

Maternal mortality from a human rights perspective: A case study of North-Eastern Nigeria

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DEDICATION

I dedicate this work to all the women who lost their lives to preventable maternal mortality, and in loving memory of my late parents; my mother Hajiya Kaka Banaru Abubakar and my father Alhaji Banaru Abubakar (*Barayan Gombe*).

DECLARATION

I, IBRAHIM BANARU, ABUBAKAR, do hereby declare that this research 'Maternal mortality from a human rights perspective: A case study of North-Eastern Nigeria' is my original work. It has not been submitted either in whole or in part to any other institution. Where others' ideas have been used, it has been duly acknowledged.

Ibrahim Banaru Abubakar

Signature.....

Date.....

Supervisor: Dr Ashwanee Budoo

Signature.....

Date.....

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LIST OF ABBREVIATIONS

AIDS	Acquired immunodeficiency syndrome
AU	African Union
ANC	Ante-Natal Care
CIDA	Canadian International Development Agency
CSO	Civil Society Organisation
CESCR	Committee on Economic, Social and Cultural Rights
CEDAW Women	Convention on the Elimination of all forms of Discrimination against Women
DFID	Department for International Development
EmOC	Emergency Obstetrics Care
EPMM	Ending Preventing Maternal Mortality
FGM	Female Genital Mutilation
HIV	Human Immunodeficiency Virus
PIH	Pregnancy Induced Hypertension
ICPD	International Conference on Population and Development
ICESCR	International Covenant on Economic, Social and Cultural Rights
MDSR	Maternal Death Surveillance Response
MM	Maternal Mortality
MDG	Millennium Development Goals
NHA	National Health Act
NHRC	National Human Rights Commission
NRHPS	National Reproductive Health Policy and Strategy
OAU	Organisation of African Unity
PPH	Postpartum Haemorrhage
TBA	Traditional Birth Attendant
UN	United Nations

UNICEF	United Nations Children Fund
UN MMEIG	United Nations Maternal Mortality Estimation Inter-Agency Group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UHC	Universal Health Coverage
WMHCP	Ward Minimum Healthcare Package
WHO	World Health Organisation

ABSTRACT

Nigerian women, especially those from the North-East sub-region continue to suffer preventable maternal mortality. Recent statistics places Nigeria as the highest contributor of maternal deaths globally. These avoidable deaths disproportionately affect women from the North-East due to socio-economic inequalities that are discriminatory. More so, the low socio-economic status of women in the region has been further worsened by humanitarian crisis with attendant increase in the incidence of maternal mortality.

Maternal mortality has been framed a human rights issue that can be mitigated through a human rights-based approach. Thus this research engages with a multi-disciplinary approach in uncovering the factors that contribute to the worrisome statistics of maternal deaths in the North-East and investigates through a human rights-based perspective the need for a holistic approach to ending preventable maternal deaths in the sub-region.

Findings reveal many interrelated socio-economic factors intersect to inflame the continued tragedy of maternal mortality in the region. For the North-East to break the negative cycle of maternal mortality, a holistic approach is imperative considering the complexities of the predispositions to maternal mortality, the socio-economic reality of the region and the inadequacies of legal framework.

Keywords: *maternal mortality; human rights; North-East; Nigeria; holistic approach*

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CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Maternal mortality (MM) rate remains a phenomenon that affects African women with an estimated ratio of 542 deaths per 100,000 live births.¹ Sub-Saharan Africa accounts for 66% of global MM burden in 2017, when it was found that about 196,000 women died due to pregnancy and childbirth related complications.² These complications include severe bleeding after delivery, high blood pressure, infections, complications following delivery and unsafe abortion.³ Women in sub-Saharan Africa are particularly more vulnerable to death during pregnancy, because of poor accessibility to and quality of reproductive healthcare.⁴

Between 2000 and 2017, there was a worldwide reduction in MM by 38%.⁵ Every region has advanced in preventing maternal deaths except sub-Saharan Africa which continued to record unacceptably high MM.⁶ Despite the very high MM in 2017, sub-Saharan Africa achieved some reduction in MM rate by 38% since 2000 from an estimated MM ratio of 878 deaths per 100,000 live births to 542 deaths per 100,000 live births.⁷ The high MM rate in 2017 could be traced to the continued existing gap in comprehensive coverage of maternal health services, especially in emergency obstetrics care and the availability of adequate number of competent healthcare providers.⁸ According to the United Nations Maternal Mortality Estimation Inter-Agency

¹ United Nations Economic Commission for Africa *maternal mortality ratios, by country* (2015) https://www.uneca.org/sites/default/files/uploaded-documents/Africa-Business-Investment-Forum/2018/maternal_mortality_ratios_en.pdf (accessed 11 April 2019).

² WHO 'Maternal mortality' (2019) <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality> (accessed 11 April 2019).

³ WHO 2019 (n 2) para 8.

⁴ WHO 2019 (n 2).

⁵ WHO *Trends in maternal mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (2019).

⁶ WHO 2019 (n 5) at 40.

⁷ WHO 2019 (n 5) at 40.

⁸ WHO 2019 (n 5) at 52.

Group (UN MMEIG), in 2017, 808 women died daily from complications of pregnancy and childbirth, of whom 536 were from sub-Saharan Africa.⁹

Recognising that many women are victims of death during childbirth, the international community has adopted several initiatives such as: the Safe Motherhood Initiative of 1987, which aimed to raise awareness about the unacceptably high numbers of women dying from pregnancy and childbirth related causes each year, and to challenge the world to address it;¹⁰ the 1994 International Conference on Population and Development (ICPD) in Cairo,¹¹ the largest inter-governmental conference on population and development, which recognised the realisation of sexual and reproductive rights as the cornerstone for development and reached consensus to provide universal access to the full range of reproductive health services and reduce MM; and the Millennium Development Goals (MDGs) adopted in the year 2000¹² targeting a three quarters reduction in the MM ratio given that maternal deaths could be avoided.¹³

Despite these initiatives, many women across sub-Saharan Africa continue to be victims of death during or after childbirth. This is also a reality in Nigeria where about 183 women of childbearing age succumb to pregnancy related complications daily.¹⁴ With an annual birth statistics of about 7 million, Nigeria recorded 67,000 maternal deaths in 2017, or a MM ratio of 917 deaths per 100,000 live births¹⁵ and ranked as the highest contributor to the MM figures globally.¹⁶

The incidence of MM varies significantly across regions of Nigeria and there are several factors attributable to socio-economic and political inequalities that influence this

⁹ WHO 2019 (n 5) at xi.

¹⁰A Rosenfield 'The history of the safe motherhood initiative' (1997) 59 *International Journal of Gynaecology and Obstetrics* s7 para 2.

¹¹ United Nations Population Fund (UNFPA) *Program of action adopted at the international conference on population and development, Cairo, 5-13 September 1994* (2004) iii para 5.

¹²United Nations Development Programme 'Millennium development goals' https://www.undp.org/content/undp/en/home/sdgoverview/mdg_goals.html para 3 (accessed 21 March 2019).

¹³ UN 'Goal 5: Improve maternal health; target 5a: Reduce by three-quarters, between 1990 and 2015, the MM ratio' <https://unstats.un.org/unsd/mi/pdf/mdglist.pdf> (accessed 20 April 2019).

¹⁴ National Population Commission & ICF International *Nigeria demographic and health survey 2013* (2014) at 274.

¹⁵ WHO 2019 (n 5) at xi.

¹⁶WHO 2019 (n 5) at xi.

phenomenon¹⁷ North-Eastern Nigeria bears the greatest burden compared to the other regions due to many factors including poor health infrastructure, low literacy level and long distance from health facilities in the region.¹⁸

North-Eastern Nigeria has an incidence of 1549 maternal deaths per 100,000 live births.¹⁹ The figure 1549 may not even be the true reflection of the gory picture of the maternal deaths in the region since registration of such incidences is almost non-existent in the North and hence most deaths that occur at home go unreported.²⁰

1.2 Problem statement

It has been proven that a human rights approach can be applied to remedy the disadvantages faced by women that predispose them to vulnerabilities during pregnancy.²¹ The avoidable deaths of women while pregnant has been linked to inherent human rights such as the right to life, the right to highest attainable standard of health, the right to non-discrimination and the right to be free from inhumane and degrading treatment.²² These inherent rights mentioned are guaranteed by some of the international and regional human rights instruments that Nigeria is a state party to. The Convention on the Elimination of all forms of Discrimination against Women (CEDAW)²³ provides for the protection of women's rights from discrimination and to the highest attainable health. The same right to health for women is also recognised by the

¹⁷ E Kalu 'Governance can kill: The politics of maternal bodies in Nigeria' (2015) *Public Health Theses* 1145 <https://elischolar.library.yale.edu/ysphtdl/1145/> (accessed 21 March 2019).

¹⁸ WHO *Trends in maternal mortality 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (2015) at 21.

¹⁹ WHO 2015 (n 18).

²⁰ V Sharma et al; 'High maternal mortality in Jigawa state, northern Nigeria estimated using sisterhood method' (2017) 17 *BMC Pregnancy and Childbirth* at 163.

²¹ R Khanna 'Training manual on maternal health' (2013) *CommonHealth* at 44.

²² E Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 165 *Journal of Legal Pluralism and Unofficial Law* at 103.

²³ Arts 1 & 12 CEDAW; Nigeria ratified CEDAW on 23 April 1984 https://lib.ohchr.org/HRBodies/UPR/Documents/Session4/NG/NHRC_NGA_UPR_S4_2009anx_RatifiedHumanRightsInstruments.pdf (accessed 20 April 2019).

International Covenant on Economic, Social and Cultural Rights (ICESCR).²⁴ At the regional level, Nigeria's human rights obligation to protect women from dying during pregnancy and childbirth can be found in the African Charter on Human and Peoples' Rights (Banjul Charter) and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol). The rights to life, dignity, and information as well as the right to health are guaranteed by the Banjul Charter and state parties are obliged to ensure all citizens attain these rights.²⁵ The Maputo Protocol guarantees women's right to health including sexual and reproductive health.²⁶

The journey to reducing MM in Nigeria has been slow paced, attributable to varied challenges including poor infrastructure, pandemic lack of access to services and inadequate manpower.²⁷ Most of the pregnancy related deaths and the severe complications are preventable through effective governmental policies such as strengthening health systems, addressing inequalities in access to and quality of care as well as ensuring accountability of care.²⁸ The country has legal obligations²⁹ to adopt necessary measures in preventing maternal deaths and making motherhood a safe experience for the expectant mothers and their families.³⁰ Despite these obligations, MM still remains a problem in North-Eastern Nigeria.

1.3 Research question

²⁴ Art 12 CESCR; Nigeria ratified ICESCR on 29 July 1993 https://lib.ohchr.org/HRBodies/UPR/Documents/Session4/NG/NHRC_NGA_UPR_S4_2009anx_RatifiedHumanRightsInstruments.pdf (accessed 20 April 2019).

²⁵ Arts 4, 5, 9 & 16(1&2) Banjul Charter; Nigeria ratified Banjul Charter on 22 June 1983 https://au.int/sites/default/files/treaties/36390-sl-african-charter-on-human-and-peoples-rights_2.pdf (accessed 20 April 2019).

²⁶ Art 12 Maputo Protocol; Nigeria ratified Maputo Protocol on 16 December 2004 https://au.int/sites/default/files/treaties/7783-sl-protocol-to-the-african-charter-on-human-and-peoples-rights-on-the-rights-of-women-in-africa_5.pdf (accessed 20 April 2019).

²⁷National Population Commission & ICF International (n 14) at 273.

²⁸ WHO 2019 (n 2).

²⁹ Convention on the Elimination of all forms of Discrimination against Women (CEDAW); International Covenant on Economic, Social and Cultural Rights (CESCR); African Charter on Human and Peoples' Rights (Banjul Charter); Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol).

³⁰Khanna (n 21) at 44.

The main research question studies the steps North-Eastern Nigeria can take to ensure a reduction in MM rate. To answer the main question, the following sub-questions are posed:

1. What are the causes of MM in North-Eastern Nigeria?
2. What are the obligations of Nigerian government in accordance with international human rights laws to reduce MM rate?
3. Based on a holistic approach, what strategies can be applied in North-Eastern Nigeria with the view of achieving a reduction in MM?

1.4 Definition of terms

1. Maternal mortality or maternal death

The World Health Organisation (WHO) defines maternal mortality as follows:³¹

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

2. MM ratio

The WHO defines MM ratio as:³² 'The number of maternal deaths per 100,000 live births, a measure of the risk of death once a woman has become pregnant'.

3. MM rate

The WHO defines MM rate as:³³ 'The number of maternal deaths (direct and indirect) in a given period per 100,000 women of reproductive age during the same time period'.

1.5 Research objectives

³¹WHO 'maternal mortality ratio' (2016) <https://www.who.int/healthinfo/statistics/indmaternalmortality/en/> (accessed 30 November 2018).

³²WHO 2016 (n 31).

³³WHO 2016 (n 31).

The objective of the research is to contribute to the growing discussion on finding enduring solution to MM in Nigeria especially in the North-Eastern region.

On one hand the study identifies the causes of MM as a human rights violation in North-Eastern Nigeria and the factors that constrain the reduction in MM. On the other hand, the study aims to highlight how the application of a holistic approach will bring about significant reduction in MM and the realisation of women's right to safe motherhood.

1.6 Research methodology

In order to answer the research questions, this work is a qualitative study utilising secondary sources of information such as the Nigeria population census, researches on reproductive health and MM, health reports, statements and surveys of relevant health agencies on the rights of women to have safe pregnancies. A multidisciplinary approach such as socio-economic, political, educational and cultural have been used to identify causes and possible remedies for MM. Essentially secondary sources of information have been reviewed, which are information collected by others.

This research is essentially a literature and desktop based research. The United Nations (UN) SDGs, the Nigeria National Health Act³⁴ and other instruments relevant to furthering maternal health formed focus of discussion, upon the established incidence and correlates of MM especially in North-Eastern Nigeria.

1.6.1 Case study

I focused on the North-Eastern part of Nigeria, because beyond the pandemic socio-economic problems in Nigeria, women and girls living in the North-Eastern sub-region of Nigeria are facing overwhelming crisis as they struggle to cope with nutritional problems, sexual and gender based violence as well as risks to their health including

³⁴ National Health Act of 2014.

maternal death.³⁵ Thus there is need to highlight the plight of this vulnerable population to promote their rights to highest attainable standard of health.

Despite regional and international human rights obligations, as stated in the statement of problem,³⁶ North-Eastern Nigeria is still struggling with high rates of MM because of the absence of strategic framework that is holistic. Given these many contributing factors to MM with compounded human rights violations, a single approach to solving the problem may not yield result, thus a holistic approach has been adopted to face the issue. A holistic approach is based on the WHO recommended strategies towards ending preventing maternal mortality (EPMM).³⁷

1.6.2 Human rights-based approach to MM

This research has taken insight from the technical guidance on human rights-based approach to reduce preventable maternal morbidity and mortality provided by the office of the High Commissioner for Human Rights which identifies the human rights correlates of avoidable maternal morbidity and mortality.³⁸ The guidance elucidates the human rights implications for stakeholders in the policy making cycle as well as implementation and review cycles. It also further highlights the imperatives of peer review, cooperation and partnerships towards reducing maternal morbidity and mortality in accordance with human rights standards.

A human rights-based approach to MM is sourced from international human rights laws.³⁹ The approach recognises right-holders and their entitlements as well as the corresponding obligations of duty-bearers. This recognition is in an effort to strengthen

³⁵ UNFPA <https://www.unfpa.org/press/women-girls-North-East-nigeria-face-severe-crisis-urgently-need-increased-support-including> (accessed 17 April 2019).

³⁶ Page 3 above.

³⁷WHO *Strategies toward ending preventable maternal mortality (EPMM)* (2015).

³⁸ OHCHR 'Human rights-based approach to reduce preventable maternal morbidity and mortality: Technical guidance' <https://www.ohchr.org/Documents/Issues/Women/WRGS/Health/TGReduceMaternalMortality.pdf> (accessed 30 November 2018).

³⁹OHCHR (n 38) at 4.

the capacities of right-holders to make their claims and for the duty-bearers to meet their obligations.⁴⁰

Empowering women to be able to claim their right to health is an integral part of the rights-based approach. It expresses the recognition of sexual and reproductive health in constitutions and national laws and the institutionalisation of accountability mechanisms essential to the realisation of health rights.⁴¹

Through rights-based approach, states address social determinants of health that affect women's realisation of civil, political, economic, social and cultural rights. In so doing power differentials between men and women that manifest as poverty and gender discrimination in law are addressed. In effect, it also mitigates the multiple interdependent rights violations against women such as early marriage, nutritional taboos and female genital mutilation (FGM).⁴²

Human rights-based approach ensures no one is left behind. This is achieved through particular attention to vulnerable groups such adolescent girls, persons living with HIV, women with disabilities, displaced women and those living in remote areas.⁴³ This speaks to the plight of a number of women living in North-East Nigeria who are either displaced or live in hard to reach communities. This approach places women regardless of social status as active participants in matters that affect their sexual and reproductive health.

Rights-based approach is holistic in guiding health system strengthening to meet the sexual and reproductive health needs of women. In meeting women's health needs, there must be the availability of facilities with well-motivated trained professionals and essential drugs.⁴⁴ The facilities should be physically, economically and non-discriminatorily accessible to women.⁴⁵ While accessing facilities, confidentiality as well as culture and beliefs are respected in a way acceptable to the women. Similarly the

⁴⁰ OHCHR (n 38) at 4.

⁴¹ OHCHR (n 38) at 5.

⁴² OHCHR (n 38) at 5.

⁴³ OHCHR (n 38) at 9.

⁴⁴ OHCHR (n 38) at 6.

⁴⁵ OHCHR (n 38) at 6.

rights-based approach requires respectful care to women and provision of services that are of good quality.⁴⁶

Rights-based approach seeks the protection of women against third party interference with their sexual and reproductive rights.⁴⁷ It also amplifies the need for gender sensitive budgeting with multi-sectorial approach to social and economic planning.⁴⁸ To achieve the full realisation of maternal health through a human rights-based approach, accountability is key. Accountability is enhanced through monitoring, efficient oversight and institutionalisation of remedies.⁴⁹

1.7 Scope and Limitations

This research highlights the implications and modalities to reduce MM in North-East Nigeria. Beyond focus on state actors, I drew from recent literatures how the input of other stakeholders influence policy in realisation of rights.

Limitations of this research is that it is only a desk review with no field study of North-Eastern Nigeria to empirically assess current situation. The research also focuses only on North-East Nigeria and therefore cannot be generalised in other contexts.

1.8 Literature review

1.8.1 MM as a violation of human rights

Many scholarly writings have focused on the nexus between MM, the right to health and the right life, and the obligations of states to ensure women's access to reproductive

⁴⁶ OHCHR (n 38) at 6.

⁴⁷ OHCHR (n 38) at 9.

⁴⁸OHCHR (n 38) at 7.

⁴⁹OHCHR (n 38) at 15.

health services.⁵⁰ Several studies have looked at the public health approach to ending the scourge of avoidable maternal deaths in Nigeria but not much has been documented about the human rights dimensions to it.⁵¹ Given that accessing maternal health has been framed a human right⁵² and Nigeria is party to a number of international and regional treaties relevant to maternal health, a human rights approach that is holistic will go a long way in reducing the incidence of maternal deaths in the North-East sub-region.⁵³

Cook and others in 'Reproductive health and human rights: Integrating medicine, ethics and law' analysed reproductive rights of women from a gendered perspective and highlighted the synergy between reproductive health and rights.⁵⁴ Similarly in a recent related work, Cook highlighted pertinent human rights implications to reducing MM such as the right to life, right to non-discrimination and the right to health per the landmark judgement in the case of *Alyne da Silva v Brazil*.⁵⁵ This decision is landmark since it was the first time an international human rights treaty monitoring body held a state accountable following the state's failure to prevent avoidable death during child birthing. Cook highlighted that the decision has opened a new dimension in the human rights approach to maternal death by making it possible for families to recognise the role of injustice, gender and economic discriminations as determinants of maternal death.⁵⁶

Durojaye unbundled the fact that beyond medical causes of maternal deaths, there lie great predispositions from socio-cultural factors such as low socio-economic status and the lack of respect for women's fundamental rights.⁵⁷ This furthers the argument that the

⁵⁰J Bueno de Mesquita & E Kismödi 'Maternal mortality and human rights: Landmark decision by United Nations human rights body' (2012) *Bulletin of the World Health Organization*.

⁵¹ A Bankole et al 'Barriers to safe motherhood in Nigeria' https://www.guttmacher.org/sites/default/files/report_pdf/motherhoodnigeria.pdf (accessed 17 April 2019).

⁵²OHCHR 'Information note: Maternal mortality is a human rights issue, says a new UN study' https://www.ohchr.org/Documents/Issues/MDGs/Infonote_maternal_mortality.pdf (accessed 20 April 2019).

⁵³ C McFadden & MF Oxenham 'The paleodemographic measure of maternal mortality and a multifaceted approach to maternal health' (2019) 60(1) *Current Anthropology* at 141.

⁵⁴RJ Cook et al *Reproductive health and human rights: Integrating medicine, ethics and law* (2003) Oxford University Press.

⁵⁵ RJ Cook 'Human rights and maternal health: Exploring the effectiveness of the Alyne decision' (2013) 41 *The Journal of Law, Medicine & Ethics* at 103; Communication 17/2008 *Alyne da Silva Pimentel v Brazil*, UN Committee on the Elimination of Discrimination against Women (August 16 2011), UN Doc CEDAW/C/49/D/17/2008.

⁵⁶ Cook (n 55) at 103.

⁵⁷Durojaye (n 22) at 107.

worrisome statistics about MM arise from many factors which will require holistic and synergistic approach to tackle.

Keeping to its supervisory mandate, the National Human Rights Commission of Nigeria (NHRC), in a deposition titled 'Nigeria's human rights approach towards eliminating maternal mortality and morbidity',⁵⁸ owned up to the fact that the statistics about MM in Nigeria is worrisome and far from declining. The submission further hinted the North-Eastern part of Nigeria bears the highest incidence of maternal deaths partly occasioned by the socio-economic inequalities.⁵⁹ The NHRC has developed a national plan of action in an effort to see to the promotion and the protection of human rights for Nigeria.⁶⁰ This action plan is deposited with the OHCHR and it contains strategies related to preventing avoidable maternal deaths.

Given the multiple preventable predisposing factors for maternal death, studies analysed the progress of MDGs in Nigeria with propositions on addressing socio-cultural barriers to maternal health as the progress needed to meet the SDGs.⁶¹

From the foregoing, it is clear the high incidence of MM continues due to many factors such as the socio-economic and political inequalities that women face as highlighted above. There is also the concept of three delays that contribute to MM: the first is the delay in making decision to access maternal health service, the second is the delay in reaching the point of service and the third being delay in getting the required service.⁶² These delays concept further highlight the socio-economic and political inequalities

⁵⁸ OHCHR 'Nigeria's human rights approach towards eliminating maternal mortality and morbidity' <https://www.ohchr.org/Documents/Issues/Women/WRGS/MortalityAndMorbidity/NHRCNigeria.pdf> para 2 (accessed 30 November 2018).

⁵⁹ OHCHR (n 58) para 2.

⁶⁰ OHCHR 'National action plan for the promotion and protection of human rights in Nigeria 2009 – 2013' https://www.ohchr.org/Documents/Issues/Education/Training/actions-plans/Excerpts/Nigeria09_13.pdf (accessed 21 March 2019).

⁶¹ RN Ogu et al 'Engendering the attainment of the SDG-3 in Africa: Overcoming the socio cultural factors contributing to maternal mortality' (2016) 20(3) *African Journal of Reproductive Health* at 62; AO Paul et al 'An exploratory assessment of Nigeria's performance in millennium development goals (MDGs): Towards a better performance of sustainable development goals (SDGs)' (2017) 4 *IOSR Journal of Humanities And Social Sciences* at 25; A McKenzie et al 'Creating the foundation for health systems resilience in northern Nigeria' (2016) *Journal Health Systems & Reform* at 357; and E Kalipeni et al; 'Maternal and child health in Africa for sustainable goals beyond 2015' (2017) 12 *Journal Global Public Health* at 643.

⁶²EJ Calvillo et al 'Applying the lessons of maternal mortality reduction to global emergency health' (2015) *Bulletin of the World Health Organization*.

associated with maternal death, as many sectors and stakeholders are involved at each delay level.

1.8.2 MM in North-East Nigeria

A. Individual characteristics

There exist a gender gap in literacy and educational level in North-Eastern Nigeria.⁶³ Culturally girls are less likely to be enrolled in school owing to mythological misconceptions that an educated woman will not be obedient to her husband and also male preference, that a male child goes to school so as to inherit the family name.⁶⁴ School enrolment for the girl child has been proven to be effective in delaying age at first marriage. Delaying early marriage reduces the risk of maternal death as a result of teenage pregnancies.⁶⁵ An educated woman will more likely understand the importance of maternal health services and will more likely attend ante-natal care and seek a supervised institutional delivery.⁶⁶ Evidently the low educational status of women in North-Eastern Nigeria with poor girl child school enrolment contributes to the worsening indices of maternal deaths in the region. Literacy rate for girls is 15.4 in the North-East compared to 40.0 and 79.9 in the North-Central and South-West regions of Nigeria respectively.⁶⁷

⁶³ British Council *Girls' education in Nigeria report 2014: Issues, influencers and actions* (2014) 21 <https://www.britishcouncil.org/sites/default/files/british-council-girls-education-nigeria-report.pdf> (accessed 23 April 2019).

⁶⁴ GA Makama 'Patriarchy and gender inequality in Nigeria: The way forward' (2013) 9(17) *European Scientific Journal* 115 at 121 para 2.

⁶⁵ The World Bank 'Educating the girls, ending child marriage' <https://www.worldbank.org/en/news/immersive-story/2017/08/22/educating-girls-ending-child-marriage> (accessed 25 April 2019).

⁶⁶ UNESCO *Global education monitoring report: Gender review creating sustainable future for all* (2016) at 48.

⁶⁷ UNESCO (n 66) at 48.

From poor education, women in the North-East region remain largely unemployed.⁶⁸ Without means of economic sustenance the women cannot make decisions about accessing maternal health services because adequate income is an important factor in being able to utilise health care services. Many government run health facilities as well as programmes come with user fees with reasons that user fees cushions the effect that usually constrained budgets due to increased demand for services, however user fees have proved to be a significant barrier to access.⁶⁹ It is arguable that when gainfully employed and having some reasonable financial security, women in North-East will have better maternal health outcomes because they can be able to make informed decision on accessing ante-natal care (ANC) and supervised deliveries even where service fees are present.

B. Community and societal characteristics

Decision making power is another key factor that promotes poor maternal health outcomes in North-Eastern Nigeria.⁷⁰ The patriarchal culture of silencing women in decision making even when it is directly related to their health is one reason why women do not attend ANC services and cannot access institutional deliveries because all decisions lie with their husbands or male guardians.⁷¹ Even in situations where imminent danger has been seen by the women, the husband or male guardian who might be far way at the time of need bears the decision making duty.⁷² Thus a situation

⁶⁸ European Asylum Support Office *Country of origin information report Nigeria key socio-economic indicators* (2018) 25 https://www.ecoi.net/en/file/local/2001365/2018_EASO_COI_Nigeria_KeySocioEconomic.pdf (accessed 26 April 2019).

⁶⁹ NN Kalu-Umeh et al 'Costs and patterns of financing maternal health care services in rural communities in northern Nigeria: Evidence for designing national fee exemption policy' (2013) 2(1) *International Journal of MCH and AIDS* at 163.

⁷⁰ British Council (n 63) at 39.

⁷¹ Makama (n 64) at 121.

⁷² Nigerian restrictive laws and women's sexual and reproductive rights <https://www.thenigerianvoice.com/news/274942/nigerias-restrictive-laws-and-womens-sexual-reproductive-r.html> (accessed 14 September 2019).

that is amenable to timely intervention will turn fatal because of the delay in decision making, this is the first of the three delays as earlier captured in the literature review.⁷³

C. Insecurity

The *Boko Haram* insurgency that started sometime in 2009 in many locations in the North-East has also been noted to have negative effects on overall maternal health services.⁷⁴ Women displaced from their homes took refuge in internally displaced persons camps and few of the camps had adequate health services to attend to the needs of the women.⁷⁵ In a study that looked at the reproductive health indices of communities within the North-Eastern part of Nigeria that suffered *Boko Haram* attacks, there was reduction in the chances for taking up ANC, delivery at a healthcare facility, and delivery supervision by a skilled healthcare professional.⁷⁶

D. The health systems characteristics

Governance in Nigeria is structured into three administrative tiers, the federal at the centre, the states and local governments, but the Constitution remains silent on specific healthcare responsibility of each tier.⁷⁷ This lack of clear distribution of responsibility oftentimes bring about an overlap in responsibility and at the same time makes the local governments especially prone to avoiding any responsibility in healthcare service provision.⁷⁸ This affects the provision of maternal health services including maternal health at the local level.

⁷³ Pages 9 & 10 above.

⁷⁴ A Chukwuma & EU Eseosa 'Armed conflict and maternal health care utilization: Evidence from the boko haram insurgency in Nigeria' (2019) *Social Science & Medicine* at 226.

⁷⁵ European Asylum Support Office (n 68) at 52.

⁷⁶ Chukwuma & Eseosa (n 74) at 226.

⁷⁷ Centre for Reproductive Rights & Women Advocates Research and Documentation Centre *Broken promises: Human rights, accountability and maternal deaths in Nigeria* (2008) at 17.

⁷⁸ Centre for Reproductive Rights & Women Advocates Research and Documentation Centre (n 77) at 18.

Another problem at the system level is the apparent lack of political will to implement policies.⁷⁹ Health policies might have been well captured on paper, but the will to translate the policy into actionable plans is lacking. One of the violations to fulfil right to health is failure of state parties to adopt or implement national health policy that ensures the right to health for all.⁸⁰ The National Health Act was signed into law in 2014, however it is yet to be fully implemented. More so because health as a social service in Nigeria is categorised in the concurrent legislative list, it implies that states in the North-East have to first domesticate provisions of the Act within the framework of their local laws for it to stand operable.⁸¹ There is currently no policy or law that makes it compulsory to confidentially report and document maternal deaths,⁸² hence many deaths will go unaccounted for and no lessons learnt to prevent future occurrence.

Health financing is generally poor in Nigeria, with annual budget for health below the 15% agreed at the 2001 special summit of the African Union (AU) Heads of Government ‘the Abuja Declaration on HIV/AIDS, tuberculosis and other related infectious diseases’ (Abuja Declaration).⁸³ This poor resource allocation to health impacts reproductive health services the most. A cross section of Nigerians have identified absence of gender responsive budgeting at all level of governance in Nigeria which negatively impacts the accessibility and availability of quality maternal health services.⁸⁴ The CEDAW Committee notes that states have an obligation to employ appropriate measures, including appropriate budgetary allocations in fulfilling women’s right to healthcare.⁸⁵ Similarly, in its concluding observation to Nigeria’s fifth periodic report, the African Commission on Human and Peoples’ Rights (the African

⁷⁹ Centre for Reproductive Rights & Women Advocates Research and Documentation Centre (n 77) at 18.

⁸⁰ The Right to the Highest Attainable Standard of Health: UN Committee on ESCR General Comment No 14, UN Doc E/C.12/2000/4. Para 43(f).

⁸¹ S Khemani ‘Fiscal federalism and service delivery in Nigeria: The role of states and local governments prepared for the Nigerian PER steering committee (2001) <http://www1.worldbank.org/publicsector/decentralization/march2003seminar/fiscalfedreport.pdf> (accessed 26 April 2019).

⁸² Centre for Reproductive Rights & Women Advocates Research and Documentation Centre (n 77) at 22.

⁸³ International Centre for Investigative Reporting ‘Nigeria remains perpetual defaulter of the ‘Abuja declaration’ on health funding’ (2019) <https://www.icirnigeria.org/nigeria-remains-perpetual-defaulter-of-the-abuja-declaration-on-health-funding/> (accessed 26 April 2019).

⁸⁴ Centre for Reproductive Rights & Women Advocates Research and Documentation Centre (n 77) at 26.

⁸⁵ Article 12 of the Convention (Women and Health): UN Committee on CEDAW General Comment No 24, UN Doc A/54/38/Rev.1, chap.1 para 17.

Commission) raised concern about the high MM rate in the country.⁸⁶ The Commission enjoined Nigeria to urgently strengthen initiatives aimed at addressing MM through the elimination of barriers to accessing services and increased budgetary allocation to health in line with the Abuja Declaration.⁸⁷ Other recommendations of the Commission include increasing human rights-based private investment in health, revision of abortion laws in line with international human rights laws and ensuring all federating states adopt the federal legislation pegging 18 years as age at first marriage.⁸⁸

From the literature review MM as a human rights violation is an evident reality in North-Eastern Nigeria. While building on available literature underscoring state obligations on MM as a human rights issue, this study attempts at filling the knowledge gap on the application of a holistic approach to ending MM and how absence of such approach prevented the achievement of significant reduction of MM in North-Eastern Nigeria over the years.

1.9 Chapter outline

The study is divided into 5 chapters as follows:

Chapter 1 deals with the general structure of the study laying a foundational roadmap to the aim of the study. The chapter demonstrates the burden of MM in North-East Nigeria, tracing the trends in sub-Saharan Africa. It also highlights the concept of human rights-based approach to MM.

Chapter 2 answers one of the research questions on the various causes of MM in North-East Nigeria. It engages with the medical causes and socio-economic causes of MM. Some statistics were shown about the medical causes such as postpartum haemorrhage and hypertension in pregnancy. The socio-economic causes gave insight about the socio-economic reality of the region.

⁸⁶ African Commission Concluding observations and recommendations on the 5th periodic report of the Federal Republic of Nigeria.

⁸⁷ The African Commission (n 86).

⁸⁸ The African Commission (n 86).

Chapter 3 answers the second research question on legal framework on MM in Nigeria. It highlighted international and regional human rights obligations of the country relevant to MM. National laws and policies in relation to MM reduction were also interrogated exploring inadequacies and opportunities.

Chapter 4 deals with the strategic framework necessary to reducing MM in North-East Nigeria. It engages with various factors that promote MM in North-East Nigeria that hinder significant reduction. It goes further to proffer practicable solutions based on holistic approach to reducing MM burden in the region.

Chapter 5 outlines a general conclusion to the study. Conclusions were drawn from the findings. Some key recommendations were proposed for state actors and other stakeholders in an effort to reduce MM in North-East Nigeria.

CHAPTER TWO

CAUSES OF MATERNAL MORTALITY IN NORTH-EASTERN NIGERIA

2.1 Introduction

Factors associated with MM are complex and interrelated. While there are recognised medical causes, socioeconomic issues like poverty and educational attainment are also determinants of MM.⁸⁹ The medical causes of maternal death can be classified into direct and indirect obstetrical causes.⁹⁰ The direct causes of MM are obstetrical complications women develop during pregnancy as a consequence of poor access to quality healthcare. Severe bleeding after child birth, maternal infections, obstructed labour, presence of high blood pressure during pregnancy, and unsafe abortion are some of the direct causes of MM accounting for 75% of all cases of maternal deaths globally.⁹¹ As earlier mentioned these predispositions are preventable with adequate access to quality healthcare services. A recent study in a North-Eastern Nigerian tertiary hospital revealed high incidence of these preventable obstetrical complications with attendant rising incidence of MM.⁹²

The indirect obstetrical causes of MM arise when some medical conditions present before pregnancy get worsened by the pregnancy or poorly managed during routine ANC.⁹³ Recent studies show indirect causes account for about a quarter of global maternal deaths with increasing prevalence in developing countries. In sub-Saharan Africa, disease entities and signs like malaria, human immunodeficiency virus (HIV) and anaemia are the leading indirect obstetrical causes of maternal deaths.⁹⁴ The North-

⁸⁹Durojaye (n 22) at 103.

⁹⁰WHO 2019 (n 2).

⁹¹WHO 2019 (n 2).

⁹²HA Usman et al 'A continuing tragedy of maternal mortality in a rural referral center in Northeast Nigeria: A wake-up call' (2018) 35 *Tropical Journal of Obstetrics Gynaecology* at 18.

⁹³ WHO 2019 (n 2).

⁹⁴ WHO 2019 (n 2).

Eastern tertiary hospital study also reported anaemia as the leading indirect cause of maternal deaths, others were cardiac disease, malaria and tuberculosis.

2.2 Medical causes of MM

A. Bleeding

Severe bleeding especially after delivery is one of the leading causes of maternal deaths globally.⁹⁵ Severe bleeding immediately after birth termed, postpartum haemorrhage (PPH) is characterised by estimated blood loss after delivery of greater than or equal to five hundred millilitres (500ml) within the first 24 hours after delivery.⁹⁶ PPH was responsible for more than a quarter of the 303,000 maternal deaths that occurred around the globe in 2015 and affects about 6% of all women giving birth of which majority of the victims were from developing countries.⁹⁷

PPH is an everyday occurrence in North-Eastern Nigeria being the second highest contributor to maternal deaths in the region.⁹⁸ Like other causes of MM, PPH is preventable with skilled birth supervision through the application of the WHO active management of the third stage of labour technique.⁹⁹ The third stage of labour is a critical stage for the mother and the baby because the most immediate events at that

⁹⁵ WHO 2019 (n 2).

⁹⁶ WHO 'Recommendations on prevention and treatment of postpartum haemorrhage and the WOMAN trial' (2018) https://www.who.int/reproductivehealth/topics/maternal_perinatal/pph-woman-trial/en/ (accessed 30 June 2019).

⁹⁷JP Vogel et al 'WHO recommendations on uterotonics for postpartum haemorrhage prevention: What works, and which one?' (2019) 4 *BMJ Global Health*.

⁹⁸GU Sadiq et al 'How parity affects postpartum haemorrhage prevention in Maiduguri, Nigeria' (2011) 1 *IJPI's Journal of Hospital and Clinical Pharmacy*.

⁹⁹ Sadiq (n 98).

instance like delayed cord clamping and gentle placenta traction come with grave consequences when inappropriately done.¹⁰⁰

Active management of the third stage of labour as recommended by WHO involves prophylactic administration of uterotonic drugs that increases tonicity of the uterus thereby reducing the incidence of haemorrhage.¹⁰¹ Other components of the active management of the third stage of labour include delayed umbilical cord clamping and cutting as well as controlled cord traction to deliver the placenta.¹⁰² Active management of the third stage of labour is obviously a skilled service that is best provided by trained personnel at a facility and following the standard practice procedure as provided for and recommended by the WHO. Active management of the third stage of labour reduces the need for blood transfusion after birth. In North-Eastern Nigeria where there is shortage of health workforce and fewer health facilities in relation to population, active management of the third stage of labour is a cheaper possible means to reduce need for blood transfusion services which are erratic and ultimately reduce maternal deaths from bleeding postpartum.¹⁰³

B. Infections

Maternal infections collectively known as puerperal sepsis is one of the leading causes of MM globally, with an estimate of 75,000 deaths annually which mostly occur in developing countries.¹⁰⁴ Puerperal sepsis is the occurrence of genital tract infection in women at the onset of membrane rupture, active labour and anytime within 42 days postpartum.¹⁰⁵ It is characterised by high fever in the setting of pelvic pain, vaginal discharge or delayed normal reduction in the size of the uterus postpartum. Estimating

¹⁰⁰ CM Begley et al 'Active versus expectant management for women in the third stage of labour' (2019) *Cochrane Database of Systematic Reviews*https://www.cochrane.org/CD007412/PREG_delivering-placenta-third-stage-labour (accessed 30 June 2019).

¹⁰¹WHO 2018 (n 96).

¹⁰²WHO 2018 (n 96).

¹⁰³ Giving birth in Nigeria: The staggering odds facing pregnant women <https://nigeriahealthwatch.com/giving-birth-in-nigeria-the-staggering-odds-facing-pregnant-women/> (accessed 14 September 2019).

¹⁰⁴ WHO 'Recommendations for prevention and treatment of maternal peripartum infections' (2015) <https://www.ncbi.nlm.nih.gov/books/NBK327082/> (accessed 30 June 2019).

¹⁰⁵ WHO 2015 (n 104).

the incidence of puerperal sepsis in North-Eastern Nigeria is hard because majority of the cases occur after discharge from facility and few mothers utilise post-natal clinics.¹⁰⁶

C. High Blood Pressure

Hypertensive disorders during pregnancy affects about 10% of pregnant women across the globe. Among the hypertensive complications in pregnancy, pre-eclampsia and eclampsia are the leading causes of maternal deaths due to hypertension. The hypertensive disorders induced by pregnancy come in spectrum from pregnancy induced hypertension (PIH) to pre-eclampsia and eclampsia.¹⁰⁷ PIH is the presence of elevated blood pressure in a pregnant woman that was otherwise normotensive and the elevated blood pressure is traceable to the pregnancy. Pre-eclampsia on the other hand is a constellation of signs and symptoms seen in pregnant women after the 20th week of gestation.¹⁰⁸ The signs and symptoms are those of elevated blood pressure, headache and presence of protein in the urine upon urinalysis. If left untreated pre-eclampsia develops into eclampsia characterised by presence of convulsions in a woman with pre-eclampsia.¹⁰⁹

Hypertension in pregnancy is associated with profound risk of death for both the mother and her baby. Death arising from PIH are prevented through accessible and qualitative ANC, continuing professional development to maintain standard and up-to-date practices in the management of PIH. Drug supplies at facility level is also crucial to the prevention of deaths due to PIH.¹¹⁰ Facilities in North-East Nigeria are often out of stock of lifesaving drugs needed to control PIH.¹¹¹

¹⁰⁶ National Population Commission & ICF International (n 14) at 277.

¹⁰⁷ WHO 'Recommendations for Prevention and treatment of pre-eclampsia and eclampsia' (2011) https://apps.who.int/iris/bitstream/handle/10665/44703/9789241548335_eng.pdf?sequence=1 (accessed 30 July 2019).

¹⁰⁸ WHO 2011 (n 107).

¹⁰⁹ WHO 2011 (n 107).

¹¹⁰ SM Ibrahim et al 'Eclampsia in university of Maiduguri teaching Hospital: A 10-year review' (2014) 1 *ARID Medical Journal* at 9.

¹¹¹ Giving birth in Nigeria: The staggering odds facing pregnant women <https://nigeriahealthwatch.com/giving-birth-in-nigeria-the-staggering-odds-facing-pregnant-women/> (accessed 14 September 2019).

D. Unsafe abortion

Unsafe abortion occurs when abortion is carried by a person who lacks the necessary skills or when it is done in an environment that fall shorts of minimal basic medical standard such as use of unsterilised instruments or unorthodox materials.¹¹² It is unsafe abortion, such a pregnancy termination not done in a standard practice short of the WHO recommendation for the gestational age. Around 25 million unsafe abortions occur annually around the globe and African women are disproportionately affected with 520 deaths per 100,000 unsafe abortions. Generally Africa accounts for 29% of global unsafe abortions and 62% of all deaths attributable to unsafe abortion.¹¹³ Statistics of unsafe abortion and deaths related to it in North-Eastern Nigeria is quite hard to come by due to restrictive abortion laws that makes it hard for people to volunteer information and such cultural practices of victims shaming.

Nigeria has restrictive abortion laws. Abortions are only procured in certain circumstances of foetal abnormality and life threatening maternal health conditions.¹¹⁴ With these laws in force pregnancies that are not desired and do not fall into the 'legally' allowed category for safe termination may end up being attended to unsafely.

Attempts at liberalising Nigeria's laws on abortion in the recent past suffered set back.¹¹⁵ North-Eastern Nigeria is predominantly a muslim population with Shari'a law in place, majorly abortion by choice is prohibited by Shari'a, however certain scholarly interpretations offer a more liberal interpretation of risk to the mother to include mental health not only physical health.¹¹⁶ When abortion laws are restrictive, women resort to unsafe means of procuring abortion with attendant risk of death.¹¹⁷ In the North-East

¹¹² WHO 'Preventing unsafe abortion' <https://www.who.int/en/news-room/fact-sheets/detail/preventing-unsafe-abortion> (accessed 30 July 2019).

¹¹³ Guttmacher Institute 'Abortion in Nigeria' <https://www.guttmacher.org/fact-sheet/abortion-nigeria> (accessed 30 July 2019).

¹¹⁴ Guttmacher Institute (n 113).

¹¹⁵ Guttmacher Institute (n 113).

¹¹⁶ Da'awah Institute of Nigeria 'Dilemmas regarding the pregnant victims of the boko haram atrocities and possible solutions: An Islamic perspective' <https://lawyersalert.wordpress.com/2015/06/05/dilemmas-regarding-the-pregnant-victims-of-the-boko-haram-atrocities-and-possible-solutions-an-islamic-perspective/> (accessed 30 July 2019).

¹¹⁷ Guttmacher Institute (n 113).

unsafe abortion has been reported to have significantly contributed to the burden of MM.¹¹⁸

E. Obstructed labour

Obstructed labour is another direct obstetrical cause of MM and contributes to the global burden of maternal deaths.¹¹⁹ It occurs when the presenting part of the foetus cannot pass through the birth canal despite adequate uterine contractions. Obstructed labour is almost non-existent in developed countries where there are functioning health services.¹²⁰ Obstructed labour maybe occasioned by disproportionate size of the presenting part of the foetus in relation to maternal pelvis leading to mechanical trapping of the foetus as it descends through the birth canal.¹²¹ Teenage pregnancy, illiteracy and unsupervised pregnancy are risk factors for obstructed labour.¹²² The consequence of obstructed labour for a mother that escapes death include uterine rupture and obstetrics fistula. Obstructed labour increases the risk of perinatal mortality and other morbidities like birth asphyxia. Globally mainstay of prevention is availability of skilled personnel and obstetric services.¹²³

A study at a tertiary hospital in North-East Nigeria,¹²⁴ revealed that the prevalence of obstructed labour was more in mothers who were teenagers, unemployed, with low educational status and unsupervised pregnancies. The common causes were cephalo-pelvic disproportion, persistent occipito-posterior position and mal-presentation of foetus. The study concluded that obstructed labour is a significant cause of poor

¹¹⁸ Guttmacher Institute (n 113).

¹¹⁹ WHO 'Managing prolonged and obstructed labour' (2010) https://apps.who.int/iris/bitstream/handle/10665/44145/9789241546669_4_eng.pdf?sequence=4 (accessed 30 June 2019).

¹²⁰ WHO 2010 (n 119).

¹²¹ WHO 2010 (n 119).

¹²² WHO 2010 (n 119).

¹²³ C Dolea & C AbouZahr 'Global burden of obstructed labour in the year 2000' (2003) *Evidence and Information for Policy (EIP) World Health Organization* https://www.who.int/healthinfo/statistics/bod_obstructedlabour.pdf (accessed 30 July 2019).

¹²⁴ Bako et al 'Prevalence, risk factors, and outcomes of obstructed labor at the university of Maiduguri teaching hospital, Maiduguri, Nigeria' (2018) 21 *Sahel Medical Journal* at 117.

maternal outcomes, thus effort should be made to address the risk factors such as early child marriage and poor access to maternal health services.

2.3 Socioeconomic causes of MM in North-East Nigeria

A. Poverty

560 million people living in Sub-Saharan Africa live in multi-dimensional poverty being left behind in education, health and living standards,¹²⁵ they live in dire struggle to meet up with the basics of livelihood including health, education water and sanitation. There are more women living in extreme poverty than men, with 122 women aged 25 to 34 years living in extreme poverty compared to 100 men of same age group.¹²⁶ This age bracket fall within the reproductive age for women, signifying the burden of poverty on maternal health.

Poverty is more than just lack of income and material resources to carter for and sustain everyday living.¹²⁷ Poverty can manifest in many facets of livelihood including hunger leading to malnutrition and inability to access education and basic social amenities including health.¹²⁸ As previously discussed, education and finance determine access to maternal health services.¹²⁹ The more educated a woman is the more likely she will access maternal health services and the ability to pay for the services is income dependent.¹³⁰

Poverty also manifests as social discrimination and exclusion from decision-making. One in 10 people living in developing countries like Nigeria live on less than \$1.90 per

¹²⁵ UNDP 'Beyond income: A broader picture of poverty' (2018) <https://feature.undp.org/multidimensional-poverty/> (accessed 30 June 2019).

¹²⁶ UNDP 2018 (n 124).

¹²⁷ UN 'Ending poverty' (2019) <https://www.un.org/en/sections/issues-depth/poverty/> (accessed 30 June 2019).

¹²⁸ UNDP 2018 (n 124).

¹²⁹ Pages 3 & 4 above.

¹³⁰ KO Osungade & OO Ayinde 'Maternal complication prevention: Evidence from a case-control study in southwest Nigeria' (2014) *Africa Journal Primary Health Care Family Medicine*.

day, the global agreed poverty line.¹³¹ About 90 million people in Nigeria roughly half the Nigerian population live in extreme poverty making Nigeria the country with the highest poverty rate in the world.¹³² Disaggregated data shows North-Eastern Nigeria bears greater burden of poverty than other regions in the country partly due to the significant damages occasioned by the *Boko Haram* insurgency.¹³³

Poverty limits access to basic social services like health and food supply. The ability to utilise health facilities by women is dependent on the capacity to pay. The developmental circumstances of a girl child including nutritional support can affect her reproductive health later in life and can manifest during pregnancy and delivery. Malnutrition is essentially a problem of poverty and it affects the body's immune system response to infection and the body's ability to utilise intake.¹³⁴ The effects of malnutrition in the growing girl child and later in her reproductive age are threats to maternal survival in pregnancy.¹³⁵ Women are doubly more vulnerable to malnutrition because of the high nutritional requirement during pregnancy.¹³⁶ Women with nutritional deficiency such as iron micronutrient deficiency are at risk of anaemia in pregnancy which can predispose to MM.¹³⁷ With wide spread socio-economic inequalities in the North-East, women are at risk of malnutrition.

Apart from the mythological belief that early marriage prevents unwanted pregnancies,¹³⁸ girls in North-East marry early for some economic reasons. Parents see the girl child as an economic means to secure benefits from would be in-laws or an economic burden that by marrying her out there is one less person to carter for under the parent's roof.¹³⁹ A girl child married off is deprived of basic education, her

¹³¹ UN 2019 (n 127).

¹³² World Economic Forum 'Three things Nigeria must do to end extreme poverty' (2019) <https://www.weforum.org/agenda/2019/03/90-million-nigerians-live-in-extreme-poverty-here-are-3-ways-to-bring-them-out/> (accessed 30 June 2019).

¹³³ UNDP 'National human development report 2018' (2018) <http://www.ng.undp.org/> (accessed 30 June 2019).

¹³⁴ UNDP 2018 (n 133).

¹³⁵ UNDP 2018 (n 133).

¹³⁶ Care <https://www.care.org/maternal-nutrition-maternal-and-child-health> (accessed 14 September 2019).

¹³⁷ Care (n 136).

¹³⁸ JA Oyindo & AN Bramaifa 'Girl-child marriage in the Nigerian society, causes, impacts and mitigating strategies' 4 (2018) 4 *World Journal of Social Sciences and Humanities* at 104.

¹³⁹ Oyindo & Bramaifa (n 138) at 104.

adolescence and is placed at higher risk of complications during pregnancy that may result in her avoidable death.

B. Gender equality

MM as a human rights issue is a consequence of gender inequality characterised by discrimination against women, health inequity and the failure to guarantee women's human rights.¹⁴⁰ Gender inequality is a key driver of health disparities. Deep rooted gender inequalities hinder women from taking active roles and participating in decisions that affect aspects of their own health and welfare, this culture contributes to the high rate of maternal deaths women are faced with.¹⁴¹ Educating the girl child, stopping forced child marriage and women empowerment are necessary in promoting reproductive health. When women have higher levels of autonomy and are able to participate in decision making, when they are educated and equally access job opportunities reproductive health will improve.

The patriarchal culture of subordination of women and girls has been in practice in North-East Nigeria for ages and was further worsened by the *Boko Haram* insurgency that ravaged the communities keeping women more vulnerable.¹⁴² The insurgency witnessed abduction of women and girls and displacement of families. Displaced women who found refuge in IDP camps were subject of gender based violence having to engage in transactional sex with camp authorities for food and favours.¹⁴³ Access to maternal health services also drastically reduced as a direct consequence of the *Boko Haram* insurgency.

¹⁴⁰OHCHR 'Maternal mortality and morbidity and human rights' https://www.ohchr.org/Documents/Issues/Women/WRGS/OnePagers/Maternal_mortality_morbidity.pdf (accessed 17 April 2019).

¹⁴¹OHCHR (n 38) at 6.

¹⁴² A Pillay A 'Harnessing gender transformative opportunities within humanitarian crises: A field note from North-East Nigeria' <https://www.accord.org.za/conflict-trends/harnessing-gender-transformative-opportunities-within-humanitarian-crises/> (accessed 30 June 2019).

¹⁴³ Pillay (n 142).

Gender inequities have multi-dimensional negative effect on maternal health services utilisation. Gender roles determine control over financial resources and affects health seeking behaviour. Women who have access to financial resources are more likely to access maternal health services. Limitation of autonomy of women to take decisions about their health such as where women have to ask permission from their husbands to be able to attend ANC and lack of safe abortion services are gender discriminations against women that invariably contribute to MM.¹⁴⁴

Men affect women's access to maternal health services and the outcome of pregnancies in their roles as partners, community leaders, and health providers because they have control over resources and decisions.¹⁴⁵ Thus addressing gender related inequities in healthcare involves putting an end to health discriminations that are a result of social constructs of gender. Women and men should have equal opportunities in access to social services and means to attain good health. WHO recommends that strategies of involving men in maternal health should target women's care-seeking decision making in relation to their health without reducing women's autonomy and fashioned in such a way that promotes women empowerment and positive role men can play as partners.¹⁴⁶

C. Education

There exist a gender disparity in the literacy and educational level in North-Eastern Nigeria.¹⁴⁷ From age old patriarchal culture, girls are less likely to be enrolled in school owing to mythological misconceptions that an educated woman will not be obedient to her husband and also male preference that a male child goes to school so as to inherit and carry on with the family name.¹⁴⁸ Studies show that people with advanced level of

¹⁴⁴ PC Banda et al 'Women at Risk: Gender Inequality and Maternal Health' (2016) *Women & Health* <https://www.tandfonline.com/doi/full/10.1080/03630242.2016.1170092> (accessed 30 June 2019).

¹⁴⁵ Banda (n 144).

¹⁴⁶ WHO 'Recommendations on male involvement interventions for maternal and neonatal health' <https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-male-involvement-interventions-maternal-and-neonatal-health> (accessed 30 June 2019).

¹⁴⁷ British Council (n 63).

¹⁴⁸ Makama (n 64) at 121.

education have better health and longer lives than those without, with positive relation between maternal educational level and health service utilisation. Lack of education is a known stressor of negative maternal health outcomes.¹⁴⁹

Level of education improves health seeking behaviour and plays pivotal role in women's acceptance of maternal health services.¹⁵⁰ Educational attainment is directly related to wealth and decision making, with limited education comes limited wealth and loss of decision making power translating to negative consequence to maternal health.¹⁵¹ With advancing educational attainment, women are more likely to have the capacity to seek, utilise, and understand basic health information about the benefits of ANC and the reproductive health services.¹⁵² Such women will take appropriate self-care initiatives such as adequate nutrition, ability to note changes and report symptoms of impending complications and ask appropriate questions from skilled personnel. Furthermore with education, women will have more equal position in the society to make important decisions such as contraceptive usage and attending health facility for ANC and delivery services.¹⁵³

D. Cultural and Religious practices

Many cultural practices negatively impact women in North-East Nigerian like obtains in other societies. Traditionally social constructs of gender, dictates women should stay at home tending to domestic chores and children. This deems women's capacity to

¹⁴⁹ R Morgan et al 'Gender dynamics affecting maternal health and health care access and use in Uganda' (2017) 32 *Health Policy and Planning* at 13.

¹⁵⁰ Morgan (n 149) at 13.

¹⁵¹ Morgan (n 149) at 15.

¹⁵² Morgan (n 149) at 15.

¹⁵³ Morgan (n 149) at 13.

negotiate contraception and child bearing as well as access to social services including maternal health services.¹⁵⁴

Women's health seeking behaviour is often determined by the social norms, beliefs and cultural practices of their community. The community a woman resides in, influences her attitude and behaviour. Most women particularly tend to conform to culturally constructed norms when it comes to seeking healthcare during pregnancy and childbirth.¹⁵⁵ Where the norm abhors orthodox health services there is likelihood such expectant mothers will deliver at home unsupervised or attended to by traditional birth attendant (TBA) with potential risky outcomes.

Maternal age at first birth and the number of children a woman will eventually have are greatly influenced by sociocultural practices.¹⁵⁶ Women in North-Eastern Nigeria marry young and have a total fertility rate of 6.3 meaning every woman on average will bear 6 children.¹⁵⁷ There is this cultural belief that early marriage prevents the girl child from pre-marital sexual activity and unwanted pregnancy.¹⁵⁸ However scientific evidence has it that lower age at first birth puts a woman at higher risk of MM.¹⁵⁹

Some religious practices in North-East Nigeria have been noted to negatively affect women's access to maternal health services,¹⁶⁰ these include *pardah* practice among some Muslims, the practice keeps women in seclusion, confined to their husbands houses and cannot go out without express permission of the husband. Another religious practice noted is refusal of blood transfusion by adherents of *jehovah* witness Christian

¹⁵⁴ R Abubakar et al 'Cultural perceptions influencing obstetric complications among women in Kaduna, Northwestern Nigeria' (2018) 21 *Nigerian Journal of Clinical Practice* at 832.

¹⁵⁵ UNFPA 'Socio-cultural factors that affect reproductive health in Latin America: Emerging opportunities, challenged and learning on context, concept and practice' <https://www.unfpa.org/publications/socio-cultural-factors-affect-reproductive-health-latin-america-emerging-opportunities> (accessed 30 June 2019).

¹⁵⁶ USAID 'Country development cooperation strategy' https://www.usaid.gov/sites/default/files/documents/1860/Nigeria_CDSCS_2015-2020.pdf (accessed 30 June 2019).

¹⁵⁷ National Population Commission & ICF International (n 14) at 67.

¹⁵⁸ Oyindo & Brambaifa (n 137) at 104.

¹⁵⁹ WHO 2019 (n 2).

¹⁶⁰ Sinai et al 'Demand for women's health services in Northern Nigeria: A review of the literature' (2017) 21(2) *Africa Journal of Reproductive Health* at 96.

tenets. A participatory action research conducted in North-East Nigeria found that religious scholars misconceive maternal health services and preach against access in situations like allowing a male doctor attend to a pregnant woman. The research later found improved access to maternal health services upon enlightenment of the scholars against the misconceptions.¹⁶¹

2.4 Conclusion

In this chapter, the issues regarding MM in North-East Nigeria were addressed. Specifically the causes of MM, the direct and indirect obstetrical causes. I found the direct obstetrical causes to include, severe bleeding, sepsis, hypertension, unsafe abortion and obstructed labour while the indirect causes include malaria, HIV and anaemia.

Furthermore in this chapter, some answers to one of the research questions have been highlighted, some socioeconomic and cultural practices found in North-East Nigeria that constrain the needed reduction in MM which include poverty, poor education, early marriage and harmful traditional practices. Findings in this chapter substantiate the need for a holistic approach rather than a single pronged approach to tackle the multi-dimensional factors that fuel the incidence of MM in the North-Eastern region of Nigeria.

¹⁶¹ Once Opposed To Maternal Health, Islamic Scholars Become Champions <https://www.npr.org/sections/goatsandsoda/2016/09/21/488426505/once-opposed-to-maternal-health-islamic-scholars-become-champions> (accessed 10 November 2019).

CHAPTER THREE

LEGAL FRAMEWORK ON MATERNAL MORTALITY IN NIGERIA

3.1 Introduction

Nigeria is a federal state and like other democracies, negotiation and ratification of treaties lies with executive arm of the government and upon ratification, such treaties are not operable as municipal laws until they are domesticated by way of parliamentary legislation.¹⁶²

Section 12 of the Constitution of the Federal Republic of Nigeria, 1999 as amended provided the procedural guide to treaty domestication as follows;¹⁶³

- (1) No treaty between the Federation and any other country shall have the force of law except to the extent to which any such treaty has been enacted into law by the National Assembly.
- (2) The National Assembly may make laws for the Federation or any part thereof with respect to matters not included in the exclusive legislative list for the purpose of implementing a treaty.
- (3) A bill for an Act of the National Assembly passed pursuant to the provisions of subsection (2) of this section shall not be presented to the President for assent, and shall not be enacted unless it is ratified by a majority of all the Houses of Assembly in the Federation.

Powers of legislation are divided between the national and state legislative assemblies.¹⁶⁴ Issues relating to citizenship, census, aviation and others are on the exclusive legislative list which only the national assembly may legislate on.¹⁶⁵ Other matters like social services are on the concurrent list, meaning there is a need of concurrence of state assemblies to domesticate.¹⁶⁶ Matters that are not captured in

¹⁶² FA Onomrerhinor 'A re-examination of the requirement of domestication of treaties in Nigeria' (2016) *Nnamdi Azikiwe University Journal of International Law and Jurisprudence* at 17.

¹⁶³ Onomrerhinor (n 162) at 20.

¹⁶⁴ C Mwalimu *The Nigerian Legal System, Volume 2* 13.

¹⁶⁵ Mwalimu (n 164) at 14.

¹⁶⁶ Mwalimu (n 164) at 17.

either of the exclusive or concurrent lists are considered as the residual legislative list.¹⁶⁷

Therefore implementation of assented treaties affecting matters that are on the exclusive legislative list, requires only the legislation of the national assembly to become domesticated as municipal law. Whereas if the matter is categorised under the concurrent or the residual lists, such a treaty also requires the concurrent approval of the majority of the state houses of assembly.¹⁶⁸ In this chapter discussion is on health and women's human rights which are not categorised under the exclusive legislative list. Therefore matters relating to women's health and rights fall within the concurrent and residual lists. It follows therefore the provision of aforementioned sub-section 3 of the Constitution,¹⁶⁹ that no law passed by the national assembly relevant to the implementation of a treaty dealing with health rights of women will be applicable to all states of the federation in Nigeria automatically. It will require the concurrent approval of at least two-thirds of houses of assembly.¹⁷⁰

This chapter discusses international and regional treaties relevant to maternal health ratified by Nigeria, the discussion is critical in the light of the reality of MM in North-East Nigeria. Similarly in this chapter, references have been made to domestic legal framework and policies of state towards reducing MM. The chapter is divided into three sections, first section is discussion on global instruments, second is on regional instruments, then national laws and sustainable development goals followed by a conclusion.

¹⁶⁷Mwalimu (n 164) at 14.

¹⁶⁸ Mwalimu (n 164) at 12.

¹⁶⁹Mwalimu (n 164) at 14.

¹⁷⁰Mwalimu (n 164) at 14.

3.2 Global laws

A. Convention on the Elimination of all forms of Discrimination against Women (CEDAW)

Nigeria in 2004 ratified the CEDAW,¹⁷¹ the central and the most comprehensive international human rights treaty establishing and informing the protection of women's rights.¹⁷²

CEDAW in Article 12 calls on state parties to ensure principles of equality in the access to healthcare including family planning.¹⁷³ Similarly CEDAW calls on state parties to ensure adequate nutrition for mothers and the availability of health services to women during pregnancy, confinement and postpartum periods and where possible make these services free.¹⁷⁴

The monitoring body of CEDAW (CEDAW Committee) made a landmark decision in 2011 that brought the attention of state parties and the international community on holding states to account for avoidable maternal deaths.¹⁷⁵ The *Alyne da Silva Pimentel v Brazil* was the case in question highlighting that states have a human rights obligation to guarantee for all women regardless of ethnic, economic or other social backgrounds equitable access to quality maternal health services without discrimination.¹⁷⁶ Facts of the case, involved Alyne da Silva Pimentel, a Brazilian woman of African background who died as a result of pregnancy.¹⁷⁷ Her death followed a delayed arrangement for emergency obstetrics care at a Brazilian health centre.¹⁷⁸ Following the incidence her mother through the Centre for Reproductive Rights, approached the CEDAW committee

¹⁷¹UN treaty collection https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8&chapter=4&clang=en (accessed 14 September 2019).

¹⁷²OHCHR 'Convention on the Elimination of All Forms of Discrimination against Women New York, 18 December 1979' <https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx> (accessed 14 September 2019).

¹⁷³ Art 12 CEDAW.

¹⁷⁴ Art 12 CEDAW.

¹⁷⁵ Centre for Reproductive Rights 'Case of Alyne da Silva Pimentel Teixeira ("Alyne") v. Brazil' https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/LAC_Alyne_Factsheet_0.pdf (accessed 14 September 2019).

¹⁷⁶ Centre for Reproductive Rights (n 175) at 2.

¹⁷⁷ Centre for Reproductive Rights (n 175) at 2.

¹⁷⁸ Centre for Reproductive Rights (n 175) at 3.

seeking a redress arguing that the Brazilian government failed in its responsibility to put in place professional services and that she could not access justice in Brazil.¹⁷⁹ The circumstances of Alyne's death were in similar fashion to what obtains in North-East Nigeria, where avoidable maternal deaths occur among a certain segment of women who are faced with disadvantages like poor socio-economic status and often the deaths go unreported for reasons discussed in earlier chapter.¹⁸⁰ The CEDAW Committee found the state of Brazil wanting in contravention of CEDAW specifically Article 12(2), and made reference to the General Recommendation 28,¹⁸¹ which provides that states should make actionable policies that are well funded. The Committee also referred to the General Recommendation 24, which enjoined state parties to ensure maximum available resources are mobilised to promote the realisation of women's right to safe pregnancy and access to EmOC.¹⁸²

In its concluding observation to Nigeria in 2017,¹⁸³ the CEDAW Committee made observations specifically in relation to MM. The Committee noted Nigeria's effort towards improving the health status of women and girls such as the 2016 National Health Policy.¹⁸⁴ However the Committee noted with concern, the high MM rate in the country occasioned by lack of skilled care and unsafe abortions and the unavailability of modern contraception to women and girls. The Committee also noted the state party has the highest global burden of HIV which mostly affects women and girls especially sex workers. Another concern raised by the Committee is the worrisome incidence of obstetric fistula, and the limited access to antenatal, delivery and postnatal care owing to physical and economic barriers.¹⁸⁵ The Committee then recommended that Nigeria should redouble effort in reducing maternal mortality by addressing socio-economic barriers to accessing maternal health services and availability of modern contraception.¹⁸⁶

¹⁷⁹ Centre for Reproductive Rights (n 175) at 6.

¹⁸⁰ Pages 3, 4 & 5 above.

¹⁸¹ Cook (n 55) at 105.

¹⁸² Cook (n 55) at 105.

¹⁸³ CEDAW Committee 'Concluding observations on the combined seventh and eighth periodic reports of Nigeria' UN Doc CEDAW/C/NGA/7-8.

¹⁸⁴ CEDAW Committee (n 183).

¹⁸⁵ CEDAW Committee (n 183).

¹⁸⁶ CEDAW Committee (n 183) para 38.

Going by Section 12 of the Constitution earlier quoted,¹⁸⁷ CEDAW has not been domesticated in Nigeria and it requires concurrence of state houses of assembly even when passed by the national assembly.¹⁸⁸ Be that as it may, and in line with the argument of this study, I subscribe to the argument of some scholars that notwithstanding the domestication of CEDAW, its provisions are applicable in Nigeria's domestic laws implicitly. The argument is that the Banjul Charter has been domesticated,¹⁸⁹ and that Article 18(3) of the Banjul Charter states that;¹⁹⁰

...the state shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

This provision of the Banjul Charter implicitly makes CEDAW applicable in Nigeria by virtue of the allusions of the Banjul Charter to the protection of the rights of women as provided for by international conventions. Therefore advocacy for the domestication of CEDAW should go hand in hand with pushing the narrative that in the light of already domesticated Banjul Charter, CEDAW provisions are enforceable.

B. International Covenant on Economic, Social and Cultural Rights (ICESCR)

It is over 50 years since the ICESCR came into force.¹⁹¹ Over the years, the monitoring body of the treaty, the Committee on Economic, Social and Cultural Rights (CESCR) has echoed women's right to health with a number of recommendations.¹⁹² Articles 2 and 12 of CESCR are relevant to MM providing for non-discrimination and highest attainable standard of health respectively. Similarly CESCR General Comment 14 on the right to the highest attainable standard of health, the CESCR highlighted concern on

¹⁸⁷ Sec 12 Constitution of the Federal Republic of Nigeria 1999.

¹⁸⁸ Constitution of the Federal Republic of Nigeria (n 184).

¹⁸⁹ WILDAF 'CEDAW daily implementation in Nigeria' <http://www.wildaf-ao.org/index.php/en/resources/publications-en/training-manuels-and-tools/177-cedaw-daily-implementation-in-nigeria/file> (accessed 14 September 2019).

¹⁹⁰ Art 18(3) Banjul Charter.

¹⁹¹ The Global Initiative for Economic, Social and Cultural Rights 'The International Covenant on Economic, Social and Cultural Rights at 50: The significance from a women's rights perspective' September 2016 <http://globalinitiative-escri.org/wp-content/uploads/2016/10/ICESCR-and-Womens-ESC-Rights-FINAL.pdf> (accessed 14 September 2019).

¹⁹² The Global Initiative (n 191).

maternal health stating that, ‘there is the need to develop and implement comprehensive national strategies for promoting women’s right to health throughout their life span in an effort to lower maternal mortality rate’.¹⁹³

Another pertinent recommendation by CESCR is the General Comment 22, where the Committee notes the existence of close linkage between civil and political rights on one hand and sexual and reproductive health on the other.¹⁹⁴ According to the CESCR failure to make provision for emergency obstetrics care or abortion services, resulting in maternal deaths constitute violations of the right to life and also circumstantially may amount to torture, cruel, inhuman or degrading treatment.¹⁹⁵ Family planning by way of modern contraception has important implication on maternal health and reduction of MM,¹⁹⁶ on family planning, the CESCR noted concerns on the poor access of family planning services in states healthcare services. Thus enjoined states to make efforts in eliminating barriers to accessing emergency contraceptives, and to develop strategies aimed at overcoming cultural prejudices against the provision of contraception to women.¹⁹⁷

With communities like those of North-East Nigeria in mind, the CESCR recommends that physical and economic access to reproductive healthcare services and contraceptives should be given high priority, especially in rural communities. It further enjoined state parties to take legal and policy measures to guarantee all individual’s access to affordable, safe and effective contraceptive services and comprehensive sexuality education.¹⁹⁸ Similarly on staffing of health centres and cost of services which are barriers to safe motherhood in North-East Nigeria, the CESCR expressed concerns on the inadequate number and quality of staff as well as the cost of services which continue to place women at risk.¹⁹⁹

¹⁹³ CESCR General Comment 14 UN Doc E/C 12/2000/4.

¹⁹⁴ CESCR General Comment 22 UN Doc E/C 12/GC/22.

¹⁹⁵ CESCR General Comment 22 (n 194).

¹⁹⁶ WHO ‘Family planning/contraception’ 8 February 2018 <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception> (accessed 14 September 2018).

¹⁹⁷ CESCR General Comment 22 (n 194).

¹⁹⁸ CESCR General Comment 22 (n 194).

¹⁹⁹ CESCR General Comment 22 (n 194).

The CESCR recommends that state parties should ensure universal accessibility to pocket-friendly primary healthcare and specialised reproductive health services by taking specific measures to allow women to give birth attended to by trained health professionals. State parties are also enjoined to increase skilled attendance during birth, antenatal and postnatal care services, especially in rural and hard to reach communities. The CESCR particularly recommended that state parties should build efforts to ensure pregnant women and girls receive proper medical care during pregnancy, at childbirth and postpartum.²⁰⁰

3.4 Regional laws

A. The African Charter on Human and Peoples' Rights (Banjul Charter)

Nigeria has fully incorporated the Banjul Charter as part of its municipal laws via domestication legislation.²⁰¹ The Banjul Charter was adopted by the resolution of the Organisation of African Unity (OAU) the predecessor of the African Union in 1981.²⁰² The Banjul Charter has been seen as a progressive tool for holding state parties to account, and for individuals, it is a veritable legal instrument to utilise in claiming human rights concerns as provided for by the Charter.²⁰³ The Banjul Charter provides for the rights to life, dignity, health and non-discrimination which are all relevant in addressing MM as a human rights issue.²⁰⁴

The Charter in Article 30 provided for the establishment of a monitoring body, to be known as the African Commission on Human and Peoples' Rights (African Commission).²⁰⁵ Since inception, the African Commission has made several interpretations and recommendations that has given direction to state parties by way of

²⁰⁰ CESCR General Comment 22 (n 194).

²⁰¹ MA Olong 'Human rights, the environment and sustainable development: Nigerian women's experiences' (2012) 5 *Journal of Politics and Law* at 100.

²⁰² African Charter on Human and Peoples' Rights 1981.

²⁰³ F Viljoen *International human rights law in Africa* (2012) at 237.

²⁰⁴ Arts 4, 5, 16 & 18 Banjul Charter.

²⁰⁵ Art 30 Banjul Charter.

positive policy influence through legislation and state practice.²⁰⁶ The African Commission concluded that MM constitutes a violation of the rights to life, dignity, health and non-discrimination.²⁰⁷ Specifically in response to Nigeria's fifth periodic report adopted in November 2015, the Commission notes high MM in Nigeria and called on the government to urgently institute measures to reduce the burden.²⁰⁸

B. Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)

The Maputo Protocol came into being pursuant to Article 66 of the Banjul Charter which provides for supplementary special protocols and agreements within the framework of the Charter.²⁰⁹ The Protocol became enforceable on 25 November 2005, and Nigeria ratified the Protocol on 18 February 2005.²¹⁰ This African regional instrument addresses concerns that are not explicitly covered in other African treaties especially on African women.²¹¹ This instrument guarantees the reproductive rights of women, enjoining state parties to eliminate the violation of women in the form of female genital cutting and the right to safe medical abortion particularly in the instances of rape, incest and such situation that puts a woman at physical or mental risk should the pregnancy continue, these are as provided for in Articles 5 and 14.²¹²

Articles 2 and 14 of the Maputo protocol speak to matters of concern about maternal health.²¹³ Article 2(1) calls on state parties to eliminate discriminations against women by means of appropriate legislation and institutional measures.²¹⁴ In so doing the state parties are to maintain the principles of equality between men and women in their municipal laws. I have in the previous chapter subscribed to the argument that maternal

²⁰⁶ History of the African Commission on Human and Peoples' Rights <https://www.achpr.org/history> (accessed 14 September 2019).

²⁰⁷ African Commission General Comment 2 on Art 14 (1) & 14(2) of the Maputo Protocol.

²⁰⁸ African Commission concluding observations and recommendations on the 5th periodic report of the Federal Republic of Nigeria.

²⁰⁹ Art 66 Banjul Charter.

²¹⁰ The Maputo Protocol <https://maputoprotocol.com/about-the-protocol> (accessed 14 September 2019).

²¹¹ Preamble Maputo Protocol.

²¹² Arts 5 & 14 Maputo protocol.

²¹³ Arts 2 & 14 Maputo Protocol.

²¹⁴ Art 2(1) Maputo Protocol.

deaths are a result of discriminations against women, thus should state parties eliminate discriminations against women, then the incidence of maternal deaths will also reduce.²¹⁵

Similarly Article 2 enjoins state parties to put in regulatory measures including those prohibiting harmful practices which endanger the health and general well-being of women,²¹⁶ this provision implicitly calls for putting in place maternal death accountability frameworks that will ensure reportage of cases of maternal deaths and morbidities with a view to mitigating future occurrences. Gendered policy decision is another issue the Maputo Protocol expects of state parties.²¹⁷ In relation to maternal health, gender sensitive policies can be in the form of fiscal policy on maternal health. I have earlier established in the introductory chapter that capacity to pay for services is one of the key determinants of safe and supervised birthing process for women in North-East Nigeria.²¹⁸ Therefore increased budgetary allocation will invariably increase maternal health services access leading to better maternal health outcomes and reduced incidence of MM.

Article 14 on the other hand charges state parties to guarantee the rights of women to health, including sexual and reproductive health.²¹⁹ Sexual and reproductive health of women is guaranteed if state parties adhere to allowing women control their fertility, and their agency to determine whether or not to have children. Women should also have the right to determine the number of children and spacing of birth through choice and access to modern contraceptives of their choice. Similarly Article 14 requests of state parties to make possible for women the right to protection from sexually transmitted infections including HIV and Acquired Immunodeficiency Syndrome (AIDS) in accordance with global best practices.²²⁰ Article 14 essentially speak to the provision of the generality of information and access to sexual and reproductive health services that will enable women pass through their reproductive lives without risk of contracting diseases, unwanted pregnancies and fatal maternal health outcomes. In the General

²¹⁵ Page 10 above.

²¹⁶ Art 2 Maputo Protocol.

²¹⁷ Art 2 Maputo Protocol.

²¹⁸ Pages 2 & 6 above.

²¹⁹ Art 14 Maputo Protocol.

²²⁰ Art 14(1) d & e Maputo Protocol.

Comment 2 on Article 14 of the Maputo Protocol,²²¹ the African Commission highlights the rights to safe abortion, contraception and ending child marriage which are all of implication to the cause of ending MM in North-East Nigeria.²²² The General Comment gives a comprehensive direction to state parties on domestication of the Protocol with the desired political will, backed by just allocation of resources and enhancing legal framework relevant to the realisation of Article 14(1) a, b, c and f of the Maputo Protocol.

3.5 The Sustainable Development Goals (SDGs)

Following the tenure expiration of the MDGs in 2015, world leaders from UN member states convened and committed to partnerships with a universal call to action to end extreme poverty around the world.²²³ This action agenda to be known as the SDGs is a fifteen year race to reducing inequalities and ensuring no one is left behind development.²²⁴ The SDGs are 17 inter-sectorial goals that are connected with the overarching objective that by the end of the year 2030 everyone around the world is carried along in sustainable development.²²⁵

Pertinent to improving maternal health, the SDGs furthers the framing of health as human right. To this end, the goals seek to end extreme poverty, ensure good health and well-being as well as achieve gender equality among others. Specifically goal 3, speaks about good health and well-being. The goal weighs on human rights-based approach to health including sexual and reproductive health. Goal 3 targets reducing MM ratio to less than 70 deaths per 100,000 live births; achieve Universal Health

²²¹ African Commission General Comment 2 (n 207).

²²² African Commission General Comment 2 (n 207).

²²³ Sustainable development goals <https://www.un.org/sustainabledevelopment/sustainable-development-goals/> (accessed 14 September 2019).

²²⁴ Sustainable development goals (n 223).

²²⁵ Sustainable development goals (n 223).

Coverage (UHC); access to quality essential health services and national strategies safeguarding reproductive health.²²⁶

UHC which is central to achieving the SDGs seeks to ensure that no one suffers financial hardship while accessing healthcare.²²⁷ This is an important target considering the huge barrier that inability to pay at point of services poses on access to maternal health services in Nigeria and more so in the North-East.²²⁸ Skilled and motivated health workforce are necessary for the quality of maternal health services, thus the SDGs promotes the development of adequate, skilful and motivated health professionals.

To accelerate the SDGs, there are a number of global programmes anchored by development partners. One of such is the global strategy for women's, children's and adolescent's health 2016-2030.²²⁹ This strategy pushes for global priority around children, adolescents and women placing their health rights in fore front of the SDGs discourse.²³⁰ The strategy aims to end preventable maternal deaths, ensure the strengthening of health systems and ensure women enjoy their human rights. With nine point action areas in tandem with the SDGs, the strategy promises to accelerate the SDGs.²³¹

3.6 National laws

Nigeria has policy documents that speak of human rights based approaches to socio-economic rights.²³² These policies also speak on mitigating health disparities occasioned by the country's ailing health system.²³³ As I later argue, policies on paper alone do not bring about the desired goal, unless there is an accountability framework in place.

²²⁶ Goal 3 SDGs.

²²⁷ WHO 'Universal health coverage across the life course' (2019) <https://www.who.int/life-course/partners/global-strategy/en/> (accessed 14 September 2019).

²²⁸ Osungbade & Ayinde (129).

²²⁹ WHO 2019 (n 227).

²³⁰ WHO 2019 (n 227).

²³¹ WHO 2019 (n 227).

²³² Kalu (n 17) at 39.

²³³ Kalu (n 17) at 39.

A. The Constitution of the Federal Republic of Nigeria

The Constitution of the Federal Republic of Nigeria 1999 as amended may be seen as framed with human rights tone and has implicit provision for maternal health.²³⁴ In Section 16 of the Constitution, it is explicitly stated that the objectives of the policies of the state are to ensure social justice and make for the distribution of resources to serve the common good of the people.²³⁵ The Constitution further provides that fundamental rights include the right to life, the right to dignity and right to non-discrimination.²³⁶ These rights are the fundamental human rights relevant to maternal health as framed by human rights scholars which have direct implication on maternal health of women in Nigeria. Therefore one can be right arguing that in words, the Constitution is responsive to maternal health as a human rights issue.

Though written in human rights language, the right to health is arguably non-enforceable. Most economic, social and cultural rights including health are found under Section 6 of the Constitution; the direct principles of state policy, which are not justiciable.²³⁷ Issues listed under the direct principles of state policy imply that it is discretionary for the state to guarantee them and thus are not justifiable in Nigerian courts.²³⁸

Thus failure of the State or its agents to avail a woman her fundamental human rights of maternal health services resulting in maternal death is arguably non-justiciable.²³⁹ Unlike civil and political rights that are prioritised, the Constitution relegates social, economic and cultural rights to the background, even with available legal precedence from other jurisdictions that maternal death is a violation of the fundamental right to life.

²³⁴ Chapter 2 Constitution of the Federal Republic of Nigeria 1999.

²³⁵ Sec 16(1) a & b Constitution of the Federal Republic of Nigeria 1999.

²³⁶ Section 33 Constitution of the Federal Republic of Nigeria 1999.

²³⁷ J Dada 'Human rights under Nigerian Constitution: Issues and problems' (2012) 2 *International Journal of Humanities and Social Science* at 42.

²³⁸ Dada (n 237) at 42.

²³⁹ O Nnamuchi 'Kleptocracy and its many faces: The challenges of justiciability of health care in Nigeria (2008) 52 *Journal of African Law*.

Nigerian government and state authorities in the North-East have not been held accountable for the avoidable pregnancy and childbirth related deaths recorded.²⁴⁰

B. Acts of Parliament

I. The National Health Act (NHA)

The National Health Act (NHA) became a domestic law in 2014. The Act proposes to create enabling processes to coordinate primary healthcare in Nigeria. More so, the Act will ensure more funding for infrastructural development, enhancing service delivery and a data driven policy of improving health management information system.²⁴¹ The Act also stipulates that at least 1% of Nigeria's consolidated revenue fund be allocated as basic healthcare provision fund to finance health at primary level including maternal health.²⁴²

Although passed in 2014, it was not until 2018 when the national government allocated the 1% consolidated revenue to fund basic healthcare. Like other matters on the concurrent legislative list, the NHA can only take effect in jurisdictions within North-East when state parliaments in North-East domesticate the Act.²⁴³

II. 'Abortive' Gender Equality Bill

In 2006, a gender equality framework was adopted, known as the National Gender Policy. The policy calls for the promotion of gender equality and women and girls empowerment.²⁴⁴ Specifically the policy seeks for gender responsive evidence-based

²⁴⁰ Khanna (n 21) at 44.

²⁴¹ Art 11 National Health Act (n 34).

²⁴² Art 11 National Health Act (n 34).

²⁴³ Mwalimu (n 164) at 17.

²⁴⁴ 'National gender policy strategic framework (implementation plan) federal republic of Nigeria 2008 – 2013' August 2008 <http://extwprlegs1.fao.org/docs/pdf/nig151427.pdf> (accessed 14 September 2019).

health system and the overall reduction of MM by 35%.²⁴⁵ Sadly the gender equality framework did not yield any significant result in over 10 years of its adoption. It is said that the framework was not effective because it does not address the prevailing governance structure in the country, where gender responsive resource allocation is somewhat non-existent.²⁴⁶

Further to the gender policy, an important gender equality piece of legislation was aborted in 2016, when the Nigerian National Parliament voted down the 'Gender Equality Bill'.²⁴⁷ The Bill is premised on the provisions of CEDAW and the Maputo Protocol.²⁴⁸ The Bill failed to scale through because many of the lawmakers felt certain provisions of the Bill such as pegging the age at first marriage, inheritance and divorce contravene their religious beliefs.²⁴⁹

The Bill seeks for affirmative action to the realisation of women and girls rights. Specifically relevant to MM reduction, the Bill calls for action to mitigate discriminations and harmful traditional practices that negatively impact women. The Bill also addresses age at first marriage stipulating the age at 18.²⁵⁰

C. Policy framework

Nigeria has put in place policies and guidelines to regulate health service delivery in relation to maternal health.²⁵¹ These policies are in response to international and regional human rights instruments the country has signed and assented to, as well as affirmations of international agreements on maternal health such as the International Conference on Population and Development (ICPD) and the SDGs. Nigeria enjoys bilateral and multilateral support in effort to reduce MM. Nigeria's government through

²⁴⁵ National gender policy (n 244).

²⁴⁶ SM Kura & BU Yero 'An analysis of gender inequality and national gender policy in Nigeria' (2013) *International Journal of Scientific & Engineering Research*.

²⁴⁷ PLACNG <http://placng.org/legist/gender-equality-bill-fails-senates-2nd-reading/> (accessed 25 September 2019).

²⁴⁸ PLACNG (n 247).

²⁴⁹ PLACNG (n 247).

²⁵⁰ PLACNG (n 247).

²⁵¹ OHCHR (n 58) at 15.

the Health ministry has received years of technical support in developing programmatic guidelines on maternal health services from UN agencies such as the WHO, United Nations Population Fund (UNFPA) and United Nations Children Fund (UNICEF) and other development partners like the Canadian International Development Agency (CIDA), United States Agency for International Development (USAID) and Department for International Development (DFID).²⁵² Nigeria also enjoyed counterpart funding from development partners in financing quality improvement in reproductive health. Some of this funders include the McArthur foundation, the Global Fund and the World Bank.²⁵³

Systemic corruption with attendant funds misappropriation has proven to be one of the causes of poor health indices in Nigeria even in the presence of donor funding. One such moment of sanction due to systemic accountability failure was when the Global Fund suspended a huge counterpart funding to Nigeria for the reduction of mother to child transmission of HIV. The suspension by the Global Fund was due to the failure of the Nigerian government to meet up with targets on accountability and transparency.²⁵⁴

I. National Reproductive Health Policy and Strategy (NRHPS)

Nigeria adopted the NRHPS in year 2001 with the aim of addressing amongst others the unacceptably high incidence of maternal morbidity and mortality.²⁵⁵ The policy seeks to protect the rights of all individuals to bodily autonomy and their agency of making decisions about their own reproductive health.²⁵⁶ The policy also sought to reduce by 50% all pregnancy and childbirth related deaths between 2001 and 2006.²⁵⁷

The NRHPS points at the availability of WHO recommended emergency obstetrics care (EmOC) and access as well as training and adequate staffing of reproductive health

²⁵²<https://www.unicef.org/nigeria/media/1376/file> (accessed 14 September 2019)

²⁵³ The Global Fund 'Nigeria' <https://www.theglobalfund.org/en/search/?q=nigeria+50+million+2005> (accessed 14 September 2019).

²⁵⁴ The Global Fund (n 253).

²⁵⁵ National Reproductive Health Policy (n 253) annex 2. <https://pdfs.semanticscholar.org/f776/8a255bf757e0ca1dcca55b190a012db31353.pdf> (accessed 14 September 2019).

²⁵⁶ National Reproductive Health Policy (n 255) annex 2.

²⁵⁷ Goal 3(2) National Reproductive Health Policy.

service providers as a strategy to reducing maternal deaths.²⁵⁸ Other issues the policy set out to address include removal of barriers to reproductive health services, promotion of sexual and reproductive health information and expanding the funding envelope for reproductive health services.²⁵⁹

The policy calls on all tiers of government to comply with its provisions in an effort to promoting the attainment of the highest attainable level of reproductive health without any discrimination on the basis of age, sex or socio-economic status.²⁶⁰ This is an impressive choice of language by the policy framers, however it is a mere dud-cheque in comparison with the living reality of women in North-East Nigeria. From the 2008 demographic health survey findings, one can conclude that this policy did not achieve its major aim of reducing by 50% the number of maternal deaths in North-East Nigeria.²⁶¹ Reasons for this failure has re-echoed in the discussions in preceding chapters.²⁶²

II. Ward minimum healthcare package (WMHCP)

The WMHCP is another product of bilateral partnership. It came as a result of the technical support of the WHO to the Nigeria's primary healthcare agency in 2001 with a revision covering the period 2007 to 2012.²⁶³

The package provides a set of primary healthcare interventions and services that address health issues at the first point of contact. The overall aim of the package is to enable substantial health gains at minimal cost to the government and partners.²⁶⁴

Components of the WMHCP with implications to MM include skilled birth attendance, resuscitation and management of emergencies. To achieve standardised service

²⁵⁸ National Reproductive Health Policy (n 255) annex 2.

²⁵⁹ Goal 4(2) National Reproductive Health Policy.

²⁶⁰ National Reproductive Health Policy (n 255).

²⁶¹ National Population Commission & ICF International (n 14).

²⁶² Pages 1, 2, 3 & 5.

²⁶³ NPHCDA *Minimum standards for primary health care in Nigeria* (2007) at 1.

²⁶⁴ NPHCDA (n 263) at 2.

delivery, the package states at each level of primary healthcare the recommended infrastructure, human resource and minimum expected services to be provided.²⁶⁵

III. National Policy on Population for Sustainable Development

Nigeria adopted in 2004, a national policy on population. The policy mentions concern on reducing MM. Specifically the policy ambitiously sought to reduce by 75% Nigeria's MM ratio between 2004 and 2015. This target is ambitious as it is well above the target set by the UN's MDGs.²⁶⁶

The policy set standards on improving access to the continuum of reproductive health and synergistic promotion of policies and programmes on maternal health.²⁶⁷ While it remained an impressive document of hope, at the end of 2015 Nigeria did not attain the MDGs target in MM reduction by two-third let alone this policy that proposed a 75% reduction.²⁶⁸

IV. Health sector reform programme

The health sector reform programme of Nigeria 2004, established a framework for the improvement health service delivery through priority interventions.²⁶⁹ The programme comes with seven goals that are essentially human rights responsive and intended to better healthcare delivery including maternal health.

The goals of the programme with implication on maternal health include, 'improvement of government's stewardship; strengthening the national health systems and its management; improving the management of health resources; improving access to and

²⁶⁵ NPHCDA (n 263) at 2.

²⁶⁶ Health Policy 'Nigeria's 2004 national policy on population for sustainable development: Implementation assessment highlights' http://www.healthpolicyplus.com/ns/pubs/7141-7252_NPPIImplementationAssessmentBriefMay.pdf (accessed 14 September 2019).

²⁶⁷ Health Policy (n 266).

²⁶⁸ Health Policy (n 266).

²⁶⁹ WHO 'The Nigerian health system' <https://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf> (accessed 14 September 2019).

quality of services; and improving consumer awareness and community participation'. Specifically the programme mentions maternal health issues including skilled birth attendance and acceptable facility availability of EmOC per 500,000 population.²⁷⁰

V. The integrated maternal, new-born and child health strategy

To harmonise existing policies and programmes on maternal health across the country, Nigeria's health ministry, in 2007 adopted the integrated maternal, new-born and child health strategy. The strategy sought to ensure non-overlap of mothers' interests and those of children. The policy spells out a harmonised approach to scale up country's maternal and child health interventions with improved infrastructure.²⁷¹

The policy strategically proposes an improvement in facility based deliveries to 70% and escalate the number of facilities offering EmOC to 70%. More so, in a departure from other policies, this integrated programme established a health insurance system intended to offer free services to pregnant women.²⁷²

3.7 Conclusion

In this chapter, I focused on international and regional human rights instruments relevant to the realisation of maternal health rights. I have discussed the obligations of Nigerian state in relation to the instruments. I have also dwelled on national laws and policies where I was able to establish that Nigeria's programmatic framework relevant to maternal health speak with human rights tones, however there is absence of accountability to drive actualisation of the rights. Furthermore I demonstrated a claw-back evident by the arguable non-justiciability of health rights per Nigerian Constitution.

²⁷⁰ WHO (n 269).

²⁷¹ COO Chukwu 'Maternal, newborn and child health in Nigeria: Where are we now?' https://www.who.int/pmnch/about/steering_committee/B11_11_02_nigeriapresentation.pdf (accessed 14 September 2019).

²⁷² Chukwu (n 271).

CHAPTER FOUR

HOLISTIC APPROACH TO MATERNAL MORTALITY IN NORTH-EAST NIGERIA

4.1 Introduction

This chapter argues the need for a holistic approach to reducing MM in North-Eastern Nigeria, given the many interconnected determinants of MM and the apparent inadequacies of existing policies on maternal health in the region. Beyond just human rights framed legislation on MM, there are social, economic, cultural, religious and communal factors earlier addressed in preceding chapters that make laws insufficient.²⁷³ Therefore measures need to be put in place to carefully address those factors in a holistic manner, so that upon implementation the laws can be effective and human rights responsive tools.

In this regard, I explored and engaged with some identified factors that in my opinion will enable state actors in North-Eastern Nigeria to reduce the burden of MM and ensure accountability on maternal health in a human rights responsive manner. Here, I made reference to my research questions, providing answers to factors constraining the reduction of MM in North-East Nigeria and the holistic strategies to tackling them.

4.2 The need for holistic approach to reducing MM in North-East Nigeria

Holistic approach recognises the fact that multiple inter-connected factors intersect to cause MM, therefore a pathway to remedying such a problem requires holistic strategy. Such strategy involves system thinking approach that looks at each component of the

²⁷³ Pages 12, 13, 14 & 15 above.

whole.²⁷⁴ The medical causes of MM are known and can be prevented, however the social determinants that lead to the medical causes as well as the indirect causes of maternal death require more than medical expertise to remedy. Another angle to the holistic approach is effective accountability. Effective accountability goes beyond litigation, it involves monitoring the enjoyment of the rights related to MM through accountability frameworks such as administrative, political, legal and social forms of accountability, which were earlier discussed in the introductory chapter.²⁷⁵ These accountability measures ensure full enjoyment of rights comes through a variety of stakeholders such as the government, private organisation and individuals, the communities, health professionals and donors.

In line with sustainable development, WHO in collaboration with partners, conducted a large multi country survey to strengthen methodology on the estimation of maternal deaths and ascertain trends in MM and morbidity with the aim of informing strategies for remedy.²⁷⁶ This resulted into the availability of improved data on MM and morbidity over the years 1990 and 2010. The findings reflected a traceable trend of countries transitioning from periods of high prevalence of maternal morbidity and mortality with high fertility rates to lower MM and fertility rates. Also from predominance of direct obstetrical causes of mortality in the presence of low institutional supervision of pregnancy and birthing to the prominence of indirect causes and increased institutional pregnancy supervision with attendant medicalisation of pregnancy and birthing. This transition known as the obstetric transition offers an implication for policy making aimed at reducing MM.²⁷⁷ In the case of North-Eastern Nigeria, a sub-national level, this model will offer a veritable perspective in the light of the holistic factors needed to be checked to address MM.

²⁷⁴ Durojaye (n 22) at 107.

²⁷⁵ Pages 2 & 11 above.

²⁷⁶ C Chavez et al 'Obstetric transition in the World Health Organization multicountry survey on maternal and newborn health: Exploring pathways for MM reduction' (2015) 37 *PubMed*.

²⁷⁷ Chavez (n 276) at 38.

4.3 Highlight of the factors needed to be addressed to remedy the burden of maternal deaths in North-East Nigeria

Having discussed the predispositions to MM in North-East Nigeria based on individual, societal and systemic characteristics,²⁷⁸ I highlight the factors unique to North-East Nigeria that when addressed will bring about a transition from the region's current obstetric transition stage towards realisation of safe motherhood.

Nigeria is in stage two of the obstetric transition, however disaggregated data situates the North-East in stage one in relation to absolute MMR figure,²⁷⁹ however characteristic features within the North-East are of the stage two. In stage two MM and fertility rates remain high but greater percentage of women seek institutionalised supervision of pregnancy and birthing. Therefore access to care is critical in improving outcome at this transitional stage. The socio-economic realities of the North-East is that of poor basic amenities such as road network and health facilities.²⁸⁰ These systemic problems coupled with low educational level of women and inadequacy of health workforce limits access to and utilisation of the available maternal health services.

In order to increase demand for services policies should be directed towards infrastructural development, human resource strengthening and primary preventive strategies which will eliminate the aforementioned 'three delays'²⁸¹ concept.

A. Gender affirmative policies including gender responsive budgeting and a National Gender Equality Act

Maternal deaths are resultant effects of discriminations against women. Similarly as earlier cited in the introductory chapter,²⁸² *Alyne's* case opened a new dimension in the

²⁷⁸ Pages 10 & 11 above.

²⁷⁹ Chavez (n 276) at 38.

²⁸⁰ World Economic Forum 'Three things Nigeria must do to end extreme poverty' <https://www.weforum.org/agenda/2019/03/90-million-nigerians-live-in-extreme-poverty-here-are-3-ways-to-bring-them-out/> (accessed 30 June 2019).

²⁸¹ Calvello (n 62).

human rights approach to maternal death by making it possible for families to recognise the role of injustice, gender and economic discriminations as determinants of maternal death. The stories of women from North-East Nigeria are similar to Alyne's where discriminations abound without effective laws to address them. A concerted and enduring response to discriminations predisposing women to maternal deaths therefore rely greatly on adoption of effective gender responsive policies. Though not the silver bullet to end maternal deaths, gender sensitive laws such as a National Gender Equality Act are indispensable.

Recognising prejudices against women and girls and the limitations of laws, UN women in collaboration with partners came up with a multi-stakeholder strategy for action towards equality in law for women and girls by 2030.²⁸³ The strategy calls for full legal protection of women in line with provisions of international instruments such as the CEDAW, the Beijing Declaration and Platform for Action, and the 2030 Agenda for Sustainable Development. In doing so, the initiators of the call to action seek the repeal of 'claw-back clauses' discriminatory against women's agency including sexual and reproductive autonomy.²⁸⁴

The technical guidance on human rights-based approach to reduce preventable maternal morbidity and mortality underscores the core obligation of states at national and subnational levels to develop policies on sexual and reproductive health encompassing maternal health.²⁸⁵ Furthermore the guidance implies gender sensitivity by calling on state actors to ensure policies drawn are based on up-to-date women's sexual and reproductive health needs and informed by reliable disaggregated data.²⁸⁶

Policy regulations and guidelines should also comply with imperatives of equality between men and women and health as a human right. To this end laws and policies impeding access to the continuum of sexual and reproductive health must be changed, such laws as those criminalising services only needed by women like safe and legal

²⁸² Cook (n 55) at 43.

²⁸³UN Women 'Equality in law for women and girls by 2030: A multi stakeholder strategy for accelerated action' <https://www.unwomen.org/en/digital-library/publications/2019/03/equality-in-law-for-women-and-girls-by-2030> (accessed 14 September 2019).

²⁸⁴ UN Women (n 283).

²⁸⁵ OHCHR (n 38) at 15.

²⁸⁶ OHCHR (n 38) at 15.

abortion services. There should also be explicit plan of action affirmative to women's access to the range of sexual and reproductive health services including comprehensive sexuality education for adolescent girls and policies aimed at checking barriers to access.²⁸⁷

Legal mechanisms include policies that uphold human rights principles in the context of maternal health. Laws ensuring access to the generality of maternal healthcare services, providing for universal health coverage. Gender responsive legal framework will also put in place mechanisms for legal redress to ensure accountability for those whose rights are abused or fall shorts of international and regional treaties. In the case of North-East for instance, a gender responsive legal framework will address poor school enrolment for the girl-child, forced child marriage and discriminatory practices that devalues equality between men and women.

The abortive Gender Equality Bill,²⁸⁸ offers a national instrument that speaks to the rights of women in line with the provisions of CEDAW and the Maputo Protocol. Thus state actors and advocates should rally around to represent the Bill at the National Assembly for consideration. Similarly states in North-East Nigeria relying on concurrent legislation,²⁸⁹ can go ahead to adopt the Bill in their jurisdiction in a context specific manner.

B. Poverty reduction

In developing countries, as poverty increases, the risk of dying from pregnancy related causes also increases.²⁹⁰ With growing link between poverty and MM, the individual woman of North-East Nigeria's demand for maternal services is affected by poverty.²⁹¹

²⁸⁷ OHCHR (n 38) at 9.

²⁸⁸PLACNG <http://placng.org/legist/gender-equality-bill-fails-senates-2nd-reading/> (accessed 25 September 2019).

²⁸⁹ PLACNG (n 285).

²⁹⁰ Morgan (n 149) at 14.

²⁹¹ Morgan (n 149) at 14.

User fees at point of maternal healthcare expand the existing disadvantages faced by the poor in access to healthcare, further widening the gap between the rich and the poor in maternal health services utilisation and outcomes. For instance, the introduction of fees in a district in Nigeria resulted in the drop of institutional delivery by 50 percent, with resultant doubled number of maternal deaths.²⁹² Therefore there is the need for deliberate empowerment of women in line with rights-based approach earlier mentioned.²⁹³ Existing initiatives aimed at women empowerment should be strengthened in line with international human rights principles.

C. Involvement of civil society organisations (CSOs) and strengthening the capacity of the National Human Rights Commission (NHRC)

The race for the reduction of MM in North-East Nigeria will be highly inadequate without the complementary role of CSOs. CSOs working in the sexual and reproductive health space are important stakeholders in the effort to reduce MM worldwide.²⁹⁴ Thus North-Eastern state actors should harness the role of CSOs.

CSOs support MM reduction effort through provision of information, comprehensive sexuality education, advocacy, policy influencing research and strategic litigation.²⁹⁵ An example in the global space on MM, is the Centre for Reproductive Health's effort in the earlier mentioned *Alyne's* case.²⁹⁶ Locally in Nigeria and specifically in the North-East CSOs have offered help in bridging the gap in the availability of maternal health services, through the provision of health posts and health professionals in hard to reach communities ravaged by insurgency.²⁹⁷

²⁹² Centre for Reproductive Rights & Women Advocates Research and Documentation (n 77) at 17.

²⁹³ OHCHR (n 38) at 15.

²⁹⁴ Centre for Reproductive Rights & Women Advocates Research and Documentation (n 77) at 22.

²⁹⁵ Centre for Reproductive Rights & Women Advocates Research and Documentation (n 77) at 22.

²⁹⁶ Centre for Reproductive Rights & Women Advocates Research and Documentation (n 77) at 22.

²⁹⁷ SFH Nigeria <http://www.sfhigeria.org/giving-birth-in-nigeria-the-staggering-odds-facing-pregnant-women/> (accessed 25 September 2019).

The CSOs have not only shown relevance in policy research but have also helped in the training and retraining of health professionals.²⁹⁸ Similarly CSOs have been in forefront pushing for legislation on softening abortion laws in Nigeria and offering free family planning services to women in North-East Nigeria.²⁹⁹ The important role of CSOs in reducing MM was recognised by the WHO.³⁰⁰

The NHRC has a unit dedicated to sexual and reproductive rights.³⁰¹ The Commission has shown some commitment in leading a human rights-based approach to maternal mortality through stakeholder engagements.³⁰² One key achievement over a decade ago was the preparation of a National Action Plan for the protection and promotion of human rights.³⁰³

The National Plan was adopted by the highest political office in Nigeria and deposited with the OHCHR in 2009.³⁰⁴ With over a decade of existence and states in North-East still counting high MM, it calls for giving the Commission more strength and independence to offer the country the desired ombudsperson status in holding states to account for avoidable maternal deaths.

The OHCHR technical guidance recommends that NHRC should promote accountability in sexual and reproductive rights through the investigations of violations against women, monitoring the implementation of legislation and recommendations of international human rights organisations.³⁰⁵ It was also recommended that NHRC conduct public hearings and awareness creation on preventing MM.³⁰⁶ This strategic strengthening of the Human Rights Commission can be supported by states in North-East Nigeria in an effort to offer rights-based trajectory to ending MM.

²⁹⁸ SFH Nigeria (n 297).

²⁹⁹ SFH Nigeria (n 297).

³⁰⁰ SFH Nigeria (n 297).

³⁰¹ OHCHR (n 60) at 39.

³⁰² OHCHR (n 60) at 1.

³⁰³ OHCHR (n 60) at 1.

³⁰⁴ OHCHR (n 60) at 1.

³⁰⁵ OHCHR (n 38) at 5.

³⁰⁶ OHCHR (n 38) at 11.

D. Involvement of traditional and community leaders

Traditional leaders are the gate keepers of the communities in North-East Nigeria through whom community mobilisation on maternal health can be achieved.³⁰⁷ Community mobilisation campaigns are long term strategies that seek social change by leading attitudinal change, shift in norms and values.³⁰⁸ These community strategies should therefore involve working with ranking members of communities who exert influence to deal with socio-cultural determinants that promote MM.

Traditional leaders offer socio-cultural directions to their communities, which is an essential cue to action.³⁰⁹ These leaders are the custodians of culture and traditions, they take centre stage at the everyday lives of the people and how the society evolves. There is profound evidence as to the positive role of traditional leaders in public health interventions, of particular mention the promotion of immunisation leading to polio eradication in Northern Nigeria.³¹⁰ Thus such an invaluable leadership should be utilised in prioritising maternal health. Traditional leaders are able to speak directly to the people in the language they understand and to their doorsteps even the hardest to reach.

An evidence to the role of traditional leaders in driving reduction in MM comes from the maternal, new-born and child health programme in Northern Nigeria (MNCH2).³¹¹ MNCH2 engaged traditional leaders in select intervention states through formal sensitisation campaigns. The engagements upon review yielded positive results, informing possibility of rewarding scale up. Words of traditional leaders are powerful in Northern Nigeria, the Emir of Daura, a foremost traditional ruler spoke on the MNCH2,

³⁰⁷ MNCH2 'Improving maternal and child health with the help of traditional leaders in Northern Nigeria' https://www.mnch2.com/wp-content/uploads/2018/01/TSC-MNCH2-CS_8_Traditional_Leaders_SINGLE.pdf (accessed 14 September 2019).

³⁰⁸ MNCH2 (n 307) at 2.

³⁰⁹ MNCH2 (n 307) at 2.

³¹⁰ MNCH2 (n 307) at 3.

³¹¹ MNCH2 (n 307) at 4.

stating the willingness of the traditional institution to support initiatives on reducing MM.³¹²

E. Involvement of religious leaders and faith-based organisations

Faith-based leaders possess an ordained leadership role through the organisations they lead. Serving as role models for care and compassion, religious leaders can shape social values and promote behaviours that are responsive to the dignity and sanctity of life.³¹³ This speaks to human rights principles of dignity and right to life which are human rights components of maternal health. Similarly being closely knit to the communities, religious leaders serve as reliable communicators. In so doing, religious leaders are well placed to address social issues and have the ability to set the agenda and bring communities together. Once convinced on an idea, faith-based leaders are well situated to shift their community's beliefs on issues surrounding maternal health.³¹⁴ Through this, the negative misinterpretations can be addressed paving way for improved maternal health services in women friendly manner.

Religious leaders through faith-based organisation may offer a key role in raising awareness and mitigating misconceptions surrounding access to maternal health services in North-East Nigeria. A promising example that North-East Nigeria can learn from is an Ethiopian participatory platform that engaged faith-based leaders.³¹⁵ Recognising how religion is highly intertwined with the Ethiopian culture and social norms and how religion is at the core of everyday lives of the people, the maternal, neonatal and child health (MNCH) sought to involve religious leaders as health promoters. The influence of religion and the leadership offered by religious leaders narrated in the Ethiopian programme is similar to what obtains in North-East Nigeria, where Christianity and Islam takes centre role in the social norms of the people.

³¹² MNCH2 (n 307) at 4.

³¹³ Healthy Newborn Network <https://www.healthynewbornnetwork.org/hnn-content/uploads/Synthesis-Report-Religious-Leaders-Engagement-002.pdf> (accessed 14 September 2019).

³¹⁴ Healthy Newborn Network (n 313).

³¹⁵ Healthy Newborn Network (n 313).

F. Awareness raising campaigns

Efforts to engage in awareness campaigns that would enlighten communities in North-East Nigeria about human rights aspects of MM is necessary in improving accountability for maternal health. Effective awareness campaigns are those with messages that are rightly drafted with creative and practicable ideas.

The technical guidance on human rights response to MM speaks to creation of awareness on the notion of laws as remedies to ensure effective applicability of the laws.³¹⁶ The guidance calls on national human rights bodies to organise public education on MM and morbidity and human rights.³¹⁷ The OHCHR says to ensure effective utilisation of remedies, states must systematically raise awareness about the applicability of claims relating to women's sexual and reproductive health rights among legal practitioners and judicial officers as well as the general public.³¹⁸

Awareness campaigns in North-East Nigeria should be multi-pronged including promotion of better health seeking behaviours and human rights aspects of sexual and reproductive health. This will involve behavioural change communication strategies as well as through comprehensive sexuality education. The communities should come to the understanding that women are not only right bearers on maternal health but can be rights claimants. Important pieces of legislation and policies should be mass produced in easy to understand terminologies to promote understanding. For instance the duty to care and standard operating procedures in maternal health services can be produced in info-graphical communication formats so that women can understand what to expect from facilities and can therefore raise concerns where services fall short of standard.

³¹⁶ OHCHR (n 38) at 18.

³¹⁷ OHCHR (n 38) at 18.

³¹⁸ OHCHR (n 38) at 19.

G. Involvement of men

There has been increased recognition of the need to involve men in maternal health programmes since the early 1990s.³¹⁹ This recognition is due to the important role they play as partners, fathers and community members. The WHO in 2015 recommends the involvement of men in interventional programmes during pregnancy, childbirth and after childbirth. The WHO's recommendation is aimed at facilitating and supporting self-care for the woman and improved home care practices for the woman. Similarly the recommendation envisages that involving men will lead to improved use of skilled care during pregnancy, childbirth and post natal care. In line with human rights principles and gender equality, WHO puts a caveat to the recommendation that it should only be done provided that a woman's autonomy in making her own decision is respected.³²⁰

A systematic review in 2018 provided evidence for action on male involvement in maternal health.³²¹ The study reviewed 13 studies that looked at male partner involvement as interventional strategy to improve maternal health in low and middle income countries. Findings from the study demonstrated that the engagement of male partners as stakeholders in maternal health led to the increased utilisation of ANC services and delivery at health facilities. Similarly as pointed out by WHO the systematic review study found improved home care practices like birth preparedness and complication readiness.³²²

In North-East Nigeria where there is culture of patriarchy,³²³ male involvement should be carefully implemented linking it to other programmes that promote egalitarian gender norms and women empowerment. This can be achieved through community

³¹⁹ WHO <https://extranet.who.int/rhl/topics/improving-health-system-performance/who-recommendation-male-involvement-interventions-maternal-and-neonatal-health> (accessed 14 September 2019).

³²⁰ WHO (n 316).

³²¹ AG Mersha 'Male involvement in the maternal health care system: Implication towards decreasing the high burden of MM' (2018) 18 *BMC Pregnancy and Childbirth*.

³²² Mersha (n 321) at 18.

³²³ Makama (n 64) at 121.

mobilisation and education for men on supportive roles that do not harm the autonomy of women in making decisions.

H. Political prioritisation and the tackling of *Boko Haram* insurgency

It is evidently clear that the issues that serve to perpetuate MM are complexly interconnected and there is no silver bullet to attack it.³²⁴ It is also noteworthy the issues predisposing to MM in North-East Nigeria I had earlier highlighted including socio-cultural and discriminatory norms are not necessarily a matter of financial resource but rather of commitment and goodwill from the government and the society as a whole.³²⁵ Setting the tone of the political will and societal goodwill towards improved maternal health in North-East Nigeria is imperative to reducing maternal deaths, however the pathway to achieving that seems a huge challenge.

Scholars have argued that lack of resources alone do not tie low income countries to the burden of MM.³²⁶ Conversely it is political and social commitment to public health and women empowerment that matter.³²⁷ Opposing argument is that even when there exist the political support, lack of resources to execute the needful leaves the support as mere goodwill but no further action.³²⁸ Without intension of delving into the argument, for the purpose of this dissertation and in resonance with living realities in North-East Nigeria, I subscribe to the need for making maternal health a political priority.

The challenge of preventing conditions that predispose women to death during pregnancy aside social, economic and cultural factors lies the political factor. The political factor is about the distribution of power and resources within and between countries.³²⁹ Perhaps the political factor is an important driver why MM continues to

³²⁴Durojaye (n 22) at 103.

³²⁵ Page 10 above.

³²⁶R Agbonkhese 'Agenda setting for maternal mortality in Nigeria: A comparative study of the media agenda for maternal mortality and HIV'<https://pdfs.semanticscholar.org/a45a/ed91160e34f092c1017a6095707abccf2baa.pdf> (accessed 14 September 2019).

³²⁷ Agbonkhese (n 326) at 189.

³²⁸ Agbonkhese (n 326) at 190.

³²⁹ Agbonkhese (n 326) at 368.

remain a challenge in North-East Nigeria, because political will does not require financial resources but rather a deliberate desire to bring about change.

Achieving the desired political patronage to improve maternal health in North-East Nigeria will therefore require setting the agenda because competing health priorities influence policy decisions.³³⁰ In an endeavour to push for maternal health as priority, advocacy plays key role in providing practical political solutions that will attract the patronage of state actors.

I. Media involvement

There is the need for deliberate policy aimed at active and conscious engagement of the mass media. The traditional media when effectively utilised will break even positive change in the way women view maternal health services not as a privilege of the few that can afford or a hub for the educated but their fundamental human rights.³³¹

The WHO has identified the effectiveness of campaigns delivered through the mass media and the new media. Zamawe and colleagues in Malawi published their findings in 2016 supporting the positive effect of media in promoting the utilisation of maternal health services.³³² Their findings was an evaluation of *Phukusi la Moyo* which literally translates as 'tips of life', a community driven mass media campaign on maternal health. They found that women who received information through the *Phukusi la Moyo* were more likely to utilise maternal health services than those who did not.

Therefore in order to strengthen awareness on maternal health services and their human rights implication in North-East Nigeria, state actors should promote positive media reportage that will promote behavioural change in health seeking towards active utilisation of maternal health services. Without unethical censoring, state actors should actively strengthen media accountability modalities that will effectively promote gender

³³⁰ Agbonkhese (n 326) at 369.

³³¹ COF Zamawe et al 'The impact of a community driven mass media campaign on the utilisation of maternal health care services in rural Malawi' (2016) 16 *BMC Pregnancy and Childbirth*.

³³² Zamawe (n 331) at 4.

equality and deconstruct patriarchal norms that may hinder women's agency and reproductive autonomy. The radio and the *Kannywood* (the Northern Nigeria film industry) will serve as good media to promote safe motherhood, challenge child marriage and increase contraception awareness.

J. Social autopsy

Social autopsy is an innovative strategy that serves as a social accountability tool.³³³ It enables dialogue between the community and government agents to identify bottlenecks that impact maternal and child deaths. The dialogues seek to understand the factors at the family and community levels that prevent seeking timely facility intervention thus facilitating a community driven response. The first application of social autopsy was a Bangladeshi programmatic action.³³⁴

Social autopsy offers a concrete information on the socio-cultural barriers causing the deaths and the errors that facilitated them.³³⁵ Interactions during social autopsy gives the community a non-judgmental accountability retrospection to identify mistakes that might have resulted in fatal events. By so doing it gives the community an opportunity to identify actions in order to avert future occurrences of maternal deaths. When implemented social autopsy will provide reliable and quality data that will inform community driven actions.

K. Implementation of maternal death surveillance response (MDSR)

Accurate and reliable data will lead to appropriate and informed decision making which in turn favours positive outcome. Understanding exactly the 'how' and 'why' a woman died during pregnancy or around the time of childbirth is an important first step in

³³³ WHO 'Social autopsy triggers community response for averting maternal and neonatal death in Bangladesh' (2019) https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/case-studies/social-autopsy-bangladesh/en/ (accessed 14 September 2019).

³³⁴ WHO 2019 (n 333).

³³⁵ WHO 2019 (n 333).

preventing another woman from dying the same way. This gap is what maternal death surveillance and response seeks to fill.³³⁶

The MDSR is a maternal death monitoring tool in an action cycle that is continuous.³³⁷ It monitors the medical causes of maternal deaths as well as the socio-cultural determinants. The MDSR probes into the personal story of the woman lost to maternal death. It seeks answers as to the precise circumstances of her death. Answers are sought such as her address, whether there was the understanding she needed emergency care. It also probes if the care was available and in good quality. Similarly it interrogates if there were barriers in accessing the care.³³⁸ WHO buttressed the need to answer these questions when in 2014 it highlighted essential information required and the need to follow-up the information with interventions. The essential information according WHO should include 'how many mothers are dying', 'where', 'when' and 'why'.³³⁹ This is aimed at data driven design of policies and programmes targeting elimination of preventable maternal deaths.

If adopted by states in the North-East, the MDSR will help government's accountability in monitoring interventions impact in the effort to mitigate maternal morbidity and mortality. This can include disaggregated data on how socio-cultural and systemic issues including individual characteristics related to maternal deaths affects women such as those living with disabilities, ethnic minorities, the displaced and refugee women, older or younger women and from different social strata. In the end, there will be the availability of evidence driven data that will inform the choice of appropriate interventions and provide for reliable impact evaluation of interventions in the effort to reduce burden of maternal deaths in North-East Nigeria.

L. Implementation of facility level standards and monitoring

³³⁶WHO 'MDSR' (2019) https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/ (accessed 14 September 2019).v

³³⁷ WHO 2019 (n 336).

³³⁸ WHO 2019 (n 336).

³³⁹ WHO 2019 (n 336).

As established in previous chapters, ensuring that pregnant women are attended to and assisted during pregnancy, child birth and the postnatal period is critical to reducing the incidence of maternal death.³⁴⁰ Evidence driven interventional strategies aimed at reducing MM are well known, however optimally required interventions coverage has proven a challenge. That is why the quality of maternal health service has remained a concern in developing countries.³⁴¹ This necessitates the need to have evidence-based strategies to reduce the existing quality gap.

The quality enhancement process identifies the right and evidence-based interventions that are fashioned to address specific concerns hindering the provision of good quality services. It also improves the structure of governance assigning tasks and responsibilities while monitoring projects implementation. Through this process, therefore issues like staff retraining and continuing professional development will be identified and addressed. Similarly provider attitudes to duty and biases will be mitigated while eliminating administrative bottlenecks that hinder smooth running of health services.

An example of the application of quality monitoring was reported by Kabo and others in Bauchi, Nigeria.³⁴² The implementation study utilised standard based management and recognition approach (SBM-R) in select health facilities in Bauchi state. Overall the study concluded that introduction of an SBM-R tool with supporting interventional activities led to meaningful improvement in the level of compliance with standards and the overall enhancement in the quality of maternal health outcomes.

M. Peace building effort to tackle insecurity

The insecurity in North-Eastern Nigeria occasioned by *Boko Haram* insurgency which began around 2009 has been noted to have negative impact on overall maternal

³⁴⁰ Pages 12 & 13 above.

³⁴¹ Kabo et al 'Monitoring maternal and newborn health outcomes in Bauchi State, Nigeria: An evaluation of a standards-based quality improvement intervention' (2016) *International Journal of Quality Health Care*.

³⁴² Kabo (n 341) at 3.

health.³⁴³ The joint security effort of the Lake Chad basin has succeeded in diminishing the combat capacity of the *Boko Haram* group and the communities hitherto under siege have witnessed gradual return of civilians to their homes.³⁴⁴ Peace building and reconstruction efforts are therefore imperative in building the resilience of the post conflict communities.

Bearing in mind the devastating infrastructural collapse and weakened institutions due to repeated attacks, the Nigerian government has put in place a federal funded agency the North-East Development Commission (NEDC) to oversee reconstruction of the region.³⁴⁵ Women and children are the most affected by the crisis, thus one of the key mandates of the Commission is improving the health status of the communities including maternal health.³⁴⁶ To this end, a multi-stakeholder collaboration is suggested to ensure context specific and human rights responsive resilience building by the Commission.

Considering the complex nature of the crisis, innovative and multi-pronged solutions are needed to mitigate the socio-economic collapse in the North-East. Similarly at the political level, a UN special representative alluded to the need for a regional strategy to address the root causes of the insurgency as a way of ensuring enduring peace and development.³⁴⁷

4.4 Conclusion

It is clear that adopting a holistic approach is imperative to achieving reduction in maternal morbidity and mortality in North-East Nigeria. A holistic approach that is human rights responsive will address the burden of maternal morbidity and mortality in the region. Though not by any means exhaustive, as I am limited by resources and

³⁴³ UN <https://news.un.org/en/story/2017/09/564862-peacebuilding-efforts-needed-tackle-boko-haram-end-lake-chad-basin-crisis#.WbxRALKGNEY> (accessed 25 September 2019).

³⁴⁴ UN 2019 (n 343).

³⁴⁵ North-East Development Commission Act 2017.

³⁴⁶ Sec 2 North-East Development Commission Act (n 345).

³⁴⁷ UN 2019 (n 343).

time, it is my opinion that engagement with these strategies and more will break the jinx of maternal deaths in North-East Nigeria and communities in similar obstetric transition phase.

I have discussed that promoting gender sensitive laws and policies will cause a shift in patriarchal norms that hinder access to maternal health services. Deliberate policies that empower women educationally and economically will enable women take charge of their agency and exercise their reproductive autonomy. As suggested by the technical guidance from the OHCHR, state actors should ensure women understand their rights to access maternal health services and are able to access the services in good quality without financial barrier.³⁴⁸ Similarly state actors should ensure accountability processes and ensure women are informed about the availability of ombudsperson to seek redress for perceived denial of access to services or complications sustained from substandard services. Without engaging with these strategies through the lens of human rights, maternal health as a human right will remain only a topic of academic exercise but not living reality for women in North-East Nigeria.

³⁴⁸OHCHR (n 38) at 15.

CHAPTER FIVE

CONCLUSION AND RECOMMENDATIONS

5.1 Concluding remarks

The principal aim of this research has been to contribute to the growing discussion on finding enduring solution to MM in Nigeria especially in the North-Eastern region. On one hand the study identified the causes of MM as a human rights violation in North-Eastern Nigeria and factors that constrain the reduction of MM. On the other hand, the study highlighted how the application of a holistic approach will bring about significant reduction in MM and the realisation of women's rights to safe motherhood. The state's responsibility to protect and promote human rights is fundamental to ending the continued tragedy of avoidable maternal deaths in Nigeria particularly in the North-East region.

I have established that MM in the North-Eastern region of Nigeria has persistently remained high and a challenge. I have highlighted the obstetric causes of MM to include postpartum bleeding, pregnancy induced high blood pressure, maternal infection, unsafe abortion and obstructed labour. Other medical causes referred include malaria and HIV infection. Beyond the medical predispositions, I have cited social, economic and cultural factors that predispose women in North-East Nigeria to MM. Poverty which incapacitated women from being able to pay for maternal health services. Gender inequality construed in patriarchal norms as well as lack of education all hinder the realisation of safe motherhood, leaving women at increasing risk of death.

Given the multiple and interrelated factors that predispose women to MM, I observed the human rights aspects of maternal death including the right to health, the right to life, the right to dignity as well as other fundamental human rights earlier referenced. When human rights principles are applied, majority of the deaths will be prevented. As I have cited, almost all known causes of maternal death are preventable. This research has found that due to the governmental structure and pluralistic legal system in Nigeria the domestication of international and regional treaties relevant to the

realisation of safe pregnancy and childbirth have been too slow, despite Nigeria's ratification of relevant instruments like the CEDAW, Banjul Charter and the Maputo Protocol. The realisation of women's rights related to MM is still an issue of concern. Even where the federal government has domesticated an international human rights instrument, local implementation at state level in the North-East must follow state-level domestication. In this instance the Child Rights Act, which could prevent child marriage is yet to be domesticated across the North-East.

Finally the research engaged with measures that can be adopted by states in North-East Nigeria to ensure effective reduction in maternal deaths. Using the holistic approach which touched many issues in order to properly mitigate the problem of avoidable maternal deaths. The holistic approach, which involves the utilisation of key strategies in a human rights responsive manner, is premised on building an efficient and enduring collaborative effort as suggested in the technical guide to human rights response to MM.³⁴⁹ The study notes that a holistic approach will also promote improved understanding of the circumstances surrounding maternal deaths, provide data driven evidence-based priorities and ultimately lead to better maternal health outcomes.

5.2 Recommendations

In the light of the analysis and the findings in this study, I recommend the adoption of a holistic approach by states in North-East Nigeria that will speak to the social, cultural, economic and systemic barriers to the access of good quality maternal health services. Every well-meaning individual is a stakeholder in breaking barriers to safe motherhood, with the government at the forefront. I will specifically highlight recommendations to key stakeholders as follows.

³⁴⁹ OHCHR (n 38) at 4.

5.3 Specific recommendations

For North-East Nigeria to obstetrically transit favourably to reduced maternal deaths in line with the SDGs and EPMM, state actors must take the lead with requisite political will in order not to leave the region behind. Political will is key, the government must accept the tragic reality of daily avoidable maternal deaths and confront it with due diligence.

Confronting the structural issues and legal complexities can be through a constitutional review. This buck is beyond individual states in the North-East, as constitutional review is a national issue. Legislators at the state and national levels should propose constitutional amendment in an effort to achieving human rights compliant municipal laws. Such amendment should foster justiciable socio-economic rights, gender equality as well as clear jurisdiction of health services supervision. I have earlier exemplified how lack of clear delineation of authority makes some federating states sleep on responsibility in providing health services.³⁵⁰

Through legislation, states in North-East can be able to take appropriate actions to stop discrimination against women in all its forms and also ensure the elimination of harmful traditional practices that subordinate women, preventing them from accessing maternal health services. State legislators can take advantage of the already passed Child Rights Act of the national assembly and domesticate it in their respective states to allow for elimination of discriminatory cultural practices such as early marriages and other practices that predispose to MM.

The government should build institutional capacity and promote accountability. Good governance initiatives should be put in place to address gaps in institutional capacity. Through continuing professional development, task shifting to mitigate the shortage of manpower. Similarly placement of capable administrative and managerial personnel and set standards to improve performance of public health institutions. There should be the promotion of performance through innovative sectorial service delivery strategies

³⁵⁰ OHCHR (n 60) at 1.

like performance and result based financing. Performance can be monitored using new technologies such as electronic health records and means to systematically improve vital registrations for use in administrative and political accountability.

State actors should ensure educational reform with a view to incorporating comprehensive sexuality education to empower growing boys and girls with necessary information to be responsible adults thereby promoting better health seeking behaviours and responsible adulthood. There should be affirmative action in the region to improve the presence of women in governance and the economy. When actively engaged by way of deliberate policy, women will have more standing to voice the needs of fellow women. Similarly economically empowered women are more likely to utilise maternal health services with better outcomes. There should also be active cultivation of civic engagements for improved maternal health indices in the North-East. The existing communality, through various traditional and faith-based institutions should be enhanced. This will bring about shift in social norms and value reorientation. Through this communal networking social accountability will be achieved.

Deeper and more holistic engagement of all well-meaning individuals and institutions as stakeholders in the effort to end preventable maternal mortality will form the bedrock for developing broader and enduring strategies. To a large extent, this will lead to an increase in the number of activists and organisations interested in promoting maternal health. This will translate into the large-scale social change that is imperative to achieving safe motherhood that this research seeks to promote.

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Annexure

Geography of North-East Nigeria

North-East Nigeria, is one of the six geopolitical zones of the country. It comprises of six states namely, Adamawa, Bauchi, Borno, Gombe, Taraba and Yobe. The region covers about one-third of Nigeria's land area and contributes to about 13.5% of the country's population. The zone shares international borders with Cameroon to the East, Chad to the North-East and Niger to the North.

