the Highest Attainable Standard of Health (2008) 10(1) Health and Human Rights Journal <Health systems and the right to the highest attainable standard of health – Health and Human Rights Journal (hhrjournal.org)>accessed 30 December 2023.

[34] Notably objections to the application of human rights or specifically the right to health to reduce MM are rare.

[35] Benjamin Mason Meier and Asley M Fox, 'Development as Health: Employing the Collective Right to Development to Achieve the Goals of the Individual Right to Health' (2008)30 (2) Human Rights Quarterly 259; Timothy Goodman, 'Is there a Right to Health' (2005) 30 Journal of Medicine and Philosophy 643, 647.

[36] ibid Timothy Goodman.

[37] Kevin M De Cock and Dorothy Mbori-Ngacha and Elizabeth Marum, 'Shadow on the Continent: Public Health and HIV-AIDS in Africa in the 21st Century'(2002) The Lancet <doi:10.1016/S0140-6736(02)09337-6 (thelancet.com)> accessed 30 December 2023.

[38] S Gruskin 'Do Human Rights Have a Role in Public Health Work?' (2002) 360 The Lancet 1880.

[39] Jonathan Mann and Daniel Tarantola, 'Responding to HIV/AIDS: A Historical Perspective' (1998) 2 (4) Health and Human Rights 5, 8; Tehmina Ghafur, 'Rights-Based Approach to Health: Critical Reflections and Contemporary Challenges' (2018) 29 Dhaka University Stud Part F 55.

[40] Jonathan Mann and Daniel Tarantola (n 39) 7.

signified the capability of the human rights approach to change focus when presented with relevant evidence.[41]

Another ground for opposition is based on instances when the application of RH has failed to achieve the prevention or reduction of the public health problem. Some reasons advanced for RH's weakness and ineffectuality include the persistence or emergence of health inequities due to systemic failures of the health system,[42] unreasonable accountability through the courts, and the curative nature of the healthcare model of the RH.[43] However, some of these reasons are based on a narrow understanding of the right. For instance, the assertion that RH is essentially biomedical and more concerned with curative healthcare is wrong. Similarly, although the nature of judicial interventions in many jurisdictions has adversely resulted in making RH claims more accessible to individuals than the generally affected populace, suggesting that the right to health is incompatible with collective or group goals of public health may not be completely correct. The authoritative interpretation by the UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment no. 14, describes the right as including underlying determinants of health. Treaty monitoring bodies such as the African Commission on Human and Peoples' Rights (African Commission) have also decided that a collective right to health exists.[44]

Nevertheless, there is merit in the observation that despite the overwhelming global consensus in the choice of HRBA as the framework for addressing various health problems, it has not always been successful. Regarding maternal health, the limited impact of global RMNCAH policies and other strategies adopted by the WHO and its various partners, which advocate the HRBA, point to limitations or challenges. Indeed, Nigeria, the country in focus, has also taken steps to comply with its global commitments in respect of RMNCAH. As a result, this thesis repeats its earlier proposal that although HRBAs have evidently been useful in the struggle to end MM, in light of the concerns, it is important to evaluate the approach's potential to achieve the much sought-after MM reduction in Nigeria. This will not just enable the

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[41] Leslie London, 'What is a Human Rights Based Approach and Does it Matter?' (2008) 10 (1) Health and Human Rights Journal.

[42] Lucia D'Ambruoso and Peter Byass and Nuru Siti Quomariyal, 'Can the Right to Health Inform Public Health Planning in Developing Countries? A Case Study for Maternal Healthcare from Indonesia' [2008] 1 Global Health Action 1, 5-7<Can the right to health inform public health planning in developing counties? A case study for mater (tandfonline.com)> accessed 30 December 2023.
They confirm that the RH approach is useful as indicators of what can be done to improve health services but conclude that RH has no impact because Indonesia does not comply with all its right to health obligations.

[43] Benjamin Mason Meier and Asley M Fox (n 35) 292.

[44] *SERAC v Nigeria*, Communication 155/96, African Commission on Human and Peoples Rights (2001) 261, 291-293.

identification of areas for improvement, but also unveil factors that can enhance its potential for efficiency within the Nigerian context.

## 1.2 Background to the Original Contribution

Since MM was recognised as a human rights issue in the late 1980s and early 1990s, discussions on MM and human rights have been deepened by various factors. The factors range from outcomes of key international conferences to an increased focus on the issue by UN bodies, human rights and public health experts, and civil society advocates.[45] But rather than focus on RH or any other right specifically, the deepening has mostly revolved around the various rights (multi-rights approach)[46] which are fundamental components of the human rights-based approach to health.

Fathalla,[47] Cook[48] and Dickens,[49] the early reproductive health rights writers all identified and interrogated multiple rights relevant to MM reduction. However, Freedman,[50] Yamin and Maine,[51] specifically discussed RH and, in addition, identified general human rights principles or values (as Freedman refers to them) such as non-discrimination and dignity. Some commentators, especially UN human rights bodies and special procedures, further worked on clarifying the links between some individual human rights and MM. For example, the UN Committee on the Elimination of Discrimination against Women (CEDAW Committee) in General Recommendation 24 focuses on discrimination against women in the field of healthcare.[52] Among other recommendations, it urges states to ensure healthcare services

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[45] Judith Bueno de Mesquita (n 11) 228-9.
[46] ibid 231.
[47] Mahmoud M Fathalla, 'Women Have A Right To Safe Motherhood' [1998]1 Planned Parenthood Challenges 1< Women have a right to safe motherhood - PubMed (nih.gov)> accessed 30 December 2023. ; See also M Fathalla, 'Human Rights Aspect of Safe Motherhood'(2006) 20(3) Best Practices and Research: Obstetrics and Gynaecology 409< https://doi.org/10.1016/j.bpobgyn.2005.11.004 > accessed 30 December 2023.
[48] Rebecca J. Cook, 'Advancing Safe Motherhood Through Human Rights' (1999) 21(4) Journal SOGC 363< https://doi.org/10.1016/S0849-5831(16)30072-6 > accessed 30 December 2023. ; See also Rebecca J. Cook, *Women's Health and Human Rights: The Promotion and Protection of Women's Health through International Human Rights law* (WHO 1994).
[49] R J Cook and B M Dickens, 'Human Rights to Safe Motherhood' (2002) 76 (2) International Journal of Gynaecology and Obstetrics 225< https://doi.org/10.1016/s0020-7292(01)00568-9 > accessed 30 December 2023.
[50] L P Freedman, 'Using Human Rights in Maternal Mortality Programs: from Analysis to Strategy'(2001) 75(1) International Journal of Gynecology & Obstetrics 51< https://doi.org/10.1016/S0020-7292(01)00473-8 > accessed 30 December 2023.
[51] Alicia Ely Yamin and Deborah Maine (n 9) 601.
[52] CEDAW General Recommendation No. 24 of the Convention (Women and Health A/54/38/Rev.1, Chap.1.

throughout the life cycle, to refrain from denying women access to certain reproductive services required by women only and to address various forms of violence against women.[53]

The HRC also updated their General Comment on the right to life,[54] declaring that the right to life was not only concerned with arbitrary deprivation of life,[55] but extends to the prevention of reasonably foreseeable threats to life, such as those that deprive women and girls of their lives in pregnancy and childbirth. In this respect, it required states to refrain from actions that arbitrarily and unfairly expose women and girls to unsafe abortion.[56] At the same time, it emphasised that positive measures were also necessary to preserve lives. These include ensuring access to medical examinations and treatments that can reduce maternal and infant mortality.[57]

The Special Rapporteur on the right to health went to great lengths to place MM at the forefront of global human rights concerns, [58] and to demonstrate the especially close relationship between the realisation of the right to health and MM reduction. In relation to the latter endeavour, a report was submitted to the General Assembly which explored the implications of the CESCR's General Comment 14 on the right to health for MM reduction.[59] The framework that emerged from the Special Rapporteur's exploration of the contribution of the components of RH and which has also been used by the WHO, forms the structure of the detailed analysis of the framework to be carried out in Chapter 4. The Special Rapporteur's analytical framework was also copiously referred to in all the United Nations General Assembly (UNGA) and HRC reports on MM that were produced after it.[60] The framework is an improvement on previous frameworks such as the UN Guidelines[61] developed by UNICEF and public health experts at Columbia University in 1999. The Guidelines focused mainly on access to and utilisation of obstetric services for complications. Therefore, to a large extent,

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[53] ibid paras 2 and 14.
[54] See Human Rights Committee (HRC), General Comment 36 on Article 6, Right to life, 3 September 2019, CCPR/C/GC/35.
[55] ibid para 3.
[56] ibid para 8.
[57] ibid para 26.
[58] Report of the Special Rapporteur on the the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (2006) E/CN.4/2006/48.
[59] UN General Assembly, Note by the Secretary-General: the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. (2006) UN Doc. A/61/338.
[60] For instance, OHCHR, 'Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity' (2012) (Technical Guidance) <https://www2.ohchr.org/english/issues/women/docs/a.hrc.21.22_en.pdft>accessed 30 December 2023.
[61] Deborah Maine and others, *Guidelines for Monitoring the Availability and Use of Obstetric Services* ( 2nd edn, UNICEF 1997).

the indicators in the Guidelines mirror the AAAQ elements of the GC14. However, this framework, developed by the former special rapporteur and others, is comprehensive and encompasses core RH standards such as women's entitlement to reproductive healthcare and services as well the underlying social, economic, cultural and political determinants.

From these early days, the human rights attention on MM has become phenomenal. Traditional civil society organisations, human rights experts, more UN bodies and regional organisations have all taken up the gauntlet. In 2010, the Inter-American Commission on Human Rights published a report on access to maternal health services from a human rights perspective. It argued that the right to personal integrity without discrimination guaranteed in the American Convention includes the obligation to guarantee women equal access to the health care services they need in relation to pregnancy and the postpartum period.[62]

Earlier, in 2008, the African Commission adopted a resolution emphasising that MM is a violation of the rights to life, health, dignity and equality.[63] The Human Rights Council (HRC)'s resolution in 2009 also noted the inadequate protection of those same rights and others, such as rights to education, information, the benefits of scientific progress and freedom from discrimination.[64] The HRC further encouraged the development of the human rights based approach to eliminating preventable MM by requesting clarifications on the exact modalities of inculcating a human rights approach into MM reduction initiatives.[65] As a result of these clarifications, in addition to the framework provided by the norms and obligations of the relevant human rights, seven principles - accountability, participation, transparency, empowerment, sustainability, international cooperation and non-discrimination, were identified as useful for developing and implementing effective measures to reduce preventable MM. [66]

This led to the emergence of two complementary approaches, the first, made up of the norms and obligations of relevant human rights as contained in the instruments, is described as the legal approach. The other approach based on the human rights principles is tagged the

[62] Organisation of American States 'Access to Maternal Health Services from a Human Rights Perspective' (2010) OEA/Serv. L/V/II. Doc 69.
[63] African Commission, Resolution on Maternal Mortality in Africa ACHPR Res 135(XXXXIV) 08.
[64] HRC Resolution (n 12) para 2.
[65] ibid para 6.
[66] See also OHCHR, 'Report on Preventable Maternal Mortality and Human Rights' [2010]UN Doc A/HRC/14/39 para 8 <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G10/129/49/PDF/G1012949.pdf?OpenElement > accessed 30 December 2023.

development-centred approach.[67] The seven principles, which have also been elaborated on by the OHCHR, are described as the working principles which form the basis of a human rights approach generally.[68] The right to health approach or framework examined in this thesis is one that combines the standards of the right to health and the development oriented or working principles of the HRBA.

Research and advocacy into the HR approach to MM has led to the realisation that human rights can provide a powerful medium for advocating health and other sector reforms that can bring about MM reduction. National-based women's rights and health rights NGOs, physicians, other advocates and even governments have responded to the opportunity by using human rights in their advocacy and in the text of policies and programmes. Many of such policies and programmes have attracted technical and or financial assistance from donors.[69] There have also been reports dedicated to auditing government policies and actions, donor and even UN bodies initiatives and activities from a human rights perspective.[70]

In Nigeria, MM was not the first women's reproductive health issue to be associated with human rights.[71] However, the high MM ratio which has been generating advocacy efforts since the 1980s[72] from civil society groups such as the Society of Gynaecologists and Obstetrics of Nigeria (SOGON), features prominently in Nigeria's women's human rights discussions.[73] This also means that human rights has become a prominent framework by which Nigeria's maternal health situation, policies and programmes are assessed.[74] Nigeria has

[67] UNFPA and Harvard School of Public Health, 'Human Rights Based Approach to Programming: Key Elements of a HRBA' < Session3_Presentation5_KeyElements_HRBA.PPT (live.com) > accessed 30 December 2023.
[68] Technical Guidance 2012, para 32.
[69] Jhpiego, 'Our Mission' <History & Mission - Jhpiego> accessed 30 December 2023.
See also, Jhpiego, 'Countries We Support' < Countries We Support - Jhpiego> accessed 30 December 2023.
[70] A Yamin and R Cantor, 'Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights Based Approaches to Health (2014) 6(3) Journal of Human Rights Practice.
[71] Child marriage and especially female genital mutilation have also been on the horizon since colonial times. Hajara Usman, 'Reproductive Health and Rights: The Case of Hausa Women of Northern Nigeria' (1997) 22(1) Africa Development 79.
[72] Maternal death numbers in the mid-1980s was between 1300 and 2800. Tola Olu Pearse, 'Death and Maternity in Nigeria' in Meredeth Turshen (ed), African Women's Health (African World Press 2000) 2.
[73] For instance: Obiajulu Nnamuchi, 'Right to Health in Nigeria' (2007) Law School University of Aberdeen Draft Report.
[74] For instance, Lawoyin and others prescribe human rights as the antidote to the low value given to women. They argue that improvement in the socio-economic situation, including education of women, will increase protection for women's rights and reduce MM. Taiwo Lawoyin and Olusheyi O C Lawoyin and David Adewole, 'Men's Perception of Maternal Mortality in Nigeria' [2007] Journal of Public Health Policy 299, 315. Okwor argues that being a product of human rights and development problems, by addressing these issues, maternal mortality can 'easily' be prevented. Okwor Uchechukwu Victoria 'Where are the Mothers?

continually scored low in realising its obligation in respect of the right to maternal health with the MM ratio as the most obvious evidence of failure.[75] There are several concerns in relation to the existence of conditions that facilitate MM and these discussions have been avenues to point to Nigeria's failings in respect of giving effect to the dictates of the RH approach relating to MM reduction. For instance, attention has been called to Nigeria's notoriety for child marriages,[76] the inadequacy of health facilities and skilled personnel despite efforts to increase their availability,[77] problem of accessibility and acceptability of healthcare,[78] bad work ethics of medical staff,[79] and the socio-economic and cultural situation of most Nigerian women. In the words of Aniekwu:

> Maternal mortality and morbidity levels in Nigeria remain among some of the highest in the region and worldwide. Critical factors contributing to this situation include traditional and religious systems that support early and/or forced marriage, early and excessive childbearing, and different forms of gender-based violence. Female genital mutilation, widowhood rites, and discriminatory customary practices directly and indirectly limit reproductive choices and seriously compromise women's health. Also relevant is the inadequate legal and policy framework for the protection of reproductive health and rights... The wide gap between policies and action and the absence of genuine political will, remain challenges to the protection of women's health.[80]

Some authors embark on a much broader analysis where they observe that achieving the goals of human rights suffers from challenges within the legal, social, political and

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Interrogating Maternal Mortality as a Violation of the Right to life and Health: A Nigerian and Ethiopian Perspective' (LLM Thesis, University of Pretoria 2009).
Okonofua and L Omo-Aghoja, 'End use of Health Policy Analysis in Nigeria, the Case of Maternal Mortality Reduction in Nigeria'(2010)17(1) Tropical Journal of Health Sciences < http://dx.doi.org/10.4314/tjhc.v17i1.52786 > accessed 30 December 2023. ;
MacArthur Foundation in Nigeria, Report on Activities' (2006) <NIGERIA_2006.PDF (iupui.edu)> accessed 30 December 2023.

[75] Although it can be argued that since improvement in the level of a country's achievement of maternal health cannot be based on reduction in maternal mortality figures, their non-performance should also not be determined on the same basis.

[76] Hawa Ije Obaje and others, 'Ending Child Marriage in Nigeria: The Maternal and Child Health Country Wide Policy' (2020) 17(1) Journal of Science Policy and Governance <http://doi.org/10.38126/JSPG170116 > accessed 30 December 2023.

[77] Edward Okeke and others, 'Going to Scale: Design and Implementation Challenges of a Program to Increase Skilled Birth Attendants in Nigeria' (2017)17 (356) BMC Health Services Research< https://doi.org/10.1186/s12913-017-2284-2 > accessed 30 December 2023.

[78] Aliyu Mohammed and Prince Agwu and Uzoma Okoye, 'When Primary Healthcare Facilities are Available but Mothers Look the Other Way: Maternal Mortality in Northern Nigeria' (2020) 35(1-2) Social Work in Public Health < https://doi.org/10.1080/19371918.2020.1726850 >accessed 30 December 2023.

[79] Okwor Uchechukwu Victoria (n 74) 53-54.

[80] Aniekwu Nkolika Ijeoma, 'The Convention on the Elimination of All Forms of Discrimination Against Women and the Status of Implementation on the Right to Health Care in Nigeria' (2006) 13(3) Human Rights Brief 34, 35.

economic systems of the country.[81] They observe that the specific issues that cause MM are products of anomalous conditions in these sectors of the country.[82] Recommendations from these studies include ensuring acceptable maternal healthcare (availability and accessibility of family planning, access to contraceptives and comprehensive family and sexuality education for adolescents,[83] reformation of abortion laws, facilitating awareness of safe abortion medications, eliminating violence against women, including harmful cultural practices, preventing discriminatory access to healthcare by abolishing user fees, advocating the right to safe motherhood, and ensuring substantive equality where women's enjoyment of RH guarantees transcend focusing on women generally but also to individual circumstances in order to cater for vulnerable women.[84] The limitless belief held in human rights, including the right to health, as a means of improving maternal health by human rights scholars can be glimpsed from Nnamuchi's statement:

> Therefore, the irresistible conclusion must be that had the obligations imposed by relevant international human rights instruments been taken seriously in ratifying or acceding nations, there would certainly have been no need for the Millennium Declaration or the MDGs.[85]

As shown earlier, Ambruoso and colleagues are examples of scholars who think otherwise, although in their case, some of the issues they raised were flawed and arguable. Yet, there are other criticisms bordering on the nature of the framework and its application in local circumstances that merit investigation. In the case of Nigeria, its dismal maternal health record and failure to conform to right to reproductive and maternal health standards are often expressed on the pages of various research outputs. This thesis argues that applying a sociolegal lens to examine the societal context in which the standards of the right are to be adopted or implemented could provide valuable insight into the true potential of the human rights approach for MM reduction in Nigeria. Undertaking the above task is one of the objectives of this thesis.

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[81] Nkiru Felicita Agbakwa, 'Enforcing Maternal Health rights in Nigeria: Options and Challenges' (LLM Thesis, University of Toronto 2004); Obadina Ibrahim (n 15); Nnamuchi Obiajulu, 'Maternal Health and Millennium Development Goal (MDG) 5 In Nigeria: Any Catalytic Role for Human Rights?' (2015) 34(1) Journal of Law and Medicine 381.

[82] Idongesit Eshiet, 'Gender and Reproductive Health: Religious and Social Perspectives to Women's Health Right in Nigeria' (2015) 10 (3) International Journal of Interdisciplinary Social and Community Studies 25.

[83] Oluwakemi Ayanleye, 'Women and Reproductive Health Rights in Nigeria' (2013) (6)(5) OIDA International Journal of Sustainable Development 127.

[84] Idongesit Eshiet (n 82); Kikelomo Mbada, 'Human Rights-based Approach to Maternal Health Policy and Implementation: An Analysis of Abiye Safe-Motherhood Policy of Ondo State Nigeria' (2020) 10(4) Journal of Public Administration and Development 315; Durojaye (n8)

[85] Obiajulu Nnamuchi, 'Millennium Development Goal 5, Human Rights and Maternal Health in Africa, Possibilities, Constraints and Future Prospects' (2014) 23(1) Annals of Health Law 92, 127.

This would involve an assessment of the compatibility of the RH approach or HRBA to health with the causes of MM in Nigeria and with the Nigerian economic, social, political and legal landscape.

By scrutinising the framework, the thesis aims to draw attention to the often oversimplified, unscrutinised and unchallenged transplantation of international human rights norms and laws to resolve social justice issues within states.[86] Human rights are described as a colonial project.[87] This assertion is not only due to its Western beginnings, but because some of its ideals are presented as synonymous with civilisation, the pretentious reason given for colonisation.[88] And despite - as some scholars have argued[89]- human rights itself becoming the tool of emancipation for the colonised territories, concerns remain about human rights as neo-colonialism and the continued potential of human rights to serve as a vehicle for entrenching existing unequal power relations. The dominance of western nations in human rights discourse, as well as the local nature of human rights wrongs, make it imperative to view the application of human rights in the local context.[90] Therefore, although this thesis is not about the decolonisation of human rights, the decolonisation of human rights implicitly (as defined below) influences the critical thinking throughout the thesis.

According to Barreto, the decolonialisation of human rights could take different forms including critiquing the Western /Eurocentric theory of human rights and replacing them with the notions of human rights that have existed in the colonised nations since the 16th century.[91] Some issues may make this approach difficult in the context of Africa. This is because, apart from problems like coming up with a notion of African human rights,[92] it has also been argued that rather than the decolonisation agenda in Africa being useful for enhancing human rights,

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[86] Merris Amos, 'Transplanting Human Rights Norms: The Case of the United Kingdom's Human Rights Act' (2013) 35 Human Rights Quarterly 386.
[87] Kayum Ahmed, 'Decolonizing Human Rights: Sovereignty, Tactics and Disruption' (OxHRH Blog, 9 January 2017) <Decolonizing Human Rights: Sovereignty, Tactics and Disruption | OHRH (ox.ac.uk)>accessed 30 December 2023.
[88] Salil Shetty, 'Decolonising Human Rights' (Speech by Secretary General Amnesty International at London School of Economics 22 May 2018) <Decolonising human rights - Amnesty International> accessed 30 December 2023.
[89] Roland Burke, *Decolonisation and the Evolution of International Human Rights* (University of Pennsylvania Press 2010) cited in Jan Eckel, 'Human Rights and Decolonisation: New Perspectives and Open Questions' (2010)1(1) Humanity: An International Journal of Human Rights, Humanitarianism and Development 111, 112.
[90] This thesis maintains that human rights are universal. However, it is also viewed as an agenda to protect people from oppression and abuse of power which may not manifest uniformly.
[91] Barreto explains that based on the idea of natural rights, the colonised peoples had begun to struggle against colonialism by this time. Jose- Manuel Barreto, 'Decolonial Thinking and Quest for Decolonising Human Rights' (2018) 46(4-5) Asian Journal of Social Science 484, 486.
[92] Problems range from lack of homogeneity on the continent to entrenching impunity and upholding harmful cultural practices.

it is sometimes a cloak for avoiding accountability for human rights violations.[93] To the extent that a decolonial exercise includes the development of strategies of local relevance based on the existing human rights laws or even coming up with additional principles based on local conditions, this thesis supports the decolonialisation of human rights.[94]

Thus, this study intends to fill the gap of critically and comprehensively reflecting on the nature, status, regime, and the prospects and problems of the human rights-based approach to health standards as a framework for reducing MM.[95] While it is beneficial to interrogate the entire gamut of the human rights approach,[96] the constraints of word limits would make it difficult to provide an original contribution on the entire HRBA to health in a work of this nature. As has been mentioned above, more than ten guaranteed human rights have been associated with an HRBA to MM and the number of human rights principles could vary depending on the civil society organisation, UN body or expert involved.[97]

This thesis, therefore, focuses on the right to health (RH). One of the reasons for this decision is because it is the most mentioned right in the HR/MM discourse. Additionally, the peculiarity of MM is that the causes and interventions revolve around issues that are properly within the scope of RH. Most of the causes and interventions, though spanning other rights, are most closely related to sexual and reproductive health rights[98] which is an integral part of RH. As a result, the recommendations in the literature from epidemiology, public health, sociology and other relevant fields, on applying human rights to MM, resonate with the standards and norms of the RH more than that of any other right in the HRBA to MM.[99] Additionally, the

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[93] Stef Vandegiste, 'Decolonising Human Rights Protection in Africa: Impunity Rhetorically Repackaged' Africa Policy Brief (Egmont Institute, June 2021).
[94] Stef suggested four ways by which decolonialisation of human rights could take place, including the development of strategies of local relevance. This resonates with one of the key recommendations of this thesis made in Chapter 7. ibid.
[95] This is especially because the actions required in the right to health framework have often been presented as actions that the government or other relevant actors may simply perform. However, complying with some of these requirements may pose challenges. Examples of complex recommendations include liberalising abortion policies, criminalising harmful cultural practices, ensuring the provision of healthcare, encouraging judicial activism to secure socio-economic rights, ensuring access to contraceptives for adolescents and enacting stricter regulations on medical practice.
[96] Also known as the multi-rights approach.
[97] Sofia Gruskin and Dina Bogecho and Laura Ferguson, 'Rights-based Approaches to Health, Policies and Programmes: Articulations, Ambiguities and Assessment' (2010) 31(2) Journal of Public Health Policy 129.
[98] SRHR itself is described as comprising various existing human rights.
For instance, the Special Rapporteur on Violence Against Women draws upon the protection offered by SRHR to highlight gender-based violence such as rape, domestic violence, and child marriage which are related to mm. OHCHR, 'A Human Rights Based Approach to Maternal Mortality and Morbidity' contribution by Rashida Manjoo, UN Special Rapporteur on Violence Against Women, its Causes and Consequences
<[Special Rapporteur on Violence Against Women (ohchr.org)](Special Rapporteur on Violence Against Women (ohchr.org)) > accessed 30 December 2023.
[99] The UN Special Rapporteur on Violence Against Women explained that this violation of the right to life was caused by a failure of the right to health, equity and non-discrimination (meanwhile equity and non-

inclusive nature of the right allows for at least a limited interrogation of other rights relevant to MM. Those rights, such as the right to equality and non-discrimination, to health-related education and information address integral parts of RH.

Similarly, some of the human rights principles that underlie the HRBA to health, such as participation and accountability, are features of the RH. The elaboration of RH as extending beyond healthcare and covering the underlying determinants of health enables RH to cover social issues such as rape, domestic violence, and child marriage, which all relate to MM.[100] Moreover, elucidations of the right to life, which is the second most cited right in respect of MM, refer to measures to preserve women's lives in pregnancy and childbirth, which can properly be interpreted as 'appropriate (health) services in connection with pregnancy, confinement and post-natal period' as provided by CEDAW on RH.[101] Indeed, the HRC observed that to guarantee the right to life, health care services like EmOC and measures to avoid clandestine abortions (both right to health competencies) were necessary.[102]

Hunt also points to the central role of the RH in health interventions[103] and argues that ESC rights, rather than civil and political rights, are more suited to achieve positive rights which usually involve costly interventions and some time to achieve.[104] In this way, ESCR principles such as international assistance, progressive realisation and 'maximum available resources' become available to operationalise and sustain MM interventions, policies, and initiatives.[105] To reiterate: against the background of the absence of concerted scrutiny of the right to health approach with respect to its applicability, challenges, and appropriateness to reduce MM in Nigeria, this thesis attempts to fill that gap in the literature.

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discrimination are integral parts of RH). ibid. Some authors also indicate they are discussing the HRBA but focus on RH. For instance, Obadina Ibrahim (n 15).

[100] Again, the Special Rapporteur on violence against women drew upon the protection offered by SRHR to highlight gender-based violence. Rashida Manjoo (n 98).

[101] GR24 CEDAW, para 27.

[102] Laura Katzive, 'Maternal Mortality and Human Rights' [2010] *Proceedings of the Annual Meeting (American Society of International Law)* 383. <https://doi.org/10.5305/procannmeetasil.104.0383.> accessed 30 December 2023.

[103] Hunt affirmed the importance of RH in HRBA to health when he said that a HRBA to health 'that only implicitly includes the right to health lacks credibility and legitimacy'. Paul Hunt, 'Interpreting the International Right to Health in a Rights Based Approach to Health' (2016) 18(2) Health and Human Rights Journal 109. The OHCHR Technical Guidance on MM also agrees that RH is essential to a HRBA on MM. Technical Guidance (2012).

[104] Hunt (n 103) 117.

[105] ibid

## 1.3 Aims of the Research and Research Questions

The central aim of the thesis is to investigate the potential of the right to health framework for achieving MM reduction in Nigeria and the challenges to its application. To realise this aim, the thesis proceeds by formulating a central research question to guide the direction of the research, as well as interconnected sub-questions addressing the various objectives derived from the aim of the research. The main research question and the sub-questions are as follows:

**Can the international human right to health framework contribute to reducing maternal mortality in Nigeria?**

**Sub-questions:**

a. What is the international human right to health framework?
b. What are the causes of maternal mortality (generally and in Nigeria) and what are the interventions needed to address them?
c. How can the right to health framework be applied to reduce maternal mortality?
d. What is the nature of Nigeria's compliance with the RH framework and to what extent are they compatible with the actions needed to reduce maternal mortality in Nigeria?
e. What are the challenges of applying the right to health framework for the reduction of maternal mortality in Nigeria?
f. What recommendations can be made to surmount the challenges identified in order to make the framework more useful to bring about a reduction in maternal mortality in Nigeria?

To provide the answer to the main research question in a systematic and orderly manner, the six sub-questions are answered by the last six chapters of the thesis, as the thesis consists of seven chapters altogether. Chapter one is this introductory chapter, and it provides a background for the research.

Chapter two provides an answer to the first sub-question. Thus, it examines the legal and conceptual basis of the international right to health. The chapter establishes the RH as the central right within the human rights-based approach to MM and evaluates the RH framework as a legal system within which health goals and, particularly women's reproductive health rights, can be realised. As a result, the chapter considers the nature of the right, legal instruments and the availability of enforcement mechanisms.

Chapter three addresses the second sub-question. Thus, it investigates the causes of MM, generally and in Nigeria, and the interventions necessary for its reduction or prevention. Additionally, in line with the socio-legal outlook of the thesis, it takes an in-depth look into the social context of maternal mortality in Nigeria. It identifies the societal conditions that support the continuous occurrence of MM in Nigeria.

Chapter four answers the third sub-question as it interrogates how the application of the normative constituents of the right to health framework can bring about a reduction in MM. This involves an elaborate and critical evaluation of the specific elements of the right and the human rights principles of the broader HRBA to health to give a comprehensive insight into the potential and the challenges of applying the framework.

Chapter five deals with the extent of Nigeria's compliance with the international RH approach which is the subject of sub-question 4. The chapter critically examines the framework applicable to maternal health in Nigeria. This enables an evaluation of the extent to which Nigeria's laws, policies and programs relevant to MM conform with RH standards. The potential of RH, as well as its limitations to provide a viable framework for MM reduction in Nigeria, is revealed thereby. At the same time, examining Nigeria's policies and legal framework involves determining the extent to which Nigeria has taken cognisance of its peculiar circumstances while adopting measures recommended under the international right to health approach.

Chapter six attempts to answer sub-question 5 on the challenges of applying the right to health framework to MM reduction in Nigeria. To achieve this, it investigates the implementation of different aspects of the framework and identifies the challenges of applying them given Nigeria's current legal, political, economic, social and cultural environment. This chapter reports the findings of an empirical study which involved interviewing stakeholders in relevant government departments who are in a position to provide in-depth information about the implementation of various aspects of the framework.

Based on the findings of the thesis, Chapter seven makes recommendations on how the identified challenges may be overcome. In view of the limitations, the chapter suggests how this research may be taken further. Regarding recommendations, the thesis also relies on the findings from the interviews of the implementers of different aspects of the framework who are in a strategic position to offer insight into the best ways to enhance the framework. It was

found from the preliminary research that the perspectives of these stakeholders have been largely excluded, and their efforts are usually vilified in human rights analysis of MM.

## 1.4 Methodology

This thesis uses a combination of library or desk-based research and field study. Broadly, the research is interdisciplinary because by adopting a socio-legal approach, [106] it allows an interaction between law and the domain of sociology. The socio-legal approach analyses the law or legal phenomena within the context of a social environment.[107] It aims to bridge the gap between legal idealism and social realities by enquiring into the social understanding of the law and its effects on intended targets.

At the same time, various factors that may influence the law's efficacy are highlighted and may include an investigation into the results of its application.[108] The aims of sociolegal research thus necessitate a combination of research methods drawn from traditional legal research and from the social sciences – sociology, anthropology and so on- which are mainly empirical and grounded in social theories.[109] In the case of this thesis, it also draws on findings from public health, medicine/medical ethics and epidemiology.

Despite the volume of research that has been dedicated to exploring the conceptual, theoretical and practical aspects of right to health and maternal mortality reduction efforts globally and in Nigeria, some of this research is, to a large extent, exploratory. This is because while the existing research stops at identifying the factors that shape the efficacy of the internationally prescribed standards in Nigeria, this thesis intends to scrutinise the standards themselves and their potential to bring about significant MM reduction in Nigeria, given the country's legal, social, cultural, political and economic circumstances. Thus, after attaining the aim of ascertaining the extent to which Nigeria's laws and policies conform with the

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[106] Although this type of research is referred to by some authors as non-doctrinal research, this research would not adopt that term because the doctrinal methodology is still utilised in the thesis to achieve some of its objectives. Crucially, doctrinal research is an essential starting point for non-doctrinal research in law. Khushal Vibhute and Filipos Aynalem, *Legal Research Methods: Teaching Material* (Justice and Legal Research Institute 2009) <chilot.wordpress.com> accessed 30 December 2023.
Also, L Epstein and G King, 'Empirical Research and the Goals of Legal Scholarship: The Rules of Inference' [2002] University of Chicago Law Review 1.

[107] Donovan describes it as being driven by a jurisprudential commitment to study law in its context. See Darren O Donovan, 'Socio-legal Methodology: Conceptual Underpinnings, Justifications and Practical Pitfalls' in Laura Cahillanne and Jennifer Schweppe (eds) *Legal Research Method: Principles and Practicalities* (Clarus Press 2016) 4.

[108] ibid. See also Khushal Vibhute and Filipos Ayanalem (n 106).

[109] ibid 8.

international framework, the thesis will go beyond to investigate Nigeria's experience with adopting and implementing policies and initiatives that give effect to Nigeria's RH obligations.[110] To the best of my knowledge, investigating whether the framework is appropriate or workable in Nigeria has not been previously explored in the existing literature on the issue.

This study also intends to adopt the doctrinal, and qualitative research methodology. The doctrinal method will be employed to identify, analyse and critically evaluate RH, particularly the maternal health framework, both on the international, and national (Nigeria) levels. The analysis involves the international instruments, laws, policies, and initiatives on maternal health or MM reduction, and published studies investigating different aspects of the framework. Both primary and secondary[111] sources of law on the right to health and particularly maternal health on both the international and national levels will be examined and analysed. International law sources include binding and non-binding instruments from international and regional bodies.[112]

The non-binding instruments include authoritative interpretations of relevant norms by treaty bodies, detailed guidance by specialized agencies such as the Special Rapporteur on the right to health, international conference declarations and programme of actions of the International Conference on Population and Development (ICPD) and the Beijing Women's Conference.[113] These non-binding instruments are examined because they are considered clarifications of the obligations contained in the relevant binding instruments.

[110] The literature has identified problems with compliance or full compliance with applying different aspects of the framework globally and in Nigeria. However, it is believed that some of the challenges are associated with the framework and therefore not limited to Nigeria, although many of them are peculiar to Nigeria and relate to the country's political, legal, social, cultural and economic environment. Some of these challenges have been identified in previous studies from preliminary research.

[111] In addition to other secondary sources, books, and scholarly articles material to maternal mortality and the right to health, national and international law reports would also be reviewed for jurisprudence relating to the topic.

[112] Though s. 12 of the Nigerian Constitution necessitates domestication of international law for such to become applicable in the country, Nigeria is a signatory to many instruments which confer some level of obligations on the country. Constitution of the Federal Republic of Nigeria 1999 CAP C4 LFN 2004 (CFRN).

[113] Relevant examples include General Comment No. 14 of the Committee on Economic Social and Cultural Rights,
Limburg Principles on the implementation of the ICESCR, E/CN.4/1987/17.
Maastricht Guidelines on Violations of Economic Social and Cultural Rights of 26 January 1997, Vienna Declaration and Programme of Action adopted in June 1993 in Vienna, Austria, (available at www.ohchr.org/english/law/vienna.htm),
The Programme of Action of the International Conference on Population and Development 1995 (UNFPA, A/CONF.171/13/Rev.1
The Beijing Declaration and Platform for Action adopted at the Fourth World Conference on Women, 27th October 1995.

On the national level, the Constitution, laws, policies, and judicial decisions on the right to health in Nigeria would also be referred to. The main laws and policies of Nigeria to be reviewed are the ones enacted by the federal government which is the primary maker of health laws and policies, although all three tiers of government concurrently deliver healthcare.[114] Through the examination of these laws and policies, published studies, and the Concluding Observations of treaty monitoring bodies, the extent to which Nigeria's legal and policy framework has incorporated the provisions of the international instruments and the recommendations of relevant international bodies would be determined.

The empirical method is employed because while the doctrinal method allows for an analysis of the laws, it will be insufficient to answer the research questions as the goal of interrogating the interaction of the laws and policies with the political, social, economic and political environment, will require empirical evidence. [115] Therefore as stated earlier, qualitative interviews are employed for this purpose. Semi-structured interviews of critical medical personnel and officials of the Ministry of Health who are stakeholders in the maternal health sector and saddled with adopting and implementing relevant policies are utilised to get first-hand insight into their experiences, including the obstacles facing the adoption and implementation of the RH standards and guidelines for ending preventable MM. Their contributions are expected to give room for more credible recommendations as well.

The empirical study is planned to be limited to one state because although the federal government constitutionally has the duty of signing or ratifying any international instruments on behalf of the country, legislation on health being under neither the exclusive nor concurrent legislative list of the Constitution, is a residual matter. [116] It is, therefore, within the purview of the component states of the Federation which decide implementation. Also, it is necessary to keep the thesis focused and manageable, especially against the background that the empirical study is one of the methods of the research specifically being used to gain practical knowledge of the national operation of the international framework.[117] Investigating several states may, therefore, make the thesis unwieldy.

[114] CFRN (n112) Schedule 4, section 2 (c).
[115] M D Pradeep, 'Legal Research Descriptive Analysis on Doctrinal Methodology' (2019) 4(2) International Journal of Management Technology and Social Sciences 101.
[116] CFRN (n112) s 4.
[117] It has been observed that the size and complexity of the country are challenges for health policy makers. Federal Ministry of Health 'National Strategic Health Development Plans (NSHDP) II Annual Operational Planning (AOP) Guidelines 2018-2022' (FMOH 2019) 5.

Lagos State was selected as the setting for the interviews. The choice of Lagos was for pragmatic as well as strategic reasons. First, the state has a high maternal mortality ratio.[118] Additionally, it has been proactive in domesticating the federal government's health policies including the Maternal and Perinatal Death Surveillance and Response (MPDSR), Health Insurance Scheme and regulation of traditional birth attendants (TBAs), which are major public health initiatives through which the country is discharging its MH obligations. In accordance with the general framework of the research, the empirical study explores a human rights approach. The questions explore the implementation of various standards of the RH and HRBA to health framework, which Nigeria is obliged to comply with in order to fulfil women's right to SRH and maternal health.

In sum, this thesis argues that there is a dearth of research critically evaluating the applicability of RH framework to MM reduction in Nigeria, thus, necessitating more research on the subject. This thesis, therefore, intends to fill this gap by providing a critical and holistic assessment of the prospects, suitability and challenges of the framework in the context of Nigeria. This task is proposed to be achieved through the research methods highlighted above. The evaluation commences with the next chapter, in which RH is interrogated.

[118] Okonofua Friday and Others,' Maternal Death Review and Outcomes: An Assessment in Lagos State, Nigeria' (2017) PLOS ONE <Maternal death review and outcomes: An assessment in Lagos State, Nigeria | PLOS ONE> accessed 30 December 2023.

# Chapter 2

## The Concept of the Right to Health

### 2.1 Introduction

To reiterate the objective of this thesis: it is to investigate the potential of the human rights-based approach- with a focus on the international right to health - to secure the reduction of maternal mortality in Nigeria, a maternal mortality hotbed. From this emerges the two main concepts around which the thesis is built- maternal mortality (MM) and the right to health (RH). This chapter provides part of the conceptual foundation for the thesis by engaging with the right to health. The chapter interrogates the RH as a legal framework within which states' obligations to reduce MM can be located and enforced. As a result, the framework's strength and imperfections are exposed. This examination extends to the historical underpinnings of RH and the nature of obligations the right evokes. It involves examining legal instruments in which states' obligations in respect of the right are located, particularly in connection to realising women's right to health and the arrangements for their enforcement. The right to health includes the right to sexual and reproductive health (SRH).[1] The interrogation is extended to these components of RH because maternal health (MH) is a subset of SRH.[2] Therefore, this chapter draws on research undertaken by scholars on women's sexual and reproductive health rights (SRHR) field as well as the broad RH and public health disciplines.

This chapter starts out with a brief introduction of the human rights approach to MM, and then RH, (including SRH), is introduced by way of a brief discussion of its antecedents. Next, the chapter focuses on the nature of the right, drawing attention to some controversies around its guarantee, then discusses the sources of the right generally and in relation to SRH/maternal health specifically. Finally, it surveys the available enforcement mechanisms and their prospects for realising sexual and reproductive health and/ or women's right to health.

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[1] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant 11 August 2000 E/C.12/2000/4 (GC 14) paras 8, 11, 36, 21.

[2] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 22 (2016) of the CESCR on the Right to Sexual and Reproductive health E/C.12/GC/22, paras 18, 45.

## 2.2 Human Rights and Maternal Mortality

The contemporary international preoccupation with maternal mortality was born in the 1980s.[3] At the time, MM was viewed mainly as a public health problem. However, it also received attention because of its effect on global population and development. [4] The interest from the development sector was premised on the impact on women as a population group, as well their role in producing future generations. [5] By the 1990s, the acknowledgement of MM as a human rights issue gained ground, especially following the recognition of sexual and reproductive health rights at the 1994 International Conference on Population and Development (ICPD), 1995 World Conference on Women (Beijing Conference) and the 2005 World Summit for Social Development in Copenhagen. The outcomes of the ICPD and Beijing Conferences notably influenced the inclusion of goal 5 on maternal health in the United Nations' Millennium Development Goals (MDGs) adopted by the General Assembly in 2000. [6] Following the momentum, the Human Rights Council (HRC) adopted a resolution declaring MM to be a human rights issue. [7] The Council, therefore, requested states and international bodies to incorporate human rights analysis in their initiatives to end MM.

Although a human rights-based approach (HRBA) had found its way into development issues since the late 1990s, that HRC resolution served as an impetus to several international human rights bodies and international development agencies for adopting a human rights-based approach (HRBA) to MM. A human rights-based approach is predicated on the understanding that the root of development problems are discriminatory practices, inequalities and unjust power relations which are antithetical to human rights.[8] This understanding resulted in focusing on the realisation of human rights to solve development problems. The processes and programmes are shaped by human rights standards and principles which ensure that human rights are realised and that the goals attained can be sustained. It also involves building the

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[3] Sarah Zureick-Brown and others, 'Understanding Global Trends in Maternal Mortality' (2013) 39(1) International Perspectives of Sexual & Reproductive Health 32.
[4] ibid.
[5] The close relationship between the health of the mother, foetal development, childhood survival and wellbeing in adulthood, makes it imperative for societies and nations to safeguard maternal health.
[6] UN Human Rights Council, 'Preventable Maternal Mortality and Morbidity and Human Rights' Resolution adopted by the Human Rights Council on 17 June 2009 A/HRC/RES/11/8, (HRC Resolution on MM) Preamble.
[7] ibid.
[8] WHO/OHCHR, 'Human Rights Based Approach to Health'( WHO, 2009) <(Microsoft Word - hrba_to_ health.doc (ohchr.org))> accessed 30 December 2023.

capacity of the rights holders to claim their rights while strengthening the duty bearers to meet such claims.[9]

As explained previously, the human rights-based approach comprises two distinct but complementary approaches: one draws on human rights standards in international human rights law. Here, the specific treaty obligations associated with the individual rights are the standards to be complied with in order to inform the necessary interventions. The importance of these internationally agreed human rights standards lies first and foremost in the legality they bestow on the claims. The other approach is the development-centred approach that additionally requires that practices such as equality and non-discrimination, participation, inclusion and accountability be inculcated in implementation processes.[10] These principles are also drawn from the general human rights framework, but their interpretation is not confined to human rights when used to address the broad dimensions of the root causes of development problems. That is, owing to the fact that the underlying basis of inequalities, marginalisation and discrimination that characterise developing countries require multi-faceted interventions, various methods and organisational structures are needed to implement these principles.

The rights implicated in the MM discourse provide specific legal standards and principles for the HRBA to MM.[11] The HRC's resolution for instance identified various rights as being implicated by MM.[12] However, this thesis argues that the right to health which guarantees the right to sexual and reproductive health is the key right in a HRBA to maternal health. The centrality of this right to any discourse on the application of human rights to health, constitutes one of the grounds for focusing on it in this thesis.

Besides the right to health, two other rights: the right to life and the right to equality and non-discrimination, appear most often in literature interrogating MM and human rights. Guaranteeing the right to life has been cited by both the committee overseeing civil and

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[9] ibid.

[10] DFID Health Resource Centre, 'How to Reduce Maternal deaths: Rights and Responsibilities' (2005) <Microsoft Word - KCGuidanceNote21Jan05.doc (ohchr.org)> accessed 30 December 2023.

[11] UNFPA and Harvard School of Public Health, 'Human Rights Based Approach to Programming: Key Elements of a HRBA' < Session3_Presentation5_KeyElements_HRBA.PPT (live.com) > accessed 30 December 2023.

[12] Elaborated on by the OHCHR. OHCHR, Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity ( OHCHR, 2012) <https://www2.ohchr.org/english/issues/women/docs/a.hrc.21.22_en.pdf> accessed 30 December 2023. .

political rights (CCPR)[13] and the CEDAW Committee,[14] as a basis of urging states to make efforts to reduce MM ratios. For instance, the CCPR requests states to address MM, by improving access to medical examinations and treatments and acting against gender-based violence and life-threatening illnesses like malaria and HIV-AIDS.[15] The persistence of MM globally and in specific countries has also been traced to discrimination in the enjoyment of medical facilities or the underlying determinants of health which are very important for preventing MM. The stipulations of these treaty monitoring bodies (TMBs) in respect of these two rights further buttress the prominence of RH standards in MM prevention because they emphasise that states should fulfil their obligation to provide maternal health care and underlying determinants of health as well as ensure equality in the enjoyment of healthcare and the underlying determinants of health. The position of RH as a major repository of SRHR which guarantees a fulfilling and safe reproductive life further justifies the focus on the right to health in the interrogation of the potentials of HRBA for the reduction of maternal mortality.

Furthermore, as the aim of the HRBA is to realise human rights,[16] and RH is considered a key right for MM, the HRBA applicable to MM is a HRBA to health which makes use of the standards of RH to secure the health rights of women in order to protect them from MM. However, as a HRBA is not only about the outcome but also the processes, the standards of RH are combined with the general human rights principles or development-oriented practices of a HRBA[17] which guide the processes of implementing the standards.[18] As an approach which grew within the field of international development, it fundamentally aims at addressing disadvantages that cause or perpetuate underdevelopment. It represents a shift from the welfare approach whereby development institutions tried to eliminate poverty by providing 'often misappropriated funds' and in some cases, directly providing essential goods and services.[19]

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[13] Human Rights Council (HRC) Concluding Observations Hungary (CCPR/CO/74/HUNG) para 11; Human Rights Council (HRC)Concluding Observations Mali (CCPR/CO/77/MLI) para 14; Human Rights Council (HRC) Concluding Observations Democratic Republic of Congo, 26 April 2006 (CCPR/C/COD/CO/3) para 14.
[14] CEDAW Committee Concluding Observations Madagascar (a/49/38) para 244.
[15] Human Rights Committee (HRC), General Comment 36 on Article 6, Right to life, 3 September 2019, (CCPR/C/GC/35) para 26.
[16] WHO, 'Human Rights Based Approach to Health' (n 8).
[17] empowerment of right holders and duty bearers, non-discrimination and equality, monitoring and accountability, participation and inclusion
[18] Elaborated on by the OHCHR. OHCHR, Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity ( OHCHR, 2012) <https://www2.ohchr.org/english/issues/women/docs/a.hrc.21.22_en.pdf> accessed 30 December 2023.
[19] Raymond C Offenheiser and Susan H Holcombe, 'Challenges and Opportunities in Implementing a Rights-Based Approach to Development: An Oxfam America Perspective' (2005) 32(2) Non-Profit and Voluntary Sector Quarterly 268, 271.

Briefly, empowerment refers to building the capacity of the state as the major duty bearer to perform its obligations which include ensuring that the state as well as non-state actors act in conformity with the guaranteed rights. The empowerment also extends to the rights holders who must also be equipped to claim their rights. Non-discrimination obligates states to ensure that the actions towards guaranteeing human rights meet the needs of all by considering various grounds that could facilitate disadvantage. Inclusion and equality /equity are crucial for enabling equal opportunity of access irrespective of social group, class, location or economic capability.

Accountability involves one party recognising and acting in consonance with the right of another which, it has a duty to fulfil,[20] while the opportunity to monitor the decisions and actions [21] being taken make accountability possible. Participation enables people and communities to have an input in the design and review of policies and programs made towards realising their rights based on their local or peculiar circumstances. [22] International assistance and cooperation is key to enabling states which do not have the resources to acquire the infrastructural and human resources to meet their human rights obligations from developed states and development partners.

In practice, these principles reinforce the RH legal standards even though some of the principles, that is, participation, non-discrimination and equality, accountability and international cooperation and assistance, are inherent parts of the RH framework[23] and should as a matter of course, characterise the measures to realise the right to health. An analysis of their application to the realisation of maternal health or MM reduction is undertaken in Chapter 4. In the same vein, while this chapter highlights the standards that make up the framework of the RH, the application of those standards for reduction of MM is explored in Chapter 4.

[20] DFID Health Resource Centre (n 10) 11.
[21] Technical Guidance (n 18) 68.
[22] Paul Hunt and Judith Bueno De Mesquita, 'Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health' (Human Rights Centre University of Essex, and United Nations Population Fund 2006 ) <https://www.unfpa.org/sites/default/files/pub-pdf/reducing_mm.pdf > accessed 30 December 2023.
[23] To explain: participation and inclusion, has found their way into RH discourse since the Alma Ata Declaration. Non-discrimination, equality are inbuilt features of RH. Accountability is an inherent feature of every right because as they say *'ubi jus ubi remedium.'* Then, as a right codified by the International Covenant Economic, Social and Cultural Rights, international cooperation and assistance comes from its legal origin.

## 2.3 The Right to Health

### 2.3.1 Brief History

The phrase 'right to health' is a shorthand phrase to capture the various phraseologies by which the right is known in different international and national legal documents. [24] Though the recognition of health as a right may be of relatively recent occurrence, health protection is a matter that has attracted considerable public responsibility and personal attention through the ages. Undoubtedly, its role in the preservation of life makes it important universally and aptly described by the WHO as 'a resource for living'. [25] For individuals too, good health is synonymous to well-being. Furthermore, the connection of health with the preserving human dignity which meaning includes, amongst other things, the prevention of suffering, makes health protection a paramount good.[26] The protection of health is also important to economic development because the state of the workforce determines productivity and economic growth.[27] Consequently, health protection has come up in issues such as wartime medical experiments, safety at work, disease prevention, population growth and even environmental protection.

The contemporary human rights regime is traceable to the end of the Second World War wherein atrocities related to health such as non-consensual human experiments and the killing of groups with bio-medical weapons were carried out on a large scale. Though connected to this tragedy, the recognition of a human right to health, is generally attributable to the emergence of health protection as an international concern. Starting from the 19th century and until early in the 20th century, there was a rise in national and regional attention to the relationship between hygiene, medical assistance and the spread of diseases which led to transnational cooperation though mainly within Europe and the Americas. Global epidemics such as Asiatic cholera, yellow fever, the plague and 'any other disease reported to be importable' propelled international sanitary conferences in the two regions.[28]

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[24] Virginia Leary, 'The Right to Health in International Human Rights Law' (1994) 1 (1) Health and Human Rights 34.
[25] WHO, 'Health Promotion: A Discussion Document of the Concepts and Principles' (1984) 4 <E90607.pdf (who.int)> accessed 30 December 2023.
[26] Jonathan Mann, 'Dignity and Health: The UDHR's Revolutionary First Article' (1998)3 (2) Health and Human Rights 30, 37.
[27] Julius B Tutor and Melanio Leal, 'The Egg or the Hen: The Unending Debate Between Population Health and Economic Development' (2023) 45(2) Journal of Public Health e390.
[28] John Charles, 'Origins, History and Achievements of The World Health Organisation' (1968) 2 The British Medical Journal 293; John Tobin, *The Right to Health in International Law* (2011 Oxford Scholarship Online) ISBN-13:9780199603299.

In 1907, the Rome Agreement signed by 12 states created the first international health body, Office Internationale d' Hygiene Publique, primarily tasked with the prevention and control of epidemics. A second body known as the Health Organisation created pursuant to the Covenant of the League of Nations, was added in 1923. The provisions of the Covenant, which were relevant to health protection, obligated states to prevent and control diseases[29] and to encourage and promote the national Red Cross organisations which had the duty to improve health, prevent diseases and mitigate suffering.[30] This wide modus operandi enabled the Health Organisation to go beyond the immediate reason behind its creation to engaging in matters such as global prevalence of other communicable diseases such as malaria, trypanosomiasis, even cancer and heart disease.[31] It established commissions on health education, disease and death classification and even wrote a classic on the physiological bases of nutrition.[32]

The Second World War and the subsequent dismantling of the League of Nations meant the end of its work. Officially, both organisations were dissolved in 1945 following the creation of the WHO by the United Nations (UN) which replaced the League of Nations. The new organisation (UN) which had one of its main objectives as the promotion of human rights in its article 55 made specific mention of promoting solutions of 'international …health… problems' in the Charter[33] and the creation of a world health organisation had been mooted at the creation of the UN. [34] That health was specifically mentioned in its own right under the Charter, and not lumped under social problems, which was also mentioned, clothed the issue with some importance. It would appear that the vigorous work of the defunct international health organisations, the high level of international cooperation previously bestowed on health matters, as well as the World War II health-related atrocities contributed to laying the foundation for making health promotion fundamental to the human rights regime, which followed the war.

Thus, with the creation of a body like the WHO, states could transfer some of their sovereignty to an international organisation in order to co-operate in respect of a specific field and in this case, health promotion. [35] Other factors such as the interpretation of USA's

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[29] League of Nations, Covenant of the League of Nations 1919. Art 23(f).
[30] Article 25; Charles (n 28); Tobin (n 28).
[31] ibid Charles.
[32] ibid.
[33] United Nations, Charter of the United Nations signed 24th October 1945 1 UNTS XVI.
[34] Cass R Sunstein, 'Incompletely Theorized Agreements' (1995) 108 (7) Harvard Law Review 1733.
[35] Alison Lakin, 'The Legal Powers of the World Health Organization' (1997)3 (1) Medical Law International, 23, 24.

Roosevelt's 'freedom from want' to include a healthy life and the socialist human rights philosophy of the Latin Americas played a role in placing RH in the first human rights instrument adopted after the creation of the UN[36]- the Universal Declaration of Human Rights (UDHR).[37] These formative factors present a picture of a right rooted in humanitarianism as well as benevolence, and conceived as a common good to be attained for all, even if it required international cooperation. The first proclamation of health as a human right was made by the WHO in 1946 before the adoption of the UDHR. It stated:

> The States Parties to this Constitution declare, … that the following principles are basic to the happiness, harmonious relations and security of all peoples:
>
> 'The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions.

It defined health, stating: 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. [38]

By this definition, health was conceived as transcending physical health, or even the presence or absence of disease, and was extended to promoting human wellbeing. The definition remains a classic one, [39] setting the stage for a holistic understanding of health and promoting the idea that the body and the mind are inseparable when it comes to wellness.[40] The definition has attracted a good amount of disapproval for the use of the words 'complete,' 'social' and 'wellbeing'. It is argued that by aiming for a 'complete' state, bringing in the 'social' element, and conflating 'wellbeing' with health,[41]unrealistic expectations are being

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[36] Before WWII following the revolutionary struggles, Latin American countries were already protecting Economic and Social Rights as a practical means of addressing the needs of the poor. ibid.
[37] Universal Declaration of Human Rights Adopted by General Assembly Resolution 217 A (III) of 10 December 1948.
[38] United Nations General Assembly, World health Organisation Constitution, 17 November 1947 A/Res/131 (Preamble)
[39] There are arguments that due to the shortcomings over the years, other definitions have been provided by the WHO. But it is submitted that they are clarifications and not official replacements.
WHO Regional Office for Europe, *Health Promotion: a Discussion Document on the Concept and Principles. Summary Report of the Working Group on Concept and Principles of Health Promotion, Copenhagen 1984* <E90607.pdf (who.int)> accessed 30 December 2023.
Also WHO, *Global Strategy for Health by the Year 2000* (2012) 15 para 2.<9241800038.pdf> accessed 30 December 2023.
[40] Norman Sartorious, 'Meanings of Health and its Promotions' (2006) Croat Medical Journal 662, 663 <CroatMedJ_47_0662.pdf (nih.gov) > accessed 30 December 2023.
[41] Fabio Leonardi, 'The Definition of Health: Towards New Perspectives' (2018) 48(4) International Journal of Social Determinants of Health and Health 735< https://doi.org/10.1177/0020731418782653 > accessed 30 December 2023.

created for the healthcare system.[42] Additionally, it is argued that in light of scientific advancements on human ability to adapt and self-manage, a fixation on protecting a social state of health is outdated.[43]

Despite the various criticisms[44] however, the fact that it makes the connection between health and social and environmental conditions is immensely important. This aspect remains relevant as it informs every meaningful health protection strategy, including the promotion of MH which was listed as one of the functions of the WHO.[45]

Despite the recognition of the right, it was several decades later that the actual application of human rights to health took root. This may be connected with the delay by the Committee on Economic, Social and Cultural Rights (CESCR) to provide an authoritative interpretation of the provision.[46] In 1994, Jonathan Mann and others observed that despite the mutual interest of both health and human rights in promoting wellbeing, they had rarely been brought together. They noted that health and human rights interacted in about three ways.[47] First, health policies and programs, could impact human rights. Second, human rights violations could have negative implications on health. Third, the promotion and protection of human rights and the promotion and protection of health are inextricably linked because practically and conceptually, the concerns of human rights are conditions that determine the population's health status.[48] Their conclusion that RH needed to take its rightful position as a bridge between human rights and the field of health is commended as pivotal for the promotion of RH.

## 2.4 Overview of the Nature of the Right to Health

Human rights are described as moral rights which people have by virtue of their humanity. Notwithstanding, beyond a moral or even political basis, they are also legal rights due to being

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[42] Marianna Nobile, 'The WHO Definition of Health: A Critical Reading' (2014) 33 (2) Medicine & Law 33.
[43] Machtel Huber and others, 'How do we Define Health' (2011)343:d4163 The BMJ.
[44] For more critiques of the WHO definition, see Stephen Marks, 'The Emergence and the Scope of the Human Right to Health' in Jose M Zuniga and Stephen P Marks and Lawrence O. Gostin (eds) *Advancing the Human right to Health* (2013) ISBN 13: 978019966169; Catherine Mc Donald, 'Problems with the WHO definition of health' < Problems with the WHO Definition of 'Health' • Catherine McDonald > accessed 30 December 2023.
[45] WHO Constitution, UNGA, Entry into force on 17, November 1947, A/RES/131. Article 2 para l.
[46] Paul Hunt, 'Right to The Highest Attainable Standard of Health' (2007) 370(9585) The Lancet 369 <https://doi.org/10.1016/S0140-6736(07)61173-8 > accessed 30 December 2023.
[47] Jonathan Mann and others, 'Health and Human Rights' (1994)1(1) Health and Human Rights 6.
[48] ibid 13.

protected by various legal regimes.[49] Other definitions, such as that of Wasserstrom add that human rights, being universal, are assertable against the whole world. [50] And for some theorists, rights are seen as valid claims[51] which makes human rights, claims that people have on account of their humanity. According to Charlotte Bunch, the concept of human rights is progressive, and this enables it to expand to cover emerging issues that it ought to respond to.[52] Wolff also emphasises that rights are enforceable claims as against hand-outs due to benevolence or charity. [53] The historical as well as contemporary origins of human rights portray the protection of the vulnerable and marginalised, from discrimination and oppression, as the overarching objective of human rights. [54] The preamble of the UDHR states:

> Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people[55]

However, it is no secret that the concept is as attacked as it is accepted, and so despite almost a century of universal recognition of human rights, the concept is still subjected to opposition. The origins, the notion, as well as some provisions in particular instruments have continuously been criticised. [56] Amongst these criticisms are the contentions that human rights are an imposition by the West due to links between the rights guaranteed and historical struggles for liberties in the West,[57] as well as works of western philosophers such as John Locke, Immanuel Kant and Jeremy Bentham.[58] It is also contended that human rights embody values which are not common to all societies of the world leading to calls for the cultural relativism of human rights. [59] The fact that many African and Asian states were under

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[49] Anthony D'Amato, 'The Concept of Human Rights in International Law' (1982) 82(6) Columbia Law Review 1110, 1127, 1128.
[50] Richard Wassestrom, 'Rights, Human Rights, and Racial Discrimination' in D. Lyons (ed.), *Rights* (Wadsworth Publishing Company 1979) cited in Alison Dindes Renteln, *Concept of Human Rights* (Nomos Publishing 1988) 348.
[51] Joel Feinberg, *Social Philosophy* (Prentice-Hall 1973) ISBN 0138172544 63-64.
[52] Charlotte Bunch, 'Women's Rights as Human Rights: Toward a Re-Vision of Human Rights' (1990) 12 (4) Human Rights Quarterly 486, 487.
[53] Jonathan Wolff, *The Human Right to Health* (2013 W.W. Norton &Company) 15.
[54] ibid 124.
[55] Universal Declaration of Human Rights Adopted by General Assembly Resolution 217 A (III) of 10 December 1948 Preamble.
[56] Renteln (n 50) 350.
[57] For instance, the adoption of Magna Carta (1215), the English Bill of Rights (1689), the American Declaration of Independence (1776) and so on.
[58] Tasioulas John, 'On the Foundations of Human Rights' in Cruft and Liao and Renzo, *Philosophical Foundations of Human Rights* (eds) (OUP 2014).
[59] But Alison argues that if societies were to device their own rights it would no longer be human but cultural rights. Rentel (n 50) 351.

colonialism when the UDHR was adopted and were not involved in the drafting is also often cited as a reason.[60]

Nevertheless, it has been pointed out that these states ratified the Declaration upon independence. In addition, they ratified the ICESCR and ICCPR and have supported the human rights regime in various ways.[61] Notwithstanding, scholars have maintained, concerning Africa, for instance, that values like communalism, being duty-oriented and harmonious living make the individualistic, rights focused and combative human rights incompatible with Africa.[62] The subsequent adoption of a human rights instrument which spotted 'peoples' rights as well as correlative duties of members of the community illustrated these sentiments. Scholars have also refused to come to an agreement on the justification for protecting human rights; nature, human needs, human dignity, rationality and self-evidence are all various grounds that have been advanced and argued against.[63] The preceding is the context within which the right to the highest attainable standard of health has been recognised.

The scope of the right to health is broad. Besides healthcare, it encompasses other socio-economic entitlements (like food, housing and water which are also guaranteed human rights) necessary to ensure good health.[64] According to Akim and Tomossy, this definition virtually links the right across all aspects of human existence and confirms the fundamental nature of the right.[65] This broad interpretation is however not surprising considering the interdependence, indivisibility and interrelatedness of human rights.[66] Additionally, this interpretation of the right emphasises that it requires more than access to healthcare to realise the right to health. This conception of the right is supported by the UDHR[67] which lists medical

[60] Wicktor Osiatynski, *Human Rights with Modesty: The Problem of Universalism* (Springer Dordrecht 2004) 39.
[61] ibid.
[62] Claude Ake, 'The African Context of Human Rights' (1987) 33(1/2) Africa Today 5; Josiah Cobbah, 'African Values and the Human Rights Debate: An African Perspective' (1987) 9 (3) Human Rights Quarterly 309.
[63] Tasioulas (n 58) 10.
[64] Human rights are interlinked, their full realisation is often dependent on the realisation of another right. They are equally important and the fulfilment of one right can lead to improvement in others.
[65] Sheikh Mohammad and Towhidul Karim and George F. Tomossy, 'Progressive Realisation of the Right to Health: An Opportunity for Global Development' (2019) 27 Waikato Law Review 31, 32.
[66] Highlighting this fact first became necessary in relation to the early civil, political/economic social dichotomy and was recently reaffirmed at the Vienna World Conference on Human Rights 1993.
[67] Article 25(1) of the UDHR provides:

> 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

care as one of a non-exhaustive list of determinants.[68] Subsequent clarifications of the right have also highlighted this feature.[69] And in 2005, the WHO established the Commission on Social Determinants of health (CSDH) to support countries and global health partners in addressing the social factors causing ill health and health inequities. [70]

As a right in the economic, social and cultural rights (ESCR) bracket, RH is considered second generation or second class. [71] Thus, in some quarters, it is less supported than its civil and political rights (CPR) counterparts referred to as 'first generation rights.'[72] As argued by Jensen, although the initial use of the word 'generation' was intended to represent 'categories', the unsubstantiated dichotomisation into generations to depict the order of existence became popular. [73] The divide between the two classes of rights was buttressed by the adoption of two different covenants to protect each class of right. [74] This provided a pragmatic solution to the various questions that were grappled with in the process of drafting a document to turn the aspirations of the UDHR into a binding document. The questions concerned which rights to include, the nature of state obligations, as well as mechanisms for enforcement.[75]

Historically also, the guarantee of ESCRs mostly supported by the Eastern bloc[76] have been fraught with many arguments while the CPRs, having been recognised due to earlier rights struggles in the West, enjoyed more support than ESCRs. Several arguments, including the

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[68] Wolff supports the view that the UDHR distinguishes between health and medical care. Medical care being one of the means to attain health. Wolff (n 53) 6.
[69] Such as GC14 (n 1).
[70] WHO, Commission on Social Determinants of Health, 2005 -2008 (2008)< Commission on Social Determinants of Health (who.int)> accessed 30 December 2023.
[71] OHCHR, 'Key concepts on ESCRs: Are Economic, Social and Cultural Rights Fundamentally Different from Civil and Political Rights?' ( OHCHR 1996-2023) <Key concepts on ESCRs - Are economic, social and cultural rights fundamentally different from civil and political rights? | OHCHR > accessed 30 December 2023.
[72] The term was said to have first been used by Karel Vasak in 1977.; Karel Vasak, 'A 30 Year Struggle; The Sustained Efforts to Give the Force of Law to the UDHR' (1977)< Southern Africa at grips with racism - UNESCO Digital Library> accessed 30 December 2023.
[73] One of his arguments was that Vasak's generational divisions was dated post 1945, whereas economic rights had always featured in historical rights struggles such as the French Revolution. Steven LB Jensen, 'Putting to Rest the Three Generations Theory of Human Rights' (Open Global Rights, 15 November 2017) < Putting to rest the Three Generations Theory of human rights | OpenGlobalRights> accessed 30 December 2023.
[74] The International Covenant on Economic Social and Cultural Rights and the International Covenant on Civil and Political Rights (ICCPR) were adopted on 16th December 1966. However, they came into force at different times in 1976 when they had each received the required number of ratifications. Human Rights Committee, 'Background to the Covenant' (1996-2023) <Background to the Covenant | OHCHR> accessed 30 December 2023.
[75] Maya Herig Randall, 'History of the Covenants: Looking Back Half a Century and Beyond' in Daniel Moeckli, and Helen Keller and Corina Heri eds, *The Human Rights Covenant at 50, Past Present and Future* (Oxford University Press 2018)7.
[76] Sheikh Mohammad and Towhidul Karim and George F. Tomossy (n 65) 31, 32.

vagueness of the content of the ESCRs,[77] the application of the progressive realisation doctrine to same, non-justiciability,[78] the erroneous understanding that CPRs were negative rights largely fulfilled by government inaction while ESCRs as positive rights required action[79] and therefore resources are some factors influencing the distinctions drawn between the rights. [80] These arguments have been contested on different fronts.

For instance, on vagueness of RH, Jamar notes that although a broad conception of the right which would include policy or morality-based claims[81] may perpetuate the argument on vagueness, salient features of the right (narrow conception of the right) are identifiable. He argues that features such as restraint from taking actions that would harm the health of the population, ensuring access to some level of healthcare and protecting public health can be glimpsed from international instruments as well as the actions and pronouncements of international bodies.[82]

Non-justiciability has been countered with submissions that unelected judges are no more justified to adjudicate on CPR cases than ESCR cases because like in CPR cases, judges do not make the laws on which CPR cases depend on.[83] Additionally, claiming matters involving resources require expertise that the judges may not possess is not an adequate reason to preclude them from all such matters, as the nature of the decision will vary from case by case. It is further argued that the ESCR cases do not always involve resources, and judicial review may be based on a breach of democratic principles or even the desire of the electorate to hold the elected accountable. [84]Advantages of judicial determination such as individualised remedies, faster response than the executive or legislature, possibility of well-reasoned decisions due to their interpretative expertise and skills and so on, have also been highlighted.[85]

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[77] Brigit Toebes, 'Towards an Improved Understanding of the International Right to Health' (1999)21 (3)Human Rights Quarterly 661.
[78] Marius Pierterse, 'Coming to Terms with Judicial Enforcement of Socio-Economic Rights' (2004) 20 (3) South African Journal on Human Rights < https://doi.org/10.1080/19962126.2004.11864827 > 383, 389.
[79] Paul O'Connell, *Vindicating Socio-Economic Rights: International Standards and Comparative Experiences* (Routledge 2012) 10.
[80] Amongst other arguments, Goodman states that rights such as the right to health which makes a claim on the resources of others have no basis in law and are contrary to the initial conception of rights. Timothy Goodman, 'Is there a Right to Health' (2005) 30 Journal of Medicine and Philosophy 643, 647.
[81] Which he deems legitimate aspects of the right.
[82] Steven D. Jamar, 'The International Human Right to Health' (1994) 22 Southern University Law Review 1, 4, 5; Paul O'Connell (n 79) 8.
[83] Marius Pierterse (n 78) 390.
[84] Michael K. Addo, 'The Justiciability of Economic, Social and Cultural Rights' (1988) 14 Commonwealth Law Bulletin 1425. Also, ibid 391.
[85] ibid 395.

With respect to negative versus positive rights, it has since emerged through practice and more clarifications of the ensuing obligations by national and international judicial or quasi-judicial bodies that CPRs require positive actions and involve resources as well.[86] As an example, the right to life has been interpreted by international human rights bodies and national courts to be realisable by positive actions to fulfil the right to health.[87] Most importantly, there are linkages between certain CPRs and ESCRs such that a violation of one could lead to a violation of another and the protection of one may be necessary for realising the other.

Realistically, however, although the separate codification influenced their ratification and domestication,[88] and led to their respective obligations being guided by different rules,[89] this does not appear to be the main determinant of realisation. What has led to this observation is the fact that in respect of the African Charter on Human and People's rights to which Nigeria is a state party, all human rights guaranteed therein enjoy equal status, but this has not translated into greater realisation of socio-economic rights in African states.[90] Instead, African countries' lackadaisical commitment towards the ESCRs they guaranteed mirrors the hostile attitude towards ESCRs at the international level. Meanwhile, the Western states which opposed ESCRs, including the European states that colonised African countries, developed welfarism, and provided varying measures of social welfare and healthcare to their citizens.[91] However, welfarism does not have international legal support, and in fact is increasingly unpopular[92] so it does not contradict the earlier assertion that ESCRs receive less endorsement.

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[86] The Vienna Declaration and Limburg Principles which eliminate clear cut distinctions between CPRs and ESCRs. UN General Assembly, Vienna Declaration and Programme of Action, 12 July 1993, A/CONF. 157/123 paras 5, 15, 31;
UN Commission on Human Rights, Note Verbale dated 5 December 1986 from the permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ('Limburg Principles'), 8 January 1987 E/CN.4/1987/17 para 3.

[87] Human Rights Committee (HRC), General Comment 36 on Article 6 (n 15). Also, African Commission on Human and People's Rights, General Comment No. 3 on The African Charter on Human and Peoples' Rights, Article 4, Right to life, 18 November 2015, para 41; *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37.

[88] Some African states have refrained from constitutionalising the rights. And some countries like Nigeria have constitutionalised the rights but stripped it of justiciability in the law courts.

[89] The ESCRs are progressively realised while the CPRs are applicable without conditions. Article 2 of both Covenants.

[90] Danwood M Chirwa and Lilian Chenwi, 'Introduction' in Danwood M Chirwa and Lilian Chenwi, (eds)*The Protection of Economic, Social and Cultural Rights in Africa: International Regional and National Perspectives* (Cambridge University Press 2016) 3, 6.

[91] Wade M Cole, 'Strong Walk and Cheap Talk: The Effect of the International Covenant of Economic, Social, and Cultural Rights on Policies and Practices' (2013) 19(1) Social Forces 165, 168.

[92] James Petras, 'The Western Welfare State: Its Rise and Demise and the Soviet Bloc' (2018) Global Research < The Western Welfare State: Its Rise and Demise and the Soviet Bloc - Global ResearchGlobal Research - Centre for Research on Globalization> accessed 30 December 2023.

The right to health is a social right[93] which refers to rights or claims for the provision of necessities or physical things that make for human well-being or underpin an adequate standard of life.[94] Although they are guaranteed to everyone, they are of particular importance to disadvantaged and underprivileged groups who usually lack basic provisions.[95] Some critics insist that such rights on account of their subject matters can only have a moral basis. [96] Therefore, it has been argued that the idea that individuals are entitled to social and economic rights is at variance with the contemporary neo-liberal market-based policies. [97] Neoliberalism itself finds support in the classic idea of human rights which is against totalitarianism and threats to human liberty. In this traditional view, lack of market competition is injurious to individual freedom and a manifestation of autocratic political power.[98] Despite this opposition, however, it is argued that neoliberalism cannot succeed in blotting out the notion of human rights,[99] as a source of protection for the disadvantaged.

These social and economic rights obligate governments to provide interventions ranging from regulating markets to the actual provision of basic social services free or subsidised. As a result, these social rights, such as health, education, housing, food, water and economic rights, such as the right to work, are allowed to be progressively realised. Article 2(1) of the ICESCR from which the phrase emanates states:

> Each State Party … undertakes to take steps, … to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

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[93] Scholars like Kinney consider the right to health as an economic right on the basis that the right emerged from the economic problems of the industrial revolution and subsequent arguments of philosophers on the right to economic security. However, human rights bodies like the Council of Europe describe it as a social right. Commissioner for Human Rights, 'Social rights' (Council of Europe, 2023) <Social rights - Commissioner for Human Rights - Commissioner for Human Rights (coe.int) > accessed 30 December 2023.
Eleanor D Kinney, 'The International Human Right to Health: What Does it Mean for Our Nation and Our World' (2001) 34(4) Indiana Law Review 1457, 1459. https://mckinneylaw.iu.edu/ilr/pdf/vol34p1457.pdf > accessed 30 December 2023.
[94] Gopal Subramanium, 'Contribution of Indian Judiciary to Social Justice Principles Underlying the Universal Declaration of Human Rights' (2008) 50(4) Journal of Indian Law Institute 593, 594.
[95] Paul O'Connell (n 79) 5.
[96] Hugh Breakey, 'Positive Duties and Human Rights: Challenges, Opportunities and Conceptual Necessities (2015) 63(5) Political Studies https://doi.org/10.1111/1467-9248.12150 > accessed 30 December 2023.
[97] Wade M Cole (n 91) 165.
[98] Jessica Whyte, T*he Morals of the Market: Human rights and the Rise of Neo Liberalism* (Verso Books 2019) 19
[99] At least, Moyn observes that human rights is still left with some ground to gain, though little, due to the pervasive effect of neo liberalism to eliminate economic inequality locally and globally. Samuel Moyn, '*A* Powerless Companion: Human Rights in the Age of Neo liberalism' *in* Ben Golder & Daniel McLoughlin (eds) *The Politics of Liberality in a Neo-liberal Age* (1st edn, Routledge 2018) 129.

Considerations in respect of the availability of resources and the needs and interests of the right holders and the state made the adoption of progressive realisation inevitable. [100] These considerations remain relevant because resource allocations are usually made at the expense of an alternative to which the same resources can be put. [101] Additionally, the realisation of social and economic rights cannot be static because though they are fundamental, they must also respond to changes in local situations and in time. However, conscious of the unenthusiastic acceptance of ESCRs and the danger of non-performance, there have been various elaborations of the interpretation of the progressive realisation doctrine, in a bid to clarify the nature of responsibility it entails. [102] Besides the General Comment by the CESCR to clarify state obligations on ESCRs,[103] other experts such as the International Commission of Jurists have also provided clarifications in respect of implementing and identifying violations of ESCRs.[104] These clarifications notwithstanding, the doctrine is still considered incapable of being used to gauge the compliance of states with their ESCR obligations. [105]

This overview demonstrates that the content, legitimacy, and indicators to determine state compliance are still the subject of debates.[106] These controversies pose problems for the RH approach and, therefore constitute challenges to the RH approach to MM. However, these are not the only problems trailing the right. Other problems which are briefly expatiated below include the terminology, lack of an identifiable scope, thus making it a mere conglomeration of other rights, lack of a philosophical foundation, and impracticability. These problems all impact the protection and implementation of the right. It affects the enshrinement in legal documents and leads to reluctance in the adjudication of cases on the right. This is especially

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[100] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 3: The Nature of States Parties Obligations (Article 2 para. 1 of the Covenant), 14 December 1990 E/1991/23 (GC3) para 1.
[101] Norman Daniels and others, 'Role of the Courts in the Progressive Realization of the Right to Health: Between the Threat and the Promise of Judicialisation in Mexico' (2015) 1(3) Health Systems & Reform 229, 230.
[102] For instance, the Limburg principles (n 86).
[103] GC3 (n 100).
[104] International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 26 January 1997.
[105] In spite of numerous attempts at its clarification, the principle has dogged the realization of the rights contained in the Covenant. Questions like: how is it measured? Within what length of time? How does a State show that it is making provision to the maximum of its resources when there are other competing claims and human rights supposedly do not have a hierarchy? Does it protect everyone, even those who have the resources? P Alston and J. Crawford, *The future of UN Human Rights Treaty Monitoring* (Cambridge University Press 2002).
[105] Elzuwey Saleh M, The Right to Healthcare in International Law (PhD Thesis, University of Glasgow 2013).
[106] Sheikh and Towhidul and Tomossy (n 65).

true as attempts at identifying the right and clarifying the scope have been unable to clear the uncertainty as to the exact obligations of the rights. [107]

## 2.5 Controversies about the Right to Health

This subsection sets out to highlight the existence of criticisms of the right to health which may have implications for the construction of a framework for MM reduction around the right.

### 2.5.1 Arguments in Respect of the Nomenclature

Although the term RH has come to be recognised as the right relating to health sought to be protected by the WHO and the guardian international human rights organisations, the term or appellation 'right to health' is variously criticised. The reason for the interest is because, arguably, the label will influence the nature and meaning given to the right. [108] Although the phrase 'right to highest attainable standard of health' is widely employed in treaties including the ICESCR, critics point to a lack of specificity; they ask: 'what is that standard?'[109] Thus, scholars have argued that the 'right to medical care', or the right to healthcare are better terminologies, although these have also been judged inadequate. [110] Indeed in respect of many health issues, including MM, the literature shows there is a focus on curative or healthcare intervention,[111] thereby revealing a preference for that interpretation. However, this conception of RH is detrimental to the potential of the right to reduce preventable MM, the occurrence of which is as much a product of societal conditions women experience as their lack of access to healthcare. It is contended, in addition, that to limit RH to healthcare is unreflective of the thinking that led to the WHO definition, which has been considered above.

[107] For an exhaustive discussion of the interpretation of the right to health, see Lougarre CMV, 'Right to Health Using Legal Content through Supranational Monitoring' (PhD Thesis, University College London 2016).
[108] The name by which a right is codified has implications even for its justiciability because it relates to the identity and scope of the right. For instance, if the right enshrined is the right of medical care, litigating other RH obligations under that right may meet a stumbling block.
[109] Reidar K. Lie 'Health, Human Rights and Mobilisation of Resources for Health' (2004) 4 BMC International Health and Human Rights.
[110] Virginia Leary (n 24); Brigit Toebes (n 77).
[111] LS Johnson, 'The Right to Maternal Health Care: Developing International Human Rights Law to Prevent Maternal Mortality' (2010) 11 University of Botswana Law Journal 39.

### 2.5.2 A Right Considered Lacking in Foundation

Critics who are preoccupied with the issue of the foundations of RH protest that there are no philosophies or theories supporting or justifying the protection of the right, only the inclusion in legal documents.[112] The implication of this, they argue, is that it makes it difficult to delineate the scope of the right and even prioritise the different aspects of the right in the face of competing claims for resources. A theoretical or philosophical basis is important, especially with the problem of the proliferation of human rights and the additional problems the proliferation creates for human rights protection.[113] Thus, to respond by arguing that positive laws are no less laws or that the lack of foundation of many laws has not prevented their enactment and implementation, does not obliterate the essence of the criticism.

As an example, one could point to the post-colonial African leaders' rejection of all notions of human rights on the basis of it being a continuation of imperialism.[114] The availability of an objective foundation may have been beneficial for the human rights arguments at a time when the African nationalists were opposing anything that had the semblance of colonialism. It may similarly improve Africa's attitude to the relatively newly recognised sexual and reproductive health rights, and women's SRHR in particular, which realisation are crucial for MM prevention. However, this contention has been countered by scholars who think rights in international instruments should not be subject to such expectations. For instance, Tobin argues that rights in international instruments, such as RH in this case, is made possible by agreement between states not necessarily because it has a theoretical basis.[115] Also, as Leary explains, the basis of human rights was to guarantee needs basic to human existence; therefore, representing health as a human right, clothes it with the importance that it deserves.[116]

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[112] This lack of foundation according to Venkatapuram will make it impossible to justify rights in the face of scarce or insufficient resources. Sridar Venkatapuram, *Health Justice: An Argument from a Capabilities Approach* (Cambridge and Malden, 2011). Also, Daniels wrote 'rights are not moral fruits that spring from bare earth … without cultivation' Norman Daniels, *Just Health: Meeting Health Needs Fairly* (2008) 86(8) Bulletin of the World Health Organisation, both referred to in Audrey Chapman 'The foundations of a Human Right to Health: Human Rights and Bio ethics in Dialogue' (2015) 17(1) Health and Human Rights

[113] In the words of Clapham, 'These days it is not long before a problem is expressed as a human rights issue.' Andrew Clapham, *Human Rights: A Very Short Introduction*, (1st edn., Oxford University Press 2007) 1; Philip Alston, 'Conjuring Up New Human Rights: A Proposal for Quality Control' (1984)78 (3) American Journal of International Law 607.

[114] Henry F Carey, 'The Postcolonial State and the Protection of Human Rights' (2002) 22(1&2) Comparative Studies of Africa & The Middle East 59, 70 <The Postcolonial State and the Protection of Human Rights (jhu.edu) >accessed 30 December 2023.

[115] John Tobin, 'Incompletely Theorized Agreements' (2006) 18 Yale Journal of Law and Human Rights

[116] Virginia Leary (n 24).

### 2.5.3 A Right Considered Impractical

The practical implication of the right evokes comments about being unrealistic. One such comment stems from the claim of the right to universal applicability; that is, like all human rights, RH should be guaranteed everywhere and to everyone in the world. On this point, even supporters of the right, such as Wolff, admit that the resources for meeting the dictates of RH for everyone in every nation, especially in the poorer countries, is a difficult issue.[117] Professor Easterly, writing in the Financial Times, also weighed in on the issue during the US healthcare debate by drawing a difference between the initial WHO aid campaigns that provided vaccines and antibiotics to the poorer world and the new preoccupation with universal health.[118] By using the HIV-AIDS campaign example, he explained that this new movement would take resources away from the less politically visible health issues as well as mainly benefit the rich and middle class. Wang and Ferraz confirmed that this situation played out in Sao Paulo, Brazil, where legal aid lawsuits for expensive individualised treatments were more successful than litigation to guarantee access to primary healthcare for the most disadvantaged. [119]

The preceding sections, therefore, reveal that certain challenges emanate from the nature of the right as a human right and one from the ESCR category. In addition, the disagreement on the appropriate terminology of the right contributes to disparate understandings of the right. It was also observed that despite several elucidations on progressive realisation, the exact assessment of the principle remains nebulous and capable of providing underperforming governments with a defence. Furthermore, the lack of a philosophical foundation may have affected the acceptance and moral legitimacy of some standards of the right among countries in the global south and given room for subjecting some of the standards to cultural relativism. As highlighted, the issues relating to funding a right to health for all, diverting aid funds to politically visible diseases and benefitting the economically well-off are also germane problems plaguing the right to health.

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[117] Wolff (n 53) 16.

[118] William Easterly, 'Human Rights are The Wrong Basis For Healthcare' (Financial Times 12 October 2009) < Human rights are the wrong basis for healthcare | Financial Times (ft.com) > accessed 30 December 2023.

[119] Daniel W Liang Wang and Octavio Luiz Motta Ferraz, 'Reaching out to the Needy?: Access to Justice and Public Attorneys' Role in Right to Health Litigation in the City of Sao Paulo' (2013) 18 Sur - International Journal on Human Rights < Reaching Out to the Needy? - Sur - International Journal on Human Rights (conectas.org)> accessed 30 December 2023.

This next section briefly outlines the legal framework of the right to health, spanning its codification and enforcement mechanisms. This discussion is not intended to be in-depth; a more detailed analysis will take place in the context of protection of women's right to sexual and reproductive health and /or maternal health in particular in subchapter 2.7.

## 2.6 The Nature of the Legal Protection of the Right to Health

Since the adoption of the UDHR, many other instruments, both binding and non–binding, have codified the right or some aspects of it, thereby cementing its legitimacy. The sources can be discussed under four categories: International treaties, the regional treaties, national constitutions and other international legal documents. Treaties and constitutions represent the binding sources, while the other documents, though non-binding, are nonetheless important because, in many instances, they reflect shared expectations between the states who have consensually adopted them. It is also important to note that while some RH provisions are contained in instruments of general applicability, some are in instruments protecting certain categories of people and some in instruments prohibiting discrimination.

On the international level, the provision in the International Covenant on Economic Social and Cultural Rights (ICESCR) is the only one of general applicability, that is, it applies to all classes of persons and all regions. Being one of the first two binding human rights instruments adopted right after the UDHR, it is the first and most important document[120] to provide for the right to health. Its provisions were influenced by the contents of the UDHR and the WHO Constitution. Article 12 of the Covenant states that 'The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. Provisions guaranteeing the right of health to certain categories of persons include Article 24(1) of the Convention on the Rights of the Child, [121] and the International Convention on the Elimination of Discrimination Against women (CEDAW). [122]

[120] It enjoys enormous international acceptance having been ratified by 171 countries to date. Its provisions on RH are the most extensive and the provisions have also influenced other instruments. OHCHR, 'Status of Ratification' (OHCHR 02 August 2020) <- OHCHR Dashboard> accessed 30 December 2023.
[121] UN General Assembly Convention on the Rights of the Child 20 November 1989, United Nations Treaty Series, Vol. 1577 p. 3
[122] 11 (1) (f). Articles 12 and 14 (2) (b) are also related to health.

At the regional level, the sources of the right to health applying to all persons include the African Charter on Human and Peoples Rights (African Charter),[123] the European Social Charter (ESC),[124] the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (San Salvador Protocol) [125] and the European Convention on Human Rights and Biomedicine.[126] Regional instruments guaranteeing the right to health of particular persons include the Protocol to the African Charter on the Protection of Women's rights (Maputo Protocol)[127] and the African Charter on the Rights and the Welfare of the Child.[128]

At the national level, many constitutions of countries from all the continents have provisions relating to the health of persons within their jurisdictions.[129] This development is, however, not entirely due to human rights but, according to Eze, were also in furtherance of government obligations to protect public health.[130] Thus, in many countries, constitutional provisions guaranteeing health as a right did not appear until after the ICESCR was ratified. Even then, they were often placed in the Constitutions as aspirations to guide government policies. As a result, their non-observance had little legal consequence. This was especially the case in the common law countries; Nigeria, with the non-justiciable 'fundamental objectives and directive principles of state policy' in its Constitution, is an example. [131] The common law

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[123] OAU Doc. CAB/LEG/67/3 rev. 5; 1520 UNTS 217; 21 ILM 58 (1982) art 16. Additionally in Article 24 it guarantees the right to an environment favourable to development. On the basis of these two provisions and many others, the African Commission on Human and Peoples Right found a violation of the Ogoni people of Nigeria's right to health. *SERAC and CESR v Nigeria* (2001) AHRLR 60 (ACHPR 2001).

[124] Article 11. Other references to health in the Charter are in Articles 3, 13, 7, 17, 12.

[125] Article 10(1) Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being'. It is the first human rights provision to explicitly use the terms 'right to health' and 'physical, mental and social well-being', as done in the WHO Constitution. Brigit Toebes, 'Right to health and Other Health Related Rights' in Brigit Toebes and others(eds) *Health and Human Rights in Europe* (1st edn, Intersentia 2012).

[126] Guarantees equitable access to healthcare of appropriate quality. Council of Europe, European Convention on Human Rights and Biomedicine, 1997.

[127] AU, Protocol to African Charter on Human and People's Right on the Rights of Women in Africa Adopted by the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November 2005, Art 14.

[128] AU, African Charter on the Rights and Welfare of the Child OAU Doc. CAB/LEG/24.9/49 (1990) (entered into force Nov. 29, 1999), art 14.

[129] Toebes, 'Towards an Improved Understanding' (n 77).

[130] O.C. Eze, 'Right to Health as a Human Right in Africa' in Rene Jean-Dupuy (ed) *Le Droit a la Sante en tan que Droit de L'Homme/The Right to Health as a Human Right* (Sijthoff & Noordhoff 1979) 76.

[131] Directive Principles with non-justiciable social, economic and cultural rights are found in Chapter II of the Nigerian Constitution. The Constitution of the Federal Republic of Nigeria 1999 Cap C23 LFN 2004. Other examples include Part IV (Articles 36-51) of the Indian Constitution, Constitution of India 1950; Article 11 of the Constitution of Sierra Leone, Constitution of Sierra Leone 1991; Chapter 6 of the Ghanaian Constitution, Constitution of the Republic of Ghana 1996.

countries allegedly followed in the steps of Great Britain which did not guarantee the right to healthcare but provided healthcare through the social welfare system.

Soft law, despite not creating obligations in the strict sense, constitutes an invaluable source of government responsibilities. [132] Sometimes they are used to set the development of international law in new areas as was the ICPD Plan of Action and may be a first step in the treaty-making process as the UDHR, or may be mechanisms for interpreting or strengthening the provisions of a treaty as is the role of the General Comments and Concluding Observations of treaty monitoring bodies. [133] Notably both the Concluding Observations and General Comments of treaty bodies are useful for giving directions to national courts in their interpretations of international human rights provisions and domestic provisions similar to the international provisions. [134] The most important of the General Comments which form discussions in subsequent chapters of this thesis are General Comment No. 14 of the Committee on Economic, Social and Cultural Rights (CESCR) (GC14), General Recommendation No. 24 of the Committee on the Elimination of Discrimination against Women (GR24),[135] General Comment No. 22 (2016) of the CESCR (GC22) made in respect of the right to sexual and reproductive health, General Comment No.2 of the African Commission on Article 14.1 (a) (b) (c) and 14.2 (a) and (c) of the Maputo Protocol[136] and General Comments of the CRC which touch on SRHR of adolescent girls.[137]

Other non-binding sources which are important because they represent consensus between states on the recognition of RH and are evidence of sustained efforts at legitimising the right include the Declaration of Alma Ata that came up with the Primary Health Care

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[132] Matyas Bodig, 'Validity, Soft law and International Human Rights Law in Paul Westerman and Others (eds), *Legal Validity and Soft Law* (Springer 2018) 221.
[133] ICESCR arts 16, 17, 21.
[134] Kanetake cited the use of GC14 in the Indian Mandal case. Michiko Kanetake, 'UN Human Rights Treaty Monitoring Bodies before Domestic Courts' (2017) International & Comparative Law Quarterly 201, 209-210 < https://doi.org/10.1017/S002058931700046 > accessed 30 December 2023.
[135] Committee on Elimination of Discrimination Against Women (CEDAW) General Recommendation No. 24 of CEDAW on Women and Health UN GAOR, 1999, Doc A/54/38 Rev 1.
[136] African Commission, General Comment No.2 on Article 14.1 (a) (b) (c) and 14.2 (a) and (c) of the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014).
[137] UN CRC General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003) CRC/C/GC/4.

idea,[138] which today remains a key feature of healthcare provision. [139] Other documents arising from United Nations World Conferences, such as the Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights (1993),[140] Program of Action adopted at the International Conference on Population and Development (1994),[141] Declaration and Platform for Action adopted at the Fourth World Conference on Women, Beijing (1995)[142] and its various follow-ups, represent international policymaking on the right to health.[143]

Given the number of instruments guaranteeing RH, it is reasonable to agree with Hunt's assertion that every country is a party to at least one instrument in which RH is protected and is able to provide a viable legal aspect for the HRBA to MM.[144] In further support of its viability, there have been arguments that states' non-party status to the instruments should be of no consequence as all states are deemed to recognise the right.[145] They argue that its enshrinement in the UDHR, -which has the unofficial status of a customary international law- and in so many other international instruments, could be taken as evidence that recognising RH has become general practice among states. Although the claim about the UDHR is debatable,[146] the point being made about a widespread consensus among states in relation to the protection of the right to health [147] is valid.

[138] This it has been noted was just the formal recognition for PHC because before 1978, in the 1960s and 1970s, China, Tanzania, Sudan and Venezuela successfully practiced basic but essential comprehensive primary healthcare programs for their poor rural populations. John J Hall and Richard Taylor, 'Health for All Beyond 2000: the Demise of the Alma Ata Declaration and Primary Health care in Developing Countries' (2003) 178 (1) Medical Journal of Australia 17.
[139] The Declaration has remained a defining point for much later clarifications of the scope and obligations arising from the right. GC14 (n1) para 38.
[140] It is particularly important for reaffirming the core objectives of the UDHR and the UN Charter. Also, for emphasising the universality, indivisibility, interdependence and interrelatedness of human rights. Vienna Declaration and Programme of Action, U.N. GAOR, World Conf. on Hum. Rts., 48th Sess., 22nd plen. mtg., U.N. Doc. A/CONF.157/24 (Part I) (1993).
[141] Programme of Action, adopted at the International Conference on Population & Development, Cairo, 5-13 of September 1994, UN Doc. A/ CONF.171/13/Rev.1(1995).
[142] Recognised that women's health was also determined by the economic, social and political context they lived in. Declaration and Programme of Action, adopted at the Fourth World Conference on Women Beijing 4-15 September 1995 U.N. Doc A/CONF.177/20 (1995) para 91.
[143] The Ottawa Charter for Health Promotion 1986 is remarkable for its contribution to the expansion of the fundamental conditions and resources for health to include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.
[144] Paul Hunt, 'Interpreting the International Right to Health in a Rights Based Approach to Health', (2016) 18(2) Health & Human Rights Journal 109, 111.
[145] Leary (n 24) 32; ibid Hunt; Wolff (n 53)9.
[146] The Law Commission's latest report on the formation of customary international law made no mention of human rights as a field that has produced customary international law. M Wood, First Report on Formation and Evidence of Customary International Law by Special Rapporteur International Law Commission (2005) A/CN.4/663.
[147] Eleanor D Kinney (n 93) 1464.

## 2.7 International Legal Protection of Sexual and Reproductive Health / Maternal Health

Sexual and reproductive health rights (SRHR) are not new rights,[148] but their recognition on the international human rights scene is of relatively recent origin. They were first brought to light in discussions at the 1968 International Conference on Human Rights,[149] which took place in Tehran, but the 1994 ICPD is credited with their definition and recognition. [150] They were also reiterated at the 1995 UN World Conference on Women in Beijing. [151] Sexual and reproductive health is an integral component of RH while maternal health is a subset of SRHR.[152]

Like the WHO definition of health, the ICPD Programme of Action states that reproductive health is not merely concerned with absence of disease or infirmity as to the reproductive system, function and processes but also means that people are able to have a satisfying and safe sex life, be able to reproduce if they want and determine the timing.[153] So, on this basis, reproductive health means that men and women have the right to be informed about, and have access to, family planning methods and birth control and healthcare services that will enable women go safely through pregnancy and childbirth. These rights, are, however, faced with contestations from various actors including populist politicians, religious groups, and cultural adherents.[154] The rights to access safe abortion, contraceptives and comprehensive sexual education, accessible also to adolescents, are considered the most contested.[155]

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[148] ICPD PoA describes them as embracing already recognised human rights. Principles 7.3 and 1.15. A_HRC_18_27-EN.pdf mentions at least six of such rights. para 17

[149] Mainly in recognition of the fact that over population could affect the realisation socio economic human rights. But a shift occurred at the 1974 Bucharest Conference on Population as it was argued that over population was due to underdevelopment not the other way round. Lucia Berro Pizzarossa, 'Here to Stay: The Evolution of Sexual and Reproductive Health and Rights in International Law' (2018) 7(3) Laws 29.

[150] ICPD Programme of Action (n 141) principle 7.2. The definition was an outcome of processes spanning 2 decades and a number of international population and international human rights conferences. Pizarossa, ibid.

[151] UN Beijing Declaration and Platform for Action adopted at the UN World Conference on Women 27th October 1995 A/CONF.177/20, para 94.

[152] The Maastricht Guidelines in their explanation of RH actions which could prevent MM refers to the obligations created by the ICPD and Beijing conference. Maastricht Guidelines (n 104) para 7.

[153] ICPD PoA, (n 141) principle 7.2.

[154] Linda Gilby and Meri Koivusalo and Salla Atkins, 'Global Health Without Sexual and Reproductive Health and Rights?: Analysis of United Nations Documents and Country Statements, 2014-2019' (2021)6(3) BMJ Global Health < https://doi.org/10.1136%2Fbmjgh-2020-004659 > accessed 30 December 2023.

[155] Wanda Norwica, 'Sexual and Reproductive Rights and the Human Rights Agenda: Controversial and Contested (2022)19(38) Reproductive Health Matters <https://doi.org/10.1016/S0968-8080(11)38574-6 > accessed 30 December 2023.

Although SRH relates to both men and women, it is more critical for women[156] because diseases related to their sexual activities and reproductive function constitute one of the ten leading causes of death in women, although in recent times, non-communicable diseases such as cardiovascular diseases, cancer, dementia are the major causes- constituting 80%.[157] The contribution of SRH to the disease and disability burden among women stems from their complex reproductive system that is susceptible to illnesses or disabilities. Sexual and reproductive health is also important for women because their reproductive health is vulnerable to the impact of negative social, cultural and religious attitudes such as domestic violence, sexual abuse, female genital mutilation, and so on.[158] These factors underscore the basis of the argument that maternal mortality is a failure of governments to fulfil their obligation to protect women's rights.

Some advocates have observed that MM persists because it affects only women thereby indicting the women's human rights protection regime.[159] The protection of the rights of women had historically been considered secondary, first to men,[160] to other causes[161] and even to children.[162] Thus, it was explained that this shaped the initial response of the women's human rights community to safe motherhood initiatives. The women's rights advocates were focused on not allowing the safe motherhood initiatives to derail the agenda of getting women to be recognised first as humans. There was a real fear that by focusing on maternal health, the safe motherhood initiatives presented women first as 'wombs' and only deserving of protection because of their reproductive function rather than humans. Undoubtedly, any lingering constraints to the protection of women's human rights will have implications for the human rights-based approach to MM. However, it will appear from the discussions below that, to a large extent, the RH protection for women takes cognisance of their disadvantaged experiences in the society.

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[156] Rebecca J Cook and Bernard M Dickens and Mahmoud M Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Clarendon Press 2003) 8.
[157] Sanne A E Peters and others, 'Women's Health: A New Global Agenda' (2016) BMJ Global Health <http://dx.doi.org/10.1136/bmjgh-2016-000080 > accessed 30 December 2023.
[158] Cook and Dickens and Fathalla (n156) 9.
[159] Luisa Cabal and Morgan Stoffregen, 'Calling a Spade a Spade: Maternal Mortality as a Human Rights Violation' (2014)<CallingASpade_Cabal_ResArt.pdf (harvard.edu)> accessed 30 December 2023.
[160] WHO, *Advancing Safe Motherhood Through Human Rights* (2001) 8 < https://apps.who.int/iris/handle/10665/66810 > accessed 30 December 2023.
[161] Cabal and Stoffregen (n 159) 4.
[162] Allan Rosenfield and Deborah Maine, 'Maternal Mortality – A Neglected Tragedy: Where is the M in the MCH'? (1985) 326 (8446) The Lancet 83.

### 2.7.1 International Human Rights Instruments

Although the WHO Constitution listed the promotion of maternal health as one of the functions of the WHO,[163] MM as an issue has not been provided for by any binding instrument including CEDAW. The 1987 Safe Motherhood Initiative[164] and the 1994 International Conference on Population and Development (ICPD), however contributed to putting safe motherhood and sexual and reproductive health on the international agenda. However, in reality, the provision of rights to protect women's health in relation to reproduction began with the UDHR which stipulated that motherhood be accorded special care and assistance.[165] No further elaborations were provided, but this laid a foundation for subsequent binding instruments protecting gender and SRHR.[166]

The International Covenant on Economic Social and Cultural Rights (ICESCR)'s [167] Article 12 guaranteeing the right to health has been described as being male-oriented as it makes no direct mention of maternal health or reproductive health. [168] Nevertheless, that provision and other provisions in the Covenant, can be drawn upon to ensure the safety of women with respect to reproduction. For instance, all the examples of actions required of states mentioned in Paragraph 2 of Article 12 are useful to protect the health of childbearing women; this applies to Articles 10(2) and 11 as well. In comparison to the stilted and non-binding provisions of the UDHR, these provisions are more elaborate and binding, though the general language of some of the provisions leaves room for divergent and conflicting interpretations.[169] To remedy this, the CESCR, in their interpretative role has provided elaborations of a good number of its provisions including Article 12 on the right to health through the medium of General Comment No. 14 (discussed infra under soft law). Another factor which impacted on

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[163] WHO Constitution (n 40) art 2 para l.

[164] World Bank, 'Safe Motherhood Initiative' (1987) <http://www.safemotherhood.org/> accessed 30 December 2023.

[165] UDHR (n 55) art 25.

[166] Eszter Kismodi and Laura Ferguson, 'Celebrating the 70th Anniversary of the UDHR, Celebrating Sexual and Reproductive Rights' (2018) 26(52) Reproductive Health Matters 1.

[167] G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16 U.N. Doc. A 6316, 993 U.N.T.S. 3 (Jan. 3, 1976). Nigeria ratified the ICESCR in July 1993.

[168] Audrey Chapman, 'Monitoring Women's Right to Health Under the International Covenant on Economic Social and Cultural Rights' (1994)44 (4) American University Law Review 1157,1165.
There are attacks against the potential of international law as a source of women's rights by scholars who point out that international law follows the trend where public law issues fall under international law and issues such as customary practices, that affect women are private law. P Masore, 'An Evaluation of the Role of the African Court on Human and Peoples' Rights in the Protection of Women's Rights Under the Maputo Protocol' (LLM Thesis, University of Nairobi 2021).

[169] Michael J Dennis and David P Stewart, 'Justiciability of Economic, Social, and Cultural Rights: Should there be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing and Health?' (2004) 98 American Journal of International Law 462.

its contribution to women's health was that the Covenant did not offer protection to groups of people in the vulnerable category such as women, children, the disabled etc. Women were singled out for protection only in Article 7 which prohibited discrimination against women in respect of working conditions and wages.[170] This oversight was in spite of a growing recognition of discrimination against women at the time, culminating first in the adoption of the Declaration on the Elimination of Discrimination Against Women (DEDAW) in 1967[171] and later the Convention on the Elimination of Discrimination Against Women in 1979.

The Convention on the Elimination of Discrimination Against Women (CEDAW),[172] being a women-specific document provided more binding obligations in respect of maternal health through its provisions on the reproductive health rights of women. Article 12 on the right to health urges states parties to eliminate discrimination against women in the field of healthcare and to ensure women are provided with appropriate services in connection with pregnancy, confinement and the post-natal period, as well as adequate nutrition during pregnancy and lactation.[173] Other provisions which protect maternal health are Articles 2, 5(b), 11(d), 10(h), 16 and 14(b) which provide protection on issues such as safe work conditions for pregnant women, access to family planning information, access to health services for rural women, discriminatory customs and so on. However, it is well known that the CEDAW has the record of being the highest reserved human rights instrument. Some of the reservations relate to Articles 2 and 16 considered by the CEDAW Committee to be the core articles of the Convention and which are both useful for MH.[174] At least 30 states entered a reservation to the treaty thus indicating a lack of political will to support the enjoyment of the rights in those states.[175]

Despite the adoption of a Protocol to improve the enforcement of the CEDAW, it is suggested that implementation is still a major problem of the instrument. The fact that in the face of rampant breach of the Convention worldwide, the CEDAW Committee, unlike other TMBs that monitor compliance can only consider the progress made in implementation is

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[170] Article 10 does not apply to all women, only to women who are mothers.
[171] UNGA Res 2263 (XXII), A/RES/22/2263, 7 November 1967.
[172] G.A. Res. 34A, U.N. GAOR, Supp. No. 21, U.N. Doc. A/34/180 (September 3, 1981). Nigeria ratified the CEDAW on thirteenth July 1985
[173] art 12 (2).
[174] UN Women, 'Convention on the Elimination of Discrimination Against Women: Reservations to CEDAW' <https://www.un.org/womenwatch/daw/cedaw/reservations.htm> accessed 30 December 2023. .
[175] Marsha A Freeman, 'Reservations to CEDAW: An Analysis for UNICEF' (2009) <https://www.unicef.org/gender/files/Reservations_to_CEDAW-an_Analysis_for_UNICEF.pdf > accessed 30 December 2023.

fundamental.[176] The extent to which CEDAW inculcates intersectionality while addressing discrimination, also features in discussions as 'inadequate'.[177] The observation is made on the basis that the Article 2 defining discrimination focuses on gender discrimination to the exclusion of all types of discrimination that women face. Further safeguards for women's health in pregnancy and childbirth are found in the Child Rights Convention (CRC)[178] since the healthcare needs of mothers are often interwoven with that of their children[179] and also because, without the requisite protection, girls are potential victims of MM. Actions required of states parties, such as ensuring appropriate pre-natal and post-natal health care for mothers, developing family planning education and services and protecting children from cultural practices prejudicial to their health[180] are useful to protect maternal health. To its credit, the Convention has the reputation of being one of the highest ratified human rights treaties which should therefore benefit MH. Ironically, however, the statement in the preamble that, a child should be accorded protection 'before' as well as after birth has proved an albatross for reproductive health and MH as it is a natural argument against legalising abortion.[181]

Additionally, the CRC introduced the concept of evolving capacities to guide the interpretation of the Convention.[182] The concept takes cognisance of the fact that the development of children's emotional, cognitive and mental capacities as they grow entitles them to participate in decisions concerning them. However, some of the problems that undermine the utility of the concept include determining the stage of capacity, societal differences, contextual variables, and achieving a balance between protection (parental and others) and autonomy.[183] As a result, the potential of this concept to the realisation of the SRHR of children particularly adolescent boys and girls, is limited with scholars also confirming that

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[176] Art 17(1)

[177] Lauren Buck Woolins, The Challenge of Enshrining Women's Inequality in International law (2018) 20(3)Public Integrity 257, 263; Paulina Montez, 'Women's Rights are Human Rights: CEDAW's Limits and Opportunities'(2021) Berkeley Journal of International Law <Women's Rights are Human Rights: CEDAW's Limits and Opportunities (berkeleyjournalofinternationallaw.com)> accessed 30 December 2023.

[178] Nigeria ratified the CRC in 1991. It has also enacted a Child Rights Act which to a large extent is modelled on the CRC.

[179] Helene Julien, 'Is There a Human Right to Safe Motherhood Within the UN Legal System?' (2015) 2(1) Queen Mary Human Rights Review 4.

[180] CRC (n 127) art 23.

[181] ibid preamble.

[182] Arts 5 and 14(2); Sheila Varadan, 'The Principle of Evolving Capacities under the UN Convention on the Rights of the Child' (2019) 27 International Journal of Children's Rights 306.

[183] Sari Leanne Kives, 'Adolescent Consent in Sexual and Reproductive Health Decision Making: Should There be an Arbitrary Age of Consent or Should it be Based on Evolving Capacities of the Child?' (2008) 21 Journal of Paediatric and Adolescent Gynaecology 47, 49, 50.

the impact of the concept has not been significant.[184] For example, it is reported that, in many communities in low and middle income countries, adolescent girls are still unable to escape unwanted pregnancies as they are forced into early marriage, early childbearing and lack access to contraceptives.[185] In these countries, the principle is often left out of adolescent and child health policies and programs.

### 2.7.2 Regional Instruments

The development of regional human rights systems has been an opportunity to provide more protection and /or protection that more specifically caters to the needs of the people in the region. The African human rights system to which Nigeria subscribes is no exception. [186] On account of this, some of the region's instruments are instructive with regard to protecting women in the region from maternal death and disability. While the region's main human rights instrument, the African Charter on Human and People's Right (African Charter) does not make any reference to maternal health or reproductive rights of women, it guarantees the right to health,[187] and enjoins states parties to eliminate all discrimination against women.[188] On the other hand, and in comparison to any other international or regional instrument, the Maputo Protocol made certain pioneer provisions regarding SRHR of women which reflected Africa's commitment to the outcome of the Programme of Action of the International Conference on Population and Development (ICPD PoA) and the Declaration and Platform for Action of the UN World Conference on Women.[189]

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[184] Ana Maria Buller and Marie Celine Schulte, 'Aligning Human Rights and Social Norms for Adolescent Sexual and Reproductive Health and Rights' (2018) 26(52) Reproductive Health Matters 38,< https://doi.org/10.1080/09688080.2018.1542914 > accessed 30 December 2023.

[185] ibid 39; R Cook and BM Dickens, 'Recognising Adolescents Evolving Capacities to Exercise Choice in Reproductive Healthcare' (2000) 70 International Journal of Gynaecology & Obstetrics 13, 14.

[186] For instance, an African Refugee Convention, to cater for the problems peculiar to refugees in Africa, was adopted in 1977.

[187] African Charter (n 123) art 16.

[188] ibid art 18(3). Aniekwu and Adjetey observe however that the African Charter's emphasis on African traditional values was tantamount to reinforcing the practices which violate women's rights. Adjetey noted in particular that discrimination is not defined in the Charter and so leaves room for arbitrary interpretations which is to the detriment of women. Fitnat Naa- Adjeley Adjetey, 'Religious and Cultural Rights: Reclaiming the African Woman's Individuality: The Struggle between Women's Reproductive Autonomy and African Society and Culture' (1995)44 (4) American University Law Review 1351, 1376; Nkolika Aniekwu, 'The Additional Protocol to the African Charter on Human and People's Rights: Indication of Capacity for African Municipal Systems' (2009)13(2) Journal of Law, Democracy and Development 22, 27.

[189] F Banda, 'Blazing a Trail: The African Protocol on Women's Rights comes into Force' (2006) 50(1) Journal of African Law 73.

Focusing on the realities of women in Africa, the Protocol addresses core SRHR issues such as strict abortion regimes[190] female genital mutilation[191] and the right to self-protection against HIV/AIDS[192] thus surpassing the protection offered by CEDAW. In spite of the wide acclaim, the Protocol has not been free of criticisms. For instance, the radical and well-meaning SRHR provisions were believed to have the potential to be ineffective as provisions guiding their implementation were not made.[193] It is also argued that rather than guaranteeing abortion in specified cases,[194] the Protocol should have made the right to abortion the unqualified right of every woman.[195] However, the criticisms may be considered overambitious given the hitherto reluctance of the previous documents to guarantee abortion. The fear of ineffectiveness may also be mitigated on the basis that the SRHR protections and other provisions in the Protocol have been the basis for one decision of the African Court [196] and various national court decisions whose subject matters resonate with the measures needed to reduce MM rates.[197]

The African Charter on the Rights and Welfare of the Child (ACRWC),[198] in addition to guaranteeing most of the same rights as the CRC,[199] attempts to address human rights challenges unique to the African child. As a result, besides guaranteeing children's right to health in an expansive manner,[200] African-specific provisions including those relevant to the MM discourse were made. For instance, while like the CRC, the ACRWC prohibits the subjection of children to harmful cultural practices prejudicial to their health and life,[201] it goes on to specifically prohibit child marriage and betrothal of girls which occur in Africa and are among the factors which predispose women and girls to MM. Ahead of the CRC, the Charter created a committee, African Committee of Experts on the Rights and Welfare of the Child, (ACERWC) to oversee the implementation of the Charter. Over the years, the Committee has produced General Comments on various issues capable of preconditioning the African girl to

[190] art 14(2) Maputo Protocol.
[191] ibid art 5.
[192] ibid art 14(1).
[193] See further, Dejo Olowu, 'A Critique of the Rhetoric, Ambivalence and Promise in the Protocol to the African Charter on Human and Peoples Right on the Rights of Women in Africa' (2006) 8 (1) Human Rights Review 78.
[194] art 14(2) (c)
[195] ibid
[196] APDF & IHRDA V Rep of Mali (046/2016) (2018) AfCHPR 15.
[197] SOAWR, *Breathing Life into the Maputo Protocol* (2015) <Breathing Life into the Maputo Protocol – SOAWR> accessed 30 December 2023.
[198] ACWRC (n 128) Nigeria ratified the African Children's Charter on 23rd July 2001.
[199] It repeats the best interest principle as the primary consideration in all actions that concerns children, and like the CRC guarantees both CPR and ESC rights.
[200] Art 14 guarantees the rights of children to the best attainable standard of physical, mental and spiritual health and prescribes several measures which states parties must adopt to implement the right.
[201] ibid art 21(1)(a).

MM, such as child marriage[202] and sexual exploitation.[203] Like the CRC, it makes the child's best interests the primary consideration in all actions concerning the children and again, like the CRC, does not provide adequate guidance on the implementation of the concept, thus limiting its benefit for issues affecting children.[204]

The Charter also suffers from a proliferation of claw back clauses, which although, a means by which states legitimately balance their international obligations with specified public interests, affect the protection of MH. [205] The limitation to the right to privacy which is essential for children's SRHR and relevant to MM, is one of such. Guaranteeing, children's right to privacy and subjecting it to the supervisory right of parents and guardians[206] in a place like Africa, is tantamount to perpetuating by codification the very thing human rights should prevent - lack of autonomy. Furthermore, the concept of evolving capacities, although guaranteed, is as a result of the challenges earlier described, weak in terms of implementation.

These international and regional instruments create various relevant obligations which being binding are enforceable. However, in terms of standard setting, interpretation, or even more detailed guidelines for implementation, soft law sources, though mainly of persuasive authority, [207] are very useful.

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[202] African Union, Joint General Comment of the African Commission on Human & People's Rights & the ACERWC on Child Marriage (2018)< Joint_General_Comment_ACERWC-ACHPR_Ending_Child_Marriage_March_2018_English.pdf> accessed 30 December 2023.

[203] African Union, General comment no 7 on Article 27 of the ACERWC on Sexual Exploitation(2020) <General-Comment-on-Article-27-of-the-ACRWC_English_0.pdf (acerwc.africa)> accessed 30 December 2023.

[204] Adu-Gyamfi J and Keating F, 'Convergence and Divergence between the UN Convention on the Rights of the Children and the African Charter on the Rights and Welfare of the Child' (2013) Sacha Journal of Human Rights. 3(1): 47, 51, 52.

[205] Rosalyn Higgins, 'Derogation under Human Rights Treaties' in Rosalyn Higgins, *Themes and Theories* (Oxford University Press 2009) 458.

[206] art 10.

[207] Michele Olivier, 'The Relevance of Soft Law as a Source of International Human Rights' (2002) 35(3) The Comparative and International Law Journal of Southern Africa 294.

### 2.7.3 Soft Law Sources

Despite various opinions about the nature of soft laws,[208] they have proved indispensable to the human rights regime as they complement the binding hard laws.[209] The General Comments of the Committees of ICESCR, CEDAW and CRC on the right to health and the ICPD PoA and the Declaration and Platform for Action of the UN World Conference on Women (Beijing), considered to be seminal documents on SRHR,[210] provide clearer and more detailed state obligations on MH. Although non-binding, states may be held accountable for not fulfilling obligations arising from these documents.[211] However, the level of accountability they attract is low as condemnation for their breach will be less severe than that of a binding instrument.[212] This feature reveals the ambivalent nature of soft law which on one hand encourages cooperation among states on controversial issues, but on the other hand is attractive to blame-avoiding governments.[213]

To expatiate on Article 12 of the ICESCR, General Comment No. 14 (GC 14) was issued.[214] Employing a combination of specificity and flexibility, the comment fleshed up the bare bones of Article 12, delineated the scope, set out the norms and obligations including actions that may constitute violations of the right.[215] As the authoritative interpretation of the right to health, of which MH is a subset, a substantial consideration of the contents of the Comment is attempted below.

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[208] Claims range from a misunderstanding of the types of soft laws, to their legal character, and their uses. Michael Bothe, 'Legal and Non-Legal Norms: A Meaningful Distinction in International Law (1980) 11 Netherlands Year Book of International Law 65; C M Chinkin, 'The Challenge of Soft Law: Development and Change in International Law [1989] 38 International & Comparative Law Quarterly 850; Olufemi Elias and Chin Leng Lim, 'General Principles of Law, Soft Law and the Identification of International Law' (1997) 28 Netherlands Yearbook of International Law 3.

[209] Chinkin (n 208).

[210] They are the most frequently mentioned in the MM discourse. HRC Resolution on Maternal Mortality Human Rights Council A/HRC/33/L.3/Rev.1 October 30 2016.

[211] Olivier (n 207) 297. Moreover, like treaties, they are also drafted, voted for and signed by states representatives.

[212] Chinkin (n 208) 866.

[213] Evgeniya Plotnikova, 'Cross-Border Mobility of Health Professionals: Contesting Patients' Right to Health' (2012) 74(1) Social Science & Medicine 20.

[214] GC14 (n 1).

For a detailed discussion of events leading to the adoption, see Hunt, 'Interpreting the International Right to Health' (n 144); Brigit Toebes, 'Right to Health and Other Related Rights' (125).

Also, Hausermann J, 'The Right to the Highest Attainable Standard of Physical and Mental Health', Conceptual Framework Working Paper for WHO Informal Consultation on Health and Human Rights (December 4-5, 1997 Geneva)

[215] Eleanor D Kinney (n 93)1471.

General Comment 14 states clearly that the right to health is not a right to be healthy as 'highest attainable' refers to the standard that is reasonably possible in the light of an individual's biological and socioeconomic conditions and the resources available to states parties.[216] The realisation of some other rights also underlie the enjoyment of the right to health[217] As a result, it affirms the UDHR's position that the scope goes beyond the right to healthcare and extends to the underlying determinants of health such as food and nutrition, housing, access to safe and potable water which are protected by the other rights that health is dependent on.[218] The right is assured to everyone in the form of freedoms and entitlements. The freedoms include the right to control one's health and body including sexual and reproductive freedom and the entitlements include a system of health protection which provides equality of opportunity to everyone to enjoy the highest health (including sexual and reproductive health) standard attainable.[219] Realising the right also requires action to eliminate the social, economic, political and cultural barriers that prevent the enjoyment of the right.

Protective measures aimed at vulnerable categories of people including women were recommended. With respect to women, the lowering of MM rates was declared to be a goal.[220] The Comment also takes note of the non-medical causes of MM as it recommends action to shield women and girls from the impact of harmful traditional practices and norms that deny them their full reproductive rights. It highlights four interrelated elements to which both the right to healthcare and underlying determinants must conform. They are the Availability, Accessibility, Acceptability and Quality (AAAQ) scheme which is also to be further implemented according to the situation of each state party.[221] Availability relates to both health care components and the underlying determinants being functional and available in sufficient quantity. Accessibility means no barrier due to finances, distance and discrimination. It also means access to health information. Acceptability ensures that medical ethics and cultural

[216] GC14 para 9.
[217] The rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. ibid, para 4.
[218] ibid paras 4 and 11.
[219] ibid para 8.
[220] ibid para 21.
[221] The United Nations developed the 4A-scheme (well known in relation to right to education) comprising of four elements: Availability, Accessibility, Acceptability and Adaptability, representing conditions under which the rights may best be enjoyed. The last A was changed to quality in respect of right to health.
ibid para 12; UN Committee on Economic Social and Cultural Rights General Comment No. 22 on the right to Sexual and Reproductive health (article 12 of the International Covenant of Economic Social and Cultural Rights) (2016) E/C.12/GC/22 (GC22) paras 12, 15, 20, 21. Also Pretoria Declaration on Economic, Social and Cultural Rights 2004, para 7.

sensitivities are respected while quality relates to good quality of health goods and facilities and underlying determinants.

Besides elaborating on RH actions as enunciated in Article 12.2, GC14 proclaimed the obligations of states parties to respect, protect and fulfil the right to health.[222] The duty to respect entails not interfering with the enjoyment of the right, protect means to prevent others from interfering with the enjoyment of the right and to fulfil, states parties have to take legislative, budgetary, promotional, administrative and other actions for the enjoyment of the right. Without giving details with respect to their duties, the Comment recognises other members of the society such as 'health professionals, families, local communities, intergovernmental and non-governmental organisations, civil society organisations, as well as the private business sector as having roles to play in order to realise the right. For further guidance, a non-exhaustive catalogue of actions that can constitute violations are presented and failure to reduce MM rates is explicitly identified as a violation.[223]

Other features of the right incidental to its ESCR status such as international assistance and cooperation in form of technical and economic assistance from developed countries to developing countries, [224]and the doctrine of progressive realisation (PR)[225] are also expatiated upon. Also, since the doctrine of PR only applies to non-immediate obligations, GC14 specifies those obligations which are of immediate effect in the context of RH.[226] In the same vein, in light of the ESCR Committee's stipulation of minimum essential levels of each right or 'core obligations'[227] it provides a list of these in relation to RH. But unlike CESCR General Comment No. 3, it declares that these core obligations are not subject to resource constraints and comes up with other obligations described as being of comparable priority as the core obligations. These core obligations and the obligations of comparable priority[228] include ensuring maternal healthcare.[229] The principles of non-discrimination, equality, participation, monitoring and

[222] GC14 (n 1) para 33.
[223] ibid para 52.
[224] ibid paras 38-40.
[225] An arrangement by which states parties are allowed time to fully realise the rights guaranteed in the ICESCR. ICESCR (n 167) art 2(1).
However, the Limburg principles still require states to expeditiously and immediately take steps to fulfil their non-immediate obligations under the ICESCR. Limburg Principles (n 86) para 21.
[226] Non-discrimination and taking steps towards fulfilling the rights, GC14 (n 1) para 30.
[227] GC3 (n 100) para 10.
[228] Ensuring reproductive and maternal and child healthcare is the first of these obligations of comparable priority. GC14 (n1) para 44.
[229] ibid para 43.

accountability declared to be integral components of the right to health were equally elaborated on.[230] This elaboration of RH in GC14 also forms the basis of a framework developed by the CESCR and the Special Rapporteur on the right to health through which the relevance of RH to a specific health issue may be interrogated.[231] This framework consisting of key features or elements of the right is therefore employed in Chapter 4 to interrogate the relevance of RH to reducing preventable MM.

These details, being an attempt to clarify the nature of the obligations attached to RH, are an improvement on the bare provisions of the Convention but there are drawbacks.[232] One, the sheer volume of these contents poses some problems. For instance, from the analysis, it is difficult to pinpoint the standard with which to assess the application of RH. About four or five interrelated frameworks under which the application of RH may be discussed can be identified. There is mention of freedoms and entitlements, of healthcare and underlying determinants, AAAQ, the tripartite obligations, the elaborated Article 12.2 and even the general human rights principles. Though the focus of the frameworks appears different, they are so interrelated that the same discussions can be repeated under each framework if they are employed individually, therefore making it impossible to employ all at the same time. Yet, each one of the frameworks is not adequate on its own. This presents some confusion in assessing the implementation of RH in countries or in respect of individual health issues. [233]

It also appears that the wide range of the scope of the Comment may have affected its capacity for depth as some of the elements could do with more detailed explanations. This is one of the reasons why there is still confusion as to what constitutes 'steps' towards implementation of the right. [234] For example, it could have contributed more to clarifying how to ascertain that a state is progressively realising the right to health by creating a general standard against which the progress of a state can be determined. Instead, it encourages states to individually create their own bench marks and indicators to monitor their own progress

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[230] ibid para 3.
Paul Hunt, 'The Right of Everyone to the Enjoyment of The Highest Attainable Standard of Physical and Mental Health' (2006) UN Doc. A/61/338 para. 28. The African Commission also recognised, non-discrimination and equality as key components of Economic Social and Cultural Rights; The Pretoria Declaration (n 221) para 4.
[231] In the words of the Special Rapporteur,
'The framework provides a useful prism through which to understand the relevance of the right to health in the context of maternal mortality and can also serve as a useful reference point for integrating the right to health into policymaking'. ibid.
[232] Hunt says GC14 leaves many questions unanswered. Paul Hunt (n 230).
[233] Lougarre (n 107) 44.
[234] ibid.

towards realising RH.[235] Again, legislative steps are considered immediate obligations that are not affected by progressive realisation, but why should a country through its law guarantee a right which it has no immediate means of providing and allow the courts to embark on a futile exercise when non-compliance is challenged?

The Comment's elucidation of the core obligations, that is the minimum a state must provide was complicated. A long list of core obligations was drawn up unlike CESCR General Comment No. 3[236] which only mentioned 'essential healthcare'. This inconsistency highlights the uncertainties trailing the implementation of RH.[237] Also, despite the overwhelming support, recognition and protection RH enjoys internationally and nationally, it has encountered opposition to some of its stipulations. Participation as an example has had a history of being unpopular with states and was one of the unaccepted aspects of the Alma Ata Declaration.[238]

Thus, it is worthy of note that the contents of GC14 are landmark contributions to the RH discourse.[239] It also contributes to providing guidance on obligations relating to women, the girl child and adolescents' health by leveraging on many of the points made by the CEDAW committee in the earlier General Recommendation 24. Additionally, GC14 has influenced General Comment 22 on SRHR. Through General Comment 22, RH's normative content has been expanded to give effect to various SRH freedoms and entitlements.[240] However, one of the limitations of the role of the General Comments is the fact that treaty bodies do not give specific guidance concerning the interpretation and implementation of the instruments across states in varying degrees of economic development and in different socio-cultural contexts. This practice is borne of a combination of convention as well as established rules.[241]

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[235] GC14 (n 1) paras 57-58.
[236] GC3 (n 100) para 10.
[237] Lisa Forman and others, 'Conceptualising Minimum Core Obligations under the Right to Health: How Should We Define and Implement the Morality of the Depths' (2016) 20(4) International Journal of Human Rights 531.
[238] Hall and Taylor (138)17,18.
[239] Being a culmination of principles, which have been agreed upon over the years (before 2000) in works done by scholars in public health and human rights fields and by international human rights bodies.
[240] Benjamin Mason Meier and Virginia Bras Gomes, 'Human Rights Treaty Bodies: Monitoring, Interpreting and Adjudicating Health Related Human Rights' in Benjamin Meier and Lawrence O Gostin (eds) *Global Health: Rights Based Governance for a Globalising World* (Oxford University Press 2018)509, 516.
[241] At the establishment of the precursor to TMBs – intergovernmental committees-, the UN General Assembly empowered the committees to make non-state specific recommendations and comments. The earliest treaty bodies, the Committee on Elimination of Racial Discrimination and the Committee Against Torture also had the authority to make recommendations of a general type. The Commission on human rights acted in line with this practice. Subsequent treaty bodies have acted within the same powers. Helen Keller and Leena Grover, "General Comments of the Human Rights Committee and Their Legitimacy." In Helen Keller and Geir Ulfstein (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy (*Cambridge University Press)116, 121.

As mentioned above, another treaty body, the CEDAW Committee through General Recommendation No. 24 [242] on the CEDAW's Article 12 makes some crucial pronouncements in relation to MH and SRHR which were conveniently adapted by GC 14 to provide states parties with guidance on fulfilling women's reproductive health/maternal health obligations. While Article 12 itself largely protected access to healthcare, it is notable that this document recommends a whole range of measures covering not only healthcare but also underlying determinants of health. Measures such as the provision of EmOc, unrestricted access to family planning services and protection from harmful cultural practices ensure safe motherhood which according to the Committee the state is obligated to safeguard. [243] However, a noticeable shortcoming is the fact that the Committee does not suggest adequate mechanisms to ensure compliance. The advent of new reproductive technologies and societal factors may also limit the efficacy of the recommendations.

The Child Rights Committee's (CRC Committee) detailed interpretation of RH by way of General Comment No. 15 (GC15)[244] acknowledges that the realisation of the mother's right to health is crucial for children's health and lays out obligations to achieve MH. This includes the request to states parties to ensure that health systems meet the peculiar SRHR needs of adolescents particularly, the girls. This is further reinforced by General Comment 20 (GC20) on the implementation of the rights of the child during adolescence which specifically guarantees their SRHR. [245] The comments have influenced international and regional bodies that have adjudicated on children's SRHR.[246]

As earlier mentioned, the strategic role that the ICPD and Beijing conferences played in pinning the SRHR of women and maternal health on the international agenda makes it necessary to refer to their outcome documents. Though they have both been criticised for not clarifying the practical steps and strategies needed to address the MM scourge, [247] a few obligations arising from their provisions must be noted. Per the ICPD Programme of Action (PoA), states were committed to taking a wide range of actions needed to ensure safe

[242] GR24 (n 135)
[243] ibid para 27.
[244] CRC General Comment 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (art. 24), 17 April 2013, CRC/C/GC/15.
[245] General Comment No. 20 on the Implementation of the Rights of the Child during Adolescence. CRC/C/GC/2.2016.
[246] See the cases of *KL v Peru* CCPR/C/85/D/1153/2003, *LC v Peru* CEDAW/C/50/D/22/2009 (2011), PS v Poland (ECtHR) Application No.57375/08. 30 OCT 2012.
[247] Alicia Ely Yamin, 'From Ideals to Tools: Applying Human Rights to Maternal Health' (2013) 10 (11) PLoS Medicine e1001546 < https://doi.org/10.1371/journal.pmed.1001546 > accessed 30 December 2023.

motherhood, having endorsed it as a strategy to reduce MM.[248] As evidence that the actions necessary to end MM are well known but often unimplemented for lack of political will,[249] these actions are again in tandem with the interventions needed to end MM already put forward by the WHO and public health experts.

The 10, 15, 25-year reviews of the ICPD have also contributed by introducing new approaches based on recent findings in research.[250] However, the political compromise which led to the lack of support for abortion as a method of family planning[251] was viewed as a blow to women's SRHR struggle.[252] Besides reiterating the principles of the ICPD PoA[253] the Beijing Platform for Action[254] also supports the rights of women to reproductive health by calling on states to inter alia review their stance on criminalised abortion, remove all barriers to women's health and make healthcare services including EmOc available.[255] Incidentally, but unsurprisingly considering the reservations to the ICPD PoA, these provisions and others relating to SRHR of women were popular subjects of reservations.[256]

In summation, there have been efforts internationally and at the regional level, to address the reproductive health of women, maternal health, and in some cases MM, through hard and soft laws on the right to health. While the critical analysis of the provisions of these documents has revealed enormous potential to contribute to the realisation of women's right to health and also preventable maternal mortality, it is also obvious that limiting factors exist.[257]

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[248] ICPD PoA, (n 141) para 8.19.
[249] As far back as 2006, Fathalla and others noted that what was absent in the maternal mortality reduction efforts was political will and commitment as the technologies and resources were available. M Fathalla and others, 'Sexual and Reproductive Health for All: A Call to Action' [2006] 368 Lancet, 2095.
[250] For instance, the advice on the use of antenatal visits to detect complications in pregnancies has been changed to providing emergency obstetric care because complications are not always detectable and could occur during or after childbirth. See Mindy Jane Roseman and Laura Reichenberg, 'International Conference on Population and Development at 15 years: Achieving Sexual and Reproductive Health and Rights for All?' (2010) 100(3) American Journal of Public Health 403.
[251] ICPD PoA (n141) paragraphs 8.25 and 7.24.
[252] Leila Hessini, 'Global Progress in Abortion, Advocacy and Policy: An Assessment of the decade since ICPD' (2005) 13(25) Journal of Reproductive Health Matters https://www.tandfonline.com/doi/full/10.1016/S0968-8080%2805%2925168-6 accessed 30 December 2023.
[253] Carmel Shalev, 'Rights to Sexual and Reproductive Health, the ICPD and the CEDAW' Paper presented by CEDAW Expert Member at International Conference on Reproductive Health Mumbai on March 18 1998 <https://www.un.org/womenwatch/daw/csw/shalev.htm >accessed 30 December 2023.
[254] Beijing (n 142) para 97.
[255] ibid para 90.
[256] Jeanette A Johnson and Wendy Turnbull, 'The Women's Conference where Aspirations and Realities met' (1995) 27(6) Family Planning Perspectives 254.
[257] Manuel Manrique Gill and Anete Bandone and Anastasia Calvieri, 'Human Rights Protection Mechanism in Africa, Strong Potential, Weak Capacity' (2013) European Union 5.

## 2.8 Enforcement Mechanisms

The standards set by RH constitute rights and obligations therefore the existence and efficacy of mechanisms to monitor enforcement must be surveyed. The mechanisms are highlighted in the first instance and then followed below with an examination of the extent of their relevance to women's right to health, reproductive health or MM reduction discourse.

At the international level, in a bid to improve on enforcement, an optional protocol similar to that of the First Optional Protocol of the ICCPR, was added to the mechanisms for monitoring the states' implementation of the Covenant's rights. The Optional Protocol (OP-ICESCR) brought about three additional means by which the right may be monitored.[258] The CEDAW had earlier on adopted an optional protocol with similar jurisdiction.[259] On this basis, a monumental contribution was made by the CEDAW through the case of *Alyne Pimental v Brazil* [260] to women's reproductive health rights which is the first case in which a country was held to be in breach of their maternal health obligations by a treaty monitoring body.[261] In this case, a Brazilian woman of African descent who was six months pregnant suffered complications including haemorrhage, and needed to be transferred to a better-equipped hospital. The state hospital refused to allow the use of their ambulance. She got to the hospital 8 hours later and eventually died as she was not attended to for 21 hours. The Committee found a violation of the CEDAW based on the discrimination (based on her ethnicity) she suffered in accessing health facilities and health care. Among other remedies, a reformation of the health schemes was ordered. It was however reported that as characteristic of most supranational bodies, it took five years after that historic decision for a technical follow-up commission to be created[262] and some years after that before compliance was achieved.[263] Further, the CEDAW's

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[258] UN General Assembly, Optional Protocol to International Covenant Economic, Social and Cultural Rights, Resolution adopted 5 March 2009, A/RES/53/117. Allows individual communications on violations by states parties (art 2) Second, it provides for the inquiry procedure (art 11). Third, allows interstate communications (art 10).

[259] UN General Assembly, Optional Protocol to International Convention on the Elimination of Discrimination Against Women 6 October 1999, UN Treaty Series [2131] 83.

[260] CEDAW/C/49/D/17/2008. (*Alyne's* case).

[261] RJ Cook, 'Human rights and Maternal health: Exploring the Effectiveness of the *Alyne* Decision' (2013) 41 Journal of Law, Medicine & Ethics 103

[262] Alicia Yamin and Beatriz Galliz and S Valongueiro 'Implementing International Human Rights Recommendations to Improve Obstetric Care in Brazil' (2018) 143(1) International Journal of Gynaecology and Obstetrics.

[263] As of March 2018, 7500 judgments of the European Court of Human Rights were reported to be unenforced. See V Fikfak 'Changing State Behaviour: Damages before European Court of Human Rights (2018) 29(4) European Journal of International Law 1091 at 1092.

optional protocol is considered weak because it has an opt-out clause whereby a country at signing or ratification may indicate non-acceptance of the inquiry procedure, thereby contributing to its under-utilisation.[264]

The Special Rapporteur on the right to health created in 2002 and vested with powers[265] by the Commission of Human Rights to gather information, monitor and report on the realisation of the right to health worldwide, is another mechanism created to ensure the realization of RH. Through the Special Rapporteur's work, greater visibility has been given to hitherto obscure ESCR issues. The first Special Rapporteur on RH, Paul Hunt, is credited with making great efforts to connect the violations of RH to MM.[266] The Universal Periodic Review (UPR) also represents another means by which the Human Rights Council supervises implementation of international human rights obligations.[267] The WHO found that in both the first (2006-2012 ) and second ( 2012-2016) UPR cycles, states' obligations in relation to health featured prominently thereby facilitating greater accountability and actions from states in respect of health and health-related issues.[268]

At the level of the African human rights system, the African Commission on Human and Peoples' Rights (African Commission),[269] the African Court on Human and Peoples' Rights (African Court),[270] and national courts are the main human rights enforcement mechanisms. The continent also has a peer review mechanism which predates the UN's Universal Periodic Review (UPR). The African Committee of Experts on the Rights and

[264] Catherine O' Rourke, 'Bridging the Enforcement Gap: Evaluating the Inquiry Procedure of the CEDAW Optional Protocol (2019) 27(1) American University Journal of Gender, Social Policy & the Law 1.
[265] OHCHR, 'The Special Rapporteur on the Right to Physical and Mental health:' (Purpose of the Mandate)< OHCHR | Special Rapporteur on the right to physical and mental health > accessed 30 December 2023.
[266] Hunt (n 144). Paul Hunt, 'Report of The Special Rapporteur on The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, (2006) UN Doc. E/CN.4/2006/48.
[267] OHCHR, 'Basic facts about the Universal Periodic Review' < OHCHR | UPR Basic Facts about the UPR > accessed 30 December 2023.
[268] WHO, *Advancing the Right to Health Through the Universal Periodic Review* (WHO 2019) ISBN 978-92-4-151388-3.
[269] The African Commission has a quasi-judicial role whereby it interprets the provisions of the Charter as well as receiving and considering reports of violations of the provisions of the Charter from states and NGOs. It acts in an advisory capacity. It is also tasked with preparing cases to be submitted to the African Court for adjudication. Arts 30, 45, 47.
[270] The Court is empowered to hear and give binding decisions in respect of all cases submitted to it concerning the interpretation and application of the Charter, the Court's Protocol and every other human rights instrument the state has ratified. Additionally, based on other provisions of the Protocol, the Court's jurisdiction is categorised as adjudicatory, advisory and conciliatory. Arts 2. 4(1) and 9 of the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of the African Court on Human and Peoples' Rights. Robert Wundeh Eno, 'The Jurisdiction of the African Court on Human and Peoples' Rights' (2002) 2 African Human Rights Law Journal 223, 225.

Welfare of the Child is also the world's first body empowered to receive complaints on violation of children's rights.[271] Obligations in respect of the right to health in the Charter have been argued in various cases before both the Commission and the African Court. In these instances, the Commission had always taken a broad approach, recognising violations of RH through violation of access to healthcare, underlying determinants of health or health related rights. This approach, which the African Court has also followed, is valuable for health issues like MM that have a social dimension.[272]As earlier mentioned, one case involving reproductive rights has come before the Court and it was decided against the state party.[273]

While the number of monitoring procedures may be considered quite adequate, their operations have however generated considerable criticism. As noted above, the TMBs are primarily tasked with ensuring that states fulfil their obligations in relation to the rights guaranteed in their covenants. The TMB's procedure whereby they issue Concluding Observations has been faulted for not having clearly identifiable standards by which state performance is measured. Their approach has been principally described as 'ad hoc'.[274] It has been suggested that this lack of predictability results in incoherence and inconsistency which has implications on the legitimacy of their pronouncements as a valid source of state obligations.[275] Further, as agreed at the inception,[276] the TMBs' approach merely involves determining whether sufficient progress is made[277] and not declaring whether states comply with treaty obligations or not. However, this approach has been described as inefficient. [278]

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[271] Gill and Bandone and Calvieri (n 257)7.
[272] For instance, the African Court took a broad approach in *Kwoyelo v Uganda*, by referring to the Commission's decisions in *Ken Saro Wiwa v Nigeria,* Communications 13/94-139/94-154-96-161/97; AHRLR 212 (ACHPR 1998) and *Media Rights Agenda et al v Nigeria* (2000) AHRLR 200 (ACHPR 1998) both cases wherein the right to medical care of prisoners were in contention but distinguished them from *Kwoyelo*. *Kwoyelo v Uganda,* Communication 431/12, African Commission on Human and Peoples Rights 129 (2018).
[273] The Malian Persons and Family Code was alleged to be in violation of the Protocol concerning age of marriage of girls, forced marriage and some other traditional practices inimical to the rights of girls and women**.** *APDF & IHRDA V Rep of Mali* (046/2016) (2018) AfCHPR 15.
[274] Lougarre (n 107) 256.
[275] Daniel Moeckli, 'Interpretation of the ICESCR: Between Morality and State Consent' in Daniel Moeckli and Helen Keller and others (eds)*The Human Rights Covenants at 50: Their Present, Past and Future*(Oxford Online edn., 2018) ISBN 9780191864902 < https://doi.org/10.1093/oso/9780198825890.001.0001 > accessed 30 December 2023.
[276] UN Secretary General, Draft International Covenants on Human Rights (1 July 1955) UN Doc A/2929/C3 124.
[277] This process also involves the consideration of shadow reports submitted by NGOs or other civil society on government actions and inactions with respect to their treaty obligations. This alternative source of information is useful to give the TMBs a comprehensive view. However, most civil society follow specific causes so information submitted may be only in respect of the cause they are pursuing.
[278] Scott Leckie, 'The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform in Alston and Crawford(eds) The Future of UN Human Rights Treaties Monitoring Bodies (Cambridge University Press 2000) 143, referred to in Lougarre (n 107) 63.

This is on account of their observations being based solely on reports generated by states themselves which can rarely be designed towards complete transparency. Follow-ups by the bodies on improvements recommended do not appear to be carried through as subsequent Concluding Observations to the states do not mention efforts at follow-up.[279]

The adoption of the OP-ICESCR has received as many knocks as praises. While it was acclaimed and praised in certain quarters as long overdue, sceptics doubt its ability to make any difference to the realisation of ESCRs especially in states which have never been known to be ESCRs supportive.[280] This may not be unconnected with the long-held objection to the ability of courts to adjudicate on ESCRs as the individual communications procedure is seen as similar to courts. That, only 26 states have ratified the OP-ICESCR since its adoption may be interpreted as evidence of limited support.[281] The UPR's performance is also limited. In response to doubts on the contribution of UPR to ESC rights, the Centre for Economic and Social rights (CESR) commissioned a study which found that less than one-fifth of UPR recommendations are focused on ESCRs.[282] Again, an evaluation of the first cycle of the UPR found that the acceptance rates of recommendations in respect of sensitive issues such as sexual rights was low.[283] Cooperation and acceptance of equality among states which is very important to the efficacy of the UPR is low as well.[284] Patently false reports have been known to receive acceptance by members of the HRC especially from states which have members

[279] ibid Lougarre.

[280] Claire Michelle Smyth, 'The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights in Ireland: Will it make a Difference' (2012) CCJHR Legal Research Working Paper Series No. 2 University College Cork.

[281] United Nations, 'United Nations Status of Optional Protocol to International Covenant on Economic Social and Cultural Right's <UNTC> accessed 30 December 2023.

[282] There are various reasons for this including the fact that the NGOs focus less on ESCRs as well as a general mindset that ESCRs are more within the discretion of states. Centre for Economic and Social Rights, 'The Universal Periodic Review, a Skewed Agenda: Trends Analysis of the UPRs Coverage of Economic Social and Cultural Rights' (2016) <CESR_ScPo_UPR_FINAL.pdf> accessed 30 December 2023.

[283] Edward McMahon, 'The Universal Periodic Review: A Work in Progress' An Evaluation of the First Cycle of the New UPR Mechanism of the United Nations Human Rights Council ( Freidrich –Ebert-Stiftung, September 2012) <The Universal Periodic Review : a work in progress ; an evaluation of the first cycle of the new UPR mechanism of the United Nations Human Rights Council (fes.de) > accessed 30 December 2023.

[284] ISHR (an international NGO) reported that in the first cycle Uzbekistan rejected 74 recommendations on the basis that they were factually wrong or do not form part of its guaranteed human rights obligations, Singapore and Egypt also rejected some recommendations on the first ground. In the second circle, Israel failed to attend its review and Russia attempted to remove two recommendations made by Georgia (formerly a Russian territory) from its official recommendation list. ISHR, 'Unprecedented Challenge to the Universal Periodic Review' ( ISHR, 31 May 2013) < Unprecedented challenge to the Universal Periodic Review | ISHR > accessed 30 December 2023.

sitting in the Council.[285] The office of the Special Rapporteur on RH is also faced with challenges. Paul Hunt reported that funds as well as refusal by countries being investigated to cooperate with factfinding missions hamper the potential of the office to contribute to the enforcement of RH. [286]

The non-binding nature of the resolutions of the African Commission require a strong and influential commission to command compliance. Unfortunately, the Commission is not powerful. One of its weaknesses is its subservience to the AU executive,[287] while another, is the lack of enforcement mechanisms. As a result, it relies on states to voluntarily comply with their recommendations and compliance does not occur often.[288] The African Court on the other hand is hampered by the need for states parties to ratify the Court's Protocol in order to give individuals and non-governmental organisations (NGOs) access to the Court.[289] The various shortcomings of the African region's mechanisms, has earned them the description of 'strong potential, weak capacity.'[290]

The realisation that the recognition of human rights at the international or regional level, is for implementation at the domestic level necessitate a consideration of enforcement mechanisms at that level. The instruments envisage various mechanisms from national human rights commissions to courts and ombudsmen. But the applicability and enforceability of international instruments within most national legal systems is not automatic as states in the exercise of their sovereignty determine their countries' mode of receiving international law. While some legal systems referred to as 'monist' allow treaties to become directly enforceable once ratified, dualist systems like Nigeria require such treaties to first become domesticated by a local law. [291] Although states are not expected to act in contradiction to the object and purpose

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[285] Brett D. Schaefer and Steven Groves, 'The US Universal Periodic Review: Flawed From the Start' ( Heritage Foundation, 26 August 2010 )< The U.S. Universal Periodic Review: Flawed from the Start | The Heritage Foundation> accessed 30 December 2023.
[286] Paul Hunt, 'Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges' (2006) 100(7) Transactions of The Royal Society of Tropical Medicine and Hygiene 603, 604.
[287] Ebenezer Durojaye, 'An Analysis of the Contribution of the African Human Rights System to the Understanding of the Right to Health' (2021) 21 African Human Rights Law Journal 751,778.
[288] Chairman Okoloise, 'Circumventing Obstacles to the Implementation of Recommendations by the African Commission on Human and Peoples' Rights (2018) 1(1) African Human Rights Law Journal 27, 31, 42-44.
[289] Basil Ugochukwu, 'First, Put out the House Fire: The Future of the African Human Rights System' (2018)35(2) Wisconsin International Law Journal 367, 372, 373.
[290] Gill and Bandone and Calvieri (n 257).
[291] Antonio Cassese, *International Law in a Divided World* (Oxford University Press 1986) 15.
s 12 of the Constitution of the Federal Republic of Nigeria 1999 Cap C23 LFN 2004.

of international laws they have ratified,[292] non-domestication may mean non-fulfilment. Consequently, holding governments accountable to the plethora of obligations contained in instruments necessary for maternal health is a Herculean task as international instruments on women's rights, also SRHR, are some of the least domesticated. The Maputo Protocol is a case in point. Although 44 out of 55 member states have ratified or acceded to it, a report to commemorate 20 years of its adoption revealed that the submission of reservations as well as slow implementation hamper the efficacy of the instrument.[293]

Another important condition is the existence of domestic enforcement mechanisms. Courts and therefore litigation appears to be the most prominent means of enforcing human rights at the national level where there are laws guaranteeing the right. Even in countries where RH is not explicitly guaranteed, national courts have shown activism by creatively reading the right into the right to life,[294] right to equality[295] and through judicial review of the actions of government departments involved in providing healthcare services. In comparison with recommendations in the Concluding Observations issued by TMBs, domestic court orders have been found to yield more results,[296] but there appears to be an over-dependence on courts which like most mechanisms are imperfect. For instance, courts have limited remedies available for their use. Furthermore, litigation, though potent, has drawbacks some of which are discussed under accountability in Chapter 4.

The discussions on RH reveal that features such as the historical foundations of the right, its guardianship by the WHO, its popularity, progressive realisation and the existence of relevant enforcement mechanisms, are some attributes of the RH which are useful to support the realisation of SRH including maternal health. However, challenges with respect to its nature, its philosophical foundations, codification, unclear standards for measuring compliance and the inefficacy of enforcement mechanisms are pertinent issues which may affect the potential of the RH approach to drive the MM reduction agenda.

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[292] Vienna Convention on the Law of Treaties (VCLT) (adopted 23 May 1969, entered into force 27 January 1980) art 2 1155 UNTS 331.

[293] SOAWR, *Twenty Years of the Maputo Protocol: Where are we now?* (July 2023) <Maputo-Protocol-Report.pdf (storage.googleapis.com)> accessed 30 December 2023.

[294] *Shortland v Northland Health Ltd* [1998] 1 NZLR 433.

[295] *Eldridge v British Columbia* [1997] 3 SCR 624.

[296] Lougarre, (n 107) 100.

## 2.9 Conclusion

This chapter is significant as a foundation for other chapters of the thesis. The RH which framework is being investigated for its prospects in relation to ending preventable MM has been discussed in part here. In this chapter, the focus was on its nature as a human right and its legal status. The antecedent of the right in international human rights law was traced from the period when global involvement in health was mainly in respect of arresting and preventing epidemics, to the current regime that extends to the protection of individual health. The fact that health moved from being an object of international cooperation to being codified and creating binding obligations for states has been highlighted.

The discussions also reveal that RH is a subject of controversies which cuts across several aspects of the right, including its nomenclature, justiciability and idealistic nature. These have implications for the guarantee, adoption and implementation of the right. A detailed analysis of the binding and non-binding instruments providing for the right revealed the existence of relevant provisions which states could comply with to achieve a reduction in maternal mortality reduction. The enforcement mechanisms to drive the realisation of the right was likewise assessed. In these discussions, attention was drawn to the benefits and deficiencies of the RH framework generally, and especially to women's SRH with the aim of providing a balanced view of the framework.

While this chapter lays the foundation of the connection between RH and MM, Chapter 4 is focused on the application of the right in the MM context. The application of the standards of RH as well as the contribution of the HRBA principles of equality and non-discrimination, participation, inclusion and accountability to the reduction of MM are examined therein.

# Chapter 3

## Maternal Mortality: Meaning, Causes and Interventions

### 3.1 Introduction

The present chapter follows up on the previous chapter by investigating maternal mortality, the other most important concept in the thesis. Through this, the link between MM and human rights and, more specifically, the right to health (RH) is further explored. The exposition on MM involves examining 'who, when, where and why'.[1] Thus, the discussion will involve the definition of a maternal death,[2] the scale of occurrence, among whom it occurs and the causes. Although these discussions have a global outlook, an in-depth discussion of the context of MM in Nigeria is ventured towards the end. In particular, that section lays out the socio-cultural context of MM in Nigeria. This undertaking enables the connection to be made between the determinants as well as interventions to address MM in Nigeria and the guarantees of RH. Consequently, this chapter will demonstrate that on account of the inclusive scope of the RH, including its sexual and reproductive health guarantees as well as the societally grounded HRBA principles, the framework is potentially of great relevance in combatting MM.

### 3.2 Meaning of Maternal Mortality

Maternal mortality, also referred to as a 'maternal death,'[3] is defined as

> the death of a woman while pregnant or within 42days of termination of pregnancy irrespective of the duration and site of the pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes[4]

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[1] Carine Ronsmans and others, 'Maternal Mortality: Who, When, Where and Why' (2006) 368(9542) The Lancet 1189<https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(06)69380-X/fulltext#fig1 > accessed 30 December 2023.

[2] The definition is crucial for its measurement.

[3] Carine Ronsmans and Simon Collin and Veronique Filippi, 'Maternal Mortality in Developing Countries' in Semba R.D and Bloem M.W. (eds), *Nutrition and Health in Developing Countries*, (Humana Press 2008) 34 <https://www.springer.com/978-1-934115-24-4 > accessed 30 December 2023

[4] UNFPA and others, 'Trends in Maternal Mortality:2000 to 2020: Estimates by WHO, UNICEF, UNFPA and World Bank Group and United Nations Population Division' (2023) 7< Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division >accessed 30 December 2023.

The definition allows for reference to deaths from both direct and indirect medical causes of MM, but leaves out deaths that, though occurring during pregnancy, childbirth and puerperium, do not have an obstetric basis. These latter are labelled 'pregnancy-related deaths.' [5] Nevertheless, it allows the recognition of 'late maternal deaths' - that is, deaths which do not occur within the 42-day window but occur within a year of termination of pregnancy – and have an obstetric basis. [6]

Maternal deaths are again categorized into direct and indirect maternal deaths. Direct maternal /obstetric death refers to the death of a woman resulting from obstetric complications of the pregnant state (pregnancy, labour, and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. These include conditions such as hypertensive diseases of pregnancy, haemorrhage, obstructed labour, genital tract sepsis, and spontaneous or induced abortion. Indirect obstetric death is the death of a woman resulting from a previous existing disease or disease that developed during pregnancy and was not due to direct obstetric causes but was aggravated by the physiologic effects of pregnancy. [7]

A plain understanding of the definition of MM indicates that pregnancy must be a direct or contributing cause of death. Nevertheless, it also states that the cause must be intentional and non-secondary. While what is meant by 'unintentional' is unclear,[8] excluding secondary causes may be contentious. The classification fuels that contention by only providing for medical complications as both direct and indirect causes. It is argued in subsection 3.4 that this classification is unsupportable, and a more appropriate or inclusive definition of maternal mortality is necessary.

Closely related and often jointly discussed with maternal mortality is maternal morbidity. This refers to injuries, illnesses and disabilities in the course of pregnancy or childbirth, some of which may be serious enough to be categorized as 'a near miss maternal death.'[9] Broadly speaking, maternal morbidity describes any health condition the emergence

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[5] ibid 8.
[6] ibid.
[7] ibid.
[8] It is not explained in either ICD-11 or the WHO and others' joint estimates of the trend.
[9] Natalie England and others, 'Monitoring Maternal Near Miss / Severe Maternal Morbidity: A Systemic Review of Global Practices' (2020) 15(5) PLoS One ; Lale Say and others, 'Maternal Near Miss–Towards a

of which can be traced to and/or aggravated by pregnancy and childbirth, that negatively impacts on a woman's wellbeing.[10] Depending on the severity, these conditions may have a short term impact or long term impact on the woman's health. It may lead to further morbidities or disability in the extended postpartum period (up to one year) and can negatively impact the health of her baby, the health of her other children, and the social and economic standing of her family or even lead up to her death.[11]

Postpartum maternal morbidities last for long and are often chronic, significantly impairing the quality of life of the woman. The most serious include uterine prolapse, fistula and dyspareunia (painful sexual intercourse), while the milder ones include hernias, urinary incontinence and postpartum depression.[12] In this study, maternal morbidity is not the focus; however, its close relationship to maternal mortality makes it impossible to ignore the occurrence. Maternal morbidity has the same causes as MM, so it can lead to MM or be a step short of MM. Thus, maternal morbidity, will impliedly form part of the discussion. However, the discussion is, of necessity, limited. Maternal morbidity as a problem of maternal health is important in its own right. Scholars have recommended that more attention be accorded to the problem because focusing on MM alone may lead to developed countries overlooking other major problems in obstetric care. [13] As a result, it deserves an in-depth treatment, which this work will be unable to engage in.

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Standard Tool for Monitoring Quality of Maternal Health Care' (2009) 23(3) Best Practices and Research in Clinical Obstetrics & Gynaecology 287, 288.

[10] Lori Ashford, 'Hidden Suffering: Disabilities and Childbirth in less Developed Countries (PRB, August 2002) <https://www.prb.org/hiddensufferingdisabilitiesfrompregnancyandchildbirthinldcs/ > accessed 30 December 2023.

[11] Marge Koblinsky and others 'Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health (2012) 30(2) Journal of Health Population and Nutrition 124.

[12] ibid. Also Lale Say and others, Maternal Near Miss (n 9) 293.

[13] MMWG 'Lale Say and Doris Chou and others, 'Maternal Morbidity: Time for Reflection, Recognition and Action' (2018) 141 (S1) International Journal of Gynaecology and Obstetrics 1; Marge Koblinsky and others (n 11).

### 3.3 Prevalence of Maternal Mortality[14]

Maternal mortality is the primary health problem of women in developing countries between the ages of 15-44. [15] It is acknowledged that there is no single cause of death and disability for men of the same age range that is close to the magnitude of maternal death and disability. [16] Currently the risk of MM is highest among adolescent girls under 15, [17] which is not surprising given the fact that complications in pregnancy and childbirth are higher among girls aged 10-19.[18] The Maternal Mortality Rate (MM rate) varies widely among regions with developing countries, bearing the highest burden. [19] Even within regions, individual country MM rates vary. According to the latest estimates dated 2020, the estimated number of maternal deaths globally in that year was 287,000, at approximately 800 per day.[20] Ninety-four percent of that occurred in low and middle-income countries. Sub-Saharan Africa was the region with the highest maternal deaths at 70%, while central and south Asia account for 17%. Two hundred and two thousand (202,000) deaths occurred in Sub-Saharan Africa alone, 48,000 (20%) in Central and Southern Asia, 18,000 in Eastern and SouthEastern Asia, while the rest occurred in other parts of the world. Australia and New Zealand are estimated to have the lowest number.[21]

Sub-Saharan Africa is home to 12 of the 13 countries with extremely high and very high MM ratios; that is, countries with over 1000 maternal deaths and 500-999 maternal deaths

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[14] Bale and others warn that these estimates should be viewed in context; accurate data on maternal mortality are lacking for the majority of countries especially where the problem is so acute. It is also noted that the continued dearth of basic information in most countries of the developing region, where most of the deaths occur, impedes the ability to address the question of changes in causes of maternal deaths over time. Judith R. Bale, Barbara J. Stoll, Adetokunbo O. Lucas(eds) *Improving Birth Outcomes: Meeting the Challenge in the Developing World* (National Academies Press 2003); Veronique Fillipi and others 'Levels and Causes of Maternal Mortality and Morbidity' in Black R. E and others (eds) *Reproductive Maternal, Newborn and Child Health: Disease Control Priorities* (3rd edn, Vol 2, IRBD /World Bank 2016) <Levels and Causes of Maternal Mortality and Morbidity - Reproductive, Maternal, Newborn, and Child Health - NCBI Bookshelf (nih.gov) > accessed 30 December 2023.

[15] World Bank, *World Development Report: Investing in Health* (World Bank, 1993).

[16] Paul Hunt 'Report of the Special Rapporteur on The Right of Everyone to The Enjoyment of the Highest Attainable Standards of Physical and Mental Health (A/61/338).

[17] UNFPA and others, (n 4) 47.

[18] WHO, 'Maternal Mortality' (WHO, 19 September 2019) < https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> accessed 30 December 2023.

[19] Maternal mortality rate (MMrate) is the number of maternal deaths during a given time period divided by person-years lived by women of reproductive age (age 15–49 years) in a population during the same time period.
Maternal mortality ratio (MMR) is the number of maternal deaths in a population during a given time period per 100 000 live births during the same time period. UNFPA and others (n 4) 8.

[20] WHO, Maternal Mortality (n 18). Also ibid.

[21] UNFPA and others (n 4) 32.

per 100,000 live births respectively. Nigeria is in the first category with an uncertainty interval (UI)[22] of 793-1565. Although the actual number of maternal deaths in Nigeria is described as difficult to determine,[23] Nigeria has been placed on top with 82,000, which is equal to 28.5% and more than a quarter of the global estimates. India, the Democratic Republic of Congo and Ethiopia follow, with 24,000 (8.3%), 22,000 (7.5%) and 10,000 (3.6%) of the total maternal deaths, respectively.[24]

Compared with the rates obtained at the last global periodic survey in 2000, MM rates have shown some decline. Central and Southern Asia was credited with having the greatest decline rate, 67.5%.[25] Meanwhile, that of Oceania (excluding Australia and New Zealand), Northern Africa and Western Asia, and Eastern and South-Eastern Asia, stagnated and were declared non-significant in terms of their impact on the data. Statistics from Europe, North America, Latin America and the Caribbean, however, showed a significant increase.[26]

Maternal morbidity figures are equally frightening as the WHO estimates that for every maternal death, 20-30 women who survive major illnesses brought about by pregnancy and ill health continue life with incapacitation and suffering.[27] The above figures show that the women who die or suffer varying degrees of maternal ill health are in the prime of their lives and, if the regional rates are anything to go by, all a woman needs to do to be a potential victim is to come from one of the most affected regions or more particularly, one of the identified countries. Furthermore, in these countries and even in developed countries with low MM ratios, if a

[22] Due to the problems associated with measuring MM, the lack of precision is accounted for by highlighting the possible lowest and highest points. This is interpreted as 10% chance that the true figure is above the higher limit, 10% that it is below the lower limit and 80% within the limit. UNFPA and others (n 4) 29.
[23] There are problems with availability or veracity of data.
[24] UNFPA and others (n 4) 35.
[25] ibid xv.
[26] ibid xvi. With respect to the US, it has been suggested that the noticeable increase may be due to improvement in data collection, or changes in the demographic make-up of the people who make up the populations. Ai-ris Y Collier and Rose L Molina, 'Maternal Mortality in the United States: Updates on Trends, Causes and Solutions' (2019) 20(10) Neoreviews, e561.
[27] Actually, the magnitude of maternal morbidity is not known. Tabassum Firoz and others, 'Measuring Maternal Health: Focus on Maternal Morbidity' [2013] Bulletin of the World Health Organisation 794 doi:< 10.2471/BLT.13.117564 > accessed 30 December 2023. See the same article for the reasons.

woman fits any of these descriptions: 'poor/low income', 'indigenous,[28] 'from ethnic minority groups'[29] and the like, she is a potential victim of MM.[30]

### 3.4 Causes of Maternal Mortality

Both maternal mortality and morbidity are caused by a number of direct and indirect factors. The direct factors are medically implicated, while the indirect factors include both medical and non-medical issues. The direct factors are the immediate medical causes, while the indirect factors make it possible for women to die of the immediate medical causes. Despite the significant contribution of the WHO definition of health in portraying health as comprising other determinants besides medical care, the indirect non-medical factors do not often feature in medical discussions on MM. The focus is on pathologies to the exclusion of equally critical environmental factors and in fact, the WHO definition of MM can barely be stretched to accommodate non-medical causes. [31] It is indubitable that the medical causes are very important, but they are actually risk factors in the same way as other factors. [32]

A number of reasons can be put forward for the concentration on medical factors; in western countries, preventable MM occurs on a significantly lesser scale and the eradication is largely attributed to improved medical care. [33] To buttress this argument, it is contended that improvement in living conditions (that is, environmental factors) in the United Kingdom, for instance, did not bring about notable MM reduction until improvement in medical care occurred. [34] Another reason is that medical care is more realistic and practicable. This is also because unlike the various determinants governed by the more recent phenomenon of human rights, the parameters governing the provision of medical care are long-established and have

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[28] Despite the low MM rates in Australia, aborigine women, Torres Strait Islanders and in USA also Black, Asian, minority ethnic groups such as Indian/Alaska native women are more vulnerable. UNFPA and others, 'Trends in Maternal Mortality: 2000 to 2017: Estimates by WHO, UNICEF, UNFPA and World Bank Group and United Nations Population Division' (2019) 46.

[29] ibid; Khiara M. Bridges, 'Racial Disparities in Maternal Mortality' (2020) 95 NYU L Rev 1229

[30] Paul Hunt (n 16) para 7.

[31] M Susser, 'Health as a Human Right: An Epidemiologist Perspective of Public Health' (1993) 83(3) American Journal of Public Health 418. A crucial reason for this may have been given by Ronsmans and others, who noted that the emphasis on global differences in MM and the need to create global strategies may have obscured the consideration of biological, social, cultural, geographical factors causing MM within populations. Ronsmans and others (n 2) 1198.

[32] Because it is possible for women to survive in spite of them, medical scholars argue that majority of maternal deaths can be prevented by timely medical interventions especially Emergency Obstetric Care (EmOC).

[33] Irvine Loudon, 'Maternal Mortality in the Past and its Relevance to Developing Countries Today' (2000) 72(24) American Journal of Clinical Nutrition 241S, 242-3S.

[34] ibid.

become relatively well-defined. Despite these, the contribution of the non-medical factors, cannot be denied, as even historical accounts from the developed countries, which attained low MM rates, did not eliminate the possibility of determinants other than medical care being the reason for MM persisting in some parts of the society.[35] Additionally, the amount of information which have become available from studies on the impact of social determinants on health outcomes especially from non-medical fields, should result in social determinants featuring in the formation of health protection strategies.

### 3.4.1 Direct Factors

According to the WHO, globally, 75% of the medical causes are accounted for by five major complications: haemorrhage, sepsis (infection), unsafe abortion, pre-eclampsia and eclampsia (hypertensive disorders), and prolonged or obstructed labour.[36] It was also observed that haemorrhage/excessive bleeding, hypertensive disorders and sepsis are the leading causes of death globally.[37] However, the leading causes may be more realistically determined by looking at local contexts owing to substantial differences in the way the causes of maternal death are distributed among the regions. Post-partum haemorrhage (PPH) that is, the loss of 500ml or more within 24 hours post -birth [38] or due to spontaneous or induced abortion, is also a major cause of maternal morbidity because if the woman survives, it may lead to anaemia which may persist several months following childbirth. Although the cause is unclear, its high prevalence has been linked to pregnancies at older ages, most severe forms of female genital mutilation (FGM),[39] obesity, previous cesarean delivery, or better data capture system. [40]

Preeclampsia and eclampsia, both hypertensive diseases developed in pregnancy, are more common among women in their first pregnancy, in women who are obese, women with preexisting hypertension, and women with diabetes. They often show up in the second half of

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[35] Henry Brackenbury, 'Maternity in its Sociological Aspects' (1936) The British Medical Journal, 828 831.
[36] WHO, Maternal Mortality (n 18); Paul Hunt (n 15) 7. In regions highly affected by human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), HIV was once a major cause but maternal mortality due to HIV/AIDS has declined likely due to increased availability of antiretroviral medication. Veronique Filippi and others (n 14).
[37] Lale Say, 'Global Causes of Maternal Deaths: a WHO Systematic Analysis' (2014) 2(6) The Lancet e323.
[38] WHO, 'WHO Recommendations on Prevention and Treatment of Post Partum Haemorrhage and the Woman Trial' (WHO, 15 June 2017)< WHO | WHO Recommendations on Prevention and Treatment of Postpartum Haemorrhage and the WOMAN Trial >accessed 30 December 2023.
[39] Veronique Filippi and others (n 14).
[40] Alicia Yamin and Deborah P Maine, 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations' (1999) Human Rights Quarterly 21(3) 563.

pregnancy. Both conditions are associated with perinatal deaths, placental abruption, and cardiovascular disease in the later life of the mother. A review by Lale Say et al, found evidence of regional variations, with Latin America and the Caribbean, having the highest incidence of both conditions.[41] Haemorrhage was responsible for most of the maternal deaths in North Africa. [42] Puerperal infections or sepsis are caused by transfer of an infectious agent from the cervix or vagina to the uterus during labour or pelvic examination or by transfer of bacteria from skin, nostrils, and perineum by contaminated fingers or instruments.[43] Almost all sepsis deaths took place in developing regions where it is also more commonly associated with home births. Women who survive puerperal sepsis are frequently left to cope with chronic ill health due to pelvic pain, dysmenorrhoea, menorrhagia, and/or infertility.[44]

About 90 percent of unsafe abortions worldwide occur in developing countries, [45] with Latin America, Sub-Saharan Africa and the Caribbean in the lead. [46] Unsafe abortion is defined as the termination of an unintended pregnancy "performed by persons lacking the necessary skills or in an environment not in conformity with minimal clinical standards, or both."[47] This act can lead to a variety of complications, including sepsis, haemorrhage, genital and abdominal trauma, tetanus, perforated uterus, and poisoning from an abortifacient.[48] It is also noted that it is difficult to classify maternal deaths from unsafe abortion because of underreporting of such situations which could be due to restrictive abortion laws and /or religious and cultural stigma.[49]

The incidence of obstructed labour varies widely and is exceptionally high where levels of nutrition are poor and early marriage is common. There are difficulties with capturing deaths which occur after obstructed labour because its consequences may be recorded under hemorrhage or sepsis due to definitional variations.[50] Women whose growth have been stunted

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[41] Lale Say (n 37) e332.
[42] ibid.
[43] C AbouZahr and others, 'Global Burden of Maternal Death and Disability' (2003) 67(1) British Medical Bulletin 1, 7.
[44] ibid.
[45] World Health Organisation, 'Preventing Unsafe Abortion' (WHO, 25 September 2020) <Preventing unsafe abortion (who.int)> accessed 30 December 2023.
[46] Lale Say (n 37) e328.
[47] WHO 'Sexual and Reproductive Health: How to Prevent Unsafe Abortion'( WHO, 2021) <WHO | Preventing unsafe abortion> accessed 30 December 2023.
[48] Judith R. Bale, Barbara J. Stoll, Adetokunbo O. Lucas (n 14).
[49] Veronique Filippi (n 14).
[50] Judith R Bale and others (n 14).

by malnutrition or untreated infection or who bear children before pelvic growth is complete are at greatest risk for cephalopelvic disproportion between the size of the infant's head and the bony birth canal, which is the main cause of obstructed labour. Foetal mal-presentation is another less common cause of MM. Prolonged obstructed labour may also produce injuries to multiple organ systems, resulting in vesico-vaginal or recto-vaginal fistulae, and is associated with an increased risk of sepsis, haemorrhage, and uterine rupture.[51]

The five main causes of maternal deaths globally are true for Nigeria as well. However, just as the MM ratio varies widely among the different parts of the country, the causes also differ in rank among the component states / geopolitical regions. In a study on Southwest Nigeria, abortion, ectopic pregnancies and hypertension were the most mentioned causes of death during pregnancy, while anaemia, haemorrhage, prolonged labour and obstructed labour are the common causes during childbirth.[52] Haemorrhage and hypertensive disorders are generally the most common in all parts of the country.[53] However, sepsis and obstructed labour were more common than hypertensive disorders in the northern part of the country.[54]

### 3.4.2 Indirect Causes

#### 3.4.2.1 Indirect Medical Causes

Various medical causes such as anaemia, diabetes, malaria, cardiovascular disease and sexually transmitted infections such as HIV-AIDS (pre-existing or developed during pregnancy) are described as indirect because they increase the chances of a woman dying or suffering illness from pregnancy or childbirth. Sexually transmitted diseases, especially HIV, have increased death from infections. Diabetes, malaria, mental disease, cardiovascular diseases and hepatitis are aggravated by the frequency of pregnancies. The WHO estimates that the contribution of

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[51] AbouZahr and others (n 43) for more detailed causes and interventions.
[52] Boniface Oye-Adeniran and others, 'Causes of Maternal Mortality in Lagos State, Nigeria' (2014) 7(3) Annals of Tropical Medicine and Public Health 177.
[53] Saima Tasneem and Adaugo Nnaji, Macide Artac, 'Causes of Maternal Mortality in Nigeria: A Systemic Review' (2019) 4 (3) International Journal of Health Management and Tourism 200; Peter A Awoyeseku and Dagogo Alexander MacPepple and Basil Omieibi Altraide, 'Magnitude, Trends Causes of Maternal Mortality in Rivers State' (2020) 32 (1) Journals of Advances in Medicine and Medical Research 103-109.
[54] ibid; Catherine Meh and others, 'Levels and Causes of Maternal Mortality in Northern and Southern Nigeria' (2019)19 (417) BMC Pregnancy and Childbirth < https://doi.org/10.1186/s12884-019-2471-8 > accessed 30 December 2023.

these indirect medical causes to all maternal deaths is 17%.[55] In spite of this significant input, it is noted in the literature that, except for HIV (AIDS), indirect causes do not receive the attention they deserve.[56] The most identified non-obstetric illnesses in Nigeria are severe anaemia, cardiac disease, and malaria.[57]

### 3.4.2.2 Non-Medical Causes

Non-medical causes are complex and variously described. Although the narrow definition of MM supplied by the medical field barely takes these into account, they are, however, causes because their presence often sets the course for maternal death. In literature, words like social, cultural, economic, legal or even policy/political factors are sometimes used to group them broadly.[58] Other writers add individual/family issues [59] biological, behavioural, etc. to the groups. [60] Some list them as contributory causes,[61] underlying causes [62] or determinants.[63] The general significance of these factors is explained below. The often cited three-delays model, which is usually employed to explain the relationship between determinants and immediate medical causes of maternal deaths, is examined following that discussion. [64]

Medical causes, being immediate, are usually the most recognized. Moreover, they are the primary focus of the biomedical/ public health fields. However, non-medical causes are

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[55] ibid.

[56] For instance, there is ongoing advocacy for the recognition of maternal mental ill health as an indirect cause of MM. Frederikk Storm and others, 'Indirect Causes of Maternal Death' (2014) 2 (10) The Lancet e566<Indirect causes of maternal death (thelancet.com)> accessed 30 December 2023. .

[57] AS Adeniran, 'Non-Obstetric Causes of Severe Maternal Complications: A Secondary Analysis of Nigeria Near Miss and Maternal Death Survey' (2019) 126 (S3) BJOG: An International Journal of Obstetrics & Gynecology 41,46 < https://doi.org/10.1111/1471-0528.15623 > accessed 30 December 2023.

[58] The Beijing Platform for Action notes that women's health is determined by biology and the social, political and economic context they exist in. UN Beijing Declaration and Platform for Action adopted at the UN World Conference on Women [1995] para 89.

[59] Boniface Oye Adeniran (n 52) 178.

[60] McCarthy J and Maine D, 'A Framework for Analysing the Determinants of Maternal Mortality' (1992) 23 Studies in Family Planning, 23. Catherine Meh used this inclusive framework in her article on Nigeria.

[61] Rabiatu Sageer and others, 'Causes and Contributory Factors of Maternal Mortality: Evidence from Maternal and Perinatal Death Surveillance and Response in Ogun State, South West Nigeria' (2019)19 BMC Pregnancy and Childbirth 63< https://doi.org/10.1186/s12884-019-2202-1 > accessed 30 December 2023.

[62] Gina Marie Paine and Eliva Ambugo Clinton 'Maternal Mortality Interventions: A Systematic Review' Open Journal of Preventive Medicine (2014) (4)699 < http://dx.doi.org/10.4236/ojpm.2014.49079 > accessed 30 December 2023.

[63] Veronique Filippi and others (n14) 61.

[64] However, in recognition of the recently identified limitations of the 3-delays framework, the McCarthy and Maine framework is also utilized to enrich the discussion. McCarthy J and Maine (n 60).

arguably the most important in the discussion of causes. [65] Hence, efforts to reduce MM must take cognisance of their importance. [66] One can identify at least two ways by which the connection to MM and these non-medical causes can be drawn. First, the medical causes could be directly precipitated or traceable to some non-medical factor. For instance, early marriage or stunted growth of girls due to underfeeding may translate to physically underdeveloped girls who may experience obstructed labour. Second, where it is suggested that the ill health has no known cause and could not have been prevented but could be addressed by access to emergency obstetric care (EmOC), non-medical factors such as illiteracy or poverty may prevent access to the EmOC. However, the latter context is the only context in which the WHO and most scholars recognize the non-medical determinants.

In other words, that non-medical factor aided the medical factor that led to the death because if the non-medical factor had not happened, the woman would not have died from the ill health (medical factor). The case for non-medical causes can also be made from the incidences of MM, albeit on a limited scale, in some developed countries where medical facilities and skilled personnel are available. The USA is an example; as though the MM rate is not generally high, it is high among a particular part of the country's population. [67] Therefore, while public health and the medical fields identify the epidemiology and the interventions, there is also the concern of promoting social justice to ensure fair and equitable access to the interventions.

The range of these factors is broad and includes socio-cultural influences on families and communities, low level of expenditure on health facilities, training and development of health personnel, water and sanitation. [68] Others are transportation and communication, social and economic status, low educational level [69] which is common with women in developing

[65] Filippi and others' review revealed that when non-medical causes are combined, they are the highest causes. Veronique Filippi (n 14) 54. Also, ibid.
[66] In medical circles, including by the WHO, it is mainly viewed as factors that prevent women from getting the care they need, but this thesis argues that it is more than that. It is also about the factors that predispose women to MM; although not direct causes, they put the person in the situation where he died. In both criminal law and the law of torts, such circumstances qualify as the cause of the death.
[67] Collier and Molina (n 26).
[68] According to Filippi and others, almost all sepsis deaths occurred in developing nations. Veronique Filippi and others (n14) 55.
[69] Rabiatu Sageer and others (n 61) 7. Paine's study reported a strong positive correlation between percentage of women using contraceptive, total fertility rate, adolescent fertility rate, adult literacy rate and poverty. Paine G M, 'Correlates of Maternal Mortality by Nation' (2014) Open Journal of Preventive Medicine 1.

countries, racism, domestic violence, access to nutrition, internal security,[70] availability of health services, age and parity of women. The World Bank Development Report showed that women who give birth before the age of 18 are three times more likely to die in childbirth than women who are over 18 years old.[71] More than four childbirths and birth intervals of less than 15 months also increase the risk of maternal mortality. Births by women older than 35 or birth intervals of more than five years also increase the risk of eclampsia.[72]

There is also delay in making referrals from lesser equipped health facilities, poor self-risk perception of the woman which causes the woman to disregard complication signs,[73] inability to prevent unwanted pregnancies[74] and domestic violence.[75] Unintended pregnancies led to 20 million unsafe abortions in 2000, 90% of which occurred in developing countries.[76] Thus, de-emphasising the non-medical causes or determinants or contributory factors, as they are variously referred to may prove detrimental to a RH approach. The reason is that RH is understood as encompassing both healthcare and underlying determinants, which range from water, food, housing and so on to the socio economic, cultural and political environment a woman exists in.[77]

As indicated above, a further means to explain the relationship between non-medical factors and the eventual medical factors that cause maternal deaths is the well-known three-delay model formulated by Thaddeus and Maine.[78] In light of the flaws of the framework which prevents it from highlighting some issues, another framework, the McCarthy and Maine framework is utilised to supplement the discussion.

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[70] It has been noted that for sub-Saharan Africa, countries engaged in conflict or with large, displaced populations have some of the highest MMRs. Boniface Oye-Adeniran and others (n 52).
Natural disasters can also worsen the effects of poverty on maternal health as the result is inadequate access to healthcare and malnutrition.
[71] World Bank, *World Development Report: Investing in Health* (Oxford University Press, 1993) 84.
[72] Veronique Filippi (n14) 58.
[73] Rabiatu Sageer and others (n 61) 6.
[74] The 'too young, too old, too close, too many' cliche describing the age and parity which is bad for maternal health is also linked to low level of education of women, socio cultural influences, low status of women in the society and childbirth by girls of less than 18 years of age.
[75] Domestic violence global survey shows that 1 in 3 women are beaten coerced/abused into sex or stopped from seeking health services. Rabiatu Sageer and others (n 61) 6.
[76] M Berer, 'Making Abortion Safe: A Matter of Good Health Policy and Practice' (2002) 10(19) Reproductive Health Matters 31.
[77] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 'The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant' 11 August 2000, E/C.12/2000/4, (GC14) para 9.
[78] S. Thaddeus and D Maine, 'Too Far to Walk: Maternal Mortality in Context (1994) 38(8) Social Science &Medicine 1091; D. Maine, *Safe Motherhood Programs: Options and Issues* (Columbia University, 1991).

### 3.4.2.3 The Three Delays Model of Maternal Mortality Determinants

The first delay referenced by the model, the delay in deciding to seek the necessary medical care in the case of an obstetric emergency, is usually on the part of the woman, the family or both.[79] The second is the delay in reaching an appropriate facility, and the third delay has to do with receiving adequate care when a facility is reached. Although this model has been criticized for not being comprehensive, as explained below, its basis remains valid. The objective was to highlight that, obstetric medical complications, though unpredictable,[80] and sometimes unpreventable, are not necessarily fatal. Sometimes, they lead to death only if certain factors, such as the delays highlighted by the model, are involved.

The reasons behind each of the three delays can be found among the non-medical causes that have been identified in the literature. The reasons for the first delay may include cost (economic/poverty), non-recognition of an emergency due to low educational level or lack of access to information, need for authorization caused by gender inequality, low status of women or patronage of traditional birth attendants (TBAs) (as was the finding in a maternal review on Nigeria).[81] The second delay is related to infrastructure deficits which is attributed to government's inaction or inadequate action (political, policy, legal). It may be due to lack of resources to make health facilities available everywhere or bad policies that concentrate medical facilities and personnel in certain areas (especially urban), internal armed conflicts[82] and bad transport connections between localities. The third delay may be due to shortages in skilled staff, the non-professional attitude of medical staff, or because infrastructure such as water, electricity, or medical supplies, including hospital beds, are wanting.[83]

As noted above, as potent as the three-delay model is in pinpointing the culpability of non-medical factors, it is limited in that it does not cater for some of the issues that come to

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[79] ibid, S. Thaddeus and D Maine 1092.

[80] Boniface Oye Oyediran and others (n 52).

[81] Friday Okonofua and others 'Maternal Death Review and Outcomes: An Assessment in Lagos State Nigeria' (2017) 12(12) <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0188392> accessed 30 December 2023.

[82] Candace Johnson and Surma Das, 'The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment' in G Andreopoulos and Zehra S Kabasakal (eds) *The Uses and Misuses of Human Rights* (Palmgrave Macmillan 2014) 117.

[83] WHO, Maternal Mortality (n 18). Also S. Thaddeus and D Maine (n 78).

play in maternal deaths. [84] It does not take cognizance of the fact that the starting point of maternal mortality is often the circumstances surrounding the pregnancy such that in some cases if the pregnancy can be prevented then MM can be prevented.[85] In the same vein, it does not consider the fact that some obstetric complications can be prevented. It is also faulted for assuming all complications arise at home[86] when in fact many maternal deaths occur or complications set in, at the health facilities after health facility deliveries.[87] The last situation is the basis for which some experts have introduced a fourth delay; that is a delay in respect of access to treatment for women who had already been discharged from hospital post-pregnancy or post-birth who die at home.[88] Other experts identify the fourth delay as the delay to promptly refer the woman to a better qualified facility where the initial facility cannot handle the obstetric complication. [89]

#### 3.3.2.4 The McCarthy/Maine Framework for Analysing the Determinants of Maternal Mortality

McCarthy and Maine's framework's approach is built around three cardinal points: preventing conception, preventing obstetric complications and treating complications. According to the proponents, the interventions directed at reducing MM must reduce the likelihood that a woman will become pregnant, reduce the likelihood that she will suffer serious complications during pregnancy or childbirth, or improve the outcomes for women with complications. [90] As noted above, pregnancy and childbirth to those too young or too old and women with high parity or close parity carry higher risks.

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[84] Rodolfo Carvalho Pacagnella and others, 'The Role of Delays in Severe Maternal Morbidity and Mortality: Expanding the Conceptual Framework' (2012) 20 (39) Reproductive Health Matters 155, 159 <https://doi.org/10.1016/S0968-8080(12)39601-8 > accessed 30 December 2023.
[85] Veronique Filippi (n14) 63. This was the starting point of the Maine and McCarthy framework. D. Maine, (n 77) 11.
[86] Veronique Filippi (n14) 63.
[87] For instance, a study found that more maternal deaths in the south of Nigeria occurred in urban areas where women had more access to health facilities eliciting a possible conclusion that they received substandard care. Catherine Meh (n 54).
[88] Institute of Medicine, 'Reducing Maternal Mortality and Morbidity' in *Improving Birth Outcomes: Meeting Challenge in the Developing World*, in Bale JR Stoll BJ and Lucas AO (eds) (National Academies Press 2003) (n 14). Rodofo Carvalho Pacagnella and others, 'The Role of Delays in Severe Maternal Morbidity and Mortality: Expanding the Conceptual Framework' (2012) 20(39) Reproductive Health Matters, 155.
[89] Anthony Idowu Ajayi and Wilson Akpan, 'Maternal Healthcare Services Utilisation in the Context of 'Abiye' (Safe Motherhood) Programme in Ondo State Nigeria (2020)20(362) BMC Public health 1,2. < https://doi.org/10.1186/s12889-020-08512-z > accessed 30 December 2023.
[90] McCarthy J and Maine D (n 60) 25.

The desirability of the pregnancy is also highlighted as a factor because unwanted pregnancies are one of the usual precursors to seeking abortions.[91] When women are in desperate situations, they seek abortion irrespective of whether it is illegal or highly restricted. Therefore, a woman's reproductive status (including number of births and age), health status, and access to health services including birth spacing facilities, antenatal care, EmOC and quality health services, are all factors that could influence the development and outcome of complications. Her health-seeking or healthcare behaviour, including accessing unsafe abortion services, may also determine whether the outcome of developing the complication is death or disability for the woman. [92]

This framework addresses two germane concerns that the three-delays framework did not consider namely: that prevention of pregnancy is the starting point, and that some obstetric complications can be prevented. The third point, which is improving outcomes when complications have set in, can be likened to a combination of the medical and non-medical determinants of access to reproductive /maternal health care after complications set in. This last point captures the essence of the entire 3-delay framework. So, to synthesise the contents of the two frameworks and the suggestions on a fourth delay, MM determinants are problems with preventing pregnancy, certain reproductive statuses that could increase the likelihood of complications, delay in seeking medical care for complications, delay in getting to the health facility, delay to receive appropriate medical attention including a referral when needed, and access to quality post-partum care.

### 3.5 Interventions for Prevention

With reference to interventions, the statement that recurs in literature is that almost all cases of maternal mortality are preventable [93] because both the causes and the interventions are well known.[94] Based on the causes, preventing maternal mortality is usually discussed to mean two courses of action. The first course of action is addressing the medical factors through access to

[91] Yau Garba Abass, 'Causes and Impact of Unsafe Abortion in Nigeria' (Masters Thesis Vrije Universiteit Amsterdam 2014) 12, 24.
[92] McCarthy and Maine (n 60) 30.
[93] Paul Hunt and Bueno Judith Mesquita, 'The Contribution of the Right to the Highest Attainable Standard of Health to the Reduction of Maternal Mortality'( Human Rights Centre University of Essex, and United Nations Population Fund, 2007) 4 <https://www.unfpa.org/sites/default/files/pub-pdf/reducing_mm.pdf> accessed 30 December 2023. .
[94] Gina Marie Paine and Eliva Ambugo Clinton (n 62) 700.

appropriate and quality health care services during pregnancy, childbirth and postpartum period, and to prevent pregnancy and the second is addressing the various non-medical predisposing factors through appropriate measures.

### 3.5.1 Medical Interventions

The immediate /medical causes can be addressed when women have access to high quality health care in pregnancy, during childbirth and post-childbirth. According to the HRC, only 15% of pregnancies have complications that are difficult to predict, [95] and all five major causes of MM can be addressed by both essential and comprehensive EmOC.[96]

While essential EmOC comprises the administration of antibiotics, oxytocic, anti-convulsant drugs, manual removal of placenta and removal of retained products of conception, comprehensive EmOC comprises essential EmOC, blood transfusion and caesarean section, including administering anaesthesia.[97] Antibiotics are administered to reduce the risk of sepsis from obstructed labour, vaginal examinations, infection at the health facilities and unsafe abortion. To prevent and treat PPH, manual removal of retained conception products and application of uterotonics such as oxytocin is useful. However, though oxytocin is effective it can't be self-administered and requires storage by refrigeration effectively casting doubts on its usefulness in the rural areas where it is most needed. [98] Thus, misoprostol, the alternative, with little storage restrictions and basically self-administered is considered a better option.[99]

For eclampsia, anticonvulsant drugs can be administered to lower the woman's risk, but the main cure for that has been identified to be hastening of the delivery. [100] A caesarean section, as well as assisted delivery using forceps or vacuum extractor, are interventions to

[95] United Nations Human Rights Council, 'Report of The Office of The United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity And Human Rights' [2010] UN Doc A/HRC/14/39, para 6.
[96] Ahmet Metin Gulmezouglu and others 'Interventions to Reduce Maternal and Child Morbidity and Mortality' in Black R. E and others (eds) (n13) <http://www.dcp-3.org/sites/default/files/Chapters/V2C7Gulmezoglu_01.13.15.pdf > accessed 30 December 2023.
[97] ibid.
[98] ibid.
[99] ibid.
[100] Veronique Filippi (n 14) 57.

relieve obstructed labour.[101] Still, the WHO emphasises that the caesarean section is only useful if it is not used too soon, too late, too much or too little[102] as any of these situations can lead to MM. In fact, according to statistics, in low and middle-income countries, one-quarter of the women who died due to childbirth between 1990 and 2017 had had a caesarean procedure.[103]

The above underscores the need for skilled birth attendants (SBA) who can timeously administer these essential interventions when managing labour and delivery. Thus, the main determinant is the quality of the care and not just availability. [104]The SBA should be able to recognize the onset of complications, have the tools for essential interventions, apply the interventions, acknowledge the need for a referral and organise the referral timeously.[105] The evidence for the usefulness of a skilled birth attendant is drawn by comparing the MM rates of developed nations and of urban areas in developing nations where there are mostly facility births and access to SBAs with that of rural areas in developing nations where MM ratios are higher. Historical evidence from the developed nations which once battled with high MM rates are also useful. For instance, the extremely low MM rate of Sweden is attributed to a statistics-based policy that was made to ensure a qualified midwife attended all births. [106]

A contrary observation was however made in the case of Nigeria where a study noted that, although Nigeria had worked to increase institutional deliveries, trained and engaged more health workers, MM is rife in Nigeria. [107] The Institute of Medicine gave a plausible explanation for this occurrence. According to them, using the best available evidence from developed countries as a template for developing countries could be problematic. [108] This is

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[101] According to the Institute of Medicine, unnecessary use of these interventions is bad practice. Institute of Medicine, 'Reducing Maternal Mortality and Morbidity' (n 88)

[102] WHO, Deaths From Caesarean Sections 100 Times Higher In Developing Countries: Global Study' (WHO, 28 March 2019) <Deaths from caesarean sections 100 times higher in developing countries: global study (who.int)> accessed 30 December 2023.

[103] ibid.

[104] Julia Hussein, 'Too few, Too Unskilled, Too late' (2008) (Presentation at Workshop on Reducing Maternal Mortality in Developing Countries organized by the Wilson Centre). The study involved evaluating the implication of the quality of care on maternal mortality in Indonesia and Ghana.

[105] Institute of Medicine (n 88).

[106] ibid.

[107] Catherine Meh (n 54). To highlight the role of other factors, a 15 -20-year study of reduction of MM in rural Gambia attributed the reduction to availability of EmOC, improved transport and communication. Walraven and others, 'Maternal Mortality in Rural Gambia: Levels, Causes and Contributing Factors (Bulletin of the WHO, 2000) referred to in Institute of Medicine (n 88).

[108] Institute of Medicine, 'Introduction' (n 88). Saifuddin and Fullerton also suggest that implementation is the problem. Ahmed Saifuddin and Judith Fullerton 'Challenges of Reducing Maternal and Neo natal Mortality in Indonesia: Ways forward' (2019)144(S1) International Journal of Gynaecology and Obstetrics 1.

because the differences in parameters which guided institutional deliveries in the two countries could lead to differences in outcome. To contribute to the debate, in light of the proven importance of access to skilled birth attendance anywhere in the world and the equally recognised influence of non-medical factors in determining its enjoyment, it may be hypothesised that the non-medical factors may have been the limiting factor in the Nigerian situation.

Ante or pre-natal care was initially considered extremely important to detect high-risk pregnancies, but subsequent reviews of the efficacy of interventions by international agencies' working groups on MM have revealed that it is difficult to prevent acute complications such as PPH and obstructed labour and so, it was better to prepare for it. [109] Pre-natal care has however been useful in detecting complicated foetal positions for birth, and in detecting and treating chronic conditions like anaemia, hypertensive disorders, infections, and nutritional deficiencies.[110] It was also noted that women who attended antenatal clinics were more likely to use skilled birth attendants for delivery. [111] Maternal deaths due to unsafe abortion are described as being the easiest to prevent. [112] Strategies like family planning, access to and use of contraceptives to help with birth spacing, prevention of unwanted pregnancies and widening access to abortion (if realisable) [113] will prevent unsafe abortion.

These interventions geared towards preventing MM by addressing the medical causes have through various reviews, been proven to be useful,[114] but addressing the interaction of

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The WHO has also stated that to end preventable MM, states must go beyond doing what is right to doing things right. WHO, 'Strategies Towards Ending Preventable Maternal Mortality (EPMM)' (2015) <http://apps.who.int/iris/bitstream/handle/10665/153544/9789241508483_eng.pdf;jsessionid=7A85A1EEB788408D68976FA02A6F363E?sequence=1 > accessed 30 December 2023.

[109] Alicia Yamin and Deborah Maine (n 39) 570; UNICEF and WHO and UNFPA, 'Guidelines for Monitoring the Availability and Use Of Obstetric Services' (2nd edn, August 1997)<PDFFinalgui.PDF (columbia.edu) > accessed 30 December 2023.

[110] Cleone Rooney and WHO 'Antenatal Care and Maternal Health: How Effective is it? Reviewing the Evidence' (WHO, 1992) 35.

[111] ibid.

[112] ibid.

[113] The right to abortion is one of the most contested aspects of reproductive rights. There is no region of the world where the push for more liberal abortion laws is not met with resistance. Charles G Ngwena, 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women on Africa' (2010) 32 (4) Human Rights Quarterly 783.

[114] Gina Marie Paine and Eliva Ambugo Clinton (n 62) 700-701; Adewole I F and Others, 'Magnesium Sulphate for Treatment of Eclampsia: The Nigerian Experience' (2000) 29 (3-4) African Journal of Medicine and Medical Sciences, 239; Schaider J and others, 'International Maternal Mortality Reduction: Outcome of Traditional Birth Attendant Education and Intervention in Angola' (1999) 23 Journal of Medical Systems 99; Derman R.J, 'Oral Misoprostol in Preventing Postpartum Haemorrhage in Resource-Poor Communities: A Randomised Controlled Trial' (2006) 368 Lancet, 1248.

these interventions with the broader determinants of maternal mortality is desirable as the health sector/medical interventions are short term and will in the long run be of limited impact. Long-term solutions will only come about by addressing the underlying factors.[115]

### 3.5.2 Non-Medical Interventions

In direct correlation to the non-medical causes, which range from individual factors to societal situations, the non-medical interventions require changes to be made in respect of those factors. To consider that again in the light of the integrated framework (3-delays and McCarthy/Maine), interventions should begin by enhancing the ability of women and families to prevent pregnancies. This goes beyond access to contraceptives or family planning services but involves addressing the environmental, social, and cultural factors that determine the ability of women and /or couples to regulate childbirth. Actions to prevent early marriages, adolescent pregnancy, illiteracy, lack of access to health information- including misconceptions about family planning are all important. Practically, measures would include delay of early marriages through criminalisation or cash incentives to parents,[116] individual behavioural changes to lower the risks of MM, laws against domestic violence, and removal of barriers to enable adolescents to have access to contraceptives. Some of these interventions are also relevant to lowering the risks of developing complications in pregnancy and during childbirth.

To combat the delay in deciding to access healthcare, measures such as women having access to health education and information are necessary. This could be delivered through community-based interventions where the women, relatives and traditional birth attendants (TBAs) receive training in prenatal, natal and post-natal care and how to identify the onset of complications. Cultural attitudes, which deny women autonomy over health decisions must also be addressed at the community level. Policies to reduce or eliminate user fees in hospitals can also help women decide to use hospitals.[117] To address the delay in reaching health facilities, the citing of maternal health facilities must be decentralized as much as possible, and skilled personnel as well may have to be incentivized to work in the rural areas. In some

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[115] Filippi and others gave the example of the reduction in Bangladesh's MM ratio which though credited to availability of EmOC and family planning facilities can also be linked to the increase in the number of women who gained employment. Veronique Filippi.(n 14) 65. Alicia Ely Yamin, 'From Ideals to Tools: Applying Human rights to Maternal Health' (2013) 10(11) PLoS Med

[116] Ratsma Y E and Joyce Malongo 'Maternal health and Human Rights' (2009) 21(2) Malawi Medical Journal 51, 52.

[117] ibid.

countries, the use of maternity waiting homes, where women whose delivery times are near but live far from the health facilities, have been introduced to enable such women to be within reach of skilled birth attendants.[118] Remedying the delay to receiving appropriate care will involve not only actions in respect of service delivery but also in respect of the underlying determinants of health such as potable water, sanitation, and even infrastructure such as electricity.[119] Receipt of quality healthcare services also requires effective accountability mechanisms, effective monitoring of private care providers and improvement in maternal death reporting.[120]

Finally, political commitment to the goal of reducing or preventing MM is the most important non-medical determinant.[121] Government action is needed to provide the financial and human resources for securing many of the interventions. Government action is also needed where necessary legal and policy changes must be made. The significance of this determinant underscores the overarching conclusion that MM is the result of the failure of governments to fulfil their obligations in respect of the human rights of women.

### 3.6 The Context of Maternal Mortality in Nigeria

Located in sub-Saharan Africa, Nigeria is a multi-ethnic state of over 250 ethnic groups and thus characterised by complex socio-cultural conditions. It is a former British colony formed by an amalgamation of the predominantly Muslim north[122] and largely Christian south. Consequently, the legal system is largely influenced by the legacies of the colonial government. Christianity and Islam are the two predominant religions; nevertheless, traditional worship is prevalent and some polls have reported the country to be one of the most religious societies in the world.[123] With respect to country income groups, it is classified as a lower middle-income

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[118] Ahmet Metin Gulmezouglu and others (n 96).
[119] Paul Hunt and Judith Bueno De Mesquita (n 92) 8.
[120] Institute of Medicine (n 88).
[121] Rodolfo Carvalho Pacagnella and others (n 84) 160.
[122] It was observed by Eto that the high MM ratio in the North is exacerbated by the Islamic culture that accords women little value, practice wife seclusion, early marriage and restricts women's autonomy and access to medical care. Similarly, the Christian religion has championed debates restricting women's access to safe abortion and equality. Enifome Eto, 'Government Policies and Initiatives on Maternal Mortality Reduction in Nigeria' (PhD Thesis, South Dakota State University 2016) 72.
[123] BBC, 'Nigeria Leads In Religious Belief' (BBC, 2004) <BBC NEWS | Programmes | wtwtgod | Nigeria leads in religious belief> accessed 30 December 2023. Oishimaya Sen Nag, ' Most religious Countries in the World' (World Atlas, January 11, 2018) <Most Religious Countries In The World - WorldAtlas> accessed 30 December 2023.

country.[124] The country is the most populous country in Africa with an estimated population of 206,139 million,[125] which is not unconnected with the high birth rate of 5.52 births per 1000 population and high fertility rate of 5.3 per woman.[126] Women make up 51% of the population, the average age of sexual initiation in the population is put at 15 years and 19% of women in the 15-19 age group have started childbearing.[127] The high level of fertility also means that it has a predominantly young population with statistics placing those under 24years at about 32% of the population.[128]

Inequality is rife in the country. As of 2018, 48% of the population was rural,[129] two-thirds live below the poverty line and Nigeria was ranked as the country with the largest proportion of its population living in poverty.[130] In addition, apart from the pension which applies to employees in the formal sector, access to social security is non-existent.[131] This pervasive atmosphere of want is in spite of the fact that Nigeria's rich oil reserves earned billions of dollars in revenue.[132] Misuse, misappropriation and misallocation have been cited as some of the reasons for poverty and inequality in Nigeria.[133] The South is generally more prosperous than the North and, of the geopolitical zones, the North West has the highest poverty rate while the South West has the lowest.[134]

Women and rural dwellers are also some of the most impacted by the unequal economic situation. [135] Nigeria is a patriarchal society where a lower value is placed on women who in

[124] WHO, 'Country Cooperation Strategy at a Glance: Nigeria' (World Health Organisation, May 2018) <https://apps.who.int/iris/handle/10665/136785 > accessed 30 December 2023.
[125] World Bank, 'World Bank Open Data: Population Total Nigeria' (World Bank, 2022) <World Bank Open Data | Data accessed 30 December 2023.
[126] National Population Commission, 'Nigeria Demographic and Health Survey (NDHS) 2018 Key Findings' (National Population Commission, 2020) 4 <https://nationalpopulation.gov.ng/ndhs-2018-key-finding/ > accessed 30 December 2023.
[127] ibid 15.
[128] Federal Ministry of Health, *National Policy on the Health and Development of Adolescents and Young People in Nigeria*: (2021-2025) 8.
[129] World Bank, 'World Bank Open Data: Rural Population Nigeria' (World Bank, 2022) <World Bank Open Data | Data > accessed 30 December 2023.
[130] Nigeria Federal Ministry of Health, *Gender in Health Policy: 2021-2025* (FMOH, 2020) 15 (Gender in Health Policy).
[131] SSA, 'Nigeria: Social Security Programs Throughout the World' (United States Office of Retirement and Disability Policy, 2019) <Social Security Programs Throughout the World (ssa.gov)>accessed 30 December 2023.
[132] C O Omodero and B I Ehikioya, 'Oil and Non-Oil Revenues: Assessment of Contributions to Infrastructural Development in Nigeria' (2020)23 (5) Journal of Management Information and Decision Sciences 638.
[133] Oxfam, 'Nigeria: Extreme Inequality in Numbers' (Oxfam, 2022) < Nigeria: extreme inequality in numbers | Oxfam International > accessed 30 December 2023.
[134] Catherine Meh and others (n 54).
[135] Gender in Health Policy (n 130) 27.

most customs, are denied the right to inherit[136] but viewed as chattels to be inherited and sometimes, as in the case of child marriage, exchanged for social and economic gains.[137] At least 28% of adolescents between the ages of 15-19 are married.[138] This state of affairs perpetuates situations of unequal power relations because it facilitates limited access to socio-economic benefits. Invariably, women are kept financially dependent on men or male figures and, such a factor may affect their access to health goods and services. [139] The poverty rate in rural areas is about 1.5 times higher than in urban areas.[140] Therefore, to be a woman and a rural dweller is one of the lowest statuses a Nigerian can have. This is also shown in the literacy rate. While only 35% of women in rural areas are literate as against 60% of males, women in urban areas have a literacy rate of 74% as against men's 86%.[141] Additionally, nearly two-thirds of women in the North East and North West have never been to school. In comparison, that describes only less than 15% of women in the South-South. [142]

In respect of maternal health therefore, poverty, illiteracy, gender inequality, and low social status work in concert to produce the same results.[143] While gender inequality denies women the autonomy to make decisions even in relation to their healthcare,[144] illiteracy deprives women of the ability to recognise maternal health complications as well as the capacity to afford antenatal and birthing healthcare services. Thus, in 2018, 43% of births were attended by a skilled birth attendant[145] but statistics showed that the majority of these were to women of a higher social class, women older than 20, women with at least a secondary education, and from wealthy households.[146] Similarly, the use of family planning and

[136] OK Edu, 'A Critical Analysis of the Laws of Inheritance in the Southern States of Nigeria (2015) 60(1) Journal of African Law 141.
[137] Onyeka Okongwu, 'Are Laws the Appropriate Solutions: The Need to Adopt Non-Policy Measures in Aid of the Implementation of Sex Discrimination Laws in Nigeria' (2020) 21(1) International Journal of Discrimination and the Law 26.
[138] Chimaroke O Izugbara and others, 'Maternal Health in Nigeria: A Situation Update' (2016) African Population and Health Research Centre 1.
[139] 44% of married women do not participate in their own health decision-making. NDHS 2018 (n 125) 14.
[140] UNICEF, 'State of the World's Children: Maternal and New-born Health, (UNICEF, November, 2009) <EN-SOWC09-text_CC_PDF.QXD (unicef.org) > accessed 30 December 2023.
[141] Doris Dokua Sasu, 'Literacy Rate in Nigeria 2018 by Area and Gender' (Statista, February 2022) < • Nigeria: literacy rate, by area and gender | Statista> accessed 30 December 2023.
[142] British Council, 'Girls Education in Nigeria Report 2014: Issues, Influencers and Actions' (British Council , 2014)< girls_education_in_nigeria_-_report.pdf (britishcouncil.org.ng)> accessed 30 December 2023.
[143] Gina Paine, 'Maternal Mortality in Nigeria: A literature Review' (2019) 11(1)World Medical & Health Policy 83; Rabiatu Sageer and others (n 60) 3.
[144] Gina Paine (n 143) 86.
[145] In the North East and North Central it was only 10%. National Gender in Health Policy (n130) 29; NDHS 2018 (n 126) 26.
[146] National Gender in Health Policy (n130) 32; NDHS 2018 (n 126) 26.

contraceptives which is useful to prevent having children too late, too early, and too frequently, is also more common among urban dwellers, educated women, married women, women older than 19, and wealthy women.[147] The cost of the contraceptives is likely a determinant as only 4% of women from poor households use modern methods against 30% from wealthy households.[148] It is reported that contraceptive use also varies according to ethnic groups (indicating cultural influences) and religions. Thus, though the unintended pregnancy rate at 59 per 100 women within the 15-49 age bracket[149] is the same for the North and South, contraceptive use is less common among the ethnic groups in the North but most common in the South West.

The Maternal Mortality Ratio within the geopolitical zones varies. The Northern ratios are worse than that of the South,[150] and in the South, it is lowest in the SouthWest.[151] Additionally, some states in the North like Zamfara and Kano actually have rates that are higher than that of the national average.[152] The states with the greatest burden, Jigawa, Katsina, Yobe, Zamfara, Kebbi and Sokoto are all in the North.[153] The armed insurgency taking place in some areas in that part of the country is also a contributory factor. The activities of the Boko Haram insurgent group have led to internal displacements and, according to the Office of the High Commissioner for Human Rights (OHCHR) nearly two-thirds of women and girls in the North East are exposed to SRHR violations[154] including repeated sexual violence and are therefore at risk of unintended pregnancies and sexually transmitted infections. Expectedly, due to the risk to lives and difficulty with implementing interventions, development partners have either reduced their investments to, or ended their activities in this area.[155]

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[147] Guttmacher Institute, 'Reducing Unsafe Abortion in Nigeria' (2008) 2 < Reducing Unsafe Abortion in Nigeria (guttmacher.org)> accessed 30 December 2023. ; National Population Commission, 'Nigeria Demographic and Health Survey [2013] (NDHS 2013) 97.
[148] NDHS 2018 (n126) 22. Also 28% of women within the 15-49 age bracket use contraceptive methods, only 17% of married women use any, and of that number, 12% use modern methods while the remaining 5% use traditional methods. Reasons cited for non-use include ignorance, fear of side effects, disapproving partners, unsupportive relatives, and so on. NDHS 2018 ibid 5.
[149] Nigeria Federal Ministry of Health, National Guidelines on Safe Termination of Pregnancy for Legal Indications' [2018]1.
[150] Catherine Meh and others (n 54) 2.
[151] Rabiatu Sageer and others (n 60) 2.
[152] ibid. Kano in 2008 had an MM ratio of 1600 deaths per 100,000 live births while Zamfara had 1049 deaths per live births and the national average was 545. Catherine Meh and others (n 54) 2.
[153] Nigeria Federal Ministry of Health, *Accelerated Reduction of Maternal and Newborn Mortality in Nigeria: Roadmap for Action* 2019-2021 [2019] 3.
[154] OHCHR, 'North East Nigeria, Addressing Impunity for Sexual Violence Amidst a Decade Long Conflict' (OHCHR, 5 November 2019) <OHCHR | Sexual violence in northeast Nigeria> accessed 30 December 2023.
[155] Oladeji Olusola, 'Sexual Violence Related Pregnancy Among IDPs in IDP Camps in the North East' (2021)36(5) Journal of Interpersonal Violence 4758; Kana MA and others, 'Maternal and Child Health

In various Nigerian communities, cultural and religious factors directly precipitate or increase the risk of medical causes or influence the non-use of maternal healthcare facilities. For instance, anaemia and cardiac disease which are the most common non-obstetric diseases, have the highest incidence in the North East and the North West and they are both associated with cultural attitudes. Poor child spacing,[156] and local taboos on foods consumed in pregnancy such as meat, snails, okra, eggs, beans, dairy and leafy vegetables cause anaemia.[157] Cardiac disease is linked to the practice of eating dry lake salt (*kanwa*), lying on a heated mud bed, and taking frequent baths for 40 days post-birth to stimulate lactation.[158] Child marriage and extreme forms of FGM such as *gishiri* cuts, practices also more common in the North, contribute to obstructed labour and sepsis respectively.[159]

All over the country, patronage of traditional birth attendants and faith based healers, and use of traditional family planning methods are rife.[160] Customary laws of inheritance including Islamic law encourage a preference for male children which in some cases may only be possible after 'too many births'.[161] The practice of purdah which dictates that married women have limited interactions with the opposite sex, including if those men were medical professionals, is prevalent in the northern part of the country and is one of the reasons the women avoid hospitals. In the North East and North West, home births are 79% and 88% respectively.

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Interventions in Nigeria: A Systematic Review of Published Studies from 1990 to 2014' (2015) 15 (334) BMC Public Health <
https://doi.org/10.1186/s12889-015-1688-3 >accessed 30 December 2023.

[156] Owoyemi Julius Olugbenga and Haruna Seidu Abdulkarim, 'Religious Beliefs, Cultural Influence, Economic Status the Socio-Economic Determinants of Child Spacing Practice Among Women of Reproductive Age in Dekina Local Government, Kogi State, North Central Nigeria' (2021) 6 (2) Enugu State University Journal of Social Sciences 52.

[157] Comfort Chukwuezi, 'Socio Cultural Factors Associated with Maternal Mortality in Nigeria' (2010) 1(5) Research Journal of Social Sciences, 22, 24; JIB Adinma and OS Umeononihu and M N Umeh, 'Maternal Nutrition in Nigeria' (2017) 34(2) Journal of Obstetrics and Gynecology <
https://doi.org/10.4103/TJOG.TJOG_25_17 > accessed 30 December 2023.

[158] AS Adeniran (n 57) 46.

[159] Abdullahi Dahiru, 'Some Harmful Traditional Practices in Northern Nigeria and Making Child Birth Safer in Nigeria' (gamji) < Some Harmful Traditional Birth Practices In Northern Nigeria and Making Child Birth Safer in Nigeria (gamji.com)> accessed 30 December 2023.

[160] Loretta Favour Chizomam Ntoimo and others, 'Why Women Utilize Traditional Rather Than Skilled Birth Attendants for Maternity Care in Rural Nigeria: Implications for Policies and Programs' (2022) 104 (103158) Midwifery 1, 2.

[161] Comfort Chukwuezi cited Al Meshari's research "the pattern of MM with parity showed a relatively less number of deaths of females in their second through to sixth pregnancies and a greater number of deaths in females in their seventh pregnancy and above…….and age 35 years and over." Comfort Chukwuezi (n 157) 22, 25.

Culture and religion greatly limit the extent to which adolescents' sexual and reproductive health right is given effect. Although a significant number of Nigerian adolescents are sexually active, they are discriminated against with respect to access to SRHR freedoms and entitlements. The sexuality education being offered in schools focuses mainly on abstinence because of deep-seated religious and cultural beliefs that knowledge of contraceptives will fuel promiscuity.[162] Similarly, the traditional notion of children as appendages of their parents is a stumbling block to granting adolescents more autonomy with respect to their SRHR.[163] As almost all of these have some link with culture, it has been suggested that in-depth understanding of the socio- economic and cultural factors affecting women's SRHR is a pre-requisite to proffering practical and viable solutions to these challenges.[164]

### 3.7 Nigeria - Healthcare System

Nigeria's healthcare system is pluralistic being a mix of orthodox and unorthodox, with the unorthodox comprising faith-based healers, traditional healers[165] and alternative healthcare providers.[166] Orthodox healthcare is provided by both public and licensed private facilities as well as informal healthcare providers who fall under the category of Proprietary and Patent Medicine Vendors (PPMVs). Having no formal medical training, **PPMVs** are drug retailers, usually learnt through apprenticeship. They are licensed by the Pharmacists Council of Nigeria to complement the much fewer retail pharmacies by selling over-the-counter medicines supposedly in rural areas.[167] Although they are not permitted to sell drugs like antibiotics or carry out complex medical procedures, loopholes in the regulatory system are exploited.[168]

[162] Ogundipe Stephen Oluwafunmilayo and Ojo Funmilayo Yemi, 'Adolescent Sexuality Education in Contemporary Nigeria and its Implications for Pastoral Counselling' (2015) 5 (1) International Journal of Scientific and Research Publications 1,3.
[163] ibid.
[164] Adenike O Esiet, 'Changes in Knowledge and Attitudes Among Junior Secondary Students Exposed to the Family Life and HIV Education Curriculum in Lagos State Nigeria' (2009) 13(3) African Journal of Reproductive Health 37, 40.
[165] It conforms with GC14's directive to promote traditional health practices and medicines. GC 14 (n 69) para 34.
[166] Chimaroke O Izugbara and others (n 138) 4.
[167] Maia Severding and Naomi Beyeler, 'Integrating Informal Providers into a People-Centered Health Systems Approach: Qualitative Evidence From Local Health Systems In Rural Nigeria' (2016) 16 (526) BMC Health Services Research < https://doi.org/10.1186/s12913-016-1780-0 > accessed 30 December 2023.
[168] Naomi Beyeler and Jenny Lui and Maia Severding, 'A Systematic Review of the Role of Proprietary and Patent Medicine Vendors in Healthcare Provision in Nigeria (2015) 10(1) PLoS ONE e01175165 <https://doi.org/10.1371/journal.pone.0117165 > accessed 30 December 2023.

Their accessibility and illegally unrestricted medical skills make them a major primary healthcare care provider even for some sexual and reproductive health issues including abortion.[169]

The services rendered by the government-run primary healthcare centres (PHC) are sometimes described as 'leaving much to be desired'.[170] A study of 12 PHC centres in Edo State revealed serious shortages in housing, medical facilities and equipment, essential drugs, and skilled personnel. None had ambulances, mobile phones or office equipment, only one had a laboratory, some had no nurses or midwives and the ones who had nurses or midwives had only one![171] All these deficiencies breed a lack of confidence in the public primary health care services. The consequence is the resort to alternatives in the form of PPMVs, traditional birth attendants, private providers or overburdening of the secondary and tertiary facilities. Meanwhile, most of the secondary health care, about 73%, is provided by private healthcare facilities.[172]

Specific healthcare factors also include significant delays in medical intervention, sometimes due to inadequate staff which is not surprising with 1 gynaecologist/obstetrician reportedly available to 181458 women.[173] Other reasons are unpreparedness of staff or non-registration of victims for ante natal care (emergencies), late referrals especially from traditional birth attendants, and late presentation due to distance. It was found that women were more likely to survive complications if the distance to the hospital was no more than 5km,[174] but only 71% of Nigerian women live less than 5km away from primary healthcare facilities and these may not even be equipped to administer essential EmOC.[175] Inability to pay for services has led to reports in the news and court cases against the government and private providers who have held mothers and babies hostage when they could not pay baby delivery

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[169] ibid.
[170] Loretta Favour Chizomam Ntoimo and others, 'Assessment of Service Readiness for Maternity Care in Primary Health Centres in Rural Nigeria : Implications for Service Improvement' (2021) 40 (151) Pan African Medical Journal< https://doi.org/10.11604%2Fpamj.2021.40.151.25976 >accessed 30 December 2023.
[171] ibid.
[172] Federal Ministry of Health, *National Guidelines for Maternal and Perinatal Death Surveillance* [2015] 2.
[173] Chimaroke O Izugbara and others (n 138) xi.
[174] Accelerated Reduction Policy (n 143). A distance of less than 5km was reported more likely to ensure survival in AI Adanikin and others, 'Maternal Death Review Related to Abortive Pregnancy Outcomes: A Secondary Analysis and Maternal Death Survey' (2019) 126 (s3) BJOG 33, 38.
[175] Chimaroke O Izugbara and others (n 138)1.

fees.[176] Such situations are inevitable as only 23.9% of the total health expenditure is public funded; 5.5 % is financed by external sources including donors, while any other health service is funded by the populace out of their pockets. [177]

Lack of blood and blood products, lack of radiological services and essential medication to stabilise patients, the abusive attitude of health care workers, time lag between diagnosis and attention by senior personnel, dearth of skilled staff and industrial actions, late diagnosis and treatment of abortion complications likely due to lack of institutional guidelines[178] were also recorded as problems at the health facility levels.[179] Studies that weighed in on these problems have suggested practical solutions such as free healthcare and medicines, free blood products, housing personnel near hospitals, providing official transportation during call hours, compulsory insurance system and community-based interventions.[180]

Against the background of the scope of RH as well as the discussion of the concerns of sexual and reproductive health in Chapter 2, it is evident that the causes of MM in Nigeria and the interventions needed resonate with the norms and guarantees of RH as well as the principles of the HRBA to health. The RH is preoccupied with disadvantaged groups.[181] It is concerned with equitable access to healthcare, guaranteeing reproductive freedom on a non-discriminatory basis and other health related entitlements. Complementarily, the HRBA is concerned with identifying and addressing the reasons why some women cannot access the guarantees of RH and with ensuring accountability. The description of the conditions within which MM occurs in Nigeria, from the high fertility rate, the low social status of women, to the local customs and attitudes that endanger the health of girls and women, and an unfavourable health system puts RH and other principles of the HRBA to health on the spot.

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[176] Funmi Ajumobi, ‘ Mother, Newborn Baby held Captive for 7 Months over N250,000, Hospital Bill’ Vanguard Newspaper Online, ( Lagos, 1 October 2020) <Mother, newborn baby held captive for 7 months over N250,000 hospital bill (vanguardngr.com) > accessed 30 December 2023.
[177] USAID, ‘African Strategies for Health: Health Financing Profile: Nigeria’ (2016 )< country_profile_-_nigeria_-_us_letter_final.pdf (africanstrategies4health.org)> accessed 30 December 2023.
[178] AI Adanikin (n 174) 37-38.
[179] OT Oladapo, ‘When Getting There is not Enough: A Nationwide Cross Sectional Study of 998 Maternal Deaths and 1451 near misses in a Tertiary Hospital in a Low-Income Country’ (2016) 123 BJOG 928, 929. Accelerated Reduction Policy (n 143); Oluwarotimi Ireti Akinola, ‘God’s Will: That in Reproduction There Might be Health’ (74th Edition Inaugural Lecture Series, LASU, November 2019) 1, 25-27.
[180] AS Adeniran (n 57) 47.
[181] Paul Hunt, ‘Right to the Highest Attainable Standard of Health’ (2007)370 (9585) The Lancet 369 < https://doi.org/10.1016/S0140-6736(07)61173-8 > accessed 30 December 2023.

Thus, the economic, social, and cultural environment sets a circumstantial stage for violations in respect of reproductive health freedoms as well as access to healthcare facilities and the underlying determinants of health and these require legal, policy and institutional actions from the government which is the principal duty bearer in a human rights approach. Additionally, RH anticipates the participation of the target group or community to ensure that the legal, policy or other measures are appropriate to address the issues.

### 3.8 Conclusion

The meaning, prevalence, causes and determinants, of MM and relevant medical and non-medical interventions to stem its occurrence have been dealt with in this chapter. The major objective of the chapter was to provide an in-depth analysis of the concept, being one of the basic concepts upon which the thesis is built. As mentioned in the introduction, the purpose is to facilitate the drawing of the link between MM and RH including SRH. Across all discussions, it is a given that MM is brought about by pregnancy or childbirth which are reproductive functions. Thus, the two major concerns of reproductive health – the ability to regulate fertility and access to reproductive/maternal healthcare facilities- are applicable to MM. Sexual health on the other hand finds a connection with MM in the prevention of pregnancies and the infringement of sexual freedom which predisposes women to MM. Other guarantees of RH towards ensuring a variety of conditions under which women can realise the best attainable standard of health by implication cover the various determinants of maternal health. Thus, the potential usefulness of RH for MM is further established.

In agreement with the view that, besides biological factors, the root causes of women's ill health include factors such as lack of decision-making power, finances, education, the thesis argues that the non-medical causes or determinants of MM are as important as the medical causes, (although it was observed that support for this view is more common in non-medical circles). On this basis, the interventions ought to take equal cognisance of healthcare-related actions as well as measures to deal with the relevant social, cultural and economic conditions contributing to maternal mortality occurrence.

Having identified SRHR and MH obligations in both binding and non-binding international and regional (Africa) human rights documents in Chapter 2, Chapter 4 will build on that chapter and this present chapter by exploring the potential of applying the standards of

RH as interpreted by the TMBs for the reduction of MM. The application of the development-oriented principles of the HRBA to health will similarly be analysed.

## Chapter 4

## The Application of the Right to Health Framework for the Reduction of Maternal Mortality

### 4.1 Introduction

This chapter seeks to explore the value that the implementation of the standards of the right to health and the operational principles of the HRBA to health can bring to the efforts to reduce maternal mortality (MM). Some practical difficulties and concerns with their implementation are also highlighted. Maternal mortality, the death of a woman due to a pregnancy-related cause, was established in the previous chapter to be a human rights issue. It was also observed that some features of the RH are potentially useful for MM prevention. As discussed in the said chapter, this is because the critical interventions for its prevention cut across entitlements to sexual and reproductive health and rights (SRHR) freedoms, services and goods, including maternal healthcare and the economic, social and cultural determinants of maternal health. Interventions are also derivable from the protection of other human rights, the breach of which have been linked to high rates of preventable MM. These rights,[1] in addition to RH, are components of the HRBA to health which is aimed at realising the right to health and other health-related rights.[2]

The HRBA to health is also aimed at strengthening the duty bearers to carry out their obligations and empowering the right holders to claim their health rights.[3] As explained in Chapter 2, the HRBA, developed mainly by the United Nations, governments, and non-governmental organisations represents a holistic approach as it comprises the legal standards of the rights as well

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[1] See Rebecca J Cook and Bernard M Dickens and Mahmoud M Fathalla, *Reproductive Health and Human Rights: Integrating Medicine, Ethics and Law* (Clarendon Press 2003); Paul Hunt, Report of The Office of The United Nations High Commissioner for Human Rights on Preventable Maternal Mortality and Morbidity and Human Rights (2010) UN Doc A/HRC/14/39. <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G10/129/49/PDF/G1012949.pdf?OpenElement > accessed 30 December 2023.
[2] WHO and OHCHR, 'A Human Rights Based Approach to Health' (WHO, 10 December 2022)<https://www.who.int/hhr/news/hrba_to_health2.pdf >accessed 30 December 2023.
[3] ibid.

as human rights principles which guide the implementation (operational) processes of human rights. Notwithstanding the usefulness of the other rights in the HRBA to health, [4] this thesis is committed to exploring the extent to which the RH as the central right in a HRBA to health can contribute to reducing MM in the context of Nigeria. This HRBA-to-health approach to MM advances the use of the right to health as a major framework within which to address health determinants and processes that relate to MM.[5]

This chapter is closely connected to Chapter 2 where the provisions of significant international and regional instruments on maternal health (care) and the protection of the sexual and reproductive health and rights (SRHR) of women and girls necessary to prevent MM are set out. Chapter 2 also identifies the operational principles which ensure that policies and interventions are effective and sustainable in an HRBA to health. This chapter deepens Chapter 2 by considering how those norms and standards of RH and the operational principles are applied to prevent women's avoidable death from pregnancy or childbirth-related causes. This enables a further evaluation of the potential and limitations of applying the standards of the right as well as the HRBA principles which guide the implementation of the standards of the right. Where the approach is, as in this case, an HRBA, Hunt et al. warns that the number of prevented deaths may not necessarily be the immediate outcome. Other indicators of effectiveness may include revisions of the legal and policy frameworks, as well as transformations in public attitudes and perceptions, and the development of a sense of ownership among the right holders.[6]

As clarified by General Comment no. 14 (GC14), several factors, including natural causes or human choices, influence health or ill health. It, therefore, follows that not all maternal mortalities can be prevented. However, the number can be greatly reduced, as has been done in many countries in the developed world that, up to the mid-1930s, grappled with high MM rates.[7] The discussion

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[4] Paul Hunt, 'Interpreting the International Right to Health in a Rights Based Approach to Health' (2016) 18(2) Health and Human Rights Journal 109, 110.

[5] It is similarly described by Puras, Dainius Puras, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health (2015) UN Doc A/HRC 29/33 <https://www.right-docs.org/doc/a-hrc-29-33/ > accessed 30 December 2023.

[6] Paul Hunt and Alicia Ely Yamin and Flavia Bustreo, 'Making the Case: What Is the Evidence of Impact of Applying Human Rights-Based Approaches to Health?' (2015) 17 Health & Hum Rts J 1.

[7] See Irvine Loudon, 'Maternal Mortality in the Past and its Relevance to Developing Countries Today' (2000) 72(24) American Journal of Clinical Nutrition 1S.

in Chapter 3 shows that the actions to prevent MM can be linked to both the immediate and predisposing factors causing MM. These interventions are recurrently described as well-known.[8] As discussed in Chapter 3, they include high quality-care in pregnancy, during, and after childbirth; skilled birth attendants; timely medical management and treatment to address complications; drugs such as oxytocin, antibiotics and magnesium sulfate; and means for women and adolescent girls to prevent unplanned pregnancies. These are all geared towards addressing the direct and indirect medical causes and the underlying determinants of maternal health. These actions are 'a variety of facilities, goods, services and conditions'[9] necessary for the realisation of the highest standard of sexual, reproductive and maternal health.

As explained above, the analytical framework of the right to health developed by the Special Rapporteur and largely patterned along the analysis of GC14 presents an avenue to consider how the right may be applied in terms of individual health issues such as MM.[10] The OHCHR**'s** technical guidance to reduce MM, essentially follows the same structure.[11] As a human rights-based approach, this framework features non- discrimination and equality, accountability and participation[12]- principles which are also fundamental to RH. Owing to the fact that these principles have been popularised by the development organisations which apply the HRBA in their work as operational principles, they will be discussed in this chapter under section 4.3, which

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[8] According to Osotimehin, UNFPA's Executive Director, "the solutions are deceptively simple and well known." See UNFPA, 'In Race to Save Women's Lives, Solutions are within Reach' https://www.unfpa.org/news/race-save-womens-lives-solutions-are-within-reach-says-unfpa-head accessed 30 December 2023..
WHO, 'Maternal Mortality' (WHO, 22 February 2023)< https://www.who.int/news-room/fact-sheets/detail/maternal-mortality >accessed 30 December 2023. . Ebenezer Durojaye, 'The Human Rights Council's Resolution on Maternal Mortality: Better Late than Never' (2010) 10(1) African Human Rights Law Journal 295.
[9] UN Committee on Economic Social and Cultural Rights General Comment No. 22 on the right to Sexual and Reproductive health (article 12 of the International Covenant of Economic Social and Cultural Rights) (2016) E/C.12/GC/22, para 9.
[10] According to Puras, the framework is intended to provide an answer to the question of what human rights in general, and in this case, the right to health can contribute to policymaking. Darius Puras, (n 5).
[11] OHCHR, 'Technical Guidance on The Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality' [2012] UN Doc A/HRC/21/22 (Technical Guidance).
[12] Paul Hunt 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health (A/61/338). They are underlying determinants of health para 18. Additionally, these three principles along with the AAAQ are the ones most often identified as making up the right to health approach. Lisa Montel and others, 'How Should Implementation of the Human Right to Health Be Assessed? A Scoping Review of the Public Health Literature from 2000 to 2021' (2022) 21 (139) International Journal for Equity in Health 9.

examines the implementation- guiding principles of the framework.[13] Therefore, the components of the framework discussed in this chapter are:

- Obligations to respect, protect the freedoms and fulfil the entitlements;
- Availability, Accessibility, Acceptability and Quality of healthcare goods and services and underlying determinants of health (AAAQ).
- Progressive realisation of the right
- Fulfilment of core obligations
- International assistance and cooperation between states
- Empowerment of duty-bearers and right-holders
- Non- discrimination and equality
- Participation and
- Provision for monitoring and accountability.

This chapter is organised as follows: the first part of the discussion relates to the tripartite obligations of respect, protect and fulfil and the AAAQ elements of the RH which are standards to which health facilities, goods and services as well as the underlying determinants of health must conform.[14] The implication of these elements for the realisation of MH or preventing MM are examined in this segment. The second part of the evaluation addresses the HR principles of the HRBA to health, guiding the design, organisation and programming of the various measures. To this end, the principles of non-discrimination and equality, participation and inclusion, accountability, international cooperation and assistance as well as the empowerment of right holders and/ or duty bearers are assessed for their significance in the RH framework for MM reduction. Despite featuring critiques where necessary, some of the discussions on the RH elements, as well as the HR principles, are descriptive to allow for an appreciation of the benefits of the framework. At the end, in another subsection, some critical comments which have been raised concerning the implementation of these RH/HRBA for MM prevention are highlighted. The

[13] The HRBA itself has been variously articulated. Sofia Gruskin and Dina Bogecho and Laura Ferguson, 'Rights-based Approaches to Health, Policies and Programmes: Articulations, Ambiguities and Assessment' (2010) 31(2) Journal of Public Health Policy 129 < doi:10.1057/jphp.2010.7 > accessed 30 December 2023.
[14] Technical Guidance (n 11) para 20.

role or significance of global health policies in the RH framework to MM reduction is explored as the third part of the evaluation.

## 4.2 Right to Health Standards of the HRBA to Maternal Mortality

As a human right, RH itself is an entitlement to be enjoyed by everyone, including women.[15]The variety of health facilities, services, goods and underlying determinants of health outlined in the instruments as necessary to protect the health of the populace [16] and those relevant for the health needs of women are useful to address the causes of MM. Amongst other functions, these freedoms underpin women's enjoyment of their sexual and reproductive rights.[17] As examples, entitlements and freedoms of RH such as an equitable health system, food, nutrition, and the right to make sexual and reproductive decisions free of coercion correspond to the interventions needed to prevent MM. Ensuring the entitlements and protecting the freedoms relevant to prevent MM evidently require actions that cut across all the three types of states' human rights obligations towards realising the right to health.

Studies providing factual evidence of the long-run contribution of the RH norms to the improvement of women's health are, however, scarce. Scholarly outputs mostly report on the adoption of measures that comply with the human rights-based approach to MM by states.[18] Scholars and experts have highlighted this gap,[19] but there does not appear to be great progress in that quarters.[20] According to Maya, the problem is due, in part, to the difficulty of determining what would qualify as evidence[21] since the understanding, and application of HRBAs vary

[15] Judith Asher, The Right to Health: A Resource Manual for NGOs (Brill 2010).
[16] For instance, some infectious and chronic non-communicable diseases to which everyone is susceptible are also indirect causes of MM. WHO, 'Maternal Health' in Health in 2015: From MDGs to SDGs (WHO, 2015 ) 82 <FINAL_15239_Master Layout for Web (who.int)> accessed 30 December 2023.
[17] GC22 (9) para 5.
[18] The HRBA to MM was developed on the basis of the causes as well as available evidence on effective interventions from relevant fields.
[19] Maya Unnithan, 'What Constitutes Evidence in Human Rights-Based Approaches to Health? Learning from Lived Experiences of Maternal and Sexual Reproductive Health' (2015)17 (2) Health and Human Rights Journal 45; Hunt and Yamin and Bustreo (n 6) 2.
[20] This observation was made in the course of the research for this thesis.
[21] Unnithan (n 19) 46.

according to institutions and individuals. Hunt and others also noted that such evaluation would involve interrogating at least three fields – public health, medicine and human rights. [22]

### 4.2.1 Obligations to Respect, Protect and Fulfil

The obligation to respect requires states parties to refrain from interfering directly or indirectly with the enjoyment of the right to health. In the context of the reproductive health of women, GC14 calls on states not to limit access to contraceptives and other means of maintaining sexual and reproductive health such as, sexual education.[23] GR24 emphasises that states should not criminalise medical procedures that only women need or punish them for engaging in these.[24] Where such laws exist, states are obligated to repeal them. Abortion is one of such procedures which when criminalised puts the lives of women in danger as they resort to unsafe abortions, one of the major medical causes of MM. As evidence of the usefulness of liberalising abortion rules, several individual country studies[25] and a multi-country study conducted in South Africa, Bangladesh, and Romania found that there was significant decrease in MM rates when abortion laws were liberalised. [26] Unhindered access to contraceptives has also been proved to be useful. As far back as 2012, a study of 172 states demonstrated that unhindered access to contraceptives contributed to saving as much as 272,040 women from maternal death.[27] However deep-seated religious and cultural attitudes to SRHRs constitute formidable influences that prevent governments in many countries from performing this obligation. [28]

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[22] Hunt and Yamin and Bustreo (n 6) 1.
[23] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 'The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant' 11 August 2000 E/C.12/2000/4 (GC14) para 34.
The social determinants of sexual and reproductive health have been found to be expressed mostly in laws and policies that limit choices. See UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 22 (2016) of the CESCR on the Right to Sexual and Reproductive health E/C.12/GC/22, paras 8, 40, 41.
[24] UN Committee on the Elimination of Discrimination Against Women (CEDAW) General Recommendation No. 24 of the Convention (Women and Health A/54/38/Rev.1, Chap.1 (GR 24) para 14.
[25] JT Henderson and others, 'Effects of Abortion Legalization in Nepal, 2001–2010' (2013) 8(5) PLoS One 1.
[26] J Benson and K Andersen and G Samandari, 'Reductions in Abortion-Related Mortality Following Policy Reform: Evidence from Romania, South Africa and Bangladesh' (2011) 8(39) Reproductive Health Matter 1,8; SM Latt and A Milner and A Kavanagh, 'Abortion Laws Reform May Reduce Maternal Mortality: An Ecological Study in 162 Countries (2019) 19 BMC Women's Health 1 <https://doi.org/10.1186/s12905-018-0705-y >accessed 30 December 2023.
[27] Saiffuddin Ahmed and others, 'Maternal Deaths Averted by Contraceptive Use: An Analysis of 172 Countries' (2012) 380(9837) The Lancet 111,118.
[28] Marianne Cense and Milleke de Neef and Wilco Vissche, *Culture, Religion and Reproductive Health and Rights* (Rutgers 2018) 2, 3.

The obligation to protect in the context of maternal health is satisfied by ensuring that third parties do not infringe on the right to health including equal access to healthcare, health-related services and information. It also applies to overseeing that the private sector complies with the standard of making maternal health goods and services available, accessible, acceptable and of good quality; that medical practice is regulated; that harmful traditional practices do not interfere with access to pre-and post-natal care and that women are protected from harmful traditional practices like female genital mutilation and child marriages which have been linked to MM. [29] It, therefore, includes investigating violations and providing remedies. With respect to private providers, this duty cannot be overemphasised for countries such as Nigeria and Uganda, where private healthcare providers of different cadres provide more than 50% of healthcare services. [30]

However, it has been observed that the duty to protect is often narrowly implemented in reality. That is, while it is applied to protect against violation, the positive application to bring about the realisation of the right remains unexplored. [31] These could involve, for instance, the empowerment of private healthcare providers to improve their services. Arguably, this narrow interpretation has been adopted by donor governments and organisations. This is because, despite the fact that various studies discuss the reliance of the populace in these countries on private providers, donors have focused on only the public sectors. This has implications for instance, for the capacity of the state to harness the potential of the private sector to prevent maternal mortality.[32] Measures required in respect of harmful cultural practices are often complex. This is because, amongst other things, the relationship between the perpetrators and the victims of harmful cultural practices often constitutes a challenge for developing effective protection mechanisms.[33] The issue of positive actions is also germane here as positive actions like social security measures

[29] GC 14 (n 23) para 35; GR 24 (n 24) para 15. UN Committee on the Elimination of Discrimination Against Women (CEDAW) CEDAW General Recommendation No. 19 on Violence Against Women 1992, para 20.
[30] Chimaroke O Izugbara and others, 'Maternal Health in Nigeria: A Situation Update' (2016) African Population and Health Research Centre 1, 4; Priya Agrawal and Oona Campbell and Ndola Prata, 'The Role of Private Providers in Maternal Health' (2014)2 (3) The Lancet Global Health e133.
[31] ibid Agrawal and Campbell and Prata.
[32] ibid.
[33] Yusuf Camilla and Fessha Yonatan, 'Female Genital Mutilation as a Human Rights Issue: Examining The Effectiveness of the Law Against Female Genital Mutilation in Tanzania' (2013) 13 (2) African Human Rights Law Journal 356, 378, 379.

to encourage victims to report violations by persons on whom they are financially dependent are usually lacking in many policies or laws that seek to protect against harmful cultural practices.

The obligation to fulfil[34] requires states parties to take 'appropriate legislative, judicial, administrative, budgetary, economic and other measures… to ensure that women realise their rights to healthcare'.[35] Actions concerning issues such as access of women and adolescents to reproductive health services, affordable or free maternal healthcare, appropriate prenatal, natal and postnatal care, acceptable and quality healthcare services are ostensibly useful for preventing maternal mortality. Nonetheless, there is no aspect of the right that emphasises more the problem of resources than the obligation to fulfil.[36] Various kind of resources ranging from financial, technical, information/data to human are needed but are often in short supply. Some resources, such as healthcare personnel constitute challenges globally. Equally, important to fulfilment is enactment of Health laws, as well a National Health Plan and Strategy which should detail how states plan to 'promote women's health throughout their life span'.[37] For instance, the enshrinement of the RH and specific recognition in the Constitution of Nepal was credited with the improvements in its maternal mortality rates. Notwithstanding that the country's MM ratio was still unacceptably high, the country's efforts leading to the decrease of its MM ratio in 13years from 539 to 229 was recognised with a MDG award.[38]

Collectively, the obligations to respect, protect and fulfil, encompass different actions for the realisation of MH, however, in addition to the limitations observed in their individual implementation, a general challenge is that for these obligations to be enforced on the platform of RH, the right must be legally protected in the country.[39] As of 2011, Heymann et al reported that

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[34] The Maastricht Guidelines further breaks the obligation to fulfil into the obligations of conduct and of result. Here, conduct is the action reasonably required to facilitate realisation of the right and result, is the achievement of specified goals. It specifically declares that the reduction of maternal mortality is an expected result. See International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 26 January 1997, para 7.

[35] GR24 (n 24) para 17.

[36] Abby Kendrick, 'Highest Attainable and Maximum Available: Measuring Compliance with the Obligation to Fulfil the Right to Health' (PhD Thesis University of Warwick, 2015).

[37] ibid para 29. GC14 (n 23) paras 36, 53-55.

[38] Flavia Bustreo and Paul Hunt, 'Evidence of Impact on Women and Children's Health' (WHO, 2013) 26,27.

[39] Zahara Nampewo and Jennifer Heaven Mike and Jonathan Wolff, 'Respecting, Protecting and Fulfilling the Human Right to Health' (2022) 21 (36) International Journal for Equity in Health < https://doi.org/10.1186/s12939-022-01634-3 > accessed 30 December 2023.

of the 191 UN member states, only 36% protected the broad right to health, while 13% expressed the aspiration to extend the right to all citizens.[40] In some cases, only a right to medical care which is not sufficient to realise the right to health was guaranteed. Although, in some countries, the**

### 4.2.2 AAAQ Elements

According to GC 14, the implementation of all forms and levels of the right should contain the AAAQ elements. Therefore, whatever 'appropriate means'[41] adopted to discharge the states' tripartite obligations should be channelled towards ensuring that healthcare and underlying determinants are available, accessible, acceptable and of good quality.[42] The relevance of the AAAQ in terms of MH can be summed up in this statement credited to the WHO:

> "…many pregnant women have no access to care because there are no services where they live; they cannot afford the services because they are too expensive or reaching them is too costly. Further, some women may decide not to use the services available to them because they do not like how care is provided or because the health services are not delivering high quality care."[43]

*Availability*

Where functional public health and health-care facilities, goods, services and adequately remunerated personnel, primary health care and EmOc in sufficient quantity are available within the state, it is presumed that more births will take place in health facilities and be attended to by trained health personnel.[44] The number of births attended by trained birth personnel is considered a significant determinant of maternal health. [45]Availability also relates to provision of health

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[40] Jody Heymann and others, 'Constitutional Rights to Health, Public health and Medical care: The status of health protections in 191 countries' (2013)8 (6) Global Public Health 639, 648 .
[41] International Covenant on Economic Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16 U.N. Doc. A 6316, 993 U.N.T.S. 3 (Jan. 3, 1976), art 2(1).
[42] Alicia Yamin, 'Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health' (2008) 10(2) Health and Human Rights Journal 1, 8.
[43] WHO, 'Maternal Mortality' cited in L S Johnson, 'The Right to Maternal Health Care: Developing International Human Rights Law to Prevent Maternal Mortality' (2010) 11 University of Botswana Law Journal 39.
[44] GC22 (n 9) para 28. For instance, it is reported that Ethiopia was able to accelerate progress towards meeting the MDG goal of reduction in MM rates by increasing the availability of low and middle level health personnel to man the primary healthcare centres.
The Partnership for Maternal Newborn and Child Health and others, *Success Factors for Women's and Children's Health* (Geneva 2014) **ISBN:** 9789241507479 25.
[45] Paul Hunt, Report of The Office of The United Nations High Commissioner for Human Rights (n 12) 25, 50.

information necessary to prevent ill health and infections before, during, and after childbirth,[46] essential drugs to prevent or cure health conditions predisposing women to MMM and other SRHR goods. This observation is especially important in relation to the argument that the possibility of the majority of obstetric complications cannot be detected but can be prepared for.[47] Availability is fundamental because access or the two other elements are meaningless if the facilities are non-existent.

However, the availability of the 'AAAQ' not only stipulates the provision of health facilities which is obviously capital intensive, but also expects them to be staffed with competitively remunerated personnel. The latter is clearly a myth for developing countries. In these countries not only is there a shortage of medical staff from the outset, as their few medical schools produce a limited number of doctors and nurses each year,[48] but it is further compounded by the 'brain drain'. The exodus of educated personnel in high numbers from developing countries to developed countries is very pronounced in the health sector. Brain drain is caused by factors such as the workers' desires for better remuneration, training, and work conditions which are the rights of workers. Some commonly proposed solutions to the brain drain, especially on the African continent, include training more medical personnel which may not necessarily be physicians but mid-level clinical officers and medical assistants. Indigenising the medical curriculum to reduce the western-based components and reflect more of the medical needs of the African communities, to make it more difficult for medical personnel trained in African countries to be assimilated in developed countries, has also been proposed.[49] Other recommendations include providing more opportunities for training and providing better remuneration.

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[46] Committee on the Rights of the Child (CRC), General Comment 15 (2013) on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Article 24), 7 April 2013, CRC/G/C/15 para 54.
[47] Alicia Ely Yamin and Deborah P Maine, 'Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations' (1999) 21 (3) Human Rights Quarterly 563, 569.
[48] It is predicted that instead of the 149,852 doctors and 471353 nurses that Nigeria requires by 2030, it will only be able to produce 99,120 doctors and 333494 nurses. Bolaji Aregbesola, 'Towards Health System Strengthening a Review of the Nigerian Health System From 1960 to 2019' (2021) e Journal of Public Health 19 <https://doi.org/10.2139/ssrn.3766017> accessed 30 December 2023.
[49] Adamson S Muula, 'Is There Any Solution to the Brain Drain of Health Professionals and Knowledge in Africa?' (2005) 46 (1) Croat Medical Journal 21 < untitled (mefst.hr)> accessed 30 December 2023.
Nir Eyal and Samia A Hurst, 'Physician Brain Drain: Can Nothing Be Done?' (2008) 1 (2) Public Health Ethics 180 < https://doi.org/10.1093/phe/phn026 > accessed 30 December 2023.

These solutions may be simplistic as difficulties line the path of implementing any of them. For instance, both Adamson and Olikoye have noted that the suggestion to train health personnel fit for the continent will encounter opposition on the grounds that the personnel trained according to an indigenous curriculum will be inferior to their counterparts in other parts of the world. [50] But Eyia and Hurst think this differentiation of skills should not be considered as inferiority but as a kind of specialty. A specialisation in locally relevant medicine. They argued in addition that, the notions of social justice, as well as the government's right to health obligations can support this proposal.[51] Afterall, the 'precise application' of the AAAQ elements is specifically subject to local conditions.[52] It is believed that maternal health stands to benefit from this recommendation as the complications that lead to MM are illnesses that health personnel whose training is tailored to local circumstances can handle. In fact, because developing countries experience the highest occurrences of MM in the world, the data on the causes of MM **is** said to basically describe the situation in these places.[53]

*Accessibility*

If states do not have to contend with non-availability, taking care of all four interrelated ways that affect access will go a long way to address some of the reasons for maternal deaths. Where 'accessible to all without discrimination' is assured, no population group, especially the disadvantaged or vulnerable, will be the source of high MM in the State as the distinct sexual and reproductive health needs of each group will be catered for.[54] This is because discriminatory laws, policies, practices that prevent women and adolescents[55] and ethnic minorities from accessing reproductive health care, goods and services including contraception can be challenged and done away with.[56] In developed countries like the United States of America, the fact that Blacks and

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[50] Adamson (n 31), O Ransome-Kuti, ' The Right Road to Health' [1987] 8 World Health Forum 161, 163 < WHF_1987_8(2)_p161-163.pdf (who.int)> accessed 30 December 2023.
[51] Nir Eyal and Samia A Hurst (n 49) 188.
[52] GC14 (n 23) para 12.
[53] Yamin and Maine (n 47) 568.
[54] General Comment 22 (n 9) paid considerable attention to this point. See para 24.
[55]Such girls also lose schooling opportunities due to discriminatory laws and policies that let off the male party and prescribe expulsion as punishment for pregnant schoolgirls. GR24 para 12(b).
[56] An Indian woman from an untouchable caste was denied maternal health care in Laxmi Mandal v Deen Dayal Harinagar Hospital and others, W.P (c) Nos. 8853 of 2008. Facts of case is produced infra.

other non-white races have three times the number of maternal deaths has been attributed to racial and ethnic discrimination. [57]

However, accessibility in respect of certain SRH freedoms or entitlements can be complicated. As an example, the criminalisation of abortion is usually referred to as discriminatory, but it has been observed that in countries such as India where abortion is available on request, discrimination manifests in the form of abortions being primarily sought to eliminate female foetuses.[58] According to Johnson and Das, while this may not be a reason to halt campaigns to grant women a right to abortion on request, it is an indication of some of the complexities activists have to grapple with while advocating for women's reproductive rights.[59]

Physical accessibility of health facilities such as clinics, health posts and centres is important to women in rural areas who succumb to maternal death due to the distance they have to travel before getting to a health centre, lack of convenient and affordable public transport,[60] or transportation costs for the woman and anyone who accompanies her.[61] Therefore siting health facilities in rural areas, providing transport facilities or even maternity waiting houses, as has been done in certain areas,[62] have alleviated these challenges.

Economic accessibility by way of making health services and goods affordable or free, where possible, ensures women's access to healthcare in more than one way. First, non-existent or highly affordable user fees make healthcare attractive to poor women and their families; second, it also means that women who require authorisation from their husbands may avoid delay, as they

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[57] J Phillip Gringrey, 'Maternal Mortality: A US Public Health Crisis' (2020) American Journal of Public Health https://ajph.aphapublications.org/doi/10.2105/AJPH.2019.305552 Accessed 30 December 2023. June 2020

[58] Candace Johnson and Surma Das, 'The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment' in G Andreopoulos and Zehra S Kabasakal (eds) *The Uses and Misuses of Human Rights* (Palmgrave Macmillan 2014) 135.

[59] ibid

[60] GR24 (n 24) para 21.

[61] Veronique Plouffe and others, 'User Fees Policy and Women's Empowerment: A Systematic Scoping Review' (2020) 20 (982) BMC Health Services Research 1, 8 <https://doi.org/10.1186/s12913-020-05835-w> accessed 30 December 2023.

[62] Ahmet Metin Gulmezoglu and others 'Interventions to reduce Maternal and Child Morbidity and Mortality' in Black R. E and others (eds) *Reproductive Maternal, Newborn and Child Health: Disease Control Priorities* (3rd edn, Vol 2, IRBD /World Bank 2016) <http://www.dcp-3.org/sites/default/files/chapters/V2C7Gulmezoglu_01.13.15.pdf > accessed 30 December 2023.

can access this life-saving healthcare without their spouse or his family's permission.[63] Thus the introduction or increase of user fees is usually viewed as a barrier to achieving universal health coverage. The positive effect of the removal of user fees as a factor encouraging women's utilisation of healthcare services has been reported in many developing countries including Nepal,[64] Malawi,[65] Zambia,[66] Burkina Faso,[67] and Kenya, Ghana and Senegal.[68]

It is not difficult to envisage the financial implication of this guarantee on the part of the state where resources are scarce as user fees can be a means of funding health services and infrastructure.[69] However, the state's obligation to seek financial assistance is expected to be discharged here if this measure is considered necessary. The assistance may also be in respect of essential medicines which global intellectual property laws, sometimes based on human rights, have made unaffordable.[70] Nevertheless, eliminating user fees may not always be necessary since it has also been observed in states like Egypt that payment of user fees can increase the people's confidence in the quality of the services. [71] Additionally, a note of caution has been sounded on the need to prevent the unintended effects of removal of fees such as low quality of services and low morale of healthcare service suppliers.[72]

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[63] Idowu Adenike Esther, The Socio-Cultural Context of Maternal health in Lagos State Nigeria, (PhD Thesis, Covenant University 2013).
[64] Prabhat Lamichhane and Aurag Sharma and Ajay Mahal, 'Impact Evaluation Of Free Delivery Care On Maternal Health Service Utilisation And Neo Natal Health In Nepal' (2017) 32 (10) Health Policy and Planning 1427.
[65]Gerald Manthalu, 'User Fee Exemption and Maternal Healthcare Utilisation at Mission Health Facilities in Malawi: An Application of Disequilibrium Theory of Demand and Supply (2019)28(4) Health Economics 461-474.
[66] Yohan Renard, 'From Fees to Free: User Fees Removal Maternal Healthcare Utilisation and Child Health in Zambia [2022] World Development < https://doi.org/10.1016/j.worlddev.2022.105891 >accessed 30 December 2023.
[67] Patrick Gueswende IIbuodo and Alain Siri, 'Effects of the Free Healthcare on Maternal and Child Health in Burkina Faso: A Nationwide Evaluation Using an Interrupted TIme series Analysis (2023)13(1) Health Economic Review < https://doi.org/10.1186/s13561-023-00443-w > accessed 30 December 2023.
[68] McKinnon B and others, 'Removing User Fees for Facility Based Delivery Services: A Difference in Differences Evaluation from Ten Sub-Saharan Countries' (2014) 30(4) Health Policy and Planning, 432, 437.
[69] Mushi D.P, 'Impact of Cost Sharing on Utilisation of Primary Healthcare Services: Providers vs Household Perspectives (2014)23(3) Malawi Medical Journal 83, 87.
[70] Sharifa Sekalala,' Decolonising Human Rights: How Intellectual Property Laws Result in Unequal Access To The COVID-19 Vaccine' (2021) 6 (7) BMJ Global Health <http://dx.doi.org/10.1136/bmjgh-2021-006169 > accessed 30 December 2023.
[71] Amira El Shal and Patricia Cubi-Molla and Mireia Jofrey-Bonet, 'Are User Fees in Healthcare Always Evil?: Evidence From Family Planning Maternal and Child Health Services' [2021] Economics Analysis and Policy <https://www.sciencedirect.com/science/article/pii/S0313592621001144> accessed 30 December 2023.
[72] Laurel E. Hatt and others, 'Effects of User fee Exemptions on the Provision and Use of Maternal Health Services: A Review of Literature' (2013)31(4) Journal of Health Population and Nutrition S67, S68.

Accessibility of information relating to health issues, including issues of sexual and reproductive health, is relevant because that may make the difference between life and death for many women. [73] It is also especially relevant for adolescent girls in light of the discussions in Chapter 2 wherein the constraints on their right to SRH was highlighted. As discussed in Chapter 3, delay in deciding to seek care may be due to ignorance. Certain ill health conditions such as anaemia and sepsis may be prevented when women have adequate information. In the same vein, information on how to prevent and space pregnancies can prevent unnecessary deaths from unsafe abortion. However, the level of success attained may be dependent on the realisation of the right to education. It was suggested by a WHO working group that higher educated women are likely to have a higher capacity to engage with and utilise health information necessary to prevent MM.[74] Thus, in the Brazilian Northeast, where PHCs used health education as a strategy to reduce MM, the women's level of education was an important determinant of how the health education and awareness programmes were designed.[75]

*Acceptability*

Acceptability guarantees that health facilities, goods and services will be culturally appropriate, be sensitive to life cycle needs and be respectful of medical ethics. Where women would only be comfortable using health goods and facilities on certain conditions, this RH element stipulates they should be obliged except where it is practically impossible. [76] Some women, especially those from indigenous or minority groups, do not access the available health goods and services because it is not acceptable to them due to cultural or other reasons. [77] In recent times, such reasons have included disrespectful treatment. According to Erdman, this was not initially the focus of maternal health advocates, [78] but due to necessity, even the WHO has declared that women's right to health

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[73] GR24 (n24) para 23.

[74] Saffron Kalsen and others, 'The Relationship Between Maternal Mortality and Education Among Women Giving Birth in Healthcare Institutions: Analysis of the Cross Sectional WHO Global Survey on Maternal and Perinatal Health'(2011) 11 (606) BMC Public Health< http://www.biomedcentral.com/1471-2458/11/606 > accessed 30 December 2023.

[75] Katia M S Figueiredo and others, 'Actions of Primary Healthcare Professionals to Reduce Maternal Mortality in the Brazilian Northeast' (2018) 17(104) International Journal for Equity in Health 1, 4 <https://doi.org/10.1186/s12939-018-0817-x > accessed 30 December 2023.

[76] GR24 explains that acceptable healthcare services must be sensitive of the woman's needs and perspectives. GR24 (n24) para 22.

[77] Paul Hunt (n 12) para 20.

[78] Joanna Erdman, 'Bioethics, Human Rights and Childbirth' (2015)17(1) Health and Human Rights Journal.

includes the right to 'dignified, respectful health care throughout pregnancy and childbirth'.[79] According to Bohren and others, it means care that is harm and mistreatment free, and also ensures amongst other things, dignity, privacy, confidentiality, continuous choice and support during labour and childbirth.[80]

It has been observed that no study has reported conclusively on the effect of respectful care on maternal health outcomes.[81] The variously documented incidents of health facility abuse, including court cases [82] and studies on the negative effect such abuse has on women's perception of institutional delivery, evidences the importance of addressing this problem.[83] However, owing to cultural and social differences, defining and identifying the occurrence of the abuse may be difficult, therefore leading to calls of more local-based research as some cultural practices which are unusual but harmless may be mistaken by non-natives for disrespectful abuse.[84] This disconnect has fuelled the problematic finding that some providers believe respectful maternal care may correlate to more complications in childbirth. According to Yalew and others, providers claim that in emergencies, it may be difficult for the provider to do all that is medically necessary and respect all the woman's rights at the same time.[85] It is submitted that this argument may be untenable because respectful care does not necessarily equate to respecting all the rights of the woman.

The application of the medical ethics principles of informed consent, confidentiality and non-maleficence enhances acceptability and secures the confidence of women and may encourage

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[79] World Health Organisation, *The Prevention and Elimination of Disrespect and Abuse During Facility-Based Childbirth* (Geneva, World Health Organisation 2014) WHO/RHR/14.23.
[80] Meghan A Bohren and Ozge Tuncarp and Suelles Miller, 'Transforming Intrapartum Care: Respectful Maternity Care '(2020) 67 Best Practice and Research Clinical Obstetrics and Gynaecology 113.
[81] Christine H. Morton and Penny Simkin PT, 'Can Respectful Maternal Care Save and Improve Lives? (2019) 46(3) Births 387.
[82] *Joseph Majani v Att Gen of Kenya & Ors*. Petition No. 5 of 2014 of the High Court of Kenya sitting at Bungoma.
[83] Bradley S and McCourt C and Rayment JPD, 'Disrespectful Intrapartum Care During Facility Based Delivery in Sub-saharan Africa: A Qualitative Systematic Review and Thematic Synthesis of Women's Perception and Experiences' [2016] Social Science & Medicine 157 < https://doi.org/10.1016/j.socscimed.2016.09.039 > accessed 30 December 2023.
[84] Anteneh Asefah, 'Unveiling Respectful Maternal Health As a Way to Address Global Inequities in Maternal Health' (2020)6(1) BMJ Global Health < http://dx.doi.org/10.1136/bmjgh-2020-003559 > accessed 30 December 2023.
[85] Melaku Yalew and others, 'Respectful Delivery Care and Associated Factors Among Mothers Delivered in Public healthcare Facilities of Dessie City, North East Ethiopia: A Cross sectional Study' [2022] BMC Women's Health < https://doi.org/10.1186/s12905-022-01713-1 >accessed 30 December 2023.

them to seek sexual and reproductive health care.[86] For adolescents too, 'acceptable' means provision of SRH services protective of their confidentiality.[87] Despite the barriers to ensuring this for adolescents,[88] assurance of confidentiality has been found to contribute to increasing adolescent's usage of SRH services.[89] However, the barriers to acceptable healthcare may not be easily surmountable. A study found that an intercultural birthing house, provided as a skilled birthing environment for women and their native midwives in the highlands of Chiapas, Mexico, was not used for three months after the establishment, because the women had a strong preference for home births.[90] Another significant example is the use of caesarean sections (CS). There are complaints that CS is underutilised in some places thereby leading to maternal and perinatal mortality,[91] but this could be due to its lack of popularity with the women, as is the situation in many developing countries.[92]

*Quality*

The quality of health facilities, goods and services is necessary to guarantee good outcomes from maternal health care. Adequately skilled and conscientious health personnel, who will turn out healthy mothers and babies, reduce maternal deaths. In the same vein, such good results will

[86] GR 24 para. 12(d). Cook also stated the human rights responsibilities of medical professional associations include ensuring that their members conform to ethical codes of conduct that also respect women's human rights such as autonomy and informed consent. Rebecca Cook, *Women's Health and Human Rights*, (WHO 1994) 48.
[87] GC15 (n 45) para 52.
[88] Barriers include lack of private time, parental resistance, lack of awareness of rights by adolescents, timing of hospital operating hours and so on. Varduhi Hayrumyan and others, 'Barriers to Utilisation of Adolescent Friendly Primary Healthcare Facilities in Armenia: A Qualitative Study' [2020] International Journal of Public Health 1247, 1251.
[89] Gifty Apiung Aninanya and others, 'Effect of an Adolescent Sexual and Reproductive Health Intervention on Health Service Usage by Young People in Ghana: A Community Randomised Trial' (2015) PLOS ONE < https://doi.org/10.1371/journal.pone.0125267 > accessed 30 December 2023.
[90] Kathryn Tucker, 'The Acceptability and Feasibility of an Intercultural Birth Centre in the Highlands of Chiapas Mexico'(2013)13(94) BMC Pregnancy and ChildBirth< http://www.biomedcentral.com/1471-2393/13/94 > accessed 30 December 2023.
[91] According to Boatin and others, not only was inequality in the utilisation of CS low in most African countries, the use of CS itself was also low. Adeline Adwoa Boatin and others, 'Within Countries Inequalities in Caesarean section rates: An Observational Study of 72 Low and Middle Income Countries' (2018) The BMJ < Within country inequalities in caesarean section rates: observational study of 72 low and middle income countries | The BMJ> accessed 30 December 2023.
[92] Richard Adongo Afaya and others, 'Knowledge of Pregnant Women on Caesarean section and their Preferred Mode of Delivery in Northern Ghana' (2018) 2(1) Numid Horizon 62, 70 < Knowledge_20of_20Pregnant_20Women-libre.pdf (d1wqtxts1xzle7.cloudfront.net)> accessed 30 December 2023. Qudsia Qazi and others, 'Pregnant Women View Regarding Caesarean Surgery in Northwest Pakistan' (2013)1Tropical Medicine and Surgery105< Pregnant Women View Regarding Cesarean Section in Northwest Pakistan (walshmedicalmedia.com)> accessed 30 December 2023.

lead to an increase in women seeking medical care. The quality of health facilities in terms of sanitary environments attracts greater patronage of health facilities and also ensures good health outcomes for the women who visit.[93] However, it has been observed that evaluating the quality of healthcare provided is quite difficult because the number of deaths alone is not an indicator.[94] Additionally, it was noted that improving quality in order to increase women's use of facilities may not always yield the desired patronage. This is because it has been found that, often women's perception of the quality is the decisive factor, not the actual level of quality provided.[95]

### 4.2.3 Core Obligations and the Doctrine of Progressive Realisation

The doctrine of progressive realisation, while allowing states time for full realisation, is inapplicable towards core obligations [96] and obligations of immediate effect, both of which are beneficial to maternal health. [97] For instance, the obligation of non-discrimination is both an immediate and core obligation.[98] This works to enhance the protection of maternal health by assuring equitable distribution and non-discrimination in access to all health facilities, goods and services for women and adolescent girls as well as eliminate adverse social and cultural conditions affecting their health. Other obligations which are of immediate effect, and which resonate with maternal health include provision of primary healthcare and the enactment of health-related

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[93] Paul Hunt and Judith Bueno De Mesquita, 'Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health' (Human Rights Centre University of Essex, and United Nations Population Fund 2006 ) <https://www.unfpa.org/sites/default/files/pub-pdf/reducing_mm.pdf > accessed 30 December 2023. .
[94] Yamin and Maine (n 47) 563, 581, 586 607.
[95] Beatrice Ope, 'Reducing Maternal Mortality in Nigeria: Addressing Maternal Health Services Perception and Experience' [2020] Journal of Global Health Reports 1.
[96] UN Commission on Human Rights, Note Verbal Dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles") 8 January 1987, E/CN/4/1987/17 Limburg Principles) para 25. In the case of SRHR core obligations, states parties are to be guided by current international guidelines and protocols laid down by agencies such as WHO and UNFPA. GC 22 (n 9) para 49.
[97] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.3 'The Nature of States Parties Obligations' (Article 2, para 1) of the Covenant, 14 December 1990 E/1991/23 (GC3) para 2.
[98] ibid para 1.

legislation,[99] the drawing up of a national Health strategy and Plan of Action and paying particular attention to ensure the vulnerable and marginalised are not discriminated against.[100]

The comprehensive national health plan for the country's health system is required to include appropriate indicators and benchmarks disaggregated on grounds that would reflect whether the country's health measures were reaching disadvantaged groups.[101] Disaggregated data has been of immense value in developed countries where the MM ratios though low, affect specific groups.[102] Katzive argues that outcomes, for example, ratio of MM, are inadequate as a means to determine the state's compliance and so states must be assessed with respect to their efforts towards the above.[103] They must also be assessed in respect of the percentage of resources being expended. Nonetheless, the measurement of progressive realisation remains unsettled. As Smith asks, weighing in on the argument, at what time can a state be considered economically capable, and what about countries that are corrupt or squander their economic resources? [104] Durojaye cites the case of Nigeria, noting that there is no reason why the 8th largest oil producer in the world should have a poorly funded health system.[105]

There is also the problem of how the principles should apply to individual measures or health needs, such as the availability of blood needed for blood transfusion in MH care. In February 2020, a court in Lagos State, Nigeria, gave a judgment prohibiting government hospitals in that state from requesting compulsory blood donations from family members of women who register

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[99] Both the CEDAW (in Article 2) and the CRC (in Article 4) mandate that states parties enact legislations to give effect to the rights guaranteed by their respective treaties. The CEDAW Committee also directs states parties to report on their health legislation and plans and policies for women. They must also show that the said legislations and policies are based on scientific research and have taken into account the needs of women in that country. GR24 (n 18) para 9.

[100] GC14 (n 23) para 43 (f).

[101] Paul Hunt and Gullima Backman, 'Health Systems and the Right to the Highest Attainable Standard of Health' (2008) 10(1) Health and Human Rights Journal < [Health systems and the right to the highest attainable standard of health – Health and Human Rights Journal (hhrjournal.org)]> accessed 30 December 2023.

[102] Paul Hunt (n 12) para 7.

[103] Laura Katzive, 'Maternal Mortality and Human Rights' [2010] *Proceedings of the Annual Meeting (American Society of International Law)* 383, 384. <https://doi.org/10.5305/procannmeetasil.104.0383.> accessed 30 December 2023.

[104] George P. II Smith, 'Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection' (2005) 38 Vanderbilt Journal of Transnational Law 1295, 25

[105] Ebenezer Durojaye, 'Substantive Equality and Maternal Mortality in Nigeria' (2012) 44(65) Journal of Unofficial Law and Pluralism 103, 123-124.

to use the birthing facilities of the hospitals. [106] While the Lagos state government was willing to abide by the judgment, they warned of consequences of non-availability of blood in the event of childbearing complications. This action on the part of the state which is the duty bearer elicits questions about how progressive realisation should be interpreted in the circumstance.[107]

### 4.2.4 International Assistance and Cooperation

In order to meet their core and other obligations in relation to RH, international assistance and cooperation between states is imperative. [108] The realisation of reproductive rights including maternal health stands to benefit from this stipulation. On the basis of this obligation, developed states are expected to provide technical and financial aid towards the full realisation of the right in developing countries.[109] In the case of RH, this translates to technical and economic assistance to support health systems and stimulate the development of relevant policies. states also have to respect the enjoyment of the right in other countries and prevent third parties from violating it.

As observed in the Alma Ata Declaration, the great difference in the health status of populations in developed and developing countries and even within countries is a matter of concern to all countries.[110] Maternal mortality having been identified to be one of the health problems evidencing such disparity, [111] should elicit support from developed states to developing states in their efforts to reduce the incidence.[112] Under this obligation, states must refrain from actively recruiting medical personnel from developing countries which need more medical personnel to prevent MM. The emphasis on this obligation concerning ethical recruitment practices[113] of health personnel has evidently not yielded results.

[106] *SERAP v Att Gen Lagos State &ors* (High Court of Lagos State unreported).
[107] The duty to make the blood available did not form part of the issues laid out for determination before the court.
[108] GC14 (n23) para 38.
[109] GC3 (n 96) para13.
[110] WHO, Declaration from the International Conference on Primary Healthcare Alma Ata September 1978 Art II.
[111] Cook and Dickens and Fathalla (n1)10.
[112] GC15 (n 45) paras 86 and 87.
[113] WHO, Global Code of Practice on International Recruitment of Health personnel (2010) <A63_R16-en.pdf> accessed 30 December 2023.

Nevertheless, the obligation placed on developed states to assist developing states to meet their RH goals has, to some extent, been useful for the reduction of MM. As an example, Cambodia's success in achieving its MDG goals of infant mortality and MM reduction has been attributed, in part, to the assistance of the Korea Foundation for International Healthcare, which implemented a 5-year comprehensive MCH program in some parts of the country aimed at improving availability, accessibility and quality of maternal, neonatal, and child health care services. [114] In Africa, countries such as Eritrea and Malawi also achieved considerable reductions in their MM ratios with the assistance of UN agencies and international development agencies like UNFPA and USAID. They financed the recruitment of skilled birth attendants, the promotion of contraceptive use in rural areas, and the provision of health facilities.[115]

Despite such successes, from 2013, health financing assistance from international donors to African countries has reduced.[116] Ooms stresses the unreliable and unpredictable nature of aid.[117] Furthermore, international assistance has come to be wrongly or rightly associated with 'undue influence' or 'neo-colonialism' and therefore viewed with suspicion in many countries. It is believed, among other factors, to be responsible for the fact that developing countries often adopt international human rights rules hook, line, and sinker even when these are not compatible with their economic, social, and cultural environments, and when the issues may be better resolved by adapting the recommended measures to the local situations.[118]

[114] Lee HY and Heo J and Koh H. 'Effect of a Comprehensive Program on Maternal and Child Healthcare Service in Battambang, Cambodia: A Multivariate Difference in Difference Analysis' (2019) 1(1) Journal of Global Health Science < https://doi.org/10.35500/jghs.2019.1.e2 > accessed 30 December 2023.
[115] Enifome Eto, 'Government Policies and Initiatives on Maternal Mortality Reduction in Nigeria' (PhD Thesis, South Dakota State University 2016) 17-18, 22-23.
[116] African Union, Roadmap on Shared Responsibility and Global Solidarity on AIDS, TB and Malaria (2012) 6.
[117] G Ooms and others, 'Global Social Contract to Reduce Maternal Mortality: The Human Rights Argument and the Case of Uganda' (2013)21(42) Reproductive Health Matters 134.
[118] For instance, the recently enacted federal law criminalising female genital mutilation in Nigeria may not be the best response to the problem. Timothy F Yerima, 'Combating the Menace of Female Genital Mutilation Within the Context of Criminal Law in Nigeria' (2016) 19 Nigerian Law Journal 307.

### 4.3 General Human Rights Principles in the HRBA to Maternal Mortality

As a result of repeated calls by advocates, reproductive health non -governmental organisations and other stakeholders,[119] in 2009, the United Nations Human Rights Council (HRC) passed the resolution recognising preventable MM as a human rights problem.[120] It declared therefore that a human rights analysis of preventable MM and the integration of human rights into international and national efforts would contribute to its elimination. Additionally, the international development bodies which had hitherto treated the issue of maternal deaths as a population issue keyed into the human rights paradigm to promote a human rights-based approach to maternal mortality.[121]

This led to developing strategies and tools to convert the MH and SRHR ideals framed at the ICPD and Beijing Conferences to actions and achievable goals. Being human rights oriented, the tools developed did not address MM by focusing on health systems only but included root causes like inequality and violations of other SRHR of women. This approach earned criticisms, especially in respect of actualising MDG5b, for 'depoliticising' or 'instrumentalising' SRH rights, from those who viewed it as watering down government responsibility in respect of those rights.[122] However, since operationalising the approach, success with applying those strategies and tools in areas like budget monitoring, access to family planning, respect for patients' rights in order to actualise MH and SRH have been reported.[123] As with the legal standards discussed above, a

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[119] Such as the delegates at the 20th Anniversary of Safe Motherhood Initiative. Wise J, 'Maternal Mortality is a Human Rights Issue, Delegates Insist' (2007) 335(7625) BMJ 845.
[120] UN Human Rights Council 'Preventable Maternal Mortality and Morbidity and Human Rights' Resolution adopted by the Human Rights Council on 17 June [2009] A/HRC/RES/11/8.
[121] The maternal health goals in the MDGs and SDGs exemplifies such collaboration.
[122] Alicia Ely Yamin and Kathryn L Falb, 'Counting What We Know, Knowing What to Count, Sexual and Reproductive Rights, Maternal Health and The Millennium Development Goals' (2012) 30 (3) Nordic Journal of Human Rights 350.
[123] Budget monitoring was used as a tool to hold governments accountable for maternal mortality reduction commitments. IIMMHR 'International Budget Partnership and the International Initiative on Maternal Mortality and Human Rights (2009) The missing link The-Missing-Link-Applied-Budget-Work-as-a-Tool-to-Hold-Governments-Accountable-for-Maternal-Mortality-Reduction-Commitments.pdf (internationalbudget.org) referenced in Alicia Ely Yamin, 'From Ideals to Tools: Applying Human rights to Maternal Health' (2013) 10(11) PLoS Med
Violations of patients' human rights were also detected. Human Rights Watch 'A High Price to Pay: Detention of Poor Patients in Burundian hospitals' (HRW, 2006) A1808, cited also in Yamin (ibid).
In Nepal, the inclusive approach to healthcare provision helped detect that mainly high caste Brahmin, Chetti women were using the services. Nepal Safe Motherhood Project and Institute of Medicine Nepal, *Will a Social Justice Approach to Safe Motherhood Also Meet the Public Health Objective of Maximizing Lives Saved?'* (2004)

discussion of the accompanying guiding principles of the HRBA, in the context of MM is set out below.

### 4.3.1 Empowering Rights Holders and Strengthening Duty Bearers

The empowerment of right holders and not just the prevention of deaths or morbidities' is the primary purpose of the HRBA.[124] Therefore, individuals, families, communities, and all involved must be empowered to claim their sexual and reproductive rights and other rights important to secure maternal health. It could mean empowering them to challenge governments, healthcare providers or other duty-bearers and to seek redress from designated redress mechanisms when their rights are infringed upon.[125] Therefore, measures such as access to information, education and other capacity-building measures are an essential part of the HRBA to MM. Empowerment of women notably leads to greater demand for reproductive health services.[126]

In the same vein, duty bearers which include governments chiefly, hospital boards and state and non-state healthcare providers, must be strengthened to meet their obligations to respect, protect and fulfil the human rights of women which impact their reproductive and maternal health. Duty bearers must be empowered to meet their obligations as they are stipulated by international human rights instruments and their domestic legislations. This may involve staff trainings, provision of infrastructure and other resources incidental to fulfilling their obligations.[127] Additionally, as the primary duty bearer, the State however must apply due diligence to ensure that all organs of the state including lawmakers, policymakers, government hospital managers and health professionals working in government facilities and non- state duty bearers such as private healthcare professionals, all act in conformity with the guaranteed rights. A study involving Tanzanian maternal healthcare workers reported that limited resources, lack of supervision and

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The Pan American Health Organisation has also expressed interest in adopting the HRBA to maternal mortality prevention. PAHO 'Human Rights Approach Eyed as a Way to Cut Maternal Deaths' (PAHO, 8 December 2017).

[124] Technical Guidance (n 11) para 12.

[125] SIDA, *Human Rights Based Approach at SIDA: Compilation of Thematic Area Briefs* (2015) < C202351_Sida_framsidor.indd> accessed 30 December 2023.

[126] This was one of the findings of a meta-analysis spanning 31 countries. Hannah FG Taukobong, 'Does Addressing Gender Inequalities and Empowering Women and Girls Improve Health and Development Programme Outcomes?' (2016)31 (10) Health Policy and Planning 1492, 1496.

[127] Hunt and De Mesquita (n 93)13.

lack of motivation amongst other factors, were formidable barriers that impacted on their ability to provide quality services.[128]

#### 4.3.2 Equality and Non-Discrimination

The principles of equality and non-discrimination are often jointly applied and they address inequitable distribution of health care facilities and non- prioritisation of women's health care needs which are fuelling the indirect causes of maternal mortality.[129] They particularly address the predicament of multiple discrimination which predisposes certain categories of women to MM.[130] These principles also facilitate measures that favour hitherto underserved groups, thus creating the opportunity to place vulnerable, marginalised and disadvantaged women groups at the centre of MH programmes in order to achieve substantive equality.[131]

It is also noted that in the context of maternal mortality policies, applying these principles will promote the likelihood of policies being sustainable, well-grounded and effective.[132] This is because the application of these principles will not only reveal the categories of women who are not using the healthcare services, but would also uncover the factors responsible for their non-use.[133] Measures to ensure equality and non-discrimination should however be carefully selected to prevent unintended implications. As an example, conditional cash transfers are used in some countries to encourage women's attendance at health facilities for reproductive and maternal healthcare. It was reported that its use in India to encourage attendance of antenatal and facility

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[128] Thomas Wiswa John and others, 'An Account for Barriers and Strategies in Fulfilling Women's Right to Quality Maternal Healthcare: A Qualitative Study from Rural Tanzania' (2018)18 (352) BMC Pregnancy and Childbirth < https://doi.org/10.1186/s12884-018-1990-z > accessed 30 December 2023.

[129] Hunt (n 12) para 28(b).

[130] Bell and others found that women who have never attended any school, women in rural areas, poorest women, women in the 15-19 age group were more susceptible to unsafe abortions. See Suzanne O Bell and others, 'Inequity in the Incidence and Safety of Abortion in Nigeria' (2020) 5 (1:e001814) BMJ Global Health DOI: < https://doi.org/10.1136/bmjgh-2019-001814> accessed 30 December 2023.

[131] It is argued that substantive equality where the specific differences are taken into account in decision making processes and not formal equality that treats all persons irrespective of their differences alike is important for preventing MM. Substantive equality aims for equality of outcomes which may only come about if special interest is paid to the vulnerable groups. Durojaye (n 105).

[132] Paul Hunt (n1) para 29; Hunt and De Mesquita, (n 93) 11.

[133] Kirsten Hawkins and others, 'Developing a human rights based approach to Addressing Maternal Mortality'( DFID Health Resource Centre 2005) <[ARCHIVED CONTENT] (nationalarchives.gov.uk) > accessed 30 December 2023.

births led to an unintended rise in pregnancy rates in a county that has an existing population problem.[134]

### 4.3.3 Participation and Inclusion

Participation tackles the exclusion and disempowerment of women, their families, communities and other non-state actors in health decisions and in the development and implementation of health policies, programs and plans to reduce MM. Public health policies have always been more effective and meaningful when the target population is involved[135] and participation has been an integral part of the RH since Alma Ata.[136] Activism and advocacy are important aspects of the HRBA that are necessary for participation.[137] Therefore the process often involves, and may be preceded by, capacity building of the individuals and groups involved in a bid to facilitate effective engagement and thereby fulfil purpose.[138]

Effective participation is dependent on the guarantee of rights to expression, information, assembly and association.[139] It has however been noted that determining which individuals, or type of organisations to be involved or their level of involvement in challenging existing structures that deny women their sexual and reproductive rights, can be dilemmatic[140] because there is a risk of excluding the very individuals and groups that can bring about the power shift.[141] In Utter Pradesh, the power shift that led to a vast improvement in the dismal maternal mortality figures included the formation of a women capacity-building non-governmental organisation, MSAM, which was

[134] Arindam Nandi and Ramanan Laxminarayan, 'The Unintended Effects of Cash Transfers on Fertility: Evidence from the Safe Motherhood Scheme in India' [2016] Journal of Population Economics 457.
[135] D Tarantola and S Gruskin, 'Human Rights Approach to Public Health Policy' in Chris Heggenhougen and Stella Qua (eds*) International Encyclopaedia of Public Health* (Vol.3, Academic Press 2008) 477
[136] WHO Declaration of Alma-Ata (n 95) paras. III, VII (5).
[137] Morten Broberg and Hans Otto Sano, 'Strengths and Weaknesses In A Human Rights-Based Approach To International Development – An Analysis of a Rights-Based Approach to Development Assistance Based on Practical Experiences' (2017) 22(5) 664, 668< https://doi.org/10.1080/13642987.2017.1408591 > accessed 30 December 2023. ; Sam Forster Halabi, 'Participation and the Right to Health: Lessons from Indonesia' (2009) 11(1) Health and Human Rights Journal
[138] Alicia Ely Yamin and Rebecca Cantor, 'Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights Based Approach to Health (2014)6 (3) Journal of Human Rights Practice 451, 469 < https://doi.org/10.1093/jhuman/huu019 > accessed 30 December 2023.
[139] Helen Potts, *Participation and the Right to the Highest Attainable standard of Health* ( Centre for Human Rights University of Essex 2006) ISBN 978-1-874635-40-6 2<untitled (essex.ac.uk). >accessed 30 December 2023.
[140] Yamin and Cantor (n 138) 468.
[141] ibid

able to influence maternal health service delivery amongst other interventions.[142] In their multi-paper analysis, Smith et al, observed that most studies reported the usefulness of participatory processes, but rarely reported on sustainability and society specific situations that could hinder participation.[143] This was not the case with the report on the earlier cited Utter Pradesh project as it disclosed that sustainability was difficult. Lack of funding to continue the capacity training was the challenge.[144] The significance of funding to enhance participation was also confirmed by Mulumba et al, who noted that the training of the health committees that were used to facilitate community participation was resource dependent.[145]

### 4.3.4 Monitoring and Accountability

Monitoring and accountability are integral features of the right to health which are very valuable in the quest to reduce MM rates. Together, they occupy a central position in ensuring the respect, protection and fulfilment of RH standards to achieve MM reduction.[146] Monitoring is useful to assess the scale of maternal mortality, the causes and how they are addressed within the health system. [147] However, this is often hampered by the paucity of data on MM and on causes of death in many countries. For instance, it was reported that less than two-fifths of African countries have comprehensive civil registration and vital statistics structures.[148] Yet being able to monitor progress is crucial for improving MM reduction efforts and preventing future deaths. The importance of monitoring to MM reduction is underscored by the CEDAW committee's request to states parties to include in their reports information on how measures implemented have reduced MM in their countries as a whole and among particular or vulnerable groups specifically.[149]

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[142] Abhijit Das and Jashodhara Dasgupta, 'Claiming Entitlements: The Story of Women Leaders Struggle for the Right to Health in Utter Pradesh, India (CPASAH Secretariat and Communication Hub 2015)< claiming_entitlements_-_case_study.pdf (copasah.net) > accessed 30 December 2023.
[143] H J Smith and AG Portela and C Marston, 'Improving Implementation of Health Promotion Interventions for Maternal and Newborn Health' (2017) 17(280) BMC Pregnancy and Childbirth) 1,4 < https://doi.org/10.1186/s12884-017-1450-1 > accessed 30 December 2023.
[144] Abhijit Das and Jashodhara Dasgupta (n 142) 30.
[145] Moses Mulumba and others, 'Using Health Committees to Promote Community Participation as a Social Determinant of the Right to Health' (2018) 20(2) Health & Human Rights 11.
[146] Alicia Ely Yamin, 'Toward Transformative Accountability: Applying Rights-Based Approach to Fulfil Maternal Health Obligations' (2010) 7 (12) SUR - International Journal on Human Rights 95, 96.
[147] ibid. Hunt and De Mesquita (n 93)12.
[148] African Union, Africa Health Strategy 2016-2030 (2015)14 <AHS cover2 (au.int)> accessed 30 December 2023.
[149] GR24 (n 24) para 26.

Accountability per the right to health, demands that states take responsibility for the incidence of MM and also for putting in place and implementing policies to reduce MM. This is especially important as the advancement of human rights depends on being able to utilise human rights to prevent wrongs and pursue redress for violations.[150] Besides states, accountability for maternal deaths can be demanded from non-state actors like local health authorities and public and private health-care providers on whom obligations for realising the right to health have been placed.[151] In the case of female children and adolescents, parents and caregivers can be accountable for their wards' health,[152] while funders have the duty to ensure that the funds are used for the appropriate purposes.[153] Clearly defining the accountable roles of other actors involved in the health sector such as pharmaceutical companies, bio medical researchers is useful in the HRBA.

Accountability to end MM is envisaged on different fronts such as professional, institutional, health system, private actors and donors.[154] Redress may be sought through judicial (litigation) as well as through various non-judicial means. Political accountability through persuasion, technical assistance, dialogue, and emulation' to bring about the desired change is also suggested.[155] Reassuringly, not only the treaty provisions but also the General Comments of treaty monitoring bodies on RH have been drawn upon by domestic courts to hold governments accountable for maternal deaths.[156] However, as an accountability mechanism, whether at the

[150] Cook and Dickens and Fathalla (n 1) 148.
[151] GC14 (n 23) para 42.
[152] Parents and care givers have an obligation to 'nurture, protect and support the children to grow and develop in a healthy manner' GC15 (n 45) para 78.
[153] Ooms (n117)135.
[154] Technical Guidance (n 11) para 75.
[155] S. P. Marks, 'The New Partnership of Health and Human Rights' (2001) 2 Human Rights Dialogue 21 in L. S. Johnson (n 43).
[156] Examples are the Indian cases of Laxmi Mandal v Deen Dayal Harinagar Hospital and others, W.P (c) Nos. 8853 of 2008. Jaitun v Maternal Home MCD, Jangpura and others W.P No. 10700/2009. In Laxmi Mandal, Shanti Devi, a poor woman from the untouchable caste was denied the free government sponsored medical service on account of her inability to prove her eligibility for the treatment. She died from complications related to the birth of the baby who had been dead in her womb as at the time she was being denied the treatment. In Jaitun, Fatema was forced to give birth under a tree after she was refused treatment by the hospital. It was argued on their behalf that the right to health requires the State to ensure accessibility of health facilities including through adequate supervision of their agents.
Jennifer Templeton Dunn and Katherine Lesyna and Anna Zaret, 'The Role of Human Rights Litigation in Improving Access to Reproductive Healthcare and Achieving Reductions in Maternal Mortality (2017)17(367) BMC Pregnancy and Childbirth 71.

international or domestic level, litigation is dogged by some concerns.[157] Despite being widely used in many jurisdictions, compliance is often a problem. It is alleged that in many cases, persistent follow-up and agitations of civil society attend the court decisions before governments comply.[158] The cost may also be prohibitive for the poor, leading to the observation that human rights litigation benefits only the rich.[159] With respect to Africa, Durojaye noted that recognition of the right to health as a legally enforceable right is still very poor, skilled lawyers who are versed in issues relating to the right to health are not readily available, judges are reluctant to ruffle the feathers of the executive, disadvantaged people are usually ignorant and illiterate and the cost of litigation makes litigating the right to health unaffordable. [160]

The maternal death review is an administrative investigation of the various reasons behind a maternal death in order to inform future preventive actions. This mechanism has been declared a sine qua non for reducing maternal deaths.[161] Since 2013, the Maternal and Perinatal Death Surveillance and Response (MPDSR) has been the WHO-promoted maternal death review mechanism. They are not focused on punishments, which may lead to questions about the state's duty to provide remedies when violations of rights occur. On one hand, what is the essence of identifying culprits who are allowed to get away with their wrongdoings and allowed the opportunity to commit another? On the other, the fear of punishment may be a stumbling block to gathering knowledge which may help prevent future maternal deaths. Notably, resort to this type of mechanisms is in tandem with a growing preference for non-punitive methods to provide justice for grievances such as human rights violations.[162]

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[157] Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil' (2010) 89 Texas Law Review 1643, 1646.
[158] Alicia Yamin and Beatriz Galliz and Sandra Valongueiro 'Implementing International Human Rights Recommendations to Improve Obstetric Care in Brazil' (2018) 143(1) International Journal of Gynaecology and Obstetrics DOI: 10.1002/ijgo.12579.
[159] Octavio Luiz Motta Ferraz (n 157) 1667.
[160] Ebenezer Durojaye ' Litigating the Right to Health in Africa' <Litigating the Right to Health in Africa (southernafricalitigationcentre.org) >accessed 30 December 2023.
[161] WHO states that the ability to count every maternal death is important to avert future deaths. WHO, 'Strategies Towards Ending Preventable Maternal Mortality and Morbidity' (2015) https://apps.who.int/iris/bitstream/handle/10665/153544/9789241508483_eng.pdf?sequence=1. > accessed 30 December 2023.
[162] J Heffner and O FeldmanHall, 'Why We Don't Always Punish: Preferences for Non-Punitive Responses to Moral Violations' (2019) 9(13219) Scientific Reports < https://doi.org/10.1038/s41598-019-49680-2 > accessed 30 December 2023.

A study involving four sub-Saharan countries, including Nigeria conducted between 2016-17, found the mechanism in use, though with varying levels of awareness, adoption, ownership, practice and integration of the review[163] among the countries. It was reported that the findings of the reviews have led to the formulation and implementation of evidence-based actions to reduce MM. In Bangladesh, it led to the decision to include midwives and private facilities in the exercise.[164] Similarly, the agencies working in humanitarian settings have reported the usefulness of maternal death reviews in providing opportunities to effect valuable improvements in maternal healthcare in the refugee camps.[165]

The international human rights mechanisms can be, and in fact have been, an effective means of demanding accountability in relation to maternal health. A few instances are mentioned hereunder. In 2009, the Human Rights Council (HRC) adopted its first resolution on preventable maternal mortality and morbidity.[166] Before the HRC, the African Commission, inspired by the ICPD Programme of Action and the Beijing Declaration and Plan of Action, had issued a Resolution on Maternal Mortality in Africa declaring a state of emergency in respect of the high rate of MM on the continent.[167] In the UN's Universal Periodic Review, maternal, child, and adolescent health is reportedly one of the most pertinent issues to which attention was given.[168]

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[163] Mary V Kinney and others, 'It Might Be A Statistic To Me, But Every Death Matters.": An Assessment Of Facility-Level Maternal And Perinatal Death Surveillance And Response Systems In Four Sub-Saharan African Countries (2020) PLOS ONE < https://doi.org/10.1371/journal.pone.0243722 > accessed 30 December 2023

[164] Government of the People's Republic of Bangladesh, *Maternal Health Program, MPDSR in Bangladesh: Progress and Highlights in 2019* (2020, Directorate General Health Services) 22 and 27 <MPDSR Report-06-10-2020 (unfpa.org)> accessed 30 December 2023.

[165] N Russel and others, 'Implementation Of Maternal And Perinatal Death Surveillance And Response (MPDSR) In Humanitarian Settings: Insights And Experiences Of Humanitarian Health Practitioners And Global Technical Expert Meeting Attendees (2022) 16(23) Conflict and Health <https://doi.org/10.1186/s13031-022-00440-6 > accessed 30 December 2023. ;UNHCR, 'Improving Maternal Health in Dadaab Refugee Camps' (Field Brief June 2010) <UNHCR Field Brief: Improving maternal care in Dadaab refugee camps, Kenya | UNHCR>

[166] UN Human Rights Council, Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/11/L.16, 16 June 2009.
The HRC adopted another resolution in 2016. UN Human Rights Council, Preventable Maternal Mortality and Morbidity and Human Rights A/HRC/RES/33/18, 10 October 2016.

[167] ACHPR, Resolution on Maternal Mortality in Africa ACHPR Res 135(XXXXIV)08

[168] 21% in 1st quarter and 19% in second quarter. Bueno Mesquita, 'Universal Periodic Review: A Valuable New Procedure for the Right to Health?' (2019 21(2) Health and Human Rights 263.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6927386/ accessed 30 December 2023.

In addition to the adjudicatory powers made possible by the optional protocols,[169] treaty monitoring bodies have also used the medium of Concluding Observations to draw attention to MM. The CESCR while issuing a Concluding Observation about the Gambia decried a high mortality rate of 1050 per 100,000 live births caused mainly by haemorrhage and infection which quality services could have prevented.[170] More recently, the CEDAW expressed concern at the high rate of MM in Nigeria attributable in part to a high number of unsafe abortions. It was similarly bothered about the high number of women and girls suffering from obstetric fistula and their physical and financial inability to access pre-natal, birthing, and pre-natal health care.[171]

### 4.4 Global Health Strategies and the Reduction of Maternal Mortality

The term global health has been in use since the 1940s to describe global cooperation in public health.[172] Global health has been described as a guiding principle within the broader field of health sciences. This field is concerned with the study of global health issues and the global solutions to combat them.[173] Global health strategies and initiatives are often the products of WHO negotiations and mainly influence national law and policy.[174] While RH can claim legitimacy from binding legal instruments which also sets out government obligations,[175] these global health strategies are at best soft law. Yet, they are the main means by which the WHO sets and monitors global health goals. Thus, even countries without binding health laws have adopted them. Examples of these include the health goals under the MDGs and the SDGs and specific

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[169] See chapter 2 (2.8), where the optional protocols of the ICESCR, CEDAW and ICCPR were discussed.
[170] UN, CESCR, Concluding Observations on Gambia (New York: UN, 1994), UN Doc E/C/12/1994/9 para 9, referred to in Cook and Dickens and Fathalla (n 1) 190.
[171] CEDAW, Concluding Observations on the combined 7th and 8th Reports of Nigeria. 2017 CEDAW/C/NGA/CO/7-8.
<http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsqMFgv33OTgoZv7ZAgL6thDkAcuu60Ke5O8oUKpz5hHtAD5CcXiD5zZx29kup5sgJh%2FbrUteC%2BF%2B7JPizHj03e4vdMY2Qx6U%2FxeHbOGQf%2FbTOpIjhu5tZXVb1T90JN81eA%3D%3D> accessed 30 December 2023..
[172] Xingiang Chen and others, 'What is Global Health? Key Concepts and Clarification of Misperceptions' (2020) 5 (14) Global Health Research and Policy < https://doi.org/10.1186/s41256-020-00142-7 > accessed 30 December 2023.
[173] Melissa Salm and others, 'Defining Global Health: Findings from a Systematic Review and Thematic Analysis of the Literature' (2021) 6(e005292) BMJ Global Health doi:10.1136/ bmjgh-2021-005292.
[174] Lawrence Gostin and Devi Sridhar, 'Global Health and the Law' [2014] New England Journal of Medicine 1732, 1734. For instance, WHO and UNFPA make guidelines and protocols for states to adopt.
[175] Gostin and Sridhar did not declare that RH significantly influences government actions, but they agree that health laws have found their way into national laws and landmark court decisions have been obtained thereby. ibid 1736-7.

reproductive plans of action such as Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) strategies.[176]

In relation to maternal health, difficulties with the realisation of the MDG goals led to the adoption of the Global Strategy on Women and Children's health in 2010 to guide states' actions in respect of maternal and children's health issues.[177]This was followed by the EPMM in 2015. The EPMM had a global target to reduce MM to less than 70 deaths out of every 100,000 births by 2030 and this goal was adopted by the SDG as goal 3.1[178] The national target was for countries not to have more than twice the global number, 140, also by 2030.[179] Furthermore the strategy is described as being grounded in the HRBA principles with the themes extending to the wider determinants of maternal health as well as the immediate causes of MM.[180] To enhance the SDGs targets, the Global Strategy on Reproductive, Maternal, Newborn, Child and Adolescent Health 2016-2030 has been presented as another guiding instrument. It combined indicators from the SDGs as well as other existing RMNCAH strategies.[181] This strategy inculcates health goals as well as social and economic conditions to ensure the overall well-being of women, children and adolescents. Some of the newly developed goals included supporting individuals to become agents of change, investing more in research and development, adopting a multi-sector approach and enhancing response to and protection of women in humanitarian settings.[182]

Concerning reproductive and maternal health, these are the WHO- supported policies guiding states' maternal health policies and initiatives. According to Brizela and Tuncap, implementing the strategy to the letter has the potential of bringing about the advertised reduction

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[176] WHO, Committing to Implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (2023)< Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (who.int)> accessed 30 December 2023.
[177] Vanessa Brizela and Ozge Tuncarp, 'Global Initiatives in Maternal and Newborn Health' (2017) 10(1) Obstetric Medicine 21 < https://doi.org/10.1177%2F1753495X16684987 > accessed 30 December 2023.
[178] R Rima Jolivet and others, 'Ending Preventable Maternal Mortality: Phase II of A Multi-Step Process to Develop A Monitoring Framework, 2016–2030 (2018) 18(258) BMC Pregnancy and Childbirth < https://doi.org/10.1186/s12884-018-1763-8 >accessed 30 December 2023.
[179] ibid.
[180] ibid
[181] Every Woman Every Child, 'Indicator and Monitoring Framework of the Global Strategy on Women's Children's and Adolescent's Health (Executive Summary) (2016) <gs-indicator-and-monitoring-framework.pdf (who.int)> accessed 30 December 2023.
[182] Brizela and Tuncarp (n 177).

of MM. However, the limitations of global health laws or policies have been highlighted to include inherent weaknesses to encourage their acceptance, weak implementation mechanisms and holding little attraction for international funders.[183] The MM reduction targets introduced by the MDG is criticised for replacing the bigger and broader goals set in Cairo in respect of societal reforms and SRHR of women.[184] To this end, global health strategies such as goal 4 MDG as well as the HRBA principles, are viewed as more political than legal. Additionally, being of international law origin presupposes that they apply to states, therefore, there is still some difficulty with governing non-state actors.[185]

## 4.5 Challenges of the HRBA to Health

From the discussions above, the potential of the HRBA to health to improve reproductive and or maternal health, despite the imperfections, is evident. The framework is obviously not free from criticism on account of its nature and mode of implementation. In this section, more challenges of the HRBA are highlighted. This undertaking is in line with the main argument of this thesis that, although the HRBA to health is often recommended to implement Nigeria's health obligations, an evaluation of the problems that trail the HRBA itself and which will therefore be important to address in any endeavour to adopt the framework, is usually absent.[186]

Structurally, the HRBA is complex. It involves too many participants, the components are quite many, they lack uniformity and vary according to the whim of development agencies or human rights bodies that design the HRBA.[187] Some principles such as equality has been described as incapable of a definitive meaning,[188] also some agencies use equity which is more associated with ethics and therefore not the same as equality which is a legal term and associated with duties

[183] Gostin and Sridhar (n 174)1737.
[184] Yamin and Falb, (n122) 350.
[185] ibid.
[186] In particular, contextualised conceptions of rights-based approaches are considered useful to enhance maternal mortality reduction efforts. LS Johnson (n 43).
[187] Gruskin and Bogecho and Ferguson (n 13) 131.
[188] Holtmaat 2004, cited in Durojaye (n 105) 105.

and obligations. [189] This lack of specificity is said to affect the measurement of the impact of the approach.[190] Ghafur also says the lack of clarity could lead to no real changes taking place as activities may just bear the label HRBAs and remain essentially what they were pre -HRBA.[191]

Another feature is the common occurrence of trade-offs, because the HRBA involves and depends on other enforcement methods that are not law-based.[192] Similarly, HRBAs are driven by evidence while human rights have legal standards. Yet, the existence of right holders implies that rights can be enforced, but this may not be successful where the country or other stakeholder is not under obligations to fulfil the duties.[193] Due to this, the persons involved in implementing the HRBA may sometimes have to be less hard on the authorities.[194] On the other hand, this lenient approach may be useful to facilitate policymakers' acceptance of human rights which they often view as antagonistic and are therefore unwilling to engage with.[195]

On a similar note, it has been observed that the rights-based approach is not accepted in the same degree universally. Richardson reported that although South Africa joined the consensus on adopting the MMM 2014 resolution, the country expressed its reservations about conformity with a rights-based approach as a basis for development cooperation.[196] The programmatic approach is also criticised on account of the notion that it binds governments to a duty in relation to developing and implementing social policies rather than realising the rights of individuals.[197]

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[189] Siobhan Mc Lerney Lankford, 'Human Rights and Development: a Comment on Challenges and Opportunities from a Legal Perspective' (2009) 1 (1)Journal of Human Rights Practice 51 <https://doi.org/10.1093/jhuman/hun005 > accessed 30 December 2023.; Paul Hunt, (A/61/338) (n12)para 53.
[190] Rebekah Thomas and others, 'Assessing the Impact of a Human Rights Based Approach Across a Spectrum of Change for Women, Children and Adolescents' Health' (2015) 2(17) Health and Human Rights Journal 11, 19.
[191] Tehmina Ghafur, 'Rights-Based Approach to Health: Critical Reflections and Contemporary Challenges' (2018) 29 Dhaka University Studies Part F 55,57.
[192] Broberg and Sano (n 137) 675.
[193] ibid 677.
[194] ibid 673. Xingiang Chen and others (n 172)
[195] Flavia Bustreo and Curtis Doebbler, 'The Rights-Based Approach to Health' in Lawrence Gostin and Benjamin Meier (eds*), Foundations of Global Health & Human Rights* (online edn, Oxford Academic) 89, 101 <https://doi.org/10.1093/oso/9780197528297.003.0005 > accessed 30 December 2023.
[196] Lucy Richardson, 'Economic, Social and Cultural Rights (and beyond) in the UN Human Rights Council' (2015) 15 Human Rights Law Review 409, 432.
[197] Bett Watts and Suzanne Fitzpatrick 'Rights Based Approach and Social Injustice: A Critique' in *Rebel Streets and Informal Economy* (1st Edn, Routledge 2017) ISBN 97181315641461.

This implies that human rights may become under-emphasised in development related activities[198] such that for instance in relation to health, the aim becomes the right to health rather than health.

Katsui and Kumpuvuori cite three problems of HRBA which appear interrelated.[199] They cite the age-long opposition to human rights, the guarantee of which, is the foundation of the approach. The second problem identified relates to how to operationalise the approach especially as the content and limits of some human rights (especially ESCRs) needed for a comprehensive operation are still considered vague. The third problem is the negative consequences of operationalising the approach due to inadequate conceptualisation of the approach. The example on health above is one such negative consequence. This means that policies and laws are made but no real changes follow.

Also, where the 'concerned people' are not at the very centre of actions taken, the HRBA may end up empowering the advocates rather than the rights holders. In addition, presenting human rights in absolute terms is also likely to play down any other means by which the aim may be achieved. These challenges resonate with Yamin's observation that successful HRBAs involve employing a variety of strategies and even changing decisions at several levels, when necessary.[200] Consequently, Katsui and Kumpuvuori recommend that a well-identified and conceptualised agenda in which specific outcomes have been outlined is put together.[201] Thus, the problems identified constitute some challenges and these must be considered when HRBAs are to be adopted.

## 4.6 Conclusion

This chapter has provided a critical examination of the potential of applying the HRBA to health, which comprises essential elements of RH and the HRBA principles, to achieve a reduction in MM. The evaluation of the individual aspects of the HRBA to health in relation to MM was done

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[198] Siobhan Mc Lerney Lankford (n 189) 58.
[199] Kisayo Katsui and Jukka Kumpuvuori, 'Human Rights Based Approach to Disability in Development in Uganda: A Way to Fill the Gaps between the Political and Social Spaces' (2008) 10(4) Scandinavian Journal of Disability Research 227.
[200] Alicia Ely Yamin, 'From Ideals to Tools' (n 123) 1, 3.
[201] Katsui and Kumpuvuori (n 199).

to further assess the prospects of the framework which is often recommended to end MM. The discussions have shown that the standards of the framework have the potential to address the various determinants of MM. However, the framework is not perfect. HRBAs generally, and those in respect of SRHRs, have been subjected to criticisms based on their origins and the problems with operationalising them. Most of these challenges are significant and have major implications for the efficacy of the framework. Consequently, adopting the standards of the framework without taking account of the likely challenges may render the measures ineffective or result in unintended consequences.

The next chapter focuses on Nigeria's legal, policy and programmatic framework to combat MM. Against the background of this chapter and the previous chapters, Chapter 5 will entail an examination of laws, policies and institutions that are relevant to maternal health, as well as the SRHR of women and girls, to determine the extent of their conformity with the standards associated with RH obligations. The aim is to evaluate the extent to which Nigeria's extant laws, policies, and programmes can further the reduction of preventable maternal mortality through a human rights-based approach to health.

# Chapter 5

## Maternal Mortality Reduction and The Right to Health Framework in Nigeria

> **'Women and children die not because we do not know what to do but because of lack of political will to implement the plans'[1]**

### 5.1 Introduction

The key question being addressed in this chapter is: what are the relevant laws, policies, programmes/institutions that give effect to the right to maternal health (MH) or the sexual and reproductive health rights (SRHR) of women and girls in Nigeria, and to what extent are they compatible with the interventions necessary to reduce maternal mortality (MM) through a right to health (RH) approach/human rights-based approach to health.

The obligation to 'fulfil' by adopting legislative, administrative, judicial, and other measures for the realisation of the right to health is contained in the International Covenant on Economic, Social and Cultural Rights (ICESCR) [2] and is repeated in the General Comments/Recommendations of the treaty monitoring bodies (TMBs) of the relevant instruments. Notwithstanding the recommended measures, each country is granted the discretion to determine the recommendations that would suit their specific situations.[3] As a result, where possible, the appropriateness of the measures to realise maternal health or address the causes of MM in Nigeria is also considered.[4] Additionally, it has been clearly expressed by the CEDAW Committee that in federal states where component states are also responsible for protecting the RH, the primary obligation or responsibility rests with the federal government. Nevertheless, the TMBs still draw attention to the achievements of individual component states' as well as their compliance and non-compliance with relevant federal laws in their Concluding

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[1] Federal Ministry of Health Nigeria, *Accelerated Reduction of Maternal and Newborn Mortality in Nigeria. Roadmap for Action: 2019-2021* (2020) (Accelerated Reduction Policy) 7.

[2] International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16 U.N. Doc. A 6316, 993 U.N.T.S. 3 (Jan. 3, 1976) art 2(1).

[3] UN Committee on Economic, Social and Cultural Rights (CESCR), 'General Comment No.14 'The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant' 11 August 2000 E/C.12/2000/4 (GC14) para 53.

[4] This underscores the importance of evidenced-based policies and programmes.

Observations.[5] Consequently, where relevant laws and policies of some component states, are of significance, they will be highlighted. In a way, this approach is similar to the approach adopted by the TMBs for monitoring states' compliance with their treaty obligations.[6]

The relevant laws, policies, and initiatives as well as existing studies or literature appraising their implementation, form the basis of the assessment. A two-step approach is adopted whereby the extant relevant legislative, policy, judicial, and other measures are first laid out and evaluated. This is followed by a discussion of issues in the Nigerian polity which are incompatible with the goal of achieving MM reduction through a RH approach. A HRBA to health is evidence-based, thus the framework must address issues that the discussion in Chapter 3 identified as the determinants of MM in Nigeria.

Nigeria's laws, policies and initiatives which are related to right to health obligations are laid out under two heads. Under the first head are provisions of the Constitution and laws from which Nigeria's obligation to realise the right to health may be derived, namely, the Constitution, the African Charter Act and the National Health Act. The second head follows with laws, policies and initiatives[7] which can be seen as having the potential to give effect to Nigeria's reproductive/maternal health related obligations. To determine whether Nigeria guarantees any of the interventions, recourse is majorly had to the letter of the laws and policies and to judicial pronouncements where available. The availability and efficacy of institutional measures, such as accountability mechanisms, are also surveyed. These discussions are followed up with the areas of concern or issues which the state must address for the RH approach to fully benefit MM reduction efforts in Nigeria.

The findings of this chapter will act as a basis for investigating the views of implementers on operationalising the right to health framework to reduce MM in Nigeria, which investigation will be done in Chapter 6. This chapter starts out with a brief background

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[5] CEDAW, 'Concluding Observations of Committee on the Elimination of Discrimination Against Women (CEDAW) on the combined 7th and 8th Reports of Nigeria, [CEDAW/C/NGA/CO/7-8]. 'Nigeria Concluding Observations' (2021) <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsqMFgv33OTgoZv7ZAgL6thDkAcuu60Ke5O8oUKpz5hHtAD5CcXiD5zZx29kup5sgJh%2FbrUteC%2BF%2B7JPizHj03e4vdMY2Qx6U%2FxeHbOGQf%2FbTOpIjhu5tZXVb1T90JN81eA%3D%3D> accessed 30 December 2023.

[6] First, they identify positive aspects, next, they address areas of concern and proffer recommendations to resolve the concerns.

[7] These are initiatives or programs through which the problem of MM has been or is being dealt with either at the national or component state levels. OHCHR, 'Technical Guidance on The Application of a Human Rights Based Approach to the Implementation of Policies and Programmes to Reduce Preventable Maternal Morbidity and Mortality' [2012] UN Doc A/HRC/21/22, para 12.

discussion of the legal and political situation in the country of study and an outline of the administrative organisation of the country's healthcare sector. Then laws, policies and initiatives are discussed while the discussion of the concerns follow.

## 5.2 Nigeria- Legal and Political Structure and Health Administration

### 5.2.1 Political and Legal Context

The politico-legal situation of Nigeria is quite complex. The country operates a mixed system with statutes, Sharia, customary and common law operating side by side. It has a federal system of government comprising a federal capital territory and 36 states, which are further divided into local government areas (LGAs).[8] For political purposes, the country is divided into six geopolitical zones.[9] In the Sharia states – which are all in the northern part of the country- Sharia governs criminal law and personal law such as marriage, family, inheritance, and succession. Throughout the country, customary laws also apply to similar matters except to criminal law. Customary laws are only upheld and enforced by courts after they have been found not repugnant to natural justice, equity, and good conscience and not inconsistent with any law currently in force.[10] However, that does not happen unless there is a contention in respect of the customary rule, and the parties approach the courts. The implication of this is that where they are not challenged, the customs quietly regulate the lives of the populace.

The pluralist legal system is one of the issues that feature recurrently in the Concluding Observations of the TMBs to Nigeria.[11] Their concern is due to the fact that customary laws sometimes produce detrimental results such as denial of inheritance and rights of succession to women if the marriage was under customary law. It also extends to the federal system which requires the domestication[12] of certain federal laws before they can be enforceable in

[8] The Constitution of the Federal Republic of Nigeria 1999 Cap C4 LFN 2004 (CFRN 1999) ss 3 and 6.

[9] South South, North West, North East, North Central, South West, South East.

[10] Originally a relic from Nigeria's colonial history, 'repugnant to natural justice, equity and good conscience' was held in *Mojekwu v Ejikeme* to be 'offensive distasteful and contrary', while 'any law in force' refers to a law in force in Nigeria. *Mojekwu v Ejikeme* (2000)5 NWLR 402.

[11] CEDAW, 'Nigeria' Concluding Observations of Committee on the Elimination of Discrimination Against Women on the 6th Periodic Report [CEDAW/C/NGA/CO/6]. 'Nigeria Concluding Observations'. (2008) para 17 < https://www.refworld.org/docid/4efb2f122.html > accessed 30 December 2023.
See also Nigeria Concluding Observations (2021) (n 5) para 11.

[12] Domestication is used here in the context of the federal and state laws in Nigeria. This refers to a situation where the federal government makes laws on which the component states have jurisdiction by virtue of the constitutional legislative arrangement. Here the component state adopts the same law completely or adopts but changes or deletes or adds some provisions. For instance, the Criminal Code of the Southern States becomes the Criminal Law of a state.

component states as this translates into women having varying levels of protection depending on their location within the same country. In many ways, these political arrangements are directly responsible for the differences in the MM levels in different parts of the country.

Thus, component states where Sharia law holds sway, where the Child Rights Act (CRA) is not domesticated and where gender inequality is highest based on religion and culture create conditions that facilitate MM. For instance, while the teenage pregnancy rate is 1% in Lagos, a state where the CRA is domesticated and credited with some level of implementation, the rate is 41% in Bauchi, a Sharia state that has not domesticated the Act.[13] The 'federal system' problem is also evident in the health sector where the federal government provides leadership and encouragement but does not commandeer accountability from either the state or the local governments.[14]

The legislative list of the Constitution apportions power between the federal centre and the component states to the effect that items on the exclusive list are legislated upon only by the Federal Government (FG) while matters on the concurrent list are jointly legislated on.[15] The current apportionment of power is the subject of recurrent calls for restructuring as the centre is deemed to be too controlling, to the disadvantage of the states with respect to development and other governance initiatives.[16] Children, health (except health and safety at work) and the criminal law, which are relevant to our discourse, are on neither list making them residual matters, and therefore within the purview of state governments.[17] It has been suggested that to counter the challenge of protecting children's rights, the Child Rights Convention (CRC) or its African counterpart could be domesticated by the federal assembly in order to make the provisions directly applicable as a national law. [18] However, this suggestion is presuming the political will to domesticate the entire provisions of the instruments is present at the federal level, and this is unlikely. If such political will had been present, the National Assembly would

[13] National Population Commission, 'Nigeria Demographic and Health Survey (NDHS) 2018 Key Findings' (National Population Commission, 2020) 4 <https://nationalpopulation.gov.ng/ndhs-2018-key-finding/ > accessed 30 December 2023.
[14] J Shiffman and Friday Okonofua, 'The State of Political Priority for Safe Motherhood in Nigeria' (2007) 114(2) BJOG 127.
[15] CFRN 1999, 2nd Schedule Part 1 and Part 2 respectively.
[16] Ideobodo Nwafor-Orizu and Okolo Modesta Chinyere and Eze Kierian Tochukwu, 'Political Restructuring in Nigeria, the Need, Challenges and Prospects' (2018) 18 (5) Global Journal of Human Social Science 18, 27.
[17] The Constitution empowers states to make laws on matters not on the executive legislative list. CFRN 1999. s.4. *Togun v Oputa* (2001) 16 NWLR (pt740)597@644. However, the constitutional power with respect to health is often described as concurrent because of Schedule 4, section 2 (c), where state governments' power to provide health care services in conjunction with local governments is set out.
[18] Eniola Bolanle Oluwakemi, 'Cultural Practices and Reproductive Rights of Women: A Comparative Study of Nigeria and South Africa' (PhD thesis, University of Kwazulu Natal 2017) 134.

have *ab initio* adopted the exact provisions of the CRC instead of selecting and modifying the provisions that make up the Child Rights Act.

Corruption and impunity are some of the biggest problems plaguing the country.[19] Corruption has been defined variously, with most of the definitions usually relating to public officials. It is associated with abuse of public power, public funds or public office, whether for private benefit or for use to which such should not be put.[20] Corruption indices such as Transparency International's corruption perception index (CPI) use different benchmarks and surveys to determine the pervasiveness of corruption in a country. As of 2022, Nigeria's CPI score was 24/100, placing the country 150 out of 180.[21] Corruption is ingrained in the fabric of the Nigerian society and while the private sector is not immune, [22] the public sector is completely enmeshed in it with observers acknowledging it as a way of life in Nigeria.[23] Although corruption is mostly linked to the oil fortunes of Nigeria and long military rule in the country, there is evidence that during colonial rule and the early days of independence, Nigeria was not immune to the problem.[24] There is no shortage of accountability mechanisms; courts, quasi-judicial bodies and other accountability mechanisms have been created to apply to different corruption issues.[25] However, they are weak, thereby engendering impunity.[26] Many factors, including poverty, illiteracy, moral decadence and societal pressures on public officers to live affluent lives have been held responsible for the persistence of corruption in Nigeria.[27]

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[19] Nnamuchi Obiajulu, 'Kleptocracy and its Many Faces: The Challenges of the Justiciability of the Right to Health in Nigeria' (2008) 52(1) Journal of African Law 1.

[20] Arvind K Jain, 'Corruption: A Review' (2001)15(1) Journal of Economic Surveys 71, 73.

[21] Transparency International, 'Corruption Perceptions Index: Nigeria' (2022) <2022 Corruption Perceptions Index: Explore the… - Transparency.org> accessed 30 December 2023.

[22] Leonce Ndikumana, 'The Private Sector as Culprit and Victim of Corruption in Africa' (2013) Political Economy Research Institute, University of Massachusetts Working Paper <WP330.pdf> accessed 30 December 2023.

[23] A former UK Prime Minister once described Nigeria as fantastically corrupt. BBC, 'David Cameron Calls Nigeria and Afghanistan 'Fantastically Corrupt'' (BBC News, 10 May 2016) <David Cameron calls Nigeria and Afghanistan 'fantastically corrupt' - BBC News> accessed 30 December 2023.

[24] Samson Adesote and John Ojo Abimbola,' Corruption and National Development in Nigeria's Fourth Republic: A Historical Discourse' (2012) 14 Journal of Sustainable Development in Africa, 81. It is even contended that corruption was tolerated and benefitted from by the colonial government. Robert Tignor, 'Corruption in Nigeria Before Independence' (1993) 31(2) Journal of Modern African Studies 175.

[25] The Independent Corrupt Practices and other Related Offences Commission (ICPC) for instance has the mandate of ensuring public officers steer clear of corrupt practices. Created pursuant to s.3 of the Corrupt Practices and other Related Offences Act, 2001 Cap C 31 LFN 2004.

[26] Aiguosatile Otoghile and Lambert Edigin, 'Corruption in Nigeria, A Review of Causes, Effects and Solutions' (2014)< CORRUPTION IN NIGERIA A REVIEW OF CAUSES.pdf (globalacademicgroup.com) > accessed 30 December 2023.
Ejumundo Ovie and Ikenga Ayegbunam, 'Globalisation and Corruption in Nigeria' (2015) 42 Journal of Law Policy & Globalisation 32.

[27] Yinka Omorogbe, *Oil and Gas Law in Nigeria* (Malthouse Press, 2000) 3.

State governors reportedly determine how at least half of the country's revenue is spent,[28] which fact ought to be beneficial to maternal health but has not been.[29] The local governments (LGA) are allowed certain powers[30] including the management of primary healthcare centres (PHC). However, the local governments' heavy dependence on state governments, community groups, and ward development committees, results in differing levels of efficacy in the PHCs of the LGAs. Additionally, an LGA could either benefit from or suffer due to the political party affiliation of its chairperson as, states with leaders from the same political party as the President or local governments with chairpersons from the Governor's party are certain to enjoy more support from the presidency or state government, as the case may be.[31]

The public (including maternal) healthcare system is organised on three levels and corresponds with the 3-tier governance system of the country: the provision, development and operation of the primary healthcare (PHC) including community health education, sanitation and hygiene, is the responsibility of the local government which is the least funded of the tiers of government. The LGAs are supported by the National Primary Healthcare Development Agency (NPHCDA) while states render technical assistance and have the duty of disbursing funds through the state primary healthcare boards.[32] Secondary healthcare and, sometimes, tertiary health care is provided by the state governments directly and in a referral capacity. The states also domesticate and implement FG policies and programs down to the community level under the supervision of the FG. The Federal Government is the primary provider of tertiary health care, and is in charge of the legal framework, formulating policies, monitoring implementation, research, and ensuring standardisation of healthcare delivery throughout the country as well.[33]

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[28] For this reason, in the policies, governors are placed at the centre of accountability in respect of implementation. Accelerated Reduction Policy (n 1) 12, 3, 4, 9.
Currently, the revenue is allocated as follows 52.68% for the federal government, 26.72% shared among the states and 20.60% shared among the local governments. Revenue Mobilisation Allocation and Fiscal Commission, 'New Allocation Formula in December 2021'(RMAFC, 2021) <New Revenue Allocation Formula in December 2021 | RMAFC> accessed 30 December 2023.
[29] This means that governors of high-burden states should have been able to provide dedicated financial attention to eradicating MM.
[30] CFRN 1999, s.7 and 4th Schedule.
[31] Jennifer G. Cooke and Farha Tahir, 'Maternal Health in Nigeria: With Leadership Progress is Possible' (2013) A Report of the Centre for Strategic and International Studies (CSIS) 6.
[32] Federal Ministry of Health Nigeria, *National Strategic Health Development Plans (NSHDP) II Annual Operational Planning (AOP) Guidelines 2018-2022* (2019) 32.
[33] ibid 31.

This arrangement appears to have its beginnings in colonial times. The health system which existed at that time was a combination of medical services provided by Catholic and various Protestant church missions,[34] and the colonial medical service. The former was the main provider of health service to the populace while the colonial medical service chiefly provided health service to the colonial officers and their families, the police and army, and senior members of the civil service.[35] Just before and immediately after independence, the regional governments took over healthcare provision. Though each region had a different policy, all had some form of free healthcare either for children or civil servants,[36] but not for the general populace.

All three levels of healthcare are considered important for the reduction of MM although, emphasis is often laid on primary and tertiary healthcare. Primary healthcare is relied on because of its preventive role and the large number of such facilities available while tertiary facilities are important because of the availability of skilled personnel and equipment for EmOC.[37] Meanwhile, this healthcare sharing system where the federal government plays a limited role and patients can bypass the PHC to consult at tertiary facilities, is often criticised as being complex, also 'breeding unintended dysfunction'[38] and difficulty in achieving its objectives. The underperformance of the PHC sector is linked to the weakness of the local government administration and financing.

The funding for the health sector comes from the federation account and is allocated using a formula that retains 50% for the federal services; 25% is shared between the states while the remaining 25% is shared among the local governments. Unfortunately, these funds are often delayed and, because there is no obligation on the states or local governments to account to the federal government for their use, they are inevitably diverted as a result of the

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[34] Accounts of efforts in the 1940s and 1950s by these mission hospitals to improve maternal health was to the effect that they aimed to raise the standard of midwifery in Nigeria to the standard prevailing in England. They worked on improving living standards, embarked on community education, trained more midwives, and increased their salaries while charging affordable fees. It was reported that as a result of these efforts the MM ratio at the time was low. Taiwo Daramola, 'The Challenges of Providing Comprehensive Healthcare for Nigerians' Inaugural lecture Series 54 (UNIFE Press, 1984).
[35] In the words of Daramola, 'the health service was never intended for the populace, and it never pretended to'. ibid 10.
[36] ibid.
[37] Beatrice Wuraola Ope, 'Reducing Maternal Mortality in Nigeria: Addressing Maternal Health Services' Perception and Experience [2020] Journal of Global Health Reports< https://doi.org/10.29392/001c.12733 > accessed 30 December 2023.
[38] Olusoji Adeyi 'Health System in Nigeria: From Underperformance to Measured Optimism' (2016)2 (4) Health Systems and Reforms 285, 289.

endemic graft in the country.[39] To support healthcare financing, the NHA created the basic healthcare provision fund (BHCPF) to be financed with 1% of the Consolidated Revenue and other sources.[40] Meanwhile, fear that the weak oversight on states may affect the effective implementation of the BHCPF has been expressed.[41] In the 1980s, a combination of military rule, corruption, and the IMF/World Bank Structural Adjustment Programme's economic reform truncated the growth of the health sector.[42] Unfortunately, the country did not recover.

### 5.3 Laws, Policies, and Initiatives Relevant to the Reduction of Maternal Mortality

Within the Nigerian legal system, there are a plethora of laws, policies, institutions, and initiatives which give effect to the right to health at both the federal and the state levels that have a bearing on the reduction of MM.[43] Some address basic measures in relation to healthcare, some address certain dangers to the (reproductive) health of women, while some relate to human rights protection within the country. The basic measures are relevant to any issue considered from a right to health perspective. They address the provision of healthcare services, finance of healthcare, and accountability. Other measures, especially the policies and initiatives, relate to either reproductive health or maternal health or are even specifically formulated to address MM. They cover issues ranging from the provision of reproductive and maternal health care, access to contraceptives and family planning, including for adolescents, protection of women from violence, including sexual violence, protection from unsafe abortion, and protection from harmful cultural practices inimical to the reproductive health of women and girls.

The making of national policies on, or to give effect to, government health planning started in 1988. Prior to that time, health planning had always been part of national development plans or actions to address specific health problems. In the 1996 revision, that

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[39] ibid.

[40] NHA s. 11 (3) provides the sharing formula to be 50% to support the NHIS, 45% to fund essential drugs, maintenance of facilities and improvement of human resources in eligible primary healthcare facilities and 5% for emergency medical treatment.

[41] Reem Hafez, 'Nigeria Health Financing System Assessment' (2018) World Bank Group Discussion Paper 1, 48.

[42] Alex E Asakitikpi, 'Healthcare Delivery and the Limits of the National Health Insurance Scheme in Nigeria'(2016) 41(4) African Development 29, 32; K Harrison, 'Maternal Mortality in Nigeria: the Real Issues' (1997) (1)1 African Journal of Reproductive Health 10.

[43] Because Nigeria is a federal state and health is essentially a state-level matter, provision in any of the component states is credited to Nigeria, same too for non-provision in any of the states. Then, the particular situations in each of the states also mean that they have state-specific health needs as will be seen infra.

initial health policy was described as lacking coordination but credited with being a good foundation for subsequent policies because it was realistic and well thought out.[44] Although the health policies were purportedly based on providing primary healthcare, it has been observed that they were focused on the provision of infrastructure and curative services, an observation that is still being made about the country's health policies even 25 years later.[45] Furthermore, the national health plans did not focus on women's health but articulated that maternal and child healthcare including family planning was to be provided as part of the primary healthcare services.[46] It has however been observed that, in reality, most of the attention went to child health and family planning.[47] The 2004 National Health Policy was different in that it was influenced by New Partnership for African Development (NEPAD) and the MDGs. The former placed emphasis on poverty eradication and sustainable growth and development, thus influencing the policy to emphasise good health as being a means to economic development for the country and individuals, and at a cost, the country can sustain.[48] The MDGs, on the other hand, led to the inclusion of reproductive health- one of the goals promoted by the MDGs- in the policy.[49]

### 5.3.1 Legislation Creating Right to Health Obligations

These have earlier been identified to be the Constitution, the National Health Act (NHA), the African Charter Ratification and Enforcement Act, and the Child Rights Act.

#### 5.3.1.1 Right to Health in the Constitution

The Nigerian Constitution's significance in the country's acquisition of right to health obligations is two-fold that is: as a doorway to, and a container of, the obligation. About the doorway, as the grundnorm of the country from 'which all other laws take their validity and to

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[44] Nigeria Federal Ministry of Health, *National Health Policy* (1996) (NHP) 224.
[45] Nigeria Federal Ministry of Health, *Gender in Health Policy: 2021-2025* (FMOH, 2020) 16 (Gender in Health Policy).
[46] NHP (n44) 229.
[47] Idowu Adenike Esther, 'The Socio-Cultural Context of Maternal health in Lagos State Nigeria' (PhD Thesis, Department of Sociology, Covenant University 2013) 32.
[48] NHP (n 44) 8, 229.
[49] The Reproductive Health Policy aimed for the reduction of MM by 50%, reduction of the number of unwanted pregnancies among women of reproductive age by 50%, limit all forms of gender-based violence and harmful cultural practices, increase knowledge of reproductive biology among and encourage responsible behaviour in respect of preventing unwanted pregnancies among adolescents. Federal Ministry of Health, *Reproductive Health Policy* (2017).

which all persons and authorities must conform'[50] it determines the extent to which external instruments such as international human rights laws create obligations for Nigeria. It provides in s.12 that 'No treaty between the Federation and any other country shall have the force of law to the extent to which any such treaty has been enacted into law by the National Assembly'. Meanwhile, of all the instruments which have been highlighted as creating obligations in respect of RH, maternal health or reproductive health, only two (the African Charter on Human and People's Rights and the UN Child Rights Convention), have been domesticated as national laws. Although the Constitution provides in its Chapter II entitled 'Fundamental Objectives and Directive Principles of State Policy' that the country shall honour its international treaty obligations, s. 6(6)(c) of the same Constitution stipulates that these directive principles in Chapter II are not eligible to be subjects of a judicial determination.[51] The inevitable deduction is that the country's conformity or non-conformity with obligations in other relevant treaties' cannot be a subject of determination by Nigerian courts.

Then as a repository of the obligation to guarantee the right to health, the Constitution provides in s. 17(d) of the aforementioned Chapter II that the 'State shall direct its policy to ensure that there are adequate medical and health facilities for all persons'. This provision, being under Chapter II, would have been non-justiciable but the obligation it places on the state has been deemed justiciable based on the enactment of the National Health Act. This becomes possible because the Constitution provides for any of the non-justiciable provisions of Chapter II to become justiciable if the matter is legislated on.[52]

Guarantees in the Constitution from which some of the underlying determinants of health may be derived include ensuring the safety and health of persons in employment (including pregnant women), promises to provide suitable and adequate shelter and food for all persons and the right to non-discrimination which the CEDAW Committee considers extremely inadequate to protect women.[53] This is because it does not cover all grounds of discrimination against women in line with Article 1 of the Convention. Additionally, it does

[50] CFRN, s 1.

[51] S. 6. (6)(c) states thus:

> The judicial powers … shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act of omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution.

[52] On the basis of s.4(2) which empowers the National Assembly to make laws in respect of Items on the Exclusive legislative list including Item 60(a) relating to the promotion and observance of the provisions of Chapter II of the Constitution. *Attorney General Ondo State v Attorney General Federation* (2002) 9 NWLR (pt. 772) 222.

[53] Concluding Observations Nigeria (n 5) para 9(b).

not accord any special protection to women as the CEDAW envisages. However, all these guarantees, except the right to non –discrimination which scope is inadequate are in Chapter II.

A pertinent point has been made by Roemer about the central role of the constitution if the right to health is to be enjoyed as a human right. She argues that putting a right to health in the constitution is an official statement of commitment to give effect to the right that a policy cannot sufficiently be.[54] The WHO also backs the importance of such inclusion, especially in countries where the constitution is the basic law and which prevails in the event of any inconsistency with it (like Nigeria).[55] To apply this to Nigeria, while the Constitution's provisions in respect of health facilities have become justiciable via the NHA, that justiciability does not cover the underlying determinants of health mentioned above because they are in Chapter II and are not mentioned in the NHA. It may therefore be concluded that the highest law of the land does not provide a strong base for the realisation of the full scope of the right to health.[56]

#### 5.3.1.2 The African Charter on Human and People's Right (Ratification and Enforcement) Act

The African Charter Act guarantees the right to the best attainable standard of health.[57] Although the application of this provision to enforce the right to health has received differing decisions[58] in courts, it is now settled law, that this provision being of a domesticated treaty, can form the basis of a justiciable right to health in Nigeria. Consequently, since s.16 has been held by the African Commission to comprise both health care and other conditions through which one could lead a healthy life, this means that the full spectrum of the right to health is

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[54] Roemer Ruth, 'Right to Healthcare' in Hernan L. Fuenzalida-Puelma and Susan Scholle Connor, eds., *The Right to Health in the Americas* (Pan-American Health Organization, Washington, D.C. 1989) cited in Virginia Leary, 'The Right to Health in International Human Rights Law' (1994) 1(1) Health and Human Rights Journal 34.

[55] WHO, 'Right to Health in the Constitutions of Member States of the World Health Organisation South East Asia Regions' (2011, WHO) <Right to health in the constitutions of member states.indd (who.int)> accessed 30 December 2023.

[56] Other provisions in the Constitution on which a human right to health may depend are the provisions guaranteeing easy access to courts in s.17(2)(e); equality in s. 17(2)(a) and the guarantee of other socio-economic rights like education in s.18 and opportunity to secure a livelihood in s.17(3)(a). They are all in Chapter II.

[57] African Charter on Human and Peoples Rights (Ratification and Enforcement) Act 1983 Cap A 9 LFN 2004, (African Charter Act) s. 16.

[58] *Festus Odafe & ors v Attorney General Federation* (unreported suit no: FHC/PH/CS/680/2003), *Femi Falana v FRN* (unreported suit no: FHC/IKJ/CS/M59/10).

justiciable under the Nigerian legal system.[59] In relation to the violation of RH leading to MM, the case of *SERAP v Lagos (*discussed in subsection 5.4.1) was successfully prosecuted on the basis of this law.

As discussed in Chapter 3, greater and more specific protection of women's reproductive rights exists in the Maputo Protocol (Protocol) which Nigeria has ratified.[60] However, unlike the Charter, the Protocol has not been domesticated and efforts to ensure the passing of bills containing substantial provisions of the Protocol have met with failure.[61] This is in spite of the fact that the country's policies on maternal health purport to be based on the Protocol among other instruments.[62] Therefore, legally enforceable provisions on women's sexual and reproductive health including the right to control their fertility, to reproductive health education, and to have access to safe abortion services in certain situations are unavailable to women. As evidence of disregard for ratified instruments, Nigeria entered no reservations to the provisions of the Protocol, yet in contravention of the demands of the Protocol, it has retained its restrictive abortion regime.

#### 5.3.1.3 The Child Rights Act

Section 13 of the Act guarantees children in Nigeria the right to the best attainable state of health to be provided by all persons and authorities including governments, parents or institutions responsible for the child's care.[63] To this end, extensive guarantees covering healthcare and some underlying determinants were made. Children are defined to be everyone under the age of 18,[64] which means that the category of adolescent girls (15-19) which make up a significant portion of MM victims,[65] are entitled to RH measures including those necessary

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[59] *Jonah Gbemre v Shell Petroleum Development company of Nigeria and others* (2005) AHRLR 251.
[60] The Protocol was applied by the ECOWAS Court in *Dorothy Njemanze & 3 others v FRN* (ECW/CJ/APP/17/14).
[61] Friday Okonofua and others, 'Perceptions of Policymakers in Nigeria Toward Unsafe Abortion and Maternal Mortality' (2009) 35(2) International Perspectives on Sexual and Reproductive Health 194, 195.
[62] The Gender in Health Policy declares thus 'The 2006 Gender policy takes its departure from ratified international instruments such as … Protocol on the Rights of Women in Africa (ratified 2005)' Gender in Health Policy (n 45) 20.
[63] Child Rights Act 2003 Cap C50 LFN 2004 (CRA 2004). There is provision for medical care and assistance and underlying determinants such as nutrition, portable water, hygiene and sanitation for children. s.13.
[64] CRA 2004, s 277.
[65] It has been established that adolescents are exposed to a higher level of risk of maternal mortality than the 20-24 age group, though the highest age group most at risk is the over 30 age group. Andrea Nove and others, 'Maternal Mortality in Adolescents Compared to Women of Other Ages: Evidence from 144 countries' (2014) 2(3) The Lancet Global Health e155.

to avoid MM. These include family planning, contraception and safe abortion services (where abortion is not against the law), adequate and comprehensive obstetric care.[66]

However, these recommendations are not reflected in the measures prescribed in the health provision of the Act. Health care for pregnant and nursing mothers is among some of the health entitlements mentioned in the Act, but it is contended that this entitlement pertains to the mothers of the children because a law that prohibits sexual activity with its protegees is not likely to make provisions for healthcare in the event that they get pregnant.[67] It has also been observed that one of the interventions that RH guarantees i.e., access to contraceptives for adolescents, is hampered by the proviso to the right to privacy guaranteed in the Act. The proviso states that 'nothing…shall affect the rights of parents, and where applicable legal guardians, to exercise reasonable supervision and control over the conduct of their children and wards'.[68] This provision effectively ensures that parents can legally retain control over their adolescent children in many ways which may be detrimental to their access to reproductive health services.

### 5.3.1.4 The National Health Act

The National Health Act[69] (NHA) performs the dual role of creating obligations as well as making provisions to guide the implementation of the obligations. Its first role is revealed by Section 1 of the Act which sets out its purposes. Subsections c and e being directly relevant are also reproduced. They state:

> There is established for the federation a national health system which shall define and provide a framework for standards and regulation of health services … and which shall (c ) provide for persons living in Nigeria with the best possible health services within the limit of available resources…
> (e) protect, promote and fulfil the rights of the people of Nigeria to have access to health care services

These provisions express a plan to provide health services in conformity with Art 2(1) of the ICESCR, which expects states to act within the maximum of their available resources.

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[66] UN Committee on the Rights of the Child General Comment No. 4 on Adolescent Health and Development in the Context of the Convention on the Rights of the Child (2003) CRC/C/GC/4 (GC4) para 17.

[67] Additionally, when the CRC Committee make recommendations on government's obligation to provide maternal healthcare in their Concluding Observations, the Committee refers to mothers. UN Committee on the Rights of the Child General Comment no. 15 on Art 24 on the right of the Child to the Highest Attainable Standard of Health (2013) CRC/C/GC/15 (GC 15) para 43.

[68] CRA 2004, s. 8.

[69] National Health Act 2015 Cap N …LFN 2004 (NHA 2014).

The second role of the Act is as a tool to accomplish Nigeria's RH obligations by enunciating specific measures to meet the standards of the obligation. Important provisions in the Act which variously satisfy the country's obligation in respect of the right to healthcare include the creation of a fund to finance the objectives of the Act,[70] creation of a national blood transfusion service,[71] requesting the possession of a certificate of standards to operate a health facility, recruitment, and retention of skilled personnel. [72] In a similar vein, the guarantee of emergency medical treatment for all persons which is necessary for emergency obstetric care, referral system and conscientious objection of medical personnel. recognition of traditional healthcare practitioners,[73] preserving the confidentiality of patients, right to participate in the course of one's healthcare all conform with the right to health standards.

In order to promote accountability, health facilities are required to display at their facilities, the procedure for laying complaints[74] and also post a compilation of the rights and duties of health providers and patients in their health facilities.[75] However, the contents of such compilation of rights are not mentioned in the Act and since in a HRBA, the accountability of duty bearers is closely associated with right holders' access to information, it follows that patients cannot be empowered to demand their rights if they are not informed of the duties owed them. Crucially, disrespectful treatment is rampant in both private and public healthcare facilities in many developing countries and often patients are not empowered to recognise it or react to it.[76] It has been identified as one of the stumbling blocks to accessing maternal care in Nigeria[77] and though the Act protects health care providers in case of abusive patients or sexual harassment,[78] it makes no such provision with respect to patients.

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[70] s. 11 creates the basic healthcare provision fund (BHPF) to be contributed to by the FG, international donors and states undertaking projects. It is created to finance the provision of minimum health care.
[71] s 47.
[72] ss 41, 43, 45(2).
[73] ss 23-29.
[74] s.30.
[75] Such a document mainly represents a patient's charter and is a consumer protection mechanism, (created by the Federal Competition and Consumer Protection Agency (FCCPCC), but it can serve the aim of accountability in a HRBA. GC14 (n) para 59; Jonathan Cohen and Tamar Ezer, 'Human Rights in Patient Care: A Theoretical and Practical Framework' (2013)15(2)Health and Human Rights Journal <Human rights in patient care: A theoretical and practical framework – Health and Human Rights Journal (hhrjournal.org) > accessed 30 December 2023.
[76] Ijeoma Nkem Okedo-Alex and Ifeyinwa Chizoba Akamike and Love Chimezirim Okafor, 'Does it Happen and Why? Lived and Shared Experiences of Mistreatment and Respectful Care During Childbirth Among Maternal Healthcare Providers in a Tertiary Hospital in Nigeria (2021) 34(5) Women and Birth 477.
[77] ibid.
[78] NHA 2014, s. 21.

As earlier admitted, the provisions of the Act fulfil certain aspects of the AAAQ elements of GC 14. However, there are reasons to disagree with the view that it intends to provide for the full spectrum of the RH comparable to the ICESCR provision and the interpretation in GC14.[79] Although the Act is titled National Health Act, it consistently refers only to healthcare services. As shown, the Act creates a national health system to provide persons living in Nigeria with the 'best possible health services within the limits of available resources. This is not the same as guaranteeing "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" as contained in the ICESCR and except for hygienic food and water, no socio-economic factor nor other underlying determinants including access to health education were referred to in the Act.

Again, the Act articulates that the system is to "protect, promote, and fulfil" the right to access health care services instead of 'respect, protect and fulfil the right to health' as the CESCR's General Comment no. 14 articulates. At the most, the Act conforms to General Comment 14's dictates in relation to healthcare services.[80] In relation to MM, there are two specific references to women; in one, the Act categorises women as vulnerable and recommends them as eligible to be considered for exemption from payment of user fees at public hospitals and, in the other, it provides for vaccination of pregnant women against infectious diseases.[81] But there is no mention of, or allusion to, reproductive health in the Act.

As a basic law underlying the RH framework in the country,[82] a health Act, that envisages health services only, protects minimal rights for patients in favour of medical practitioners, and makes no mention of reproductive rights,[83] does not adequately give effect to the country's RH obligations.

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[79] Obiajulu Nnamuchi and others, 'Nigeria's National Health Act, National Health Insurance Scheme Act and National Health Policy: A Recipe for Universal Health Coverage or What?' (2018) 37(4) Medicine & Law 645, 650.

[80] By contrast, the Kenyan Health Act states specifically that its objects are to 'protect respect, promote and fulfil the health rights of all persons in Kenya to the progressive realisation of their right to the highest attainable standard of health,' Section.3 Kenya Health Act No.21 of 2017.

[81] Meanwhile, the Gender in Health Policy criticises that entitlement arguing that it supports the understanding of SRH and maternal and neo-natal health as women's issues and encourages men to stand away from taking responsibility. Gender in Health Policy (n 45) 21.

[82] The Act also requires domestication by component states because health is a matter within the legislative competence of the state governments.

[83] The length of time that has elapsed between the recognition of SRH as an integral component of the right to health and the promulgation of the Act is believed to be sufficient to facilitate its inclusion in a health legislation.

### 5.3.2 Legislative, Policy and Programmatic Measures

Laws, policies and initiatives are examples of measures through which Nigeria's RH obligations can be discharged. As has been explained earlier, the undertaking of this section of the chapter is investigating how well Nigeria has used these measures to address the issues related to MM according to RH standards or how well Nigeria has complied with RH standards while using these measures to address the issues related to MM.

Having discussed the NHA 2014, which is the first measure, the chapter now turns to examining the National Health Insurance Act and Criminal Laws Protecting Women's Right to Health.

#### 5.3.2.1 The National Health Insurance Authority Act

This law, and its precursor, the National Health Insurance Scheme (NHIS) Act, [84]are measures towards meeting the country's universal health coverage (UHC) commitments. The UHC's aims extend to three specific areas: expanding priority services, bringing in more people and reducing the populace' out of pocket payments.[85] All the objectives are relevant for realising RH, with the third specifically addressing the problem of financial access to health services which is in tandem with the economic accessibility element of RH.[86] As a result of various problems of the NHIS which include, allowing voluntary participation, [87] heavy and misguided financial reliance on Federal Government (FG),[88] corruption due to inadequate checks and

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[84] National Health Insurance Scheme (NHIS) Act Cap N42 LFN 2004.

[85] WHO, *Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage* (2014)< 9789241507158_eng.pdf (who.int)> accessed 30 December 2023.

[86] NHIS Act, 2004 s.5.

[87] Monye opines that insurance is not understood by Nigerians meaning the right holders are not empowered to leverage the scheme. Felicia N Monye, 'An Appraisal of the National Health Insurance Scheme of Nigeria' (2006) 32(3) Commonwealth Law Bulletin 415.

[88] Misguided, because it is no secret that in contravention of its RH obligations, the government has never met up with its financial commitments towards the health sector. Between 2010 and 2021, the allocation fluctuated between 3.9% and 4.18%, with 5.8% in 2013 and 2015 as the highest so far. Damilola Ojetunde, "Nigeria Remains Perpetual Defaulter of the 'Abuja Declaration' on Health Funding'' (ICIR Nigeria, January 1 2019) < Nigeria remains perpetual defaulter of the 'Abuja Declaration' on health funding | The ICIR (icirnigeria.org)> accessed 30 December 2023.

accountability mechanisms,[89] little awareness among the populace, civil servants[90] and the informal sector alike, and inadequate capital generation,[91] the National Health Insurance Authority Act (NHIA) was enacted to create a replacement. Crucially, while the NHIS aimed at facilitating accessibility, the implementation model or style may not be appropriate for the Nigerian situation. A HRBA requires empowering the right holders, ensuring non-discrimination and accountability all of which the implementation of the NHIS appeared to lack.[92]

Amongst other things, the new NHIA, extends insurance coverage to all residents of Nigeria, mandates the creation of insurance schemes in all states, accredits government-run primary and secondary healthcare facilities to join the scheme, establishes a fund for vulnerable groups of people -children under 5, disabled, pregnant women, creates National Health Insurance Authority to oversee the basic healthcare provision funds as well as the vulnerable groups funds.

#### 5.3.2.2 Criminal Laws Protecting Women's Right to Health: The Criminal Code, Penal Code, and Violence Against Persons Prohibition Act

The Criminal Code and Penal Code, the two main federal criminal laws operating in the country, criminalise abortion. Objectively, the criminalisation of abortion is not incompatible with Nigeria's RH obligation because the CEDAW obligates states to decriminalise abortion 'where possible', thus granting countries a discretion.[93] Also, the Maputo Protocol does not prohibit criminalisation but merely directs states to authorise medical abortion in the case of rape, incest, mental and physical health of the mother, life of the mother

[89] Gloria Essien, 'The Challenges in the Nigerian Health Sector and Efforts Towards Achieving Universal Health Coverage' ( Voice of Nigeria, October 15, 2021) < THE CHALLENGES IN THE NIGERIAN HEALTH SECTOR AND EFFORTS TOWARDS ACHIEVING UNIVERSAL HEALTH COVERAGE – Voice of Nigeria (von.gov.ng)> accessed 30 December 2023.

[90] AI Olugbenga- Bello and WO Adebimpe, 'Knowledge and Attitude of Civil Servants in Osun State, South Western Nigeria, Towards the National Health Insurance' (2010) 13(4) Nigerian Journal of Clinical Practice 421.

[91] Gbadegesin Alawode and David Adewole, 'Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers' (2021) 21 (124) BMC Public Health < https://doi.org/10.1186/s12889-020-10133-5 > accessed 30 December 2023.

[92] Maternal Figures, 'NHIS Maternal and Child Health Insurance Programme' NHIS Maternal and Child Health Insurance Programme | Interventions | Maternal Figures - Nigeria's maternal health in focus accessed 30 December 2023.

[93] CEDAW General Recommendation No. 24 of the Convention (Women and Health A/54/38/Rev.1, Chap.1 (GR 24) para 31.

and foetal deformity. Arguably, these criminal law provisions on abortion are an attempt to prevent unsafe abortion. The prevention of unsafe abortion can be founded on the obligation to respect as well as protect women's right to health.

The obligation to protect obligates states to ensure 3rd parties do not interfere with the right to health. Unsafe abortion can be defined by two features, the termination of a pregnancy by a person lacking the necessary skills or in an environment that does not conform to minimal medical standards or both.[94] Sections 228 and 229 of the Criminal Code (CC)[95] operating in Southern Nigeria,[96] make it an offence for anyone (including the woman), 'with intent to cause a miscarriage, to unlawfully administer to the woman (or to herself) whether or not she is pregnant, any poison or noxious substance or use any force or other means'. Sections 232 and 233 of the Penal Code (PC) operating in Northern Nigeria are similar.[97] By criminalising abortion carried out by unconventional means and unskilful persons, the provisions protect women's RH.

The preservation of the mother's life is the only ground on which legal abortion is allowed in both Acts.[98] However, based on the *Bourne* case where a threat to life was interpreted as not necessarily being the threat of instant death, the exception impliedly covers a threat to the health of the mother as well.[99] The Criminal Law of Lagos State, one of the component states of the country, in its latest revision of its criminal law, reflects this common law interpretation by expressly authorising abortion to save the mother's life and health. Nevertheless, in reality, there are many other reasons, such as pregnancy from rape and incest, pregnancy out of wedlock, financial and emotional incapability, severe foetal impairment, and

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[94] WHO, 'HRP Annual Report' (WHO Department of Reproductive Health and Research Geneva, 2016)< WHO-RHR-HRP-17.06-eng.pdf > accessed 30 December 2023.
[95] Criminal Code Act 1916, Cap C 39, LFN 2004 (CC 1916).
[96] Both the Criminal Code Act and the Penal Code Act which history is traceable to Nigeria's colonial past are the basic criminal legislations applying in the Southern and Northern states of Nigeria respectively. While the Penal Code applies in its entirety in the Federal Capital Territory, all northern states have their domestic versions of the Penal Code. The situation is the same in the southern states where each state has its criminal laws modelled chiefly on the Criminal Code Act. This is because in Nigeria's federal structure, criminal law, except with respect to matters in the exclusive or concurrent list, is within the legislative competence of the component states.
[97] s. 232 Penal Code (Northern States) Federal Provisions Act (No. 25 of 1960) provides 'whoever voluntarily causes a woman with child to miscarry shall if such miscarriage be not caused in good faith for the purpose of saving the life of the woman, be punished with imprisonment for a term which may extend to 14 years imprisonment or with fine or with both'.
[98] S. 235 of the Penal Code also provides that the act which prevents an unborn child from being born alive be done in good faith for the purpose of saving the life of the mother.
[99] *R v Bourne* (1938) All E.R 315. It is relevant to Nigeria as it was based on an English Criminal law provision which also exists in the Criminal Code that England adopted for Nigeria. That provision is still the law in Nigeria, thus cases decided on it when Nigeria was a British colony are useful to Nigeria as common law. Common law is applicable in Nigeria by virtue of s 32(1) of the Interpretation Act Cap I 23 LFN 2004.

many others - some of which the Maputo Protocol also reflects - for which women seek abortions.[100] It is therefore obvious that allowing abortion on only that ground is too restrictive and therefore breaches the obligation to respect women's RH[101] especially as it forces women to resort to backdoor abortions.[102]

With regard to the obligation to protect women from unsafe abortion, the PC and CC define the qualification to undertake an abortion to be the possession of reasonable care and skill.[103] Although one may agree that possessing the necessary skills (and not merely a medical qualification or title) is important, possession of skills alone as the qualification to perform an abortion, appears to be too wide a qualification. The CC position of prioritising skills is consistent with the recommendations of the African Commission which urged that mid-level healthcare workers be trained to perform abortions due to the dearth of doctors in Africa.[104]

However, with the Nigerian situation where unqualified persons, Proprietary and Patent Medicine Vendors (PPMVs) and pharmacists already perform illegal abortions,[105] officially training and accrediting non-medical personnel to perform abortions may confuse women with a low level of education who may not know the difference. Therefore, in this case, a solution based on Nigeria's peculiar situation rather than the TMB's recommendation may be a more appropriate way to protect women's right to safe abortion. Again, Lagos State has restricted the performance of an abortion to medical doctors, [106] but this is applicable only in that state. Consequently, Nigeria's laws fall short of respecting women's RH by allowing abortion on only one ground, and at the same time, fail to protect their RH because the strict law pushes women into the hands of fake physicians, which the law was purportedly saving them from.

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[100] Akinrinola Bankole and others, 'Reasons Why Women Have Induced Abortion: Evidence From 27 Countries' (1998) 24(3) International Perspectives on Sexual and Reproductive Health 117.
[101] GC14 (n 2) para 34.
[102] Adamu Dauda Garba and John Wajim, 'Reproductive Health Knowledge and Unsafe Induced Abortion in Nigeria' (2019) 24(10) IOSR Journal of Humanities & Social Science 54, 59**;** O.M Balogun and others, 'Complications of Unsafe abortion in SouthWest Nigeria: A Review of 96 Cases' (2013) African Journal of Medical Science 42(1) 111.
[103] Section 297 of the CC provides that 'a person who performs a surgical operation on an unborn child for the preservation of the mother's life with reasonable care and skill is not criminally responsible for such act'.
[104] General Comment No.2 of the African Commission on Article 14.1 (a) (b) (c) and 14.2 (a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, (2014) (African Commission GC2) para 58.
[105] Oluwatosin Wuraola Akande and others, 'Unsafe Abortion Practices and the Law in Nigeria' (2020) 28(1) Sexual and Reproductive Health Matters 528. <https://www.tandfonline.com/doi/full/10.1080/26410397.2020.1758445> accessed 30 December 2023.
[106] s. 203 Criminal Law of Lagos State 2015.

The obligation to fulfil relates to the provision of, and access to safe abortion in the instances where the state has authorised it.[107] This also covers the provision of interpretative guidance on the legally permitted grounds to healthcare providers and the public.[108] Nigeria discharged this obligation by providing guidance for medical personnel through the 'National Guidelines on Safe Termination of Pregnancy for Legal Indications', which the FMOH published as a guide to hospitals, doctors or providers on safe termination of pregnancy.[109] The Guidelines are to enable medical doctors to identify medical conditions which threaten the life of the pregnant woman and thus qualify the pregnancy for termination under the current laws. The medical conditions identified include mental disorders like severe depression with suicidal inclination after rape or incest.[110]

This means that rape or incest can be a basis for seeking legal and safe abortion in Nigeria, but only if it causes depression with suicidal tendencies.[111] However, against the background that an extant law prescribes criminal sanctions for persons who induce abortion, the Guidelines which are mere regulations, are limited in their potential to realise women's RH. This is compounded by the fact that the 'Guidelines' do not cover all the grounds the Protocol sets out. Notwithstanding, the Guidelines gives effect to rights to information, dignity, privacy and confidentiality, freedom of expression, choice and non-discrimination, which are integral to the right to health.[112]

#### 5.3.2.3 Violence Against Persons (Prohibition) Act

The Violence Against Persons (Prohibition) Act (VAPP Act) is a federal law enacted to prohibit all forms of violence against persons, whether in private or public life. At the state level and before the federal law, Ekiti State and Lagos State had enacted legislation covering

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[107] In *K.L v Peru,* the CEDAW Committee held the country liable for not providing clear guidelines to physicians and patients on the provision of legal abortion in the country. *K.L v Peru* CCPR/C/85/D/1153/2003. Communication No. 1153/2003.
[108] Committee on the Elimination of All Forms of Discrimination against Women. *Report of the inquiry concerning the United Kingdom of Great Britain and Northern Ireland under Article 8 of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*. CEDAW/C/OP.8/GBR/1. para 15
[109] Federal Ministry of Health Nigeria, '*National Guidelines on Safe Termination of Pregnancy for Legal Indications*' (2018) (Safe Termination Guidelines).
[110] ibid 12-13.
[111] The CEDAW Committee in its latest Concluding Observations to Nigeria raised the bar by urging Nigeria to decriminalise abortion in all cases. CEDAW Nigeria Concluding Observations (n 5) para 38(b).
[112] Safe Termination Guidelines (n 108) ss 23-30.

varying aspects of the subject matter. [113] Notable contributions of the VAPPA to the obligation to protect women's right to sexual and reproductive health include the prohibition of female genital mutilation (FGM) which represents the first attempt of the Federal Government to legislate against the said harmful cultural practice. However, this criminalisation of FGM, has attracted criticisms, including being considered a blind compliance with international human rights recommendations. This is on account of the fact that a criminal sanction against FGM is more likely to drive the genital cutters underground.[114] The dearth of convictions in countries where the practice is criminalised also supports this argument. Nevertheless, through the provisions on sexual violence, the Act protects women from unwanted pregnancies. [115] However, it falls short in this duty by the non-recognition or prohibition of spousal rape in spite of the close association with unintended pregnancies.[116] It perpetuates the unjust fallacy in the criminal codes' provisions that sexual intercourse between a couple is always consensual.[117]

With respect to unsafe abortion, the prohibition of violence irrespective of person or place, could reinforce the provisions of the CC on persons who subject women to violent actions calculated to bring about an abortion. Section 38 fulfils a positive obligation as it entitles victims of violence to be informed of the availability of and to receive necessary materials, as well as comprehensive medical, psychological, social and legal assistance. Thus, women who have been victims of sexual violence can have access to pre-emptive medical treatment to prevent the initiation of a pregnancy and victims of unsafe abortion can access post-abortion medical care, psychological support and legal assistance when necessary. This legislation, like the CRA, requires domestication by the component states' legislature. Consequently, except for those states which domesticate this law or have laws on domestic or gender-based violence or specific harmful cultural practices, women in Nigeria cannot benefit from any specialised protection from violence that make them vulnerable to MM.

[113] Lagos State Protection Against Domestic Violence Law 2007, Ekiti State Gender Based Violence (Prohibition) Law 2011

[114] VAPP Act, 2015 s 6; Camilla Yusuf and Yonathan Fessha, 'Female Genital Mutilation as a Human Rights Issue: Examining the Effectiveness of the law Against Female Genital Mutilation in Tanzania' (2013) 13 African Human Rights Law Journal 356, 375.

[115] VAPP Act, 2015 ss 1, 25.

[116] Onyemelukwe reports that the male-dominated federal house of assembly did not favour such a provision. Cheluchi Onyemelukwe, 'Legislating on Violence Against Women: A Critical Analysis of Nigeria's Recent Violence Against Persons (Prohibition) Act, 2015' (2016) 5(2) De Paul Journal of Women, Gender and the Law 1, 9.

[117] CC 1916, s 6; PC 1960, s 282.

### 5.3.3 Relevant Policies

Unlike laws, policies do not engender a high level of accountability from states.[118] However, their adoption complies with the recommendation of the TMBs on measures to achieve the right to health. The first policy targeted at promoting safe motherhood was the adoption of the National Reproductive Policy in 1988. This was followed in 2002 by a National Reproductive Health Strategic Framework, with a MM reduction component.[119] Several other reproductive or maternal health-related policies have since followed. Presently the relevant policies are the National Health Policy, National Strategic Health Development Plan, Gender in Health Policy, National Reproductive Health Policy and Strategy, Nigeria's Population Policy, National tools for Maternal and Perinatal Death Surveillance and Response. Often these policies are accompanied by implementation plans and guidelines adopted to give effect to these policies. In these policies, the principles of the HRBA are inculcated as guiding principles.[120] There are many relevant policies, concerned with diverse issues.[121] Such divergence, though necessary, may lead to insufficient attention being accorded to each of the significant issues.[122]

Through the policies, Nigeria has covered the provision of medical facilities, other determinants of health, and national health planning issues like financing, medicines, information system, research, partnership, technology, and many others[123] thereby giving effect to the full range of the country's right to health obligations. They complement efforts on reproductive and maternal health by outlining strategic interventions.[124] In conformity with the direction of GC 14, the National Gender in Health Policy addresses the challenges women face in accessing healthcare and the negative impact of inequalities and discrimination on their health.[125] Again, like GC 14, emphasis is laid on MM, resulting in strategies such as making

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[118] Non-compliance will not attract redress before the law courts. *Onyirioha v. IGP* (2009) NWLR (pt.1128) 342.
[119] J Shiffman and Friday Okonofua (n 14) 128.
[120] Gender in Health Policy (n 45) 46.
[121] Policies specifically relating to health, maternal and any aspect of reproductive health of women and adolescent girls which relates to MM are retrieved from the family health menu of website of the Federal Ministry of Health (FMOH) The exception is the latest Reproductive Health Policy which is not available online.
[122] For instance, there was an omission of necessary details on the family planning services - such as the type or at which level of services such will be available.
[123] NHP (n 44), Ch 4.
[124] It aims to increase antenatal care attendance to 80%, skilled attendance at delivery to 57%, basic EmOC at 80% of primary healthcare centres and ensure that 50% of primary healthcare centres can provide comprehensive EmOC. NSHDP (n 32) 54.
[125] National Gender in Health Policy (n 45) 16.

female skilled birth attendants available in the northern part of the country where male skilled birth attendants are not culturally and religiously acceptable.[126] Provisions or plans to give effect to adolescents' reproductive health rights to health information and education, and access pregnancy and childbirth services are also articulated in the policies.[127]

Outlining specific measures to improve contraceptive prevalence is the purport of the Nigeria Family Planning Blueprint which is concerned with addressing issues of availability, accessibility, and acceptability of contraceptives. [128] One of the major accountability mechanisms for maternal deaths - the maternal death audits- was also established via the Maternal and Perinatal Death Surveillance and Response (MPDSR) policy. It investigates reasons – medical and contributory - [129] for infant or maternal death, in order to engender the deployment of tools and responses to avoid the same situation in the future. Saliently, the process is non-punitive, anonymised, and does not entail apportioning of blame, but it is submitted that there must be clarity about the actions or omissions it would apply to considering that it was the cause of a death. Therefore, if it is conceded that it has a place in remedying violations as grievous as death, a pertinent question is -which category of actions or omissions which contributed to the death would be escalated beyond such an administrative mechanism? Greater consideration is needed on this at this time because there have been calls for the enactment of a law to guarantee amnesty for affected medical officials who give evidence in the investigations.[130] This question forms part of the issues empirically investigated in the next chapter.

### 5.3.4 Initiatives to Reduce Maternal Mortality

With respect to the reduction of MM, a host of programmes and interventions have been implemented, beginning in 1989 when the Mother Care project was launched. Through the initiatives, maternal healthcare and underlying determinants have been tackled. Some initiatives have been geared towards making maternal healthcare accessible through free maternal health services in different states. Others, like the Midwives Service Scheme and the

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[126] ibid, 66.
[127] Reproductive Health Policy; National Policy on the Health and Development of Adolescents &Young People in Nigeria.
[128] Federal Ministry of Health, *Nigeria Family Planning Blueprint* (2018) 34.
[129] Federal Ministry of Health, *Maternal and Perinatal Death Surveillance and Response'* (2015) 5 (MPDSR).
[130] Oladapo Shittu and Mary Kinney, 'Assessment of Maternal and Perinatal Death Surveillance and Response Implementation in Nigeria' (Healthy Newborn Network, 15 August 2017) 33 <Nigeria-national-MPDSR-Assessment-report-FINAL.pdf (healthynewbornnetwork.org) > accessed 30 December 2023.

10,000 primary healthcare initiative, focused on the availability of healthcare facilities and skilled personnel, while the Saving One Million Lives Programme was aimed at enhancing access to quality reproductive and maternal health interventions.[131] Other initiatives include making new cost-effective interventions such as Misoprostol available to prevent post-partum haemorrhage and approval of its use for home deliveries. The introduction of Misoprostol has proved fortuitous in more than one way because the drug also became available for abortions, including unauthorised ones.[132] Studies found that due to this, the incidence of complications and need for hospital admissions, even among adolescents, has reduced. [133] However, the drug is a prescription drug[134] and its availability to the populace without a prescription is an indictment on the ability of the relevant authorities to effectively monitor access to prohibited drugs or prevent abuse of prescription drugs. On the other hand, the possibility of such safe abortions now also buttresses the fact that the reason for retaining the restrictive abortion laws in Nigeria is not about protecting women's RH.

In light of social, economic, and cultural realities dogging the availability, accessibility and acceptability of orthodox healthcare, there are initiatives to integrate traditional birth attendants (TBAs) into the maternal healthcare system.[135] This initiative is, however, mainly unsupported at the federal level, in medical circles,[136] a TBAs being a major reason why women with complications present late to health facilities.[137] The *Agbebiye* segment of the *Abiye* (Safe Motherhood) initiative of the Ondo state government gave a cash voucher and

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[131] It was an initiative of the federal government supported by the World Bank and was launched in October 2012. It sought to save one million lives of under-fives and mothers by 2015. It actually started in 2014 and ended in 2021. International Aid Transparency Agency 'Nigeria- Program to Support Saving One Million Lives (2015) < Nigeria - Program to Support Saving One Million Lives - IATI Datastore Search (iatistandard.org)> accessed 30 December 2023.

[132] A form of the drug, Cytotec, is used for treating stomach ulcers and that provides a camouflage for the prescription.

[133] FA Bello and others, 'Trends in Misoprostol Use and Abortion Complications: A Cross-Sectional Study from Nine Referral Hospitals in Nigeria' (2018) 13(12) PLoS ONE.

[134] Amy Jadesimi and Friday Okonofua, 'Tackling the Unacceptable, Nigeria Approves Misoprostol for Postpartum Haemorrhage' (2006) 32 (4) Journal of Family Planning and Reproductive Healthcare 213 (Commentary).

[135] The Lagos State Traditional Medicine Board regulates the activities and registration of TBAs.. Maternal Health Figures 'Lagos State Traditional Medicine Board' (Maternal Health Figures,) <Interventions | Maternal Figures - Nigeria's maternal health in focus> accessed 30 December 2023.

[136] K A Harrison ' The Struggle to Reduce High Maternal Mortality in Nigeria (2009) 13(3) African Journal of Reproductive Health 9,16 <The struggle to reduce high maternal mortality in Nigeria | African Journal of Reproductive Health (ajol.info)> accessed 30 December 2023.

[137] Loretta Favour Chizomam Ntoimo and others, 'Prevalence and Risk Factors for Maternal Mortality in Referral Hospitals in Nigeria: A Multicentre Study' (2018) International Journal of Women's Health 69; Loretta Favour Chizomam Ntoimo and others, 'Why Women Utilise Traditional Rather Than Skilled Birth Attendants for Maternity Care in Rural Nigeria: Implications for Policies and Programs (2022) 104 (103158) Midwifery < https://doi.org/10.1016/j.midw.2021.103158 > accessed 30 December 2023.

offered skills training for an alternative vocation[138] to TBAs in exchange for referring or physically accompanying pregnant women to the state hospital. It is argued that this strategy, which appears to be trying to phase out traditional health care, does not fully promote the eradication of MM on the basis of RH. Respecting RH requires states not to hinder access to traditional healthcare.[139] In the case of Nigeria, this is especially important as there is evidence that the availability of healthcare facilities may not deter some persons from patronising TBAs.[140]

Besides healthcare, SRH initiatives which are related to MM reduction include the provision of sexual and reproductive health education to adolescents. The Family Life and HIV/AIDS Education (FLHE) curriculum was introduced in 2003 to teach sexuality education in secondary schools.[141] This conforms with states' obligation to provide SRH education which is required to be comprehensive, based on clinical findings and in accordance with the maturity level of adolescents and youths.[142] However, it was alleged that the curriculum that was originally designed was subjected to attacks from religious and cultural entities resulting in key sexuality words like 'vagina', 'condom', 'contraception', 'unprotected sex' and 'sexuality' being omitted from the curriculum.[143] In 2008, Colleges of Education throughout the country introduced the FHLE curriculum as a compulsory course for first-year students[144] but its introduction in secondary schools had mixed success, with some states like Lagos and Oyo allowing students to receive sexuality education and states like Kano being highly resistant. Presently, the Minister of Education has directed that the course be removed from the country's educational curriculum.[145]

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[138] Lawal Oyeneyin and Olugbenga and Osunmakinwa and Yetunde Olagbuji, 'Incorporating Traditional Birth Attendants into the Mainstream Maternal Health system of Nigeria' (2021) 25(4) African Journal of Reproductive Health 82,83.
[139] GC14 (n 3) para 34.
[140] Jennifer G. Cooke and Farha Tahir (n 31). Other reasons for TBA patronage reflected in the literature include cost, accessibility, better treatment and freedom to use traditional birthing techniques. Ndidiamaka Amutah Onukagha, 'Progresses and Challenges of Utilizing Traditional Birth Attendants in Maternal and Child Health in Nigeria' (2017)6 (2) International Journal of Maternal and Child Health and AIDs 130.
[141] Jeremy Shiffman and others, 'International Norms and the Politics of Sexuality Education in Nigeria' (2018) 14 Globalisation and Health 1, 5-8. <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0377-2> accessed 30 December 2023.
[142] African Commission GC2, paras 51-52.
[143] ibid.
[144] ibid.
[145] Education as a Vaccine, 'Civil Society Statement on the Declaration by the Minister of Education on Family Life and HIV Education' (EVA, November 10, 2022) <Civil Society Statement On The Declaration By The Minister Of Education on Family Life and HIV Education (FLHE) | Education as a Vaccine (evanigeria.org)> accessed 30 December 2023.

The conception and implementation of many maternal health policies and initiatives in Nigeria are linked to international donors or organisations' technical or financial assistance, which testifies that Nigeria's RH obligation to seek such assistance is well discharged. Having said that, a framework that is overly dependent on financial assistance is unsustainable[146] as evidenced by Nigeria's experience pre-1999 when international donors withdrew funds due to prolonged military rule.[147] Consequently, although it is not a RH imperative, experts have opined that there are more prospects of ending MM through the HRBA to health, if Nigeria works towards reducing donor reliance.[148] The defunct *Abiye* project represents an example of, among other things,[149] the consequences of donor over-reliance.

The *Abiye* Project was a one-state initiative, but it represents the first and so far, only, attempt to address the medical causes of MM in Nigeria comprehensively. '*Abiye'* a Yoruba word meaning 'safe motherhood' was implemented by the Ondo State government in response to the NDHS 2008 report that revealed Ondo state had the worst MM rate in South West Nigeria.[150] The state governor at the time was a physician who decided to make the prevention of MM a priority.[151] The aim of the project focused on addressing women's utilisation of health facilities for births, by addressing 4 delays,[152] that is, the 3 delays discussed in Chapter 3 and a fourth one being the delay to make referrals. To address the first delay, health rangers were recruited and assigned to pregnant women, who monitored them individually, visited them at home and communicated with them via a free prepaid cell phone that had been given to the women. To address the second delay, transportation such as utility vehicles and even speed boats for the riverine areas were attached to the health facilities. For the third delay, new healthcare facilities were constructed, essential drugs were supplied, and more medical personnel were recruited, while the fourth delay was resolved with the creation of a tertiary hospital - Akure Mother and Child hospital- equipped to handle referred cases. Additionally, all maternal health services, routine and emergency were free.[153]

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[146] It may also encourage irresponsibility in governments, the Blueprint Policy reported insufficient government counterpart funding for family planning services. Family Planning Blueprint (n 128) 23.
[147] Obiajulu Nnamuchi, 'Right to Health in Nigeria' (Right to Health Project in the Middle East Law School, University of Aberdeen, 2007).
[148] Bazuaye and Okonofua, 'Tackling Maternal Mortality in Africa after 2015: What should the Priorities Be?' (2013)17(2) African Journal of Reproductive Health 9,11.
[149] It also demonstrates the precarity of political will.
[150] Olusegun Mimiko, 'Experiences With Universal Health Coverage of Maternal Health Care in Ondo State, Nigeria, 2009-2017'(2017) 21(3)African Journal of Reproductive Health 9.
[151] ibid.
[152] ibid.
[153] Olusegun Mimiko and others, 'Maternal Health in Nigeria- Progress is Possible: Examining the Abiye Model' Presentation at CSIS Africa Program, March 14 2017.

According to reports between 2010 and 2012 there was a 45% decrease in MM in the state,[154] and this increased to 75% by 2015.[155] The intervention was clearly capital intensive and involved a lot of human resources as well,[156] which as scarce factors in the Nigerian healthcare sector are important determinants of the sustainability of the project.[157]Subsequently, the succeeding government discontinued the initiative citing scarcity of funds.[158]

## 5.4 Accountability

This section of the chapter surveys the potential of Nigeria's accountability mechanisms to deliver right to health goals as well as in the context of achieving a reduction in maternal mortality.

### 5.4.1 Courts

The options to seek redress for health-related violations are quite limited being mainly the courts, the Medical and Dental Practitioners Disciplinary Committee and its sister tribunal for nurses and the Federal Consumer Protection Commission (FCCPC), whereas GC14 expects national ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions to be involved in providing remedies for violations of the right to health.[159]

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[154] ibid.
[155] Oyeneyin LO and others, 'Maternal Mortality Ratio in a Tertiary Hospital Offering Free Maternity Services in South-Western Nigeria – A Five-year Review' (2017) 34 Tropical Journal of Obstetrics Gynaecology 112.
[156] The erstwhile governor, Mimiko, explained how healthcare insurance was pursued and how they also had to enlist the help of private hospitals to give free or highly subsidised care, especially during times of industrial action. Olusola Isola, 'The Use of Mobile telephone in Reducing Prenatal Mortality: The Case Study of Abiye (Safe Motherhood) Project in Ondo State, Southwest Nigeria' < Sola Isola Case Study of Abiye Project Report (1) (sourceafrica.net) > accessed 30 December 2023.
[157] Mimiko, 'Experiences with Universal Health Coverage' (n 149) 13 ; An audit of the initiative on a HRBA scale found that participation, empowerment, non-discrimination and international assistance were adhered to but the observation of the principles of accountability, transparency and sustainability was limited. Also Kikelomo Abayowa Mbada, 'Human Right Based Approach to Maternal Health and Policy Implementation: An Analysis of Abiye Safe Motherhood Initiative of Ondo State Nigeria' (2020) 10(4) Journal of Public Administration and Governance 315, 322-323.
[158] This information was provided by a senior medical officer in the state. However, it has been impossible to find an authority in published works to substantiate this information, although to evidence the scarcity of funds, a recent news item on the state of the health sector revealed the State was owing salaries of health workers. Shalom S, "We are tired" – Nigerian Nurse Tearfully Calls out Ondo Government Over 8 Months Unpaid Salary' (*Gistreel*, March 11 2023) < "We are tired" – Nigerian nurse tearfully calls out Ondo government over 8 months unpaid salary (gistreel.com)> accessed 30 December 2023.
[159] GC14 (n 3) para 59.

As the traditional legal accountability mechanism, Nigerian courts have been approached regarding human rights violations resulting in MM. One of the high-profile cases, earlier mentioned in Chapter 4, *SERAP v Attorney General Lagos*, was concluded in 2020. In the case, the High Court of Lagos granted an order against the continuation of a policy that made blood donation by the families of pregnant women a prerequisite to accessing childbirth services. Amongst other things, the judge concurred that such a policy was discriminatory and effectively blocked access to maternal healthcare. It is, however, argued in this thesis that although the judgment promotes the reduction of MM, and it was indicated that the ruling was based in part on RH, it does not sufficiently promote MM reduction via the RH framework. This conclusion was reached on account of a complete lack of discussion on the standards, scope or contents of RH to substantiate its eligibility as a basis for the judgment. [160] In the same vein, despite the possible futility of granting negative aspects of socio-economic rights when the positive aspects are unmet,[161] there was no pronouncement regarding the government's obligation under RH to provide the needed blood for transfusion. It can however be argued that the latter deficiency stemmed from the applicants.[162]

Courts have also acted in respect of the underlying determinants by improving the social and economic status of women. In the cases of *Mojekwu v Ejikeme,*[163] *Mojekwu v Mojekwu,*[164] the court upheld the status of women as equal members of the society and also qualified to inherit property. There, the Court of Appeal in upholding a female's right to inherit property, held that 'any form of societal discrimination on the grounds of sex, apart from being unconstitutional, is antithesis to a society built on the tenets of democracy which we have freely chosen as a people.'[165] Therefore, apart from enhancing women's economic fortunes and consequently the ability to access healthcare, the judgment may protect women (especially from the eastern part of the country, the *locus in quo* of the cases), who have given birth to only female children, from risking their lives for an heir.

[160] *SERAP v Attorney General Lagos*. LHC Unreported Suit No. ID 2759GCM/2018.<CTC Judgment on Health.pdf (dropbox.com)> accessed 30 December 2023.
[161] Charles Ngwena 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32(4) *Human Rights Quarterly* 790.
[162] It is trite that courts are not expected to act as 'Father Christmas' by going beyond an applicant's claims. *Nkwocha v Ofurum* (2002) 5 NWLR (pt 761) 506.
[163] *Mojekwu v Ejikeme* (n 9).
[164] (1997) 7 NWLR (pt 283) 1.
[165] Per Nikki Tobi JCA.

### 5.4.2 Quasi-Judicial Institutions

The Medical and Dental Practitioners Disciplinary Committee (MDPDC)[166] and its nursing and midwifery counterpart [167] are quasi-judicial bodies with the powers of a high court. They are created to handle issues of alleged ethical misconduct levied against their members[168] and pronounce sanctions where necessary.[169] The extent of usefulness of the MDPDC to protect a human right to health has been questioned[170] because the tribunal addresses issues from a professional and regulatory perspective and not from a patients' rights perspective. Thus, their decisions do not compensate a complainant [171] but only end in a sanction of their members.[172] This observation, though apposite, may be arguable if the reasoning turns on whether all human rights violations must be remedied by personal compensation for the victim.[173] Notwithstanding, it has been observed that on account of their ethical basis, the codes of professional regulatory bodies, require the incorporation of human rights to make them more effective in a HRBA.[174]

The National Human Rights Commission's impact is limited. In countries such as Kenya and India, their human rights commissions investigate human rights violations and make awards which are validated and enforced by the courts.[175] The National Human Rights Commission in Nigeria is similarly empowered by virtue of sections 6 and 7 of the Amendment Act 2010,[176] whereby awards of the Commission are binding on parties upon application to a high court to be enforced by the court. Notwithstanding these powers, apart from

[166] Medical and Dental Practitioners Act 1988, Cap M8 LFN 2004 (MPDA).
[167] Nursing and Midwifery (Registration Etc.) Act 1979, Cap N143 LFN 2004. (NMW) s 17.
[168] MDPA 1988, s15.
[169] MDPA 1988, s 16; NMW, 1979, s 18.
[170] Aisha Haruna, 'An Analysis of the Legal and Institutional Framework for the Realization of the Right to Health in Nigeria' (PhD Thesis, Ahmadu Bello University 2007-2008).
[171] ibid.
[172] S.16(2)(a)-(c) provides for striking name off the register, suspension from practicing or admonition of the offender.
[173] Remedies for violations of human rights do not always have to be compensation, especially when it concerns social and economic rights. Kent Roach, *Remedies for Human Rights Violations: A two -Track to Supranational and National Law* (Cambridge University Press 2021) 408.
[174] Leslie London, 'What is a human rights Based Approach to Health and Does it matter?' (2008) 10 (1) Health and Human Rights 65, 69.
[175] Haruna (n170) 114.
[176] National Human Rights Commission (Amendment Act) 2010, Cap N46, LFN 2004.

commissioning a study on causes of maternal deaths in the Abuja area,[177] there are no reports of other efforts credited to the National Human Rights Commission in relation to MM reduction.

On the other hand, the efforts of the Federal Competition & Consumer Protection Commission (FCCPC), are being hampered by a power struggle between the agency and the Nigerian Medical Association (NMA). The NMA has prevented its members from appearing before the FCCPC in respect of allegations of violations of consumer rights in healthcare provision.[178] Basically, the Association claims that such interference would infringe on MDPDC's statutory powers and the medical obligation of confidentiality.[179] It was observed that considering the prospects for redress which the FCCPC has demonstrated since its inception, a collaboration between the two bodies was desirable.[180] From another viewpoint, this development could depict a potential difficulty associated with multiple accountability mechanisms which the HRBA recommends. Therefore, again, this matter, brings to the fore the issue of states giving adequate consideration to the consequences of measures to be adopted in order to avoid preventable complications as well as unintended consequences.

Civil Society has been very active in Nigeria's reproductive and maternal health landscape. The SERAP case, cited above, is an example of several NGO court cases instituted to advocate for government's action in respect of health obligations. Civil society activities have included improving governance, lobbying for health funding,[181] empowering the right holders and strengthening accountability. However, inadequate community participation in their projects and absence of coalitions[182] in order to increase their influence and push for more changes, are some of the areas in which scholars observe they are deficient.[183]

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[177] Also empowered to do under s 6 (amending s 5(d)) NHRC, 'Research Study on Human Rights and Maternal Mortality: Pilot Study on Women's Access to Health Care Facilities in Six Area Councils of the FCT' (2015) NHRC_RESEARCH_STUDY_ON_HUMAN_RIGHTS_AND_MATERNAL_MORTALITY.pdf (nigeriarights.gov.ng) accessed 30 December 2023.

[178] Damilola Ayeni, 'VERDICT: FCCPCC or MDCN, Which Can Probe Peju Ugboma's Death?' Foundation for Investigative Journalism (18 June 2021)< VERDICT: FCCPC or MDCN, Which Can Probe Peju Ugboma's Death? (fij.ng)> accessed 30 December 2023.

[179] ibid.

[180] Titilola O Adegbile, 'Examining the Role of Federal Competition and Consumer Protection Commission (FCCPC) in Regulating the Medical Profession in Nigeria' (2022) 2 Redeemer's University Nigeria Journal of Jurisprudence and International Law 209, 217, 218.

[181] Cooke and Tahir (n 31) 8.

[182] Mamaye, 'Accountability and Advocacy Require a United Front: The Case of AMHiN in Nigeria' < Nigeria-casestudy-AMHiN-002.pdf (csogffhub.org)> accessed 30 December 2023.

[183] Ali Mumtaz and Maya Khemlani David and Angela Leo, ' Communication Norms in NGOs Advocating Reproductive Health: A Comparative Study of Malaysian and Nigerian NGOs (2020) 10(1) International Association of Research Scholars International Research Journal < Communication Norms in NGOs Advocating Reproductive Health: A Comparative Study of Malaysian and Nigerian NGOs (redalyc.org)> accessed 30 December 2023.

### 5.4.3 Commitment to International Monitoring

The Chayeses argue that although commitment to international monitoring is inherent to the international rights framework, it may not be adequate as a yardstick to measure compliance. According to them, failure to file reports could either be a reflection of low priority at the domestic level or a deficiency in the administrative capacity of a state.[184] Nonetheless, it is essential to survey Nigeria's record with respect to the relevant instruments because the reports is the primary way by which monitoring is done.[185] Nigeria has been complying with the report submission system of the CEDAW since 1998 and has submitted five reports to date, the last being in 2017.[186] For the CRC, Nigeria's initial report was submitted in 1996, and has since submitted 4 reports, the latest was in 2010.[187] Only one submission has been made to the CESCR to date, and it was submitted in 1998.[188] Both the CEDAW and the CRC Committees' Concluding Observations have consistently referred to the dismal state of maternal health in Nigeria.[189] The CEDAW Committee have highlighted the same issues over the years urging, for instance, the adoption of the CEDAW and even more specifically to MM, the domestication of the CRA, and the decriminalisation of abortion. [190] To the credit of the CEDAW Committee, adopting the VAPP Act is one of the results of their previous recommendations.

## 5.5 Areas of Concern to the Right to Health Approach

This section looks at issues that impact on Nigeria's capacity to reduce MM through RH standards, but which Nigeria's RH measures and efforts have so far not addressed. This is done

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[184] Abram Chayes and Antonia Handler Chayes, 'On Compliance' (1993) 47(2) International Organization 175, 200.
[185] Under the ICESCR, states undertake to submit periodic reports. Art 16. P Watts, 'Monitoring Human Rights Treaties' (2004) Verification Research, Training &Information Centre (VERTIC ) Verification Year Book 2004, 213, 220.
[186] CEDAW Nigeria Concluding Observations (n 5).
[187] Committee on the Rights of the Child, Consideration of Reports Submitted by States Parties under Article 44 of the Convention: Nigeria, 21 June 2010, CRC/C/NGA/CO/3-4
[188] UN Committee on Economic, Social and Cultural Rights (CESCR), *UN Committee on Economic, Social and Cultural Rights: Concluding Observations: Nigeria*, 16 June 1998, E/C.12/1/Add.23.
[189] CRC Nigeria Concluding Observation (n 187) para 59.
[190] CEDAW Nigeria Concluding Observations (n 5) paras 37-38.

with the aim of showing that Nigeria may have difficulties with reducing MM through RH or to show the extent to which RH as a framework can be relied on to bring about MM reduction.

### 5.5.1 Unequal Status and Discrimination Against Women

Equality, particularly substantive equality of women, is a sine qua non for the right to health's operationalisation. Although the Constitution guarantees equality of all persons,[191] the reality, including other laws in the country, demonstrates otherwise. As an example, the Penal Code, which contains various Islamic law principles [192] and operates in the northern states, allows a man to chastise his wife with beating, thereby entrenching of a culture of violence against women.[193] The continued existence of that provision is one of the perennial issues on which the CEDAW Committee urges a change.[194]

Again, women are treated like items owned by society as it is incontestable that religious and cultural pressures, rather than the obligation to keep women alive and healthy, dictate the country's abortion regime. This is evident from the unsuccessful attempts to liberalise the grounds for a legal abortion using the instrumentality of legislation. In 2006, the Reproductive Health Bill did not pass the Senate reading because it was perceived solely as an 'abortion bill'.[195] Again, in 2012, Imo State passed a bill to allow abortion in cases of rape and incest, but it was repealed in 2013.[196]

The failure on both occasions was due to cultural and religious objections [197] based on the belief that liberalising abortion would encourage women to be promiscuous. Before these occasions, there had been previous attempts which were unsuccessful as well. It is posited that, the attitude has not changed as legislators who were interviewed for a study agreed that the

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[191] s 17(2) (a) CFRN 1999 states that every citizen shall have equality of rights, obligations and opportunities before the law.
[192] Phillip Ostien, *Sharia Implementation in Northern Nigeria 1999-2006: A Source Book* (Spectrum books Ltd, 2007) 5.
[193] Penal Code 1960, s.56.
[194] CEDAW Nigeria Concluding Observations 2008 (n 10) para 13. Also CEDAW Concluding Observations 2017 (n 5) para 11 (c).
[195] Akinrinola Bankole and others, 'The Incidence of Unsafe Abortion in Nigeria (2015) 41(4) International Perspective on Sexual and Reproductive Health 170, 172 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4970740/ >accessed 30 December 2023.
[196] P. Chibueze Okorie and Olubusola Adebayo Abayomi, 'Abortion Laws in Nigeria: A Case for Reform' (2019) Annual Survey of International and Comparative Law 165,181.
[197] Owerri Chidi Nkwopara, 'Catholic Priests to Fight Abortion Law in Imo State', VANGUARD (Nigeria, 2 September 2013) <http://www.vanguardngr.com/2013/09/catholic-priests-to-fight-abortion-law-in-imo> accessed 30 December 2023.

restrictive abortion law encourages unsafe abortion but declared their unwillingness to support its liberalisation.[198] Curiously, many Nigerian medical practitioners, who supposedly know first-hand the implication of unsafe abortion, also hold this view.[199]

### 5.5.2 Child Marriage

The stronghold of this problem comprises two things: the assignment of children's welfare to the residual list in the Constitution, thus leaving the issue under the component states' control, and allowing customary laws to regulate marriage. As a result, religion and culture which are often at loggerheads with women's rights, children's rights and sexual and reproductive health rights, are in control. Thus, child marriage in the northern states is sanctioned by the Penal Code (and Sharia Law)[200] which provides that a man may have sexual intercourse with his wife as long as she has attained puberty. The age of puberty is unspecified in the Act, but scientifically it starts in girls from the ages of 8-14,[201] meaning that girls of that age range are exposed to pregnancy and childbirth, and potentially death and disability.[202] Most of the states in the predominantly Muslim North have refused to domesticate the Act while some states that adopted the Act lowered the age of marriage.[203]

It is alleged that tacit approval for child marriage is given by the Constitution as it has maintained s. 29 (4)(b) which bestows adulthood on a married woman of any age. [204] However, opinions in support of this constitutional provision view the provision as a form of protection for women who marry for any reason before adulthood because they would be able to

[198] Friday Okonofua and others (n 61) 200.
[199] In a study involving physicians in Delta state, Nigeria, only 13.4% of physicians expressed a willingness to support the liberalisation of abortion laws in Nigeria or to carry out the procedure if liberalised. Patrick I Okonta and Peter N Ebeigbe and Ileogben Sunday-Adeoye, 'Liberalisation of Abortion and Reduction of Abortion Related Maternal Morbidity and Mortality in Nigeria' (2010) 89(8) Acta Obstetricia et Gynecologica Scandinavica 1087.
[200] Twelve states in Nigeria have expanded their penal codes to encompass Sharia law: Bauchi, Kano, Jigawa, Kebbi, Zamfara, Katsina, Kaduna, Gombe, Borno, Kebbi, Niger and Sokoto.
[201] Amy W Anzilloti, 'Understanding Puberty' (Nemours Kids Health, May 2022) < Understanding Puberty (for Parents) - Nemours KidsHealth>accessed 30 December 2023.
[202] Gender in Health Policy discloses that girls as young as 9 years old are married off. Gender in Health Policy (n 45) 29.
[203] Plateau State made it 16 years, Jigawa state's law defined a child as less than 18years for all purposes except marriage which age, according to it, is the age of puberty. The age of puberty is defined as the time of being physically and psychologically capable of consummating a marriage, ss 2(1), 15(1) Jigawa State Child Rights Law.
[204] Onyeka Okongwu, 'Are Laws the Appropriate Solutions: The Need to Adopt Non-Policy Measures in Aid of the Implementation of Sex Discrimination Laws in Nigeria' (2020) 21(1) International Journal of Discrimination and the Law 26.

independently access services an adult female may require.[205] The provision is also in tandem with the Child Rights Convention's which recognises that states may make the attainment of adulthood earlier than 18years old.[206] Be that as it may, the retention of puberty as the determinant of a girl's readiness to have sex in a marriage has earned Nigeria a position among the countries with the highest number of child brides in the world and the attendant exposure of the girls to MM and morbidity.[207]

It has been noted that, though religion and culture are complicit, there are other factors on which child marriage thrives. The first is poverty; poor families may marry their daughters off in exchange for material gains or just to have one less mouth to feed. Another reason which has been predominant among child brides in Imo state, where the CRA has been domesticated, is parents' or guardians' fear of the stigma which trails pregnancies by their unwedded adolescent daughters. A third reason relates to the inefficacy of the law. This has been the case because the officials in charge of implementing the law either ignore the provisions of the CRA or are not aware of it.[208] The NGOs also raised the lack of social services/protection for girls who would want to avoid or flee such marriages.[209]

### 5.5.3 Discrimination Against Adolescents

Adolescent girls and women represent a vulnerable group of women being subjected to discrimination because access to youth -friendly family planning services is not guaranteed in the current framework. The Adolescents' Policy, as well as, the Blueprint on Family Planning noted that one of the factors hampering adolescents' access to contraceptives is the absence of policies granting them unrestricted access.[210] Access for them is presently based on parental or spousal authorisation or provider's discretion.[211] The authorised age is currently 18 years and providers who consider it needful to provide persons under 18 with family planning services

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[205] Enyinna Nwauche, 'Child Marriage in Nigeria: (Il)Legal and (Un)Constitutional?' [2015] 15 African Human Rights Law Journal 421, 430.
[206] UN General Assembly Convention on the Rights of the Child 20 November 1989, United Nations Treaty Series, Vol. 1577 p. 3 art 1.
[207] Human Rights Watch, 'Child Marriage Remains Prevalent in Nigeria (HRW, 17 January 2022) <Child Marriage Remains Prevalent in Nigeria | Human Rights Watch (hrw.org)> accessed 30 December 2023.
[208] ibid.
[209] ibid.
[210] The Adolescents' Policy notes that although stakeholders agree that adolescents over 14 should be able to access reproductive health education and services - but not treatment - without parental consent, there is no official policy to that effect. Federal Ministry of Health, *National Policy on the Health and Development of Adolescents and Young People in Nigeria 2021-2025* (2019) 12.
[211] Blueprint on Family Planning (n128) 23.

are hesitant because they are not legally empowered to do so. As earlier pointed out, adolescents are also denied access to comprehensive reproductive and sexuality education, because the Family Life and HIV Education, having been watered down due to religious and cultural objections, did not address the use of contraceptives.[212]

### 5.5.4 Health System Governance

The decentralised nature of the health system which has been described in 5.2 complicates its governance.[213]The duplication of responsibilities makes accountability difficult. It has also led to poor implementation of policies and wastage of donor funds. Additionally, the administration is dominated by medical doctors,[214] so the valuable contributions of other professionals in the healthcare sector are limited. Then, situations such as lack of accountability in respect of funds allocated to the states' health sectors and other unaddressed forms of corruption, extending even to the defunct NHIS, are incompatible with the country's right to health obligations.[215]

## 5.6 Political Will with Respect to Right to Health Obligations

From the discussions above, it is evident that the Nigerian legal system consists of legislation, policies, and institutions which conform with the RH interventions to reduce MM. The observation expressed in the *Accelerated Reduction Policy* is to the effect that Nigeria knows what to do but the problem is political will.[216] This is an assertion also often made by the

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[212] For a comprehensive discussion of female adolescent's access to contraceptives, see Oluremi Ajoke Savage-Oyekunle, 'Female Adolescents' Reproductive Health Rights: Access to Contraceptive Information and Services in Nigeria and South Africa' (LLD Thesis, University of Pretoria 2014).

[213] Bolaji Aregbesola, 'Towards-Health-System-Strengthening-A-Review-of-the-Nigerian-Health-System-From-1960-to-2019' (2021) e Journal of Public Health < https://doi.org/10.2139/ssrn.3766017 > accessed 30 December 2023.

[214] Ogoh Alubo and Vitalis Hunduh, 'Medical Dominance and Resistance in Nigeria's Health Care System' (2017) 47(4) International Journal of Social Determinants of Health and Health Services <https://doi.org/10.1177/0020731416675981 > accessed 30 December 2023.

[215] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health (A/61/338) paras78-80.

[216] Policy on Accelerated Reduction of Maternal and New-born Mortality: Road Map for Action, (2019-2021) 7. An examination of that policy, one of the latest MM policies in Nigeria, confirms at least the first part of this assertion. The policy focuses on the highest-burden states – Jigawa, Katsina, Yobe, Zamfara, Kebbi and Sokoto. It was necessitated by the disparity in the MM ratio obtainable in the different regions of the country such that the efforts so far expended was not commensurate with the progress experienced. There was also provision for availability, accessibility, acceptability and quality of maternal healthcare services, and underlying determinants of health. It also provided for HRBA principles by involving the community, empowering the women, instituting the surveillance response, and facilitating non-discrimination.

researchers, advocates and experts from various fields who recommend the human rights approach as the panacea to Nigeria's MM problem.[217] This also supposes that Nigeria is unwilling to comply with the obligations they have under the relevant instruments to which they are parties.

Despite being ubiquitously invoked, the interpretation of the concept often varies according to the authors.[218] Nevertheless, definitions will usually involve mention of a set of leaders considering an issue worthy of support and consistently acting in support of the cause.[219] Thus, in the context of some of the examined legal and policy frameworks for reducing MM examined in this chapter, political will means government acting to sustain the beneficial aspects of the framework, as well as, to address the shortcomings in the laws, policies, processes of implementation, and funding deficits. A pertinent issue is whether the measurement of political will, should consider the capacity of the leadership.[220] According to Brinkerhoff, inaction may be due to lack of ability rather than deliberate neglect to take necessary measures to discharge their obligations.[221]

General Comment 14 makes a distinction between the inability and unwillingness of states to meet their obligations. For example, the unwillingness to use the maximum of their resources to comply fully with their obligations is considered a violation, while the inability to do so is not. Progressive realisation acknowledges that limited resources contribute to the inability of states to fulfil some of their obligations. But the states parties must show that they have taken actions to the maximum of their available resources. Additionally, retrogressive measures in respect of any of the ICESCR rights are not acceptable except they can be justified considering the full use of available resources. Budget-wise, Nigeria's allocation to health is

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[217] A O Fawole and others, 'Predictors of Maternal Mortality in Institutional Deliveries in Nigeria' (2012) 12(1) African Health Sciences 32, 39; Ijadunola Kayode and others, 'New Paradigm Old Thinking: The Case for Emergency Obstetric Care in the Prevention of Maternal Mortality in Nigeria (2010) 6(10) BMC Women's Health.

[218] Scholars and experts like Dequincy and Reed describe it as society's desire and commitment' while Rosenfeild and Maine, Shiffman and Okonofua writing on maternal health, use phrases such as 'a dramatic shift of priorities', 'a determined leadership and 'political priority'.Dequincy A Levine and Gerald Reed, 'Political Will: A Bridge Between Public Health Knowledge and Action' (2007)97 (11) American Journal of Public Health 2010; Allan Rosenfield and Deborah Maine, 'Maternal Mortality – A Neglected Tragedy: Where is the M in the MCH'? (1985) (326)8446 The Lancet 83; Shiffman and Okonofua (n 14) 129.

[219] LA Post and ANW Raile and Eric D Raile, 'Defining Political Will' (2010) 38 Politics & Policy 653 < https://doi.org/10.1111/j.1747-1346.2010.00253.x > accessed 30 December 2023.

[220] ibid 656; Derrik W Brinkerhoff, 'Unpacking the Concept of Political Will' (2010) U4 Chr Michelsen Institute< 3699-unpacking-the-concept-of-political-will-to.pdf (cmi.no)>accessed 30 December 2023.

[221] Derrik W Brinkerhoff (n 220).

nowhere near what is needed to discharge its obligation.[222] Nnamuchi and others, also agree that Nigeria has not met this obligation.[223]

In 2018, Nigeria's health system ranked 187 out of 190 countries and this has been described as the result of Nigeria's low financial commitment to the health sector.[224] As against 15% of the total budget, which was agreed at the Abuja Declaration, as least necessary to service the sector, Nigeria, has at the most, in the past 10 years allocated 5.95%[225] of its total budget to health.[226] In 2021, the health sector got 4.18%, while sectors such as works and housing, transport, and power had higher allocations.[227] The NHA's provision for 1% allocation from the Consolidated Revenue Fund to the health sector only took off in 2018. The amount was on a downward trend except in 2021 when the sum surpassed that of 2020.[228] This increment was a reflection of a higher budget. It was revealed that a third of this budget was planned to be funded by borrowing as the country was allegedly finding it difficult to generate revenue.[229] That revelation may signify a possible challenge to the country, but the obligation of progressive realisation is based on how the available resources is utilised. The issue of inability and unwillingness can also be extended to the shortcomings regarding the legal, social and cultural factors discussed above.

Identifying whether the actions or omissions that fall short of compliance stem from the lack of capacity or the unwillingness of Nigeria to comply with its RH obligations can be difficult to determine. It has been observed by Cole that there are arguments that the decision to respect or refuse to honour a human right is deliberately made by state officials.[230] He contends however that there is an unfair assumption that it is all about willingness. The managerial approach to compliance supports this view.[231] The understanding is that states

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[222] For example, the Accelerated Reduction Policy reported that only 40% and 22% of Primary Health Centres (PHCs) in the NE and NW regions respectively had supplies of oxytocin. In the case of magnesium sulphate, it was in only 20% and 13 % of PHCs in both regions respectively. Accelerated Reduction Policy (n 1) 4.
[223] Nnamuchi Obiajulu and others 'Nigeria's National Health Act, National Health Insurance Scheme, National Health Policy: A Recipe for Universal Health Coverage or What? (2019) 37(4) Medicine and Law 645, 677.
[224] Gender in Health Policy (n 45) 15.
[225] This was in 2012.
[226] Olanrewaju et al noted that the budgetary allocation kept reducing from 6.2% in 2015 to 3.9 in 2018. Olanrewaju Tejuoso, Gafar Alawode, Elaine Baruwa Health and the Legislature: The Case of Nigeria (2018) 4 (2) Health Systems and Reforms 62.
[227] Pulse Mix, 'Analysis of the 2021 Proposed Budget' (Pulse.ng, December 1, 2020) < Analysis of the 2021 proposed Health budget | Pulse Nigeria >accessed 30 December 2023.
[228] NGN26.46billion in 2020 to NGN35.03 billion in 2021. Pulse Mix (n 225); Damilola Ojetunde (n 88).
[229] Pulse Mix (n 225).
[230] Wade M Cole, 'Mind the Gap: State Capacity and the Implementation of Human Rights Treaties' (2015) 69 International Organisation 406.
[231] ibid.

intend to comply with agreements they enter into, but often do not have the capacity to comply with the treaty obligations.[232] Capacity has been defined as "the ability of individuals, institutions, and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner."[233]

As repeatedly referred to in this thesis, RH requires states to take immediate as well as progressive actions to realise the right to health. These obligations are also applicable to realising SRHR[234] and invariably a MM reduction campaign animated by the right to health. MM itself is caused by a range of complex factors and the underlying social determinants are of such expansive nature. The nature of the underlying determinants and the barriers to the right to maternal health are such that require intersectional analysis and corresponding interventions.[235] Consequently, the actions expected are quite formidable. These actions require a high level of capacity, as well as difficult and complex governance decisions to be made because both ESC rights, SRH rights and women's rights are highly contested terrains.[236]

Conversely, there are suggestions that the nature of the legal provisions providing for the obligations contribute to the level of compliance they are accorded. Although Guzman argues that compliance with international agreements should not depend on the status of the agreement but the state's stated commitment, he admits that due to the lesser status of soft law to the traditional sources of international law, states are likely to accord it less authority.[237] In the same vein, non-compliance with such an agreement, attracts lighter penalty on the reputation of the erring state. In relation to women's right to safe motherhood, it is noteworthy that apart from the often-limited provisions in binding documents, most of the details of the RH standards, including MH protection strategies, are contained in non-binding international documents as well as global health policies. Therefore, while considering the possibility of the state being overwhelmed by the onerous expectations thrust on them, this observation about the contribution of the legal nature of the obligations is equally acknowledged as plausible. In light of the foregoing, it is concluded that it remains difficult to completely categorise the nature

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[232] Chayes and Chayes (n 184); Andrew Guzman, 'A Compliance Based Theory of International Law' (2002) 90(6) California Law Review 1823, 1874

[233] UNDP, 'Measuring Capacity' (2010) < CDG Measuring_Capacity_July_2010_1_.pdf (undp.org) >

[234] GC22.

[235] Judah Batist, 'An Intersectional Analysis of Maternal Mortality in Sub-Saharan Africa: A Human Rights Issue' (2019) 9(1) JoGH< jogh-09-010320.pdf > accessed 30 December 2023.

[236] Amy Tsanga, 'Moving Beyond Rights in the Realisation of Economic, Social and Cultural Rights: Challenges in Contemporary Africa' (2007) 15 African Yearbook of International Law < afyo-article-p69_6.pdf > accessed 30 December 2023.

[237] Guzman (n 232) 1879.

of Nigeria's actions and inactions, which are often described by activists and scholars as breaches of their RH obligations, as due to lack of willingness or inability. However, the empirical investigation in Chapter 6 may throw some light on the issue.

## 5.7 Conclusion

The aim of this chapter was to investigate the extent to which the legal, policy and other aspects of Nigeria's MM reduction framework comply with right to health standards. The essence was to assess the possibility of achieving MM reduction in Nigeria through RH by evaluating the extent of compliance with the standards of the right and the ways in which compliance has been limited. The investigation was undertaken from the standpoint of the whole gamut of RH, thus covering the AAAQ of reproductive and maternal healthcare and other determinants, including factors which prevent access to healthcare or which directly or indirectly precipitate maternal death or ill health. To this end, laws and policies which address the social, economic, and cultural factors that contribute to MM were also examined. They were examined not only for their conformity with the letter of the international prescriptions but also for conformity to the underlying philosophy of the international framework which encouraged the adoption of measures relevant to local conditions. Evidence of adequacy, appropriateness and compliance of the laws, policies and initiatives with the expectations of RH or the converse, have been duly highlighted. Although some of the measures examined comply with RH standards, others require changes to improve compliance.

Generally, the findings are that compliance with right to health standards is more pronounced in respect of healthcare aspects, although despite this, there is still deficiency in the healthcare aspects. The conformity with RH standards is not a priority in addressing the political, legal, social, economic and cultural determinants that negatively impact women's health. Co-incidentally, the Gender in Health Policy had observed that Nigeria's health system focuses on the biomedical aspects of health to the detriment of the socio-economic determinants of the population's health.[238] In sum, in Nigeria, the RH approach has had more impact on the medical causes and healthcare interventions of MM than the underlying determinants.

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[238] Gender in Health Policy (n 45)16.

The findings from this chapter and the previous chapters have shown that despite the demonstrable potential of RH to contribute to the reduction of MM, some of the relevant norms and standards appear contentious. Some of them, such as, constitutionalising RH, fulfilling obligations in respect of adolescents' reproductive health, liberalisation of abortion, effective accountability measures, adequate protection against gender-based violence are the same standards that Nigeria falls short in complying with. It was been observed that while most of these issues have been the subject of previous discussions on a global scale, or in the context of Nigeria, others such as the weaknesses of maternal death reviews, the distinction between inability and unwillingness in respect of political will have not been visible In terms of political will which is repeatedly described by experts as the key ingredient to compliance, it was observed that it may be difficult to classify the criticised actions or omissions of Nigeria as due to inability or unwillingness to address all the factors impacting Nigeria's MM ratio.

Closely related to the issue of political will is the lacuna observed in the literature that there is a paucity of studies examining the RH recommendations from the viewpoint of the implementers. Therefore, the view of implementers in respect of the sector will be explored in the next chapter. The next chapter will employ empirical methodology to explore the implementation or supply side of RH, and it will focus on the experiences of the implementers. The aim is to find out their experiences with operationalising the framework, including whether their challenges resonate with the challenges that have been associated with applying the standards of the framework.

# Chapter 6

# Challenges Militating Against the Implementation of the Right to Health Framework for the Reduction of Maternal Mortality in Nigeria

## 6.1 Introduction

Nigeria has adopted various international and regional human rights instruments, action plans and blueprints which provide guidance for the reduction of preventable maternal mortality (MM). These various documents produced by a range of stakeholders, including human rights experts or international bodies which monitor countries' maternal healthcare obligations, have recommended a range of measures. These measures include healthcare interventions which is an aspect of states' RH obligations. As discussed in Chapters 2 and 4, states discharge this obligation by meeting the criteria of ensuring that healthcare services and goods are available, accessible, acceptable and of good quality (AAAQ).[1] At the same time, the implementation must also be guided by the principles of non-discrimination and equality, empowerment of duty bearers and right holders, accountability and participation which characterise a human rights approach and which have been discussed in Chapter 4.[2] Consequently, in accordance with the aim of this thesis, Nigeria's efforts to reduce MM is being examined for compliance with these standards. The most obvious evidence of compliance with international RH standards in respect of MM reduction is lower MM ratios which Nigeria has evidently failed to achieve. [3] As a social right, RH admits the progressive realisation principle which is a practical response to the reality that the unavailability of resources can hinder the immediate realisation of economic, social and cultural rights.[4] The principle, places on states, the obligation to take appropriate steps towards the realisation of socio-economic rights and in this case, maternal health (MH), to the maximum extent possible.

[1] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant, 11 August 2000, E/C.12/2000/4, (GC 14) para 12.
[2] ibid para 54.
[3] ibid para 52.
[4] ibid para 30.

The evaluation of Nigeria's compliance with multiple or single measures which form part of states' RH obligations relevant for MM reduction has been the subject of several studies and investigations. An assessment of Nigeria's framework carried out in Chapter 5, which was based on the findings in some of these studies, concluded that Nigeria's efforts were inadequate in certain respects. As a corollary, this chapter undertakes the next aim of the thesis which is to investigate the challenges experienced by government stakeholders while implementing measures to give effect to some RH standards relevant to reducing MM. Some studies in the literature which have identified challenges to compliance have been done by maternal health advocates and experts from various fields who base their reports on their own assessment of the situation and from information available in the public sphere.[5] Some scholars who employed empirical methods have reported challenges in respect of the interventions or efforts from the viewpoint of women and from NGO stakeholders.[6]

Thus, as an original contribution to the literature, this study unprecedentedly examines the standards which Nigeria has a duty to comply with from the viewpoint of the government duty bearers. The government is represented in this study by the officials who implement the measures and interventions. This study is conceived to investigate the factual extent of the State's compliance with RH standards relevant for the reduction of MM, the nature of challenges, if any, that the state/government duty bearers have to grapple with in the course of implementing the measures, and the appropriateness of the measures for the Nigerian MM situation.

Broadly, RH extends to both healthcare and the underlying determinants of health. However, as is explained below in the methodology section, combining the investigation of both components in a study will require more space than this study can provide. Therefore, the study limits its focus to the RH/MH healthcare entitlements. Broadly, this relates to the government's duty to guarantee the availability, accessibility, acceptability and good quality (AAAQ) of sexual

[5] For instance, Obiajulu Nnamuchi and Miriam Anozie and Festus Ukwueze, 'Maternal Health and Millennium Development Goal (MDG) 5 in Nigeria: Any Catalytic Role for Human Rights' (2015) 34 Medicine & Law 381.
[6] Loretta Favour Chizomam Ntoimo and others, 'Why Women Utilize Traditional Rather than Skilled Birth Attendants for Maternity Care in Rural Nigeria: Implications for Policies and Programs' (2022) 104 (103158) Midwifery; Ejiro J Otive-Igbuzor and others, 'Saving the Lives of Women, Newborns, and Children: A Formative Study Examining Opportunities to Improve Reproductive, Maternal, Neonatal, and Child Health Outcomes in Nigeria' (2017)21(3) African Journal of Reproductive Health 102.

and reproductive health facilities, goods and services[7] which are relevant to prevent maternal deaths. These interventions have been discussed generally and in the context of Nigeria in Chapter 3. In Chapter 4, the usefulness of the HRBA to health – comprising RH standards and the other HRBA principles- for MM reduction was considered. At the same time, attention was drawn to challenges involved in the application of these standards. The discussion in Chapter 5 also showed that there are concerns in respect of Nigeria's compliance with its obligation in respect of RH's healthcare entitlements. The participants in this study are drawn from two categories of healthcare implementers - regulatory bodies and policymakers. The former is represented by selected Lagos State health agencies whose role touches on maternal healthcare[8] and the Lagos State Ministry of Health (LMOH), and the latter by the government healthcare providers.

The chapter begins with a discussion of the methodology of the study, in which the study plan, selection of participants, and the collection and analysis of data are explained. The interview findings, first from the key informants (KIs) at the agencies are presented, and then that of the KIs at the hospitals are presented after it. This is followed by a summation of the findings according to the aims of the study, some observations and the conclusion.

## 6.2 Methodology

The thesis is socio-legal in approach as it studies the law in relation to the wider social, political and economic structure within which it is implemented.[9] In this case, it assesses the international RH standards and norms applicable to the reduction of MM in relation to the societal context of Nigeria. The aims of the entire thesis have been planned to be achieved through the employment of doctrinal and empirical methods. The doctrinal method has enabled an analysis of the

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[7] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 22 (2016) of the CESCR on the Right to Sexual and Reproductive health E/C.12/GC/22, paras 12-21.

[8] LASHMA, HEFAMAA, LSTMB AND LSBTS. These agencies were members of the state committee created to offer technical guidance on the various modalities needed for the reduction of maternal mortality using the National guidelines for the Integrated Maternal, Newborn and Child Health strategy (IMNCH) and the SOGON National Partnership plan for sustainable Reduction in maternal and Newborn Deaths. Lagos State Ministry of Health, 'Lagos State Maternal And Child Mortality Reduction (MCMR) Program (LSMOH, April 3 2017)< LAGOS STATE MATERNAL AND CHILD MORTALITY REDUCTION (MCMR) PROGRAM – Ministry of Health> accessed 30 December 2023.

[9] Darren O Donovan, 'Socio-legal Methodology: Conceptual Underpinnings, Justifications and Practical Pitfalls' in Laura Cahillanne and Jennifer Schweppe (eds) *Legal Research Method: Principles and Practicalities* (Clarus Press, 2016) 31.

instruments, laws and policies relevant to maternal health both on the international and national (Nigeria) levels. The present section focuses on the methodology of the empirical aspect of the thesis.

### 6.2.1 Overview of the Empirical Method

The empirical study was adopted as a research method in this thesis because there was a need to gain the perspectives of the implementers of maternal health policies on the content, implementation, and prospects of the RH framework for reducing MM in Nigeria. Owing to the fact that, the perspectives and experiences of the duty bearers or implementers, with respect to their perspectives and experiences with the recommended right to health interventions are not portrayed in the literature reviewed, this study is quite exploratory.[10]

This relative newness of the research idea, also meant that there was uncertainty about what information can be obtained and how much data can be generated.[11] Therefore, a non-probability sampling method was used to allow the possibility of any member of the target group to be able to participate in the interviews.[12] Again, being exploratory, there was no hypothesis in the study plan, although there was an expectation that one may emerge from the data. The aim of the empirical study was to get information in relation to guaranteeing various aspects of SRH of women, as well as the enforcement of those freedoms or entitlements, therefore, the initial interview plans included interviewees from the Ministry of Women's Affairs, women of reproductive age, reproductive rights NGOs and members of the judiciary at a minimum. However, upon greater reflection on the status of this study as only one chapter of the thesis and therefore subject to word limits, it was determined that an in-depth engagement would be impossible if too many issues were discussed in the study. To decide which issue to focus on, the intended interviewees were grouped along the lines of their anticipated contributions. Three groups emerged - contribution in respect of implementing the healthcare aspect, underlying determinants of health, or enforcement of the obligation. The interviewees mentioned above would have mainly been interviewed on

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[10]One of the instances that necessitates the exploratory approach is when a group, activity or issue has previously received little scrutiny. Robert A Stebbins, *Exploratory Research in the Social Sciences* (SAGE Publishing 2001)10.
[11] ibid.
[12] I Etikan and M Sa and RS Alkassim, 'Comparison of Convenience Sampling and Purposive Sampling' [2016] 5 American Journal of Applied Maths & Statistics 1.

guaranteeing the underlying determinants of health and/or their enforcement. Thus, the decision was made to select the group which had the higher number of intended interviewees and increased the possibility of gathering substantial data. The group implementing the healthcare interventions was selected.

As indicated above, besides gaining the perspectives of the implementers, the empirical study was also conceived as an opportunity to clarify the extent of Nigeria's compliance with the RH standards. There was significant reliance on government websites in earlier sections of the thesis to ascertain the different measures that were adopted by Nigeria in a bid to fulfil its MH obligations. However, some caution was necessary because some of the policies' expiry dates had passed, and the websites of the Federal Ministry of Health (FMOH) had not been updated to reflect replacements. The situation was the same with LMOH's website, so the use of interviews was a good research decision.

This empirical study is based on one of the component states in the country, although the laws and policies reviewed in Chapter 5 were developed and enacted by the federal government. As also discussed in Chapter 5, in the constitutional arrangement, the federal government formulates policies and provides funding for healthcare, but the component states domesticate those programs and policies in their states. The residual legislative powers that States have in relation to health mean that they primarily determine the health policies and programmes that operate in their states. A preparatory interview with a senior official of the FMOH also encouraged the decision to focus on states instead of the federal government whose authority was restricted to the federal capital and some tertiary healthcare institutions all over the country. He said, '...you know, the states are just collecting money, and they are just doing what they want'. This revelation brought to focus the fact that, to an extent, there were disparities in health policies among the states since the primary determinant of health policies and measures were the component states. Focusing on one state also aided manageability, especially against the background that the empirical study is only one of the methods of the research and is aimed primarily at acquiring first-hand knowledge of the application of the standards in Nigeria.[13]

[13] Moreso, it has been observed that the size and complexity of the country is a challenge for health policy makers. Federal Ministry of Health, Second National Strategic Health Development Plan (2018-2022) 5 <NSHDP II Final.pdf (health.gov.ng)>accessed 30 December 2023.

Lagos State was selected, in part, because of its accessibility to the researcher and the availability of eligible participants. It is also one of the states known for pro-activity in healthcare provision including in domesticating federal health policies. These features were considered useful for generating the data that would be relevant to achieve the aim of the study. Still, it must be noted that although the objective of the study was to investigate the experience of the implementing stakeholders of maternal healthcare in Nigeria, it may be difficult to generalise the findings to all other component states of the country due to differences in government priorities and institutions and in the social, economic, cultural situations of each state.[14] However, the findings of this study could support efforts to develop MM reduction policies, or implementation strategies that are more effectively tailored to the peculiarities of Lagos State. Different aspects of the findings would also be useful to other states in Nigeria, or sub-Saharan African countries which share any of the circumstances or situations prevailing in Lagos State. These include the high MM ratio, the causes as well as the adoption of any of the measures investigated, for the prevention of MM. Socioeconomic factors such as underdeveloped economic infrastructure and the presence of residents with a high poverty level who also adhere to strong cultural beliefs, are relevant common denominators.

Semi-structured interviews, a qualitative research method, were used to interrogate key informants.[15] Semi-structured interviews comprise pre-set open-ended questions based on an interview guide, while the guide usually comprises core or associated topics or questions, that the interviewer wishes to explore.[16] Therefore, the prepared interview questions were only a guide, and so allowed for further questions which could arise from the answers given. As a result, the key informants interviewed were informed that they could be contacted later to make clarifications or provide answers to more questions.

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[14] KIH 2 who explained that he had practiced in other parts of the country and had some knowledge of the current situation in other states specifically warned against comparing Lagos with many other states in the country.

[15] The qualitative research method facilitates an extensive understanding of the issues being investigated as it allows detailed and in-depth information to be elicited from the participants. JW Creswell, *Qualitative Enquiry and Research Design: Choosing among Five Approaches* (International Student edn., Thousand Oaks California Sage 2007); Shahid Khan, 'Qualitative Research Methods: Grounded Theory' (2014) 9 (11) International Journal of Business Management 225.

[16] Shazia Jamshed 'Qualitative Research Method Interviewing and Observation' (2014) 5(4) Journal of Basic & Clinical Pharmacy 87.

Key informants (KIs) were used in this study because they are persons considered appropriate or capable of providing the needed information based on their expertise, position or experience.[17] Moreover, key informant interviews are invaluable when the information available is not sufficient to work with.[18] The limitation however is the fact that they may be biased in giving their opinions and recommendations.[19] The researcher was very aware, and wary, of this possibility especially as all the KIs are in government employment. However, some of the information given in the interviews on the agencies' operations are well known to the other stakeholders in the health sector and had already been brought to my knowledge while making preliminary enquiries from acquaintances who work in the private health sector. Furthermore, the fact that despite being unconnected, the participants, especially the hospital KIs, gave similar information thereby corroborating each other, led to the conclusion that, where bias existed, it was minimal.

As highlighted above, the issues explored in the interviews were related to RH healthcare entitlements or interventions that are necessary for the reduction of MM. The featured agencies and healthcare facilities were selected because their functions are connected to operationalising measures connected to the standards of RH approach relevant for the reduction of MM. Specifically, the information provided was on the availability of healthcare facilities, skilled medical personnel, availability of blood for transfusion, financial and physical accessibility of healthcare, acceptability of the medical interventions and ensuring quality healthcare services and goods. Questions were also asked to get an insight on how the general human rights principles of the HRBA to health guided the discharge of their obligations. On the last aspect, the participants' responses touched indirectly on principles like empowerment of the right holders, participation, and non-discrimination, but the information they gave about accountability was quite substantial. Due to this, the findings on accountability were set out separately.

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[17] Krishna Kumar, 'Conducting Key Participants Interviews in Developing Countries' (AID Program Design and Evaluation Methodology Report No. 13. December 1986. PN-AAX-226) <PNAAX226.PDF (usaid.gov)> accessed 30 December 2023.

[18] Gloria Ann Jones Taylor and Barbara Jean, Blake, 'Focus Groups and Key Informant Interviews' in Mary de Chesnay (ed), *Nursing Research Using Data Analysis: Qualitative Designs and Methods in Nursing* (Springer Publishing 2014) 153.

[19] ibid 154.

### 6.2.2 Setting of the Study

The study was conducted in Lagos State. The State is in the southwestern part of Nigeria and is one of the oldest states in Nigeria, being one of the first 12 states. In terms of land mass, it is the smallest state (356,861 hectares of which 75,755 hectares are wetlands),[20] yet it has the highest urban population,[21] which is 27.4% of the national estimate,[22] and produces 10% of Nigeria's GDP.

The population is estimated to be 24 million[23] and in terms of ethnicity, the State is dominated by *Yorubas,* although there are *Aworis* and *Eguns* who are indigenous to Ikeja and Badagry respectively. Despite its Yoruba indigeneity, the State is cosmopolitan in outlook and therefore home to many other Nigerians and people from different parts of the world. Various healthcare facilities both public, covering all three levels that is primary, secondary and tertiary, and private abound in Lagos State. As of 2017, the number of primary health care centres in Lagos was 256, secondary healthcare facilities, 26 and, private hospitals, specialist clinics and laboratories stood at 2886.[24] The doctor-patient ratio is 5014 persons to 1 doctor[25] as against the WHO recommendation of 1:1000.[26] The maternal mortality ratio of Lagos, especially in rural areas is high[27] at 555 per 100,000 live births,[28] and more than two-thirds of the deaths are blamed on late presentation.[29] Although about a quarter of Lagos is riverine and linked by waterways, roadways are the primary mode of transportation. Poorly planned road networks, poorly

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[20]Lagos State Government, 'About Lagos' (Lagos State, 2022) <About Lagos – Lagos State Government>accessed 30 December 2023.

[21]The census conducted by the Lagos Population Commission places Kano as the most populated and Lagos second but Lagos disputes that assertion based on its own independent census. ibid.

[22] ibid.

[23] NPR, 'Lagos, Nigeria's Coastal Megacity, is Experiencing a Population Boom' (NPR, April 5 2023) <Lagos, Nigeria's coastal megacity, is experiencing a population boom : NPR> accessed 30 December 2023. There are other projections of the population but none estimates that it is lower than 15.9 million.

[24]Rasak Musbau, 'Lagos and Equitable Healthcare Services' (Lagos State Government , 5th July 2017) <LAGOS AND EQUITABLE HEALTHCARE SERVICES – Lagos State Government> accessed 30 December 2023.

[25] Maxwell Obubu and others, 'Evaluation of Healthcare Facilities and Personnel Distribution in Lagos State: Implications on Universal Health Coverage' (2023) 51(2) Hospital Practice 64.

[26] WHO, Global Strategy on Human Resource for Health: Workforce 2030 (2016) 46.

[27]Friday Okonofua and Others, 'Maternal Death Review and Outcomes: An Assessment in Lagos State, Nigeria' (2017)PLoS ONE<Maternal death review and outcomes: An assessment in Lagos State, Nigeria | PLOS ONE>accessed 30 December 2023.

[28] This information is based on the data available at the Lagos State Ministry of Health as at 2020. Sadatuoshi Matsuoka and others, 'Underlying Causes of Underutilisation of Maternal Neo-natal and Child Health (MNCH) Services in Africa: A Survey from Lagos State Nigeria' (2020)2 (3) Global Health and Medicine 184.

[29] ibid.

maintained roads, broken down vehicles and floods during the rainy season contribute to Lagos' notorious traffic delays.[30]

### 6.2.3 Study Participants

The participants were 10 in all, and they were recruited using convenience sampling, a type of non-probability sampling. This sampling method was used because it allows selection of participants based on criteria such as accessibility and availability which is ideal because the target population are busy persons who might be difficult to pin down.[31] On the basis of this, the request made to the supervisory ministry, the specific government departments and the parastatals was to be allowed to meet with available participants from the above-mentioned target groups. The plan was to interview 18 participants, that is, two participants from each of the selected agencies or the MCCs. However, it turned out that, in the four health agencies, only one official could answer the questions knowledgeably and three of them were medical personnel. I met with the senior legal officers in two of the agencies who admitted to me that they did not possess enough information to answer my questions. At the LMOH also, only one person -the director of the most relevant unit - was assigned to answer the questions.

There is no particular number of participants needed for a qualitative study although, it is possible that a limited number of participants may affect the strength and the rigour of the findings of a study.[32] Determining the number of participants needed is usually based on the aims of the study, the type of study and the questions to be answered.[33] It has also been argued that where theory, quality participants and analytic strategy are present, and it can be shown that the required information relevant to meet the aim of the study is held by the available sample, fewer participants will be needed.[34] This latter criterion may also be likened to the usual standard of determining maximum sample sizes – saturation - that is the stage where no new information is

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[30] DN Nwaigwe and others, 'Analytical Study of Causes, Effects and Remedies of Traffic Congestion in Nigeria: A Case Study of Lagos State' (2019) 5 (9) International Journal of Engineering Research & Advanced technology 11 < 0dc5b7987d69c48cdbbed3afffb81a688e1c.pdf (semanticscholar.org)> accessed 30 December 2023.
[31] Etikan and Sa and Alkassim (n 12)4.
[32] Melissa DeJonckheere and Lisa M Vaughn, ' Semi Structured Interviewing in Primary Care Research: A Balance of Relationship and Rigour' (2019) Family Medicine& Community Health 1, 4 <Semistructured interviewing in primary care research: a balance of relationship and rigour (bmj.com)>
[33] ibid.
[34] Kirsti Malterud and others, 'Sample Size in Qualitative Interview Studies: Guided by Information Power' (2015) 26 (13) Qualitative Health Research 1753.

elicited. As may be seen in this study, the category of interviewees whose professional experience and active involvement in the discharge of the obligations under investigation could satisfy the aim of the research were selected. Additionally, at the government bodies, the interviewees were the only officials, by virtue of their positions, who possessed the requisite knowledge and experience necessary to give the kind of detailed and comprehensive information the study required. A detailed and comprehensive analysis of the findings on the basis of the RH framework has also been undertaken. As a result, despite the limited number of participants in this study, the rigour of the findings of the study is unaffected.

The 10 participants consisted of five senior medical officers at the Gynaecology and Obstetrics (O&G) department of four out of the eight Mother and Child Centres (MCCs) in Lagos State. (KIH1-5). The KIHS have had between 18 to 38 years of experience. Three of the five have administrative experience. One of them has a public health qualification. In one of the MCCs, I was able to speak with an incumbent Head of Department (O&G) and a retired Head of Department. The remaining five participants were one senior official at the Maternal or Family Health department of the LMOH (KIM1), and one senior management level staff member each from Health Facility Monitoring and Accreditation Agency (HEFAMAA),[35]Lagos State Health Management Agency (LASHMA),[36] Lagos State Blood Transfusion Service (LSBTS),[37] and Lagos State Traditional Medicine Board (LSTMB) (KIA1-4).

### 6.2.4 Experiences Securing Ethical Approval, Government Permissions and the Interviews

Ethical approval for the interviews, including the permission to travel to Nigeria to conduct them, was received from Durham University Research Ethics Committee in 2021. The interviewer did not have previous experience of conducting empirical interviews in Nigeria outside a university environment. The Nigerian Health Research Ethics Committee's website contained some information including about a training program which is compulsory for persons undertaking health-related empirical research in Nigeria. However, the guidance on the various steps involved in the whole process was insufficient. Attempts was then made to ascertain Nigeria's research

[35] Health Sector Reform Law Lagos 2006 Part 5, ss45-78; HEFAMAA,' About us' <https://hefamaa.lagosState.gov.ng/ > accessed 30 December 2023.
[36] Lagos State Health Scheme Law 2015.
[37] Lagos State Blood Transfusion Committee Law no. 10 2004.

ethics approval process through previously published papers and theses, but these revealed different results.

A paper published in 2017, which involved the interview of key informants in Civil society organisations, NGOs and United Nations agencies nationwide, on barriers to Reproductive Maternal, Newborn Children and Adolescent Health (RMNCAH) among others, stated 'the study did not fall under the definition of human subjects research because personal data was not collected, rather only opinions about RMNCAH, health policies and advocacy barriers'.[38] This appeared consistent with Nigeria's National Code of Health Research Ethics (NCHRE), but the Code required exemption to be requested from the National Health Research Ethics Committee (NHREC) but which that study did not obtain. I also noted that in a 2015 thesis which involved interviewing pregnant women and medical practitioners in public hospitals in Lagos State, obtaining ethical approval was not mentioned, only the permission from the Chairman of the Lagos State health Commission to interview the medical practitioners was secured.[39] More recently (2022), a nationwide study on abortion – a health procedure- wherein medical practitioners, women and other stakeholders were interviewed was granted ethical approval by the researcher's institution's ethical review committee. [40]

Armed with my interpretation of the situations presented above, I enrolled for the mandatory research ethics training for Nigerian researchers whose research involved human subjects. Thereafter based on Section B, paragraph 2 of the NCHRE, that provides for instances where research activities involving human subjects are exempt from supervision, I applied to be granted an exemption. Relevant parts of paragraph 2 of section B are reproduced below (the emphasis is mine). The instances are:

> (b) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, **interview procedures** or observation of public behaviour, unless: (1) Information obtained is recorded in such a manner that human participants can be identified, directly or through identifiers linked to the participants;
>
> (d) Studies that are meant to evaluate the outcome of procedures, programs and services are exempt because they are designed to produce information leading to improvement in delivery of procedures, programs and services. Such studies usually evaluate measures that

[38] Ejiro J Igbuzor and others (n 6) interviewed CSOs, NGOs, international organisations.
[39] Idowu Adenike Esther, 'The Socio-Cultural Context of Maternal Health in Lagos State Nigeria', (PhD Thesis, Covenant University 2013) 94.
[40] Razaq Justice Adebimpe, 'Liberalisation of Nigeria's Abortion Laws with a Focus on Pregnancies Resulting from Rape: An Empirical Analysis' (2021) African Human Rights Law Journal 473.

are already in use and considered part of standard practice. They may include collection and analysis of data or collection of new data but they do not involve allocation into groups or randomisation.

I Studies that are designed to evaluate or assess quality of services, programs and procedures and formulate guidelines leading to their improvement are exempt. Such studies may involve the collection and analysis of some data.

I explained in the application that the interviews were anonymous, and were aimed at evaluating the procedures, services and programmes designed to reduce MM, but I did not receive a response to my application. When I approached the Lagos State Ministry of Health (LMOH), they confirmed that ethical approval was required for my proposed study but informed me that they did not have an ethical review committee. I was directed to the ethical review committee of the National Institute of Medical Research (NIMR). However, apart from the ethical approval, the LMOH presented me with other requirements. In my quest for guidance to satisfy these requirements, I looked up the papers of two of Nigeria's most prolific health law scholars, Obiajulu Nnamuchi [41] and Cheluchi Onyemelukwe.[42] I hoped to find an empirical paper from either of them that had gone through the ethical approval processes, but I found that neither of them nor any other law researcher had published a health-related empirical paper.[43] The health-related empirical papers I came across were published by non-law scholars (I checked author affiliations). This meant that my proposed study was breaking into an uncharted terrain for Nigerian health law researchers.

At NIMR, an extensive protocol was submitted, and the ethical approval was granted about three months after the application was made. After the approval, a two-stage approval spanning three weeks[44] followed in order to receive permission to interview officials at the health agencies. The first approval was at the Office of the Head of Service, and the second one at the research unit of the LMOH. For the medical practitioners, after the LMOH approval, I still had to go through

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[41] Google Scholar, 'Obiajulu Nnamuchi Profile' <Obiajulu Nnamuchi - Google Scholar >

[42] Researchgate, Cheluchi Onyemelukwe, Research Profile' <Cheluchi ONYEMELUKWE | Professor | Babcock University, Ibadan | Research profile (researchgate.net)>

[43] Recently however, I came across an empirical paper published in 2021 in which Onyemelukwe is one of several authors. Olusesan Ayodeji Makinde and others, 'The Nature of Technology Facilitated Violence and Abuse Among Young Adults in Sub Saharan Africa' in Bailey J and Flynn A and Henry N (eds) *The Emerald International Handbook of Technology Facilitated Violence and Abuse (*Emerald Publishing Ltd 2021) 83. Ethical approval was received from the Human Research Ethics Committee of the University of the Witwatersrand.

[44] I had been informed that the processes usually take as long as three months.

two more stages of approval. A third approval was sought from the Health Service Commission (HSC) who issued a letter permitting the officials to grant the interviews. At the MCCs, despite being armed with the HSC's approval letter, the officials in charge also insisted on seeing the protocol and the ethical approval before I was granted access to the doctors. This was the fourth level of approval. All of these required moving from one end of Lagos to another and visiting the supervisory government departments every day.

I encountered a greater challenge with the interviews of the medical practitioners at the hospitals than at the agencies. At the agencies, following an initial visit, I was directed to the most knowledgeable official, who usually gave me the interviews after a few hours of waiting. As noted earlier, three out of the four KIAs are doctors. The three physician KIAs were persons with immense experience who had practiced extensively at various hospitals before holding these administrative positions. The officials who attended to my request for approval at the MOH, as well KIM1, was also a doctor. Evidently, Nigeria's healthcare sector is dominated by doctors.[45]

The interviews were carried out by phone and in person. During the in–person interviews at the hospitals, it was evident that I was infringing on much-needed patient time as nurses were interrupting from time to time to inform the doctors that patients were waiting. I had anticipated this situation during the planning and therefore considered the possibility of online or phone interviews. However, I also knew that although I was going to deal with professionals, anxiety among Nigerians about phone and internet scams as well as other security issues, would require me to physically appear at the agencies or hospitals to interview the intended participants there at their convenience, or to get them to personally provide me with their phone numbers in order to interview them later, online or by phone. But the length of time it eventually took for the ethical and hospital approvals to be granted meant I had to resort to requesting an intermediary to contact them on my behalf.

The situation that followed was exactly what I anticipated would happen if I did not make the contacts personally. The initial intermediary who is a senior government health official helped with making one contact and thereafter stopped answering my messages. Other intermediaries

[45] Ogor Alubo and Vitalis Hunduh, 'Medical Dominance and Resistance in Nigeria's Health Care System' (2017) 47(4) International Journal of Health Services 778 <https://doi.org/10.1177/0020731416675981 >accessed 30 December 2023.

eventually assisted to make the contact but getting the doctors to give the phone interviews was equally difficult. Except for one of the doctors who immediately granted me the interview provided that I did not mind that he was driving, I had to chase the others down with numerous messages before they granted the interviews. On average, it took about one month each to secure each MCC interview. The participants were understandably busy.

The study also involved a lot of financial commitments which my scholarship did not cover. I incurred expenses on logistics including the ethical approval from NIMR, flights to Nigeria, and intra-Lagos transportation to the offices where I secured the approvals and to the different interview locations. However, despite the challenges, new knowledge was gained in terms of the field of study while my experience and exposure as a researcher has been enhanced. Nonetheless, because of my experience, I could not help but conclude that the dearth of empirically conducted health law research among Nigerian law researchers may be attributable to the challenges involved. This fairly detailed account of the procedures as well as the difficulties encountered are set out with the intention of being able to provide other researchers with the guidance I was unable to find.

### 6.2.5 Data Collection and Analysis

The participants were all interviewed by the researcher and the interviews were recorded after seeking the consent of the participants. Where required, the participants were furnished with a copy of the interview questions beforehand. The duration of each session depended on the participant being interviewed and their reactions to the questions posed. The shortest interview was 25minutes while the longest was about two hours and these were both with senior officials of the MCCs. As noted above, some of the interviews were conducted on-site and others through the phone. The interviews were recorded using a voice recorder.

The interviews were thereafter transcribed according to each interviewee. Being an explorative study, the information from the interviews was grouped according to the issues explored in the questions and the themes that emerged from the interviews. It was pre-determined that the agencies would address the issues within the scope of their functions. Therefore, they were queried as follows: HEFAMAA on monitoring healthcare facilities to guarantee quality services,

LSBTS on availability of blood for transfusion, LASHMA on affordable healthcare, and LSTMB on regulation of traditional birth attendants. The doctors at the MCCs were questioned on their first-hand experience of the causes of MM in Nigeria and challenges with administering the medical interventions. However, due to the non-restrictive nature of semi-structured interviews, the responses of the key informants of the agencies addressed issues within the purview of other agencies and the doctors' responses sometimes touched on issues initially conceived for the agencies. The findings from each of the participants in respect of the operations of the agencies they represented was presented. The results capture their roles, the challenges they grapple with, efforts to overcome them and recommendations to further address some of the challenges.

Then the findings from interviews of the medical personnel were thematically analysed according to the issues explored and the other issues that emerged from the interviews. These findings are essentially the implementers' viewpoint of the measures they are required to implement and their experiences in operationalising them. The results cover the nature of the efforts, challenges as well and where available, actions taken to resolve them. Summaries on the objectives of the study and recommendations follow the analyses of contents of the interviews.

### 6.3 Findings and Discussion

In Nigeria, as well as globally, the leading medical causes of maternal mortality are eclampsia/pre-eclampsia, unsafe abortion, haemorrhage (PPH), infection and obstructed labour.[46] Although some of these complications are precipitated by preventable social, cultural, economic and legal conditions, they can be addressed by specific healthcare interventions. As laid out in Chapter 4, RH entitles everyone, including women, to healthcare facilities, goods, services and conditions that facilitate the highest attainable standard of health and in the process facilitate the reduction of MM. Additionally, as required in a HRBA, these obligations must be given effect to in an equitable, non-discriminatory, participatory and accountable context.

[46] Catherine Meh and others, 'Levels and Causes of Maternal Mortality in Northern and Southern Nigeria' (2019) 19 (417) BMC Pregnancy and Childbirth 1 < Levels and determinants of maternal mortality in northern and southern Nigeria (biomedcentral.com)>accessed 30 December 2023.

The healthcare entitlements which the literature on MM in Nigeria has highlighted or which the international monitoring bodies have raised specifically as impacting the MM situation of Nigeria include availability of healthcare personnel and facilities, access to free and affordable healthcare, availability of safe abortion services, accountability mechanisms, qualitative health care, remedy for disrespectful care or medical maltreatment, and availability of blood and access to blood transfusion. Some of these factors are cited as being responsible for the high patronage of traditional birth attendants (TBAs), and the patronage is often mentioned as one of the major factors causing Nigeria's high MM ratio.[47] However, on the basis that the RH also guarantees the right to indigenous preventive care, healing practices and medicines,[48] it is argued that the government's obligation with respect to the patronage of TBAs is two-fold. The first should be to ensure that women are not forced to patronise them because of the breach of government's obligation in respect of providing orthodox healthcare. The second duty is owed to women who choose TBAs or faith-based clinics as their preferred healthcare providers. This second duty stems from the government's 'obligation to protect' and act with due diligence[49] which necessitates that adequate regulation is provided to that stream of healthcare.[50] In this study, the efforts of the government to discharge these duties are explored.

In this section, the interview findings of the individual agencies are presented first (6.3.1-6.3.4). This is followed by the synthesised interviews of the doctors at the MCCs, and the ministry official. The findings are presented according to issues which emerged from the answers to the questions posed (6.3.5.1-6.3.5.7). As explained above, LASHMA (KIA1) provided information on the operation of the health insurance to give effect to the obligation to provide affordable healthcare; LSBTS (KIA3) provided information on the two-fold duty of making blood available and guaranteeing the quality, HEFAMAA gave information on ensuring quality healthcare services (KIA2) and LSTMB provided information on the regulation and monitoring of TBAs (KIA4).

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[47] Mfrekemfon P. Inyang and Okere Uloma Anucha, 'Traditional Birth Attendants and Maternal Mortality' (2015) 14(2) IOSR Journal of Medical and Dental Sciences 21.
[48] GC14 (n 1) para 34.
[49] OHCHR, Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity (2012) (Technical Guidance ) para 22 <https://www2.ohchr.org/english/issues/women/docs/a.hrc.21.22_en.pdf>
[50] ibid para 35.

### 6.3.1. LASHMA: Affordable Healthcare (accessibility) Universal Health Coverage

The second element of the AAAQ requires governments to ensure that healthcare (and all other forms of RH) is financially accessible. Universal health coverage (UHC) is concerned with equitable access to health services by providing access to the full range of essential services without financial hardship. The UHC is described as a practical expression of the concern of RH.[51] The UHC scheme has been in operation in Nigeria since 2005, and in 2021 the federal government required states to create sub-national versions. Lagos State's version is labelled *Ilera Eko.*[52]

The scheme is available to all registered residents of Lagos who can approach public hospitals and all private hospitals who participate in the scheme after they have subscribed.[53] For maternal and child healthcare there is a free parallel system that Lagos State and donors fund. But according to KIA1 and KIH2, the free maternal and child healthcare, which appears to provide prenatal care only, still involves the payment of 'a token here and there' (KIH2). Under the insurance scheme, the basic annual premium is NGN 8500 (18 USD) for individuals and for families comprising both parents and four children under the age of 23 it is NGN40, 000 (87 USD).[54] Of particular importance to MM, is that this sum according to KIA1, guarantees a caesarean section (CS) and five pints of blood in the event they are needed at any time during the pregnancy or at childbirth. It also covers antenatal care, post-natal care and all forms of family planning which KIA1 confirmed are also available to adolescents.

Confirming the reality of the benefits, KIH2 recalled that the husband of a woman who needed a CS and was appealing to the Medical Director for a waiver was directed to register for the *Ilera Eko* scheme. The husband reportedly came back with the testimony that, due to the subscription, he did not have to expend the little funds he had put together. However, KIA1 mentioned the existence of an indigent fund, therefore it appears that had he been completely unable to fund the care, that fund may have covered access to the care. KIA1 explained that the

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[51]WHO, 'Positioning Health in the Post 2015 Development Agenda: WHO Discussion Paper ( WHO 2012) <https://ccoms.esenfc.pt/pub/WHOdiscussionpaper_October2012.pdf > accessed 30 December 2023.

[52] It's in Yoruba language and it means 'healthy Lagos'.

[53] LASHMA, 'Lagos State Health Insurance Scheme' < Home - LASHMA - Lagos State Health Scheme (lashmaregulations.com.ng) > accessed 30 December 2023.

[54] LASHMA, 'Ilera Eko Social Health Insurance Plan Benefits Package' < ILERA-EKO-NEW-STANDARD-PLAN-BENEFITS-PACKAGE.pdf (ileraeko.com)> accessed 30 December 2023.

indigent fund guarantees access to patients who are proven to be indigent and cannot afford the basic premium. She added that under the scheme, there is also a special fund guaranteed by the office of the wife of the Governor to provide free healthcare to victims of sexual abuse. Every subscriber, including adolescents who subscribed on their own or under their parents can have access to contraceptives and contraceptive information under the *Ilera Eko* scheme. According to KIA1:

> We don't stigmatise, we don't say because you are underaged, we will not provide the services for you. There are systems in place to check those that deny them and there are adolescent clinics in schools that don't close at 4pm for students who want to go there after school hours ... although these clinics that have extended hours are not everywhere yet.

KIM1 however clarified that the clinics don't offer contraceptives to those younger than 18 thereby showing that although adolescents' reproductive health rights have received more recognition, policy changes are yet to be made to ensure that children (adolescents) are treated in accordance with their evolving capacities as required by international instruments.[55]

#### 6.3.1.1 Challenges to Ensuring Affordability of Healthcare

Increasing the number of subscribers is said to be the greatest challenge of the scheme. One of the reasons for the low subscription is that the scheme lacks the support of the populace. According to KIA1, 'people don't believe in it. They think it is too good to be true'. The KIA explained that while the pricing is low in order to reflect its status as a social plan, the Nigerian public who are used to paying exorbitant out of pocket fees, are suspicious of the scheme. KIH3 corroborated this observation but gave his reason for the suspicion to be the negative experience the Nigerian populace has had with government-driven projects which are usually characterised by corruption. He also extended the allegation to private hospitals who may give patients substandard drugs in a bid to retain more of the capitation fees.

Another reason for the low subscription, reported by previous studies on health insurance in the country, is the prevalent religious and cultural belief of many Nigerians that by planning for

[55] Committee on the Rights of the Child (CRC) General Comment No. 4 (2003) on Adolescent Health and Development in the Context of the Convention on the Rights of the Child. CRC/GC/2003/4; Also section 2.7.1 of Chapter 2.

illnesses, one attracts ill will to oneself.[56] According to KIA1, the typical response among Nigerians when educated about the benefits of a health insurance scheme is ‘I reject it’.[57] She concluded that ‘… behavioural change is difficult’. To combat this, KIA1 said the agency engages in continuous education and advocacy through various media to create awareness and to re-orientate the populace, including those who do not want to subscribe to an insurance scheme, they may not benefit from. The approach taken to address this problem is to make people to think of others who may need it. In her own words, ‘we promote altruism’.

The premium charged is low and according to the KIA, unreflective of the high inflation rate in the country though the prevalence of poverty in the State makes it difficult to charge any more. Meanwhile, the healthcare providers are agitating for increase of the capitation fee. The inadequacy of the capitation fee is further compounded by an imbalance in the category of subscribers to the scheme. Presently, the scheme is heavily populated by pregnant women who will almost certainly utilise their premiums thus translating into little or no profit for the providers. To worsen the problem, the women register on the scheme while they are pregnant and do not continue on the scheme once their premiums lapse, only to return to the scheme once they are pregnant again. This challenge may not be unconnected to the existence of Proprietary and Patent Medicine Vendors (PPMVs) which as described in Chapter 3[58] often provide primary healthcare beyond their licensure.

While there are advocacy campaigns to increase subscribers and dissuade women from these attitudes, the healthcare providers are encouraged to provide optimum care to improve confidence in the scheme and also to adopt strategies to enhance the value of the present capitation paid. For instance, ‘we advise them to adopt health programmes that will improve patients’ overall health so that they will not need to come to the hospital and use the premium’ (KIA1). The low premium however means that some very expensive or high-end treatments including certain drugs to treat PPH are not available on the scheme. KIA1 also complained of the difficulty with

[56] Gbadegesin O. Alawode and David A. Adewole, ‘Assessment of the Design and Implementation of the National Health Insurance Scheme in Nigeria: A Qualitative Study Among Subnational level Actors, Healthcare and Insurance Providers' (2021) 21 (124) BMC Public Health 1, 7 < https://doi.org/10.1186/s12889-020-10133-5 > accessed 30 December 2023.
[57] It’s a common expression, of religious origin, among Nigerians by which they verbally express their determination to be exempt from negative experiences.
[58] section 3.7.

identifying the people who qualify for free care under the indigent fund. As a result of a lack of effective data management systems in the State /country to monitor residents' income, persons who can afford the cost of healthcare pose as indigents to benefit from the free treatment. She said, 'because we say it is a social insurance, people take advantage of the system.'

The challenges also extend to the enabling law, which KIA1 recommends should make subscription mandatory. The state law presently states everyone should have a plan, which gives people a choice to take out any plan. However, to ensure universal health coverage (UHC) in a low-income country, the social insurance needs to be strengthened by increasing the subscribers. KIA1 said 'Insurance is a game of numbers.' She noted that presently people are being encouraged to sign up, '...but if the law says it is mandatory, we would be able to do more.'

### 6.3.2 LSBTS: Availability and Quality of Blood for Transfusion

Blood transfusion is one of the components of the comprehensive EmOC interventions to prevent deaths of women following complications in pregnancy, childbirth or after childbirth. As a result, over the years, nationwide, public hospitals have put in place a policy making spousal blood donation a requirement for registering pregnant women for delivery at public hospitals. When this policy was quashed in Lagos by a high court in 2020 (case discussed in Chapter 5.4), various Lagos State health sector stakeholders expressed that this development would worsen the difficulty in securing the availability of blood.[59]

The Lagos State Blood Transfusion Service (LSBTS) is in charge of making blood available and also of ensuring that the blood is of good quality. It works in conjunction with the public (at the state hospitals) and private blood banks which it monitors to make good quality blood available in the State. The testimonies of other KIs are to the effect that presently there has been some success in relation to these objectives. KIH1 noted, 'I have seen someone who needed 18 pints of blood …and we got it, unlike before when we would have been running up and down'. Describing the agency's commitment to ensuring quality, KIA3 explained that all the processes

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[59] A Onwuzoo, 'Court Order Banning Compulsory Blood Donation will Lead to Acute Shortage in Lagos – LASUTH CMD' Punch Newspaper (Lagos, 4 March 2020)< Court order banning compulsory blood donation'll lead to acute shortage in Lagos —LASUTH CMD - Healthwise (punchng.com)> accessed 30 December 2023.

followed by the state government's blood banks and the private blood banks with respect to collection and preparation of blood for patients' use, are WHO-prescribed, and Lagos State validated. For instance, all kits to be used in the State are revalidated because they are imported and had therefore been tested and certified on people of a different race. This is to ensure that the kits are similarly effective, and the materials used in their production do not react in a different way with Nigerian blood. This information was repeated by KIH4.

#### 6.3.2.1 Challenges to Ensuring Availability and Quality of blood for Transfusion

According to KIA3, the difficulty of getting voluntary donors is the biggest problem. This was corroborated by KIH3 and KIH4. In the words of KIH3 '…blood is not like other medical supplies, or where will government get blood, will they dig a well or a borehole that blood will be coming out of it?' While there are commercial donors who donate without hesitation, generally, the superstitious, as well as the religious nature of the Nigerian society make it difficult to get voluntary donors. Based on superstition, people query the purpose for which their blood will be used, and on the basis of religion refuse to accept that they could ever be in need of a blood transfusion. At least five of the KIs reported patients using the famous phrase 'I reject it' when the possibility of needing a blood transfusion was raised. KIA3 however, noted that some religious institutions encourage their adherents to donate blood. For instance, Islamic precepts encourage blood donation, and the Catholic church is a great advocate of blood donation and, as a group, its members are among the LSBTS' highest donors. No other KI spoke about religious beliefs and voluntary donation although all the KIHs agreed that Jehovah's witnesses – a Christian sect- did not support blood reception.

To address the general apathy for blood donation, the agency undertakes advocacy and sensitisation of the populace about blood donation. For instance, fliers targeting the two major religions were produced. There is also a drive to recruit and retain voluntary donors as, despite the proliferation of commercial blood donors, the sale of blood is legally prohibited.[60] A 'life saver'

[60] The NHA proscribes the sale of blood but in reality, there is a huge commercial blood donation going on. While none of the KIHs supported the sale of blood, KIH4, KIH3 and KIA3 noted that most donors would insist on some form of gratification. Both KIH4 and KIA3 agree that they should be provided with some form of gratification. KIH4 said '...if it is for nothing, you can be sure our people would not want to give'. He suggested the gift could be in kind instead of cash. Unsurprisingly, given that the commercial donation is well known, studies have reported that

certificate is given to regular donors which entitles them to blood whenever needed. A study on the attitudes of blood donors in Lagos State have found these certificates useful as motivators.[61]

KIA3 revealed that, quality blood is an expensive item and that blood banks are expensive to run. For instance, blood bags with pouches useful for preventing infection[62] and blood wastage,[63] though in use at the LSBTS itself, are expensive to procure. While the funds are not yet available, the solution according to KIA3 is '...if we cannot afford the double blood bags, then we would have to train the lab scientists on an appropriate ascetic way of collecting blood'.

Power supply is another problem. KIA3 emphasised that lack of power may lead to private blood banks supplying substandard blood because blood banks need 24 hours uninterrupted power supply and power is one of the scarcest infrastructures in Nigeria. She also explained that the state blood transfusion service (LSBTS) itself depends on the national grid, diesel and petrol generators and solar inverters which may be unaffordable to private blood banks. To forestall the supply of substandard blood, KIA3 declared that LSBTS and some sister agencies carry out a joint monitoring of all blood banks in the State from time to time or upon receipt of complaints, to ensure quality. According to her, LSBTS also provides training and retraining of staff of both public and private blood banks in blood collection.

A reduction in the availability of blood, due to the 2020 judgment, was also reported by the KIHs. Most of the KIs described the judgment as promoting human rights over public health expediencies.[64] Childbirth complications are described to be one of the neediest procedures for blood transfusion. KIH2 captured it amusingly by stating, 'and when it happens, we (meaning OB & GYN patients) are the ones that drink blood like pure water.' On the judgment, KIH5 said 'it has returned us back to the time when PPH was the highest cause of maternal mortality'. This

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the desire for monetary incentives is sometimes expressed by donors. MA Olaiya, 'Knowledge, Attitudes, Beliefs and Motivations Towards Blood Donations Among Blood Donors in Lagos, Nigeria (2004) 14(1) Transfusion Medicine 13, 14.

[61] ibid 14.

[62] According to KIH3, the first few 2-5mls of blood drawn are diverted into the first pouch and that is the blood investigated. It makes the investigation more accurate as the bacteria on the skin at the first draw goes into that pouch. Presumably, it also saves money – by investigating a small quantity, they do not have to waste investigative chemicals.

[63] Additionally, specialised bags with multiple pouches allow for the separation into different components so that no component of the blood collected is wasted (KIH3).

[64] The applicant in the case was a human rights NGO and the policy was determined by the court to be in breach of human rights obligations such as the right to non-discrimination, right to life and the right to health.

shortage of blood mentioned by the KIHs is with respect to the blood generation done at the hospital level, and so does not deduct from the efficiency of the state blood bank. The distance of the state blood bank from the healthcare facilities makes it imperative that each hospital generate their supply making the blood bank a last resort. That was the case pre-SERAP judgment.

Due to the distance of KIH1's hospital, he described having to depend on the State's blood bank as a 3-hour delay. KIA3 disclosed that the State rose to the challenge brought about by the judgment by introducing a couples' clinic to facilitate informed and willing donations by spouses. Additionally, most of the KIs recommended that blood should be used as frugally as possible. Medical personnel should only request blood when it is really needed. KIH4 even noted that 'where blood is not wasted ... I want to believe ...we have enough blood in circulation.' KIH1 also emphasised that, personally, he does not offer blood transfusion unless it is 'absolutely necessary' because there is need to manage blood use.

KIA3 mentioned that the lack of a digital blood information management system to keep track of donors, their blood types, and other relevant data also pose a challenge to the efficacy of the agency, and particularly the donation drive. She revealed that this facility has been made available to HEFAMAA by an NGO which needs HEFAMAA's data. KIA3 then concluded that the LSBTS attracts low donor assistance and is very dependent on the government.

### 6.3.3 HEFAMAA: Quality of Healthcare Facilities and Services

Quality of healthcare is the factor that is often held responsible when the woman has at least managed to get to the hospital irrespective of the timing or the condition in which she came in. KIH4 opined that healthcare intervention is the focus because 'it is the system we have on ground'. But KIH1 decried the focus on the healthcare sector while emphatically expressing his opinion that MM was just one of the consequences of the chaotic Nigerian environment. In one place he said,

> …Maternal deaths have been shown to be caused by three levels of delay… the delay at the health facility is the only one that is measurable, and it is said to account for only about 40% of the causes of maternal mortality; we should look at how we can resolve the other 60%

Nonetheless, Lagos State has made provisions to ensure quality health care delivery through the creation of HEFAMAA. The agency is charged with the responsibility of registering, accrediting and monitoring all healthcare facilities in the State. The accreditation standards to be met by healthcare facilities as set by the agency concerns the availability of appropriate personnel, equipment, environment and a robust referral system which are all germane to reducing maternal deaths. The maintenance of these standards is monitored by periodic visits of the agency and a finding of non-compliance could result in sanctions being incurred by healthcare facilities or healthcare personnel. It may be important for the purpose of judging the validity of the data from the interview to note that information on the relevance of the agency was first received from private healthcare providers (who were initially wary that the researcher was a whistle-blower). In addition, the information given by the relevant KIA (KIA2) has also been corroborated by the interviews of the other three KIAs.

#### 6.3.3.1 Challenges to Guaranteeing Quality healthcare Facilities and Services

A major challenge to ensuring quality healthcare services that KIA2 raised is the shortage of personnel. He commented that due to the 'brain drain', a common phenomenon whereby educated elites migrate from developing to developed countries (discussed in Chapter 4), [65] it was difficult for hospitals to possess the required staff strength. He also reasoned that the cost of employing personnel with specialised or higher qualifications may not be feasible for some facilities. This issue was emphasised in relation to maternal health, as KIA2 commented that during their monitoring exercise, due to the shortage of personnel, 'you may get there and meet just a nurse who has not even done a diploma in midwifery, where you should have a midwife.'

Due to this shortage of healthcare personnel, private hospitals have been illegally training lay persons to function as healthcare personnel. In spite of the unlawfulness, this is a very common practice and KIA4 had a lot to say about it because the activities of these persons are mistaken for the practice of TBAs. The submissions of KIA4 will be examined under section 6.3.4, but it suffices to remark here that this illegal training creates a class of unlicensed and unsupervised

[65] Bassey Eno Effiong and G Salibi and Nikolaos Tzenios, 'Medical Brain Drain Scourge In Africa: Focusing on Nigeria' (2023) Sociology Cambridge Open Engage<Medical Brain Drain Scourge In Africa: Focusing on Nigeria | Sociology | Cambridge Open Engage> accessed 30 December 2023.

persons providing substandard healthcare to all, including women needing maternity care. To enhance the function of the agency, KIA2 added that sensitisation campaigns are carried out in public places, including over the radio to educate the populace about their healthcare rights and the role of the agency in safeguarding their health.

The efficacy of HEFAMAA's monitoring is also threatened by the unwillingness of healthcare providers to cooperate. KIA2 attributed the non-cooperation of erring personnel to the corrupt nature of the society, and in this case, they believe that they can successfully invoke social and political connections to escape sanctions when they run afoul of the regulations. However, he continued to note that in any event, discipline and accountability are expected from all HEFAMAA staff even in the face of such intimidating actions by healthcare facilities' staff and management. He added that to ensure transparency and foster accountability, the officers of the agency wear body cameras when they are on monitoring visits. Also, to foster cooperation, Health Maintenance Organisations (HMOs) have made HEFAMAA accreditation a criterion to qualify healthcare facilities for participation in the *Ilera Eko* insurance scheme.

KIA2 noted that personnel who operate in hard-to-reach areas cut corners too in the belief that they are far from the reach of the law, but he revealed that HEFAMAA has whistle-blowers in different locations within the State who report healthcare providers who are operating illegally or without the required equipment or environment to it. He further revealed that, to more adequately cover the hinterland, franchises for monitoring have been awarded to private companies to monitor on behalf of HEFAMAA. Again, he disclosed that due to the limitations of censorial enforcement, they enlist the help of consumers. The public is encouraged to look out for the HEFAMAA logo and the certificate of registration of the health facility, which facilities have been mandated to display before patronising the health facilities.

The challenges extend to the enabling law which has a lacuna that effectively enables some categories of healthcare providers to escape the monitoring of HEFAMAA. Such providers, according to KIA2, include telemedicine practitioners, artificial reproduction experts, embryologists and the likes, whose regulation are not covered by the enabling law likely because such services are relatively new to Nigeria. He recommended that the enabling law of HEFAMAA needs to be changed to ensure that the agency can perform its monitoring role in spite of various advances in medical practice.

### 6.3.4 LSTMB: Regulation of Traditional Birth Attendants

Traditional birth attendants (TBAs)are persons who assist women in the delivery of babies based on skills acquired from experience or apprenticeship.[66] While their training and integration in the health system has been found to be effective in some places,[67] in other places, their activities constitute a challenge.[68] The operation of traditional birth attendants in Nigeria is controversial, mainly because their activities are linked to the high MM ratio. Due to this, some states have attempted to stop them from operating, to which KIA4 responded, ‘it is impossible…where there is a market for a product it will always sell’. But in Lagos State, the activities of traditional birth attendants are regulated rather than prohibited. The legality of their existence and activities are covered by legislation.[69] The LSTMB has existed for 43 years, and the role of the agency includes to accredit, license, retrain, and monitor all traditional medical practitioners in the State. The accreditation process of TBAs involves interviews of applicants by experts from all categories of traditional medicine practice including traditional and faith-based birth attendants. The primary role of the interviews is to ascertain that applicants have the prerequisite professional training. Thereafter, a six-week training course covering sixteen subjects such as nutrition, physiology and anatomy, herbal medicine, stress management, hygiene, and so on, is undertaken before certificates and licenses are awarded to TBAs.

According to KIA4, the existence and patronage of TBAs are inevitable, especially at the community level where hospitals are scarce. He objected to the reservation of the word ‘skilled’ for only conventionally trained doctors and nurses. He cited affordability and faith in their services, reasons also found in the desktop research,[70] as factors that encourage their patronage. He

[66] World Health Organisation, and United Nations Population Fund & United Nations Children's Fund, *Traditional Birth Attendants: A Joint WHO/UNICEF/UNFPA Joint Statement* (1992)< 9241561505.pdf (who.int) >accessed 30 December 2023.
[67] Decio Ribeiro Samento, ‘Traditional Birth Attendants in a Health System: What are the Roles, Benefits and Challenges: A Case Study of Incorporated TBA in East Timor-Leste’ (2014) 13(12) Asia Pacific Family Medicine 1, 6.
[68] AN Ofili and AH Okojie, ‘Assessment of the Role of Traditional Birth Attendants (TBAs) in Maternal Care in Oredo Local government Area, Edo State Nigeria’ (2005)17(1) Journal of Community Medicine & Primary Healthcare 55.
[69] Health Sector Reform Law of Lagos State 2006 (n 34) Part 9, ss121-147.
[70] A O Imogie and E O Agwubike and K Aluko, ‘Assessing the Role of Traditional Birth Attendants (TBAs) in Healthcare Delivery in Edo State Nigeria’ (2002) 6 (2) African Journal of Reproductive Health 94.

concluded that, the most practical approach and which is also the WHO approach, is to engage with them as Lagos State has done. Corroborating KIA4, KIH2 also said,

> there is nothing you can do, our people will still go to them. The best we can do is to work hand in hand with them. So, we too we have changed our approach from confrontation to interacting with them.

He added that the Medical Director of the hospital has assured TBAs, in that locality, that do not have ambulances of the willingness of the hospital to provide an ambulance in the event of a referral. Furthermore, according to KIA4, a robust monitoring mechanism has been put in place to effectively regulate their activities. The monitoring is designed to be comprehensive. Practitioners are required to renew licenses yearly. The agency has effective complaint mechanisms which are accessed by the public and traditional practitioners. The agency uses inspection visits as well. As KIA noted 'some are sudden visits,' 'maybe when we receive petition,' 'we have periodic visits' and 'we do what we call unannounced visits'. The primary aim of the monitoring is not punitive; thus, it increases the propensity for compliance and reduces the risk of driving them underground. In this regard, KIA4 stated,

> ...we do what we call persuasive enforcement...in the sense that we would have come out to do advocacy and sensitisation...have a meeting with you to see what are the issues...we would have come out to give you abatement notice....

He explained the persuasive enforcement further using the monitoring visits as an example:

> ...when we go there ... if we see that... we give them what we call abatement notice ...stating what you have done in contravention of the law ... it now gives you a moratorium to fix that thing...we go back and do a check, if you have not fixed it ... if your case is so bad, we might have to close you down.

KIA4 said that, like HEFAMAA, LSTMB also involves the public, so they conduct advocacy and sensitisation throughout the state annually 'to bring to the awareness of people the activities of the traditional medicine practitioners including the dos and don'ts of traditional medicine practitioners.'

#### 6.3.4.1 Challenges Involved in Regulating the Activities of Traditional Birth Attendants

KIH2 expressed regret that, in spite of the enlightenment campaigns and trainings, the TBAs still take on the kind of cases they are advised not to take. He added that, when confronted with complications, they do not make referrals promptly; as women are still being brought to hospitals

from those places dead, or with infections or ruptured uteruses.[71] Similarly, KIH4 observed that most women that die due to MM in public hospitals are brought in from the TBAs and faith-based clinics. KIA4 disclosed that besides the initial training prior to accreditation, there was a plan in place to provide training to TBAs over three years (2022-25) specifically on early referral and proper care. KIA3 had earlier spoken about the training and the investigations that revealed its necessity. To further enhance LSTMB's training function, as well as set standards for traditional health practitioners, a model herbal laboratory and model herbal clinic has been planned by Lagos State.

Many practitioners (auxiliaries) who are illegally trained by private hospitals fraudulently operate under the guise of TBAs. Corroborating KIA2, KIA4 said 'you see, the doctors are the ones creating all these problems.' He added, 'People think they are …but they are not TBAs and don't have sufficient training.' He also complained that they give TBAs a bad name. He narrated,

> we have ... joint monitoring with HEFAMAA ... because they have been complaints on the part of HEFAMAA that some people are practising and they claim to be TBAs and in some cases, they are not this, they are not that ... all the joint monitoring revealed that most of these people constituting these nuisances claiming to be TBAs in most cases they don't have licenses. We found out that most of them are auxiliaries.

In essence, the auxiliaries are an unregulated body of health service providers being neither TBAs nor licensed practitioners, and so not fall directly within HEFAMAA or LSTMB's jurisdiction. The KIA mentioned that to further enhance the protection of the populace, a proposal to extend the extant law to cover all forms of alternative medicine has been advanced and is in the process of implementation by the State. This proposal is in line with WHO directions, international best practices and the federal government's lead. However, this information was not provided in relation to the auxiliaries but in relation to recognised alternative medicine practitioners.

A good number of the challenges also relate to funding. Like HEFAMAA, with whom the LSTMB sometimes have joint monitoring exercises, KIA4 pointed out the agency lacks utility vehicles to be able to reach the hinterland, which is where most traditional medical practitioners operate. Other problems highlighted by KIA4, include lack of equipment for testing herbal

[71] Studies in Nigeria and Ghana and East Timor have found that sometimes the women are in reality the ones who refuse to comply with the TBA referrals due to their fear of hospitals, the high fees and so on. C A Eades and others, 'Traditional Birth Attendants and Maternal Mortality in Ghana' (1993) 36(11) Social Science & Medicine 1503, 1505; Decio Ribeiro Samento (n 67) 4.

products to ensure safety of the products and funding to establish and staff offices in different parts of the State to ensure effective monitoring. In addition, they lack a digitalised information management system which KIA4 explained is necessary to preserve different records. He also said that having an online platform would make the agency more accessible to the public.

### 6.3.5 Findings on Providing Healthcare Interventions

The information in this section was received from KIs working at the MCCs (KIHs) and KIM1 a departmental head at the LMOH. Their responses are presented in line with the themes addressed in the interviews.

#### 6.3.5.1 Availability of Personnel

Ending preventable maternal mortality requires that skilled health personnel especially midwives earning domestically competitive salaries must be provided in adequate numbers. These health personnel are required to provide essential reproductive healthcare to women and to recognise and manage pre-existing medical conditions. Presently, Nigeria is experiencing an unprecedented emigration of healthcare personnel[72] which has led to a proposed bill in the National House of Assembly to place a 5-year compulsory post qualification service on medical personnel.[73] Speaking on the extent that the brain drain has badly hit Nigerian hospitals, KIH2 said 'almost every month people are dropping letter[74] and more are still going.' He expressed fear that the country's health system may collapse when he said that people like him are staying behind, '... because… we cannot allow the system to collapse, because for us when our parents were in labour, those people who took the delivery what if they were not there.' His fear of a collapse of the system appears cogent as two other KIHs independently expressed the same fear.[75] A more immediate

[72] For instance, Yakubu and others reported that the emigration of doctors from Nigeria to the UK have steadily increased from a recorded 1798 in 2008 to 4880 in 2021. For nurses the emigration to the UK was 1393 in 2002 but in 2021, 5543 exited. Kenneth Yakubu and others, 'Scope of Health Worker Migration Governance and Its Impact on Emigration Intentions Among Skilled Health Workers in Nigeria' (2023)3 (1) PLOS Global Public Health 1, 2.< https://doi.org/10.1371/journal.pgph.0000717 > accessed 30 December 2023.
[73] Nicholas Aderinto and Gbolahan Olatunju, 'Addressing Nigeria's Proposed Bill on the Emigration of Doctors' (2024)403 (10425) The Lancet.
[74] Letters of resignation.
[75] KIH1 and KIH5.

fear was also expressed by KIH2 who noted that the implication of this mass exit is that the available staff are stretched and overworked. KIH1 confirmed this situation and added that 'a tired doctor is also a dangerous doctor.'

When questioned in relation to the present mass movement of health professionals out of Nigeria, KIM1 responded that she could not think of a strategy that could stem the exodus. Nonetheless, the Lagos State government has risen to the challenge, because all the KIHs spoke of efforts being made by the government to recruit and retain medical personnel. KIH 2 noted that the new recruitment drive has been useful because some years previously the hospital did not have as many personnel. KIH1 said recruitment was done on a weekly basis and that efforts were being made to provide the staff with opportunities for residency and training in order to encourage their retention. This information confirms reports in newspapers reporting on recruitment of medical personnel by the government.[76] He also affirmed that the pay in Lagos was regular against the background of several states who were owing salaries[77] and KIH2 also mentioned that there were plans for increment in salaries and allowances. He confirmed that this recruitment also extended to laboratory scientists, 'if you go to the laboratory now, you will see more laboratory technicians.'

However, both KIH1 and KIH5 emphasised that despite the regular pay, training opportunities and increase in allowances, societal insecurity and political instability are reasons why medical personnel will emigrate. KIH1 said '…instead of taking the incentives, they will rather run away.' He also said he heard of a department in one of the teaching hospitals in a northern state where all the medical staff, including the head of department, had resigned. KIH3 on the other hand still expressed dissatisfaction with their pay. He said 'government can do more...' Although this sentiment was not repeated by any other KIH, he may not be alone in his opinion as this stance had been predicted by KIH4 who noted '… no amount of remuneration that can satisfy people. People are always expecting more'.

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[76] Segun Adewole, 'Lagos Recruits 3,000 Health Workers' (Punch Newspaper, March 7, 2023)<Lagos recruits 3,000 health workers (punchng.com)> accessed 30 December 2023; Olasunkanmi Akoni, 'Brain drain: Sanwo-Olu Approves Recruitment Of Clinical Staff For Health Sector' (Vanguard News, August 15 2021 ) <Brain drain: Sanwo-Olu approves recruitment of clinical staff for health sector - Vanguard News (vanguardngr.com)> accessed 30 December 2023.

[77] Shalom S, "We are tired" – Nigerian Nurse Tearfully Calls out Ondo Government Over 8 Months Unpaid Salary' (*Gistreel*, March 11 2023) < "We are tired" – Nigerian nurse tearfully calls out Ondo government over 8 months unpaid salary (gistreel.com)> accessed 30 December 2023

From the above, it means that with respect to ensuring availability of skilled healthcare personnel, there are two challenges, one is the adequacy of remuneration. From the responses, it is difficult to deduce whether remuneration is adequate although it is clear that remuneration is a key factor in relation to availability of skilled medical personnel. Information available in the public sphere about their remuneration is to the effect that compared to their counterparts in developed countries and even in the Middle East, that of Nigerian Doctors leave much to be desired. As at 2023, the average pay of the Nigerian doctor was reported to be 240,000 Naira monthly, (312 USD) while their UK counterparts, for instance, earned 2448 GBP (2967 USD).[78]The other problem is that there is need for more than increased pay and allowances, training opportunities and provision of other emoluments (being put in place by Lagos State) to solve this problem. The latter deduction is based on KIH1's comment on other reasons why health personnel emigrate and may line up with KIM1's blunt response about not being able to proffer a strategy to address the exodus.

### 6.3.5.2 Availability of Healthcare Facilities

Functional hospitals, clinics, and other health-related buildings, the exact nature of which will depend on the country's level of development are required to be available in sufficient quantity.[79] Functionality in relation to reproductive (or maternal) healthcare ranges from primary healthcare facilities that can provide basic EmOC to referral facilities that can provide comprehensive EmOC.[80] The challenge of providing inadequate healthcare facilities for the teeming and diversely located Lagos population especially in respect of the riverine areas of Lagos where the presence

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[78] Pelumi Salako, 'Death on Duty: State Negligence Leads to Exodus of Nigerian Doctors' (Aljazeera, October 23, 2023)< Death on duty: State negligence leads to exodus of Nigerian doctors | Health | Al Jazeera> accessed 30 December 2023; Nike Adebowale Tambe, 'Striking Nigerian doctors reject 25% salary increase, N25,000 allowance, say strike continues' Premium Times (Lagos, July 30, 2023)< Striking Nigerian doctors reject 25% salary increase, N25,000 allowance, say strike continues (premiumtimesng.com)> accessed 30 December 2023.

[79] GC 14 (n 1) para 12(a); OHCHR, Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity (2012) A/HRC/21/22., para 66 <A_HRC_21_22-EN (1).pdf > accessed 30 December 2023.

[80] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standards of Physical and Mental Health' (2006), para 16 <https://www.who.int/medicines/areas/human_rights/A61_338.pdf?ua=1> accessed 30 December 2023.

of public hospitals is almost non-existent has been a matter of repeated journalistic interest.[81] KIM1 also reported that the ever-increasing Lagos population was a challenge. KIH2 revealed that to compound this problem, residents of neighbouring states were also coming into Lagos to access healthcare facilities. The danger of the influx of women from neighbouring states to enjoy healthcare facilities in another state can be deduced from the now-rested *Abiye* intervention of Ondo State (discussed in chapter 5). It was identified as one of the challenges that made that acclaimed world-class maternal health care system unsustainable.[82]

According to KIA2 and KIA4, the inadequacy of facilities is one of the reasons why women patronise TBAs. Nonetheless, KIH2 and KIH4 who have both had several decades of practice, praised the efforts of contemporary Lagos State governments in providing the present number of health facilities. They referred to the MCCs which had recently been built in different parts of the State and others which were still under construction.[83] In addition, the revitalisation of the PHCs to provide healthcare in the rural areas and the creation of a comprehensive PHC to provide 24-hour services was described as a step in the right direction.[84] KIH2 explained that in addition to the revival of these PHCs, a networking relationship has also been created between the PHCs and neighbouring secondary healthcare facilities. By virtue of the networking, the PHCs can call them up for advice and they are also able to prepare in advance for complicated cases which are likely to be transferred to them.

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[81] Tessy Igomu, 'For Makoko Women Surviving Childbirth is a Game of Chance' Punch newspaper (Lagos, 17 May 2020) <https://healthwise.punchng.com/for-makoko-women-surviving-childbirth-is-a-game-of-chance/ > accessed 30 December 2023.

[82] Olawale Oladimeji and Olusegun Fatusi, 'Realist Evaluation of the Abiye Safemotherhood Initiative in Nigeria: Unveiling the Black box of Program Implementation and Health System Strengthening' [2022] Frontiers in Health Services < https://doi.org/10.3389/frhs.2022.779130 > accessed 30 December 2023.

[83] Between 2020 and 2022, the state opened 4 new maternal and childcare centres (MCCs) in Eti-Osa, Epe, Badagry and Igando. Tayo Ogunbiyi, 'Lagos, MCC and Access to Healthcare' (The Guardian Nigeria, July 26 2022) < Lagos, MCC and access to healthcare | The Guardian Nigeria News - Nigeria and World News — Opinion — The Guardian Nigeria News – Nigeria and World News> accessed 30 December 2023.

[84] The websites of the state's agencies as well as the media have variously reported on Nigeria and Lagos state's PHC revival which was reportedly flagged off in 2017. The extent of its factual success has however not been reported on. Nike Adebowale Tambe, 'Nigeria Flags Off Scheme to Revive 10,000 Primary Health Care Centres' Premium Times (Lagos, 10 January 2017) <Nigeria flags off scheme to revive 10,000 primary health care centres (premiumtimesng.com)> accessed 30 December 2023;
Stanley Akpunonu, 'Revitalising Primary Health Care to Achieve Universal Coverage In Lagos' The Guardian (Nigeria, 26 September 2019) < Revitalising primary health care to achieve universal coverage in Lagos | The Guardian Nigeria News - Nigeria and World News — Features — The Guardian Nigeria News – Nigeria and World News> accessed 30 December 2023 ; Onanuga, 'Lagos is Restoring Confidence in Primary Healthcare' (HEFAMAA, 2023) <Lagos is restoring confidence in primary health care – Onanuga - HEFAMAA (lagosstate.gov.ng) >accessed 30 December 2023.

### 6.3.5.3 Availability of Legal Abortion and Post Abortion Services

Healthcare interventions as well as other strategies to end preventable MM should be evidence-based, corresponding to the identified causes of MM in the country.[85] Therefore, so long as unsafe abortion remains a major cause of MM in Nigeria, measures to ensure safe abortion, such as liberalisation, is a key right to health obligation of the government.[86] The main challenge to liberalising abortion in Nigeria has been moral and religious opposition.[87] KIM1 and KIH3 repeated this observation while noting that they found the restrictive law inhibiting. KIM1 noted that 'people are just being unrealistic,' while KIH3 lamented that when it comes to other people's sexual behaviour people turn to judges. In any case, to the KIHs, the restrictiveness of the abortion laws is only an issue in the sense that medical personnel cannot provide abortion on request. They acknowledge the restrictive implications of Nigeria's abortion laws but explain that they have ethical duties that may warrant the termination of pregnancies.

This was exemplified with testimonies about terminating pregnancies of women whose lives were in danger. KIH1 recounted an incident when a putative father tried to persuade him not to terminate a pregnancy which was no longer completely viable, while the pregnant woman's life was also at risk. KIH1 recalled that he responded by asking, '...so I should leave her to go and die?' When pressed about the new, but suspended, Lagos State's guidelines on termination of abortion, KIH1 said it was nothing different from what they had known and practised. He declared that it did not make access to abortion less restrictive nor create more grounds. It is difficult to reconcile his view to the newspaper reports on the content of the guidelines because it was reported that the new guidelines permitted legal abortion to victims of sexual violence, and this was not

[85] UN Committee on the Elimination of Discrimination Against Women (CEDAW) General Recommendation No. 24 of the Convention (Women and Health A/54/38/Rev.1, Chap.1 (GR 24) para 9; Technical Guidance (n 79) para 31.

[86] As noted in Chapter 3, the unrestricted right to abortion is not guaranteed by any human rights instrument, although the Maputo Protocol gives instances when it be guaranteed. ACHPR Protocol on the Rights of Women in Africa Adopted by the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November 2005, art 14(2) (c).

[87] P. Chibueze Okorie and Olubusola Adebayo Abayomi, 'Abortion Laws in Nigeria: A Case for Reform' (2019) 23(1) Annual Survey of International and Comparative Law 165,181.

provided for in the extant laws on abortion.[88] It was also reported that this inclusion was the cause of the objection, from religious leaders, that led to the suspension.

On his part, KIH5 commented that he would not support the possibility of abortion on request but agreed the law should be liberalised to allow abortion in cases of rape, incest, and so on. Based on the responses of all the KIHs, although legal abortion on request appears to be a mirage in Nigeria for now, it is safe to say that women who present with complications after an illegal abortion will receive impartial care and do not run the risk of prosecution. According to KIH4, 'in practice, the doctor does not differentiate between induced or spontaneous abortion, a woman has just lost a pregnancy and needs medical intervention.' KIH3 remarked 'there is nothing in my medical training that asks me to inform the police.'

However, it is notable that despite the support their responses appear to convey, none of the physicians thought abortion should be available on request. KIH3 responded, '…I have never done that kind of thing' while KIH5's 'No' was very sharp. Since these are the providers of the services, it means that liberalising lawful access to abortion may not result in factual access to abortion at will.

#### 6.3.5.4 Physical Accessibility of Healthcare

The delay to reach a health facility which increases the risk of MM corresponds directly to the RH obligation to ensure physical accessibility of healthcare facilities. On the basis of this, four out of the five KIHs commented that the focus on quality of care as a cause of maternal mortality wrongly gets a lot of attention. This is because how early the woman gets to the hospital after the complications set in can affect the effectiveness of the care. Virtually all the KIHs drew attention to the distance between the homes of the women and the healthcare facilities. Bad roads and traffic congestion were cited as factors which prevent women from making a prompt decision to set off for the healthcare facilities, as well as causing a delay in their arrival.

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[88] Chioma Obinna, 'Lagos Suspends Guidelines on Safe Abortion' Vanguard Newspaper, online July 8 2022 <https://www.vanguardngr.com/2022/07/lagos-suspends-guidelines-on-safe-abortion-2/ > accessed 30 December 2023.

Lack of security, as a factor that affects physical accessibility was cited to affect providers as well as patients. According to KIH5, most maternity labours start at night and women, as well as medical personnel, are scared of travelling at night in Lagos. Previous studies investigating barriers to assessing maternal healthcare have identified lack of good roads as a barrier to patients,[89] but this testimony shows that it affects the practitioners too. KIH3 summed up the environmental challenges when he said, 'the government needs to make the country more conducive so people can follow their health to a logical conclusion.' To address the inaccessibility of facilities that led to delays, KIH2 reported the creation of critical care units in the hospital where he works. Such a facility would reduce the need of having to transport patients to tertiary facilities located some distance away. However, he was the only one who reported such a provision.

#### 6.3.5.5 Challenges with Providing Culturally Appropriate Health Care and Respect for Medical Ethics

Enhancing women's access to healthcare also requires ensuring that the health goods and services are acceptable to women.[90] For instance, services ought to be provided in a manner that respects women's perspectives in terms of culture and respects their dignity and confidentiality in line with medical ethics. Four issues relevant to both medical ethics and culturally acceptable health care were specifically raised by interviewees. These were insistence on spousal consent for maternal or reproductive care procedures, allowing culturally preferred birth positions, allowing family members to accompany women into the labour room and rights to respectful care. The responses analysed are reproduced in the following paragraphs. In addition, testimonies of the KIHs on challenges with getting women to utilise available health care services and facilities was a recurring theme. Their concerns about the utilisation are presented below after the three initial issues.

For spousal consent, although different reasons were given, three out of the five KIHs said there were reproductive procedures, in respect of which they would insist on spousal consent, when

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[89] Aduragbemi Banke-Thomas and others, 'Multistakeholder Perspectives on Access, Availability and Utilization of Obstetric Care Services in Lagos, Nigeria: A Mixed Methods Study' (2017) 8 (717) Journal of Public Health in Africa 182, 184.

[90] GR 24 (n 79) para 22.

requested by women. KIH 3 and KIH 5 on the other hand said there were no procedures for which they would insist on spousal consent. KIH 5 gave his response based on his belief in women's right to autonomy and in fact self-identified as a woman's health advocate. KIH1, KIH2 and KIH4 were the ones who replied in the affirmative, when asked if they would require spousal consent in certain circumstances. When KIH1 was pressed for the reason he said, 'yes when it has to do with procedures such as tubal ligation, the husband must consent because… reproductive health is a couple centred care.' KIH4 emphasised that when a woman is brought to the hospital by her spouse, decisions would involve him. Nevertheless, all the KIHs who replied in the affirmative still took a middle position that where the life of the woman was at stake and she was lucid enough, she would be allowed to make her decision.

From the totality of the discussion on spousal consent, it was observed that the doctors usually sought spousal consent in order to avoid legal action in the event of unforeseen consequences rather than due to paternalism or lack of respect for the woman's autonomy. KIH4's reaction to questions of what he would do where a woman insists is a clear example. He said, 'besides signing the consent form…she will sign for me and say I so so authorise myself to consent to so so surgical procedure.' It also appears that legal action is not the only barrier they face, they try to avoid other kinds of conflict too. As an example, KIH1 disclosed that there had been instances where although the woman's life was not in danger, she would insist on sterilisation while her spouse opposed it. He said, 'at such times we would have to seek higher authorities before we take the intervention.'

On culturally preferred birth positions, all KIHs explained that although they were aware that some women may prefer different birth positions, they may not be allowed because there were established protocols they had to follow. KIH1 added that any other position would require skills and other resources that the hospitals do not have while KIH4 said it would require documenting such a request and the woman signing the consent form.

With respect to having family members in delivery rooms, all the KIHs declared their willingness and support for birthing women to have spouses or family members in the labour room. They were also in agreement that it would however be impossible due to the fact the delivery wards in the public hospitals were designed to house more than one woman at a time. KIH5 said it would be against the human rights of other women in the ward if other women's husbands were allowed

into the delivery wards. KIH4 further said that in the case of surgical deliveries, the spouse or family member would have to be assessed for the ability to stand the sight of blood.

KIH4 and KIH2 were the only ones who spoke about women's right to respectful medical care without subsuming it in the ethical duty of medical practitioners which they insist they observe. KIH 4 noted that patients had 'a right to prompt, safe and effective care'. KIH2 insisted that the rights of each patient should be balanced against the rights of other patients. In his words '…you have two operating suites and …four emergencies, all of the same degree…during call hour…' He went on to narrate a recent incident where a woman was the last of the four to arrive. By the time they finished with the earlier ones, the baby was dead. The family threatened court action on the basis of abandonment, but he said that when he explained to the husband 'he appreciated' then added, 'but that is just one of the few'. Both KIHs were also quick to balance patients' rights with the rights of medical personnel as well, which very much a part of the HRBA to health,[91] is enforceable against their employers.[92] At the same time, both KIH4 and KIH2 also noted that patients and their relatives sometimes exhibit very rude behaviour towards medical and non–medical staff at the hospitals. KIH2 went on to explain that contrary to people's belief that healthcare professionals were unfeeling, healthcare professionals were only careful to empathise because their empathy is sometimes interpreted as an acknowledgement of guilt.

#### 6.3.5.6 Socio-Cultural Barriers to Providing Healthcare Interventions

In a right-based approach to health, states are obligated to address the determinants of health as well as the barriers to accessing healthcare.[93] According to KIH2, the non-medical factor causing MM, that not much is spoken about, is the attitude of patients themselves. He put it like this 'you see people themselves have their own issues'. Then KIH1 added, 'when things happen, you just want to heap the blame on the medical practitioners.' KIH4 explained that while there are many medical causes of MM, each of those complications have specific interventions. However,

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[91] Technical Guidance (n 75) paras 39, 66, 75.
[92] Thus, in reality where health professionals are unable to provide services due to systemic challenges, both the health professionals and patients have a claim against the health system. Leslie London, 'What is a Human Rights Based Approach to Health and Does it matter?' (2008) 10 (1) Health and Human Rights
[93] GC14 (n 1) para 21.

according to him, women sometimes refuse effective interventions on cultural grounds or religious beliefs.

Caesarean section (CS) and blood transfusion are popular examples of interventions which availability are considered as first line rights in the maternal health discourse[94] but according to the KIs, are problematic to implement. KIM1 said ‘they have this belief that real women give birth vaginally’. KIH5 described the reaction of women and their families to CS as ‘apathy’, while KIH1 commented, ‘in this part of the world surgery is not an option’. KIH5 explained that this reaction could be because the women usually understand that once they give birth by CS, having other births by natural means is more unlikely. He observed that women who have had antenatal care are usually more cooperative. KIH1 also said ‘the enlightened (meaning educated) ones usually see reason and agree’.

On the contrary, KIH2 recounted an incident where a well-educated woman who had had two previous surgical births and who had been advised during the antenatal visits, to have a CS for her third delivery, was brought in dead after some months. According to him, she had been promised vaginal delivery in an herbal or faith-based facility from where she was brought in dead. He concluded by asking, ‘are you telling me sincerely that a woman who has had two CS does not know the way to a hospital?’ He also highlighted that the problem was rampant among those of the Christian faith who make statements to their congregation that depict a caesarean section as unchristian.[95] He went on to say ‘in our environment here, they listen more to them than to the health workers’. He then added, ‘human rights people please help us to enlighten them…tell the religious leaders to leave us to do our jobs.’ But some kind of enlightenment is already being done, as both KIM1 and KIH2 himself spoke of yearly enlightenment outreaches in the communities where the health workers meet with community leaders and the women and educate them on health issues.

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[94] Emergency obstetric care (EmOC) which includes Caesarean Section (CS) and blood transfusion, is considered the most basic in a human rights analysis to prevent MM. Lyne Freedman ‘Using Human Rights in Maternal Mortality Programs: from Analysis to Strategy’ (2001)75 International Journal of Gynaecology &Obstetrics 67; Paul Hunt, ‘Report of the Special Rapporteur (n 80) para 13.

[95] This allegation is not unfounded. The phrase ‘deliver like the Hebrew women’ after the biblical story in Exodus 1, is synonymous with the Nigerian maternal health landscape. Based on this, Christian women hope to put to bed without caesarean sections. Emma Bryce and Wanna Udobang, ‘Why are Women Declining this Surgery? BBC Future, (19 June 2019) < Why are women declining this surgery? - BBC Future> accessed 30 December 2023.

Still on the surgical intervention, KIH1 and KIH3 alluded to another pattern of women's reaction when surgery is recommended, they said some women refuse to consent saying, 'I am waiting for my husband,' 'I am waiting for my mother-in-law' or 'my husband said no surgery for me.' According to KIH1, 60% of the time when those excuses are given it is because the women cannot afford the cost of the procedure on their own. KIH3 agreed with KIH1 but extended his observation to state that inequality and the disempowerment of women by the society which insists on placing emphasis on the man as the head of the home, giving him powers to make decisions on behalf of the whole family, also contribute. His observation is typical of the Nigerian society,[96] and it has even been reported that some men starve their wives or deny them entry to the matrimonial home following medical interventions the husbands do not support.[97]

Although there is a general hesitancy about blood transfusions, the doctors, including KIA4, testified that it is mostly the Jehovah's witness sect who refuse completely. They carry cards identifying them as Jehovah Witnesses and give instructions not to transfuse even if their lives depend on it. KIH4 related an experience where one such woman had been admitted at the hospital. The husband refused consent based on their religion and he brought in his father who persuaded the woman, who was in a very bad condition, to refuse the blood transfusion based on the beliefs of their sect. The doctors did what they could in the circumstances, and by morning, she was dead. After the death, according to the KI, the reality of the situation struck the husband, and 'he began to weep all over the place'. It then came to light that, had the father not been called in, the husband would not have gone through with the refusal.

KIH4 observed that advancements in medical science had come up with alternatives to a blood transfusion but he noted that the alternatives are not as efficient as blood itself. He noted in particular that, where the loss is severe, only immediate transfusion can save such a woman. This issue highlights how social and cultural beliefs determine health outcomes in spite of the

[96] Gina Paine, 'Maternal Mortality in Nigeria: A Literature Review' (2019) 11(1) World Medical & Health Policy 83, 86.

[97] Ogochukwu Udenigwe and others, ' Perspectives of Policy Makers and Health Providers on Barriers and Facilitators to Skilled Pregnancy Care: Findings from a Qualitative Study in Rural Nigeria' (2021) 21(20) BMC Pregnancy and Childbirth 1, 5 <Perspectives of policymakers and health providers on barriers and facilitators to skilled pregnancy care: findings from a qualitative study in rural Nigeria | BMC Pregnancy and Childbirth | Full Text (biomedcentral.com)> accessed 30 December 2023.

availability of health care facilities and personnel. It also shows the limitations of formal education as a tool against MM.

### 6.3.5.7 Ensuring Quality of Healthcare Services by the Hospitals' Managements

At the hospital level, avenues have been created for monitoring and improving the quality of healthcare services provided. One way is through the quality improvement committees of the hospitals. KIH1 explained that he is the team lead in his hospital. The committee's work according to him is to find ways to reduce delay from the time patients come in and the time they access health care, but he concluded that although they have been able to reduce that to a large extent, '...there are still some bottlenecks here and there.' On ways to reduce delay, KIH4 also suggested that the non-medical staff at the hospital, from the gatemen to the card issuer, need to be trained and reoriented to recognise their role in the prevention of delays to access prompt treatment.

Another quality improvement measure mentioned by three of the KIHs is the production of the protocols for effective management of obstetric complications. These are expected to be displayed in strategic places at the hospitals to ensure that the least experienced personnel can be guided. KIH4 suggested that these protocols which are available in public hospitals should also be made available to private practitioners who provide 70% of the healthcare services in the State.

KIH4 also reported that there were instances when altruism may be required of the medical professionals. Having witnessed the maternal death ratio drop to 0 in a hospital where he worked, he noted that the achievement required more than the standards of medical ethics or human rights. He said, '...we carried the project on our heads like the husbands of the women.' His statement may be excused on the basis that speaking from a medical ethics viewpoint, he did not realise that the dedication to duty he considered extraordinary is what a human rights approach entails. As highlighted in Chapter 4, the development-oriented aspect of the HRBA involves the use of non-law standards and there are scholars who have suggested altruism.[98] Therefore, the implication of his statement must not be lost if a human rights approach is to make an impact in the reduction of MM in Nigeria. I believe he meant that they carried out their duties in spite the limitations of the

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[98] Michael J Haslip and Michael L Penn, 'Cultivating Human Rights by Nurturing Altruism and a Life of Service: Integrating UN Sustainable Development Goals in School Curricula' in Michael J Haslip and Michael L Penn, *Interdisciplinary Perspectives on Human Dignity and Human Rights* (Emerald Publishing 2020) 151.

Nigerian environment, and most likely at some personal cost. Pending the resolution of the difficulties in the Nigerian environment, the government must look for ways to recognise and appreciate instances where health workers have made obvious sacrifices.[99]

### 6.3.5.8 Guaranteeing Accountability in Respect of Healthcare

As an integral feature of RH, accountability of stakeholders and at different levels of the health system enhances access to maternal healthcare. A human rights approach requires states to provide accessible and effective mechanisms to ensure that institutional shortcomings as well as those of health workers are addressed.[100] With respect to violations of the right to health which result in MM, the KIs shed light on courts in the State, Nigerian Medical and Dental Practitioners Disciplinary Committee (MDPDC) and the Maternal and Perinatal Death Surveillance Response (MPDSR) as accountability measures to guarantee the quality of care received. The findings on each mechanism are presented in the following paragraphs.

In relation to courts, KIA2 confirmed that patients, including families of maternal death victims, have been approaching the courts to vent their grievances and sometimes they join HEFAMAA as defendants. This is in spite of the fact that HEFAMAA itself sometimes performs the unofficial role of an arbitrator between patients and healthcare providers in healthcare-related conflicts. KIA2 reported that the outcomes of court cases have been a mixture of successes for the patients and the medical practitioners. From the testimonies, involvement in court cases among the KIs has been limited to third-party appearances. However, all medical practitioner KIs gave the impression that, as against the prevailing opinion that medical personnel, particularly doctors seem above the law and maltreat patients with impunity,[101] they are careful not to breach their

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[99] A practical example could be in form of a doctor who chose to stay back in the hospital rather than go home because of the fear that traffic congestion would prevent them from attending to any emergency that may arise in respect of a high-risk patient they are managing.

[100] Technical guidance (n 79) para 75.

[101] Ijeoma Nkem Okedo Alex and others, 'What Factors are Associated with forms of Mistreatment During Facility Based Childbirth, A Survey of Referral Health Facilities in South East Nigeria' (2022) 54(5) Journal of Bio Social Science 776; Waleola Bukola Ige and Winnie Baphumele Cele, 'Provision of Respectful Maternal Care by Midwives during Childbirth in Health Facilities in Lagos, Nigeria: A Qualitative Exploratory Inquiry' (2022) 15(100354) International Journal of African Nursing Sciences 1.

ethical duties or violate their Hippocratic oath. They all claim to do all that is within their power for their patients in order to avoid court cases.

The MDPDC too is well respected and evokes in doctors the determination to abide by their Hippocratic oath. 'But' as said by KIH3 'there was nothing to fear if you do your job diligently well, without fear or favour' in the first place. He narrated a case where a patient, who should have been offered a CS at the facility where she had her ante-natal care, showed up without a booking, gave birth vaginally, suffered post-partum haemorrhage and died. Every possible intervention was applied, including removal of the uterus. He noted that after he submitted his report to the MDPDC, the allegation of negligence was dropped. By contrast, KIH2, who has appeared before the MDPDC as an indirect party,[102] did not share KIH3's relaxed opinion as he described appearing before the MDPDC as an experience one must never have.

The WHO-initiated maternal death review - MPDSR -is fully operative in government hospitals. Although it is a facility-based review of the trajectory of actions, decisions and events that culminated in the death of the pregnant woman and or her baby, KIH1 said it also involves interrogating the relatives of the woman to gather information about the non-medical factors that contributed to the death. KIH5 described it as a laudable activity from which he has learnt not only about preventing mortality but morbidity as well. KIA3 revealed that some of the findings from the MPDSR have informed policymaking. The example she cited was, the decision to train TBAs in early recognition of risk after several maternal deaths were attributable to haemorrhage at a time when there was no shortage of blood at the hospitals. It was found that the bleeding that led to the death of the women often started at the TBAs' facilities. In support of the positive effect of the measure, KIH3 said that apart from reviewing mistakes, it also allows sharing of knowledge of effective practices. KIH2 said the critical care unit in his hospital was a recommendation based on MPDSR.

One of the KIHs however expressed some scepticism about the measure which he described as sometimes entailing a cover-up of the negligent acts of colleagues. He observed that when you do not name or blame anybody, they repeated such behaviour. When this opinion was presented to other KIHs, they disagreed, insisting that even though no name was mentioned, the

[102] A private hospital where he once worked on a part time basis was sued and he was joined as a party.

person involved would be at such meetings listening to all the comments including reprimands. They argued that it was usually a thorough investigation which does not prevent aggrieved persons from approaching the courts in respect of the deaths. The possibility of legal action, according to one KIH, is the reason why a thorough investigation is conducted to prevent the management from being accused of covering up wrong or unprofessional actions.

All KIs reported that their hospitals or agencies had multiple complaints and redress mechanisms which patients and their families used when necessary. KIH5's view of accountability which is in tandem with a HRBA is of a duty to patients that begins when they are waiting to be attended to. He said it was important that patients are kept informed about the reasons for long waits at the hospitals. He observed that such patients usually showed understanding and related complaints were often nipped in the bud. He also reported that employees of the LMOH inform patients at the public hospitals about their entitlements, encourage them to report violations and go about the hospital premises wearing T-Shirts with the words 'Ask me' on them. It is however noteworthy from KIH2's account above that the practitioners are sometimes aggressively approached by patients and their families to explain untoward incidents. A HRBA to health requires the creation of appropriate complaint mechanisms to which health workers can report these issues,[103] but the existence of such was not mentioned by the KIHs.

### 6.4 Summary and Recommendations

As noted earlier, the results of this study are subject to some limitations in respect of the category of stakeholders interviewed and the setting. Only the policy implementers in the healthcare sector were interviewed. KIM1 who was drawn from the reproductive health unit was questioned in respect of policy making but she explained that the decisions on health policies to be pursued were made at the federal level and then domesticated by Lagos State. As Lagos State was the only state featured, factors including economic, geographical, social and cultural differences may make some findings and recommendations less relevant to other states. Nonetheless, as earlier argued, the findings and recommendations still have the potential to inform policy changes and design in

[103]OHCHR, Summary Reflection Guide on a Human Rights Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and under -5 Health for Health Workers' (2016) 21 <HealthWorkers.pdf (ohchr.org)>accessed 30 December 2023.

Lagos State, other states and places beyond Nigeria. As indicated in the introduction, the study had three main objectives. The first objective was to clarify the extent of compliance with the dictates of RH or the HRBA to health for the reduction of MM, the second, to gain an understanding of the challenges faced by the implementers of the various measures designed to give effect to the State's RH obligation to reduce MM and the third, to assess the potential of those measures to reduce MM in Nigeria from the viewpoint of the implementers.

### 6.4.1 Summary on the Objective of Clarifying Compliance

With respect to compliance with the duty to ensure the availability of health care goods and services that are available in adequate numbers, it had previously been established even in terms of the entire country that efforts needed to be stepped up.[104] As seen from this study, the implementers' comments with respect to availability of health facilities, skilled personnel and blood for transfusion, still reveal this shortage in Lagos. In terms of accessibility, this confirms the findings of previous studies that physical access to health facilities is problematic not because the facilities are located too far away, but also due to other inhibitions like traffic congestion.

In terms of financial access, there is some form of free healthcare, UHC is envisaged to be the future, but the efforts to popularise the scheme needs to be intensified. Access to safe abortion services on right to health grounds is unavailable as abortion in Lagos is the prerogative of criminal law. However, the Criminal Law of Lagos expressly allows medical abortion to preserve the health of the mother unlike the federal criminal law which only mentions the *life* of the mother. As mentioned above, updated guidelines to healthcare professionals on medical conditions indicating the need for abortion was suspended a few weeks after its launch based on religious opposition. In terms of providing acceptable healthcare which respects the rights of women and medical ethics, no particular effort was revealed in the responses; rather and especially with respect to spousal consent, the system appears to be more concerned with balancing the rights of the women against that of their spouses, families, babies or even the healthcare workers. On ensuring quality of

[104] CEDAW, Concluding Observations on the combined 7th and 8th Reports of Nigeria. 2017 CEDAW/C/NGA/CO/7-8. paras 37-38 <http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=6QkG1d%2FPPRiCAqhKb7yhsqMFgv33OTgoZv7ZAgL6thDkAcuu60Ke5O8oUKpz5hHtAD5CcXiD5zZx29kup5sgJh%2FbrUteC%2BF%2B7JPizHj03e4vdMY2Qx6U%2FxeHbOGQf%2FbTOpIjhu5tZXVb1T90JN81eA%3D%3D> accessed 30 December 2023.

healthcare, goods and facilities, efforts are being made at the state level by the monitoring of HEFAMAA and also at the facility level too. Although shortcomings in terms of availability, accessibility and acceptability of healthcare services and goods have been identified as reasons for patronising TBAs, measures to regulate that stream of healthcare resonates with RH obligations to adopt measures addressing the peculiarities of the state.

Compliance in respect of the other HRBA principles including the empowerment, participation and inclusion of right holders, in this case women, can also be observed in the use of information sharing. Basically, all the KIAs, KIM1 and some KIH's mentioned enlightenment campaigns and town hall meetings with women and community leaders where information that would enable them make health decisions, and to participate in the monitoring and implementation of the various measures, are shared. The empowerment of the implementing duty bearers is also depicted by the various forms of training given to the medical personnel and even the protocols drawn up for the public hospitals. However, by not extending the capacity building to the private sector which reportedly provides 70% of healthcare in Nigeria, efforts made to strengthen the capacity of that category of duty bearers is likely inadequate. Efforts to guarantee non-discrimination can be observed in the *Ilera Eko* scheme which has varying levels of premiums to accommodate people on different economic strata.

On the other hand, under the same scheme, based on KIM1's clarification, adolescents are still being discriminated against in terms of access to contraceptives. In a HRBA and as a component of RH, accountability is required in various forms and at various levels from planning SRH policies to remedies for violations. From the interviews, some mechanisms, both traditional and peculiar to MM reduction, have been put in place to promote accountability. But there could be more as only KIH5 spoke of being accountable enough to gain the understanding of patients in respect of long waiting times. Meanwhile, long waiting times and queues have been cited by some women as reasons for avoiding hospitals, so it is definitely an important action with respect to getting women to use healthcare facilities. Additionally, HEFAMAA's informal role as an arbitrator in patient- healthcare provider disputes, is useful in a HRBA to health, because complementary accountability mechanisms are needed to realise RH goals. However, as this points to the need for a formal health sector arbitrator, the measure needs to be institutionalised for accountability purposes.

Generally, it is also commendable that efforts are being made to adapt the interventions to the Nigerian society, for instance, the maximum age of dependants for *Ilera Eko* is 23years, reflecting the propensity of Nigerians to regard their children and wards as dependants until the end of university education. Similarly, HEFAMAA's use of whistle blowers and appeal to the public to shun hospitals without the HEFAMAA logo reflects the agency's appreciation of its limitations. The efficacy of LSTMB's persuasive law enforcement is not yet the subject of investigations so as to gauge its efficacy, but it is commendable that the limitations of punitive enforcement for such offences have been recognised and attempts are being made to find alternative strategies.

### 6.4.2 Summary on the Objective of Clarifying Challenges

The interview findings show that the challenges faced by the implementers of the RH based measures that can enhance the reduction of MM, range from individual and interpersonal factors to institutional factors at the agencies or hospitals. It also relates to the wider economic, legal and political situation of Lagos State/Nigeria. Poverty, religious and cultural beliefs, and threat of legal action protrude from the level of individual members of the society. Poverty or financial hardship has been a recurrent theme in discussions of the Nigeria healthcare sector with different levels of poverty, from individual to family to community being identified.[105] The KIHs noted individual and family poverty as a major barrier to accessing surgical interventions and as a factor that influences the resort to TBAs and auxiliaries. This also lines up with previous research that has found that the economic status of women and their families and even the community influence women's decision to seek hospital care.

According to the instant study, the religious and cultural beliefs of the women, their families and communities not only impact the decisions that they make to accept certain healthcare interventions, but also affect the potential of LASHMA and LSBTS to contribute to MM reduction. The highly educated woman's story recounted by KIH2 showed the limitation of education in influencing health seeking behaviour as against the common belief (also expressed by KIH5) that educated women are more appreciative of the need for certain interventions. All the KIHs

[105] Ntoimo and others (n 6).

expressed some fear of legal action, with KIH2 and KIH3 specifically recounting incidents where families of patients threatened them with legal action before they later saw reason. It was also obvious that this fear inhibits the capability of the health personnel to contribute to a right to health approach. This points to the need to develop appropriate accountability measures to address this peculiar need.[106]

Inadequate funding, lack of electronic data systems, overdependence on altruism, and illegally trained auxiliaries are challenges directly affecting the institutional (MOH) level of the government. Inadequate government and donor funding is basic to various implementation problems revealed by the participants, as almost all the KIAs mentioned funding as a barrier to fulfilling their responsibilities. This finding is consistent with previous studies on Nigeria and other countries which have found that health sector goals are severely hampered by lack of funds.[107] The lack of electronic data systems was mentioned by all the KIAs with only the HEFAMAA recently possessing one that was set up by an INGO. Although most of the agencies tied the unavailability of the data system to lack of funds to set the system up, the context in which LASHMA's activities are affected by the lack of a data system points to the fact that the non-existence of a data system is not confined to the health sector but is systemic and even extends to other government activities.

Being forced to depend on altruism was alluded to by LASHMA, LSBTS and also KIH4 when reflecting on the achievement of no maternal deaths recorded in his hospital. His statement was to the effect that the feat was achievable because they went beyond the bounds of duty. While altruism can be a useful tool in achieving the aims of governance and even considered useful for the advancement of human right goals,[108] it is submitted that over-reliance on it is dangerous. The danger lies in the fact that in instances where a conflict of interest occurs, personal or familial interest may take precedence.[109] The illegal training of health auxiliaries is a challenge of a greater

[106] It is considered peculiar because there are a plethora of factors impeding access to courts for the common man in Nigeria such that the medical personnel should ordinarily be in a stronger position. Thus, there is need for a mechanism that would not fetter access to courts or other accountability mechanisms but would at the same time shield health personnel from unnecessary threats of court actions.

[107] Ogochukwu Udenigwe and others, ' Perspectives of Policy Makers and Health Providers on Barriers and Facilitators to Skilled Pregnancy Care: Findings from a Qualitative Study in Rural Nigeria' (2021) 21(20) BMC Pregnancy and Childbirth 1 < Perspectives of policymakers and health providers on barriers and facilitators to skilled pregnancy care: findings from a qualitative study in rural Nigeria | BMC Pregnancy and Childbirth | Full Text (biomedcentral.com)> accessed 30 December 2023.

[108] Haslip and Penn (n 98) 151.

[109] Tony S K Tam and S. Yeung, 'Altruism Social Responsibility and Government Support for Social Welfare' (1999) 9 (2) Asia Pacific Journal of Social Work and Development 79, 92.

dimension than TBAs. This is because while TBAs are specifically regulated, this category of people is not. Based on KIA4's statement that many of them parade as TBAs and the KIHs' complaints about women being brought in dead, some of the women brought in dead or with severe complications could be from the auxiliaries. Restrictive abortion laws and the State's permissive insurance laws also directly affect the ability of MOH and its institutions to implement healthcare measures that are relevant for the reduction of MM.

Corruption, societal insecurity/armed violence, lack of infrastructure, and inappropriate laws which also affect other sectors of the society are challenges within the purview of the larger state or federal government. Corruption and impunity in Nigeria are not restricted to the health sector and are exacerbated by a combination of an ineffectual legal framework and societal acceptance.[110] Although studies have often linked the non-availability of health facilities, goods and services to the misappropriation of public funds,[111] in this study it was mentioned in respect of individuals who fraudulently access health facilities meant for the indigent. Corruption was also mentioned as responsible for medical personnel who would not cooperate with HEFAMAA monitoring, and for people's lack of faith in government's health insurance scheme. The lack of two major infrastructures, good roads to assess the health facilities and constant supply of electricity to power the blood banks was highlighted. The implication of this is that concentrating on health sector reforms as a means to realise the right to health or reduce MM, is certain to yield limited results.

### 6.4.3 Summary on the Objective of Clarifying the Appropriateness of the Standards for Nigeria

The third aim of this study was to assess the appropriateness or potential of the RH framework from the viewpoint of the key informants. Being the implementers, it was expected that they would be able to identify misfitted policies, maladapted measures, under-estimated or hitherto unrecognised strategies. Therefore, questions were specifically posed in this direction. However,

[110] Salisu Ahmed Kabiru, 'Causes of Corruption in Nigeria: Implication for National Development' (2019) 1(4) Journal of Management and Economic Studies 20, 22.
[111] For instance, Nnamuchi Obiajulu, 'Kleptocracy and its Many Faces: The Challenges of the Justiciability of the Right to Health in Nigeria' (2008) 52(1) Journal of African Law 1.

none of the KIs questioned the appropriateness or otherwise of the measures because they pointed at the practical benefits of the interrogated measures and interventions and opined that the measures merely needed time to yield the desired results. Although KIA4 decried the erroneous actions taken by some states to drive TBAs underground and believed traditional medicine was not recognised in the country as much as should be, his comments were not really directed at Lagos State that had for 40 continuous years maintained a traditional medicine board and regulated the activities of traditional medicine practitioners, including TBAs, thereby.

Although from the information provided by the KIs, there does not appear to be RH/MM reduction standards, measures or actions that are ill-suited per se to the Nigerian context, it is submitted that there is still need for the duty bearers to consider how to make those measures more responsive to the social, legal and political situation of Nigeria/Lagos. A few reasons to support this submission can be cited. First, universal health coverage has been proven to be beneficial in other countries as well as Nigeria, but formidable challenges exist. Despite the difficulty being experienced with re-orientating the populace to support the scheme, a more pervasive problem would be getting the needed funding due to governments chronic underfunding of the health sector and the poverty of the people.

Second, one may describe the operation of a HRBA to health or a RH approach to MM in Nigeria as presently existing in name only. This assertion is on the basis of Nigeria's dismal record of giving effect to socio-economic and even civil and political rights obligations[112] and as well as the limited understanding of human rights among the populace.[113] For instance, although Nigeria's reproductive health policies profess to be based on the HRBA, the implementers do not appear to have a holistic understanding of the implications. As a result, all the KIs who were (except one person), medical doctors described their experiences in operationalising the right to healthcare from the public health or medical ethics perspective. KIH3 said 'if you can incorporate the concept of let me be just, let me be benevolent, I won't bring about any maleficence…' In addition, KIH3 and KIH2 ascribed human rights advocacy to only lawyers and were even resentful of the human

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[112] Apeh Elaigwu Isaac and Onoja Ujah Ferdinand, 'Literacy Promotion for Human Rights Awareness and Protection: The Case of Nigeria' (2018) 4(1) Journal of Good Governance & Sustainable Development in Africa 14, 17.

[113] Decades of military rule and the attendant struggles against repression of civil and political rights have given many Nigerians a narrow view of government as the only violator of human rights.

rights interference. Both were of the opinion that human rights and lawyers were synonymous. They also spoke of lawyers encouraging patients to bring court cases against them.

Third, a HRBA requires duty-bearers to put in place measures – including identifying and addressing challenges - to realise the right to health. The comments from all the KIHs and KIM1 indicate that religious, social and cultural attitudes of women and the society are only considered as challenges to implementing a HRBA in Nigeria. Meanwhile, the potential of these attitudes and beliefs to achieve RH goals have long been recommended but unutilised.[114]In the same vein, it is evident that the patronage of TBAs is not considered to be part of a HRBA framework to reduce MM. The comments show that their presence on the scene is being tolerated because their patronage cannot be prevented. Although KIH2 mentioned that his hospital had offered to provide ambulances to TBAs, there was no statement to show that the KIHs genuinely believed that TBAs have a legitimate role in the scheme of maternal healthcare. Giving effect to participation, non-discrimination and equality dictate that patronage of TBAs by women who prefer them, as well as cultural, religious beliefs of groups of women are acknowledged in order to arrive at the realisation of their SRHR.[115]

Fourth, it is necessary to address the complaints of healthcare providers' who are often powerless against the systemic factors in the health system that constrain them. Rather than being left to be on the defensive from aggressive actions of patients, and, or their families, accountability mechanisms should be developed where the disempowered healthcare provider as well as the rights holders are protected and able to make collective claims on the health system.

Finally, applying a human rights approach to health by a sub-national government surrounded by states with less responsive governments in a federal system of government would also require peculiar strategies.

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[114] Jacob A Adetunji, 'Preserving the Pot and the Water: A Traditional Concept of Reproductive Health in a Yoruba Community in Nigeria' (1996) 43(11) Social Science & Medicine 1561, 1566.
LSBTS strategy of producing posters containing qur'anic and biblical provisions supporting blood donation is thus acknowledged as a step in the right direction. The cultures of most Nigerian communities also promote respect for the opinion of elders; thus, this attitude too can be harnessed to realise maternal health.

[115] For instance, it was suggested that taking cognisance of the fact that some women are avoiding hospitals in Brazil due to insecurity on the roads is a human rights framing of the determinants of maternal deaths. Candace Johnson and Surma Das, 'The Human Rights Framing of Maternal Health: a Strategy for Politicization or a Path to Genuine Empowerment?' in G Andreopolous and Zehra F Kabasakal Arat (eds) *The Uses and Misuses of Human Rights : A Critical Approach to Advocacy* (Palgrave Macmillan 2014) 117<The Human Rights Framing of Maternal Health: a Strategy for Politicization or a Path to Genuine Empowerment? | SpringerLink>accessed 30 December 2023.

### 6.5 Conclusion

The objective of this study was to explore the experiences of the implementers operationalising the measures that constitute part of the RH standards for the reduction of MM. This was needed to gain an understanding of the difficulties experienced by the various stakeholders with respect to their roles and possibly receive recommendations which can enhance the RH framework for reducing MM generally. The findings clarified the extent of Lagos State's compliance with the featured measures. At the same time, challenges within the health system, from the wider society and even individual patients were identified. It was quite significant that where possible, steps were already being taken to address the challenges and, in some cases, recommendations to improve implementation were proffered. Equally significant are certain efforts made to ensure that the measures reflect the realities of the Nigerian environment. This study also reveals that some barriers to the healthcare entitlements necessary for the reduction of MM through the RH framework are well beyond the health sector. Therefore, a focus on the health sector as a means to address them will be grossly inadequate to reduce MM.

Being an exploratory study, this study brings up some issues that are worth investigating. First are the experiences of the personnel implementing the non-healthcare aspects of the RH requirements for reducing MM, such as the women's affairs ministry, civil society advocates, judicial and non-judicial institutions. Second, various ways to enhance the adaptation of MM/RH standards to the Nigerian environment needs to be further investigated, perhaps with the use of participatory research methodologies which would allow the right holders to be involved in the development of the strategies.

In the next and final chapter of the thesis, some of the findings from this study and the recommendations from the KIs are considered in greater depth; other recommendations gathered from the rest of the thesis are also considered therein.

# Chapter 7

## Conclusion and Recommendations

### 7.1 Introduction

That the problem of maternal mortality (MM) in Nigeria needs an effective framework, and urgently too, is not debatable. The figures have never been good. The country has always featured among the highest contributors to the world's MM figures, but in the last few years, it has moved to taking the lead. The dead are not numbers; they are women, individuals, daughters, wives and primary care givers on whom the survival of their new-borns and other surviving children depend.

The reasons behind the recommendations by maternal health stakeholders[1] that the human rights approach, particularly the right to health (RH), should be a framework to address MM are appreciated. Besides the fact that the institutions, such as international health and development agencies and public health experts, which have historically been involved in the global MM struggle - have turned towards human rights, it is also evident that their reasons for doing so in the global context mirror the situation in Nigeria. The strengths of human rights or the right to health in particular, are similarly acknowledged. Human rights have been instrumental in securing recognition and justice for various groups of people who were hitherto discriminated against and oppressed. And in the context of RH, the response and great successes in the HIV-AIDS,[2] tuberculosis[3] and even child mortality campaigns[4] are evidence of how powerful a RH approach or framework can be in addressing public health issues. However, MM has shown some differences. First, the historical account from countries where MM is no longer a problem points mainly to medical and other public health interventions which were not pushed through a rights framework. Second, the rights approach has become a

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[1] They comprise scholars, experts, from various fields, civil society organisations, human rights activists, international human rights bodies, international development agencies and so on, that have been referred to in various chapters of this thesis.

[2] Britta Baer and others, 'Human Rights Based Approaches to HIV, Tuberculosis and Malaria' in Jose M Zuniga and Stephen Marks and Lawrence Gostin (eds), *Advancing the Human Right to Health* (Oxford Academic 2013) 245< https://doi.org/10.1093/acprof:oso/9780199661619.001.0001 > accessed 30 December 2023.

[3] ibid.

[4] Hiroaki Matsuura, 'Exploring the Association Between the Constitutional Right to Health and Reproductive Health Outcomes in 157 Countries' (2019) 27(1) Sexual and Reproductive Health Matters 168,177 < https://doi.org/10.1080%2F26410397.2019.1599653 > accessed 30 December 2023.

feature of Nigeria's health and MM-related policies for some years now, and although some gains have been recorded, they are not significant.

Despite this, there has not been any critical appraisal of the prospects and limitations of the standards of the RH or HRBA to health in respect of Nigeria's MM reduction. There have been studies, many of which have been referred to in the thesis, investigating the country's implementation or non-implementation of health interventions that relevant fields have shown are important for MM reduction. Most of these papers and monographs have focused mostly on the failures of the government to adopt or successfully implement the directions of the various guardians of the framework.[5] They are not concerned with the shortcomings of the RH approach and the implications these may have on the local adoption or implementation. As a result, they do not present a balanced perspective of the strengths of the framework. In addition, this does not allow for the adoption or implementation of strategies that are appropriate as well as workable in the Nigerian context.

Generally, scholars, experts, non-governmental bodies and different stakeholders affirm that Nigeria's MM problem is the result of violations of various rights of women, especially their right to sexual and reproductive health (SRH), which is one aspect of human rights that embodies for women the principles of indivisibility, interrelatedness, and interdependence. For a woman, her right to sexual and reproductive health is tantamount to the sum of her life – her autonomy, her value and her identity - as her reproductive function is the main feature that differentiates her from a male. As a result, they postulate that actions to give effect to these rights will be the urgent intervention Nigeria's maternal mortality situation needs.

Be that as it may, this thesis reiterates that it objects to the copious suggestions of the framework as if it were an unquestionable panacea for Nigeria's MM situation. It also objects to the stakeholders 'portrayal of the standards in a way that, implies they can be easily adhered to – which in a way may be the attitude behind some of the measures the country has adopted without thorough consideration of potential challenges and unintended consequences. In essence, it equally disagrees with the adoption or strict adherence to the standards without

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[5] Aliyu Mohammed and Prince Agwu and Uzoma Okoye, 'When Primary Healthcare Facilities are Available but Mothers Look the Other Way: Maternal Mortality in Northern Nigeria' (2020) 35(1-2) Social Work in Public Health < https://doi.org/10.1080/19371918.2020.1726850 >accessed 30 December 2023; Idowu Adenike Esther, 'The Socio-Cultural Context of Maternal health in Lagos State Nigeria' (PhD Thesis, Department of Sociology, Covenant University 2013) 32; Adamu Dauda Garba and John Wajim, 'Reproductive Health Knowledge and Unsafe Induced Abortion in Nigeria' (2019) 24(10) IOSR Journal of Humanities & Social Science 54, 59

critical evaluations of their workability in the local context. In essence, stakeholders should go from customarily recommending RH to delineating the extent of its usefulness and determining its practical applicability in Nigeria. The government should also be wary of adopting the dictates of the framework without considering their suitability to address the actual needs of the populace and the potential to bring about the desired result. This lack of critical evaluation of the framework creates a gap in the literature that this thesis sought to fill.

The foregoing is the basis on which the thesis was conceived to investigate the potential and obstacles associated with employing the right to health (RH) framework for reducing Nigeria's extremely high maternal mortality (MM). The right to health (RH) is part of a human rights-based approach to health. Therefore, throughout this study, the analysis was guided by the international human rights' normative framework.[6] This consists of the fundamental human rights principles of the HRBA, the right to health provisions in relevant international and regional human rights instruments, as well as the General Comments of their respective monitoring bodies. It also extends to relevant portions of the Concluding Observations of the treaty monitoring bodies. Some of these standards create obligations that demand accountability.[7]

This analysis reveals that the RH framework is not just a means of providing healthcare facilities or a good health system but guarantees the government's duty to take action to realise the highest attainable standard of physical and mental health by respecting, protecting and fulfilling the right to health. This sets it apart from other frameworks like public health, health law or medical ethics through which MM reduction efforts are also delivered. Due to its possession of the AAAQ elements, progressive realisation and the obligation to request and receive international assistance, it surpasses the standards of other rights in the HRBA to MM. As a result, these distinctive features of the right enable it to bring about fresh perspectives, encourage novel actions and enhance existing initiatives to improve the health of the populace. Notwithstanding, its capability to significantly contribute to reducing MM is also dependent on engaging with the likely consequences of the weaknesses of the human rights-based framework, as well as the pertinent local conditions in Nigeria when applying these standards.

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[6] R. Sreekantan Nair and S. Sreekantan Nair, 'Human Rights, Theoretical Roots and Framework' (2011) 72 (3) Indian Journal of Political Science 651.

[7] Paul Hunt, 'The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges' (2006)100(7) Transactions of the Royal Society of Tropical Medicine and Hygiene 603, 604.

This concluding chapter is divided into four parts. It begins with the conclusions from the chapters, followed by some general conclusions from the thesis. The third part contains some recommendations to enhance the prospects of RH for reducing MM. Part 3 is divided into two sections, one part focuses on the international RH framework and the other part on the implementation of the RH in Nigeria. The fourth part reflects on the parameters of the thesis and lays out a few areas for further research.

## 7.2 Summary of the Chapters

The first chapter set the course of the thesis by providing a contextual background for the entire thesis. The chapter highlighted the original contribution of this thesis to the right to health /maternal mortality discourse. It was emphasised that, although the existing literature predominantly advocates the adoption of the HRBA to reduce MM, there is a lack of an in-depth scrutiny regarding the framework's potential, particularly in the Nigerian context. The substantive chapters of the thesis provided that critical assessment. The research questions of the thesis, which were addressed by subsequent chapters as well as the methodologies employed in the thesis, were set out in the first chapter.

Chapter 2 provided part of the conceptual foundation of the thesis as it focused on providing an in-depth analysis of RH which includes the right to sexual and reproductive health (SRH). It also began to address the second research question of the thesis, that queried the nature, scope and enforcement of the right. To this end, the characteristics of the right and issues surrounding its legitimacy, including its capacity to create obligations and enforce them were examined. Clearly, RH and especially women's right to reproductive health, a subset of which is maternal health, is extensively provided for in international and regional binding and non-binding documents. However, these documents provide varying degrees of protection based on the wording of their provisions,[8] the circumstances of their adoption[9] and the mechanisms for their enforcement.

As a framework within which to anchor MM reduction policies, the HRBA and the right to health in it have their share of problems. For instance the chapter noted that the claim

[8] Charles Ngwena, 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa' (2010)32(4) Human Rights Quarterly 783.
[9] Soft laws generally attract less authority. C M Chinkin, 'The Challenge of Soft Law: Development and Change in International Law [1989] 38 International & Comparative Law Quarterly 850, 866.

that human rights are universally applicable principles is still contested.[10] The economic, social and cultural (ESC) rights is a category that has attracted some of the greatest criticisms,[11] with the RH specifically targeted by neoliberal scholars.[12] It was, however, observed that although both the concept of human rights and RH are contested, there is virtually no country in the world that does not accept human rights in one form or another.[13]

However, the effects of such opposition persist. As an example, the constitutions of many countries, including Nigeria, decline to give a justiciable basis to ESC rights. The effect of the non-justiciability becomes more poignant when compared to countries like Kenya[14] that gave the RH a justiciable status in its constitution. Despite the inclusion of ESC rights in some constitutions, these concerns are partly responsible for the reluctance shown by judicial bodies adjudicating cases bordering on the guarantee of the right.[15] Another important issue that also borders on the viability of the right as an effective framework is the delineation of the right in terms of the scope and the measurement of progressive realisation. It was shown that supporters and critics insist that this remains a challenge in spite of the CESCR's General Comment 14 [16] and various attempts to interpret the right in respect of specific health issues or population groups.[17] While this has not prevented countries from making laws, policies and other legally enforceable commitments on the basis of their RH obligations, nor has it prevented international and national judicial bodies from adjudicating on the right, it has been noted nonetheless, that the lack of a clearly defined scope negatively impacts the demand for and tracking of states' compliance.

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[10] Charles R. Beitz, *The Idea of Human Rights* (Oxford University Press 2011) 4.

[11] Goodman argues for instance that financing healthcare is so daunting that it should not be government's business. Timothy Goodman, 'Is there a Right to Health' (2005)30(6) Journal of Medicine and Philosophy 643, 658.

[12] Chapman noted that even human rights analysts declined to refer to health as a right. Audrey R Chapman, 'Conceptualising the Right to health: A Violations Approach' (1998) 65 Tennessee Law Review 389.

[13] All countries have signed one or more documents that was inspired by the UDHR. Reimagining Education, 'What countries did not sign the Declaration of Human Rights?' < What countries did not sign the Declaration of human rights? - Reimagining Education > accessed 30 December 2023.

[14] The right to health is provided for in Article 43(1)(a) of the 2010 Kenyan Constitution. Andra Le Roux-Kemp, 'The Enforceability of Health Rights in Kenya: An African Constitutional Evaluation' (2019) 27(1) African Journal of International and Comparative Law 126.

[15] Siri Gloppen, 'Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health' (2008)10(2) Health Human Rights 21.

[16] UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No.14 The Right to Highest Attainable Standard of Physical and Mental Health (Article 12) of the Covenant 11 August 2000 E/C.12/2000/4 (GC14).

[17] George P. II Smith, 'Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection' (2005) 38 Vanderbilt Journal of Transnational Law 1295.

Closely related to this is the seeming lack of scope of the right on the account of its inclusive nature. It was argued that the numerous calls to restrict RH to the right to healthcare[18] are wrong based on the historical influences on the codification,[19] and subsequent clarifications of the right. Thus, a right to health restricted to healthcare will be of limited value in guaranteeing the highest attainable standard of health. Similarly, the concept of SRHR, though traceable to binding instruments is more popularised by non-binding instruments, for which reason it attracts an even narrower protection in many countries and oftentimes outright refusal to give effect to some of its standards. However, the adoption of such a progressive instrument as the Maputo Protocol which contains ground-breaking SRHR provisions is a significant advancement for SRHR in the African region. Furthermore, the assessment of the monitoring aspects of the international framework shows that, though imperfect, monitoring has evolved significantly since the time of Chapman's initial critique. At that time, the TMBs' Concluding Observations which are dependent on often unreliable state reporting were the main monitoring mechanism.[20]

There is now the opportunity for individual petitions through the Optional Protocol (OP) although still contingent on state ratification, and the creation of the role of the Special Rapporteur whose work has been highly contributory to making RH relevant for addressing MM. It was also found that the Universal Periodic Review (UPR) is important as an opportunity to still be able to review the countries that decline to submit reports.[21] Also notable is the information that gender-based violence and reproductive health are among the issues that have featured highest in the UPR's health recommendations. Despite this progress, the ESC rights reportedly receive less attention than their civil and political rights (CPR) counterparts[22] which may limit the potential of the Review's contribution to reducing MM through RH.

Chapter 3 answered the second sub question of the research on the causes of MM and the interventions to address them. It entailed an extensive investigation of MM with some emphasis on the causes and societal context in which MM occurs. Through this in-depth

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[18] Elzuwey in Elzuwey Saleh M, 'The Right to Healthcare in International Law' (PhD Thesis, University of Glasgow 2013).
[19] It is argued that the understanding that realising RH included the guarantee of health determinants, was reflected in the RH provision of the Universal Declaration of Human Rights (UDHR).
[20] Audrey R Chapman, 'A Violations Approach' for Monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18(1) Human Rights Quarterly 23.
[21] Lucy Richardson, 'Economic, Social and Cultural Rights (and beyond) in the UN Human Rights Council' (2015) 15 Hum Rights Law Review 409, 427.
[22] Centre for Economic and Social Rights, 'The Universal Periodic Review, a Skewed Agenda: Trends and Analysis of the UPRs Coverage of Economic, Social and Cultural rights (CESR, June 2016) < CESR_ScPo_UPR_FINAL.pdf> accessed 30 December 2023.

discussion, the chapter set the stage for the identification of the connection and possibly gaps between the contents of the RH framework to reduce MM and the societal context in which MM occurs. It was found that in many countries, MM often results from the accumulation of a lifetime of various forms of deprivation. While the immediate causes can be traced to medical complications for which up-to-date interventions exist, several factors, some of which can also impact the efficacy of the medical interventions, are responsible for perpetuating MM today. The factors fall into categories such as legal, economic, social, cultural, behavioural and so on.

Through two often utilised MM (public health) structural lenses, it was shown that these factors impact women or their families' capacities to prevent unwanted pregnancies, precondition women to suffer complications in pregnancy and childbirth, or hinder women's ability to benefit from medical care in the event of complications.[23] It was therefore argued that effective intervention to reduce MM would have to address the issues highlighted by these frameworks. Being wholly concerned with safeguarding the functions of childbearing and pregnancy as well as ensuring safe and satisfying outcomes of sexual activity and reproduction,[24] giving effect to SRH is overwhelmingly endorsed as a strategy to reduce MM. Access to non-discriminatory and quality SRH services such as family planning, contraceptive information and services and, safe abortion services, and action to shield women from harmful cultural norms and to prevent violence against women are some SRH guarantees useful to prevent MM. The section that focused on the context of MM in Nigeria enabled an exposition of Nigeria's social, economic, cultural and health system features providing an enabling environment for MM. At the end of this discussion, it was established that the RH guarantees, including the SRH components, were relevant to address the causes and determinants of MM in Nigeria.

In Chapter 4, the potential that the standards derived from the RH normative framework as well as the counterpart development-oriented principles that complement RH in the HRBA to health, hold for addressing MM was discussed. The evaluation involved the essential AAAQ elements which is the legal framework of the (RH) HRBA to health,[25] and the supporting

[23] The three delays model and McCarthy and Maine's inclusive Framework. See McCarthy J and Maine D 'A Framework for Analysing the Determinants of Maternal Mortality' (1992) 23(1) Studies in Family Planning, 23.
[24] Anna Glasier and others, 'Sexual and Reproductive Health: A Matter of life and Death' (2006) 368 (9547) The Lancet 1595.
[25] The standards of the rights in a HRBA are the legal framework. Therefore, as only the RH is focused on in this thesis, the essential elements of the RH are the relevant legal standards. UNFPA and Harvard School of Public Health, 'Human Rights Based Approach to Programming: Key Elements of a HRBA' < Session3_Presentation5_KeyElements_HRBA.PPT (live.com) > accessed 30 December 2023.

principles of equality and non-discrimination, participation and inclusion, accountability and empowerment of right holders and /or duty bearers. The focus was on the implication of implementing these standards for MM reduction. At the same time, it provided an opportunity to engage with the extent to which the HRBA may be beneficial for addressing the determinants of MM. The strengths and limits of the featured elements which are based on critical appraisals from human rights experts or commentators as well as reported outcomes of their implementation were brought to light.

It was noted generally that, focusing on the entirety of the HRBA rather than the RH norms exclusively, provides the opportunity to recognise patterns of discrimination and groups of persons who are disadvantaged. This is beneficial to MM discourse which predominantly manifests where there is some form of disadvantage. Some challenges were nonetheless identified with the framework; these include involving too many participants or stakeholders and requiring a lot of time and resources.[26] There are also difficulties with measuring the fundamental human rights principles, and determining their impact because that needs both qualitative [27] and quantitative evaluation. Additionally, the evaluation will involve the collaboration of at least three fields:[28] medicine, human rights and public health.

The chapter revealed that the AAAQ framework gives a clear idea of the guarantees of the RH framework in relation to sexual and reproductive healthcare which correspond with the interventions to prevent MM. It also pointed out that there are some issues which could represent formidable barriers with respect to giving effect to these standards. For instance, achieving AAAQ of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) workers, which include skilled birth attendants in many countries is greatly hampered by inadequate personnel among other issues.[29] For developing countries, the challenge is worsened by the dilemmatic situation involving the movement of the few inadequate health personnel to more developed countries. Ironically, by virtue of RH

[26] ibid.
[27] Qualitative because it allows measurement in ways such as improvements in policy.
[28] Paul Hunt and Alicia Yamin and Flavia Bustreo, 'Making the Case: What is the Evidence of the Impact of Applying Right Based Approaches to Health'(2015)17(2) Editorial Health and Human Rights Journal 2 <Editorial_17.2_Jan21.pdf (hhrjournal.org)> accessed 30 December 2023.
[29] Caroline Homer and others, 'Barriers to and Strategies for Addressing the Availability, Accessibility, Acceptability and Quality of the Sexual, Reproductive, Maternal, Newborn and Adolescent Workforce: Addressing the Post-2015 Agenda'(2018) BMC, Pregnancy & Childbirth < https://doi.org/10.1186/s12884-018-1686-4 > accessed 30 December 2023.

commitments, these developed countries which contribute to the lack of health of personnel in developing countries are obligated to help developing countries to meet their RH goals.

Attention was also drawn to the importance, as well as some highlighted drawbacks, of international funding and technical assistance. It was pointed out that funding specific initiatives sometimes encourages internal brain drain within the country's health sector.[30] Other drawbacks of international assistance which were highlighted include activists in receiving countries considering some assistance as neo-colonialism, overdependence on aid[31] and the unpredictability of aid.[32] Nonetheless, maternal health programs in many countries have benefitted from the funds as well as the expertise such assistance provided.

Concerning accountability, its centrality in enforcing the government's RH obligations was highlighted. It was also clarified that while states were principally responsible for ensuring accountability, non-state actors such as public and private healthcare providers were required to be accountable in their provision of health care services. The multifaceted role of civil society as agitators, motivators and educators, to mention a few, in a HRBA was revisited. The use of litigation was again examined, and while it was noted that it had been useful to secure accountability for RH violations both internationally and within countries, shortcomings were identified. In the same vein, the endorsement of recourse to non-judicial mechanisms such as the maternal death reviews (MPDSR) by right to health experts so as to enhance the supply of information which can aid a greater understanding of issues leading to MM[33] was considered both valuable and limited[34] given the nature of the human rights enforcement framework in many jurisdictions, including Nigeria, and the limited availability of alternative accountability mechanisms.[35]

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[30] Jonathan Wolff, T*he Human Right to Health* (Norton Publishers, 2012) 112-113.

[31] Gamze Erdem Turkelli, 'Official Development Assistance (ODA), Aid Dynamics and Sustainable Development' in *Partnership for the Goals* (ENIUNSDG, 2020)1, 6.

[32] G Ooms and others, 'Global Social Contract to Reduce Maternal Mortality: the Human Rights Argument and the Case of Uganda' (2013)21(42) Reproductive Health Matters 134.

[33] Paul Hunt and Bueno Judith Mesquita 'The Contribution of the Right to the Highest Attainable Standard of Health to the Reduction of Maternal Mortality'( Human Rights Centre University of Essex, and United Nations Population Fund, 2007) <https://www.unfpa.org/sites/default/files/pub-pdf/reducing_mm.pdf> accessed 30 December 2023.

[34] Yamin and Cantor emphasised that dependence on only non-judicial measures is limiting. Alicia Yamin and Rebecca Cantor, 'Between Insurrectional Discourse and Operational Guidance: Challenges and Dilemmas in Implementing Human Rights Based Approaches to Health (2014) 6(3) Journal of Human Rights Practise 451, 459.

[35] Section 46 of the Nigerian constitution directs anyone whose fundamental human rights have been contravened or likely to be contravened to seek justice from the High Court. The Constitution of the Federal Republic of Nigeria 1999 Cap C4 LFN 2004 (CFRN 1999).

Lessons from countries such as Uganda, also showed that in order to benefit from participation, the realisation of other human rights like right to information, freedom of speech must be pursued in order to strengthen the rights holders' capacity for democratic action.[36] Additionally, the actual implementation may imply different strategies for different communities with their unique challenges.[37] It was also observed that implementing equality and non-discrimination involves making compromises in the allocation of resources and other interventions even among equally disadvantaged groups or among competing needs for the same population group.[38] The effect of the unrestricted right to abortion was observed to have led to a prevalence of female feticide in India.[39] While the reasons for female feticide in India are varied, one reason, which is also a problem in Nigeria, is son preference.[40] It was also shown that non-legal measures as required in a HRBA may have unintended effects. This was exemplified with the use of cash transfers to encourage antenatal attendance and facility births in India. It was reported to have led to an increase in pregnancy rates in an already over-populated country.[41] These findings led to the conclusion that while the RH and other HRBA standards have the potential to contribute to measures to address MM, there are formidable obstacles which may affect their efficacy. At the same time, laws, policies and programmes recommended for adoption should be evaluated to prevent unintended results in the locality.

Nigeria's legal and policy framework was the subject of Chapter 5. The objective of that chapter was to determine the extent to which Nigeria's legal, policy and institutional framework applicable to MM aligns with the dictates of the international RH regime in a bid to gauge its viability as a framework to address the issue. To achieve this, the legal, political, socio-cultural and economic situation as well as the healthcare regulatory environment in which RH had to be given effect in Nigeria was laid out. The relevant laws, policies and initiatives were also assessed. The assessment of the laws, current and a few past policy

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[36] Morten Broberg and Hans Otto Sano, 'Strengths and Weaknesses in a Human Rights Based Approach to International Development: An Analysis of a Right Based Approach to Development Assistance Based on Practical Experiences' (2018) 22(5) The International Journal of Human Rights 664.
[37] Helen Potts, *Participation and the Right to the Highest Attainable Standard of Health* ( Centre for Human Rights University of Essex 2006) ISBN 978-1-874635-40-6 2<untitled (essex.ac.uk). >accessed 30 December 2023.
[38] Yamin and Cantor (n34) 451, 466.
[39] Candace Johnson and Surma Das, 'The Human Rights Framing of Maternal Health: A Strategy for Politicization or a Path to Genuine Empowerment' in G Andreopoulos and Zehra S Kabasakal (eds) *The Uses and Misuses of Human Rights* (Palmgrave Macmillan 2014) 135.
[40] In Nigeria, son preference has been highlighted as an indirect cause of MM because of the link to multiparity. So, a right to unrestricted abortion may lead to female feticide and the attendant problems in Nigeria as well.
[41] Arindam Nandi and Ramanan Laxminarayan, 'The Unintended Effects of Cash Transfers on Fertility: Evidence from the Safe Motherhood Scheme in India' [2016] Journal of Population Economics 457.

initiatives enabled a discovery of the progress or otherwise that the country had recorded in the adoption or implementation of relevant aspects of the framework. The assessment of the framework vis-a-vis the discussion of the determinants of MM in Chapter 3 facilitated a determination of gaps in the country's compliance with its obligations under the RH/MM reduction framework.

The CESCR notes that states must immediately or progressively adopt various appropriate legislative, budgetary, institutional, or promotional measures for the realisation of the ESC rights.[42] Additionally, compliance theorists opine that a state's compliance can be gauged by the laws and administrative measures it puts in place.[43] Thus, Nigeria's adoption of legislation such as National Health Act, National Health Insurance Act and various national health and reproductive health policies which are in tandem with Nigeria's commitment to global health strategies on maternal and reproductive health were deemed as acts of compliance. However, the extent to which the health plans have been turned into reality is another issue entirely due to various implementation gaps. Although the extent of Nigeria's efforts at progressive realisation remains difficult to determine in the light of those gaps, having a health plan is considered a concrete step.[44]

The chapter restated the popular argument that the constitutional limitation on the enforcement of the health care aspect of the right to health has been cured by the National Health Act (NHA), but the fact that the NHA provided for only healthcare entitlements was highlighted as one of the challenges of the RH approach earlier observed in Chapter 2. The chapter revealed that persistent shortcomings exist in terms of some reproductive freedoms and entitlements including, for example, adolescents' access to contraceptives and the restrictive law on abortion. While the former violation relates to omissions in authorising access to contraceptives for adolescents less than 18, the latter occurs through the retention of the restrictive abortion regime, thereby denying women access to services that only women need.[45] It was concluded that, as they both relate to non-discrimination, the elimination of which is an

[42] CESCR General Comment No. 3 The Nature of States Parties Obligations (art 2 para 1 of the Covenant) 1990 Adopted 14 December 1990 E/1991/23. para 33

[43] Abram Chayes and Antonia Handler Chayes, 'On Compliance' (1993) 47(2) International Organization. 175, 194.

[44] It is a core RH obligation. GC14 (n 16), para 43(f).

[45] CEDAW General Recommendation No. 24 Article 12 of the Convention (Women and Health), 1999, A/54/38/Rev.1, chap.1 para 14.

immediate obligation, technically they are not subject to progressive realisation and are clear violations of the right to sexual and reproductive health. [46]

In terms of the underlying determinants of maternal health, it was found that the country has duly adopted a Child Rights Act which could protect against child marriage, but as a consequence of Nigeria's federal system, the law is not domesticated in some states of the country. In the same vein, with respect to addressing gender inequality, the domestication of CEDAW, or the enactment of a law to guarantee the rights of women, has persistently been stalled while section 56 of the Penal Code authorising a husband to physically chastise his wife has also been campaigned against without success. Year in year out, there are also compliance deficits in terms of budgetary allocation. With respect to reporting obligations, Nigeria does not submit reports to CESCR, although it does to the CEDAW Committee. Again, Nigeria has signed the declaration to allow individual communications before the CEDAW,[47] but it has declined to make a similar declaration in respect of the African Court that has jurisdiction on the more protective Maputo Protocol. [48]

The CESCR in its GC14 directs that to determine that a violation has taken place, a distinction must be drawn between inability or unwillingness to comply, with the latter being the violation.[49] However, determining whether the criticised actions or omissions are due to unwillingness or incapacity may not be straightforward[50] especially when it is not clear whether it is due to a delay. For instance, had Chapter 5 been written a few years previously, Nigeria's shortcomings in terms of compliance would have been more than what is presently detailed. As an example, the explicit references to HRBA principles and their inclusion in the country's various reproductive health policies are recent actions. Similarly, the enactment of the National Health Act (NHA), and Violence Against Persons Protection (VAPP) Act, the institutionalisation of the maternal and perinatal death surveillance and response (MPDSR) and the establishment of sub-national insurance schemes are quite recent. It is also notable that the

[46] Lilian Chenwi, 'Unpacking Progressive Realisation, its Relation to Resources, Minimum Core and Reasonableness and some Methodological Considerations for Assessing Compliance' (2013) 46(3) De jure 742, 762; Audrey Chapman (n 20).
[47] OHCHR, UN Treaty Body Database <tbinternet.ohchr.org/_layouts/15/TreatyBodyExternal/Treaty.aspx?Treaty=CEDAW > accessed 30 December 2023.
[48] African Court on Human and Peoples' Rights, 'Welcome to the African Court' (2023) < Welcome to the African Court - African Court on Human and Peoples' Rights (african-court.org)> accessed 30 December 2023.
[49] GC14 (n 16) para 47.
[50] Because it is assumed that states intend to honour the agreements they enter. For instance, the Chayeses and Guzman both appear to proceed from that standpoint although their bases are different. Chayes and Chayes.(n 43). Andrew T Guzman, 'International Law: A Compliance Based Theory' (2002) 90(6) California Law Review 1823.

CEDAW committee persistently urged the country to enact the VAPP Act and the NHA before they were eventually enacted.

To take the study beyond discussing Nigeria's efforts towards compliance or the challenges of giving effect to the obligations of RH in Nigeria from an observer's viewpoint, it was considered important to understand the challenges from the perspective of the Nigerian duty bearers. Thus, the empirical study carried out in Chapter 6 enabled the researcher to gain first-hand insight into the experiences of the implementers of the measures and norms that are part of the RH/HRBA approach to MM adopted by Nigeria. This was also done with the aim of scrutinising these standards, particularly with respect to the nature of challenges dogging their adaptation and also their appropriateness to addressing causes of MM in Nigeria. Although based on only one of the states of the country, in line with the socio-legal approach of the thesis, the empirical study was an opportunity to appraise the societal context in which RH standards and HRBA are applied to reduce MM.

Revelations about the extent of conformity with several aspects of the framework were made by the key informants (KIs) who were selected for their length of service in the state's health sector and close involvement with implementing these standards. In terms of appropriateness, the challenge was probably less with the standards of the RH itself, but more with the means of local implementation. This is especially in view of the fact that ESC rights and the HRBA contemplate local compatibility and adaptation. In the case of Nigeria and many other developing countries, this meant making evidence-based decisions while addressing healthcare entitlements as well as the various factors determining its utilisation. The interviews suggest that the health sector, which is mainly made up of medical personnel, is not sufficiently engaging with the social, cultural and religious environment of MM in the state. For instance, Lagos State is proactive in terms of regulating traditional birth attendants' (TBA) activities but considering the role of culture and religion in the health-seeking attitude of the Nigerian society,[51] it was suggested that the state ought to consider their integration into the formal health system necessary.[52] Patronage of TBAs ought to be an open option in the same sense as

[51] Chimaroke Izugbara and Frederick Wekesah and Sunday Adedini, 'Maternal Health in Nigeria: A Situation Update' (2016) African Population and Health Research Centre 1, 4. ..<http://dx.doi.org/10.13140/RG.2.1.1291.9924> accessed 30 December 2023.
[52] As a kind of primary healthcare. John J Hall and Richard Taylor, 'Health for All Beyond 2000: the Demise of the Alma Ata Declaration and Primary Health Care in Developing Countries' (2003) 178(1) The Medical Journal of Australia 17, 18.

the orthodox facilities such that both the patrons and providers automatically anticipate referral in the event of established signs of complications. ADD FOR INTERSECTIONALISM HERE

Due to the focus of the empirical study, the investigation on the level of compliance was in relation to the RH healthcare guarantees such as ensuring that relevant SRH healthcare goods, facilities and personnel are available, accessible, acceptable and of good quality. At the same time however, evidence of ensuring key principles of non-discrimination, participation and accountability in the implementation of the measures were sought. The challenges affecting the efficacy of the agencies and that of the maternal and child medical facilities that implement these measures were also investigated through the relevant KIs. It was found that some problems like inadequate funding, lack of electronic data system, overdependence on altruism, and illegally trained health auxiliaries are institutional level factors that could be addressed at the level of the Ministry of Health. Other concerns such as corruption, societal insecurity/armed violence, lack of infrastructure, and inappropriate laws which also affect other sectors of the society, are the issues within the purview of the main state government or the federal government. The diversity of these factors buttresses the interrelatedness of the right to health with other human rights, and therefore led to the key finding of the interviews that focusing on improving the health sector alone will not solve the problem of MM anywhere in Nigeria.

### 7.3 Significant Observations

The right to the underlying determinants of health, including the social determinants, completes the picture of a comprehensive framework to realise the right to health. The thesis argues that the underlying determinants create a powerful opportunity to address as many causes of maternal ill health as possible. Indeed, underlying determinants have been described as ‘the causes of the causes’.[53] In fact, the WHO has noted that they may be the most important in the efforts to secure health.[54] The thesis however observes that despite its importance, it attracts less attention with respect to right to health issues, including MM. For instance, even the TMBs in their Concluding Observations do not discuss the underlying determinants in the section under the heading of ‘health’.

[53] Paula Braveman and Laura Gottlieb, ‘Social Determinants of Health: It is Time to Consider the Causes of the Causes’ (2014) 129 (Suppl 2) Public Health Reports 19.
[54] World Health Organisation, ‘Social Determinants of Health ‘(WHO, 2023) <Social determinants of health (who.int)> accessed 30 December 2023.

It is acknowledged that there are lapses in terms of Nigeria's efforts to meet healthcare requirements and, therefore, in need of remedying. The dismal state of primary healthcare facilities and services, the dependency on private healthcare providers, including unqualified personnel, low-quality health services and lack of attention to the rural areas are examples highlighted in the thesis. However, the findings in Chapter 5 reveal that most of Nigeria's (inadequate) efforts are geared towards providing medical care or improving healthcare delivery.[55]

Despite the importance of the various determinants, their potential to contribute to MM reduction is limited due to the low level of attention they are accorded. To further buttress this assertion on the health sector stakeholders' attitude on underlying determinants, it was noted for instance by the drafters of Nigeria's Accelerated Reduction Policy that the situation analysis which informed the policy neglected issues such as early age of marriage, age of first pregnancy, rate of adolescent childbearing and the role of education.[56] Meanwhile, the said situational analysis was conducted as recently as 2017, many years after the WHO identified its importance to health issues. In addition, government officials and healthcare workers, who should be knowledgeable, were contributors to the consultation that produced it.

Unfortunately, this neglect of non-healthcare factors may not be unconnected to the fact that the WHO and other regional or global health bodies are more focused on healthcare. The WHO's definition of MM discussed in Chapter 2 is an example. Additionally, as discussed, the opposition to the wide scope of RH is a stumbling block to effectively bring the RH framework to bear on the right to the underlying determinants of health. To worsen the Nigerian situation, the regulation and administration of Nigeria's health sector is 'doctor-dominated' which is presumably one of the reasons for focus on healthcare.[57]

Although Chapter 6 investigated only the implementation of the healthcare obligations, the above assertion is buttressed by the findings therein which revealed the effect the lapses in the non-medical aspects have on the medical aspects. The extent to which the implementers of

[55] Kana MA and others, 'Maternal and Child Health Interventions in Nigeria: A Systematic Review of Published Studies from 1990 to 2014' (2015) 15 (334) BMC Public Health <https://doi.org/10.1186/s12889-015-1688-3 > accessed 30 December 2023.

[56] Although, the importance of the determinants of health was recognised in the Accelerated Reduction Policy where a theory of change was included. Federal Ministry of Health Nigeria, Accelerated Reduction of Maternal and Newborn Mortality in Nigeria: Road Map for Action (2019-2022) 10.

[57] Ogoh Alubo and Vitalis Hunduh, 'Medical Dominance and Resistance in Nigeria's Health Care System' (2017)47(4) International Journal of Health Services 778. This was also observed during the empirical interview. All the participants, except one, were doctors.

the medical care were prepared to engage with the non-medical aspects was also telling. This is because the findings reveal that while the Lagos State health sector was making progress with the medical aspects, they appeared to be perplexed by some of the non-medical or underlying determinants. Admittedly, some of these factors are not within the jurisdiction of the Ministry of Health or even the state government; however, some are within their remit.

One of the issues which is considered within their remit concerns culture, religion, TBAs and invariably traditional medical practice vis a vis the HRBA framework. It was revealed that cultural practices as well as religion are some of the most important determinants of the health seeking attitudes of women and people generally. This is because it influences people's understanding of health, diseases and their causes.[58] Culture or religiosity sometimes leads to misconceptions, promotes fatality, and even harmful cultural practices, but the RH is limited because there are other guaranteed human rights such as the right to culture, freedom of thought, conscience and belief, to mention a few that come into conflict and there is no hierarchy among human rights.[59] It has been suggested that these culture-based misconceptions can be addressed by education, access to health information, and improvements in the general level of development.[60] Meanwhile, not all religious influences,[61] cultural beliefs and practices are bad or inutile. Therefore, the State should work on developing measures to harness those cultural and religious influences.[62]

The Nigerian (and many African countries') concept of health is holistic. It is described as encompassing mental, physical, spiritual and emotional wellbeing for individuals, their family members and the community.[63] At the same time, prevention and cure of diseases and ill health in the African view are concerned with both physical and mythical causes which traditional healers are believed to be equipped to combat.[64] The available evidence shows that

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[58] Jimoh Amzat and Oliver Razum, *Towards a Sociology of Health in African Discourse* (Springer Link, 2018) 7, 65, 66.
[59] Although practicalities may engender prioritisation.
[60] Jimoh Amzat and Oliver Razum (n 58) 71.
[61] For instance, Adedini et al's study reported that 2 out of 5 women participants were encouraged to take up family planning based on information received in religious settings. Adedini and others, 'Role of Religious Leaders in promoting contraceptive Use in Nigeria: Evidence from the Nigerian Urban Reproductive Health Initiative' (2018) 6(3) Global Health: Science and Practice October 500 < https://doi.org/10.9745/GHSP-D-18-00135 > accessed 30 December 2023.
[62] Ibhawoh argued that it is possible to reform cultural practices to make them enhance rather than antagonise human rights protection. Bonny Ibhawoh, 'Between Culture and Constitution: Evaluating the Cultural Legitimacy of Human Rights in the African State' (2000) 22 (3) Human Rights Quarterly 838, 856.
[63] Peter F Omonzejele, 'African Concept of Health Disease and Treatment: An Ethical Enquiry' (2008)4 (2) PubMed 120 < https://doi.org/10.1016/j.explore.2007.12.001 > accessed 30 December 2023.
[64] ibid.

both faith-based and traditional healers contribute highly to the provision of healthcare in Nigeria. Arguably, TBAs can satisfy the AAAQ elements.[65] But these realities about traditional healthcare are not sufficiently recognised in Nigeria's health policies. Both the African Commission and the CESCR have indicated support for traditional medical practice, with the African Commission urging states to incorporate traditional medical practice into the public healthcare system.[66] Instead, the government health sector stakeholders treat Nigerians' engagement with them as transient and their patronage as a mere stand-in for orthodox healthcare. However, it is opined that, due to Nigerians' strong belief in culture and religion,[67] the dualist societal scene where modernity and traditional conservatism exist side by side will be the reality for a considerable length of time in the future.

## 7.4 Recommendations

On the basis of the findings of this thesis, the following recommendations are made with respect to enhancing the RH framework's contribution to MM reduction globally and Nigeria specifically.

### 7.4.1 Recommendations in Relation to the Right to Health

Maternal mortality should be defined in a way that non-medical stakeholders can also identify with the dynamics that characterise its occurrence. It was observed in Chapter 2 that despite the recognition of the contribution of other determinants of health to the incidence of maternal mortality, the definition, which is also used by the office of the High Commissioner for Human Rights (OHCHR) in various published guidance on MM reduction, is very much medical and somewhat complex to the non-medical audience.

Admittedly, it is important to have a universal definition of maternal mortality or maternal death due to reporting and data gathering purposes,[68] nonetheless it is contended that

[65] For instance, two of the reasons which the physician key informants gave for not allowing cultural birthing practices - incompatibility with their medical training and lack of expertise in such practices- are not problems for TBAs. Additionally, TBAs are ubiquitous (available), accessible and their activities are not unregulated.
[66] African Commission on Human and Peoples' Rights (ACHPR), *Principles and Guidelines on the Implementation of the Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights,* adopted November 2010, para 67(w). GC 14 (n 16) para 34.
[67] Peter F Omonzejele (n 62); GA Akinola and Francis Adedara and Sanni Amidu, 'Religion and the Future of Nigeria'/Religion and the Future of Nigeria: Response I'/ Religion and the Future of Nigeria'/'Religion and the Future of Nigeria: Response II' (2015)18(1-2) African Journal of International Affairs &Development 7.
[68] M Patwardhan and others, 'Maternal Death, Case Definition and Guidelines for Data, Analysis and Presentation of Immunisation Safety Data' (2016) 34(49) PubMed 6077-6083. <https://doi.org/10.1016/j.vaccine.2016.03.042 > accessed 30 December 2023.

considering the importance of the non-medical determinants and the role of the non-medical sector, the definition should capture the non -medical determinants. For instance, the WHO classification of diseases which provides that death by accidental or incidental causes do not amount to MM, lists death from assault, rape or herbal medication as examples of accidental causes.[69] Meanwhile, there are reports of pregnant women or new mothers who develop complications and die after being subjected to assault by partners, families and communities because they fall pregnant.[70] Furthermore, if women are discouraged from patronising herbal practitioners because it may lead to complications that eventually kill the women, why should it (the incident) not be certified as a cause of maternal death?

Again, a HRBA to health or MM is not about well-educated legal advocates or medical actors, it also involves women and their communities. When the definition of the problem gives the impression that it is fundamentally medical, it can mislead the right holders and effectively exclude their involvement in arriving at solutions to the problem.

International technical and financial assistance should not focus principally on healthcare but on the underlying determinants of health as well. For instance, the challenge of acquiring digital databases in different aspects of the health sector and governance was repeatedly raised in Chapter 6. The importance of data lies in the fact that it reveals areas where there are exclusions, discrimination and marginalisation. In view of the importance of disaggregated data of numerous kinds to the realisation of RH in many developing countries, international assistance should be given to states to help in that direction.[71]

Treaty monitoring bodies (TMBs) must review states' obligations in relation to the underlying determinants of health under the health section to reinforce it as integral to the right. The findings of the empirical research with respect to the challenges posed by the socio-economic and underlying determinants of health make it imperative for the TMBs to take such

[69] WHO, The WHO Application of ICD-10 to Deaths During Pregnancy, Childbirth and the Puerperium: ICD-MM, 47 < 9789241548458_eng.pdf (who.int)?> accessed 30 December 2023.

[70] Sakineh Mohammed-Alezadeh, 'Intimate Partner Violence During the First Year After Childbirth in an Urban Area of Iran: Prevalence and its Predictors' (2018) International Journal of Women's Health and Reproduction Sciences 491,493<(PDF) Intimate Partner Violence During the First Year After Childbirth in an Urban Area of Iran: Prevalence and its Predictors (researchgate.net)> accessed 30 December 2023.

[71] It was reported that less than two-fifths of African countries have functioning civil registration and vital statistics system. African Union, 'African Health Strategy: 2016-2030' 17<AHS cover2 (au.int)> accessed 30 December 2023.
Wolff also wrote 'we need to spend money to find out where money needs to be spent'. This is to ensure that resources are channelled in the right direction. Wolff (n 30) 32.

action. Besides, it has been observed that national judges utilise country specific Concluding Observations to interpret provisions in international and domestic instruments.[72]

### 7.4.2 Recommendations to Enhance the Potential of the Right to Health to Reduce Preventable Maternal Mortality in Nigeria

In line with the key findings of the thesis, the country's plans to fulfil their RH obligations need to take special cognisance of RH's dependence on the realisation of other rights on various fronts. Although this is more commonly explained with examples of how rights to education, to privacy, to access to information enhance the right to health, there are however, other less, common relationships. As an example, the dearth of health personnel in rural areas was suggested to be addressed by mandating all health personnel to serve for 2 years in the rural areas.[73] Eze reacted by saying that although theoretically, the suggestion sounds plausible, for it to become workable, it would have to be preceded by infrastructural development such as good housing, access to potable water and sanitation[74] in the rural areas.

Nigeria must give attention to strengthening social support services for women and girls. The African society is characterised by communalism as well as dependence on social capital. As highlighted in Chapter 2, this communal nature is one of the main reasons usually advanced for the incompatibility of the individualistic system of human rights with the African value system.[75] While the benefits of communal or family support are well noted as a buffer in societies characterised by poverty and lack of government social benefits,[76] it is also a perfect setting for paternalism and abuse because it gives the providers control. The situation described in Chapter 5 about girls who are forced into early marriages and teenage pregnancies because their parents insist on it and the girls have no alternative support to turn to, is instructive concerning the need for social support services.

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[72] Frans Viljoen and Lirette Louw, 'State Compliance with Recommendations of the African Commission on Human and Peoples Right' 1994-2004 (2007) 101 (1) American Journal of International Law 1, 21.

[73] Caroline SE Homer and others, (n 29) 5. Nigeria lawmakers are presently considering this measure. Punch Reporters, 'Four Reasons Lawmakers Proposed Compulsory Five-Year Service for Medical Workers' Punch (Lagos, 7 April 2023) <Four reasons lawmakers proposed compulsory five-year service for medical workers (punchng.com)> accessed 30 December 2023.

[74] These are other guaranteed human rights on which, this suggestion shows, the RH is dependent in another way.

[75] Claude Ake, 'The African Context of Human Rights' (1987) 33(1/2) Africa Today 5.

[76] Paula Braveman and Laura Gottlieb (n 53) 25.

Maternal health-related litigation before local and international human rights courts, has contributed to securing accountability. As highlighted in Chapter Five, a pioneer legal victory to protect maternal health was won in the Lagos State High Court on the grounds of discrimination caused by compulsory blood donation as a precondition for ante-natal registration. Similarly, the African Court on Human and People's Rights (African Court) has ruled against Mali in respect of the Malian Persons and Family Code which was held to be in violation of the Maputo Protocol concerning the age of marriage of girls, forced marriage, and some other traditional practices inimical to the rights of girls and women.[77] On the international plane, CEDAW's celebrated decision in the *Alyne Pimental* case[78] has also been a turning point for maternal health rights.

As disclosed by the Nigerian NGOs which frequently filed cases against the military regime to publicise the regime's activities, litigation can also serve the purpose of inviting international pressure on the state.[79] However, in light of the limitations of litigation which were discussed in Chapter 4 as well as the HRBA support for non-adversarial accountability mechanisms, it is recommended that human rights advocates and activists give more attention to securing accountability through non-judicial means. As pointed out in that chapter, in a HRBA, accountability can be secured through non-judicial, or even administrative mechanisms which may just be focused on ensuring violations are not repeated.[80]

However, when litigation is the inevitable option, challenges emphasised by Ferraz, and Ambruoso et al, amongst others, drive home, to civil society as well as government-provided legal aid, the need to ensure that the measure remains true to protecting the most disadvantaged.[81] Similarly, the Nigerian judiciary needs to play a significant role in developing or employing principles that ensure that claims for entitlements which benefit the populace rather than individuals are prioritised.

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[77] APDF & IHRDA V Rep of Mali (046/2016) (2018) AfCHPR 15.
[78] CEDAW/C/49/D/17/2008.
[79] Louw and Viljoen (n 72).
[80] OHCHR, Summary Reflection Guide on a Human Rights Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under 5 Child Health - National Human Rights Institutions (2015)27 <RGuide_NHRInsts.pdf (ohchr.org)> accessed 30 December 2023.
[81] Octavio Luiz Motta Ferraz, 'Harming the Poor Through Social Rights Litigation: Lessons from Brazil' (2010) 89 Texas Law Review 1643; Lucia D'Ambruoso and Peter Byass and Nuru Siti Quomariyal, 'Can the Right to Health Inform Public Health Planning in Developing Countries? A Case Study for Maternal Healthcare from Indonesia' [2008] 1 Global Health Action 1, 5-7<Can the right to health inform public health planning in developing counties? A case study for mater (tandfonline.com)> accessed 30 December 2023.

The above also reiterates the need to create accessible and effective non-judicial or quasi-judicial bodies to mediate in healthcare-related disputes. The KI from HEFAMAA pointed out that the Agency was often invited to mediate in disputes, a role which is not part of its terms of reference, and it is therefore unequipped to play. In the same vein, to ensure the continual usefulness of the FCCPCC in respect of healthcare disputes, the legislative and policy confusions underlying the face-off between the FCCPCC and the NMA need to be resolved.

While the efforts of Civil Society to enforce accountability for RH obligations have been noted in Chapter 5, other areas recommended for their attention include getting medical personnel to be more knowledgeable about and involved in the human rights-based approach. To achieve this, efforts to point out important distinctions as well as draw a parallel between the HRBA and medical ethics must be inculcated in human rights training manuals. Collaborations with the medical associations should also be forged with a view to eliminating any perceived hostility to HRBA accountability mechanisms. It has been pointed out that in a HRBA, accountability includes non-judicial, or even administrative mechanisms which may just be focused on ensuring violations are not repeated.[82]

The above also reiterates the need to create accessible and effective non-judicial or quasi-judicial bodies to mediate in healthcare-related disputes. The KI from HEFAMAA pointed out that the Agency was often invited to mediate in disputes, a role which is not part of its terms of reference and is therefore unequipped to play. In the same vein, to ensure the continual usefulness of the FCCPCC in respect of healthcare disputes, the legislative and policy confusion underlying the face-off between the FCCPCC and the NMA need to be resolved.

The pluralist legal system, federalism and the pluralist healthcare sector are formidable challenges which any strategy or plan must engage with. They are creations of necessity which unfortunately have proved counterproductive in the cause of maternal mortality. Nevertheless, they have some advantages which can be put to good use.[83] The existence of layers means there is a distribution of the responsibility of governance which may lead to more responsive leadership. As a result, the problem of MM can be addressed within each of these layers. The component states can also address MM in their states with more tailored approaches. It is

[82] OHCHR, Summary Reflection Guide on a Human Rights Based Approach to Health: Application to Sexual and Reproductive Health, Maternal Health and Under 5 Child Health - National Human Rights Institutions (2015)27 <RGuide_NHRInsts.pdf (ohchr.org)> accessed 30 December 2023.

[83] Jessica Arnold and others, 'Medical Pluralism in Maternal Health Seeking Behaviour in Rural Women in Southern Ecuador' (2021) 42(4-6) Health Care for Women International 356.

recommended that the issue of MM be addressed using all legal systems and that there be more purposeful regulation of all levels of healthcare providers.

The unauthorised training of healthcare auxiliaries should receive more attention than it is presently receiving. The duty to protect and the obligation to ensure that healthcare is of good quality makes this imperative. The recognition of the peculiarity of each country by the Committee on Economic, Social and Cultural Rights (CESCR) which then urges the adoption of appropriate measures requires Nigeria to consider their peculiar circumstances while developing the means to solve their challenges.

Against the background of the dire shortage of skilled healthcare workers in Nigeria and the fact that healthcare auxiliaries can play a role in healthcare provision,[84] their training can be standardised. In countries like Malawi, non-physicians, who are called clinical officers are trained to perform caesarean deliveries.[85] The quality of training of health personnel with regard to their specific role is noted to be the greatest determinant of their performance.[86] Lagos (Nigeria) may harness the situation by converting/harmonising it with the well- established training programme of community extension workers. Alternatively, they may create a specific regulatory authority to monitor their training and their practice.

Ransome-Kuti, a former minister of health in Nigeria, had observed that the training of a country's health personnel ought to be informed by the needs of that country. He suggested that new cadres of health personnel different from those of other countries could be trained in case of specific health problems if the skills to address them, the available human resources as well as the obtainable level of technology dictate it. But he also noted that the biggest challenge to achieving this is the colonial mindset due to which the developing countries are afraid to be different and consequently branded as 'inferior'.[87]

However, since the early 2000s Cuba's Latin American School of Medicine (ELAM) has successfully trained medical graduates from different countries who have neither sought

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[84] WHO, *Using Auxillary Nurse Midwives to Improve Access to Key Maternal and Newborn Health Interventions* (2014) < WHO_RHR_14.22_eng.pdf> accessed 30 December 2023.
[85] Mhango Chisale, 'Mobilising the Community Against Maternal Death: The Malawi Community Champion Model' in Francis Omasawa and Nigel Crisp (eds), *African Health Leaders Making Change and Claiming the Future* (Oxford University Press 2014)59.
[86] O Ransome-Kuti, ' The Right Road to Health' [1987] World Health Forum 161, 163 < WHF_1987_8(2)_p161-163.pdf (who.int)> accessed 30 December 2023.
[87] ibid

employment in Northern and more prosperous countries nor entered private practice.[88] This success has been attributed to the institutional ethics of the school which is in line with training workers for the marginalised and needy populations. This goal reflects in the school's recruitment, curriculum and pedagogy.[89] The students' admission is mainly premised on their commitment to help disadvantaged populations. Their curriculum is focused more on community health promotion rather than just clinical competence. Their instructors also lead by example. Notwithstanding, it must be acknowledged that for some students, there has been the challenge of getting this qualification recognised in their own countries. Additionally, the fact that the training is heavily tilted towards primary healthcare also pose problems for returning students whose countries have less developed primary healthcare systems.[90]

It is germane to reiterate that the country ought to take cognisance of their peculiar situations while embracing globally prescribed solutions. That is, the compatibility of the solutions with the local conditions and how to make them workable in the Nigerian setting must be important considerations when adopting or implementing internationally prescribed norms. A few examples from Chapter 5 buttress this point: Ondo State has been unable to continue the *Abiye* initiative despite its notable success; the criminalisation of FGM has not resulted in prosecution despite the fact that the procedure is still being carried out in the country; the government has been forced, at least twice, to reverse laws through which it wanted to make liberal changes to abortion rules, and lastly, component states have calmly refused to domesticate any federal laws that are useful to protect the SRHR of women and girls. These are examples of measures recommended as interventions, but which have exhibited the likelihood of failure or limited success.

## 7.5 Suggestions for Further Research

It is proposed that there be further research on the possibility and modalities of instituting a social enquiry within families and friends, facilitated by incentives, to report the circumstances of maternal deaths. This is because sometimes, avoidable familial and communal pressures or actions contribute to maternal deaths. Prima facie, there is a risk that the enquiry may lead to

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[88] Rober Huish, 'How Cuba's Latin American School of Medicine Challenges the Ethics of Physician Migration' (2009) 69(3) Social science & Medicine 301.
[89] ibid.
[90] Afra Jiwa, 'The Latin American School of Medicine (Elam): Admissions, Academics and Attitudes' (2017)9 (1) International Journal of Cuban Studies 142.

families going to even greater lengths to cover up maternal deaths and consequently hamper data gathering. They may also provide untrue evidence.

However, as with the medical personnel, the possibility of facing investigations (and possibly sanctions) may act as a deterrent to relatives from taking or supporting decisions that may put a pregnant woman's life at risk. In addition, if hospitals which are at the end of the chain review their contribution, it is reasonable to review that of the wider community too with a view to preventing avoidable maternal deaths. This has been trialled with success in Malawi where the village heads have been drafted in to help educate and enforce maternal healthcare regulations. In aid of this initiative, the community heads made community laws to sanction men who allow their wives to deliver their babies at home instead of healthcare facilities.[91]

Secondly, an empirical study or more empirical studies investigating the experiences of the implementers of the non-healthcare aspects of RH in Nigeria, along the lines of the critical or balanced viewpoint that this study adopted, is essential to take this study further because the empirical research in this thesis only covered the healthcare aspects. It is important to engage stakeholders who are involved in operationalising other aspects of the HRBA such as civil society, officers of judicial and non-judicial accountability mechanisms, women and girls of reproductive age and so on, on the prospects and appropriateness of the RH framework.

As earlier observed, there have been studies on some interventions which are also recommended as part of the RH framework, however these studies were not carried out with the viewpoint of interrogating the potential or appropriateness of the RH framework. Therefore, while some of them - which have been referred to in chapter 6- investigated some interventions which are part of the framework, it was with the usual intention, as criticised by this thesis of evaluating the performance of the government, not the standards or measures.[92] Investigating, for instance, the appropriateness of the standards to the society, from the viewpoint of these categories of stakeholders, would facilitate recommendations in respect of the institution or development of more workable MM reduction plans and strategies based on RH standards.

Lastly, the issue of decolonisation of human rights was mentioned at the outset. It was highlighted that although decolonisation is not the primary focus of the thesis, it has some influence on the thinking in the thesis. It is suggested that a formidable way to deepen the investigation in this thesis is to study the connotation of the norms and standards of the

[91] Mhango Chisale (n 83) 62.
[92] See section 7.1 for more explanation on this.

framework in the context of the Nigerian society. In this study, the standards of the RH and other principles of the HRBA and their interpretations, whose implementation were discussed in relation to Nigeria proceed from the UN bodies as well as human rights experts who are mainly from the West.[93] Further, the African elucidation of the right essentially re-echoed GC14.[94] But it is argued that to have the full benefit of the standards and principles, it is important through further research to understand what those principles should entail in the context of Nigeria.[95] These would inform more appropriate measures or strategies. To give an example, published studies mention community health committees, which the human rights bodies have also endorsed as a measure to ensure participation.[96] However, these committees are hampered by shortcomings, including the usual exclusion of women,[97] which suggests this measure may not be the most effective approach to attain a MM reduction objective. [98]

[93] For instance, this study identified town hall meetings, enlightenment campaigns carried out by the health ministry, hospitals and agencies as participation based on the explanations provided by the UN bodies.

[94] ACHPR*, Principles and Guidelines on the Implementation of the Economic, Social and Cultural Rights in the African Charter on Human and Peoples' Rights,* adopted November 2010 paras 60-67< http://archives.au.int/handle/123456789/2063 > accessed 30 December 2023.

[95] The views of the stakeholders referred to in the preceding recommendation would be of essence in achieving this objective.

[96] OHCHR, Technical Guidance on the Implementation of Policies and Programmes to Reduce Preventable Maternal Mortality and Morbidity ( OHCHR, 2012) para 74 <https://www2.ohchr.org/english/issues/women/docs/a.hrc.21.22_en.pdf> accessed 30 December 2023.

[97] Robinson Karuga, 'Participation in Primary Health Care Through Community-Level Health Committees in Sub-Saharan Africa: A Qualitative Synthesis' (2022) 22(359) BMC Public Health < https://doi.org/10.1186%2Fs12889-022-12730-y > accessed 30 December 2023.

[98] In most African societies, due to patriarchy and or religious dictates, women are not supposed to be heard in community gatherings. Olanike S. Adelakun, 'The Effect of Religion and Culture on the Implementation of Women's Rights in Africa: Challenges and Prospects' (2019) 1 (1) International Journal of Comparative Law and Legal Philosophy 203, 205, 207.

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