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**THESIS**

**Title**

# RIGHTS-BASED APPROACH TO MATERNAL HEALTH: CONSTITUTIONALIZING PROTECTION OF WOMEN'S REPRODUCTIVE RIGHTS IN NIGERIA

Thesis submitted to the University of Ottawa in partial fulfillment of the requirements for the Doctor of Philosophy (Ph.D) Degree in Law

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## TABLE OF CONTENTS

## ABSTRACT

Maternal mortality in Nigeria is unacceptably high, accounting for 14 percent of global maternal deaths, thereby making it a global public health issue. Given that maternal mortality is essentially a women problem, it is a matter of justice and discrimination. In addition, significant regional disparities in maternal mortality exist within Nigeria, particularly between the northern and southern parts of the country. The maternal mortality ratio in the North is six to ten times greater than that of the South. The country's maternal mortality crisis occurs along regional and socioeconomic lines-the poorer northern Nigeria has a disproportionately higher maternal mortality ratio than the wealthier southern Nigeria. This thesis explores the disparities in maternal health across different regions in Nigeria from an intersectional perspective, taking into account economic, religious, cultural, rural, and urban differences. The study adopts intersectionality theory to examine how these factors intersect to impact maternal health outcomes in Nigeria. Furthermore, the thesis employs a functional comparative law approach, using India and South Africa as comparators, to assess how the constitutional courts of these countries have applied intersectional perspective to right to health. It highlights the importance of adopting an intersectional approach to understanding maternal health disparities in Nigeria, as it considers the multiple and interconnected factors that contribute to poor maternal health outcomes. This is particularly crucial in the Nigerian context, where maternal mortality rates remain high and access to quality maternal health services is limited, particularly in rural and underdeveloped regions.

The comparative analysis of India and South Africa sheds light on how these countries have approached constitutionalizing the right to health and intersectionality in their courts. In South Africa, the Constitutional Court has played a crucial role in advancing the right to health and applying an intersectional perspective in its judicial decisions, leading to improvements in maternal health outcomes. In India, the Supreme Court has also played an important role in interpreting the right to health to include other associated factors, but its impact on maternal health outcomes remains limited, particularly in rural areas. The thesis concludes by advocating for constitutionalizing maternal health in Nigeria, through incorporation of the right to health in the Nigerian Constitution to ensure that this right is enforceable through the court processes. The study recommends that an adoption intersectional perspective in the implementation of maternal health policies and programs, in order to address the multiple and interconnected factors that contribute to maternal health disparities in Nigeria. The findings of this thesis contribute to the existing literature on maternal health and the right to health, and have important implications for policymakers and health practitioners working to improve maternal health outcomes in Nigeria and other developing countries. By incorporating an intersectional and comparative approach, the thesis provides a comprehensive understanding of the challenges and opportunities for constitutionalizing maternal health in Nigeria and highlights the need for a more nuanced and integrated approach to maternal health policy and practice.

## ABBREVIATIONS

| | |
|---|---|
| AC | African Commission |
| ANC | Ante-Natal Care |
| Art. | Article |
| AU | African Union |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against |
| Women ACHPR | African Charter on Human and Peoples' Rights (ACHPR) |
| CESCR | Committee on Economic, Social, and Cultural Rights |
| CFRN | Constitution of the Federal Republic of Nigeria |
| CRA | Childs Rights Act |
| CRC | Convention on the Rights of the Child |
| CRPD | Convention on the Rights of Persons with Disabilities |
| CSDH | Commission on the Social Determinants of Health |
| ECOWAS | Economic Community of West African States |
| FGM | Female Genital Mutilation |
| FPDP | Fundamental Polices and Directive Principles |
| FODPSP | Fundamental Objective and Directive Principles of State Policies |
| GBV | Gender Based Violence |
| GC | General Comment |
| ICCPR | International Covenant on Civil and Political Rights |
| ICESCR | International Covenant on Economic Social and Cultural Rights |
| LGBTQ | Lesbian, Gay, Transgender, Queer Persons |
| MDG | Millennium Development Goals |
| MMR | Maternal Mortality Ratio |
| NDHS | Nigeria Demographic and Health Survey |
| NGP | National Gender Policy |
| NHA | National Health Act |
| NHP | National Health Policy |
| NNPC | Nigerian National Population Commission |
| NPW | National Policy on Women |
| NRHPS | National Reproductive Health Policy and Strategy |

| | |
|---|---|
| NRHM | National Rural Health Mission |
| SDH | Social Determinants of Health |
| UDHR | Universal Declaration on Human Rights |
| UN | United Nations |
| UNFPA | United Nations Fund for Population Activities |
| UNICEF | United Nations Children's Emergency Fund |
| VVF | Vesico-Virginal Fistula |
| WARD-C | Women Advocate Research Documentation Centre |
| W.H.O | World Health Organisation |

# CHAPTER ONE

# INTRODUCTION AND BACKGROUND TO THE STUDY

## 1.0 Introduction

Nigeria has a population of more than 200 million people, but the exact population figure is a subject of constant speculation[1]. It is Africa's most populous nation as it represents a quarter of the continent's population.[2] It is rich in vast natural resources, and globally it is the sixth largest producer of oil.[3] But despite this fact, the health indices of the country are alarming. Nigeria leads the world in maternal mortality statistics, behind India.[4] According to the Nigerian National Population Commission, the country has a maternal mortality ratio estimated at 576 maternal deaths per 100 000 live births.[5] The ratio amounts to 10 per cent of the global maternal mortality annually.[6] This makes Nigeria the country with the second highest maternal deaths in the world despite having only 2 percent of its population.[7]Also, for every of this maternal death, 20 other women suffer serious and often permanent pregnancy-related complications and health problems.[8]

Several factors have contributed to the unacceptable level of maternal deaths in Nigeria. The factors include, poverty, lack of basic social amenities, inadequate and inaccessible healthcare services, general attitude to family planning procedures, and low status of women as well as gender-based violence. Besides, there are policy related factors that have contributed to these unacceptable level of maternal deaths in Nigeria. One key factor among these is the lack of political will to tackle the problem at both the federal, state and local government levels. In addition, a meagre resource allocation to the health sector in successive national, state, local

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[1] Central Intelligence Agency (CIA) The World Factbook 2021- Nigeria (last accessed 18 May, 2021).

[2] According to projection the country's population is expected to hit 219,463,862 (July 2021 est.) CIA Factbook 2021.

[3] J. Odikpo & E. Durojaye "Litigating Right Health Issues: The Nigerian Experience" in Litigating the Right to Health in Africa: Prospects and Challenges ed. E. Durojaye Routledge (2015), 144.

[4] 'Worrisome maternal death records' *Daily Sun* 29 October 2007.

[5] 'Nigeria Demographic and Health Survey 2013'. Abuja, Nigeria: National Population Commission and ICF International 2014. Available at: http://www.population.gov.ng/index.php/2013-nigeria-demographic-and-health-survey (accessed 15 May 2020).

[6] Federal Ministry of Health, Nigeria and World Health Organisation (WHO), "Road map for accelerating the attainment of the MDGs relating to maternal and newborn health in Nigeria" (2005) 1.

[7] World Health Organization, United Nations Children's Fund and United Nations Population Fund. Maternal Mortality in 1995. Estimates developed by WHO, UNICEF and UNFPA. WHO/RHR/01.9 Geneva, World Health Organization.

[8] Center for Reproductive Rights (CRR) and Women Advocates Research and Documentation Centre (WARDC) 'Broken promises: Human rights, accountability and maternal death in Nigeria' (2008) 76.

governments' annual budgetary appropriations and the failure of politicians to address the continued subordination of women, contribute significantly to the worsening high death rate among the Nigerian women. Also, the existence of widespread cultural and religious practices that reinforce gender stereotypes undermines the autonomy of women to control their sexual and reproductive rights and is fundamental to creating this detrimental condition for women in Nigeria. These factors are discussed in detail in chapter three of the thesis.

Education of women influences maternal health in a variety of ways including attitudes towards childbearing, health-seeking behaviors, and improving earning capacity.[9] Women who are able to read and write are accessible to information for the protection of their own health and that of their families.[10] As a result, they have the capacity to change their perception and attitudes towards pregnancy, childbirth and contraception, sanitary practices, and working habits. Although substantial progress has been made in relation to women's education in Nigeria, the gains have not been even across the country, especially in most rural areas where a good number of women reside.[11] One cannot over-emphasise the importance of the link between a woman's educational level, her health and that of her children. Studies in developing countries in general and Nigeria in particular, have consistently documented a strong relationship between a mother's education and her children's survival chances.[12]

In Nigeria, the poverty level is high, and the health infrastructure is poor. Poverty underlies the poor health status of women especially in rural areas.[13] According to the World Bank, socioeconomic differentials are the clearest determinants of the status of women's health.[14] Experts have reported that poverty forces women to live under conditions that can cause many

[9] See. World Bank Development in practice: Better health in Africa, experience and lessons learned. Washington, D.C: World Bank. (1994).
[10] Belsy *et al.*, Integrating maternal and child health services with primary health care: Practical considerations. Geneva: World Health Organization. (1990), 2.
[11] S. Ahmed *et al*., "Economic status, education and empowerment: implications for maternal health service utilization in developing countries" (2010) 5:6. PLoS One 2.
[12] Hartfield, V. J.& Woodland, M. (1980). Prevention of maternal age and parity on childbearing with special reference to primilgravidae aged 15 years and under. In: British Journal of Obstetrics and Gynecology (Supplement) 5, 23 – 31.; Chukwudebelu, W. and Ozumba, B. Maternal mortality in Anambra state of Nigeria. (1988). 27 *Journal of Gynecology and Obstetrics,* 365-371.
[13] World Health Organisation: Factsheet No. 348 on Maternal Mortality, May 2012, available at: www.who.int/mediacentre/factsheets/fs348/en/index/html (accessed on February 18, 2021).
[14] World Bank Development in practice: Improving women's health in India. Washington D.C: World Bank. (1996).

physical and mental health problems.[15] The social hierarchy of the society, particularly in rural areas means that most women especially those of childbearing age are economically dependent on men.

In addition, the health system in Nigeria is generally poor and even worse in the rural areas of the country. Substandard health services, lack of medical equipment and supplies at the time of labour, delivery and immediately after birth, implicate poor maternal health.[16] Health facilities, especially those that deliver primary and preventive services, are either lacking or underutilized in most rural communities. The cost of medical services is extraordinarily high, rendering them accessible only to a privileged few, primarily due to the widespread inaccessibility of these rural communities. This economic barrier underscores the pressing need for targeted interventions to make healthcare more affordable and available for the marginalized populations in these remote areas.[17]

At the root of Nigeria's maternal mortality crisis is gender inequality, implying that the problem cannot be resolved merely through its current national health policies.[18] Solutions must be grounded in broader recognition of women's human rights to health, non-discrimination, equality, and most of all, life. Globally, women, particularly in rural communities, consistently face a subordinate social status compared to men. [19] This inherent inequality results in discriminatory practices, manifesting as the mistreatment or outright denial of reproductive rights for women. A woman's status within a society affects her access to health care, the degree of reproductive autonomy, or capacity to make independent reproductive decisions both within and outside a household.[20] In Nigeria, for example, women are often subordinated to men within a family in cultural and religious beliefs and practices.[21]

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[15] LP. Freedman, Who's got the power? Transforming health systems for women and children: UN Millennium Project: Task Force on Child Health and Maternal Health; 2005.
[16] Emergency Report "Health in Ruins: A Man-Made Disaster in Zimbabwe". Cambridge, Massachusetts: Physicians for Human Rights; 2009.
[17] Nigeria: OECD Development Center; 2014.
[18] CRR, supra note 8.
[19] WHO. Ten facts about women. Retrieved March 13th, 2020. From https.//www.who.int/entity/world-health.day/2010/en/index.html.
[20] J Nedelsky 'The gendered division of household labor: an issue of constitutional rights' in B Baines, D Barak-Erez & Tsvi Kahana *Feminist constitutionalism: global perspectives* (2012) 15.
[21] Ibid.

Islamic 'Sharia law' often codified in Northern states[22] and Customary law (ethnic, non–Islamic) that applies to members of different ethnic groups and particularly dominant in the area of personal and family relations, either exclude women participation or subordinate them to a patriarchal direction.[23] The deeply ingrained gender hierarchy in Northern Nigeria and certain ethnic communities enforces practices like seclusion, or purdah, confining women within family compounds, stripping them of autonomy. In this oppressive context, even during obstetric complications, women are bound to seek their husband's permission for treatment. [24] These patriarchal norms drastically diminish women's social standing and severely curtail their access to essential healthcare, underscoring the urgent need to dismantle such restrictive practices for the empowerment and well-being of women.

This thesis seeks to answer four central questions:

i. What are the socio-economic, cultural, and legal barriers to promoting maternal health in Nigeria?
ii. What legal reforms are necessary to address these barriers?
iii. What combination of laws are needed to address women's maternal health rights from an intersectional perspective?
iv. Given the non-justiciability of social and economic rights, what constitutional and legal framework(s) can be used to advance equality in maternal health in Nigeria?

[22] Gunnar Weimann, "Divine Law and Local Custom in Northern Nigerian zinā Trials" (2009) 49: ¾ Die Welt des Islams at 451; G. Weimann, "Judicial Practice in Islamic Criminal Law in Nigeria? A Tentative Overview" (2007) 14:2 Islamic Law and Society 240.

[23] In Nigeria, the primary sources of law include: (1) the Constitution, which has binding force on all authorities and persons throughout the country; (2) legislation, each of the 36 states and the Federal Capital Territory, Abuja, have its own laws; (3) English law; (4) Customary law (ethnic, non–Islamic) that applies to members of different ethnic groups and is particularly dominant in the area of personal and family relations; and (5) Islamic law, often codified in Northern states. In Northern Nigeria, three distinguishably different legal traditions work side by side: Customary (or native) law other than Muslim Law, Sharia and Common Law (British colonialists). Sharia Law only applies in civil and personal spheres. Islam and Sharia are deeply rooted in the mainly Muslim communities in northern Nigeria and constitute a vital part of their identity as against Christian Southern states. See. Philip Ostien & Albert Dekker, "Shari'ah and National Law in Nigeria" in Jan Otto, ed, Shari'ah Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present (Leiden: Leiden University Press, 2010) at 578.

[24] E White 'Purdah' (1977) 2 *Frontiers: A Journal of Women Studies* 31-42; 31http://www.jstor/stable/3346105 (accessed on 5 May 2022).

Since most maternal deaths are preventable, this thesis interrogates to what extent equality and justice in Nigeria can be promoted by addressing social factors that affect maternal health, through the provisions of the Constitution. Specifically, it seeks to analyze whether the social institutions and cultural factors like religion, culture, economic status, and geographical location combine to inhibit maternal health and reproductive justice of Nigerian women. The thesis critically examines the engagement template, probing the extent to which various factors contribute to entrenched gender imbalances in the distribution of social capitals and assignment of responsibilities based on gender categorization. This analysis informs a deeper interrogation of policies and legal structures implicated in perpetuating such disparities. The resultant discrimination and disadvantage are root causes of the alarming prevalence of maternal deaths in Nigeria, cutting across its regions. To address this urgent issue, the thesis advocates for the swift implementation of robust national laws and policies, ensuring alignment with international human rights instruments. This imperative extends to empowering treaty bodies responsible for overseeing the mechanisms of these human rights instruments to ensure the safeguarding of these rights through both judicial and quasi-judicial means within regional courts. Despite this critical need, the current scenario reveals a lamentable deficiency, with only a scant number of cases having been brought before the courts for the essential adjudication of rights stemming from maternal mortality. This stark reality underscores the pressing demand for a swift and comprehensive response to address the dire situation at hand.[25]

The thesis analyzes the complexity of the problem of maternal mortality through an intersectional framework, that is, the legal structures and the roles they play in shaping the experiences of pregnant women in different communities. In addition, a unique aspect of my research is in the constitutional comparative analysis. My analysis views expression and co-ordination of everyday experiences of pregnant women through socio-economic, cultural, institutional structures that are not necessarily visible from within any specific local setting from the lens of Intersectionality theory.[26] It is imperative to assert that a robust theoretical

[25] Known cases include a pending matter reviewed in this research involving an NGO Women's Advocates Research and Documentation Centre (WARD-C) v. Attorney General of the Federation & 3 Others *Suit No: FHC/L/CS/1962/15*.

[26] Crenshaw Kimberly, 'Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics' (1989) 1 *University of Chicago Legal Forum* 143.

analysis examining the social dynamics experienced by pregnant women, particularly those who are impoverished, residing in rural areas, and marginalized, is indispensable in Nigeria. The existing dearth of comprehensive studies and theoretical frameworks that address the complex issue of maternal mortality in Nigeria, particularly at the intersection of age, gender, socioeconomic status, and cultural factors, underscores the critical need for immediate attention and scholarly investigation. A rigorous exploration of these multifaceted dimensions is essential for developing targeted interventions and policies to alleviate the pressing challenges faced by this vulnerable demographic.

## 1.1 Demography and Healthcare Data of Nigeria

### 1.1.1 Demographic data

Nigeria is the largest economy in Africa, a federal state and made up of thirty-six states and the Federal Capital Territory (FCT), Abuja.[27] The thirty-six states are organized unofficially into six geopolitical zones. Although this is supposed to be based on geographical proximity, cultures, ethnic groupings, and common histories. It is more of a representation of lopsided nature of the Nigerian state itself, for the composition of some of the entities making up the sub-nationals do not necessarily align with these factors. Some ethnic groups traverse geographical space, religion and culture, to conform to this categorization.[28] British colonial rule in Nigeria fostered and amplified divisive identities, pitting Northerners against Southerners, Muslims against Christians, and various ethnic groups like the Hausa-Fulani, Yoruba, and Igbo against each other. These divisions, rooted in the varying impact of colonialism across regions, laid the foundation for enduring economic, political, and regional disparities. This has been largely retained till date.[29] Evidently, the alignments seem to follow religious and ethnic divisions, exerting a notable influence on the formulation of laws within the country. In the three northern zones North-Central, North-East, and North-West, Sharia influences the civil law.[30] This is an Islamic code of conduct for religious, political, economic

[27] Mwalimu C. The Nigerian legal system. New York: P. Lang; 2005.
[28] S. Whitaker, The Politics of Tradition: Continuity and Change in Northern Nigeria, 1946-1966 (New Jersey: Princeton University Press, 1970) 10.
[29] Táíwò, Olúfémi, How Colonialism Preempted Modernity in Africa (Indiana: Indiana University Press, 2010); Kane, Ousmane, Muslim Modernity in Postcolonial Nigeria: A Study of the Society for the Removal of Innovation and Reinstatement of Tradition (Boston: Brill, 2003).
[30] John Paden, Muslim Civic Cultures and Conflict Resolution: The Challenge of Democratic Federalism in Nigeria (Washington: Brookings Institution Press, 2005).

and social affairs. The three southern zones South-East, South-South, and South-West administer secular law.[31] Colonial education strategies wrought educational disparities, disproportionately depriving Northern Nigeria in contrast to the Southern region. Similarly, colonial economic policies led to greater economic development in the South. Politically, population-based representation favored the North, countering the Southern region's economic and educational dominance.[32] More than 370 different ethnic groups make up the country, with Hausa and Fulani representing 29 percent, Yoruba group 21 percent, Ibo 18 percent, Ijaw 10 percent, Kanuri 4 percent, Ibibio 3.5 percent and Tiv 2.5 percent.[33]

Nigeria's economic backbone is firmly tethered to the petroleum sector, constituting up to 90 percent of the nation's exports and contributing over 65 percent to the government's revenue, according to the International Monetary Fund (IMF)[34]. The 2021 CIA Factbook estimates that the gross domestic product of the country stands at $1.05 trillion US dollars, with a 3.5% percent growth rate and an exchange rate at $1 to N 358.811.[35]

Profound regional disparities characterize Nigeria, starkly evident in the unequal distribution of resources and the diverse religious, economic, and cultural orientations across regions. These variations exacerbate existing challenges, demanding a strategic and inclusive approach to bridge the gaps and foster national development. Furthermore, Nigeria boasts a rich tapestry of cultural and religious diversity, accompanied by distinct spatial variations in economic development and levels of illiteracy. Unfortunately, Guttmacher reports that a significant sixty percent of women in their childbearing years reside in the northern zones, a region consistently grappling with diminished rates of female empowerment, educational attainment, and other

[31] Joy Ezeilo, 'Milestones and Barricades: A centennial journey to Gender Equality and Women's Empowerment in Nigeria' (2014) 4 *Nigerian Journal of Religion and Society* 112.

[32] A. Jega, Identity Transformation and Identity Politics under Structural Adjustment in Nigeria (Sweden: Nordic Africa Institute, 2000) 16. For example, the majority of the multinational oil prospecting and producing companies, including Shell Petroleum Development Company, National Agip Oil and Gas Company, Totalfinalelf, ExxonMobil and Schlumberger all have major offices or headquarters in this region.

[33] CIA World Factbook 2021. Nigeria - The World Factbook (last accessed 18 May, 2021); 'Full list of all 371 tribes in Nigeria, states where they originate' *Vanguard* 10 May 2017. https://www.vanguardngr.com/2017/05/full-list-of-all-tribes-in-nigeria-states-where-they-originate/ (accessed on 08 December 2018).

[34] United States Energy Information Administration - USEIA 2010. Independent Statistics and Analysis. Country Analysis Briefs of Nigeria 2010. (last accessed 18 May, 2021).

[35] The World Factbook - The World Factbook (cia.gov) (last accessed 12 December 2022).

critical social development indicators. This underscores the urgent imperative for targeted interventions to address and rectify these disparities.[36]

The North-East and North-West have predominantly Muslim population, where majority live in rural settings.[37] But the North-Central has a larger Christian population compared to other regions in the North, especially in the urban parts of the sub-region[38]. The South-Western region has a mix of both Christians and Muslims but a larger Christian population.[39] The South-South region comprises mostly the oil producing states in the country; it is the least urbanised in the southern region and predominantly Christian[40], while the South-Eastern sub-region of Ibo residents is predominantly Christian as well.[41]

### 1.1.2 Nigeria Healthcare System

It is necessary to examine the country's healthcare data and assess the extent to which the picture becomes more challenging for pregnant women, in order to fully comprehend the barriers they face in Nigeria. These data relate to the extent of poverty, lack of basic infrastructure, health financing, political choices, medical equipment and drugs, to mention a few, particularly as a reflection of the regional disparity in the rate of maternal mortality between the North and the South.

The healthcare system and living conditions of Nigerians are alarmingly poor, with citizens facing severe limitations in accessing essential components of a decent living, such as clean water, adequate healthcare, and other vital social and infrastructural facilities crucial for a healthier life. [42] Health indices across Nigeria's regions plummet due to a dysfunctional healthcare system marred by crumbling institutional infrastructure, ineffective management, and pervasive systemic corruption, particularly at the primary health level. This dire situation

[36] Nigeria: OECD Development Center; 2014.
[37] Adebowale AS, Yusuf BO, Fagbamigbe AF. Survival probability and predictors for woman experience childhood death in Nigeria: "analysis of North-South differentials". (2012) 12 BMC Public Health 430.
[38] Ibid.
[39] Ibid.
[40] National Bureau of Statistics, Port Harcourt 2011.
[41] National Bureau of Statistics, Port Harcourt 2011. State-Level Statistics on Poverty, Total Number of Hospitals, Education, Family Planning, Prenatal Care and Religious Composition in Nigeria from 2004-2007.
[42] Omofonmwan, S. & Osa-Edoh, G., The Challenges of Environmental Problems in Nigeria. (2008) 23:1, *Journal of Human Ecology* 53-57.

requires urgent and comprehensive reforms to salvage the ailing health sector and ensure the well-being of the nation's populace.[43] A large percentage of the Nigerian population especially in rural areas does not have access to adequate primary healthcare services and infrastructure.[44] Furthermore, optimal nutrition is pivotal for fostering good health, with urban residents allocating an average of 70 percent of their household expenses to food, and rural dwellers dedicating 75 percent.[45] Consequently, poverty significantly exacerbates healthcare challenges in the country, as the inability to afford nourishing food directly impacts citizens' health.

Persistently, the Nigerian government has failed to meet its responsibilities, consistently falling short of the designated regional benchmarks for allocating resources to health in the national budget. In 2020, a meager 7.51 percent of the government's expenditure was allocated to healthcare, significantly below the regional mandate of 15 percent set for the revenue of African states. This glaring discrepancy underscores a critical need for substantial and immediate action to align budgetary priorities with the pressing healthcare demands of the nation. The percentage may be attributed to lack of political will to improve the health of women and citizens generally.[46] It highlights a glaring negligence of the critical need for a robust financial support in the health sector. This under-spending underscores a pressing demand for a substantial increase in budgetary allocations to address the urgent health challenges facing the nation.[47] Raising budgetary allocation for primary healthcare stands as a pivotal strategy outlined by the WHO to fortify the delivery of primary healthcare services, where maternal health takes center stage as a critical and indispensable component. This strategic imperative mandates substantial financial investments to bolster primary healthcare systems, particularly in the realm of maternal health, to ensure comprehensive and effective

[43] CRR, "Broken Promises" supra note 8.

[44] United States Library of Congress -USLC 2008. Federal Research Division. Country Profile – Nigeria. Available at http://www.lcweb2.loc.gov/frd/cs/profiles/Nigeria.pdf (last accessed 18 May, 2021).

[45] United Nations Development Program, Africa Human Development Report 2012, p. 91 http://www.undp.org/content/dam/undp/library/corporate/HDR/Africa%20HDR/UNDP-Africa%20HDR-2012-EN.pdf

[46] World Health Organization, 'The Abuja Declaration: Ten Years On' (2010), available at www.who.int/healthsystems/publications/Abuja10.pdf (accessed 18 May 2021).

[47] Premium Times "2021 Budget: Again, Nigeria ignores AU Benchmark for health funding" www.premiuim timesng.com (accessed on 20 October 2021); World Health Organization, Nigeria statistics summary (2002-present), http://apps.who.int/gho/data/view.country.15000 (accessed on April 23, 2013).

healthcare delivery.[48] More so, increasing health care funding will help in reducing out of pocket expenses for pregnant women.[49]

### 1.1.3 The problem of preventable maternal death

Maternal mortality refers to the death of a mother during pregnancy or within 42 days of termination of a pregnancy, irrespective of the site and duration of the pregnancy, and from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.[50] In Africa, 50% of these deaths occur within 24 hours of childbirth, 25% during pregnancy, 20% within seven days of delivery and 5% between two to six weeks after childbirth.[51] The WHO estimates that globally, close to 800 women and girls die daily from pregnancy and childbirth related complications.[52] In an ideal world, motherhood is a joyous experience, yet in many households it is synonymous with sadness since many women die in childbirth.[53] According to Cook:

> Motherhood can take a woman to the heights of ecstasy and the depths of despair; it can offer her protection and reverence. But it can also deny a woman consideration as anything more than a vehicle for human reproduction'.[54]

Ninety-nine percent of all maternal deaths occur in developing countries- more than half of these deaths occur in sub-Saharan Africa, and one third in South Asia.[55] Maternal mortality is the leading cause of premature death among women of reproductive age in developing countries, especially within the age range of 15-29.[56] The deaths far outweigh that of annual rate in men's death.[57] It exposes the range of disparities and inequalities, and reveals the

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[48] Ibid.
[49] World Health Organization (WHO), Primary Health care, achieving UHC, SDG3 and Health Security (April 2021).
[50] World Health Organization (WHO), ICD-10 International Classification of Diseases and Related Health Problems: Tenth Revision (2004) 98 cited in *Broken Promises* note 8 at 5.
[51] Africa Population and Health Research Centre, "Maternal Health in Nigeria: Facts and Figures". Fact Sheet. 2017.
[52] World Health Organisation: Factsheet No. 348 on Maternal Mortality, May 2012, available at: www.who.int/mediacentre/factsheets/fs348/en/index/html (accessed on January 10, 2021).
[53] Cabal, L & Stroffregen, M, *Calling a spade a spade: maternal mortality as a human rights violation* (2009) *Human Rights Brief* 16.
[54] R Cook, 'Gender, health and human rights' in J Mann et al, (eds) (1999) *Health and human rights* 253.
[55] WHO: supra note 52.
[56] WHO & UNICEF, Revised 1990 Estimates of maternal mortality: A new approach (1996) 2.
[57] Ibid.

greatest gap between the developed and developing countries.[58] The probability of maternal death faced by an average woman over her reproductive life-span varies from 1 in 5200 in Canada, 1 in 12,100 in Japan to 1 in 21 in Sierra Leone, to 1 in 31 in Nigeria, to 1 in 190 in India, to, 1 in 8700 in Belgium , and 1 in 14,900 in Norway.[59] These disparities manifest themselves in the variations of maternal deaths between urban and rural, non-indigenous and indigenous, rich and poor, as well as educated and illiterate populations.[60] According to the WHO, maternal mortality is higher in women living in rural areas and among poor communities.[61]

The WHO estimates that 88-98 percent of maternal deaths arise from preventable causes.[62] The causes of maternal deaths can be classified as direct or indirect causes. Direct causes are those arising from obstetric complications, health problems related to pregnancy, delivery, and the post-natal period[63]. They make up 80 percent of all maternal deaths, including causes such as: hemorrhage; pregnancy-related hypertension and eclampsia, sepsis, unsafe abortion and obstructed labour.[64]

Securing maternal health adequacy is contingent upon more than just providing a secure and fulfilling sexual life for women. It necessitates robust governmental facilitation of access to essential components, including emergency obstetric care, comprehensive family planning information, reproductive health services, safe abortion options, and education addressing the varied reproductive needs of women and girls. This comprehensive approach is imperative for ensuring the holistic well-being of women and promoting a healthcare system that addresses the multifaceted dimensions of maternal health. Furthermore, it requires an unwavering commitment to preventing all forms of discrimination faced by women and girls throughout this process, thereby fostering conditions that can significantly mitigate the alarming rates of

[58] Cabal, L & Stroffregen, supra note 53 at 2.
[59] Trends in maternal mortality: 1990 – 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. WHO 2014, available at: http://www.who.int/reproductivehealth/publications/ (accessed on September 16, 2020).
[60] These disparities result in different health outcomes depending on which side of the divide one is on.
[61] WHO Factsheet No. 348.
[62] H. De Pinho 'On the "rights" track: the importance of a rights-based approach to reducing maternal deaths' in A. Clapham & M Robinson (eds) *Realising the right to health*, (2009) *Swiss Human Rights Book* 111.
[63] World Health Organization, the World Health Report 2005 – Make Every Mother and Child Count (WHO 2005).
[64] Ibid.

maternal deaths.[65] While political, economic and social policies can improve the health of women, it is equally important to examine the role of the recognition of the right to health under the constitution and the role of judicial and institutional mechanisms for its enforcement and realization in promoting equality for women.[66]

Cultural and religious factors significantly contribute to the high rates of maternal deaths in Nigeria.[67] These factors, deeply rooted in societal norms and practices, often restrict women's access to adequate healthcare and reproductive rights.[68] Customary and religious laws, which vary across regions, can perpetuate discriminatory provisions and hinder the implementation of effective maternal health policies. Practices such as child marriage, female genital mutilation, and restrictions on women's mobility during pregnancy (such as purdah) pose serious risks to women's health and well-being.[69] Addressing these cultural and religious factors is crucial for reducing maternal mortality rates in Nigeria and requires comprehensive legal reforms that prioritize gender equality and reproductive rights.

### 1.1.4 Nigeria's public health background relating to maternal mortality

In 2013, the data from the Nigeria Demographic and Health Survey puts the national average of maternal mortality rate at 576 deaths for every 100,000 live births.[70] The data masks the regional disparities across various regions of the country along several lines, such as geographic location, education, economic status, as well as social class. The disproportionality of maternal mortality based on socio-cultural and religious factors clearly underpins the disparity in maternal health outcomes between northern and southern regions of Nigeria.

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[65] See Centre for Reproductive Rights, Briefing Paper: Surviving Pregnancy and Childbirth: An International Human Right (CRR 2005).

[66] H. Irving 'Introduction' in H Irving (ed) *Constitutions and gender: research handbook in comparative constitutional law* (2019) 1.

[67] Ogu *et. al.*, "Engendering the Attainment of the SDG-3 in Africa: Overcoming the Socio-Cultural Factors Contributing to Maternal Mortality" *September (Special Edition); (2016) 20:3* African *Journal of Reproductive Health* 62.

[68] Kisaakye, EM 'Women, culture and human rights: female genital mutilation, polygamy and bride price' in Benedek, W; Kisaakye, EM and Oberleitner, G (eds) *The human rights of women* (Zed Books 2002).

[69] Ujah et al. "Factors Contributing to Maternal Mortality in North-Central Nigeria: A Seventeen-Year Review; African Journal of Reproductive Health (2005).

[70] 'Nigeria Demographic and Health Survey 2013'. Abuja, Nigeria: National Population Commission and ICF International 2014. Available at: http://www.population.gov.ng/index.php/2013-nigeria-demographic-and-health-survey (accessed 5 June 2022).

The glaring contrast in maternal mortality rates between the northern and southern regions has prompted a rigorous examination of underlying causes. Chief among these factors are substantial variations in access to healthcare services, compounded by persistently low utilization of skilled birth attendants. This noticeable demarcation foregrounds the urgency of addressing systemic issues and implementing targeted interventions to bridge these disparities and fortify maternal healthcare across the entire nation.[71] Ezeanochie *et al.* state that there is a growing body of evidence indicating the disparity in maternal mortality rates between the northern and southern parts of the country may be due to unequal accessibility and utilization of health services between the regions, especially in the availability of skilled birth attendants.[72] The lack of access to skilled birth attendants can be attributed to women's inability to access emergency healthcare services due to economic, cultural, political, and religious, residency reasons, and the level of education attainment of the concerned women.[73]

Access to antenatal care, giving birth at health facility and attendance by skilled health services providers during delivery, differ significantly between the northern region and southern region of the country, and by implications results in higher maternal deaths in the North compared to the South.[74] For instance, while 40% of women in the North-West receives antenatal care, the South-East zone stands at 91%.[75] Similarly, while birth in health facilities by women in the North-West is 12%, the South-East zone is 78%.[76] The percentage of skilled health services providers' attendance to women during childbirth in the North-East is 12% as against 83% in the South-Western part of the country.[77]

Moreover, the onset of the COVID-19 pandemic has exacerbated existing inequality gaps, particularly in low-income countries like Nigeria and middle-income nations. The repercussions of the pandemic have significantly disrupted the accessibility, availability,

[71] I. Etukudo & A Inyang 'Determinants of use of maternal health care services in a rural Nigerian community' (2014) 4 *Research on Humanities and Social Sciences* 55-60; SH Idris *et al*, 'Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: the client's perspective' (2013) 54 *Nigerian Medical Journal* 27.
[72] M. Ezeanochie *et al*, 'Attaining MDG 5 in Northern Nigeria: need to focus on skilled birth attendants' (2010) 14 *African Journal of Reproductive Health* 2, 9.
[73] Ujah et al., supra note 69 at 8.
[74] Nigeria Demographic & Health Survey (2013)
[75] Ibid.
[76] Ibid.
[77] Nigeria Demographic & Health Survey (2013)

affordability, and overall quality of maternal health services. This foists the imperative for strategic interventions to mitigate these adverse effects and safeguard the well-being of vulnerable populations.[78] The consequent restrictions on travels, economic activities, and free access to health facilities with limited infection prevention supplies and unreliable control practices, disrupted community health worker routines and exacerbated limited access to healthcare which further negatively impact women's health.[79] It manifests direct significant impact on reproductive health in addition to indirect consequences, on rural and economically disadvantaged pregnant women who bear disproportionately heightened health risks, particularly concerning the threat of COVID-19 infection. Thus, it informs a need for targeted interventions and support systems to mitigate the specific vulnerabilities faced by these marginalized populations and ensure equitable access to reproductive healthcare in such a challenging situation. The combination of socioeconomic disadvantages and inadequate infrastructure exposes these women to a greater likelihood of contracting the virus and experiencing adverse health outcomes.[80] The intertwined nature of these effects renders them inseparable, creating a domino effect that manifests in a decline in prenatal care visits, overburdened healthcare infrastructure, and the implementation of potentially detrimental policies in low and middle-income countries. This interconnected web requires an urgency of evidence-based policy decisions to break this cycle and fortify healthcare systems for vulnerable women.[81] The social and economic implication of this period on maternal health is huge. One of this could be a high frequency of maternal mental health, such as anxiety and depression.[82]

### 1.1.5 Relevant International and Regional Human Rights Treaties on Maternal Health

My thesis aims to unveil the discriminatory gaps pervasive in the Nigerian healthcare system, a stark contradiction to Nigeria's international legal commitments, as viewed through the lens of the affected pregnant women. This scrutiny sheds light on the urgent need for systemic

[78] Mishra *et al.,* "Health Inequalities During COVID-19 and Their Effects on Morbidity and Mortality" (2021) 13 *Journal of Healthcare Leadership* 19-26.
[79] Bambra *et al*., "The COVID-19 pandemic and health inequalities" (2020) 74:11, *Journal Epidemiology Community Health* 964-968.
[80] Kotlar *et al*., "The impact of the COVID-19 pandemic on maternal and perinatal health: a scoping review" (2021), 18:10 Reproductive Health 2.
[81] Ibid.
[82] Ibid at 12.

reforms to align the healthcare system with international standards and ensure equitable access for all. It identifies and analyzes the provisions of Convention on the Elimination of All Forms of Discrimination against Women ("CEDAW")[83] and International Covenant on Economic Social and Cultural Rights ("ICESCR"),[84] together with the related jurisprudence and interpretive comments. Although, there are different international human rights instruments dealing with the right to health and maternal mortality such as the Universal Declaration on Human Rights ("UDHR")[85] and International Covenant on Civil and Political Rights ("ICCPR")[86], the thesis focuses on the rights to health, equality and non-discrimination which are guaranteed under the 1999 Constitution of Nigeria, the ICESCR,[87] and the CEDAW.[88]

Concerning women's reproductive health, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) not only delineates discrimination against women but also situates their inferior status and oppression within the context of a society. It discerns this issue not merely as a problem of inequality between men and women but explicitly identifies it as a manifestation of discrimination based on "sex" and "gender", against women. This nuanced perspective recognizes the imperative for comprehensive measures to address and rectify the multifaceted challenges women face in the realm of reproductive health.[89] The Convention requires states to mobilise national legislative, executive and judicial powers to be exercised in accordance with the provisions of the constitution of a state. This implies that states are required to bring their national constitutions and institutional apparatus to mirror their provisions to fulfilling their obligations under the CEDAW. Significantly, the CEDAW is the only human rights treaty that acknowledges that pervasive social, cultural, and economic discrimination against women impact their reproductive rights[90]. In addition, article 12 of

[83] Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979.
[84] Adopted 16 December 1966 by United Nations General Assembly Resolution 2200A (XXI) and entered into force on the 3rd of January 1976 in accordance with article 27. Signed and ratified by Nigeria on 29 July 1993.
[85] Adopted 10 December 1948 GA Res. 217 A (III).
[86] Article 2 UDHR; Article 2(1) ICCPR; Article 2(2) ICESCR and Article 2(1) Convention on the Rights of the Child among others.
[87] Adopted 16 December 1966 by United Nations General Assembly Resolution 2200A (XXI) and entered into force on the 3rd of January 1976 in accordance with article 27. Signed and ratified by Nigeria on 29 July 1993.
[88] Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979.
[89] R Cook 'The promotion and protection of women's health through international human rights law' (1999) *Women's health and human rights* 1-3.
[90] Art. 10(a)&(h), 11, 12 and 16 CEDAW

ICESCR[91] provides for sexual and reproductive rights; article 13 (right to education), 6 and 7(right to work), article 2(2) on non-discrimination as well as associated General Comments 14, 22.

At the African regional level, the African Charter on Human and Peoples' Rights (ACHPR)[92] has been domesticated in Nigeria and provides for the right to health. Also, the Protocol on the Rights of Women in Africa[93](Maputo Protocol), which Nigeria has ratified but not domesticated, contains far-reaching provisions to advance the rights of women, particularly in relation to their health and reproductive rights. The provisions of the Maputo Protocol can be seen in many ways as a reaffirmation of the principles contained in CEDAW. It requires states to eliminate every form of discrimination against women including undertaking measures to address the social and cultural patterns that perpetuate discrimination against women and girls.[94] Furthermore, the Protocol imposes a compelling obligation on state parties to institute and enforce effective measures aimed at prohibiting and eradicating all forms of discrimination, specifically targeting detrimental practices that pose a threat to the health and overall well-being of women.[95]

Despite the global protection afforded to reproductive rights, Nigeria falls short in recognizing and upholding these rights. The ICESCR, CEDAW, and Maputo Protocol, crucial instruments highlighted earlier, remain unincorporated into domestic law. This failure to domesticate international treaties, as mandated by Section 12 of the 1999 Constitution, not only signifies a breach of Nigeria's international obligations but also constitutes a violation of the rights guaranteed to Nigerian citizens under these pivotal instruments. The urgent rectification of this situation is imperative to align national laws with international standards and ensure the protection of reproductive rights for all citizens.

In Nigeria, the Right to Health and other socio-economic rights are contained in Chapter II of the Constitution, which deals with the Fundamental Objectives and Directive Principles of

[91] Art. 6, 7, 12, 12(2)(c ) & 13 ICESCR
[92] Adopted June 27 1981 OAU DOC CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982) entered into force October 21 1986. Adopted and ratified by Nigeria on 31 August 1982 and 22 June 1998 respectively.
[93] Adopted in Maputo, Mozambique 11 July 2003.
[94] Art. 2 of the African Women's Rights Protocol.
[95] Article 2(1)(b) of the African Women's Rights Protocol

State Policy ("FODPSP")[96]. The provisions of the FODPSP are non-justiciable under the Constitution.[97] Dispelling misguided notions in certain circles that economic and social rights are merely aspirational and inherently gradual, contingent upon the availability of optimal resources, it is unequivocally established in international law that socio-economic rights encompass a dual obligation framework for the State: to both respect and protect these rights, as well as actively fulfill them. This clarifies the imperative for immediate and comprehensive action, debunking the misconception that these rights are mere aspirations subject to gradual realization contingent on resource availability.[98] The provisions of the FODPSP existing as mere aspirational objectives without constitutional enforceability, inadequately address the contemporary challenges confronting Nigeria.[99] A transformative enhancement in maternal health is contingent upon amending Chapter II provisions of the Nigerian Constitution to grant them constitutional enforceability, particularly concerning the incorporation of socio-economic rights.[100] This critical step is imperative for aligning the constitutional provisions with the pressing needs of the nation and ensuring tangible improvements in maternal health outcomes.

As a signatory to several international instruments affecting maternal mortality, the denial of pregnant women access to courts on grounds of justiciability in cases of right to health, violates the country's international obligations voluntarily entered into[101] under the principle of *pacta sunt servanda.*[102] In the fifth chapter of this thesis, I contend vehemently that the Nigerian judiciary, notwithstanding its challenges, has the essential capabilities to rigorously assess the health and socioeconomic policies implemented by the government. This assertion holds the

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[96] S Ebobrah, 'The future of economic, social and cultural rights' (2007) 1 *Review of Nigerian Law and Practice* 109 118; S. I. Nwatu, 'Legal Framework for the Protection of Socio-Economic Rights in Nigeria' (2011-2012) 10 *Nigerian Juridical Review*; CA Odinkalu 'Implementing economic, social rights' supra note 64 at 178-218; S Ibeh 'Implementing economic, social and cultural rights in Nigeria: Challenges and opportunities' (2010) 10 *African Human Rights Journal* 197, 201.

[97] Section 6(6) (c) of the 1999 Constitution of the Federal Republic of Nigeria.

[98] Malcolm Langford, "The Justiciability of Social Rights: From Practice to Theory" (2008) eds, Malcom Langford; Social Rights Jurisprudence: Emerging Trend in International Comparative Law (Cambridge University Press) 1, 5.

[99] Read, James S. 'The New Constitution of Nigeria, 1979: "Washington Model"? (1979), 23:2 *Journal of African Law*, 131-174, 135.

[100] Okonjo-Iweala, Ngozi, Reforming the Unreformable: Lessons from Nigeria, (Cambridge, Massachusetts: MIT Press, 2012), 64-65, 142.

[101] Vienna Convention on the Law of Treaties 1969, May 23, 1969, 1155 UNTS 331, art. 26.

[102] Ibid at art. 26.

judiciary to the pivotal role it can play in critically evaluating and shaping policies to address the complex and pressing issues in the realm of health and socioeconomic development. The judiciary has always been an ally of the ordinary citizen in Nigeria, but its hands "remain tied" by the impositions of limitations by the non-justiciable socioeconomic rights provisions of the Nigerian Constitution.[103] Even when treaties are domesticated in Nigeria, they are not 'immune' from the justiciability and enforcement challenges. As stated earlier, the African Charter[104] has been domesticated in Nigeria. The Charter contains provisions relating to the right to health and offers potential for litigants to evoke the provisions of the Charter in the absence of justiciable right to health under the Nigerian Constitution.

My thesis focuses on the realisation of the right to health, equality and non-discrimination as a means of giving expression to gender justice through constitutionalising the prevention of maternal deaths in Nigeria. The justification is the fundamental nature of the right to life, non-discrimination and equality under sections 33 and 42 of the Constitution and relevant international human rights instruments. It also offers an opportunity for judicial enforcement of other rights which are violated by acts of discrimination.

## 1.2 Project Overview

### 1.2.1 Theoretical Framework & Methodology

The research adopts an intersectional approach. The approach considers the treatment of women from multiple perspectives of unequal social factors, to ensure equality and justice.[105] Feminist intersectionality is "a theoretical framework for understanding how multiple social identities such as race, gender, sexual orientation, socio-economic status and disability intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression".[106] It provides a theoretical framework to the barriers that underlie health inequities. The discrimination and unequal treatment of pregnant women has the effect of denying women their autonomy and equality of treatment over the years, hence the relevance

[103] L Mamman, 'Law and Development in Nigeria: A Need for Activism,' (2011), 55:1 Journal of African Law, 59-85, 82.
[104] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, laws of the Federation 2004.
[105] Crenshaw, supra note 26 at 139.
[106] Mullings, L. & Schulz, AJ, Intersectionality and Health: An Introduction. In: Schulz, AJ.; Mullings, L., editors. Gender, Race, Class & Health: Intersectional Approaches. Jossey-Bass; San Fransisco, CA: (2006), 3-17.

of intersectionality as an approach.[107] Intersectionality reveals that different groups have specific "social locations in systems of power in the health care system," and that health inequalities are not random, but are systemic and can be produced by class, racism, gender inequality and ethnicity, when applied to health disparities.[108] In this instance, pregnant women in Africa encounter cultural and religious discrimination which affect maternal mortality outcome in every society, including Nigeria. Thus, intersectional thinking is important to understand health policies and laws as socially constructed and rooted in the workings of power, social relations, and the distribution of resources.

In addition, intersectionality can be applied to the socially and politically derived categories of regional residence and ethnicity, particularly to explain the experiences of a northern pregnant woman from those of a southern pregnant woman in Nigeria. It allows us to conceive of maternal mortality in Nigeria as a problem explicitly about power and the way in which the oppressed are deprived material resources in systematic ways across lines of gender, socioeconomic status, geography, and ethnicity.

Finally, my thesis adopts comparative methodology used by Zweigert and Kötz.[109] More specifically, I use functional comparative method. I did not engage in full comparative research which typically includes exploring a deeper understanding of comparators including empirical research; and so, my work is only a partial representation of comparative methodology. I recognize that there are limitations to using the comparative method in understanding problems in a multi religious, cultural and plural system like Nigeria.[110] There are valuable opportunities for comparison since similar experiences of women and legal structures abound between the

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[107] Ebenezer Durojaye & Satang Nabaneh 'Human rights and access to healthcare for persons with albinism in Africa' (2019) 7 *African Disability Rights Yearbook* 35-58; Charles Ngwena 'Interpreting aspects of the intersection between disability, discrimination and equality: Lessons for the Employment Equity Act: Part 1 (Defining disability)' (2005) 2 *Stellenbosch Law Report* 221.

[108] Ibid.

[109] Zweigert, Konrad and Kötz, Hein, Introduction to Comparative Law, (Oxford: Clarendon Press, 1998) (3rd ed. Translated from German by Tony Weir); Banakar, Reza and Travers, Max (eds.) Theory and Method in Socio-Legal Research, (Oxford and Portland Oregon: Hart Publishing, 2005); Langford, Malcolm (ed.) Social Rights Jurisprudence: Emerging Trends in International and Comparative Law, (Cambridge: Cambridge University Press, 2008); Jacob, Herbert *et al.* (eds.) Courts, Law, and Politics in Comparative Perspective, (New Haven and London: Yale University Press, 1996).

[110] Tushnet, Mark, 'The Possibilities of Comparative Constitutional Law,' (1999), *Yale Law Journal* 1225-1309, 1227-1228, 1307; Choudry, Sujit, 'Globalization in Search of Justification: Toward a Theory of Comparative Constitutional Interpretation,' (1998-1999) 86 *Indian Law Journal* 819-892, at 825.

comparators.[111] This comparative constitutionalism gives room for courts to engage in creative constitutional analysis which will positively impact their decisions.[112] Engaging in comparative research allows me to identify additional institutional practices and discourses in these jurisdictions that can positively influence the experiences of pregnant women in Nigeria who suffer maternal death.

In addition, the thesis adopts a doctrinal legal research methodology to analyze the constituionalisation of maternal health for the protection of women health rights in Nigeria. In principle, doctrinal legal research is characterized by a systematic analysis of law and study of legal institutions through 'legal reasoning or rational deduction.' It often involves the formulation of legal doctrines in[113] particular contexts that are in turn used to "clarify ambiguities within rules, place them in a logical and coherent structure, and describe their relationship to other rules."[114] The exposition, logical analysis[115] and interpretation of the legal rules are thus the core methods of doctrinal legal research.[116] Accordingly, this methodology is deployed to examine the constitutional provisions, statutes and policies related to maternal health and women's rights in the context of access to healthcare services in Nigeria, drawing lessons from countries with similar national legal orientation, like South Africa and India as well as the treatment of social determinants of health of these jurisdictions. The examination of the laws and policies of the legal regimes in these countries help identify the role of incorporating or otherwise of the right to health, and evaluation of social determinants in facilitating access to healthcare services for women. To this end, the research method involves reference to, interpretation and the analysis of relevant statutes, treaties, cases, national constitutions, and policy documents. The doctrinal analysis also draws on particular relevant international health treaties both due to their significance for maternal health and their

[111] Glendon, Mary Ann; Gordon, Michael W. and Osakwe, Christoper, Comparative Legal Traditions, (St. Paul, Minnesota: West Publishing Company, 1982)10.
[112] Nsongurua Udombana "Interpreting Rights Globally: Courts and Constitutional Rights in Emerging Democracy" (2005) 5:1 *African Human Rights Law Journal* 47-69.
[113] See S. N Jain, "Doctrinal and Non-Doctrinal Legal Research" (1975) 17: 4 J Indian L Inst 516 at 516.
[114] Terry Hutchinson and Nigel Duncan "Defining and Describing what we do: Doctrinal Legal Research" (2012) 17:1 *Deakin Law Review 83-119, 99-100.*
[115] Paul Chynoweth, "Legal Research," in Andrew Knight & Les Ruddock, eds, Advanced Research Methods in the Built Environment 197 (Oxford: Wiley-Blackwell, 2008) 28 at 29.
[116] See Generally Mark Van Hoecke, "Legal Doctrine: Which Method(s) for What Kind of Discipline?" in Van Hoecke, Methodologies of 198 Legal Research: Which Method for What kind of Discipline? (Oxford: Hart Publishing, 2011).

processes of transformation into the national constitution. Further, relevant secondary sources such as relevant journals, books, commentaries and electronic resources are consulted.

### 1.2.2 Significance of the study

This thesis makes a significant contribution to the field of maternal health in Nigeria by applying health laws and policies to identify critical "governance gaps" within the country's legal and healthcare frameworks, for equality and justice. Despite the state commitments to international policies and treaties, I argue that the existing legal mechanisms regulating maternal health in Nigeria are flawed and ineffective. To address the alarming rate of maternal deaths, a proper role must be accorded to the right to health within Nigeria's legal framework. While current policy focuses on regulating child marriage and engaging institutional health structures, these approaches, though effective to some extent, have limited capacity to reduce the maternal mortality rate in the country. Therefore, this research seeks to highlight the need for comprehensive and transformative approaches that address the systemic challenges faced by pregnant women, which could ultimately pave the way for improved maternal health outcomes and enhanced reproductive rights in Nigeria.[117]

I argue that incorporating right to health in a constitution can significantly contribute to social justice for pregnant women. Such incorporation directly or indirectly binds governments to provide essential healthcare services, making the constitution a powerful instrument to improve health outcomes and reduce health inequities. As the supreme law of the land, a constitution provides a solid foundation for developing and implementing health and medical laws and policies. When the right to health is constitutionally recognized, it empowers various actors, including civil society, to demand accountability from governments and individuals in positions of authority, for ensuring better monitoring and implementation of health policies. By establishing the right to health in the constitution, countries can enhance their capacity to translate health policy into actionable measures, and granting citizens the means to demand public goods and exert constraints on executive power through judicial inquiry. This research

[117] E Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism* 114; Broken promises: human rights, accountability and maternal death in Nigeria (2008) Centre for Reproductive Rights & Women Advocates Research and Documentation Centre 17.

aims to shed light on the effectiveness of constitutionalizing the right to health as a potent tool for promoting social justice and improving maternal health outcomes in Nigeria.

The thesis seeks to emphasize the need for equality in the application and interpretation of constitutional and statutory provisions to address discrimination against women and girls. By critically analyzing the formal notion of equality guaranteed by the Nigerian Constitution, which fails to address issues of prejudice and disadvantage, the thesis advocates for a shift towards substantive equality. This approach, endorsed by the CEDAW Committee, CESR, and Constitutional Courts of South Africa and India, recognizes that the right to health cannot be separated from matters of equality, particularly when interrogating maternal deaths. By elucidating the interpretation of non-discrimination provisions through treaty bodies and comparative jurisdictions, this thesis provides a guide for Nigerian courts in conceptualizing substantive equality to tackle maternal death disparities effectively.[118]

Moreso, the thesis highlights the role of domesticating and judicially applying international human rights treaties and instruments as a legal tool for improving maternal health equality at all levels of the Nigerian state. Going beyond mere formal entitlements, the approach acknowledges the importance of addressing the underlying determinants variables for health outcomes, including social, cultural, and economic conditions. By promoting a substantive equality framework, the thesis steers away from the pitfalls of formal equality and emphasizes a more comprehensive approach to addressing social inequalities related to maternal health.[119] Ultimately, this research accentuates the urgent need for rights-based approach to maternal health in Nigeria. It advocates for transformative measures that uphold the right to health and substantive equality for all women and girls, thus contributing to broader efforts towards achieving health equity and justice in the country.

I argue, based on comparative analysis, that there is a need to expand the scope of maternal health from a biomedical perspective towards a social model i.e that considers the social environment, economic, geographical, cultural factors, for effective restructuring of the health policy frameworks in Nigeria. This research contributes to the maternal health discourse

[118] Williams *supra* at 58.
[119] Williams *supra* at 57.

through such recommendations which is capable of being deployed by legislatures and policy makers in Nigeria, at all levels in the country. Recognising social factors affecting health will enhance a holistic definition and understanding of maternal health, with a view to inextricably link health with mental, economic, societal and environmental factors, differences, and inequalities.[120] Health includes all aspects of human experience including the interplay of social structures and embodied human agency.[121] This embraces the relationships between individuals and their peer groups, families, communities, schools, workplaces and broad economic, social, cultural, and physical environmental conditions at the local, national and global level.[122]

The law plays an essential role in addressing lack of intersectionality in maternal health policies in developing countries like Nigeria. One avenue for intervention lies in the constitutional recognition of the right to health and its due application by the law courts. This has the tendency for adjudication that encompass principles of universality, accessibility, acceptability, and quality healthcare services. Courts can play a crucial role by adopting a substantive equality approach in ensuring that policies consider the specific needs and experiences of diverse populations, particularly those marginalized based on intersecting identities such as gender, ethnicity, socioeconomic status, and geographical location. Moreover, international human rights instruments, such as the CEDAW and the ICESCR, provide a framework to address intersectional discrimination in maternal health. The jurisprudence of the treaty bodies further informs the understanding and application of intersectionality by examining the intersecting forms of discrimination faced by individuals and calling for comprehensive and inclusive policies.

Based on the themes and intersecting identities emerging from the literature examined, I propose an intersectional approach to addressing maternal mortality disparities in Nigeria. To have more equitable, gender-responsive, and inclusive health systems that reflect these values

[120] Atsenuwa A 'In search of transformative justice: the proselytism of legal feminism' University of Lagos Inaugural lecture series 2014.
[121] Kavanagh, M Constitutionalising health: rights, democracy and the political economy of health policy (2017) iii; Dissertation University of Pennsylvania; https://repository.upenn.edu/edissertations/2863 (accessed on 11 April 2019).
[122] Ibid.

at all levels, examinations of gender biases in health system governance, using intersectional analysis, is needed. The thesis applies intersectionality theory to health to highlight the value of addressing the complexity of power imbalance that hold true for vulnerable women across the regions of Nigeria and at all levels, especially the deeply Islamic religious Northern Nigeria. Although different forms of the theory emphasize other grounds for differences, my research finds that these theories are quite related to the Kimberly Crenshaw's that essentially emphasizes the value of economic, political and affirmative action, formal and informal structures required for the expansion of individual and collective goals. As such, this thesis affirms Crenshaw's as a stronger perspective for addressing maternal health issues in Nigeria. By using intersectionality alongside a comparative model, the thesis helps to identify, highlight ways and provide insights into how different social identities (i.e gender, class, race etc.) intersect to shape access to maternal health care. This can help to deepen our understanding of how the role of law affect health outcomes in Nigeria and the extent to which maternal health policies and programs have been successful in addressing structural inequalities and marginalization in health disparities, for improvement of services for the marginalized groups.

Moreover, the research is also significant in other respects. It advocates a role for comparative constitutional law, since the shaping of national constitutions sometimes draws from both international and comparative constitutional law. While a national constitution or its interpretation may be influenced by the provisions of supranational law and human rights treaties, there also exists, a horizontal influence on national constitutions by constitutions of other states, particularly, those with similar historical experiences and legal traditions. In this instance, I draw experience from India and South Africa in their approach of deploying intersectionality in laws and policies to address health challenges within their respective legal systems. More particularly, the emphasis is on the treatment of the right to health under constitutions, non-discrimination and application of CEDAW and ICESCR, as well as judicial approach in addressing social inequality to creative interpretation of their constitutions to enhance substantive equality.

The health inequalities which have been perpetrated and perpetuated by age-long practices and social stratification are identified, recognised and reforms proposed using Crenshaw's model of intersectionality. These inequalities have become the societal norms and deeply rooted in

the consciousness of the societies, such that even the victims themselves have come to accept them as being normal. This is the situation in Nigeria with its long history of patriarchy, which manifests in political, social, cultural, and religious practices.[123] While advocacy by the feminist movements in Nigeria has yielded some legal and policy reforms, the judiciary has contributed to the landmark records in women's struggle in Nigeria,[124] by declaring certain customs that discriminate against women on the basis of sex, unconstitutional and inequitable.[125] The study draws up recommendations, which, if effectively implemented, will contribute significantly to the reduction of preventable maternal deaths in Nigeria. These include the amendment of the Nigerian Constitution and other laws, generation of necessary political will, developing a robust policy framework, increased budgetary allocation for maternal healthcare services, eliminating gender stereotypes, to ultimately improve maternal healthcare in Nigeria.

### 1.2.3 Scope of the study

The scope of the study is defined both in terms of geographical focus as well as subject matter. In terms of geographical focus, the study focuses on promoting health equity in Nigeria. The study investigates whether Nigeria's laws and policies by their provisions, promotes quality health services, substantive equality, and non-discrimination. This directly or indirectly impacts on preventable maternal deaths, and there is a need to make appropriate recommendations about how the constitutional reform agenda may help to improve maternal mortality as they affect the southern and northern regions in the country.

This research looks at a new way of applying theoretical approaches by judicial bodies to constitutionalised principles driven by equality and justice. It is important to state that reference to human rights in this study is restricted to rights as guaranteed by the constitution and other international instruments affecting maternal health in Nigeria. Also, non-discrimination can be understood as a standing fundamental human right falling into the

[123] For a detailed study of patriarchy in Nigeria, See GA Makama, 'Patriarchy and Gender Equality in Nigeria: The Way Forward' (2013) 9 *European Scientific Journal* 17.
[124] Ezeilo, supra note 31 at 112.
[125] *Mojekwu v. Mojekwu* (1997) 7 NWLR pt. 512, (where the Court of Appeal declared a custom that allowed only male children to inherit their father's property unconstitutional), See Mojekwu v. Ejikeme (2000) 5NWLR pt. 657. These cases are discussed in Chapter Six of the thesis at 6.6.2 (infra).

framework of human rights treaties, primarily into the category of 'civil rights' and justiciable under most constitutions including Nigeria's. However, under an approach emphasizing the interdependence and indivisibility of all human rights, non-discrimination is both a human right on its own and a constitutive element of all human rights, be they civil, cultural, economic, political, or social rights.[126]

### 1.2.4 Limitations of the research

The study is selective and limited in scope. Even within the purview of equality and non-discrimination, not all factors that affect maternal mortality are considered. For instance, while unsafe abortion contributes to the high level of maternal deaths in developing countries because of restrictive laws, its analysis as a human rights issue has been subjected to in-depth analysis by other researchers.[127] This research focuses on the extent to which the socio-economic factors result in regional disparity in maternal health outcomes in Nigeria. In addition, parity, the prevalence of HIV/AIDs, the right to education, nutrition and information also affect the health of poor, uneducated and rural women. This study focuses specifically on the right to health, equality and non-discrimination. Although, several human rights may be engaged when a maternal death occurs, it does not take up all in equal measure. This study does not try to solve all the problems relating to high maternal mortality rates, but to make a positive contribution to solving the problem through addressing associated socio-cultural factors and constitutionalising the right to health.

Another limitation to this study is the fact that judicialisation as a subsection of constitutionalisation, has limitations. Access to courts for women in developing countries like Nigeria suffers under the weight of low literacy, low economic status and the subjugation of women to men as entrenched through stereotypes founded in religion, culture, and traditions.[128]. This creates a huge obstacle which the national governments must intentionally

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[126] K Krause & M Scheinin 'The Right not to be discriminated against the case of social security' in T Orlin, A Rosas & M Scheinin (eds.) *The jurisprudence of human rights law: an interpretive approach* (2000) 255.

[127] See for example, CG. Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the rights of women in Africa' (2010) 32 *Human Rights Quarterly* 783-864; CG Ngwena, 'Protocol to the rights of women in Africa: Implications for access to abortion at the regional level*'* (2010) *International Journal of Gynecology and Obstetrics* 110, 163 – 166.

[128] C Ngwena & E Durojaye 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights: an introduction' in C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 2.

address in the light of their obligations arising from the constitutions, international, regional, and national laws. This requires a sort of delicate balancing and anticipatory leadership that can manage local cultural outlook on international plane. Governments have a responsibility to implement robust policies that align with international standards, including those grounded in human rights. By making such policies, governments can ensure that social inequalities are addressed and reduced, in line with universally accepted standards.

Experts and civil society organizations wield a plethora of potent schemes, including mobilization, sensitization, empowerment, litigation, and leveraging constitutional principles alongside international human rights provisions to assertively hold the government accountable for fulfilling its dual obligation to ensure health equity for women and prevent maternal deaths. This study, nonetheless, stands as a formidable cornerstone, poised to catalyze further research endeavors to delve into the intricacies of women's reproductive health in Nigeria. Its findings lay the groundwork for an intensified pursuit of comprehensive solutions and heightened advocacy efforts to advance the well-being of women in the realm of reproductive health.

### 1.2.5 Overview of chapters

Chapter One provides a general introduction and background to the study of maternal health generally, and Nigeria in particular. It includes the statement of problem, methodology, significance, scope and limitations of the study. In this chapter, I identify appropriate mechanisms for addressing maternal mortality in Nigeria as well as clarify concepts that are relevant to the study.

Chapter Two discusses the theoretical and methodological perspectives used in this research. It explores the concept of health inequality as well as the intersection between the constitution and health. It considers feminist intersectionality as a theory for analysing the multiple social-economic and political inequalities affecting women in Nigeria. I rigorously scrutinize Kimberly Crenshaw's multifaceted typification of components of intersectionality, while delving deep into the nuanced layers that encapsulate the complex interplay of various dimensions. Furthermore, I critically analyze the approach of international treaty bodies in

addressing intersectional discrimination, dissecting the myriad forms of inequality through a lens that acknowledges the intricate intersections of identity and experience. This dual examination provides a comprehensive understanding of the degree of potentials held by intersectionality in giving a fresh perspective for addressing inequality on multiple fronts. I explore what lessons courts and policy makers in Nigeria can learn from such approach.

Chapter Three explores the theory of intersectionality and maternal health in Nigeria to see how maternal health disparities fundamentally results in systemic inequalities between the southern and northern regions in Nigeria. Systemic discrimination refers to the pervasive and ingrained patterns of inequality and prejudice that permeate various aspects of a society, leading to the consistent and disproportionate disadvantage faced by certain groups[129], including women in Nigeria. In the context of challenges facing women, including maternal health in Nigeria, systemic discrimination manifests through unequal access to healthcare services, limited reproductive rights, gender-based violence, and deep-rooted cultural norms that perpetuate gender disparities, hindering women's overall well-being and reproductive health.[130] It argues that social and economic inequality are gendered. It examines the different factors: economic, political, and health-based inequalities affecting women which result in worsening case of maternal deaths. It details the inequality and discrimination experienced by women in the southern and northern regions, regarding women's reproductive health rights. It analyses factors such as location, economy, politics, certain religious practices, and some customs that affect different women in these regions of Nigeria.

Chapter Four examines the prospects and challenges of constitutionalising the prevention of maternal death in Nigeria. I examine the status of socio-economic rights in Nigeria where socioeconomic rights are not justiciable, but are listed as fundamental objectives and directive principles of state policy under Chapter II of the 1999 Constitution of the Federal Republic of Nigeria. I examine the justiciability debate under the Nigerian constitution and argue that making the right to health constitutionally enforceable offers prospects for the Nigerian legal system and the health of women. I consider factors that make implementation of international

[129] General Recommendation 24 on the core obligations of States Parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW/C/GC/28) adopted on 16 December 2010.
[130] E Durojaye 'Substantive equality and maternal mortality in Nigeria' supra note 117 at 105.

and national laws difficult in addressing maternal health problems. This includes the spheres of intersection between gender equality and the constitution: women's political participation, the forms of equality guaranteed, the challenge of multiculturalism, division between private and public spheres, the challenges of health system governance and structural issues affecting the effective realization of maternal health in Nigeria.

In Chapter Five, I examine comparatively the role of the Indian courts in realizing health equality and the right to health. I analyze how India has ameliorated the limitations of a constitutional tradition strongly opposed to constitutionalized socioeconomic rights, using judicial activism and reading civil and political rights to realizing socio-economic rights including health. I examine the influence of military intervention on the activism of the Nigerian judiciary and its reluctance to advance right to life to enforce the government health obligations. I argue also that Nigeria can benefit from the experiences of Indian courts in its approach of placing premium on determinants of health such as education, economic empowerment, in addressing socio-cultural and health inequality and improving accountability of public governance through the subjection of government policies to a minimum threshold of scrutiny by the judicial branch.

Chapter Six engages in an analysis of the transformative constitution of South Africa which contains enforceable socioeconomic rights. It critically evaluates the interpretation of most prominent constitutionally mandated socioeconomic rights decisions of the Constitutional Court of South Africa. This includes examination of the equality and non-discrimination provisions in addressing health inequalities and disparities, which involves gender issues. I consider the different contexts and experience of Nigeria as against South Africa vis-a-vis the judicial attitude to rights, institutional, and constitutional structures. I conclude that Nigeria has positive lessons to learn from the justiciable right to health in South Africa, in improving governance and in the crafting and implementation of health policies.

The seventh and concluding chapter of this thesis integrates the comprehensive outlook on the right to health, taking into account the complex geopolitical dynamics in Nigeria and the intersecting factors of intersectionality analyzed in previous chapters. By considering these multifaceted aspects, the recommendations put forth in this chapter aim to promote the

recognition of constitutional and legal foundations for fundamental rights, including the right to life, non-discrimination, gender equality, and the right to health. The proposed measures encompass both judicial and non-judicial strategies, ensuring accountability for preventable maternal deaths through constitutional remedies and the establishment of robust accountability mechanisms. Additionally, the chapter highlights the significance of relaxing rights of standing and reforming constitutional power divisions to create a more inclusive and effective approach to maternal health policy. By embracing this comprehensive framework, Nigeria can usher in a new era of improved maternal health outcomes and safeguard the fundamental rights of women, thereby making substantial progress in reducing preventable maternal deaths.

# CHAPTER TWO

# THEORETICAL FRAMEWORK AND METHODOLOGY

## 2.0 Introduction

The gap in the risk of maternal deaths between developed and developing countries is the "greatest health divide in the world".[131] It has roots in intersectional identities which are "socially and politically defined hierarchies". The heightened risk of maternal mortality in developing countries undermines women's agency and restricts their ability to exercise reproductive autonomy. The potential for death during pregnancy poses significant barriers that impede women's decision-making power and control over their reproductive choices.[132] Several international human rights instruments characterize women's inferior status and oppression not just as a function of sex and gender discrimination against women but rather a problem of inequality between men and women, the rich and poor, urban and rural dwellers.[133] Intersectionality makes clear the needs to accommodate women's differences in a just way that ensures that they live worthy and dignified lives. Beyond the general principles enunciated in its approaches, it provides a framework for the practical application of the legal paradigm to social contexts and how they can be positively engaged.[134] The theory can be applied to the socially and politically derived categories such as residence, economic status, and ethnicity, and how they contribute to health inequalities.[135] It allows us to conceive of health inequalities as a problem explicitly about power and the way in which material resources are deprived of the oppressed in systematic ways across lines of socioeconomic status, gender, region, and ethnicity.

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[131] United Nations Children's Fund (UNICEF) (2008) The State of the World's Children Report-Maternal and Neoborn Health. New York, USA; Freedman LP, Graham WJ, Brazier E, Smith JM, Ensor T, *et al*., Practical lessons from global safe motherhood initiatives: time for a new focus on implementation. (2007) 370 *Lancet*: 1383–91.

[132] S. Fredman, "Beyond the Dichotomy of Formal and Substantive Equality: Towards a New Definition of Equal Rights", in Boerefijn, I., et al (eds.), *Temporary Special Measures: Accelerating de facto Equality of Women under Article 4(l) Convention on the Elimination of All Forms of Discrimination Against Women*, (2003), *Intersentia,* 15.

[133] L Pruitt 'Towards a feminist theory of the rural' (2007) *Utah Law Review* 438.

[134] L Weber & ME Fore. Race, Ethnicity, and Health: An Intersectional Approach. In: Vera H, Feagin JR, eds. Handbooks of the Sociology of Racial and Ethnic Relations: Springer; (2007), 191-218.

[135] Floya Anthias and Nira Yuval-Davis, "Contextualising Feminism: Gender, Ethnic and Class divisions" IN (1983) 15 *Feminist Review,* 62-75; Lesley McCall, "The Complexity of Intersectionality" (2005) 30:3, 1771-1800, 1771.

This chapter rigorously explores the application of feminist intersectional theory in the realm of maternal health to unveil the intricate web of social and structural factors impacting pregnant women's well-being. Grounded in feminist intersectionality, it contends that women in diverse social contexts face compounded discrimination, which exacerbates their challenges in accessing quality maternal health services. The chapter commences with an in-depth examination of the theory's essence, scrutinizing its application to gender disparities in accessing maternal health services. Delving into the tenets of intersectionality as elucidated by Crenshaw, it navigates the contours of the theory and probes into ongoing debates and drawbacks associated with its application in public health discourse. Furthermore, the chapter explores the relevance of national and international human-rights instruments, particularly the ICESCR and CEDAW, using intersectionality as a platform for advancing the right to healthcare for pregnant women.[136]

Incorporating an intersectional feminist approach in a legal research to appraise maternal health issue seeks to achieve three main purposes, which are: first, to describe and analyse intersectionality as a framework and a means of understanding and addressing maternal health and health inequities. Second, it helps to study the social factors affecting health for women dying from pregnancy related problems and through this application explores the utility of an intersectional approach to generate knowledge on legal solutions for policy makers and legislatures. Lastly, it shows some potential implications of using an intersectional framework in maternal health. Then, I scrutinize the regulation of maternal health, delving into the diverse socio-economic and political components within society that are detrimental and disadvantageous to women. I explore strategies for reform to rectify these issues and pave the way for a more equitable and supportive framework for maternal health.[137]

## 2.1 Understanding Feminist Intersectionality

Intersectionality makes a strong case that oppression does not just act along one axis: when a person suffers a discrimination, more often than not, they have suffered several other

[136] Cook, R. 'Human rights and maternal health: Exploring the effectiveness of Alyne Decision', (2013) 41:1, The *Journal of Law, Medicine and Ethics* 103-123.
[137] Katharine T Bartlett, "Feminist Legal Methods," (1990) 103 *Harvard Law Review* 837, 848.

discriminations by virtue of the same act.[138] These factors include gender, status, class, geographical location, and ethnicity. Intersectionality illuminates the inner workings of inequities: which are power and identity. The concept of *intersectionality* is an important analytical tool for understanding complex social realities and provides a theoretical basis for understanding the oppressive choices that underlie health inequities and discrimination that operate against pregnant women which can lead to harmful health consequences and equally prevent access to care for them.[139] Women are generally historically disadvantaged and continue to encounter challenges regarding their sexual and reproductive health.[140] Being a pregnant woman can further aggravate the situation, as these women may encounter multiple forms of discrimination in healthcare settings.

Feminist Intersectionality offers a framework for understanding how multiple social and political identities such as race, gender, sexual orientation, socio-economic status and disability, intersect at the micro level of individual experience to reflect interlocking systems of privilege and oppression i.e., racism, sexism, classism, and so on, at the macro social structural level.[141] It argues that multiple social identities combine and contribute to a systematised injustice and social inequality.[142] It exposes the danger in the assumption of a singular simplistic understanding of the nature of women's oppression and disadvantage.[143] Since its introduction, the term 'intersectionality' has become a catchphrase for gender and development initiatives, and emerges as a key theoretical framework in feminist scholarship.[144]

Intersectionality as a tool has evolved significantly over the years, and has been used in different contexts. For instance, it has been applied in research works on disability as well as

[138] Crenshaw *supra* note 26.
[139] Crenshaw *supra* note 26.
[140] The UN Fact Sheet No.23, "Harmful Traditional Practices Affecting the Health of Women and Children" (UN, 1995) 1.
[141] Bowleg, L. The problem With the Phrase women and minorities: Intersectionality—an important theoretical framework for public health. (2012) 102:7 *American Journal of Public Health*, 1267–1273.
[142] Ibid.
[143] May, V. M., Pursuing Intersectionality. Unsettling Dominant Imaginaries, Routledge, (2015) 82.
[144] Crenshaw, supra note 24.,; Crenshaw, K., "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color", *Stanford Law Review*, Vol. 43, 1991, pp. 1241–1299; Hill Collins, P., et al, "Symposium on West and Fenstermaker's 'Doing Difference'", in Fenstermaker, S. and West, C. (eds.), *Doing Gender, Doing Difference*, Routledge, 2002; and Kapur, R., "The Tragedy of Victimization Rhetoric: Resurrecting the 'Native' Subject in International Post-Colonial Feminist Legal Politics", (2002) 15 *Harvard Human Rights Journal*, 2.

employment[145], albinism[146], abortion[147], assisted reproduction,[148] and maternal health program.[149] The concept was originally coined and conceptualised by Kimberle Crenshaw, an American race scholar in her seminal work *'Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics'*.[150] In capturing the plight of black American women on the overlapping and inter-depending discrimination they face in the American system, she notes that 'boundaries of sex and race discrimination doctrine are defined respectively by white women's and black men's experiences'.[151] She argues that intersectionality responds to the lived experiences of different individuals and groups, and helps capture oppressions experience simultaneously. The treatment of the lived experiences is not generic and undifferentiated. Crenshaw explains:

> Intersectionality is what occurs when a woman from a minority group … tries to navigate the main crossing in the city … The main highway is "racism road". One cross street can be Colonialism, then Patriarchy Street … She has to deal not only with one form of oppression but with all forms, those named as road signs, which link together to make a double, triple, multiple, a many layered blanket of oppression.*[152]*

The theory opposes analytical systems that treat each oppressive factor in isolation, as if the oppression is homogenous and applies to every group or individual in similar ways. To highlight the diverse nature of discriminatory practices black women encounter, she metaphorically explains as follows:

> Consider an analogy to traffic in an intersection, coming and going in all four directions. Discrimination, like traffic through an intersection, may flow in one direction, and it may flow in another. If an accident happens in an intersection, it can be caused by cars travelling from any number of directions and,

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[145] Ngwena "Interpreting aspects of the intersection" *supra* note 107 at 221.
[146] E Durojaye & S Nabaneh "Human Rights and Access" *supra* note 107 at 221.
[147] Cook, *supra* note 89 at 105-123.
[148] Khader Serene, "Intersectionality and the Ethics of Transnational Commercial Surrogacy" (2013) 6:1 *International Journal of Feminist Approaches Bioethics* 68.
[149] Janani Suraksha Yojana (JSY). JSY is a central government scheme which aims to reduce maternal deaths by financially incentivizing women to deliver in hospitals. See. Das, A. 'The challenge of evaluating equity in health: Experiences from India's maternal health program', in S. Sridharan, K. Zhao, & A. Nakaima (eds.), *Building Capacities to Evaluate Health Inequities: Some Lessons Learned from Evaluation Experiments in China, India and Chile. New Directions for Evaluation*, (2017) 91–100.
[150] K Crenshaw 'Demarginalizing the intersection of race and sex' supra note 26 at 143.
[151] Ibid.
[152] Ibid., according to a report of the 2001 World Conference against Racism as cited in Yuval-Davis, N., "Intersectionality and Feminist Politics", (2006) 13 *European Journal of Women's Studies*, 196.

> sometimes, from all of them. Similarly, if a black woman is harmed because she is at an intersection, her injury could result from sex discrimination or race discrimination … But it is not always easy to reconstruct an accident: Sometimes the skid marks and the injuries simply indicate that they occurred simultaneously, frustrating efforts to determine which driver caused the harm.[153]

Essentially, Crenshaw questions the understanding of discrimination and calls for a reconsidering of the nature and meanings of discrimination, which hitherto perceive sex and race as mutually exclusive, thereby rendering the simultaneous experience of gendered racism almost non-existent. Instead, she argues for a more realistic definition taking cognisance of historical, systemic and structural oppression of black women. Carastathis' observation also resonates Crenshaw's idea when she notes that:

> Intersectionality has become the predominant way of conceptualising the relation between systems of oppression which construct our multiple identities and our social locations in hierarchies of power and privilege.[154] Some of the benefits of applying intersectionality include simultaneity, complexity, irreducibility and inclusivity.[155]

This theory gives theoretical legitimacy to the already established idea of multiple discrimination an individual faces. It is an interaction of multiple identities, social processes and power systems.[156] Multiple social identities converge and contribute to systematic injustice and social inequality. The problematic assumption of a single axis framework discrimination hinders black women's access to justice.

The theory has specifically caught the imagination of scholars from different disciplines including public health experts who have interest in understanding the interplay between different kinds of social inequality[157]. Over the years, a framework has been evolved to include location, education, immigration status, caste, and other identities as axes of identity which define women experiences within every local context.

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[153] K Crenshaw 'Demarginalizing the intersection of race and sex' *supra* note 26 at 149.
[154] A Carastathis 'The concept of intersectionality in feminist theory' (2014) 9 Philosophy Compass 304.
[155] Ibid at 306.
[156] Ibid at 306.
[157] Sen *et al.* 'A methodology to analyse the intersections of social inequalities in health', (2009) 10:3, *Journal of Human Development and Capabilities*, 397-415, 399.

In feminist circles, the term 'intersectional feminist' is increasingly gaining currency because ideally, feminism should incorporate the concerns of all women and what concerns all women. There have been earlier discussions on multidimensional discrimination among scholars, but Crenshaw's contribution is seminal.[158] In a speech for example, Sojourner Truth in 1976 spoke on her identity as a black female living in a classist, racist, and sexist society[159].

Addressing the societal inequalities arising from the distribution of resources and the systemic subordination of women will have the effect of challenging the extant approach adopted in Nigeria of viewing women issues as a singular and universal problem requiring merely addressing the specific problem such as health inequality, employment, etc. Therefore, there is a need to overcome the perception of singular unitary axis to health inequality enquiry. It contradicts multiple axes of discrimination affecting the health of women in reality. The assessment of health inequalities on the basis of the categorisation such as sex/gender or race/ethnicity is narrow. It yields results from a focus on a main category set as a benchmark. A model of multiple intersecting identities focuses on each individual unique experience to explore the dependence of quality healthcare needs is made on those specific intersecting identities. This can be problematic if a person has multiple identities that are traditionally prejudiced against in a healthcare system.[160] Intersectionality can make an important contribution in rectifying the negative influence of the unitary approach to health issues. This will amplify the effects of marginalization within healthcare institutions, since various identities interact and have potential to put individuals under multiple layers of oppression.[161] Consequently the solution lies in the task of unravelling the discrimination, seeing each component clearly, and combating it with aggressive policies to keep healthcare institutions accountable.[162]

[158] In 1851, a freed slave, Sojourner Truth, interrogated the intersections of race and gender in her famous 'Ain't I a Woman?' speech at the Women's Convention in Ohio, United States of America (Truth, 1851). This speech is one of the earliest recorded accounts of multidimensional discrimination.

[159] Loewenberg BJ, & Bogin R. *Black women in nineteenth-century American life: their words, their thoughts, their feelings*. University Park: Pennsylvania State University Press; (1976)

[160] Mullings, L. & Schulz, AJ. Intersectionality and Health: supra note 106 at 3.

[161] Ibid.

[162] Ibid.

Most national constitutions and international human rights instruments have conventionally relied upon a "single-axis" approach to define and enforce legal provisions prohibiting discrimination.[163] The focus of these human rights instruments and mechanisms have been on discrete, mutually exclusive grounds of discrimination[164] including the UDHR , which prohibits distinctions based on "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status."[165] The interpretations, definitions and remedies provided pursuant to these provisions in individual cases have tended to reinforce the singular notion of discrimination, which, in turn, entrenches normative and institutional fragmentation and discursive hierarchies through which experiences of discrimination are identified and redressed.[166] However, the treaty bodies of these instruments has progressively interpreted these provisions in such a manner to give effect to the reality and lived experienced of women. This thesis relies on the CESCR and CEDAW Committees' decisions. The *Alyne* case is instructive in this regard and can be helpful to Nigerian courts in deciding cases before it. Moreso, the South African and Indian courts discussed in chapter five and six of the thesis have adopted this intersectional and substantive equality approach regarding cases with women health, despite their limitations under international instruments.

Experts argue that the unique forms of discrimination that occur at the intersection between several systems of oppression should be observed using new analytical tools and remedied through specific measures that may go beyond those typically provided in cases of discrimination on a single ground.[167] Such tool for analysis must consider intra-group differences as very important as those between groups, and asserts that it is possible for individuals and groups to be simultaneously oppressed and privileged.[168]

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[163] May, V. M., '*Pursuing Intersectionality'. supra* note 143 at 82.
[164] Section 42 of the Nigerian Constitution 1999.
[165] Universal Declaration of Human Rights, GA Res 217A (III), UN Doc A/810 at 71 (1948) art. 2.
[166] See E Durojaye & S Nabaneh above note 107 citing ES Hong et al, 'Albinism in Africa as a public health issue' (2006) 2 *BMC Public Health* 212.
[167] Fredman, S., "Beyond the Dichotomy of Formal and Substantive Equality" supra note 132 at 15.; E Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism* 111; C Albertyn 'Substantive equality and transformation in South Africa' (2007) 23 *South Africa Journal on Human Rights* 257.
[168] See E Durojaye & S Nabaneh, *supra* note at note 107.

Early theories about multidimensional discrimination have a strong root and history in critical race feminism and in post-colonial studies.[169] In the early 1990s, several feminist scholars working within these different traditions advanced models of intersectionality as a counterbalance to the dominant essentialist conception of inequality that advocate the homogenous fixed groups, as categories within national and international anti-discrimination law and policies.[170] The intersectional proponents argue that individuals and groups cannot be defined by fixed, singular, unchanging attributes, but rather that identities are constantly changing, shaped and reconstructed as a result of multiple characteristics and experiences.[171]

These arguments contrast the recent discussions on the cumulative approach to discrimination on related and aggregation of different grounds. According to Andersen *et al.* "intersectional approaches differ from cumulative or multiple conceptions of discrimination which add together a number of grounds of discrimination – ethnic origin, gender, social class, disability, age – as discrete, sequential and severable identity factors".[172] It is argued that when discrimination or oppression occurs at the intersection of different factors and grounds, to produce effective results in terms of remedies, different analytical tools is required contrary to those required under discrimination laws, especially when the discrimination is based on usual single ground.[173]

Rejecting the singular notion of oppression and re-echoing the systemic nature of the oppression arising from the cumulative effect of the categories of oppression, Collins applies

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[169] See, for example, K. Crenshaw, "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color"; Kapur; Bulbeck, C., *Re-orienting western feminisms: women's diversity in a postcolonial world*, Cambridge University Press, (1998); Padilla, L. M., "Intersectionality and Positionality: Situating Women of Color in the Affirmative Action Dialogue", (1997), 66 *Fordham Law Review*, 843; Lenard Hutchinson, D., "Identity Crisis: 'Intersectionality', 'Multidimensionality', and the Development of an Adequate Theory of Subordination", (2001) 6, *Michigan Journal of Race and Law*, 285; and Grillo, T., "Anti-Essentialism and Intersectionality: Tools to Dismantle the Master's House", (1995) 10 *Berkeley Women's Law Journal*, 16.

[170] Crenshaw, *supra* note 26 at 119; Crenshaw, "Demarginalizing the Intersection of Race and Sex" supra note 26, ; Kapur; and Bulbeck, C., *Re-orienting western feminisms: women's diversity in a postcolonial world*, Cambridge University Press, (1998).

[171] Lenard Hutchinson, D., "Identity Crisis: 'Intersectionality', 'Multidimensionality', and the Development of an Adequate Theory of Subordination", (2001) *Michigan Journal of Race and Law*, 6,; and Grillo, T., "Anti-Essentialism and Intersectionality: Tools to Dismantle the Master's House", (1995) 10 *Berkeley Women's Law Journal*, 10.

[172] Andersen, M. L. & Hill Collins, P., *Race, Class and Gender: An Anthology*, Wadsworth Publishing, (2015).

[173] Fredman, S., "Beyond the Dichotomy of Formal and Substantive Equality" supra note 132 at 15, 17.

intersectionality to the black female lived experience and emphasizes that oppression is not "an additive model", the variables of gender, class, and race cannot just be summed up to arrive at a degree of oppression.[174] Rather, she argues that these categories make up "interlocking systems of oppression", component of a larger, social and historically created "structure of domination".[175] These categories cannot be easily separated from one another in terms of the overall cause and effect. Thus, intersectional theory relies on a background framework that recognizes the intricately entwined workings of both identities and power.[176]

Undoubtedly, there is a general consensus among feminist scholars and human rights practitioners on the fundamental limitations of the singular notion approach to discrimination.[177] Regarding the disagreement, the extent to which intersectional theory or methods are capable of providing adequate responses to problems and challenges resulting from the multiple experiences of inequality and oppression,[178] some scholars argue that intersectionality forms:

> [A] project of limitless scope and limited promise … It ensures that the focus of intellectual, political and legal energy is directed towards infinite elaboration of inequality subgroups, engendering a slow but steady march towards conceptual fragmentation and, ultimately, dissolution.[179]

Ehrenreich argues that intersectionality offers positive prospects in addressing a group experienced differences. However, the theory will fail to achieve its goal and likely to create the opposite of its objectives, creating "infinite regress problem" when it focuses on sub-groups identities categories, reversing the subjects of analysis with the individual remaining the standing unit, while the group disappears.[180] This approach makes it impossible to design

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[174] Hill Collins P. *Black feminist thought: knowledge, consciousness, and the politics of empowerment*. Boston: Unwin Hyman; (1990).
[175] Ibid.
[176] Hill Collins, P., "Learning From the Outsider Within: The Sociological Significance of Black Feminist Thought", (1986) 33 *Social Problems*, 2,; and Satterthwaite, M., "Crossing Borders, Claiming Rights: Using Human Rights Law to Empower Women Migrant Workers", (2005) 8 *Yale Human Rights and Development Law Journal*, 1.
[177] Ibid.
[178] Conaghan, J., "Intersectionality and the Feminist Project in Law", in Cooper, D. (ed.), *Law, Power and the Politics of Subjectivity: Intersectionality and Beyond*, Routledge Cavendish, (2008).
[179] Ibid.
[180] Ehrenreich, N., "Subordination and Symbiosis: Mechanisms of Mutual Support between Subordinating Systems", (2002), 71 *University of Missouri-Kansas City Law Review* 267.

legislative interventions, programmes and policies, strategies that would further the interests of a larger group.[181] This point of view further means that, even within a system of oppression, smaller groups can be privileged and others oppressed when juxtaposed with them.[182] This perspective offers valuable insights and strategies for effective reform of maternal discrimination even within regions in Nigeria. It encourages policy maker to recognize that the problem of oppression in Nigeria is not just a south against north problem but goes deeper to rural to urban, and to community-based oppression.

What determines the hierarchy of domination in a group is one's location within it. Also, a larger group may dominate other groups and oppresse them. This is described by some scholars as the "relativism problem". This illustrates that oppression is human inherent and challenges the several attempts at developing a normative framework on anti-discrimination and equality. Every individual could be an oppressor. This renders the framework worthless.[183] A claim of discrimination by a sub-group seeking a redress faces challenges and limits the application of intersectionality. [184] Proponents of this views argue that without a structure to measure the degree of inequality, an attempt at intersectional remedy locks individuals and groups into a cycle of "battle of oppressions". [185] In addition, they claim that intersectionality should be limited to mapping and identifying those groups that deserve greater attention in policies and laws to redress inequalities. According to Conaghan:

> [T]he primary concern of intersectionality analysis is with how law represents women's experiences. Indeed, much of the work on intersectionality can be understood as a critique of the "map" of gender inequality offered by law and legal feminism, accompanied by calls for a better representation, a richer topography of women's lives.[186]

[181] *Ibid*. at 266–267.
[182] Roseberry, L., "Multiple Discrimination" in Sargeant, M. (ed.), *Age Discrimination and Diversity: Multiple Discrimination from an Age Perspective*, Cambridge University Press, (2011) 28.
[183] Ehrenreich, "Subordination and Symbiosis" supra note 166 at 271.
[184] May, "Pursuing Intersectionality" *supra* note 143 at 82.
[185] Ehrenreich, "Subordination and Symbiosis" 180 at 269.
[186] Conaghan, J., "Intersectionality and the Feminist Project in Law", *supra* note 178 at 137.

This evaluation positions intersectional approaches to anti-discrimination as incapable of radically transforming the modes of formulation and implementation of laws and policies in Nigeria to address intersectional forms of oppression.[187]

The implications of intra-group discrimination can be significant to maternal health disparities in Nigeria since the different identities are interconnected in how they shape individual experiences and access to resources. Discriminatory practices within a group impact and define individual experiences in this context, and often aggravate it. However, examination of this is beyond the scope of this research. But it is important to highlight the need to address such in developing laws and policies to address not only the broader disparities between different groups but also the inequities that persist within these groups in a multi-cultural and religious society like Nigeria.

## 2.2 Intersectionality: Existing Debates and Criticisms

In examining the complex dynamics of maternal health using intersectionality theory as a framework, it is important to acknowledge and critically evaluate the criticism that have been raised regarding this theory. While intersectionality offers valuable insights into the intersecting dimensions of social inequality and how they shape individual's experiences, some critics argue that it may fail to capture the complexities of power dynamics within different social contexts, as it essentializes and over-simplifies it.

Nash critically examines the assumptions underlying intersectionality and identifies four major challenges that confront it. [188] Firstly, the theory lacks a definite methodology. Scholars argue that "despite the emergence of intersectionality as a major paradigm of research in women's studies and elsewhere, there has been little discussion of how to study intersectionality, that is its methodology".[189] The difficulty in using intersectionality as a research paradigm has led scholars like Davis to label the theory as a buzzword.[190] Writing about multiple forms of discrimination and differentiation without essentializing these categories of the research

[187] Tomlinson, B., "Colonizing Intersectionality: Replicating racial hierarchy in feminist academic arguments", (2013) 19 *Social Identities: Journal for the Study of Race, Nation and Culture* 254–272.
[188] Nash, J. 'Re-thinking intersectionality', (2008) 89 *Feminist Review* 1-15 at 8 at 1.
[189] McCall 'The Complexity of Intersectionality', supra note 135 at 1775-6.
[190] Davis, Kathy. "Intersectionality as Buzzword: A Sociology of Science Perspective on What Makes a Feminist Theory Successful." (2008). 9:1 *Feminist Theory* 67–85.

subject poses the greatest methodological challenge for intersectionality.[191] The difficulty in locating the relevant categories of the differences in a particular context and how to avoid essentializing fixed categories but rather engage their mutual constitution remain doubtful methodologically. [192]

Secondly, the theory focuses and relies on black and third world women as prototypical intersectional subjects. "This reliance leads to black and third world women being treated as a unitary and interchangeable monolithic entity i.e. differences between black women, including class and sexuality are obscured in the service of presenting 'black women' as a category that opposes both 'whites' and 'black' men".[193]

Thirdly, she argues that there is no clear concise and clear definition of intersectionality to allow for engagement with mutually constitutive nature of social categories and the consequent location of groups.[194] Nash argues that intersectional theory has concealed the question of whether all identities are intersectional or whether only multiple marginalized subjects have an intersectional identity, to serve as an analytical category.[195]

Finally, Nash argues that there is lack of coherence between intersectionality and lived experiences of multiple identities. Scholars emphasise the "necessity of assessing whether intersectionality accurately describes the lived experiences of identity and develop methodological tools that attend to the myriad intersections that constitute identity".[196]

Zack argues that since women are historically socially disadvantaged; "all women are intersectional subjects, precisely because of the possibility that their womanhood which exposes them and which intersects with other social positions multiply to disadvantage them".[197] This unsettled debate makes it uncertain whether intersectionality is a theory of

[191] McCall 'The Complexity of Intersectionality', supra note 135 at 1775-6.
[192] Carstensen-Egwuom "Connecting intersectionality and reflexivity: Methodological approaches to social personalities" (2014), 68:4, *Erdkunde* 265–66.
[193] Nash, 'Re-thinking intersectionality' supra note 188 at 8.
[194] Ibid.
[195] McCall 'The Complexity of Intersectionality', supra note 135 at 1775-6.
[196] Chang, R.S. & Culp, J.M. 'After intersectionality', cited in Nash 485–491, (2002) 71 University of Missouri-Kansas City Law Review 6.
[197] Zack, N. 'Inclusive Feminism: A Third Wave Theory of Women's Commonality', Lanham, MD: Rowman & Littlefield Publishers, Inc., cited in Nash, (2005),10.

marginalized subjectivity or a generalized theory of identity. Chang and Culp note that intersectionality is not limited in its theoretical framing, but extends to the depoliticization of the theory, citing Yuval-Davis on intersectionality in United Nations instruments on collapsing "identity" in the face of complex arguments.[198] Yuval-Davis states thus:

> [I]ntersectionality analysis 'does not attend to the differential positioning of power in which different identity groups can be in specific historical contexts, let alone the dynamics of power relations within these groups. Nor does it give recognition to the potentially contested nature of the boundaries of these identity groupings and the possibly contested political claims for representation of people located in the same social positioning.[199]

In recognising the challenges of bringing justice to everyone through giving due consideration to the diverse voices and complex experiences, Putnam agrees with Benhabib by stating that the ultimate goal of an interactive universalism would consist of precise enhancement of one's ability to recognise a diversity of 'least advantaged' positions and possibilities of responding to objections raised from these perspectives.[200] Listening to the voice of the marginalised through such interactive universalism, has the potential to deliver free, equitable and just society where apparent, protested and voiced injustices are addressed by applying reflective equilibrium to arrive at a balanced and adjusted principles of justice that ensures that social justice and equality are served[201]

When some feminists argue for the representation of women, they fail to acknowledge which group of women are to be represented. They universalise and substitute the experience of professional, urban middle class women for all women. [202] This universalisation of class representation masks the various forms of intersectional discrimination to which women are subject, and which also impacts on gender equality in multicultural society like Nigeria., Women suffer gender discrimination and injustices not just on the basis of biological identity of being women but also because they are poor, or Muslim, or reside in either rural or urban

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[198] Yuval-Davis, N. 'Intersectionality and Feminist Politics', (2006) 13:3 *European Journal of Women's Studies*:3 193-209 at 196.
[199] Ibid at 204.
[200] R Putnam 'Why not a feminist theory of justice' in M Nussbaum & J Glover (eds) *Women, Culture and Development* (1995) 301 at 311
[201] Ibid.
[202]Ibid at 323. .

areas. It is significant therefore to acknowledge that different individuals and groups experience discrimination differently in various respects. Socio-economic status, race, rural-urban residency among others, are the various ways in which discrimination manifests in Nigeria for example. Benhabib terms this approach the 'substitutionalist universalism' and advocates the replacement of that character with 'interactive universalism', a modern universalist political theory. Rather than substituting the experiences of 'white male adults who are propertied or professional' for the experiences of all human beings, 'interactive universalism' recognizes the multiplicity of the modes of being human and seeks to develop moral attitudes and encouraging political transformations that can yield a position that is universally acceptable.[203]

It is the legal, political, cultural, social and economic contexts which seek to perpetuate the foundation of oppression and discrimination which results in preventable maternal death in Nigeria that must be reformed to redress the existing inequalities therefrom, and promote substantive justice.

Additionally, human rights experts and practitioners have also expressed concern regarding the added-value of an intersectionality approach in connection with the issue of remedies.[204] They argue that it offers a false promise to applicants and complainants but lack definite and specific compensation that meaningfully address the root causes of inequality and power imbalances.[205] Critics maintain that implementation of intersectionality is difficult considering the several human rights instruments and differences existing in the institutional structures, their lack of capacity and coherent cross-referencing among the different human rights mechanisms.[206] These practical difficulties, according to critics, may lead to a disjointed and partial application of intersectional analysis, thereby creating inconsistencies in the interpretation by the judicial bodies,[207]and multiple approaches to discrimination.

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[203] S Benhabib 'The Generalised and concrete order' in Benhabib et al (eds) *Feminism and Critique* (1987) 81.
[204] Davis, A.N., "Intersectionality and International Law: Recognizing Complex Identities on the Global Stage", , (2015) 28 *Harvard Human Rights Journal* 205–242.
[205] May, "Pursuing Intersectionality" *supra* note 143 at 82.
[206] Davis, "Intersectionality and International Law" supra note 204.
[207] Bond, J.E., "International Intersectionality: A Theoretical and Pragmatic Exploration of Women's Human Rights Violations," (2003) 52 *Emory Law Journal*, 74.

While these criticisms of intersectionality as a tool for promoting social change are not entirely unsupported, the shortcomings identified can be surmounted and the theory can be effectively deployed to implement, monitor and guarantee substantive equality. Taken to their logical conclusion, intersectional methods of analysis demand a thorough and radical rethinking of the way human rights institutions operate. Bowleg similarly states that, despite critiques and apprehensions regarding intersectionality:

> [T]he fact cannot be dismissed that intersectionality provides a unifying language and theoretical framework for public health scholars who are already engaged in investigating intersections of race, ethnicity, gender, sexual orientation, economic status, and disability to reduce and eliminate health disparities.[208]

Yuval-Davis states that the intersectional approach provides insight for law to be more responsive to the harms resulting in women's experiences of discrimination and social inequality,[209] and can assist in adjudicating and formulating an acceptable "test" such that "concrete experiences of oppression, can be recognized as "always constructed and interlinked in other social divisions such as, gender, social class, disability status, sexuality, age, nationality, immigration status, geography, etc."[210] The arguments put forth in this thesis highlight the social, cultural and economic and legal challenges that contribute to maternal health disparities in Nigeria. Moreover, it emphasizes the importance of adopting a substantive equality approach by courts in addressing these challenges within the context of a multi-cultural, multi-ethnic and multi-religious society. By acknowledging the complexities of social identities and power dynamics, the thesis aims to avoid oversimplification or essentialization of identities, ensuring a marked understanding of the intersecting factors that contribute to maternal health disparities, Also, by examining the limitations of identity-based categories, the thesis aims to expand the scope of analysis to include relevant factors influencing maternal health outcomes. By taking these criticisms into account and incorporating a multi-dimensional and context specific understanding of intersecting inequalities, this thesis seeks to provide a comprehensive framework for addressing maternal health disparities in Nigeria, ensuring that

[208] Bowleg, L. "The problem with the phrase women and minorities: Intersectionality" supra note 97 1267–1273.
[209] Yuval-Davis, *supra* note 198 at 195.
[210] Ibid.

substantive equality approach considers the diverse needs and experiences of women within the Nigerian society.

## 2.3 Forms of Intersectionality

Although, there are several conceptions and contradictions[211] in the literature about intersectionality,[212] Crenshaw and Weber's works identify the central theoretical tenets of intersectionality which serve as a useful framework of the theory's central constructs. Weber identifies three tenets namely, contextually specific social constructions, multilevel power relations, and simultaneity.[213] Crenshaw[214] uses and explains three different forms of intersectionality to describe the discrimination, oppression, and violence that women experience: structural, political and representational.

### 2.3.1 Crenshaw's Forms of Intersectionality

Crenshaw identifies structural intersectionality which captures how the experiences of people within a particular identity group or category are qualitatively different from each other, depending on their other intersectional identities or locations.[215] She focuses on individual or group experiences of people at the intersections of multiple identities. This classification is used to describe how different structures work together in a society to produce a complex challenge which highlights the differences in the experiences of women[216]. Additionally, it entails the ways in which class, sex, and race interlock to oppress women while moulding their experiences in different arenas[217].

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[211] McCall, L. 'The Complexity of Intersectionality', supra note 135; Nash, J. 'Re-thinking intersectionality', *supra* note 188, 1-15.

[212] McCall L. *supra* note 121; McCall, L. Introduction. In: Berger, MT.; Guidroz, K., editors. The Intersectional Approach: Transforming the Academy through Race, Class & Gender. The University of North Carolina Press; Chapel Hill, NC: 2009; Hankivsky O. Women's health, men's health, and gender and health: implications of intersectionality. (2012) 74:11 *Social Science and Medicine.* 1712–1720.

[213] Kimberle Crenshaw, "Twenty Years of Critical Race Theory: Looking back to Move Forward Commentary: Critical Race Theory: A Commemoration: Lead Article" (2010) 43 *Connell Law Review* 1253.; Weber, L. Reconstructing the Landscape of Health Disparities Research: Promoting Dialogue and Collaboration between Feminist Intersectional and Biomedical Paradigms. In: Schulz, AJ.; Mullings, L., editors. Gender, Race, Class & Health. John Wiley & Sons, Inc; San Fransico, CA: (2006) 2-59.

[214] Crenshaw "Mapping the Margins" *supra* note 144 at 1259.

[215] Ibid.

[216] Crenshaw, supra note 26.

[217] Ibid.

Crenshaw's analysis of structural intersectionality is used to study battered women. In the study, she uses intersectionality to display the multi-layered oppressions that women who are victims of domestic violence face.[218] To put it into proper context, when social structures that create and organize different social groups along the lines of e.g. gender, race, etc., interact to produce effects that may not be intended by the very structure, movement of feminism from individual to groups become a critical point for identity.[219] In Nigeria for instance, the multiple needs of women across different social lines must be factored in and addressed to achieve the goal of equality and to address the disparity in the maternal death ratio. The Nigerian legal system must identify marginalized groups who are experiencing structural and systemic oppression.

Political intersectionality captures how inequalities, and their intersections are relevant to policies and political strategies of groups of people who are marginalised and occupy multiple locations and identities.[220] It reflects the movement away from the individual level of analysis, to engage multiple inequalities in theorizing about identity categories that mutually define, shape and reinforce one another[221]. Crenshaw argues that this form highlights two conflicting systems in a political arena, which separates white women and women of colour into two subordinate groups.[222] The experiences of women of colour differ from those of white women and men of colour, due to their race and gender which often intersect. She argues that although, white women suffer from gender bias, and men of colour suffer from racial bias; however both of their experiences differ from that of women of colour because women of colour experience both racial and gender bias.

Crenshaw argues that a political failure of the anti-racist and feminist discourses is the exclusion of the intersection of race and gender that places priority on the interest of "people of colour" and "women", thus suppressing one while emphasizing the other. Hence, political engagements should reflect support of women of colour; a prime example of the exclusion of

[218] Ibid.
[219] Crenshaw K. "Mapping the margins" *supra* note 144.
[220] Ibid.
[221] Crenshaw, *supra* note 26 at 1254.
[222] *Collins, Patricia Hill* "Gender, black feminism, and black political economy". (March 2000). *568:1 Annals of the American Academy of Political and Social Science 41–53.*

women of colour that shows the difference in the experiences of white women and women of colour is the women's suffrage march.[223] Through political intersectionality, Crenshaw shows political struggles of women of colour whose concerns were neither addressed by feminist movement nor by anti-racist movement. She argues that the failure of mainstream feminism to interrogate race, will often replicate and reinforce the subordination of people of colour, and their failure of anti-racism to interrogate patriarchy, means that anti-racism will frequently reproduce the subordination of women[224]. The failure of feminist struggle to capture multiple harmful cultural practices of minority groups create added layer of oppression and challenge for maternal health reforms in Nigeria.

This classification captures political, economic, judicial structures marginalization of women. It puts in place movements and interventions strategies of reform to deal with cases of marginalization in racism and sexism within a legal system. When women are marginalized by the very movements that claim them as a part of their constituency, Crenshaw refers to such discrimination as a critical form of political intersectionality. This oppression occurs when political movements working towards justice for different groups such as feminism and anti-racism, interact to exclude or marginalize the interest of some subset of the groups, or reinforce another form of injustice. Political intersectionality in a practical sense is the lack of policies to address the differential suffering of intra-groups, on geopolitical basis such as rural or urban dichotomy of the southern and northern Nigeria.

Representational intersectionality advocates for the creation of perception of representational imagery that is supportive of women. It argues that women should be present in both symbols and actual representation. This form of the theory condemns sexist and racist marginalization of women of colour in representation. It highlights the rejection of their representation which ignores and distorts the complexity of the group, especially in contemporary settings. In the context of reproductive rights, representational intersectionality may encompass the capacity for women to get involved in the making of laws and policies affecting maternal and reproductive rights. The imperative for women's active participation in law and policy making

[223] Hill Collins P. "Black feminist thought: knowledge, consciousness, and the politics of empowerment". Boston: Unwin Hyman; (1990), 277.
[224] Crenshaw *supra* note 144 at 1252.

is crucial to ensure adequate representation that aligns with the principles of intersectionality that highlight Crenshaw's ideals.[225] I argue that there is a combination of structures in a society that produce unjust systems for women.

Understanding the theory is a vital element of gaining political and social equality and improving a democratic system.[226] By integrating intersectionality into a democratic electoral reform, Nigeria can address the underrepresentation of marginalized communities in political decision-making processes.[227] This reform would involve measures such as gender quotas, reserved seats for minority groups, and affirmative action to ensure greater inclusion of women, ethnic minorities, religious minorities, and other marginalized groups in elected positions. By acknowledging and dismantling systemic barriers to political participation, intersectional democratic electoral reform can create a more level playing field, giving marginalized individuals a better chance to compete for and hold public office.[228] Moreover, incorporating intersectionality into electoral reform would lead to policies that are more responsive to the needs and interests of diverse constituencies in Nigeria. By considering the different perspectives and experiences of various social groups, elected officials can craft legislations and policies that address the complex and varied challenges faced by their constituents.[229] This approach fosters a more representative democracy that reflects the diverse demographics of the country and ensures that the voices of all citizens are heard and accounted for in the decision-making process. Without doubt, an increased participation and representation of women in the political process has invariably led to the adoption of laws and policies that promote gender equality and eliminate discrimination, support of affirmative action, and curbing violence against women even in African countries such as Senegal, South Africa, Mozambique, Uganda and Angola, where there is a high level of women's representation in parliament. In a democratic system, the requirements or political

[225] Ibid.

[226] Patil, Vrushali "From Patriarchy to Intersectionality: A Transnational Feminist Assessment of How Far We've Really Come". (2013) 38:4 *Signs: Journal of Women in Culture and Society* 847–867.

[227] Palacios, Jone Martinez Equality and Diversity in Democracy: How Can We Democratize Inclusively?. Equality, Diversity and Inclusion: An International Journal, (2016) 35:5/6, 350-63; Christine M. Slaughter and Nadia E. Brown, Intersectionality and Political Participation (July 2022).

[228] Patricia Hill Collins The Difference That Power Makes: Intersectionality and Participatory Democracy (2017) (Rev.) (2017) 8:1 *Investig. Fem* 19-39.

[229] D'Avigdor, Lewis Participatory Democracy and New Left Student Movements: The University of Sydney, 1973-1979. (2015) 61:2 *Australian Journal of Politics and History* 233-47.

representation, affirmative action, and quota system in the representation of women in legislative, executive and judicial arms of government represent a practical application of this approach.

Political participation is a major spot for inequality against women, such representation extends to institutions of the states including the process for constitutional drafting and amendment, to ensure women have significant role to play in moulding legal structures and institutions of the state. For substantive issues like health and/or gender discrimination to come to the front burner in national debates and adequate attention in Nigeria, women must have adequate representation in the constitution making process.[230] This will provide an avenue to advocate for gender inequality and participation in the running of the state's affairs including making of effective policies to address issues that concern women only. [231] The historical evolution of the political process both in developed and developing countries has witnessed male domination and women's disenfranchisement.[232] The introduction of gender quotas in constitution writing reflects the application of affirmative action principles aimed at redressing structural discrimination and inequality, over a period of time.[233] The quota requirements and affirmative action remain illusory in Nigeria despite the ,development in some African countries.[234] Although the exact role of affirmative action policies and plans in the creation and continuation of social change remains controversial,[235] its application often gives rise to substantive equality as against formal equality.[236]

### 2.3.2 Weber Constructs on Intersectionality

Although, I focus on Crenshaw's template of Intersectionality, Weber's construct offers a critical and complementary exposition in explaining the focus of the theory regarding differences resulting in systemic inequality. Both Crenshaw and Weber approaches share a

[230] SH Williams 'Introduction: Comparative constitutional law, gender equality and constitutional design' in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 20.
[231] B Baines & R Rubio-Marin 'Towards a feminist constitutional agenda' in B Baines & R Rubio-Marin (eds) *The gender of constitutional jurisprudence* (2005) 7.
[232] Ibid.
[233] Ibid.
[234] The requirements of gender quota and affirmative action are extensively discussed as challenges to realization of effective constitutionalisation in chapter four of the thesis.
[235] S. Clayton & F Crosby *Justice, gender and affirmative action* (1992) 11.
[236] Ibid.

commitment to understanding the ways in which multiple forms of oppression intersect and create unique experiences of inequality.[237] Both emphasize the need for a structural analysis of power and the importance of recognizing the agency of marginalized groups in creating social change. Weber's works also identify some theoretical tenets of intersectionality which serve as a useful framework of the approach's central construct: contextually specific social constructions, multilevel power relations, and simultaneity.[238] According to Weber, race, class, gender and sexuality are social systems that perpetuate inequality in a society and are historically and geographically contextual relations that are simultaneously expressed and experienced at both macro level of social institutions and the micro level of individual lives and small groups.[239]

### 2.3.3 Contextual Social Construct

Weber argues that social positions are relational and that the relationship between different subjects in a society shapes everyday social life.[240] Hence, situating the formation of these subjective creations of identities in everyday experiences enables an examination of the multiple ways the different social categories are organized and ordered.[241] Weber describes the broad social categories such as race, gender, and class, along with more specific social categories such as motherhood,[242] as socially constructed, fluid, flexible, and contextually grounded in history, culture[243] and geographical location.[244] He explores social relationships marked by a power differential in which one group is subordinate and another is dominant, as well as how those relationships persist.[245]

Understanding intersectional discrimination in this manner offers a unique description of how historically, cultural, regional and criminal laws within the Nigerian legal system are structured

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[237] Grillo, T., "Anti-Essentialism and Intersectionality: Tools to Dismantle the Master's House", (1995) 10 Berkeley Women's Law Journal 2.
[238] Weber L & Fore ME. Race, Ethnicity, and Health: An Intersectional Approach. In: Vera H, Feagin JR, eds. *Handbooks of the Sociology of Racial and Ethnic Relations*: Springer; (2007), 191-218.
[239] Ibid at 192, 193.
[240] Weber L Understanding Race, Class, Gender, and Sexuality: A Conceptual Framework. New York: McGraw-Hill (2001), 2.
[241] Ibid at 4.
[242] Ibid at 4, 5; Collins, PH. Shifting the Center: Race, Class and Feminist Theorizing about Motherhood. In: O'Reilly, A., editor. Maternal Theory: Essential Readings. Demeter Press; Toronto, CA: (1994), 311-330.
[243] Ibid. Hankivsky O. "Women's health, men's health" supra note 170 1712–1720.
[244] Weber L Understanding Race, Class, Gender" supra note 240 at 2.
[245] Weber, L. "Reconstructing the Landscape of Health" supra note 213 at 2-59

to disadvantage women in different social locations and communities.[246] For instance, social constructions of race are not based on the assumption that discrete biological races exist, rather they are concerned with how race is constructed by historical conditions which lead to inequity, based on hierarchies and systems of oppression.[247]

In the case of motherhood as a social construction, it is assumed to be a universal phenomenon with a single objective definition of mothering. Rather, mothering is a relationship in which a person's actions to nurture and care for another is based on a historical and cultural context.[248] In support of Weber, Collins' theorizing about motherhood explicitly challenges universalism, acknowledges inherent diversity in conception of motherhood, and suggests a shift to a concept that accommodates the diversity of race, ethnicity, and social class.[249] Collins' work on motherhood is firmly grounded in an intersectional approach.[250] She argues that, there is no one meaning of motherhood, manhood, womanhood or the likes; they are deeply embedded in the social context from which they arise.[251]

Motherhood as a social construct rejects the general assumption that it is naturally biological. Depending on the relevant society, there are factors responsible for this notion within the constraint of different perceptions. [252] There exists a societal expectation that women are designed to give birth and have children to attain the "Woman" or "Mother figure" or completeness, or a rite of passage largely through the prism of men or husbands[253]. These views by implications argue that women can only have control over their identity and exert power through "motherhood". Discourse on motherhood is often generalized. Women who do experience or have contrary position are regarded as deviant and abnormal[254]. Recent trends in motherhood construction such as lone parenting, lesbian mothers, LGBTQ, and other

[246] CR Guglielmino et al, "Cultural Variation in Africa: Role of Mechanisms of Transmission and Adaptation" (1995) 92 *Proc. Natl. Acad. Sci.* 7585.
[247] Weber *et al,* "Race, Ethnicity, and Health" *supra* note 134 at 191-218.
[248] Ibid at 200.
[249] Collins, *supra* note 242 at 371-372.
[250] Collins, *supra* note 242 at 378.
[251] Collins, *supra* note 242 at 381.
[252] Karin Sardadvar "Social Construction of Motherhood" Encyclopedia of Motherhood edn. Andrea O'Reilly
[253] Collins, Patricia "Learning From the Outsider Within: The Sociological Significance of Black Feminist Thought", (1986) 33: 6, *Social Problems* S14-S32.
[254] See BA Oladele, "Yoruba Understanding of Authentic Motherhood" in Toyin Falola & Sati Umaru Fwatshak, eds, Beyond Tradition: African Women and Cultural Spaces (Trenton: Africa World Press, 2011).

mothering situations which fall outside the traditional definition of motherhood, have further complicated the process of role definition.[255] Arendell refers to these developing trends in motherhood as the deviant discourses of mothering,[256] and suggests that these groups of women are often subject of extreme forms of mother blaming, including responsibility for devaluing conventional fabric of the society. However, this may devalue the concept of motherhood because of social compulsion of race, class, gender, sexual identity, and so on.[257]

Several factors influence and reinforce the idea of the societal perception of motherhood in Nigeria. Culture, tradition and religion influence these perceptions and reinforce traditional gender roles which limit the steps towards gender equality. The fertility level in Nigeria is inextricably tied to traditional customs that emphasize the importance of children in the continuation of an extended family.[258] In most Nigerian culture and traditions, women are deemed to be the baby-makers, the ones who produce the next generation. The status of a Nigerian woman in a family and community is positively correlated to the number of children she bears, especially if they are of male gender.[259] Hence, a woman's power assessment is based on her ability to give birth as well as the number of children she bears for her husband. The practices are almost pervasive throughout the entire Nigerian society and exposes majority of women to reproductive health risks in the country.[260]Active participation of women surrounds perpetuation of the prevalent inequitable cultural and religious norms.[261] As such, it limits the capacity of a state to legislate and reform these relations, and particularly the fact that women within this cultural setting work directly and indirectly to sustain these practices.[262]

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[255] P. Collins, "Shifting the Center: Race, Class, and Feminist Theorizing about Motherhood" in Evelyn Nakano Glenn, Grace Chang & Linda Rennie Forcey, (eds.), Mothering: Ideology, Experience, Agency (London: Routledge, 2016) at 58.

[256] Arendell, T. "Conceiving and investigating motherhood: The decades of scholarship". (2000) 62 *Journal of Marriage and Family,* 1192-1207, 1192.

[257] Thurer, Shari "The Myths of Motherhood: How Culture Reinvents the Good Mother". London: Penguin Books Ltd. (1995).

[258] Oladele, *surpa* note 254 at 196.

[259] Upadhyay UD and Robey B. "Why Family Planning Matters". Population Reports (1999) Series J 49 Baltimore, Johns Hopkins University School of Public Health, Population Information Programme.

[260] Oladele, *surpa* note 254 at 196.

[261] Ndulo Muna "African Customary Law, Customs and Women's Rights" (2011) 18:1 *Indiana Journal of Global Legal Studies* 88; December Green, Gender Violence in Africa: African Women's Responses (St Martin's Press: 1999) 105.

[262] A. Diduck, "Legislating Ideologies of Motherhood" (1993) 2:4 *Social & Legal Studies* 461 at 467.

### 2.3.4 Persistent Power Relations

Intersectional thinking is valuable to understand health as rooted in the workings of power. Weber argues that race, social class, gender, and sexuality are all social systems and that, while they change over time and across cultures, persist to preserve the privilege of some groups over that of others.[263] These concepts, he argues, are used by some societal groups to sustain their power and social control.[264] Intersectional feminists argue that race, class, gender, and sexuality are systems of oppression with which a historically dominant group gains power, exerts superiority and control over the resources and institutions of the society.[265] Such group maintains the power to exploit, resulting in unequal and unfair distribution of resources against the oppressed, minority or other groups in the society, thereby creating power relations. [266] They argue that while race, class and sexuality and other intersecting factors change in time and space, these categories show resilience and persist over time, leading to the belief that the grounds are immutable. [267] The explanation for such resilience is that there are intersecting systems of power relationships. Macro-level power differentials manifest structurally in the form of policies, rules, or laws benefiting only certain groups; while micro level power differentials present in individual relationships in which one individual exerts power over another.[268]

For example, the majority of laws and policies seeking to address women's health in Nigeria are set by men, elite women, middle class and urban dwellers. The location of such advantages and benefits in the Nigerian system is in the urban areas like Lagos, Abuja and Port Harcourt. This is the residence of the educated and economically privileged. The rationale for this situation justifies the unequal treatment that some women in remote states of the North and South experience when they are outside such states. Hence, the primary purpose of intersectionality is to deepen the understanding of the intersections of region, gender, status, class, to demonstrate how to analyse these intersections in time and place, to look beyond the visible dimensions of social inequality and reveal how subtle power dynamics are

[263] Weber L, "Understanding Race, Class, Gender, and Sexuality" supra note 240.
[264] Ibid at 10.
[265] Weber, L. "Reconstructing the Landscape of Health" *supra* note 213 at 2-5.
[266] Ibid at 10.
[267] Ibid at 10.
[268] Ibid at 10.

systematically embedded in structures and mechanisms to maintain oppression in the fabrics of the country.

Lastly, Weber states that socially constructed differences are multiplicative.[269] The constructs exist simultaneously and vary as a function of one another depending on the social locations to which an individual belongs.[270] Similar to the approach adopted by discrimination laws and human rights instruments, Weber's social construct operates on multi-layer model, beyond a single-axis analysis denying homogeneity to a multi-axis analysis which embeds heterogeneity.[271] Possessing multiple identities which are equally oppressive and marginalizing have effects that are not of necessity additive, or even multiplicative. Rather, these identities interact in diverse and complex ways. "Mutually constituted" describes the ability of the constructs to vary as a function of one another in creating a specific social location for individuals.[272] Thus, an individual's social location based on mutually constituted social inequities is an important concept in intersectionality. Specifically, the gender of the different identities may operate to produce different health outcomes.[273]

For instance, the inequality that women experience with respect to maternal health operates in multiple ways and collectively to disadvantage pregnant women. A poor pregnant woman in the South-western Nigeria experiences discrimination based on her gender, and ethnicity, religion, class and urban location but a poor pregnant woman in Northern Nigeria suffers from multiple dimensions of discrimination based on her gender, class, ethnicity, and region. The combined implication of these different factors affects women individually and generally. Thus, a pregnant woman in Nigeria may face different challenges depending on whether she resides in the "urban region" or being "poor". There must be specifics such as gender, class, ethnicity and region, to understand a woman's chances of surviving a pregnancy.[274]

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[269] Weber, L., & Parra-Medina, D. Intersectionality and women's health: Charting a path to eliminating health disparities. In V. Demos, & M. T. Segal (Eds.) Advances in gender research: Gender perspectives on health and medicine (2003)181–230. Mullings, L. & Schulz, AJ. Intersectionality and Health supra note 106 at 17

[270]. Ibid at 3, 4.

[271] Kelly UA. "Integrating intersectionality and biomedicine in health disparities research", (2009) 32:2, Advances *in Nursing Science* E42–56.

[272] Weber, L., & Parra-Medina, D. "Intersectionality and women's health" *supra* note 269.

[273] Ibid at 18.

[274] Narayan D., Voices of the poor June (2001)13:1, *African Development Review-Revue Africaine DeDeveloppement* 173.

## 2.4 Health Inequalities and Maternal Health Policies

Intersectionality theory provides a critical lens to understand and address health inequalities, including maternal health disparities, as it acknowledges the impact of various social characteristics such as wealth, education, race, gender, and social conditions on access to quality healthcare experiences and overall health outcomes.[275] Health inequalities, health inequities, and health disparities variously refer to differences in a span of life, and the quality of health care experiences.[276] Health experts define health inequalities as "health disparities between population groups defined by social characteristics such as wealth, education, occupation, racial or ethnic group, sex, rural or urban residence, and social conditions".[277] On the other hand, health equity is the "absence of systematic disparities in health between social groups who have different positions in a social hierarchy".[278] The principle of distributive justice[279] determines the concept of "equity". Whitehead argues that when health inequalities are "unnecessary, avoidable, or unfair," they are health inequities.[280] When the design of health policies are without equity as foundational principle and adequate consideration for the different interests of different groups, it results in unfair advantage to some individuals and groups. It is also capable of perpetrating systemic discrimination.

Systematic maternal health disparities in a society[281] are avoidable health inequities because they are about choices, political and social, and distribution of power, politics and material resources. These inequities are a result of uneven distribution of the social determinants of health. Daniels *et al.,* cite four central findings from the literature on social determinants of health in support of the claim that inequities are about choices.[282] First, they argue that social

[275] Whitehead M. The concepts and principles of equity and health. (1992) 22:3, International Journal of Health Services 429-445.
[276] Weber *et al.* "Racial and Ethnic Health Inequities: An Intersectional Approach (2018) Handbook of Sociology of Racial and Ethnic Relations 134-136.
[277] Braveman P, Starfield B, Geiger HJ. World Health Report 2000: how it removes equity from the agenda for public health monitoring and policy. (2001), BMJ. 323.
[278] Braveman P & Gruskin S. Defining equity in health. (2003), 57:4, *Journal of Epidemiology & Community Health.* 254-258.
[279] Whitehead M. The concepts and principles of equity and health. (1992), 22:3, *International Journal of Health Services* 429-445.
[280] Ibid at 445-6.
[281] Ibid.
[282] Daniels N, Kennedy BP, Kawachi I., Why justice is good for our health: The social determinants of health inequalities. (1999), 128:4, *Daedalus.* 215-251.

and health policies by policymakers[283] influence income-health differences. Secondly, the level of inequality in every society [284]influence income-health gradient. Third, relative socioeconomic status is as important as or even more important than absolute income in predicting health status, once a society has reached a certain threshold.[285] Lastly, policy choices[286]affect inequality.

Studies that analyse the intersectionality of health policies, programmes and practices seek to establish models for the formulation and implementation of public health policies, primarily directed at marginalized groups.[287] Hankivsky *et al*.[288] propose a model for critical intersectional analysis in the formulation and implementation of health programs and policies, and strongly call for public health laws and policies to move towards the incorporation of intersectionality, given its inherent potential to support empirical studies and formulate health policies committed to social justice in the face of growing health inequalities globally.[289]

## 2.5 Intersectionality and Maternal Health in Nigeria

The application of an intersectional approach to maternal health and reproductive rights in Nigeria necessitates a deliberate exploration of how various social identities and geographical locations construct the experiences surrounding maternal health. The recognition of the complex interplay of these factors within the Nigerian legal system becomes crucial to examining reproductive rights in the light of their diverse, contradictory, and contested entitlements and burdens. This approach seeks to address the nuanced differences and disparities in access to quality maternal healthcare to ground a reproductive freedom in a context of intersecting social identities. The adoption of such an intersectional view can help develop a comprehensive understanding of the challenges faced by individuals across different social contexts, which enables the formulation of inclusive policies that promote equitable

[283] Ibid.
[284] Ibid.
[285] Ibid.
[286] Ibid.
[287] Williams *et al.* "Integrating multiple social statuses in health disparities research: the case of lung cancer".. (2012) 47:3, *Health Services Research*1255-1277; Hankivsky *et al.* An intersectionality-based policy analysis framework: Critical reflections on a methodology for advancing equity, (2014) 13: *International Journal for Equity in Health*. 119.
[288] Hankivsky *et al. supra* note 287 at 119.
[289] Bauer, G. R. "Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity". (2014) 110, *Social Science & Medicine* 10–17.

maternal health outcomes and reproductive autonomy for all. [290] Situating pregnant women in a gendered, racialized, and class-based hierarchies of power in Nigeria reveals the broader contexts of the women's psychological and physical individual experiences.[291] The government's inadequate allocation and distribution of resources, coupled with a lack of support for vulnerable communities in Nigeria, contribute to an overwhelming disparity in access to essential resources. Even when resources are allocated, the transparency of their distribution is limited, and the application of regulations is often imbalance and unclear.[292] In addition, there is exclusion of women in the decision-making process in the country especially in the Northern Nigeria, where women are generally restricted from participating in politics based on the Islamic doctrine which is dominant in the region[293]. The Maliki Islamic school of thought dominates the interpretation of Islamic laws in Northern Nigeria, with some influence extending to certain southern regions.[294] This interpretation has significant implications for women's reproductive rights claims in Nigeria. As customary law, including Islamic law, is legally enforceable in Nigeria, the Maliki school restrictions on women's rights may result in limited access to reproductive healthcare, limited reproductive choices, and lack of protection against harmful traditional practices in these regions.[295] Additionally, the Supreme Court of Nigeria's recognition of Muslim law as customary law further solidifies the application of the Maliki School's interpretation, potentially reinforcing gender-based inequalities and restricting women's autonomy over their reproductive health and choices.[296]Thus, the processes of developing and setting priorities for the intervention for maternal health[297] exclude women generally and they do not have adequate representation.

Understanding the ways in which inequality affects health status is important for achieving goals set by domestic governments and international agencies to alleviate the maternal health

[290] E Durojaye & S Nabaneh "Human rights and access to healthcare" *supra* note 107 at 35-58.
[291] Ibid.
[292] Obiajulu Nnamuchi, 'Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria' (2008*) 52:1 Journal of African Law,* 4.
[293] JN Ezeilo, *supra* note 31 at112.
[294] See Derek Asiedu-Akrofi, "Judicial Recognition and Adoption of Customary Law in Nigeria" (1989) 37:3 *The American Journal of Comparative Law* at 572.
[295] See AO Obilade, The Nigerian legal system (Ibadan: Spectrum Law Publishing, 1990).
[296] See Kharie Zaidan v Mohsse [1973] 1 ALL N.L.R. [Pt. 11] (S.C. Nigeria) at 86; Asifa Quraishi, "What if Sharia weren't the Enemy: Rethinking International Women's Rights Advocacy on Islamic Law" (2011) 22:1 Colum J Gender & L at 179.
[297] Ezeilo, *supra* note 31 at 1120,113.

challenges women face in different communities, both in the Southern and Northern regions of the country. A comprehensive reform of laws and policies that address girls and women's economic empowerment, affirmation actions by the state, cultural and religious barriers affecting girls and women, have the potential to improve the health services outcome and create positive effect on maternal experiences in Nigeria.[298]

As against women who face generalized discrimination, pregnant women occupy diverse positions within economic, social, and political realms. Reform efforts that overlook or inadequately address these distinct points of intervention are less likely to meet their specific needs.[299] Uniform standard approach to maternal health needs of women in the country ignore the fact that women depending on their status have different needs and often demand different priorities in terms of resources allocation, and failing to recognise this can hinder the ability of laws and policy initiatives to achieve their intended purposes. This only leads to health injustice. Thus, when a group is economically, religiously, and culturally marginalized within a dominant group in a society, policies must target them specifically. The fact that poor, rural women in Northern Nigeria suffer from the effects of multiple subordination with institutional expectations based on inappropriate non-intersectional contexts, shapes and ultimately limits the opportunities for meaningful interventions on their behalf. Maternal health policies in developing countries often fail. This is due to their lack of an intersectional approach. It does not adequately address the complex and intersecting factors that contribute to maternal health disparities among the diverse populations.

Majority of the differences in the health outcomes of pregnant women can simply explain wide variant patterns of access to health services. In Nigeria, some urban women tend to be socio-economically disadvantaged as well. Therefore, while location and gender are relevant intersecting identities, the determinative points are socio-economic status. Women who can afford high quality private health insurance have better access to medical services than women who have no health insurance or have to rely on public health systems or general private healthcare in the country, especially in the urban centres. It explains differences in health

[298] Dhamoon RK, Considerations on mainstreaming intersectionality. (2011) 64:1, *Political Research Quarterly* 230-243.
[299] Crenshaw "Mappings the margins" supra note 144, 1241–1299.

outcomes.[300] This supports the conclusion of public health research which is unequivocal in its claim that maternal death can best be prevented by better medical care and availability of medical equipment which are generally available in urban centres at the time of deliveries.[301]

Moreover, a poor pregnant woman, who is economically disadvantaged is likely to face discrimination based on her pregnant status for employment purposes. This can further put her pregnancy at risk. There should be a daily inclusive treatment of experiences and not exclusive of dealing with discrimination. This is consistent with the idea of structural intersectionality, which seeks to 'render visible phenomenological experiences of people who face multiple forms of oppression without fragmenting those experiences through categorical exclusion'.[302] Intersectionality resonates perfectly with the lived experiences of women in general and pregnant women in particular.

The role of law is essential in addressing the lack of intersectionality in maternal health policies in developing countries like Nigeria. One avenue for intervention lies in the constitutional recognition of the right to health and its due application by the law courts. This has the tendency for adjudication that encompass principles of universality, accessibility, acceptability, and quality healthcare services. Courts can play a crucial role by adopting a substantive equality approach in ensuring that policies consider the specific needs and experiences of diverse populations, particularly those marginalized based on intersecting identities such as gender, ethnicity, socioeconomic status, and geographic location. Moreover, international human rights instruments, such as the CEDAW and the ICESCR, provide a framework to address intersectional discrimination in maternal health. The jurisprudence of treaty bodies further informs the understanding and application of intersectionality by examining the intersecting forms of discrimination faced by individuals and calling for comprehensive and inclusive policies. In the next section of this thesis, I delve into the role of international human rights treaties in addressing the complex dynamics of intersecting identities and their impact on maternal health outcomes.

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[300] Peter Berman & Laura Rose "The role of private providers in maternal and child health and family planning services in developing countries" (Oxford University Press, 1996)11:2, *Health Policy and Planning* 142-155.
[301] Alicia Yamin and Deborah Maine "Maternal Mortality as a Human Rights Issue: Measuring Compliance with International Treaty Obligations" (1999) 21:3 Human Rights Quarterly, 563-607.
[302] A Carastathis 'The concept of intersectionality in feminist theory' *supra* note 154 at 305-6.

## 2.6 International Human Rights and Women Intersecting Identities

As stated earlier, international human rights monitoring mechanisms have traditionally relied upon a "single-axis" approach to enforce legal provisions prohibiting discrimination.[303] The CEDAW and the ICESCR[304] are two major international instruments examined in this section to reflect the approach of international human rights instruments and treaty bodies to intersectional discrimination. The approaches of the CEDAW and ICESCR to intersectional discrimination are of immense significance in addressing maternal mortality regulation in Nigeria. These treaties recognize the interconnectedness of different forms of discrimination and advocate for the protection of women's rights, including reproductive health and maternal healthcare. Despite the lack of domestication of these treaties in Nigeria, their relevance lies in their normative guidance and the potential for advocacy, to influence policy-making, and hold the government accountable in addressing the intersecting factors that contribute to maternal mortality disparities. Although, none of the instruments expressly mention intersectionality, the Committee ot CEDAW recognizes these forms of discrimination when it states that: Non-discrimination is a core human-rights principle that is enshrined in different human-rights treaties.[305] Article 1 of the CEDAW,[306] adopts a comprehensive and encompassing definition of discrimination especially at it relates to women. It defines discrimination as:

> Any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[307]

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[303] May, V. M., "Pursuing Intersectionality" *supra* note 143 *at* 82.
[304] Ibid.
[305] Art. 2 International Covenant on Civil and Political Rights; art 2 International Covenant on Economic, Social and Cultural Rights; art 2 Convention on the Rights of the Child; art 7 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families; art5 5 Convention on the Rights of Persons with Disabilities. The Convention on the Elimination of All Forms of Racial Discrimination prohibits discrimination on the ground of race and the Convention on the Elimination of All Forms of Discrimination against Women on the ground of gender.
[306] Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) GA Res 54/180 UN GAOR 34th session Supp 46 UN Doc A/34/46 1980.
[307] CEDAW *supra* note 83 at art. 1.

The provision of the article protects two forms of identity or grounds: i.e. sex and marital status: 'the term "discrimination against women" means any distinction made on the *basis of sex* which has the effect or purpose of impairing...the recognition by women, *irrespective of their marital status,* on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field'.

Although CEDAW has no specific definition for "sex" or "women", a comprehensive reading of the provisions as well as interpretive comments indicates that it contemplates sex-based discrimination[308]. To feminist scholars, sex only refers to the biological differences between men and women, while gender 'refers to socially constructed identities, characteristics and assigned roles for women and men, and society's social and cultural meaning for these biological differences in hierarchical relationships between women and men in the distribution of power and rights that privileges men to the disadvantage women'.[309] It has been argued that the definition by CEDAW aims at achieving substantive equality and not merely formal equality.[310] Its aim captures the historical differences and the different grounds that are subject of injustices that women face.

There are other identity grounds that are specifically protected in CEDAW. Article 4(2) and article 11(2) offer specific protection to women based on pregnancy and motherhood. Article 14 protects rural women and guarantees them the right to participate and benefit from rural development and access to health care, transportation, housing, social security, water, and sanitation. In addition, article 7 of the Convention provides for the right to participate in public life and political decision-making.

The effective implementation of this right would mean effective representation and involvement of women in designing and implementing national health policies and programmes in several communities in Nigeria. This will obviously lead to improvements in women's maternal health. In addition, the CEDAW Committee in its recent general

[308] However, recently the CEDAW Committee in General Recommendation No. 28 on the state's core obligations holds that CEDAW covers gender-based discrimination against women.
[309] UN Committee on the Elimination of Discrimination Against Women (CEDAW), *General Recommendation No. 28 on the Core Obligations of States Parties under Article 2 of the Convention on the Elimination of All Forms of Discrimination against Women*, 16 December 2010, CEDAW/C/GC/28 para 5.
[310] E Durojaye & S Nabaneh 'Human rights and access" *supra* note 107 at 40.

recommendations has also espoused intersectional discrimination[311] in the famous case of *Alyne Patel v Brazil* discussed in detail subsequently in chapter 3.

The ICESCR recognizes the existence of multiple forms of discrimination and acknowledges how various factors can intersect to disadvantage women. However, it is worth noting that the text of the ICESCR does not explicitly reference intersectional discrimination. Nonetheless, its provisions encompass the broader understanding that discrimination can result from the intersection of various factors, including gender, socioeconomic status, and other social identities.[312] It prohibits discrimination on various grounds including 'economic status religion, sex, nationality, colour', and the open-ended category 'other status'. This can be purposively interpreted to extend protection to vulnerable groups such as pregnant women.

The CESCR addresses intersectional discrimination in its General Comments when it observes that 'some individual or groups of individual face discrimination on more than one of the prohibited grounds... such cumulative discrimination has a unique and specific impact... and merits particular consideration and remedying'. This remains an essentially grounds-based approach that examines the interaction between enumerated or analogous status-based grounds.

Article 12 of the ICESCR, which addresses the right to health, and General Comment 14 issued by the CESCR, provide important guidance on the right to health and the obligations of states parties. While they do not explicitly adopt an intersectional approach, they provide a framework that can apply in analyzing and addressing intersectional health disparities. They have principles and provisions that their interpretations are applicable in a manner that considers the intersecting factors contributing to health disparities. These instruments emphasize the need for non-discrimination and equitable access to healthcare. This links inherently to addressing the intersecting forms of discrimination faced by individuals.[313] It clarifies the difference between indicators that reflect achievement levels of countries

[311] General Recommendation/Comment No. 31 and 35.
[312] International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 (entered into force 3 January 1976) in accordance with art. 27.
[313] General Comment 14 on the right to the highest attainable standard of physical and mental health (art. 12 of the ICESCR) E/C.12/2000/4 11 August 2000.

considering their peculiar circumstances.[314] This issue can be addressed by examining both the determinants of health and the corresponding rights that states are obligated to uphold, protect, and fulfill under the Convention.[315] The right to health links with sanitation, potable water supply, and regular access to adequate food, among other enabling conditions.[316] Health-care provision entails availability and accessibility, acceptability and quality of care.[317] It has its base in "…safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs…"[318] The elimination of infant and maternal mortality also comes under the umbrella of the right to health under article 12(2)(a) of the CESCR.[319] In 2008, the United Nations, also clarifies the normative concept surrounding the socioeconomic right to health,[320]stating that "States must show that they are making every possible effort, within available resources, to better protect and promote all rights under the Covenant."[321] This approach is in consonance with addressing the social, cultural and economic factors affecting maternal health.

Article 12 illustrates the implicit commitment to intersectional discrimination. It requires state parties to 'take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health

[314] Ibid. paragraphs 57-58.
[315] Ibid. paragraph 5.
[316] Ibid. paragraph 11.
[317] Ibid. paragraph 12.
[318] Ibid. paragraph 12 (a)
[319] Ibid. paragraph 14. Article 24 of the Convention of the Rights of the Child enjoins States: (a) "To diminish infant and child mortality"; (d) "To ensure appropriate pre-natal and post-natal health care for mothers"; (e) "To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents." full text available at: http://www2.ohchr.org/english/law/pdf/crc.pdf (accessed on March 10, 2021); Article 12(2) of CEDAW also stipulates that: "State Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation." Full text available at: http://www.un.org/womenwatch/daw/cedaw/text/beconvention.htm#article12 (last visited on April 23, 2021).
[320] http://www.ohchr.org/Documents/Publications/Factsheet31.pdf (accessed on March 2, 2022)
[321] Ibid. at 23.

care.'[322] To eliminate discrimination and achieve gender equality in health care, it is necessary to appreciate the unique and multiple causes of discrimination.

The recognition of intersectionality by the treaties and regional instruments is critical to addressing discrimination against women, and especially for pregnant women. For pregnant women in Nigeria, the magnitude of discrimination is enormous especially for the poor women who cannot afford private healthcare services[323]. The impact of poverty and limited economic resources on the health of disadvantaged women can be significant, particularly when considering the additional challenges faced by women based on their regional location and religious affiliation. For instance, there is a general exposure of women from Northern Nigeria to discrimination mostly on account that religious values require strict adherence to Islamic rules which subject women to control of their male counterparts under the guise of Sharia law. These have implications for their reproductive autonomy.[324]

The CEDAW and ICESCR adopt an enumerated and analogous grounds approach to discrimination. For instance, article 2(2) of the ICESCR, holds that 'each state party to the present Covenant undertakes to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.' In addition, article 3 ICESCR also prohibits discrimination on the basis of sex.[325]

The CESCR uses 'other status' to import new analogous grounds, including disability, age, nationality, marital and family status, sexual orientation and gender identity, health status, place of residence and economic and social situation.[326] In addition, the CESCR observes that 'some individual or groups of individual face discrimination on more than one of the prohibited grounds... such cumulative discrimination has a unique and specific impact... and merits

[322] R Cook 'The promotion and protection of women's health through international human rights law' *Women's health and human rights* (1999).
[323] CRR, "Broken Promises" *supra* note 8.
[324] Quraishi, Asifa, "What if Sharia weren't the Enemy: Rethinking International Women's Rights Advocacy on Islamic Law" (2011) 22:1 Colum J Gender & L 179.
[325] ICESCR *supra* note 84 at art 13.
[326] CESCR GC No. 20 para 28-35.

particular consideration and remedying'.[327] The CESCR's interpretation of the ICESCR acknowledges the intersecting nature of discrimination by recognizing that individuals may face multiple and overlapping forms of disadvantage based on various grounds such as gender, race, socioeconomic status, and disability.[328] The Committee's General Comments and Concluding Observations often address the need to address multiple and intersectional forms of discrimination in the realization of economic, social, and cultural rights. By recognizing the specific vulnerabilities and barriers faced by marginalized and disadvantaged groups, the CESCR demonstrates an understanding of intersectionality and the need for inclusive approaches to combat discrimination and promote the full enjoyment of economic, social, and cultural rights. The provisions of these instruments offer a legal insights to the required legal, judicial and quasi-judicial approach to resolving the multiple forms of discrimination and inequality confronting different women in Nigeria. Specifically, laws and policies must reflect these interpretations and understanding in the formulation and design of maternal health policies and programmes to be socially just and effective.

## 2.7 Intersectional Discrimination and the Right to Health

This section of the thesis examines the issue of intersectional discrimination in relation to the right to health provisions in Nigeria, as well as with international human rights treaties. It delves into the complexities of how multiple social identities intersect to shape health disparities and the legal framework provided by both national and international instruments to address these intersectional challenges. It brings together the relevant provisions in the ICESCR and CEDAW, the interpretations and elucidation of their respective treaty bodies and the conceptualization of systemic equality as developed in this thesis. Asides from the treaties, this section also looks at the Women's Protocol to provide a deeper analysis of how the regional instruments address discrimination and inequalities faced by women in assessing health services. Since the focus of this thesis is to interrogate how discrimination against women impacts on preventable maternal deaths, a closer examination of the right to health provisions of the relevant treaties is imperative.

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[327] Bond, J.E., "International Intersectionality: A Theoretical and Pragmatic Exploration of Women's Human Rights Violations," (2003) 52, *Emory Law Journal* 93.

[328] Rebecca J Cook & Susannah Howard "Accommodating Women's Differences under the Women's Anti-Discrimination Convention (2007) 56:4 *Emory Law Journal* 1039.

Despite the clear provisions of the right to health of the Convention and the clarification the CESR offers, the core obligations of the standard of physical and mental health remains unattainable for majority of citizens of developing countries especially Nigeria. The enjoyment of all the rights contained in the ICESCR is subject to the equality provision with obligations to 'take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively, the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly, the adoption of legislative measures'.[329] The obligation extends, not only to the provision of health goods and services in an accessible way, but also to ensure that it is done without discrimination.[330] This underlines the Committees' recommendation that States integrate a gender perspective in their health-related policies, planning, programmes and research, with the aim of promoting better health for women and men. The recommended obligations of the Committees are in line with intersectionality proposition. The gender-based approach acknowledges that biological and socio-cultural factors play a significant role in positively influencing the health of men and women.[331]

The various forms of discrimination affecting women's health interrelate. Consequently, the CESCR emphasises that the right to health closely connect to and dependent upon the realisation of other human rights, including the rights to life, human dignity, non-discrimination, and prohibition against torture, food, work, education, information. [332] Guaranteeing these rights makes the actualisation of the right to health meaningful.[333] This is particularly important for my thesis considering the adoption of comparative approach of the Indian jurisdiction in reading socioeconomic rights to influence other civil and political rights and right to life[334]. In Nigeria, there is an exposure of pregnant women to multiple forms of discrimination and violation of rights, such as unemployment, domestic and sexual violence,

[329] ICESCR supra note 84 at art. 2(1).
[330] E Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism* 114.
[331] E Durojaye & S Nabaneh *supra* note 107.
[332] General Comment No.14 para 3.
[333] E. Durojaye & Olubayo Oluduro Normative Framework on the Right to Health under International Human Rights Law In "Litigating the Right to Health in Africa: Challenges and Prospects" (Eds) E Durojaye, Routledge (2015) 10.
[334] This is extensively discussed in Chapter Five of the thesis.

lack of access to education, information regarding reproductive health and healthcare in general.[335] As earlier established, cultural practices and misconceptions fuel discrimination against pregnant women in some region. This often extends to the healthcare setting where discriminatory practices manifest against such women, since healthcare providers are products of the society[336].

These multiple forms of discrimination intersecting and their treatment cannot be in isolation. They often have roots in cultural and religious practices that tend to perpetuate existing beliefs and thereby negatively affect women and prevent them from enjoying good standard of health. Marginalised, minority of women face a greater health challenge and have higher risks by reasons of their vulnerability.[337] The CEDAW Committee unequivocally states the goal of addressing the need for special consideration of intersecting multiple forms of discrimination when it states that:

> The position of women will not be improved as long as the underlying causes of discrimination against women, and of their equality, are not effectively addressed. The lives of women and men must be considered in a contextual way, and measures adopted towards a real transformation of opportunities, institutions and systems so that they are no longer grounded in historically determined male paradigms of power and life patterns.[338]

Discrimination on grounds of sociocultural factors, religion and economic factors affect women from seeking timely and quality access to healthcare. The CEDAW recognises the harmful impact of discrimination in accessing healthcare services by women and makes unambiguous provisions in that regard. It requires States Parties to take all appropriate measures to eliminate discrimination against women in the field of health care, in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.[339] It imposes obligations on states to ensure that women have appropriate services in connection with pregnancy, confinement and the post-natal period,

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[335] E Durojaye 'Substantive equality' *supra* note 117.
[336] Ibid.
[337] Charlotte Abaka "Framework for a human rights approach to women's health -the work of the CEDAW Committee" Framework for a human rights approach to women's health (un.org) (accessed 20 April 2021).
[338] General Recommendation No 25, 30th session (2004) on Article 4(1) on temporary special measures para 10.
[339] ICESCR, supra note 84 at art. 12(1).

granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.[340] These provisions are specifically targeted at reducing to the barest minimum, undesirable rate of preventable maternal deaths in developing countries like Nigeria where women lack access to basic amenities and financial ability to access proper maternal healthcare services.

Moreover, the CESR has established guidelines for states to adopt appropriate laws, policies and programmes relating to the health needs of pregnant women. The Committee pursuant to General Comment 14 establishes the – availability, accessibility, acceptability and quality (AAAQs)- approach[341] requirement of the determinants of health. Not only must the resources to guarantee such health be available in abundance, they must also be accessible according to the CESR, which encompasses four dimensions including physical accessibility, information accessibility, economic accessibility, and non-discrimination.[342] In essence, states would need to ensure that pregnant women enjoy unhindered access to healthcare services, and more importantly they must ensure that maternal health services are ethically and medically acceptable, and do not undermine their human dignity. Failure to meet the health needs of different pregnant women clearly shows lack of political will on the part of a state and a violation of its obligations under these instruments.

**The Maputo Protocol Regime**

At the regional level, article 14 of the Maputo Protocol explicitly codifies similar obligations. This section of the thesis examines the intersectional aspects of discrimination and their implications for the right to health provisions in the Maputo Protocol. It emphasizes the significance of this regional instrument in addressing health disparities and promoting gender equality in relevant contexts.[343] A broad interpretation of the provision predisposes it to protecting sexual and reproductive health of persons, including pregnant women. In expounding the provision of article 14 of the Maputo Protocol, the African Commission advise

[340] ICESCR, supra note 84 at art. 12(2).
[341] General Comment 14 para 34.
[342] General Comments 14, See also E. Durojaye & Olubayo Oluduro Normative Framework on the Right to Health under International Human Rights Law In "Litigating the Right to Health in Africa: Challenges and Prospects" (Eds) E Durojaye, Routledge (2015).
[343] Maputo Protocol, art. 14

states to take appropriate measures towards eliminating stigmatisation and discrimination in relation to sexual and reproductive health.[344] This position of the Commission provides a bulwark front for pregnant women who often encounter discrimination in healthcare services especially in Nigeria.

Even without domestication of the Protocol in Nigeria, the country can still take a substantive-equality approach to addressing the multiple forms of discriminatory practices against pregnant women.[345] The Protocol also requires states to adopt positive measures including the provision of emergency obstetric care, training of healthcare providers, and allocation of resources to meet the needs of pregnant women. It also requires that women must have adequate representation and it involves any measures aimed at addressing stigma and discrimination against them.[346]

Effective participation in the designing, formation and implementation of laws and policies on women's health is an integral part of the right to health. The CESCR supports this position.[347] It is a powerful means of guaranteeing the autonomy of people over decisions concerning their lives, especially for the vulnerable and marginalised women. Supporting this view, Yamin argues that effective participation enables disadvantaged groups to challenge political and other forms of exclusion that prevent them from exercising agency over decisions and processes that may affect their lives and health.[348] This is in line with representational intersectionality. According to Crenshaw, women must be adequately represented formally and in substance in the determination of decision making process affecting their health and in the development of laws and policies regulating same.[349] In Pott's view, people who a health policy or programme may likely affect should have equal opportunity to be part of the decision-

[344] UN 'Report of the International Conference on Population and Development (ICPD): 5-13 September 1994' UN Doc A/CONF.171/13 (18 October 1994) https://www.un. org/popin/icpd/conference/offeng/poa.html (accessed 4 March 2019). para. 44

[345] Durojaye, E, *supra* note 117 at 113.

[346] Crenshaw *supra* note 26.

[347] CESCR General Comment 14.

[348] A Yamin 'Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health' (2009) 11 Health and Human Rights 6.

[349] Crenshaw, *supra* note 26.

making process.[350] Participation empowers the marginalised and disadvantaged groups to have a say in matters affecting their lives.[351]

Maternal decision-making process that does not involve women is discriminatory and a violation of the right to health, and has implications for other human rights including dignity and non-discrimination. As Yamin notes: 'If health is a matter of rights, it cannot be considered a handout, and the people who receive services are not objects of charity from their own governments…; they are agents who have a role to play in the definition of programmes and policies that structure the possibilities for their own wellbeing'.[352] In addition, Nigerian governments need to commit adequate resources to the health sector to meet the healthcare needs of pregnant mothers and prevent disturbing mortality statistics in the country. Chapter Four establishes the rights framework in this thesis. It further discusses these aspects in detail.

## 2.8 Conclusion

Understanding health disparities and health inequality especially from equality and non-discrimination prism establishes the relevance of intersectionality i.e. the systemic, multiple and interlocking discrimination affecting effective realization of health equity. The search for an appropriate theory to address health inequality goes beyond political, economic and judicial interventions to the relationship between the different socio-cultural, economic and regional grounds on discrimination, and the way in which feminists understand power relations and women oppression in different communities. It also acknowledges the application of the intersectional approach to health as a means of promoting justice. The suggestion for incorporation of the intersectionality into constitutional provisions of nations and in the design of policies and interventions, highlights the importance of the constitution and international instruments as a tool for promoting equality and reproductive justice. The potential of utilising the framework in the national, international, and regional instruments on discrimination are relevant in advancing maternal health in Nigeria. The maternal mortality rate in the different regions in Nigeria as a result of socio-economic and regional factors needs further exploration.

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[350] H Potts, Participation and the right to the highest attainable standard of health (2008) 8.

[351] See Report of the Special Rapporteur on extreme poverty and human rights: Participation of people living in poverty in decisions affecting their lives (11 March 2013).

[352] A Yamin 'Suffering and powerlessness" *supra* note 348 at 4.

The following chapter discusses how Nigeria's maternal death disparities has various differential impact along gender, regional, ethnic, and socioeconomic lines.

## CHAPTER THREE

## Intersectional Discrimination and Maternal Health in Nigeria

### 3.0 Introduction

Discrimination relating to pregnant women is commonplace in Nigeria.[353] Pregnant women, often face a multitude of intersecting forms of discrimination that can have severe and even fatal consequences, throughout Nigeria. These forms of discrimination encompass social, cultural, biological, and political factors that interact in ways that significantly impact maternal health.[354] Official records attribute maternal deaths to medical complications as they are publicly visible reasons. But intrinsically a maternal death is often an outcome of mutually interlocking discrimination at multiple levels and in different forms.[355] These forms of discrimination range from social exclusion of women from marginalized communities to lack of emergency obstetric care services in public health institutions.[356] It also reveals the inequalities in the health of the privileged and marginalised, even within developed countries. In Nigeria, maternal health continues to be a major public health challenge.[357]

Chapter Three of this thesis critically examines the intersectional discrimination present in maternal health outcomes in Nigeria. It focuses on the disparities in maternal mortality rates between the northern and southern regions, uncovering the factors responsible and their violations of international human rights instruments such as CEDAW and ICESCR. By analyzing the economic, political, and health-based inequalities affecting women, including socio-economic status, contraceptive use, age of marriage, religion, cultural values, and geographical location, this chapter highlights systemic inequities and discrimination experienced by pregnant women. Through the lens of feminist intersectional theory, which acknowledges the interplay of multiple social factors, it illuminates the urgency to address these disparities and promote equality and justice in maternal healthcare across different states

[353] CRR 'Broken promises" supra note 8 at 76.
[354] Yamin, A. E. Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why They Matter. Pennsylvania: University of Pennsylvania Press. (2013); World Health Organization. (2012). Trends in Maternal Mortality: 1990 to 2010. Geneva: World Health Organization.
[355] CRR 'Broken promises" supra note 8 at 10.
[356] Cabal, L & Stroffregen, M supra note 53 at 2.
[357] J Shiffman, "Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries", , (2007) 97: 5, *American Journal of Public Health* at 798.

and regions in Nigeria.[358] By examining the diverse experiences of pregnant women in Northern and Southern Nigeria, this chapter acknowledges that intersectionality responds to the lived experiences of women[359], accounting for the various factors that impact them across different states and regions.[360]. Through this lens, the chapter sheds light on the complex dynamics at play, amplifying the urgency for comprehensive measures to address intersectional discrimination and promote maternal health equity in Nigeria.

## 3.1 Intersectionality, Discrimination and Maternal Health Rights

### 3.1.1 The Right to Health and Non-Discrimination under International law

The right to the enjoyment of the highest attainable standard of health, popularly referred to as 'the right to health', has evolved at the international level over several years and its jurisprudence has developed at both international and regional levels. Notable among these is the clarification provided by UN treaty monitoring bodies such as the CESCR[361] and CEDAW[362]. These clarifications have proved a useful guide to states, individuals and civil society groups, for providing a better understanding of the right to health. Against this backdrop, this section of the thesis examines the normative framework for the realization of the right to health as set out under the ICESCR, CEDAW, the African Charter and the Maputo Protocol, and attempts to make connection as regards the nature of these provisions at international, regional and national levels.[363]

The Right to Health has been documented as a fundamental human right for several years. The origin of the recognition is the 1946 Constitution of the World Health Organization which provides that:

> Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition … The extension to all peoples of the benefits of

[358] Crenshaw, supra note 26 at 139.
[359] Mullings, L & Schulz, AJ, supra note 106 at 3.
[360] Ibid at 4, 5.
[361] See. CESR General Comment No 14 on art. 12 ICESCR on the Right to Health.
[362] CEDAW Committee General Recommendation 24 on art. 12 on the right to health of women.
[363] The UN Special mechanisms such as the Special Rapporteur on health and the African Commission on Human and Peoples' Rights in contributing to the understanding of the right to health.

> medical, psychological and related knowledge is essential to the fullest attainment of health.[364]

Although there is no consensus on what amounts to quality healthcare services, but the different ramifications of health encompass equality in its application to citizenry.[365] Many other rights, categorized as civil and political rights such as the right to life and liberty, have links to health.[366] Equality or non-discrimination is a central principle in international human rights law; it is reflected in all major treaties like the ICESCR, CEDAW and the African Charter. To shed light on the impact of discrimination against women on preventable maternal deaths and to provide a comprehensive analysis, we delve into the relevant provisions of treaties such as ICESCR and CEDAW, which Nigeria has committed to uphold. Building upon the earlier exploration of non-discrimination and equality in previous chapter, this section delves deeper into the implications of these treaties within the context of maternal health. By examining the legal framework and human rights instruments, we gain valuable insights into the urgent need to address discrimination and ensure the right to health for all women. This discussion serves as a crucial foundation for effectively reducing maternal mortality rates and advancing equitable maternal healthcare practices in Nigeria.

### 3.1.2 The United Nations Human Rights Treaties: The ICESCR

The most authoritative international human rights provision in this regard is article 12 of the ICESCR; it recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[367] The responsibility for promoting, implementing and enforcing this right is the function of the Committee on ESC rights.[368] It elucidates the nature and content of the right, as well as the obligations of State Parties. The Committee interprets the right to

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[364] The Constitution of the World Health Organization was adopted in New York in June 1945 and opened for signature on 22 July 1946. World Health Organization Constitution 14 UNTS 185.

[365] ED Kinney & BA Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) *Cornell International Law Journal* 285, 289.

[366] Civil and Political rights contained in international and domestic constitutions including, rights to life, not to be subjected to torture or cruel, inhuman or degrading treatment, and to information – and economic, social and cultural – rights to food, housing, hygiene, clothing, food, work, water, education, healthy occupational and environmental conditions, and access to health-related education and information.

[367] ICESCR, *supra* note 84 at art. 12.

[368] Nigeria became a signatory to ICESCR in October 1993 without any reservation, but, yet to ratify the Optional Protocol to the ICESCR. General Comment No. 14 on the right to the highest attainable standard of physical and mental health (art. 12 of the ICESCR) E/C.12/2000/4 11 August 2000.

health, as defined in article 12(1), as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water, access to health-related education and information, including on sexual and reproductive health.[369] The CESCR emphasizes that states must give priority to the right to health of vulnerable groups, including women and children[370]. The Committee clarifies that as a core element of the right to health, accessibility includes four elements-physical, economic, non-discrimination and information.[371] Failure by a state to address the barriers that hinder the availability, accessibility, acceptability, and quality of maternal care services signifies a compromising stance. It indicates a lack of commitment to fulfilling its obligations. By neglecting to take the necessary steps to ensure adequate maternal healthcare, the state disregards the well-being and rights of its citizens, particularly women.[372]

The ICESCR presents a viable framework for addressing maternal death disparities in different regions of Nigeria as it requires the governments to provide maternal health care services on the basis of equality that are physically and financially accessible to all pregnant women, especially those in rural areas.[373] It also requires the state to address discriminatory laws, policies, practices and gender inequalities in health care services in societies that prevent women and adolescent girls from accessing good quality services, including maternal care services.[374] The Committee further states that health services must be affordable to socially disadvantaged groups and that there should not be disproportionate burden of health expenses on the poor households compared to their rich counterparts.[375] A major impediment for women in several communities in Nigeria is the inability to afford medical expenses especially in the absence of adequate public goods.[376] Thus implementing the provisions of General

[369] the General Comment No. 14 issued by the CESCR, a treaty body which extends the right to include sexual and reproductive rights as well as other determinants of health. General Comment No 14, para. 11.
[370] Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (1986) paras 36 and 39.
[371] CESCR in General Comment No 14.
[372] Afulukwe-Eruchalu "Accountability for non-fulfilment of Human Rights Obligations: A Key Strategy for Reducing Maternal Mortality and Disability in Sub-Saharan Africa" in Ngwena, C & Durojaye, E (eds) Strengthening the protection of sexual and reproductive health and rights in the African region through human rights (PULP 2014), 125.
[373] CESCR in General Comment No 14, paras 18- 19.
[374] General Comment No 14, para 12(b).
[375] General Comments 20 para 46.
[376] CRR 'Broken promises" *supra* note 8.

Comment 14 would bridge the gap between the economically buoyant urban women and the financially inadequate rural women, since laws and policies aim at reforming specific discriminatory provisions which affect different groups especially the vulnerable.

The obligation of the Nigerian government extends, not only to the provision of health goods and services in an accessible way, but also to ensure that it is done without discrimination.[377] This underscores why the Committee in its initial report on Nigeria, recommends that Nigeria integrate a gender perspective in its health-related policies, including budgeting, infrastructure, planning, programmes and research, in order to promote better health services for both women and men. The Committee notes with concern that:

> …gross under-funding and inadequate management of health services during the last decade had led to the rapid deterioration of health infrastructures in hospitals. … Frequently, hospital patients not only have had to buy drugs, but have also had to supply needles, syringes and suture thread, in addition to paying for bed space. As a result, many Nigerian doctors have chosen to emigrate. [378]

The ICESCR requires states to adopt a positive approach to the right to health, despite the budgetary implications for states as well as the tendency for individuals to bring claims for their realization in the court of law which could lead to floodgates of litigations. This approach is in line with intersectional approach to maternal health, especially in Nigeria where majority of maternal health services and facilities are not available. An intersectional examination of maternal health in Nigeria requires the availability of maternal healthcare services in rural areas as a critical factor in addressing maternal health disparities. In rural areas, the intersection of limited healthcare infrastructure, transportation challenges, and socioeconomic disparities further compounds the barriers faced by pregnant individuals, underscoring the need for targeted interventions to ensure equitable maternal healthcare. Such an approach will enhance citizens' ability to demand accountability for maternal death, resulting from lack of maternal health services in different communities.

[377] ICESCR, supra note 84 at art 12(1).
[378] CESR of Reports Submitted by States Parties Under Articles 16 And 17. The Committee considered Nigeria's initial report (E/1990/5/Add.31) at its 6th to 9th meetings held from 29 April to 1 May 1998. paras. 9, 14, 39 and 40.

### 3.1.3 The CEDAW

The CEDAW plays a crucial role in addressing the gender-specific issue of maternal mortality. CEDAW's significance lies in its mandate to combat discrimination that affects vulnerable members of a community, including pregnant individuals. It serves as a powerful tool in promoting maternal health and reducing maternal mortality rates. The CEDAW recognises the negative impact of discrimination on access to healthcare services by women, and makes explicit provisions in that regard.[379] The CEDAW recognizes non-discrimination as a fundamental principle, and extends its application to the right to health.[380] Article 1 of the CEDAW[381] adopts a comprehensive and nuanced definition of discrimination against women. It defines discrimination as:

> [A]ny distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.[382]

In providing clarity to State Parties obligations under article 12 of the Convention on the right to health, the CEDAW Committee emphasizes the duty of States Parties to ensure, on a basis of equality between men and women, access to health care services. Information and education imply an obligation to respect, protect and fulfil women's rights to health care.[383] According to Byrnes:

> [T]he changed nature of the conceptualization and definition of discrimination and that intersectional awareness is now to be seen as part of a suite of state obligations, or a form of discrimination to be likewise "eliminated" and "abolished" and the purpose and essence of the convention."[384]

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[379] CEDAW, *supra* note 81 art. 2. See. MacNaughton, Gillian. "Untangling Equality and Non- Discrimination to Promote the Right to Health Care for All" (2009) 11:2 *Heath Human Rights* 47.
[380] Gillian, *supra* note 379 at 47-48.
[381] CEDAW, *supra* note 83 art. 1.
[382] CEDAW, *supra* note 83 art. 2.
[383] General Recommendation 24.
[384] Andrew Byrnes, "Article 2" in Marsha Freeman, Christine Chinkin & Beate Rudof, eds, UN Conv Elimin Forms Discrim Women Comment, Oxford Commentaries on International Law (Oxford University Press, 2012) 71.

The Convention thus requires governments to take all appropriate measures to eliminate discrimination against women in every form in the area of health care, in order to ensure access to health care services including those related to family planning.[385] States parties have the responsibility to ensure that legislations, executive actions, and policies comply with the obligations to protect, respect and fulfil the rights guaranteed.[386] They must also put in place a system which ensures effective judicial action.

In order to effectively engage the enduring discrimination against women based on cultural and religious factors which contribute to the majority of maternal mortality causes, the provisions of CEDAW hold immense significance for maternal health reforms in Nigeria. Governments at all levels must take decisive actions to eliminate and address discriminatory practices affecting pregnant women, as failure to do so constitutes a violation of Article 12 of CEDAW[387]. Moreover, States Parties have the responsibility to allocate resources accordingly[388] to ensure women's right to safe motherhood and emergency obstetric services. These provisions underscore the need for Nigeria to align its domestic laws with international obligations, as emphasized by the CEDAW Committee's Concluding Observations during its 30th session[389]. It sheds light on the challenges faced by women in terms of their sexual and reproductive health, particularly the impact of culturally discriminatory laws.

A major challenge to the implementation of these provisions is that Nigeria is yet to domesticate both the CEDAW and ICESCR. Besides, the non-domestication, the Coalition of NGOs has issued a Shadow Report pursuant to the provisions of CEDAW, highlighting the challenges confronting Nigeria in the implementation of the Convention.[390] The report includes an analysis of the inequity in maternal mortality rates in the country and the challenges of rural

[385] ICESCR *supra* note 84 art. 12(1).
[386] CEDAW, *supra* note 83 arts 2-4. Which contains State obligations to enact a policy of non-discrimination through legislation, institutional mechanisms and regulatory policies as well as to promote equality through all appropriate means.
[387] General Recommendation No. 24 para. 13.
[388] Ibid at para. 27.
[389] The Committee considered the combined fourth and fifth periodic report of Nigeria (CEDAW/C/NGA/4-5) at its 638th and 639th meetings, on 20 and 21 January 2004 (see CEDAW/C/SR.638 and 639).
[390] The Nigeria CEDAW NGO Coalition Shadow Report submitted to the 41st session June 2008 available at https//www.refworld.org/docid/48a0007a2.html (accessed on 1 May 2022) See also, the NGO Coalition Shadow Report to the 7th & 8th Periodic Report of Nigeria on CEDAW NGO Coalition Shadow Report to the 7th & 8th Periodic Report of Nigeria on CEDAW submitted to UN CEDAW Committee, Geneva, Switzerland June 2017.

women in accessing health services. It also issues recommendations in form of socio-economic reforms and economic empowerment for women.[391] The stark reality is that Nigeria is a patriarchal society, and the failure to domesticate the provisions of the international instruments in question has a lasting negative impact on gender equality in the country, and by extension maternal mortality disparities across regions in the country.

In the case of *Alyne da Silva Pimentel Teixeira (deceased) v. Brazil*[392], the CEDAW Committee determined whether Brazil was in breach of its obligations under CEDAW provisions following the death of Alyne, a woman of African descent, from complications arising from the inappropriate care she received in relation to her pregnancy.[393] In a groundbreaking decision, the Committee supports the petitioner's claim and acknowledges its validity and finds that Alyne's avoidable maternal death is discriminatory and that Brazil is in breach of its obligation to prevent avoidable maternal death by ensuring adequate emergency obstetric care for her benefit.[394] The case marks the first time that a human rights committee identifies and analyzes the discriminatory gaps in a country's healthcare system from the perspective of a poor, pregnant, minority woman.[395] According to the expert view of the Committee, '[t]he lack of appropriate maternal health services in the State party…..clearly fail[ed] to meet specific, distinctive health needs of and interests of women,[396] and therefore constitutes discrimination in violation of CEDAW's provisions.[397]

The Alyne case highlights the devastating consequences of intersecting forms of discrimination, particularly when it comes to access to maternal healthcare. The case underscores the importance of adopting an intersectional approach in addressing maternal health disparities under CEDAW, and ensuring protection of the rights of the marginalized women. This is a decision that has far-reaching implications in outlining the obligations of states in relation to preventable maternal death, especially for a country like Nigeria.

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[391] See the 7th and 8th Shadow Report on Nigeria, articles 13, 14, 15 & 16 of the report.
[392] CEDAW/C/49/D/17/2008, (decided August 10, 2011).
[393] Alyne case *supra* at para 7.4
[394] *Xákmok Kásek Indigenous Community v. Paraguay* Inter-American Court of Human Rights (Aug. 2010) Ser C No 214.
[395] R Cook, *supra* note 124 at108.
[396]See Alyne, *supra* at 7.3, 7.6–7.7.
[397] Ibid at 7.3, 7.6,-7.7.

There is a discussion of the relevance of this case later in this chapter, but, there is a need to point out that the decision of the CEDAW Committee clearly recognizes various forms of structural intersectional discriminations which contribute in varying degrees to the violation suffered by the victim.[398] Gender, poverty and race are critical factors that play intersecting roles in determining the nature of maternal health services that are available to Alyne and which, when reviewed against the rights to which she should benefit from, amounts to discrimination.

In addition to treaty implementation, it is crucial for states to adopt gender-inclusive and participatory policies that can effectively address the deficiencies in maternal health services. The clarification of the Special Rapporteur on the Right to Health supports this approach. In addition to the treaties discussed above, in April 2002, the Commission on Human Rights appointed a Special Rapporteur on the right to health to focus among other things, on clarifying the scope of the right to health and state obligations.[399] With a mandate to monitor, promote and raise awareness on the right to health around the world, the Special Rapporteur highlights in several reports, that an essential feature of the right to health is the active and informed participation of individuals and communities in health decision-making that affects them.[400] For instance, the Special Rapporteur advises that 'States have a human rights responsibility to establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities.'[401] It advises that 'women with unwanted pregnancies should be offered reliable information and compassionate counseling, including information on where and when a pregnancy may be terminated legally'.[402] The elucidation is consistent with the intersectional principle requiring women to take active part in determining maternal health policies and programs, especially disadvantaged communities in rural and

[398] Crenshaw, *supra* note 26 at 1259-60; Carastathis, *supra* note 154 at 304.
[399] Special Rapporteurs are independent experts appointed by the UN to monitor and report back on a country situation or a specific human rights theme through the presentation of annual reports.
[400] Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt (19 January 2006) UN Doc E/ CN.A/2006/48/Add 2, para 36; Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt (11 February 2005) UN Doc E/CN.4/2005/51, paras 59-61.
[401] Ibid at para 29-30.
[402] Ibid at para 30.

deeply cultural and religious settings like northern Nigeria where there is exclusion of women and girls from the decision making processes including over their reproductive decisions .[403]

The application of human rights in the healthcare context poses significant challenges, as there is limited but steadily increasing experience in their implementation both at national and international levels. Experts acknowledge the recognition of the complexities involved in effectively integrating human rights principles into healthcare practices.[404] Indeed, the Special Rapporteur also declares that 'the legal content of the right is not yet well established', thereby serving as an impediment to the realisation of the right.[405]

The effective implementation of these international human rights treaties is hindered in Nigeria due to several contradictory provisions within the Nigerian constitution. This is, despite the ratification of these various human rights treaties by Nigeria. Chapter Four of the thesis extensively explores this challenge. It delves into the framework of rights and examines the complexities associated with aligning Nigeria's constitutional provisions with its obligations under international human rights treaties.[406] The limitations include political processes to give implementation status, exclusionary provisions that remove personal and customary law which affect pregnant women from the purview of the constitution and ultimately empowers states in such federal structure to determine the nature of rights of women.[407] The treatment of the right to health under the Nigerian Constitution plays a crucial role in addressing the pressing issue of high maternal mortality rates, even in the absence of domestication and full implementation of international health treaties voluntarily entered into by Nigeria. This is due to the need for constitutional amendments necessary to give effect to these treaties. To ensure healthcare entitlements and impose positive obligations, it is imperative to elevate the right to health to a higher status.

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[403] Toyin Falola, Violence in Nigeria: The Crisis of Religious Politics and Secular Ideologies (Rochester: University of Rochester Press, 1998) at 13; Abdulmumini Oba, "Religious and Customary Laws in Nigeria" (2011) 25 *Emory International Law Review* at 885-886.

[404] R Cook, M Dickens & M Fathalla *Reproductive health and human rights: integrating medicine, ethics and law* (2003) 148.

[405] Report of the Special Rapporteur *supra* note 400 at 39.

[406] Section 12 of the 1999 Constitution of Nigeria on domestication of treaties. See Abdullahi An-Na'im, Human Rights Under African Constitutions: Realizing the Promise for Ourselves (Philadelphia: University of Pennsylvania Press, 2003).

[407] Johanna Bond, "Gender and Post-colonial Constitutions in Sub-saharan Africa" in Helen Irving, ed, Constitutions and Gender (Cheltenham: Edward Elgar Publishing, 2017) at 87.

### 3.1.4 Regional Human Rights Instruments: The African Charter

At the regional level, in recognition of the problem of maternal mortality on the African continent, article 16 of the African Charter contains provisions on the right to health, including access to maternal health care services.[408] It imposes obligations on states to take the necessary measures to protect the health of their people and ensure that they receive medical attention when they are sick.[409] In *SERAC and Another v Nigeria,*[410] there are various allegations of human rights violations, including environmental pollution and threats to a healthy environment against the Nigerian government, the African Commission found that the Nigerian government violated articles 4 on right to life, 16 on right to health, and 24 on right of peoples to a satisfactory environment.[411] It held that it violated the right to enjoy the best attainable state of physical and mental health under Article 16(1) of the African Charter. The court further held that the right to health is justiciable, affirming that individuals have the right to seek legal remedies and hold the government accountable for violations of their right to health. The court recognizes that access to essential health services is fundamental and integral to the realization of other human rights. This landmark ruling establishes the justiciability of the right to health in Nigeria, setting a precedent for future cases and affirming the importance of judicial remedies in addressing health-related grievances.[412]

The African Commission has played a crucial role in advancing the right to health in the region especially sexual and reproductive rights of women, through the adoption of resolutions and general comments. In 2008, the Commission adopted an important resolution on maternal

[408] Adopted June 27 1981 OAU DOC CAB/LEG/67/3 Rev. 5, 21 I.L.M. 58 (1982) entered into force October 21 1986. Adopted and ratified by Nigeria on 31 August 1982 and 22 June 1998 respectively. Nigeria ratified the African Charter on the 22 June 1983 and was the first country to incorporate the Charter wholesale into its national laws through domestication in line with its Constitution through, the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act 1983. See Frans Viljoen International Human Rights in Africa (2nd edn. Oxford University Press); Victor Ayeni "The impact of the African Charter and Women's Protocol in Nigeria in Center for Human Rights, The Impact of African Charter and Women's Protocol in Selected African States (Pretoria University Law Press 2012).

[409] African Charter, *supra* note 92 art. 16.

[410] Report of the Special Rapporteur, Paul Hunt *supra* note 400 at paras 59-61. SERAC v Nigeria (2001) AHLR 60 (ACHPR 2001)

[411] SERAC Case (*supra*)

[412] Report of the Special Rapporteur, Paul Hunt *supra* note 400 at para 41. See also H Potts, 'Human Rights in Public Health: Rhetoric, Reality and Reconciliation' (PhD thesis, Monash University, 2006).

mortality as a human rights challenge in Africa.[413] However, several challenges remain obstacles to implementation to these efforts,[414] even despite the ratification and domestication of the African Charter by state parties including Nigeria. [415] Despite the Charter being integrated into Nigerian law, the Nigerian judiciary has not fully integrated the national obligations in their pronouncements to align with the Charter's overarching objectives. This hinders its effective implementation.[416] Likewise the existing jurisprudence of the court[417] are yet to interpret the law as providing a different form of protection not provided by the chapter IV. The courts are yet to realize that the domesticated African Charter has conferred justiciability status on the right to health in Nigeria. It limits recognition to giving effect to civil and political rights such as liberty and dignity of human persons.[418] Several factors are responsible for the status quo. To implement the Charter will require that Nigeria implement legislative initiatives specifically to address maternal mortality, including constitutional review of responsibilities of different levels of governments to ensure health equality especially on matters concerning private sphere affecting maternal health.

### 3.1.5 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women: Maputo Protocol

In 2003 the African Union adopted the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women (Maputo Protocol). [419] This is to eliminate the challenges faced by individuals in enforcing their rights under the African Charter, especially with relation to

[413] The African Commission on Human and Peoples' Rights Meeting at its 44th Ordinary session held in Abuja, Federal Republic of Nigeria, passed a Resolution on Maternal Mortality in Africa - ACHPR/Res.135(XXXXIV) 08.

[414] Lack of political will and poor implementation of laws, inadequate allocation of resources to sexual and reproductive health issues, deep-rooted cultural practices and stereotypes have continued to hinder efforts at advancing sexual and reproductive health and rights of Africans. Till date, some laws or the absence thereof are in conflict with the African Charter and the Women's Protocol which Nigeria has ratified. Cultural and customary beliefs are at loggerheads with the Women's Protocol. Female genitals mutilations still exist in some parts of the country as well as child marriage and wife inheritance. See. Ngwena, C & Durojaye, E "Strengthening the protection of sexual and reproductive health and rights in the African region through human rights" (PULP 2014), 10.

[415] F Banda, Women, law and human rights: An African perspective (2005) 66-82.

[416] Odinkalu, *supra* note 96.

[417] Ibid.

[418] Ibid.

[419] The Maputo Protocol has been ratified by at least two-thirds of African states including Nigeria. However, Nigeria is yet to domesticate in line with its Section 12 Constitution on ratification and domestication of international treaties. See. Banda "Women, law and human rights" *supra* note 51 at 68.

the core content of the right to health, bringing claims at the regional courts in the light of national courts attitude to provisions of the Charter. It plays a crucial role in realizing the right to health for women in Africa. It specifically addresses various aspects of women's health, including reproductive rights, maternal health, and access to healthcare services.[420] Article 14 of the Protocol guarantees women's rights to health care, including sexual and reproductive health care. More importantly, article 14(2) enjoins states to:

> (a) provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
> (b) establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding.[421]

In line with an intersectional approach, article 14(2) (b) of the Protocol shifts from the negative rights approach to imposing positive obligations on state parties to promote sexual and reproductive services by enjoining states to establish and strengthen pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while breastfeeding.[422] The Protocol not only supplements the African Charter, it enunciates the rights and duties that are essential in redressing gender inequality affecting women's reproductive rights. It includes explicit guarantees of social, economic and cultural factors contributing to maternal death disparities in Nigeria including rights to: control fertility, decide whether to have children, the number of children and the spacing of children;[423] choose any method of contraception;[424] protect against sexually-transmitted diseases;[425] access to adequate, affordable and accessible health services,[426] abortion,[427] amongst others. However, the effectiveness of the Maputo Protocol in realizing the right to health depends on its

[420] O Afulukwe-Eruchalu 'Accountability for non-fulfilment of human rights obligations: a key strategy for reducing maternal mortality and disability in Sub-Saharan Africa' in C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 124-125.
[421] Maputo Protocol, *supra* note 66 at art. 14(2).
[422] Maputo Protocol, *supra* note 66 art. 14 (2)
[423] Maputo Protocol, *supra* note 66 arts 14(1)(a) & (b).
[424] Maputo Protocol, *supra* note 66 art 14(1)(c).
[425] Maputo Protocol, *supra* note 66 arts 14(1)(d) & (e)
[426] Maputo Protocol, *supra* note 66 art 14(2)(a).
[427] Maputo Protocol, *supra* note 66 art 14(2)(c).

implementation and enforcement by national courts.[428] While certain national courts in African jurisdictions have acknowledged the significance of the Protocol and integrated its provisions into their domestic legal systems, other courts may encounter obstacles or display hesitancy in enforcing its mandates[429]. The attitude of national courts towards the enforcement of the African Charter can impact the extent of the realisation of the right to health as outlined in the Maputo Protocol.[430]

The signing and ratification of various international instruments pertaining to the right to health signify the obligation of states to ensure the fulfillment of these rights for every individual. Governments have a duty to provide equal opportunities for all members of a society to enjoy the highest attainable standard of physical and mental health. Failure to fulfill this duty can amount to a violation of the rights enshrined in these instruments and deprives individuals of their fundamental human rights.[431] Notwithstanding the several instruments and the core provisions of the instruments, skepticism remains with respect to the content and realization of the right to health across the African continent including Nigeria. According to Riedel, "While all these instruments with relevance to health matters have either been adopted or approved… strictly speaking they have no legally binding effect on states and governments".[432] In Nigeria, the right to health remains challenging because it depends on states financial ability to fulfil. This according to Durojaye makes litigating the rights by citizens challenging and negatively affect maternal deaths, since legal claims or actions are difficult to maintain against the state for their realization[433].

The right to health is often unrealized in practice[434] in many developing countries, including Nigeria. Several State Parties have continued to treat these rights as mere international declarations and policy statements for governments, without any domestic enforcement for

[428] O Afulukwe-Eruchalu 'Accountability for non-fulfilment of human rights obligations" supra note 372.
[429] See E Durojaye 'Monitoring the right to health and sexual and reproductive health: Some considerations for African governments' (2009) 42 Comparative and International Law Journal of Southern Africa 227-263.
[430] Ibid.
[431] E. Durojaye & Olubayo Oluduro, *supra* note 333 at 10.
[432] E Riedel, 'The Human Right to Health: Conceptual Foundations' in A. Clapham and M Robinson (eds) Realizing the Right to Health (Rüffer & Rub 2009) 21, 22.
[433] Durojaye 'Monitoring the right to health and sexual and reproductive health' *supra* note 429 at 230.
[434] Ibid at 240.

individuals beyond local provisions.[435] Friesen also notes that 'a human right, even one supported by international law, is not a legal right – it is not justiciable, and thus cannot be used as a tool by… citizens who wanted to be proactive in improving and maintaining the quality of their public health care'.[436] However, with recent international developments across countries and regions, these assertions and criticism may sound misplaced as discussed later in Chapter four of this thesis. There should not be an underestimation of the reproductive health provisions in the African Charter. Inspite of ineffective utilisation of these African Charter provisions, there is no over emphasizing their potential impact and influence for state parties, particularly in countries like Nigeria where maternal mortality rates remain unacceptably high. The eventual testing of these provisions could provide significant insights and establish standards to address the issue, which could in turn ultimately address the discrimination against women in relation to maternal health.[437] The provision of these instruments provides textual guarantees for women's sexual and reproductive health, woman's right to control her fertility, judicial procedure for individuals for enforcing the Charter including its positive and negative duty connotations which accommodate women maternal health issues within the extant constitutional framework.[438]

### 3.2 Health Inequalities and Maternal Death Rates in Nigeria

A major concern for maternal health in Nigeria is inequality in the level of health status across the different regions in the country, that is between the Northern and Southern Nigeria.[439] There are notable disparities in the general quality of women's health between the two regions due largely to economic, religious and geographical reasons, and among different social, ethnic, and economic groups. There are also differences in the quality of services offered. The subsequent subsections demonstrate the extent of these regional disparities. Ezeanochie *et al.*, conducted a study on the situation in Nigeria and found that there is increasing evidence that

[435] PK Sandhu, 'A Legal Right to Health Care: What can the United States Learn from Foreign Models of Health Rights Jurisprudence? (2007) 95 *California Law Review* 1159.
[436] T Friesen, 'The Right to Health Care' (2001) 9 *Health Law Journal* 205.
[437] Concluding Observations of the African Commission on Human and Peoples' Rights on the 3rd Periodic Report of the Federal Republic of Nigeria, 44th session para 24 (2008).
[438] CG Ngwena, 'Protocol to the rights of women in Africa: Implications for access to abortion at the regional level*'* (2010) *International Journal of Gynecology and Obstetrics* 110 163 – 166.
[439] See. Kalu, Erinma, "Governance Can Kill: The Politics of Maternal Bodies in Nigeria" (2015). Public Health Theses, 1145; Ebeniro, Jane. The geography of maternal mortality in Nigeria. Master of Science (Applied Geography), University of North Texas, May 2012.

the difference in maternal mortality between the northern and southern parts of the country may be due to disparity in the accessibility and utilization of health services, especially in the availability of skilled birth attendants between the regions.[440]

As I discuss later in chapter four of this thesis, there is a reflection of an entrenched unjust power relations within the Nigerian societal structure[441] as well as lack of political will on the part of the Nigerian governments at various levels to address marginalization of women in the country's approach to women's health.[442] This lack of commitment on the part of the various levels of government results in unjust and unfair distribution of public goods and resources, leading to preventable maternal deaths. To address the rate of maternal mortality across the various regions in Nigeria, I argue that the country needs to adopt an intersectional approach in initiating policies and programs, as it aims at addressing multiple forms of discrimination against women in the context of maternal health. Legal reforms must specifically target different categories of women depending on their geographical location, economic status, religious and cultural relationships. The factors contributing to health inequalities in Nigeria are multifaceted, including socioeconomic status, access to prenatal care, safe abortion services, cultural and religious practices and place of residence. I discuss these determinants thoroughly in the following section. I examine them to shed light on their significant implications for maternal health disparities in the country.

## 3.3 Factors Influencing Maternal Health Disparity

### 3.3.1 Socioeconomic Status

Socioeconomic status encompasses not just income but also educational attainment, employment and other social status indicators.[443] These factors combine to impede women's ability to utilize healthcare services and produce huge number of preventable maternal

[440] M Ezeanochie *et al*, 'Attaining MDG 5 in Northern Nigeria: need to focus on skilled birth attendants' (2010) 14 *African Journal of Reproductive Health* 2, 9.
[441] There is structural divide in Nigeria, due to poor governance which set the North against the South, Rural and urban and rich and poor which have implications for healthcare outcomes. See. Kalu, *supra* note 365 at 6.
[442] There is a detailed discussion of Challenges to Constitutionalising Maternal Health in Nigeria including the power imbalance in chapter four of this thesis. See. Yamin AE. From ideals to tools: applying human rights to maternal health. (2013), 10:11 PLoS Med..
[443] Ahmed S et al., "Economic status, education and empowerment: implications for maternal health service utilizatin in developing countries (2010) 5:6 PLoS One 2.

fatalities.[444] In Nigeria, the major contributing socioeconomic factors are income, women's education (especially secondary education), employment, spousal education, and problems with obtaining permission to seek health care services.[445] These factors have a serious effect on women decision in utilizing health care services[446] and maternal deaths Poverty undermines economic security and independence of women as well as their access to reproductive healthcare services. The poor and uneducated women lack voice, power, and reproductive autonomy which subject them to exploitation.[447]

Regional disparity in terms of economic resources in Nigeria is high. The majority of Nigerian women are poor and they rely on their husbands for sustenance.[448] This has effect on their ability to access independently maternal health services, and reinforces inequities along intersectional lines with the largely poorer and rural women more affected than their educated, urban counterparts.[449] In 2018, Nigeria was regarded as the poverty capital of the world when it displaced India and posted the largest number of people living in extreme poverty.[450] Statistics on poverty in Nigeria indicate that 60 per cent of poor Nigerians are women.[451] Indeed, more than half of rural women live below the nationally defined poverty line, lacking access to basic education, decent nutrition, adequate health and social services.[452] The rate of poverty is 18% in the urban areas of the country compared to 52.1% in the rural area.[453]

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[444] Harrison, K. Maternal mortality in Nigeria: The Real Issues". (1997), 1:7 *African Journal of Reproductive Health* 13.
[445] Demographic and Health Survey (DHS) conducted in Nigeria (2008).
[446] Graham *et al*., The Familial Technique for Linking Maternal Death and Poverty. (2004), 363 *Lancet* 23-27; K. Gary & M. Christopher, 'Rethinking Human Security' (2001-2002) 116: 4, *Political Science Quarterly* 585-610, 603.
[447] Graham *et al*., ibid.
[448] A. Mohl, "Monotheism: Its Influence on Patriarchy and Misogyny" (2015) 43:1 The Journal of Psychohistory 2.
[449] Adebowale *et al.,* "Survival probability and predictors for woman experience childhood death in Nigeria: "analysis of North-South differentials". (2012), 12:430 *BMC Public Health* 4.
[450] In 2019, 40.1 percent of the total Nigerian population were classified as poor. In other words, on average 4 out of 10 individuals in Nigeria had real per capita expenditure below 137,430 Naira per year. Nigeria Still Poverty Capital of the World – Report, Nigeria Still Poverty Capital of the World - Report - allAfrica.com (accessed on 9 September 2021).
[451] IMF statistics suggest that Women constitute over 60% of the poorest people in Nigeria, a country which has over 87million people in extreme poverty i.e 52million women under extreme poverty. See. Onwuka *et al.,* "Poverty among Women in Nigeria-Psychological and Economic perspective: A study based on South-West Nigeria" (209) 14:11 International Journal of business and Management 2.
[452] Federal Office of Statistics 2011.
[453] National data on the rate of poverty shows the percentage of women living below $1.25 a day has 42-92 percent of the female population living in poverty in the rural northern regions. *Nigeria Living Standards Survey, 2018-19.* Poverty and Inequality in Nigeria-2019.

According to a data, the northern states have the highest concentration of women who, owing to religious practices, require permission from their husbands or a male family member to seek medical services from a healthcare facility.[454] Kebbi, Niger, Kano, Bauchi and Borno states, all in the northeast and northwest have the highest rates at 18-40%, while Lagos, Ondo, Edo and Osun states in the southwest having the lowest rates at 0.9-4 percent of the women requiring permission.[455]

Lack of independent economic ability also prevents women from seeking needed healthcare attention and postnatal care. According to a survey, the states that have largest concentration of women with no postnatal care is Kebbi, Sokoto, Niger, Zamfara, Katsina, Kano, Bauchi and Adamawa states in the northeast and northwest where there is the highest rates of women who have no postnatal care visits.[456] Also there is a record of only 4-21 percent delivery in a healthcare facility in states such as Sokoto, Kebbi and Zamfara in the north.[457] Similarly, the northern region has the highest concentration of populations with the least educational attainment. An estimated 91-96 percent of the population having less than secondary school education,[458] Erulkar & Bello estimate that 75 percent of young women living in rural areas of North-east or North-west have never been to school.[459]

The southwestern states of Lagos, Ogun, Oyo, Ekiti and Ondo; South-eastern states of Abia, Imo and Anambra, and the Federal Capital Territory have the highest percent of women who receive postnatal care from skilled providers at 84-97 percent.[460] The southern states of Lagos, Osun, Ekiti, Edo, Imo, Abia and Anambra have the highest rates at 67-94 percent of women who deliver in a healthcare facility.

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[454] Ibid.; L Adriano *et al.* "Husband's Dominance in Decision Making about Women's Health" Demography (2021), 4.
[455] Ebeniro, *supra* note 439 at 27.
[456] Ibid at 17.
[457] Ibid at 28-29.
[458] Predominantly Muslim Northern states such as Sokoto, Zamfara, Jigawa, Katsina, Borno and Yobe have some of the largest low educational attainment populations in the country.
[459] Southern states of Rivers, Imo, Anambra and Abia record lower populations with less than secondary education. See Erulkar & Bello, The Experience of Married Adolescent Girls In Northern Nigeria (Abuja: The Population Council, 2007).
[460] Ibid at 28.

Poor pregnant women are more likely to suffer death than their wealthier counterparts,[461] for several reasons.[462] First, there is general shortage of health facilities and infrastructure in their communities, thereby raising the demand and competition for the available few especially in the rural areas[463]. This in turn tilts the balance of access to the privileged and the consequential increase in the cost of access to health services. Hence, poor pregnant women are less likely to get medical care or go to a healthcare facility.[464] Poor pregnant women are often compelled to spend a significant portion of their meager income on healthcare expenses[465] as there is a failure of public hospitals to provide safe and affordable maternal health services. This financial burden exacerbates the already challenging circumstances faced by these women and their families. Consequently, exploring the practical effects of charging user fees becomes essential in understanding the implications of such financial barriers on access to maternal healthcare. In a practical sense, the effect of the economic status reflects in both public and private facilities for maternal health services in the introduction of user fees. It constitutes serious barriers to obtaining quality maternal health care, resulting in women either not seeking care or denial of essential services when they are unable to pay the associated fees.[466] In Nigeria, out-of-pocket payment in form of antenatal registration, cost of basic maternity packs, bed space accommodation, cost of drugs and caesarean procedures charges can be very high and result in adverse and differential consequences on pregnant women, including constituting a barrier of access to maternal health services amongst vulnerable groups, such as poor women.[467] There is evidence that maternal deaths increased by 56% and hospital deliveries fell by 46% after user fees were introduced.[468] This correlation between ability to pay user fees as well as other financial obligations, and maternal health outcome, reinforces the differential impact of economic status on maternal health outcomes across the regions. In most cases, it is

[461] Graham *et al., supra* note 446.
[462] Prata *et al.,* Saving Maternal Lives in Resource-Poor Settings: Facing Reality. (2009) 89:2, *Health Policy* 131-148.
[463] Okoli *et al.,* Prenatal care and basic emergency obstetric care services provided at primary healthcare facilities in rural Nigeria. (2012) 117:1 Int J Gynaecol Obstet 61-65.
[464] Ibid at 135.
[465] Filippi *et al.,* Maternal Health in Poor Countries: The Broader Context and a Call for Action. (2006). 368: 9546, *Lancet* 1535–1541.
[466] CRR, Broken promises, *supra* note 8 at 39.
[467] Ibid at 11.
[468] Gender responsive budgeting and women's reproductive rights: a resource pack (2006) UNFPA & UNIFEM 74.

the poor, uneducated, rural women who bear the brunt of the introduction of user fees in health facilities, as their urban, wealthy counterparts can afford the payment of such fees.

CEDAW's General Recommendation No. 28[469] on the Core Obligations of States Parties under Article 2 of the Convention explicitly addresses the economic challenges women face.[470] It highlights the importance of eliminating discrimination against women in the economic sphere[471], including access to financial resources and economic opportunities, as these factors significantly impact their ability to access healthcare services.[472] This provision is the broader framework of the CEDAW. It provides a justification for the elimination of user fees for maternal services for pregnant women in Nigeria. It emphasizes the link between economic empowerment and the realization of women's right to health.[473] The issue of user fees in accessing healthcare services is of significant concern.[474] It directly impacts women, particularly those from disadvantaged socio-economic backgrounds, who often bear the burden of paying a large portion of their meagre income for essential maternal health services.[475] In response to such economic challenges, the CEDAW has sought to address this issue through its General Recommendation No. 24 on Women and Health.[476] This recommendation calls for the elimination of discriminatory practices, including user fees, that hinder women's access to healthcare services and emphasizes the importance of ensuring women's equal access to affordable and quality healthcare without a financial hardship.[477]

The relevance of the CEDAW Committee recommendation on Nigeria lies in its emphasis on addressing the economic challenges faced by women in accessing healthcare and removing barriers that hinder it. The Committee's recommendation calls on Nigeria to take measures to

[469] Similar provisions are contained in the CESCR, general comment No. 14, para. 14; Maputo Protocol (Art. 14, para. 2).
[470] CEDAW General Recommendation No. 28 - 2010 - The Core Obligations of State Parties under Article 2 of CEDAW, CEDAW/C/GC/28.
[471] In 2006, Nigeria established a National Gender Policy pursuant to the policy it established the National Economic Empowerment Development Strategy (NEEDS), aimed at reducing poverty and improving the socioeconomic status women since it incorporated a gender responsive budget, policies and program.
[472] CEDAW General Recommendation No. 28 at paragraph 22.
[473] Gender responsive budgeting and women's reproductive rights: a resource pack (2006) UNFPA & UNIFEM 74.
[474] Ibid.
[475] Ibid.
[476] CEDAW, General Recommendation No. 24, para. 27.
[477] Ibid.

ensure women's equal access to affordable healthcare services, including by eliminating user fees and providing financial support for those who cannot afford the cost of healthcare. [478] By implementing these recommendations, Nigeria can effectively remove economic barriers that disproportionately affect poor pregnant women and ensure their right to access healthcare without any financial hardship, thus promoting gender equality in the realm of providing healthcare services.

There is "a significant discrepancy between the respective life expectancies in different regions of Nigeria including urban and rural areas".[479] This situation requires that the Nigerian government must take a sharper focus on health and poverty eradication programs to address this discrepancy.[480] The structural categorisation of Crenshaw's intersectionality theory aligns with this. It calls on states to address social stratification and redistribution of economic resources and political power along specific axes.[481] Experts advocate a fair distributive dimension to address socioeconomic disadvantages that women and some other groups experience due to failure of the governments and policy makers to prioritise the provision of resources proportionately across communities[482]. The failure to provide adequate and emergency health resources and services that pregnant women need in the vulnerable regions would amount to a violation of the right to health and discrimination of pregnant women under the ICESCR and CEDAW[483]. There is a need to address and reform this. If implemented, women centered economic policies and empowerment programmes could help to address these inequities by enabling women to increase access to health services[484]. When woman are less

[478] The Committee considered the sixth periodic report of Nigeria (CEDAW/C/NGA/6 and annex2) at its 836th and 837th meetings, on 3 July 2008 (see CEDAW/C/SR.836 and 837) See also for example: CEDAW concluding observations: Cape Verde (CEDAW/C/CPV/CO/6), para. 30; Indonesia (CEDAW/C/IDN/CO/5), para. 37; Togo (CEDAW/C/TOG/CO/5), para. 29; CESCR concluding observations: Kenya (E/C.12/KEN/CO/1), para. 33; Nepal (E/C.12/NPL/CO/2), para. 46; CRC concluding observations: Cambodia (CRC/C/15/Add.128), para. 52; Kazakhstan (CRC/C/KAZ/CO/3), para. 52 (b); Maldives (CRC/C/15/Add.91), para. 19.
[479] CEDAW Committee on Nigeria *supra* note 389 at para. 275.
[480] Graham *et al.*, *supra* note 446 at 23-27.
[481] Crenshaw, *supra* note 26 at 1259.
[482] Nira Yuval Davies "Beyond Recognition and redistribution Dichotomy: Intersectionality and Stratification in Helma Lutz, Maria Teresa Herera and Linda Spik (eds), Framing Intersectionality: Debates on a Multi-facted Concept in Gender studies, Farnham:Ashgate 2011; Lesley McCall "The Complexity of Intersectionality" *supra* note 121 at 1771.
[483] ICESCR, *supra* note 84 General Comment 14, CEDAW, *supra* note 83 General Recommendation 24.
[484] The Committee considered the combined fourth and fifth periodic report of Nigeria (CEDAW/C/NGA/4-5) at its 638th and 639th meetings, on 20 and 21 January 2004 (see CEDAW/C/SR.638 and 639) at para. 279. See

financially dependent on their husbands, it effectively reduces maternal deaths by improving their reproductive decision making. This approach to policies would increase access by the poor, rural, northern women to health services since majority of Nigerian women are below poverty line and reside in rural areas. Such gender-responsive approaches responds to the differential, intersectional needs of both males and females.[485] It applies intersectional analysis to health governance and ensures the alignment of economic and political policies with social needs.[486]

### 3.3.2 Prenatal Care and Maternal Deaths

Prenatal care plays a significant role in reducing complications and the frequency of maternal death, miscarriages and other preventable health problems during pregnancy. The relationship between education and access to prenatal care is significant, as higher levels of education associates with increased knowledge about the importance of prenatal care and better access to healthcare resources.[487] Education plays a crucial role in preventing maternal deaths by empowering women with the information and resources they need to seek timely and appropriate prenatal care, make informed decisions regarding their health, and adopt healthy practices during pregnancy.[488]

Early prenatal care has the possibility of identifying risks associated with pregnancies and mostly prevent the major pregnancy complications that require emergency obstetrical care.[489] Reasons for non-use of prenatal care varies significantly from wealth status, educational attainment, residence, geographical locations, age, and marital status particularly because of the social perception of pregnancy outside wedlock.[490] The WHO recommends in the absence of complications, that pregnant women should have at least 3 prenatal care hospital visits to

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Ejumudo KB 'Gender equality and women empowerment in Nigeria: the desirability and inevitability of a pragmatic approach (2013) 3 *Developing Country Studies* 61.

[485] CRR "Broken Promises" *supra* note 8 at 25.

[486] UNFPA & UNIFEM, Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack 12 (2006).

[487] Chukuezi, C. Socio-Cultural Factors Associated with Maternal Mortality in Nigeria. (2010) 1:5 *Research Journal of Social Sciences* 22-26.

[488] Lindroos, A. Antenatal Care and Maternal Mortality in Nigeria. Public Health Program – Exchange to Nigeria (2010).

[489] CEDAW, *supra* note 83 General Recommendation No 24, para 31(c).

[490] Lindroos, *supra* note 488 at 8, 10.

ensure a normal pregnancy.[491] Although a close analysis reveal that rural women seek prenatal care with traditional and unskilled professionals.[492] On one hand, there is a belief that these centers are cheap and efficient. On the other hand, they can have negative effect on a pregnancy in cases of complications.[493]

Utilization of Institutional Prenatal care is very low in Nigeria[494]. Over one third of pregnant women do not attend antenatal care service.[495] 61 percent of Nigerian women visit skilled providers at least once during the lifespan of a pregnancy compared to the average of 79 percent in low-middle income countries.[496] Access to institutional prenatal services is much lower in rural areas of the country in comparison to the urbanized regions.[497] Unmet needs for prenatal care in Nigeria remain high and contribute to high maternal mortality. According to Okpani & Okpani, the rate of use of institutional antenatal care is low among women in Nigeria especially in the rural areas where women have less financial capacity to afford the services and have lower educational attainment.[498]

National data reveals that the rate of prenatal care varies significantly across the regions in the country. In the Northeast, 52 percent of pregnant women are unable to attend prenatal care compared to 14 percent in the Southeast region.[499] In particular, Northeast and Northwest states of Kebbi, Sokoto, Niger, Zamfara, Katsina, Kano, Bauchi and Adamawa have the highest rates of women who have no prenatal care visits.[500] The inability of women to engage in pre-natal care in the Northern region is primarily due to poverty, non-availability of medical equipment, a dearth of professional medical personnel, and the Islamic religious belief that makes women

[491] Ibid at 4.
[492] Lindroos, *supra* note 488.
[493] Ibid.
[494] Majority of poor and rural women in developing countries, including Nigeria, often rely on unskilled professionals or traditional birth attendants for prenatal care. See; Adebowale et al. supra note 449.
[495] A Fabamigbe & E Idemudia "Barriers to ante-natal care use in Nigeria: Evidence from non-users and implications for maternal health programming" (2015) 15, *BMC Pregnancy Childbirth* 95.
[496] Khan *et al.,* "Antenatal care satisfaction in a developing country: A cross sectional study from Nigeria" (2018), 18 *BMC Public Health* 268.
[497] Nigerian Population Commission (NPC) [Nigeria] 1999. Nigerian Demographic and Health Survey 1999. Abuja, Nigeria: National Population Commission and ICF Macro 2000.
[498] Okpani, A. & Okpani, J. "Sexual Activity and Contraceptive Use among Female Adolescents: A Report from Port Harcourt, Nigeria" (2000) 4:1 African Journal of Reproductive Health 40-47.
[499] A Fabamigbe & E Idemudia *supra* note 495 at 95.
[500] See. National Bureau of Statistics, Port Harcourt 2011. State-Level Statistics on Poverty, Total Number of Hospitals, Education, Family Planning, Prenatal Care and Religious Composition in Nigeria from 2004-2007.

subject to their husbands' decision-making even in reproductive health decisions.[501] These reasons may be due to the low data on pre-natal care patronage in the northern region compared to the predominantly Christian southern part of the country.[502] These factors cumulatively prevent women from seeking proper care and contribute to high rate of maternal mortality in various communities in the northern region as well as rural southern Nigeria.

The disparities in access to prenatal care between the poorer rural areas of Northern Nigeria and the urban regions of Southern Nigeria highlight the urgent need for equitable healthcare provisions. These disparities have prompted the international human rights community to address these issues through various provisions outlined in key treaties and conventions, including the CEDAW and ICESCR. International law[503] protects access to prenatal care, unrestricted access to health facilities, and information that is essential components of the right to health. Articles 10(h) and 16(1)(e) of the CEDAW guarantee women, including those in rural areas, access to family planning information. Article 9 also provides the right to receive information; and 16 (right to physical and mental health) of the African Charter; article 23(1)(b) of the Maputo Protocol also affirms this right. Art 25 ICESCR on freedom from discrimination clarifies the right to reproductive choice and autonomy and covers access to prenatal and contraceptives and other reproductive health information. Similarly, the African Women's Rights Protocol, particularly article 14(2)(a), tasks states with providing adequate, affordable, and accessible health-related information, particularly for women in rural areas.[504]

The CESR Committee urges that states must implement holistic policies which include removing barriers interfering with access to health services, education, and information that women need for prenatal health services.[505] The obligations under the Convention extend to preemptive measures to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.[506] In Nigeria, traditional beliefs

[501] CRR, 'Broken promises' *supra* note 8 at 58.
[502] Lindroos, supra note 488.
[503] ICESCR, *supra* note 84 arts. 13 and 6.
[504] Maputo Protocol, *supra* note 66 art.14(2)(a).
[505] CESR Committee on Nigeria supra note 378.
[506] CEDAW, *supra* note 83 General Recommendation 24 para. 21.

contribute to the failure to access prenatal care in Southern Western Nigeria.[507] The practice of keeping pregnancy news secret until it becomes physically visible, driven by a desire to protect the unborn and fueled by the fear of previous miscarriages, serves as a significant barrier preventing pregnant women, particularly those who have faced fertility challenges and miscarriages, from accessing necessary antenatal care in a healthcare setting as well as the societal shame associated with pregnancy outside of wedlock, are examples of conflicting factors inherent in regulating maternal health.[508] As such, women seldom seek early medical advice which has significant effect on their maternal health including threat to their lives.

In addition, the CEDAW Committee explains that in order to make an informed decision, women must have adequate information about reproductive health measures and their uses, and access to sex education and family planning services guaranteed in accordance with article 10(h) of the Convention on access to family planning education. Such information must be free of discrimination.[509] The insufficient health-care facilities and family planning services and lack of access to prenatal and ante-natal care facilities and services in some parts of Nigeria amount to violation of the rights to life and health under CEDAW, which include prenatal services.[510]

Despite the negative effects of lack or prenatal care, evidence suggests that women are reluctant to access such care. At the heart of the maternal mortality disparity issues is the need to understand this peculiar disposition which creates unending conflicts and boundaries for law reforms. The issues affecting prenatal care are beyond the 1999 Constitution, and must be addressed at the state and community level to ensure that women and mothers have control over and decide freely and responsibly on matters related to their sexuality including maternal health, free of coercion and control.

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[507] Azuh *et al.* "Factors influencing maternal mortality in southwestern Nigeria" International Journal of Women's Health (2017) at 9.
[508] Annie Bunting, Benjamin Lawrance & Richard Roberts, Marriage by Force? Contestation over Consent and Coercion in Africa (Ohio: Ohio University Press, 2016) 3.
[509] CEDAW, *supra* note 83 General Recommendation 24 para.
[510] CEDAW, *supra* note 83 General Recommendation 24 para. 31(c); Maputo Protocol, *supra* note 64 art 14(2).

### 3.3.3 Abortion and Maternal Mortality

Nigeria has one of the most restrictive abortion laws in the world: there is only a permission "to save the life of a woman", and persons who violate the law are subject to lengthy jail terms, up to seven years for a woman obtaining an abortion for other reasons and 14 years for any provider convicted of performing an illegal procedure.[511] Evidence suggests that there is 2.7 million abortion procedures annually in Nigeria. The majority of these are secretly and in dangerous conditions, with the poor and uneducated women most at risk.[512]

Low rates of contraceptive use result in unwanted and unintended pregnancies; a substantial number of women resort to clandestine and unsafe abortion which can lead to maternal deaths.[513] Several reports indicate that unsafe abortion is a critical public health problem and a leading cause of maternal mortality.[514] Evidence also suggests that equitable provision of contraceptives services can help women achieve significant progress in reducing the rate of abortion.[515] The high rate of illegal, unsafe abortions is due in part to the criminalization of abortion and its negative effect on women's autonomy, and due to the high cost of securing the service safely in private institutions.[516]

Regional disparities with respect to abortion persist in Nigeria. The illegal and unsafe abortion accounts for 20-40percent of maternal death in Nigeria.[517] Evidence suggests that contraceptive use is lowest among women in the rural areas where early marriages, low female

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[511] Ogiamien TE, Abortion law in Nigeria: the way forward, Occasional Seminar Papers, Benin City, Nigeria: Women's Health and Action Research Centre, (2000), 1.

[512] Chitra Nagarajan "Secret abortions spike in Nigeria with Boko Haram Chaos" 14 October 2019. Thomas Reuters Foundation (assessed on 17th November 2021)

[513] The low rate of contraception in Nigeria, particularly in the northern region, can be attributed to a combination of cultural, religious, and socio-economic factors. The influence of conservative religious beliefs and practices, such as Islamic teachings and adherence to Sharia law, often discourage or limit the use of contraception. Additionally, limited access to reproductive health services, lack of awareness about contraceptive methods, and gender inequality contribute to the challenges faced in promoting and utilizing contraception in the region. Oluwaseyi *et al.,* "Determinants of Contraceptive Use and Unmet Need for Family Planning among Younger and Older Women in Nigeria: Insights from a Nationally Representative Survey" (2020) PLOS One DOI: 10.1371/journal.pone.0228335.

[514] Henshaw *et al.,* The incidence of induced abortion in Nigeria, (1998), 24:4, *International Family Planning Perspectives* 156-164; Bankole *et al.* 'The incidence of abortion in Nigeria' (2015) 41:1 *International Perspectives on Sexual and Reproductive Health* 170-181.

[515] Harmonisation for Health in Africa, Investing in Health for Africa: The Case for Strengthening Systems for Better Health Outcomes (2011) 1-4.

[516] Okonofua F, Preventing unsafe abortion in Nigeria, (1997), 1:1, African Journal of Reproductive Health 25-36.

[517] Ibid at 26.

literacy, and reduced healthcare access are common.[518] It is important to note that unsafe abortion practices contribute significantly to maternal deaths in both regions. Studies have shown that the rate of abortion is generally higher in the southern region compared to the northern region. The rate of abortion is lowest in Southwest Nigeria at 11 percent, and highest in the Northeast at 16percent, and South-South at 17percent. In South-West Nigeria, women are more disposed to various methods of contraception as against the Northeast.[519] The Federal Ministry of Health[520] estimates that in the Southwest women access 27 abortions per 1000 women; North central zones 31 per 1000 women; north-west and Southeast zones 41 and 44 per 1000 respectively.[521] There are various factors that account for this division, including differences in cultural and religious norms, access to reproductive health services, and knowledge about contraceptives. Thus, regional disparities in abortion rates in the northern region is the evidence of increased unwanted pregnancies which further pushes women to illegal abortion services and maternal deaths. This is a deprivation among women who are already grappling with multiple dimensions of health and socioeconomic disadvantages.[522]

The striking disparities in abortion rates and their impact on maternal mortality rates between Northern and Southern Nigeria underscore the urgent need to analyze the provisions of international human rights treaties in addressing these issues. By examining the rights-based frameworks established by these treaties, such as CEDAW, ICESCR, and the Maputo Protocol, we can gain insights into how they can address the underlying factors contributing to the regional divide in abortion rates and improve access to safe reproductive healthcare services. The CESR Committee has established that the right to sexual and reproductive health requires health facilities, goods, information and services, including safe abortion and post-abortion services, which are available, accessible, acceptable and of good quality.[523] The Committee explains that States "have a core obligation to ensure, at the very least, minimum essential levels of satisfaction of the right to sexual and reproductive health which includes measures to

[518] Ibid at 26-27.
[519] Guttermather Institutte, Abortion in Nigeria Facts sheet 2015.
[520] Nigeria Federal Ministry of Health, "Abortion and Maternal Health in Nigeria", FMOH-Nigeria: (1992), 5.
[521] Ibid.
[522] Raufu A, Unsafe abortions cause 20,000 deaths a year in Nigeria, (2002), 325:7371 *BMJ* 988; Oye-Adeniran *et al.,* Complications of unsafe abortion: a case study and the need for abortion law reform in Nigeria, (2002), 10:19 *Reproductive Health Matters* 18-21.
[523] ICESCR, *supra* note 84 General Comment 14 at paras. 8, 12.

prevent unsafe abortion."[524] Similarly, the Special Rapporteur on the right to health has stated that laws criminalizing abortion "infringe women's dignity and autonomy by severely restricting decision-making by women in respect of their sexual and reproductive health."[525]

Reacting to the criminalization of abortion by state parties, the CEDAW Committee expresses particular concern about the fact that rural women are more likely to resort to unsafe abortion than women living in urban areas, thereby putting their lives and health at risk.[526] It further states that "violations of women's sexual and reproductive health and rights, such as criminalization of abortion, denial or delay of safe abortion and/or post-abortion care, and forced continuation of pregnancy, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment."[527]

The UN Working Group on Discrimination against Women has observed that "in countries where induced termination of pregnancy is restricted by law and/or otherwise unavailable, safe termination of pregnancy is a privilege of the rich, while women with limited resources have little choice but to resort to unsafe providers and practices." [528] It urges states to remove such barriers considering their discriminatory nature.

The CEDAW in its concluding observations on Nigeria urges the country to take measures to assess the impact of its abortion laws on women's health and introduce a holistic and life cycle approach to women's health, taking into account General Recommendation 24 on women and health.[529] Nigerian women's maternal health needs must be holistically addressed to prevent needless deaths.[530]

To effectively address the high death rate resulting from clandestine abortion, it is imperative to implement comprehensive reforms that encompass not only abortion laws but also tackle

[524] ICESCR, *supra* note 84 General Comment 22, para. 49.
[525] Special Rapporteur, Paul Hunt *supra* note 400 paras. 21, 65.
[526] CEDAW, *supra* note 83 General Recommendation 34 (2016) on the rights of rural women, para. 38.
[527] CEDAW, supra note 83 General Recommendation 35 (2017) on gender-based violence against women, updating general recommendation 19, para. 18.
[528] Working Group on the issue of discrimination against women in law and in practice A/HRC/38/46(2018), para. 35.
[529] CESR Concluding Observation on Nigeria, *supra* note 378 at para 11.
[530] Ibid.

societal attitudes towards pregnancy outside wedlock and gender preference. These interconnected reforms are essential in mitigating the risks associated with unsafe abortions and preventing avoidable maternal deaths. By reforming abortion laws and challenging societal norms that perpetuate stigma and discrimination, we can create an environment that ensures access to safe and legal abortion services, promotes reproductive autonomy, and safeguards the health and well-being of women in Nigeria.

At the regional level, article 14(2)(c) of the Maputo Protocol provides that states should ensure access to medical abortion services, including in cases of sexual assault, rape, incest, and danger to the mental and physical health of a woman, or to the life of a fetus.[531] Unwanted or unplanned pregnancy for adolescents is likely to be more distressing because of limitations in emotional, physiological, and financial resources with which to cope. The Protocol provides governments with a human rights resource for taking a lead in reforming laws that impede access to safe abortion.[532] Furthermore, in its General Comment 2 on other provisions of article 14 of the Protocol, the African Commission calls on African governments to address unsafe abortion and mortalities among women and girls.[533]

Nigeria has neither domesticated the Protocol nor embarked on its implementation despite the rate of maternal mortality due to unsafe abortion. Despite the high rates of morbidity and mortality associated with unsafe abortion, the Nigerian government has taken very little action to address the problem. Although Nigeria has national policies on reproductive health and safe motherhood, none explicitly address the problem of unsafe abortion.[534] The country's approach runs contrary to its international obligation under ICESCR, CEDAW and Maputo Protocol, to protect the reproductive rights of women through holistic and concrete measures.

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[531] Maputo Protocol, *supra* note 66 art 14.
[532] See. The African Commission on Human and Peoples' Rights Resolution on Maternal Mortality in Africa Meeting at its 44th ordinary session held in Abuja, Nigeria, 10-24 November 2008, ACHPR/Res 135 XXXXIIII.
[533] African Commission, General Comment 2 on article 14(1)(a), (b), (c) and (f) and article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted during the 55th Ordinary Session in Angola 28 April -12 May 2014.
[534]Federal Ministry of Health, National Reproductive Health Strategic Framework and Plan, 2002-2006, Abuja, Nigeria: 2002.; Shiffman J & Okonofua FE, The state of political priority for safe motherhood in Nigeria, (2007),114:2 BJOG 127-133.

The highly restrictive approach to abortion, especially its criminalization has also been criticized as violating article 14(2) of the African Women's Protocol. It impacts health and lives of women since significant level of illegal and unsafe abortion relates to mortality.[535] The restrictions deny women reproductive autonomy and complicate the barriers experienced by the underprivileged and marginalized women.[536] Despite the criminalization of abortion in Nigeria, it is evident that safe abortion services are accessible, particularly in urban areas, albeit within private settings and for those who can afford it. This clear disparity in access underscores the lack of equality and the detrimental impact on the marginalized and economically disadvantaged women who face significant barriers in obtaining safe and legal abortion services.[537] Evidence suggests that liberalization of abortion laws can significantly reduce abortion related deaths.[538] Thus to promote women's health and prevent fatalities, abortion must be decriminalized, therapeutic abortion permitted, a positive right for funding and provision of abortion facilities as well as adopting an approach that addresses social and psychological factors affecting abortion services should be made available.[539]

### 3.3.4 Cultural and Religious Factors and Maternal Health

#### 3.3.4.1 Female Genital Mutilation (FGM) and VVF

Cultural factors that assign gender roles and responsibilities affect women's maternal health. The social assignment of gender roles in various cultures, particularly in developing countries, has evolved over the years, such that the injustices perpetrated against women have become accepted as the norm, even by women themselves.[540] I acknowledge that numerous cultural practices in Nigeria violate the rights of women, but it is beyond the scope of this thesis to enumerate all of them.[541] They include female genital mutilation (FGM), girl child marriages resulting in Vesico-Virginal fistula (VVF), and the practice of Islamic seclusion of purdah.

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[535] Durojaye & Ngwena *supra* note 118.
[536] Ibid.
[537] Bankole *et al., supra* note 514.
[538] WHO Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 (2011) http://whqlibdoc.who.int/publications/2007/ 9789241596121_eng.pdf (accessed 20 May 2021).
[539] Gruben Vanessa "Regulating Reproduction" in Canadian Health Law and Policy, 5th Ed., Edited by Jocelyn Downie, Timothy Caufield, Colleen Flood, and Mark Stabile, 459-494. Markham, Ont.: Lexis (2018) 412.
[540] A Sen 'Gender inequality and theories of justice' in M Nussbaum & J Glover *Women, culture and development: A study of human capabilities* (1995) 266.
[541] EM Kisaakye 'Women, culture and human rights: female genital mutilation, polygamy and bride price' in W Benedek, EM Kisaakye and G Oberleitner (eds) *The human rights of women* (2002) 268 – 281, 268.

These practices have medical, legal, social, economic implications. For instance, there is an estimation that 5 per cent of pregnancies globally results in obstructed labour and accounts for 8 percent of global maternal death average as well causes 90 percent of VVF in Africa.[542]

Obstructed labour among young girls is a significant contributing factor to the high levels of maternal mortality observed within Muslim communities in the Northern region of Nigeria, and sometimes leading to devastating consequences such as VVF.[543] A study on Nigeria estimates the prevalence of VVF at 50 to 80 per 100,000 live births.[544] Early girl child marriage in many communities in Nigeria contributes to the high prevalence of VVF, because the pregnant adolescent has not fully completed her skeletal growth with regard to her height and the size of her pelvis. The immature and inadequate size of the pelvis leads to obstructed labour as the baby is often too large for the pelvis.[545] VVF and RVF are chronic conditions which have connection with pregnancy complications, such as obstructed and prolonged labour because of poor delivery practices, or a damage to the reproductive tract due to unsafe abortions.[546] VVF occurs when there is a connection between the vagina and the bladder, allowing urine to pass out uncontrollably from the vagina. [547] These unfortunate conditions make life unbearable for the affected women leading to social ostracization.[548] Many of these young girls come from poor homes where they are unlikely to be taken to hospital on time and they are frequently left to struggle in labour alone[549]. The immediate medical attention required in cases of obstructed labour is usually through a caesarean session. The lack of emergency services in Nigeria is a significant concern that affects both rural and urban areas. While rural settings, particularly in the northern regions, often face challenges in accessing emergency

[542] Hinrichsen D. "Obstretric Fistulae: Ending the Silence, Easing the suffering" Info Reports Sept (2004) 2 1-11 Baltimore, John Hopkins Bloomberg School of Public Health, The Info Project.
[543] Daru PH *et al.,* "The Burden of Vesico-Vaginal Fistula in North Central Nigeria" (2011) 1:2 *The Journal of West African College of Surgeons* 50.
[544] Ampofo KE "Risk Factors of Vesico Vaginal Fistulae in Maiduguri Nigeria: A Case Control Study", (1990) 20:3, *Tropical Doctor* 138-139.
[545] [545] L Wall 'Dead mothers injured wives: the social context of maternal morbidity and mortality among the Hausa of northern Nigeria' (1998) 29 *Studies in Family Planning* 349.
[546] C Chukuezi 'Socio-cultural factors associated with maternal mortality in Nigeria' (2010) 5 *Research of Social Sciences* 25.
[547] JA Karshinia *et al.,* Textbook of Obstetrics and Gynaecology for medical students (eds) (2006), 39-51
[548] Durrenda Ojanuga, "Preventing Birth Injury Among Women in Africa: Case Studies in Northern Nigeria" (1991) 61:4 *American Journal of Orthopsychiatry* 533; UNICEF, "Early Marriage: Child Spouses" (2001) at 11, online (pdf): https://www.unicef-irc.org/publications/pdf/digest7e.pdf.
[549] AJ Umoiyoho *et al.,* 'Quality of life following successful repair of vesico-vaginal fistula in Nigeria' (2011) 11*Rural and Remote Health* 1734.

healthcare services due to infrastructural deficiencies, it is worth noting that the majority of urban areas, predominantly located in the southern regions, also encounter similar issues. Therefore, the absence of adequate emergency services is present in both rural-urban and southern-northern contexts in Nigeria,[550] with consequences of increased risk to life and avoidable maternal deaths.

Another harmful traditional cultural practice that affects women's health is female genital mutilation (FGM). A reduction in FGM practice is a vital consideration in the control of high number of preventable maternal deaths in Nigeria, as it is a major risk factor for obstructed labour.[551] This can result to infections and complications with tremendous socio-economic, psychosocial health implications and consequences for the victims.[552] Beyond these effects, it also continues to affect maternal health outcomes negatively in several parts of Nigeria.[553]

The cultural practices prevalent in Nigeria, such as FGM and VVF, significantly contribute to maternal deaths, in both the northern and southern regions. These harmful practices reflect the urgent need for effective regulation and eradication of this practice to safeguard women's health and prevent unnecessary loss of life. [554]The provisions of CEDAW, the Maputo Protocol and CESCR, are crucial in addressing and combating these harmful cultural factors and ensuring the protection and promotion of women's rights to health. The CESCR in General Comment 14 establishes acceptability as an essential component of maternal health services.[555] Acceptability as a component requires that healthcare services must be culturally and ethically acceptable. 'Culture' is broadly interpreted to mean the various ways that we conduct and mediate social business through language, symbols, rituals, and traditions. Issues such as race, ethnicity, religion,, and so forth influence this.[556] Harmful cultural or traditional practices are

[550] World Bank. Rural population. Retrieved from http://data.worldbank.org/indicator/SP.RUR.TOTL.ZS (2016).
[551] Chukuezi, *supra* note 487 at 25.
[552] M Kabiru *et al.*, Medico-social problems of patients with vesico-vaginal fistula in Murtala Mohammed Specialist Hospital, Kano (2003) 2 *Annals of African Medicine* 55. Also, the *"Gishiri Cut"* involves the cutting of the vagina using unsterilised cutting implements such as a razor blade, knives, or sharp glasses, in an attempt to widen the birth canal and make delivery easier especially for teenage girls.
[553] CO Izugbara *et al.,* 'Maternal health in Nigeria: a situation update' (2016) African Population and Health Research Centre (APHRC) 1.
[554] Chukuezi, *supra* note 487.
[555] CEDAW, *supra* note 83 General Recommendation 14.
[556] Sylvia Tamale "The Right to Culture and the Culture of Rights: A Critical Perspective on Women's Sexual Rights in Africa" (2008) 16:47 Feminist Legal Studies 69 at 47.

thus those cultural practices and norms that tend to impair or undermine the integrity, dignity, equality and autonomy of a person including, women. These have enormous implications for health, status and the reproductive rights of women and girls in a community, including both in the private and public spheres.[557] Article 3 ICESCR recognizes the impact of customs and traditions on the rights of women and expounds the content of the article as well as outlines State Parties' obligations.[558]

General Comments No 16 ICESCR elaborates on the equality provisions (Art 3):

> Women are often denied equal enjoyment of their human rights in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination. Many women experience distinct forms of discrimination due to the intersection of sex with such factors as race, colour, language, religion, political and other opinion, national or social origin…other status such as age, ethnicity resulting in compounded disadvantage.[559]

The General Comment explicitly recognizes the intersecting factors negatively affecting women enjoyment of economic, social, and cultural rights including the right to health. The provisions of these instruments have yielded further development and crystallization of the equality norm as a cross-cutting principle in international law.

At the regional level, article 5 of the Maputo Protocol calls on states to prohibit through legislative measures backed by sanctions, all forms of female genital mutilation and other cultural harmful practices.[560] Despite these provisions, these cultural practices still continue legally to exist in majority of communities in Nigeria with their negative effects on women's lives. Nigeria's intervention in this regard have been medical rather than cultural reform.[561]

The CEDAW Committee notes the "patriarchal nature of the Nigerian society and the predominance of cultural stereotypes that are prejudicial to women, which perpetuate a negative image of women and represents a real obstacle to implementation of the

[557] J Ezeilo *Women, law and human rights: global and national perspectives* (2011) 248.
[558] Communication 294/2004—*Zimbabwe Lawyers for Human Rights and the Institute for Human Rights and Development* (on behalf of Andrew Barclay Meldrum) v. *Republic of Zimbabwe* (ACHPR).
[559] CESCR, General Comment No. 16, para. 5.
[560] Maputo Protocol, *supra* note 66 art. 5
[561] Oluwakemi Amodu, Bukola Salami & Magdalena Richter, "Obstetric Fistula Policy in Nigeria: A Critical Discourse Analysis (2018) 18:269 *BMC Pregnancy and Childbirth* 5.

Convention.[562] The Committee adopts a specific general recommendation 14 solely addressing harmful cultural practices such as the FGM. It recognizes the cultural, traditional, and economic factors that perpetuate the practice of FGM and identifies the health related consequences, and makes recommendations to states regarding steps to eliminate such practices.[563] It notes as a challenge, "the existence of a three-pronged legal system, namely, statutory, customary and religious law, which results in a lack of compliance by the State party with its obligations under the Convention and leads to continuing discrimination against women,"[564] as well as lack of awareness, fear of exercising the rights, and inadequate technical resources which are contributing factors to lack of its implementation in the country.[565]

The multicultural and plural nature of the Nigerian legal system provides strong support for the practices.[566] While the system allows for recognition and preservation of diverse cultural practices, it can also impede efforts to enact reforms and eliminate practices that violate human rights.[567] Therefore, a careful and nuanced approach is necessary to strike a balance between cultural sensitivity and the promotion of universal human rights principles in order to effectively eradicate these harmful practices. In order to address the associated maternal deaths from these practices, Nigeria must seek to modify or abolish existing cultural and discriminatory laws, including provisions of the Criminal and Penal Codes, and to implement concrete legal measures to address maternal health of women and take the specific cultural needs of the different groups, including rural and urban women,[568] into consideration. This involves policy makers identifying laws and policies at the state level that target interventions with the consideration for peculiarities of each geographic location where women's participation in health decision making is particularly low and need a well-designed context-specific policies.[569]

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[562] CEDAW Concluding Observation on Nigeria *supra* note 389 at paras. 282-316.
[563] CEDAW Committee, General Recommendation 14: female circumcision (9th Sess., 1990) in compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, at 326, U.N. Doc. HRI/GEN/1/Rev.9 (Vol. II) 2008.
[564] CEDAW Concluding Observation on Nigeria *supra* note 438 at 295.
[565] CEDAW Concluding Observation on Nigeria *supra* note 438 at 308.
[566] IO Agbede 'Legal pluralism and the problems of ascertaining personal laws: A consideration of Yinusa v Adesubokan (1971) *Nigerian Bar Journal* 69-73.
[567] See also Ahmed Yusuf, Nigerian Legal System: Pluralism and Conflict of Laws in the Northern States (New Delhi: National Publ. House, 1982) at 26-28.
[568] CEDAW Concluding Observation on Nigeria *supra* note 438 at para. 304.
[569] Adriano *et al., supra* note 454 at 4.

### 3.3.4.2 Child Marriage

Early child marriage or girl child marriage increases both maternal and infant mortalities[570]. Higher mortality rates have been observed among women who have babies at high and low extremes of maternal age i.e. women younger than 20 and above 40 years of age.[571] In developing countries where the under-aged marriage remains prevalent[572], there are over 2 million deaths annually resulting from pregnancy related complications. Girls under the age of 15 are 5 times likely to develop complications and be exposed to death, while within the 15-19 gap are two times more likely to die from pregnancy or childbirth, compared to their counterparts of 20 years of age.[573] In sub-Saharan Africa, teenage pregnancy within marriage institutions is an accepted norm, but it has social consequences as girls who marry early are less likely to be equipped for the physiological and psychological experiences of pregnancy and childbirth. It often has devastating consequences for the girls' health and education.[574] Much as it benefits the parents financially as an economic survival strategy for poor families as it reduces the burden of number of mouths to feed,[575] the social implications of this is burdensome on the affected young girls involved directly. In fact, evidence suggests that the practice of child marriage associates closely with lower educational attainment, early pregnancies, intimate partner violence, maternal and child mortality, increased rates of sexually transmitted infections, intergenerational poverty, and the disempowerment of married girls.[576]

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[570] See. Nawal Nour, "Child Marriage: A Silent Health and Human Rights Issue" (2009) 2:1 Rev Obstet Gynecol 51–56.
[571] Ujah *et al., supra* note 69 at 32.
[572] WHO Report *supra* note at 459.
[573]UNFPA State of World Population, 2004. Available at http://www.unfpa.org/swp/2004/english/ch9/page5.html.
[574] Atsenuwa A "Promoting sexual and reproductive rights through legislative interventions: A case study of child rights legislation and early marriage in Nigeria and Ethiopia" in Strengthening the protection of sexual and reproductive health and rights in the African region through human right Pretoria University Law Press (2014) 279 at 292.
[575] N Otoo-Oryortey & S Pobi 'Early marriage and poverty: Exploring links and key policy issues' (2003) 11 *Gender and Development* 42-51; Eno-Obong Akpan, "Early Marriage in Eastern Nigeria and the Health Consequences of Vesico-Vaginal Fistulae (VVF) among Young Mothers" (2003) 11:2 *Gender and Development* 74.
[576] United Nation's Children Fund, "Towards ending Child Marriage: Global trends and profile of Progress", UNICEF, New York, 2021.

The adolescent birth rate remains high in the African region at 117 per 1,000 of women aged 15-19 years as compared to 50 per 1,000 for the global estimate in 2010.[577] In Nigeria, pregnancy is the highest cause of death in women aged 15-19 years.[578] The reality of the effect of the maternal age reflects in the statistics in Northern Nigeria, where there are pressure on girls to marry at a tender age.[579] In Nigeria, not less than 48 per cent of Hausa-Fulani girls marry by age 15, while 78 per cent marry at 18.[580] In a national survey, all the northeastern and northwestern states record between 86-93% percentage of females marriage before 20.[581] This is a contrast to southern region with a lower rate, for example, Lagos, Imo and Abia states in the southern region record the lowest percentage of the population with 32-37 percent of the female population having their first marriage before they are 20 years of age.[582]

Young girls in Nigeria have little or no knowledge of sexual and reproductive health, coupled with low levels of contraceptives awareness among sexually active Nigerian girls.[583] This contributes to the high number of teenage pregnancies and abortions, especially in the rural and the impoverished urban areas.[584] One of the underlying reasons for child marriage is extreme poverty. This undoubtedly results in the disparity in the rate of maternal mortality across these regions and represents the extent of health inequality within the Nigerian society.

Unfortunately, religious and cultural groups in the country consistently resist efforts to criminalize child marriage.[585] This is largely because the "Nigerian Constitution mandates that the legislative jurisdiction on matters affecting children belongs exclusively to states. The federal law is insufficient as a means to extend protection to all Nigerian children and, therefore, there is a need for adoption by the states"[586]Although the government of Nigeria has

[577] See. WHO, World Health Statistics Report (WHO 2012).
[578] WHO, UNFPA. Pregnant Adolescents. Geneva: WHO, (2006).
[579] Atsenuwa, *supra* note 574 at 292.
[580] See Erulkar & Bello, *supra* note 459 at vii
[581] Ibid.
[582] Nigerian Population Commission (NPC) [Nigeria] 1999. Nigerian Demographic and Health Survey 1999. Abuja, Nigeria: National Population Commission and ICF Macro 2000.
[583] Okpani, A. & Okpani, *supra* note 498 at 40-47.
[584] A Karlyn *et al.,* 'Adolescent early marriage in Northern Nigeria: Evidence to effective programmatic intervention' paper presented at the Union for African Population Studies, Tanzania, 2007.
[585] Abdallah, BA, "Girl Child Marriage and Women Development in Nigeria: Contemporary Issues" (201l) 14:9 Journal of Development and Psychology 248.
[586] Tim S Braimah, "Child Marriage in Northern Nigeria: Section 61 of Part I of the 1999 Constitution and the Protection of Children against Child Marriage" (2014) 14 *African Human Rights Law Journal* 474-488, 476.

exhibited her commitment to end child marriage by signing and ratifying international and regional instruments which aim at protecting children, the political will to fully implement the provisions of the treaties are absent[587]. For instance, Nigeria has ratified and domesticated the Convention on the Rights of the Child (CRC)[588], and the African Charter on the Rights and Welfare of the Child (African Children's Charter)[589]. The Child's Rights Act (CRA) 2003 also prohibits this practice. Despite Nigeria's passing of the CRA, it is left to the states to ratify the Act and most Northern states in Nigeria have not. The continuance of these practices violates the provisions of CRC, the African Children's Charter, and the CRA.[590] Given the pluralistic nature of the Nigerian legal system, the CRA which derives its normative values from culture and religion, falls short of effectively implementing comprehensive reforms aligned with international human rights instruments regarding the sexual and reproductive rights of girls. The reliance on cultural and religious norms within the CRA hampers its effectiveness to uphold international standards, and impairs its capacity to address critical issues related to the rights and well-being of girls in Nigeria. One area of contention which has prevented the objective is stipulating the age of marriage under the CRA. Experts argue that such age stipulation under the international regime violates state and customary laws, and denies girls sexual autonomy and agency to determine their sexuality before such age and outside marriage settings.[591] It also risks criminalizing sexual act that is widely engaged in globally.[592]

Article 16(2) of Child Right Convention (CRC) states that marriage of children shall have no legal effect.[593] However, the omission of definition of 'a child' in the Convention, makes

[587] Eboibi, Felix, "The Impact of Federalism and Legal Pluralism on the Enforcement of International Human Rights Law against Child Marriage in Africa" (2017) 1 AJLHR 79.
[588] The Convention on the Rights of the Child (CRC) on 16 April 1991 domesticated by the Child Rights Act, No. 26 of 2003.
[589] African Charter on the Rights and Welfare of the Child (African Children's Charter) on 12 July 2001 domesticated by the Child Rights Act, No. 26 of 2003.
[590] Section 21 of the CRA specifically prohibits child marriage by stating that "No person under the age of 18 years is capable of contracting a valid marriage, and accordingly, a marriage so contracted is null and void of no effect whatsoever". While Section 23 criminalizes the practice by stating that "A person—(a) who married a child; (b) to whom a child is betrothed; (c) who promotes the marriage of a child; or (d) who betroths a child, commits an offence and is liable on conviction of a fine of 500,000 Naira or imprisonment for a term of five years or both such fine and imprisonment".
[591] Atsenuwa, *supra* note 574 at 290.
[592] G Lansdowne 'The evolving capacities of children' (2005) http://www.unicef-irc.org/ publications/pdf/evolving-eng.pdf
[593] Convention on the Rights of the Child, 20 November 1989, UNTS art 24 (entered into force 2 September 1990).

ambiguous the nature of marriage prohibited, thereby giving state parties power to decide this through local laws. Although, the Committee further establishes that 18 years shall be the marriage age under the Convention,[594] state parties have failed to comply through local enactments including Nigeria where three different systems of law and judicial systems, namely, the state-based laws, customary law, and Islamic law determine personal laws of marriage.[595] Nigeria must therefore take proactive and innovative measures, including full domestication of the CEDAW, to remove contradictions among the three legal systems and to ensure the resolution of any conflict of law with regard to women's rights to equality and non-discrimination, in full compliance with the provisions of the Convention. [596]

### 3.3.4.3 Religious Practices

Religious practices impact on the ability of women to receive education, engage in economic activities, and access sexual and reproductive health information and services.[597] In fact, evidence shows that Islamic religion in Africa promotes high fertility, early marriage, non-use of contraceptives, and low or non-use of hospital care.[598] It causes delays in seeking healthcare services and early ailment detection. For instance, there is a prohibition of the use of contraception among Christian Apostolic sect members. Their doctrinal support of high fertility highlights low usage of contraceptives. They believe that it is contrary to God's commandment.[599]

In Islamic religion, the purdah – a practice of secluding woman from men, non-relatives, and others male gender including healthcare providers – finds religious justification under Islamic law. It is one of such religious practices that affect women's health.[600] In Nigeria, Islamic law is not formally defined, but in Northern Nigeria, the predominant interpretation of Islamic law

[594] CEDAW, supra note 83 art. 16(2); CEDAW, supra note 83 Committee, General Recommendation No. 21 para. 36.
[595] The civil law refers to the body of law and institutions made up of received English law (where applicable), statutes and case law. It is so used only to contrast this body of law from the body of law derived from customs indigenous to African peoples and known as customary law.
[596] CESR, Concluding Observation Nigeria *supra* note 321 at para 11.
[597] Chukuezi, supra note 466 at 28; Nour, Nawal, "Child Marriage: A Silent Health and Human Rights Issue" (2009) 2:1 Rev Obstet Gynecol 51.
[598] Wei Ha *et al.*, Equity and Maternal and Child Health: Is religion the forgotten variable? Evidence from Zimbabwe, UNICEF Harare, Zimbabwe (2012), 4-6.
[599] Mbizo *et al.*, "Maternal mortality in rural and urban Zimbabwe: social and reproductive factors in an incident case referent study" (1993) 36:9 Social Science Medicine 1197-1205.
[600] E White, supra note 24 at 31.

is based on the Maliki School. [601] It is essential to acknowledge that there are numerous sects within Islam, each with different approaches to practices like purdah or seclusion. While debates exist among various Islamic schools of thought on the use of purdah, the majority in Northern Nigeria adheres to the Maliki School, which permits its usage.[602] However, it is crucial to recognize that many Muslim women in communities across Nigeria observe lesser rules of purdah and still consider themselves to be abiding by Islamic law. It is also important to note that Islamic religious Purdah prohibits the exposure of a woman's body to a man other than her husband. This religious practice has implications for women's reproductive rights, as it can impact their access to reproductive healthcare and decision-making autonomy within certain communities. The acceptance of varying practices within Islamic communities highlights the flexibility and adaptability of Islamic teachings to religious obligations. Active engagement with religious and community leaders can play a significant role in determining the reviews of norms and the use of services, fostering a more inclusive and rights-based approach to women's reproductive health. Recognizing the diversity within Islamic practices and engaging in open dialogue with religious leaders can help promote a more nuanced understanding of women's reproductive health and rights within Islamic communities in Nigeria. A complex interplay of factors, including socioeconomic status, educational attainment, geographic location, and personal preferences under both Christianity and Islamic laws, [603] influence religious practices. It is essential to recognize that they are part of a broader matrix that can lead to the discrimination, subjugation, and oppression of women[604].

While there may be a lack of available empirical data specifically attributing maternal deaths to religious factors, it is evident that certain cultural practices, particularly those attributable to the influence of Islamic religion, have a significant impact on women's health. Although official records may not exist, it is important to acknowledge that many of the issues affecting women's health in Nigeria have deep root in ethno-religious customs and norms. For example,

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[601] The Maliki School has been the dominant school in the North since around the thirteenth century. See also Ahmed Yusuf, Nigerian Legal System: Pluralism and Conflict of Laws in the Northern States (New Delhi: National Publ. House, 1982) at 26-28. Abdulmumini Oba, "Religious and Customary Laws in Nigeria" (2011) 25 Emory International Law Review at 885-886 at 886.

[602] A Imam, "The Development of Women's Seclusion in Hausa land, Northern Nigeria" (1991) 9:10 Women Living Under Muslim Laws Dossier 4; FH Ruxton, Maliki Law (London: Luzac and Co., 1916) 93.

[603] H Papanek 'Purdah in Pakistan: seclusion and modern occupations for women' (1971) 33 *Journal of Marriage and Family* 519.

[604] Y Zakaria 'Entrepreneurs at home: secluded Muslim women and hidden economic activities in northern Nigeria (2001) 10 *Nordic Journal of African Studies* 111.

the practice of purdah is prevalent in northern Muslim communities, while it is less common among Muslims in southern Nigeria. These cultural and religious influences shape and justify norms and practices, ultimately impacting the well-being of women. [605] The prevention of male doctors' interaction with Muslim women in cases of medical treatment and delivery, pushes northern women to rely on home delivery or unskilled birth attendants.[606] Purdah limits the ability of Muslim northern women to attend antenatal care when they are pregnant and during delivery period. It also has a negative effect in relation to the ability of women under seclusion to attain the highest attainable standard of physical and mental health.[607] Restriction of women to the four walls of their homes, with little or no ability to seek access to reproductive health information, medical help, and their reproductive health resource limits sources of their information to their spouses, female relatives and other women.[608] This practice is one of the factors responsible for the high rate of maternal mortality and morbidity in the northern region.[609] It also reflects intersectional and multiple axes of discrimination, as the practice mostly centers on uneducated women in rural areas and from poor families.

Religious laws have often been invoked to deny women and girls their fundamental rights.[610] Harmful and discriminatory religious practices violate state obligations under the ICESCR which guarantee comprehensive access to maternal health services for all men and women.[611] The practice of seclusion affects all the indices of women's autonomy i.e. by restricting their physical, economic and ability to make independent sexual and reproductive health decisions.[612] It is equally contrary article 12 of CEDAW which provides for non-discrimination on the ground of religion. General Recommendation 24 reinforces the importance of concrete actions by states and urges states to eliminate harmful cultural and

[605] Ibid at 108.
[606] Muslims mostly concentrate in northern Nigeria with percentage Muslim population ranging between 78-99 percent. In contrast, Christians comprise 86-99 percent of the population the southern states of Nigeria. (Federal Ministry of Health 2011).
[607] White, *supra* note 24 at 512.
[608] Barbara Callaway, "Ambiguous Consequences of the Socialization and Seclusion of Hausa Women" (1984) 22:3 *The Journal of Modern African Studies* 439.
[609] Galandanci *et al*., Maternal health in Northern Nigeria—a far cry from ideal. (2007), 114, BJOG 448–452.
[610] Nawal, *supra* note 570 At 53, 54.
[611] White, *supra* note 24 at 512-3.
[612] Ibid.

religious norms, as well as increase education and employment opportunities which could improve the health knowledge of women[613].

Religion remains a significant factor in preventing the effectiveness of human rights protection in Nigeria. For example, most religious issues affecting maternal health in the northern region are largely due to the application of Islamic law defined as "culture". Customary laws have different connotation as operative in the southern parts of the country.[614] Legal reforms are therefore critical in any attempt to resolve the entrenched system of patriarchy under the Islamic law operating in the northern region. Although, capturing a broad reference to law reforms, judicial interventions in the nature of the dialogue between religious and cultural practices is difficult, a form of legal relief has a strong effect on customs and religious practices.[615] Precedents are emerging from the African Commission which has pronounced on the legality of gendered religious laws which provide for lashing of only females for intermingling with males as discriminatory and violate the principles of equality under the African Charter.[616] Nigerian Supreme Court has equally made a pronouncement on customary inheritance as discussed in chapter six[617].

### 3.3.5 Place of Residence

Place of residence has significant impact on maternal health service utilization. Women in rural areas are less likely to receive the required number of antenatal visits, access to skilled birth attendants and quality postnatal care, due to limited health facilities, high rate of poverty and low education.[618] It is well established that rural areas in developing countries, such as Nigeria, tend to receive less healthcare attention compared to the urban areas.[619] Wall also finds that in India and Nigeria, the two countries with the highest maternal mortality rates in the world, both

[613] General Recommendation 24; article 2 of African Charter.
[614] Abdulmumini Oba, "Religious and Customary Laws in Nigeria" (2011) 25 Emory International Law Review at 885-886.
[615] Ndulo, Muna, "African Customary Law, Customs and Women's Rights" (2011) 18:1 Indiana Journal of Global Legal Studies 88.
[616] See African Commission decision in Curtis Doebbler v. Sudan (2003) AHRLR 153 (ACHPR 2003). Where The Commission was able to contextualize the suffering and indignity of women and girls as a result of oppressive religious laws and practices and its effect on its followers.
[617] See Mojekwu's case (*infra*).
[618] Adebowale *et al.,* Survival probability and predictors for woman experience childhood death in Nigeria: "analysis of North-South differentials". (2012)12 BMC Public Health 430.
[619] Boserup, E. Population, the Status of Women, and Rural Development. (1990) 15: *Population and Development Review* 45-60.

countries have large rural populations, 73.9 percent and 59.5 percent respectively, as well as highly under-served rural communities with regards to healthcare services.[620] As with many other health outcomes, pregnant women in the rural areas and the impoverished urban areas are at an increased risk of developing illnesses and complicated pregnancies, have poorer nutrition, and face more challenges in accessing timely healthcare services compared to their wealthy counterparts resident in the rich urban areas.

Pruitt provides a framework for theorizing rural women's difference as being at a disadvantage and for arguing that it merits attention in the analysis of human rights and gender issues.[621] She argues that rurality is highly relevant to many legal analyses, even though law has rarely recognized it in relation to, and in combination with gender.[622] Rural dwellers face structural barriers, often associated to the physical distances that separate them from the needed services.[623] Rural women generally have less economic, social, cultural, and political power than both urban residents and rural men,[624] and there is an urgent need for a more grounded and nuanced understanding of women's lived realities which requires policy makers, judges and stakeholders to engage geography, because spatial aspects of women's lives implicate inequality and moral agency.[625] They have direct relevance to an array of legal issues.[626]

Nigeria's maternal mortality crisis occurs along regional lines.[627] Studies show that place of residence when combined with other social factors have negative effect on maternal death ratio in Nigeria i.e. the maternal death ratio of the poor, uneducated rural women in comparison with their rich, educated urban counterparts remains high.[628] There exists a high maternal death in the north-west and north-eastern regions of the country; these regions have some of the worst

[620] Wall, L., "Dead Mothers and Injured Wives: The Social Context of Maternal Morbidity and Mortality among the Hausa of Northern Nigeria" (1998) 29:4, Studies in Family Planning 341-359.; World Bank 1995. Improving Women's Health in India, Washington DC.
[621] Pruitt, L 'Deconstructing CEDAW's Article 14: Naming and Explaining Rural Difference' (2011) 17 *Wm. & Mary J. Women & Law.* 347, http://scholarship.law.wm.edu/wmjowl/vol17/iss2/379
[622] Ibid at 347-348.
[623] Ibid at 348.
[624] Ibid at 348.
[625] Nigel Rice & Peter Smith "Ethics and Geographical equity in Healthcare" (2001) 27:4 *Journal of Medical Ethics, 256-261.*
[626] Lisa R. Pruitt, Gender, Geography, (2008) 23 *Berkeley Journal of Gender Law & Justice* 338 Available at: http://scholarship.law.berkeley.edu/bglj/vol23/iss2/3.
[627] Ujah *et al., supra* note 69 at 2-4.
[628] Ibid at 5.

health and social statistics in the world.[629] Socioeconomic status affects access to healthcare services, hence residence remains a key factor that determines the differences in maternal mortality ratio between the regions in Nigeria as well as between different sections of a state.[630] Thus, poor women who reside in rural areas have higher risk of pregnancy related complications which may result in death. The largest urban areas in Nigeria concentrate in the south. They include Lagos, Abuja (Federal capital) Osun, Rivers and Anambra with the highest urban population, although with some pockets of exceptions in the north[631]. There is a high population concentration in rural areas in the northern part of Nigeria however, with Sokoto, Zamfara, Jigawa, Taraba and Benue having the largest rural populations in the country.[632]

According to a national data, women from the rural northern areas live below $1.25 a day in Northern states of Sokoto, Zamfara, Katsina, Jigawa, Yobe and Bauchi states at 42-92 percent of the female population living in poverty.[633] This suggests that the rate of maternal mortality is higher by reasons that women in rural area experience financial difficulty in accessing quality healthcare, especially in the absence of adequate healthcare infrastructure.

Moreover, a national health survey finds a significantly higher rural mortality rate of 828 versus an urban rate of 531.[634] Also a 2015 study estimates the ratio in rural areas as 44 deaths per 1,000 live births and 34 deaths per 1,000 live births in urban areas,[635] although with some exceptions such as in the rural south especially in Lagos State and Rivers State. Over 80 percent of states in the country shows a death rate below the national average of 545 per 100, 000 deaths. In Kano state, a largely northern Muslim population, it records a mortality rate of 2200 death per 100,000 live births similar to Lagos state's 2100 rate. The rate may be due to the large poor urban population. The WHO finds that the risks of maternal death are greater for

[629] Campell J. Why Nigeria's North South Distinction is Important. Huffington Post, 2011.
[630] See. Adebowale *et al*., "Survival probability and predictors for woman experience childhood death in Nigeria: "analysis of North-South differentials". (2012) 12 BMC Public Health. 430.
[631] States like Kano, Abuja, Kaduna have large urban populations compared to some states in the South.
[632] The North has a higher proportion of rural residence than the South, and these areas are mostly underdeveloped, and poor. See. Adebowale *et al., supra* note 449 at 432-433.
[633] Federal Office of Statistics, *supra* note 453.
[634] Federal Ministry of Health, Port Harcourt 2011. State-Level Statistics on Maternal Mortality Figures in Nigeria.
[635] Nigeria Demographic and Health Survey 2013 the DHS Program STATcompiler. (http://www.statcompiler.com). Corroon M, *et al.,* The role of gender empowerment on reproductive health outcomes in urban Nigeria. (2014) 18:1 *Maternal Child Health Journal* 307-315.

certain Nigerian women, such as those in the underdeveloped northern region of the country, rural women, and low-income women[636] without formal education.[637]

The considerable disparities in infrastructure between northern and southern regions of Nigeria contribute to the disparities in maternal mortality rates. With the majority of Nigeria's population residing in rural areas, the concentration of maternal health services in urban areas further exacerbates the challenges faced by pregnant women in accessing adequate care.[638] For rural women, especially, public health facilities are often too far away from home and transport is either lacking or unaffordable.[639] The non-availability of healthcare facilities and services reinforces the intersectional discrimination with respect to the essential component of the right to health. It results in the huge disparities in the health outcomes and violates the provisions of article 12(1)(2) of ICESCR, which requires states parties to make necessary health services available, accessible, acceptable and of acceptable quality (AAAQ). [640] These provisions of the right to health entail both 'freedoms' and 'entitlements'– the former relates to the right to consensual medical treatment while the latter relates to access to healthcare services.[641] The CESCR explains that availability means that healthcare services must be of sufficient quantity, while accessibility implies that healthcare services must be physically and economically accessible, particularly to the vulnerable and marginalised groups.[642]

The Nigerian government must prioritize addressing the rural-urban divide in the regulation of the right to health, in line with the provisions of international human rights instruments. Failure to do so would result in discrimination against vulnerable groups. General Comments 1 and 2,

[636] World Health Organization (WHO) et al., Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA, and the World Bank 5 (2007), *at* http://www.unfpa.org/upload/lib_pub_file/717_filename_mm2005.pdf

[637] The northern states like Sokoto, Zamfara, Jigawa, Katsina, Borno and Yobe have some of the largest low educational attainment populations with 91-96 percent of the population having less than secondary school education is the least region with women educational attainment. This contrasts with Southern states Lagos, Rivers, Imo, Anambra and Abia with estimated 37-56% in secondary educational attainment.

[638] Henshaw *supra* note 514 above.

[639] Idris, *et al.*, 'Barriers to utilisation of maternal health services in a semi-urban community in northern Nigeria: the client's perspective' (2013) 54:1 *Nigerian Medical Journal* 27.

[640] CESCR General Comment 14.

[641] ICESCR, supra note 84 General Comment 14 para 33.

[642] Ibid.

relating to Article 14 of the African Women's Protocol[643], underscore the significance of providing non-discriminatory access to sexual and reproductive healthcare services for all women. These provisions highlight the need to focus on the health needs of marginalized groups, including the rural population, refugees, and women with disabilities. I argue that failure of the Nigerian government to provide equal opportunities is inconsistent with the normative content of the right to health under the ICESCR, CEDAW and African Charter. The dearth of relevant facilities in the rural areas in Nigeria results in one of the three-type delays that result in preventable maternal death i.e – delay in reaching treatment, delay in identifying the problem, and delay in getting help. When pregnant women are unable to access healthcare services due to their non-availability in rural areas, it amounts to intersectional discrimination and requires political will on the part of the Nigerian state to meet this reproductive health needs.

### 3.3.4 Government Policies on Reproductive Health of Women

The federal nature of Nigeria has led to multiple initiatives at both the national and state levels to address maternal health[644], with some governments forming partnerships with international organizations including the WHO. The responsibility for health policy formation, including maternal health policies, primarily rests with the Federal Ministry of Health (FMOH) in Nigeria.[645] In the exercise of the constitutional power, the country adopts the National Health Policy and Strategy to achieve the goal of guaranteeing a socially, economically productive

[643] See ACHPR General Comments: Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2012); ACHPR General Comment 2: Article 14(1)(a),(b),(c) and (f) and Article 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2014).

[644] Initiatives include: *MotherCare Nigeria*, which focuses on improving delivery services through training of midwives and furnishing health facilities and equipment, expanded role of the midwives and the targeting of hospitals as training centres.; *Misoprostol Use Approved* addresses the rate of maternal death resulting from postpartum hemorrhage. In addition, the "Free Maternal and Child Health Policy" was introduced in 1999 and adopted at the state level in 2001; *Midwives Service Scheme (MSS)* employed midwives in selected primary health care facilities in remote communities for a period of one year to reach remote rural communities due to shortage of midwives.

[645] The Ministry has several departments specializing in different aspects of health care. The Family Health department is concerned with creating awareness on reproductive, maternal and neonatal and child health, ensuring sound nutrition including infant and young child feeding, and care of the elderly and adolescents. The department of Public Health coordinates formulation, implementation and evaluation of public health policies and guidelines. It undertakes health promotion, surveillance, prevention and control of diseases.

health for all Nigerians.[646] The Policy states that health is an essential component of social and economic development. Although it fails to make specific provision for reproductive health; a major setback for maternal mortality in Nigeria. It includes primary health care as a critical component of the policy which encompasses maternal health. The implication of the omission for reproductive health is that it focuses on family planning and child healthcare at the expense of women's and girls' reproductive health.[647] This may explain away the present approach which fails to address several reproductive health challenges in the country including low contraceptive use, the HIV/AIDs and Female Genital Mutilation crises, despite their effects on women's health and indeed maternal mortality in the country.

In 2001, National Reproductive Health Policy and Strategy (NRHPS) was drafted to complement and address the shortcomings of the National Health policy regarding reproductive health and to address the "unacceptably high levels of maternal mortality and morbidity".[648] Recognizing the limited approach of national laws towards reproductive health, the policy acknowledges the need to protect women's reproductive health and promote the wellbeing of citizens and address the major obstacles of poor reproductive health services in the country. Specifically, the policy objectives include: reduction in maternal mortality and morbidity due to pregnancy and childbirth by 50%; reduction in perinatal and neonatal morbidity and mortality by 30%; reduction in the level of unwanted pregnancies in all women of reproductive age by 50%, amongst others.[649] In recognizing the need to advance women's status and health considering the age long discrimination they experience within the Nigerian society, the National Policy on Women (NPW) was adopted and includes several health objectives with regard to women, especially on vulnerable groups of women. It makes provisions for the reform of several social and harmful cultural practices including low social status, high illiteracy rate, and canvassing an integrated multi-sectoral approach to women's health. The NRHPS's language is also equity-sensitive, as it calls for compliance by "all tiers of government and individuals with all…policies and laws supporting the attainment of the highest level of reproductive health irrespective of age, sex, ethnicity, religion and socio-

[646] National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians. In: (Nigeria) Federal Ministry of Health, ed; 2001.
[647] Ibid.
[648] Ibid.
[649] Ibid.

economic status".[650] The policy includes reforms in the form of legislation on mandatory provisions on maternal health services to all women, VVF, and other harmful practices. It recommends fixing a minimum age of 18 for all forms of marriage i.e. statutory, customary, and religious.[651]

In my view, the National Reproductive Health Policy (NRHP) falls short in its approach to addressing various harmful practices that significantly impact women's health. While the policy acknowledges the need to eliminate these practices, it lacks explicit provisions stating that legislation should be enacted at the federal and/or state levels to prohibit or criminalize such practices. Furthermore, the absence of enforceable legislation at all levels of government undermines the policy's effectiveness, which is primarily due to the lack of clear delineation of powers over maternal health in the Constitution. Even the federal National Health Act of 2014, as discussed in Chapter Four of this thesis, fails to prioritize the issue of maternal mortality.[652]

### 3.5 Nigeria's Maternal Mortality Policies and Intersectionality

Maternal death has traditionally been attributed solely to medical causes, including factors such as hemorrhage, hypertensive disorders of pregnancy, puerperal sepsis, unsafe abortion, and prolonged/obstructed labor. Basically. The society see women as patients, whose death can occur due to failures in medical procedures.[653] I now analyze these factors from issues resulting from the delays in seeking medical care in relation to pregnancy. Intersectionality seeks to address the social relation and understand the social factors such as age, sex, place of work, etc.,[654] which have significant affect on the ability of women to access adequate healthcare services when pregnant. Such factors have implications for women's social and reproductive autonomy.[655]

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[650] National Reproductive Health Policy and Strategy to Achieve Quality Reproductive and Sexual Health for all Nigerians. In: (Nigeria) Federal Ministry of Health, ed; 2001.
[651] Ibid.
[652] See Chapter Four of the Thesis on the Role of the National Health Act 2014 on Maternal Health regulation in Nigeria.
[653] See C Ngwena, supra note 107 at 221.
[654] C Thomas, 'How is disability understood? An examination of sociological approaches' (2004) 16 *Disability and Society* 569.
[655] Ibid at 571.

Maternal health policies in Nigeria unduly focus on institutional and medical factors. Policies and initiatives operate with the assumption that women when they receive appropriate intervention especially in institutional settings would have improved maternal health.[656] In reality, numerous practical barriers discussed above[657] hinder women's access to both prenatal and general maternal health services, especially for the impoverished women living in remote rural areas. As stated earlier, these factors result in disparities in the rate of maternal death between the rich, urban privileged women and the poor, rural and marginalized women. Structural intersectionality focuses on the lived experience of women and canvasses different solutions to different problems.[658] Without a gendered approach to maternal health, policies especially at the national level will fail to meet international human rights standards, which require that laws and policies specifically target pregnant women depending on their social location. Maternal health laws and policies must target the marginalised women and consider the different experiences of women as being socially constructed category. Since the African society has different roles for different gender, there is an expectation required of a female gender which has implications for their health.[659] It must consider the socio-demographic and the cultural factors that confront women in underprivileged communities, to regulate maternal health in Nigeria.

### 3.5.1 Nigerian Jurisprudence and Intersectional Discrimination

A discussion on application of the intersectionality framework in Nigeria demands an evaluation of the approach of Nigerian jurisprudence towards multidimensional discrimination experienced by women. The provision of the right to freedom from discrimination in Chapter IV of the Constitution expressly declares it to be a subject of judicial inquisition. Specifically, section 42 guarantees the right to freedom from discrimination.[660] The provision prohibits

[656] CRR, "Broken Promises" supra note 8.
[657] See Chapter 3 at pages 64-119.
[658] Yuval-Davis, N. 'Intersectionality and Feminist Politics', European Journal of Women's Studies, (2006) 13(3), 193-209 at 196; Crenshaw, supra note 26 at 1241-1250.
[659] Crenshaw, *supra* note 26 at 1250.
[660] It provides as follows: "A citizen of Nigeria of a particular community, ethnic group, place of origin, sex, religion or political opinion shall not, by reason only that he is such a person;

(a) be subjected either expressly, or in the practical application of any law in force in Nigeria or any executive or administrative action of the government to disabilities or restrictions to which citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religious or political opinions are not made subject; or

either the conferment of privilege or benefit as well as the imposition of disabilities or restrictions simply on any of the grounds listed. Thus, any suffering of deprivation or disadvantage because of any law, policy or their implementation and application, by citizens, private institutions, and governments, on account of their sex, religion, ethnicity, runs contrary to the express provisions of the Constitution.

On the face of it, the non-derogable nature of the right to freedom from discrimination under the 1999 Constitution as amended, would appear to entrench a commitment of the state to respect and protect this constitutional right.[661] However, a cursory look at the provision shows that it guarantees equality formally and not substantially. Having regard to the analysis of formal and substantive equality, this provision of the Nigerian Constitution cannot yield substantive gender equality. Women in Nigeria continue to suffer discrimination and oppression which arise from the patriarchal nature of the society as well as cultural and religious practices. A substantive model of equality considers the social cultural practices, and institutions that can allow a neutral rule to engage a systematically discriminatory environment.[662] In essence, the interpretation of the constitutional guarantee of non-discrimination as contained in section 42 restricts the prohibition of discrimination to a single ground, preventing the recognition of intersectional and other complex forms of discrimination. Nwabueze states the limits of the provision[663] and argues for a construction of discrimination jurisprudence in such a way that accommodates other grounds of discrimination in line with intersectionality theory.

The provision of non-discrimination in the Constitution is essential for maternal health and other forms of discrimination. However, a major challenge to the provision exists in the same Constitution since it contains exclusionary provisions that remove personal and customary law

(b) be accorded either expressly by, or in the practical application of, any law in force in Nigeria or any such executive or administrative action, any privilege or advantage that is not accorded to citizens of Nigeria of other communities, ethnic groups, places of origin, sex, religious or political opinions.

(2) No citizen of Nigeria shall be subjected to any disability or deprivation merely by reason of the circumstances of his birth".

[661] BO Nwabueze *The presidential constitution of Nigeria* (1982) 452.

[662] SH Williams 'Equality, representation, and challenge to hierarchy: justifying electoral quotas for women' in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 57-58.

[663] Nwabueze, *supra* note 661 at 184.

from its purview.[664] Therefore, even in the establishment of multiple discrimination, the limits imposed by the Constitution renders the process of utilizing the provision for maternal health of no valuable consequence.

The maternal health policies in Nigeria fail to set health priorities for different groups who suffer differential harm despite its effort to be inclusive. Intersectionality places explicit focus on differences and diversity in the experiences of women among groups and how the various social factors interact to shape these experiences. Extant policies assume that all women regardless of their age, cultural background geographical location, socio-economic status, religion and sexual orientation and other categories of differences, share the same experience, and priorities. This universalization is a critical roadblock in its objective to tackle maternal mortality in Nigeria. It assumes that a rural Northern Muslim woman and a rural poor Southern woman – whose lived experiences and social statuses are different –have similar knowledge, agency and bargaining power when it comes to maternal choices. This heterogeneity also operates at sub-group levels within a state or community. For instance, while a huge number of rural and poor women prefer traditional birth attendants to modern forms of prenatal healthcare, the policies have failed to develop this aspect through training of such attendants as a strategy to making maternal health policies gendered and culturally sensitive in line with CESR essential health components.[665] Galadanci *et al.,* conducted a research among tribal communities in Northern Nigeria. It shows that "the health system is completely ignorant about the traditional pregnancy delivery, and childcare practices of the tribal communities".[666] The legal system approach to maternal health privileges of different categories of women lacks the understanding of the local context and lived experiences of the marginalised women.

Nigeria's reproductive health policy fails to address women's decision-making power, and participation in setting health policies and priorities. One of the key components of intersectionality in which manifests gender inequality is that of political participation. The absence of power, voice and decision-making autonomy have a significant impact on the health

[664] Johanna Bond, "Gender and Post-colonial Constitutions in Sub-saharan Africa" in Helen Irving, ed, Constitutions and Gender (Cheltenham: Edward Elgar Publishing, 2017) at 87.
[665] CESR on AAAQ approach.
[666] Galadanci *et al.,* "Programs and policies for reducing maternal mortality in Kano State, Nigeria: a review: original research article." (2010) 3:14, *African Journal of Reproductive Health: Special Issue* 31-36.

and lives of women.[667] These are crucial elements of substantive equality as a basic requirement of human rights approach.[668] For any of the substantive issues relating to protection of women's health and equality to receive adequate attention, women must be actively present in the process of law and policy making.[669] The increased participation of women in the political process has invariably led to the adoption of laws and policies that promote gender equality and eliminate discrimination and disadvantage.[670]

The policies ignore the role of social determinants of health in the design and implementation of maternal health programmes in the country. This National Health Policy and the subsequent Reproductive Health Policy focus their interventions on the challenge of medical and institutional problems associated with maternal health. It places lesser attention on the conditions in which women are born, grow, live, work and age as factors critical for intervention for effective maternal health. Socio-cultural and economic and religious aspects of health are important considerations that can shape policy interventions, because they maintain social hierarchies and result in structural inequality leading to inter and intra state disparities in health outcomes.

The country's Free Maternal and Child Health Policy eliminates user fees for pregnant women, thereby resulting in increase in women's participation in prenatal services.[671] It however suffers two main challenges. First, it operates at the state level, hence the less financial viable states both in the South and Northern Nigeria could not properly implement the policies. In 2006, it was adopted by the national government in all federal health institutions but with

[667] Barnes, T & Burchard, S "Engendering" Politics: the impact of descriptive representation on women's political engagement in sub-Saharan Africa" (2012) 46:7 *Comparative Political Studies* 767-790,768.
[668] See, art 21, UDHR 25, ICCPR, 14 CEDAW; OHCHR, the principles and Guidelines for a Human Rights Approach to Poverty Reduction Strategies (2006) 14:64.
[669] Williams, *supra* note 568 at 20. Nigeria designed the National Women Policy aimed at complementing the national reproductive health policy. However, nowhere in this document is political representation and adequate participation of women prioritized as a form of improving women's sexual and reproductive health.
[670] Hessel *et al.,* "Women's Political Representation Associated with Reduction in Child Mortality in Brazil" (2020) 39:7, *Culture of Health, Health Affairs* 1166-1174.
[671] The user fee policy has been implemented in piecemeal i.e 16 out of the 36 states of the federation: Bauchi, Gombe, Kaduna, Katsina, Kebbi, Kwara, Niger, Sokoto, and Zamfara. Other states are: Federal Capital Territory - Abuja (North Central); Lagos and Oyo (South-West); Edo, Rivers, and Delta (South-South); and Enugu (South-East).

limited outreach.[672] Second, it was designed as a knee jerk policy reaction to the alarming rate of maternal fatality, hence its development is not to be a permanent solution but a short-term intervention due to its financial implications on the federal government. As stated earlier, the continued application of out-of-pocket expenses and users' fees in several parts of the country violate the right to health of women under provisions of both ICESCR and CEDAW, which require states to provide maternal health services. The burden of out-of-pocket expenses during the antenatal, delivery, and postnatal periods acts as a disincentive for poor, rural women in Nigeria, discouraging them from accessing skilled healthcare services. The *Alyne's case* earlier discussed in chapter 3 shows the human rights implication of this user fees. This also relates to the Nigerian case of *WARD-C v A.G Federation & 3 ors,*to be discussed below.

Although, the policies recognize the harmful effect of cultural practices such as Child Marriage, FGM, unsafe abortion, VVF and Islamic purdah, the policies have failed to address the legal challenges through such concrete measures as enacting, banning, and repealing of laws. The failure to reform discriminatory cultural practices and traditional norms denies women dignity and their ability to make independent reproductive health decisions and it violates the non-discrimination provisions of the Nigerian 1999 Constitution, article 12 of ICESCR and CEDAW. For example, the country has enacted the Child's Rights Act (CRA),[673] which specifically prohibits child marriage. However, before the CRA becomes applicable within states, there is a need for an adoption of legislative powers in section 4(7) of the Constitution[674]and most Northern states in Nigeria have not.[675] I submit that even if Nigeria domesticates the ICESCR and CEDAW which seek to address women discrimination in maternal health, it will suffer the same fate as the CRA due to the constitutional limitation on the subject matter. This approach reflects a lack of comprehensive approach and political will

[672] Okonofua *et al.,* "Advocacy for free maternal and child health care in Nigeria - Results and outcomes." (2011) 99:2, *Health Policy* 131-138 at 135.
[673] Section 21 of the CRA specifically prohibits child marriage. However, child rights matters are residual matters within the exclusive legislative powers of states in accordance with section 4(7)(a)(b) & (c) of the Constitution and can only be applicable upon its adoption at the discretion of such state assemblies. See. Enyinna Nwauche, "Child Marriage in Nigeria: (Il)Legal and (Un)Constitutional" (2015) 15 *African Human Rights Law Journal* 421 at 423.
[674] Section 4(7) Constitution of Nigeria.
[675] The third list, the residual list, is consequential. See Attorney-General Abia State & 35 Others v Attorney-General of the Federation (2002) 3 SC 106.

to address the legal, ethno-cultural and religious tensions perpetuating these cultural roadblocks to guarantee equality for women especially as they affect their maternal health.

### 3.6 WARD-C v A.G Federation-An Assessment of intersectional discrimination in Nigeria

Despite the high level of maternal mortality in Nigeria, only one case has been presented before the Nigerian domestic courts, seeking to hold government accountable for a maternal death. In the case of *Women Advocates Research & Documentation Centre (WARDC) v The Attorney General of the Federation; The Minister for Health; Prof. Chris Bode, Chief Medical Director, LUTH and Lagos University Teaching Hospital*[676], the plaintiff, an NGO for women's rights, sued on behalf of the husband of a deceased Mrs. Folake Oduyeye. The deceased died of complications following a childbirth, due to her detention and false imprisonment as a result of her inability to pay her medical bills.[677] The applicants initiated a legal action, seeking a declaration that the actions in question constitute a violation of the deceased individual's rights to life, health, non-discrimination, liberty, freedom from arbitrary detention, dignity, and freedom from cruel, inhuman, and degrading treatment, as protected by sections 33, 34, 35, and 42 of the 1999 Constitution. They argued that detaining patients who are unable to immediately settle their medical bills until they can afford to do so is illegal, unconstitutional, and runs counter to the constitutional and human rights standard that Nigeria should uphold.

The defendant's contention in the case relies on torts since the right to health is not justiciable and the locus standing of the plaintiff at the appellate court cannot be established. As at April 2022, the appeal was still pending before the Court of Appeal of Nigeria.[678] This case presents the Nigerian courts with an opportunity to make a notable pronouncement on intersectional discriminatory factors and policies that violate constitutional provisions which affect maternal health. It also offers the Nigerian courts a rare opportunity to opine on the judicialization of

[676] *Women Advocates Research & Documentation Centre v The Attorney General of the Federation; & 3 Ors. Suit No: FHC/L/CS/1962/15*
[677] *Ward-C v. Attorney General of the Federation. Supra.*
[678] The case has also been instituted at the African Commission by WARDC and Dullah Omar Institute seeking a declaration that the actions of the Nigerian government violate the right to life and dignity guaranteed under the African Charter and Maputo Protocol which Nigeria is a signatory. See, "African Commission to hear case on Maternal Deaths Brought by the Center and Partners". Center for Reproductive Rights www.reproductiverights.org (accessed on 4th September 2020)

maternal death in the country. The hope is that the case yields a precedent as in the case of *Alyne*,[679] that will not only result in appropriate remedies but also inform policy decisions of a general nature that prevent the continued application of the policy of imposing economic barriers and financial obligations especially on the poor and underprivileged women. The discriminatory practice amounts to violations of the fundamental rights of women in Nigeria and presents a classical representation of unconstitutionality. The economic status of the plaintiff has significant effect and intersect with her rights to life and dignity. As in *Alyne case*, the financial status determines what quality of maternal health services are accessible to Mrs. Oduyeye. The act of withdrawing medical treatment due to her inability to pay for maternal health services violates her right to life.

While the decision in the *Alyne* case deals specifically with discrimination in the context of Brazilian health system and the liability of private entities for violation of human rights, the principle of law established by the Committee can potentially have positive implications for Nigeria, particularly in light of the CEDAW Committee's application of an intersectional approach to women's rights, and more importantly it is relevant in addressing discriminatory practices against pregnant women including those discriminated against on grounds of economic status and location as in the case of *WARD-C v AG Federation.* It does not necessarily mean the decision *in Alyne* is binding on the Nigerian Courts. But it can serve as a guide and reference point for both the Nigerian judiciary and policy makers regarding the treatment of the right to health and its determinants, within its domestic context regardless of the non-implementation of international instruments like CEDAW and ICESCR.[680] The case lays down positive obligations in respect of maternal mortality issues and the need to address structural challenges in the health system.[681] Particularly, the Committee's reference to intersectional discrimination regarding maternal health is instructive.[682] In light of these

[679] Alyne *supra.*
[680] Judy A. Oder, "Keeping Promises: Litigation as a Strategy to Concretise the Right to Health in Africa" In "Litigating the right to health in Africa: challenges and prospects" by Ebenezer Durojaye, Routledge (2016) at 234.
[681] Ibid at 229.
[682] For examples of concluding observations regarding the failure to reduce preventable maternal mortality as offending the Convention, see R. Cook and V. Undurraga, "Article 12 [Health]," in M. Freeman, C. Chinkin, and B. Rudolf, eds., The UN Convention on the Elimination of All Forms of Discrimination against Women: A Commentary (Oxford: Oxford University Press, 2012): at 311-333.

considerations, the failure of Nigerian governments to acknowledge and address intersectional grounds of discrimination, as well as ensure equitable access to healthcare services for women, would constitute a violation of their rights to life, health, and non-discrimination. I examine these issues in greater depth in Chapter Four of this thesis.

It is evident from the aforementioned points that the recognition of human rights violations stemming from maternal death depends on various factors. These include: the recognition of the rights in national and international instruments, factors that may impede effective access to health services and may lead to maternal death, and the institutional competence and willingness of the judiciary to pronounce positively on the issue despite the status of the relevant international human instruments under the legal system. Since pregnancy and childbirth are within women's biological capacity[683], adequate attention must be paid to the inequalities and inequities which result from discriminatory laws, policies and practices, particularly in the context of healthcare, and how they contribute to the high rate of preventable maternal deaths in Nigeria.

The promotion of maternal health through a focus on the economic, cultural and religious elements remains a valuable contribution of my research as they have effect on women's right to equality but maternal mortality is merely a symptom. They have continued to shape the everyday experiences of pregnant women across the regions in Nigeria. Intersectionality accounts for the gendered nature of the maternal mortality. It affords me the opportunity to center my analysis on the marginalized group. I acknowledge that several intersections of discrimination exist such as race and other disabilities which can affect maternal health, the exposition in this thesis does not cover deployment of intersectionality from these other

[683] I acknowledge the existence of LGBTQ+ transgender, non-binary and other gender non-conforming individuals while focusing specifically on cis gendered women and girls in this dissertation to better understand the unique challenges they face in relation to sexual and reproductive Rights in Nigeria. In this dissertation, my focus is solely on cis gendered women and girls, individuals whose gender identity matches the one assigned at birth. I acknowledge the existence of other gender identities along the feminine spectrum within cultural communities in Nigeria, but I limit the scope of my research to avoid conflating their experiences. By focusing on cis gendered women and girls in specific regions in Nigeria, I aim to maintain the integrity of this study and respect the diversity of experiences without making inappropriate or discriminatory generalizations. See: Joan Wallach Scott, "Gender: A useful category of historical analysis" in Feminist History Reader (Milton Park: Oxon: Routledge, 2006) 133; See. Judith Butler, Gender Trouble: Feminism and the Subversion of Identity (New York: Routledge, 1990); Gayle Rubin, "Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality" in Deviations: Gayle Rubin Reader (Durham, NC: Duke University Press, 2011).

perspectives. This opens potential opportunities for further research in specific gender-based, cultural and religious practices affecting women across different locations in the country.

## 3.7 Conclusion

In this chapter, I present the economic, cultural and religious issues responsible for the disparity in maternal death ratio between the Northern and Southern Nigeria. I argue that despite Nigeria's commitment which seeks to significantly reduce maternal deaths to 70 per 100,000 live births by 2030 as well as the country's obligations under both its national Constitution and international human rights treaties, the Nigerian government has failed in its responsibilities and commitments towards maternal health with differential effects across the regions. The failure is largely due to the patriarchal nature of the traditional Nigerian state deeply governed by ethnic, religious and customary laws. I contend that policymakers should prioritize Nigerian women as a vulnerable population when designing intervention programs, focusing on initiatives such as improved accessibility to high-quality healthcare facilities and the provision of free prenatal and postnatal care. Although committing to the goals of eradication of discrimination in maternal health in Nigeria is paramount in the reduction of maternal mortality in Nigeria, rights-based and intersectional approaches, beyond rights rhetoric to culturally acceptable reforms, are essential in the process. Addressing maternal mortality in Nigeria requires targeted interventions that address specific challenges in different regions. This includes addressing the role of Islamic law in personal laws such as child marriage in the North and decriminalizing abortion in the Southwest. The interplay and relationship of Islamic personal laws and customary laws are more particularly discussed in the next chapter on the challenges affecting maternal health in Nigeria. Given the federal nature of Nigeria and the divisions of legislative lists, the political will at both federal and state levels is crucial for effective regulation and reform. The governments must be deeply sensitive to the extraordinarily unique and intersectional identities of the poor, marginalised, rural and uneducated women. This will be in line with achieving equity, justice, and accountability. I turn to the legal and constitutional structure required to regulate maternal deaths in Nigeria.

# CHAPTER FOUR

## Constitutionalising the Right to Health and Gender Equality in Nigeria

### 4.0 Introduction

In this chapter, I critically examine an issue that presents a challenge in the advocacy of socioeconomic rights in Nigeria, particularly the constitutionalization of the right to health and gender equality. One key goal in this regard is to scrutinize the justiciability of the right to health, and the varying approaches taken by different countries in its realization and the correlating implications for maternal health. I examine the apparent departure of the Nigerian state from the modern constitutional approach to socioeconomic rights. The chapter also examines the need for the Nigerian government to live up to its international obligations under various human rights treaties, and the gendered ways in which allocation of resources through culture, religion and constitutional structures impact on women's health and well-being. The ensuing analysis examines the extant constitutional framework for the right to health and gender equality in Nigeria, and identifies the legal system failures that lead to preventable maternal deaths in the Nigeria's health system. It further examines challenges and opportunities that exist within the context of Nigeria's legal framework for the constitutionalisation of gender equality and the right to health. This includes recognition and enforcement of the right to health, its ratification and domestication, the division of healthcare responsibilities, the spheres of intersection between gender equality and the constitution: women's political participation, the forms of equality guaranteed, the challenge of multiculturalism, and the division between private and public spheres governance. I argue that failure to effectively recognize these factors have negative effects on the realization of effective maternal health, and I apply intersectionality theory to address these multiple and interlocking issues under the Nigeria constitutional structure .

### 4.1 Application of International Human Rights Treaties in Nigeria

The staggering magnitude of preventable maternal mortality in Nigeria raises a crucial question: Are the constitutional objectives of promoting good governance, equality, and justice truly holds in practice? In the face of such a pressing issue, it becomes imperative to explore the role that the constitution can play in providing solutions for improving maternal health outcomes. In the preceding part of this thesis, it is established that social and regional inequality

results in health inequities. An analysis of the legal context and approach of interpreting international human rights instruments to give meanings to constitutionally guaranteed rights is necessary to challenge the current judicial approach in Nigeria. The legal structure for domesticating international treaties under the 1999 Constitution has its own role in promoting or impeding the realization of adequate health for women[684]. Nigeria operates a dualist system, whereby treaties, including human rights treaties, are not automatically applicable within domestic settings until their incorporation through domestic legislation.[685] The executive arm of the Federal Government of Nigeria has exclusive power to enter into international treaties on behalf of the nation.[686] For the treaty to be enforceable in Nigeria, under section 12(1) of the 1999 Constitution, the legislative arm of the Federal Government must enact it as a law.

Section 12(1) provides that: "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."[687] The National Assembly pursuant to this provision enacts the Treaty Making Act for the purpose of implementing treaties, even in respect of matters not included in the Exclusive Legislative List.[688] In the Supreme Court of Nigeria case of *Ibidapo v Lufthansa Airlines,* Wali JSC explains that, "Nigeria, like any other Commonwealth country, inherited the English common law rules governing the municipal application of international law."[689] In *Oshevire v British Caledonian Airways Limited,* the Nigerian Court of Appeal establishes the supremacy jurisprudence that ratified and domesticated treaties, being international treaties are superior to domestic laws.[690]

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[684] B Odunsi & O Adewole, "Domestication and reception of International reproductive health law and the Limits of Law-Perspectives from Nigeria and South Africa in Irehobhude Iyiode "Women's Health and the Limits of Law-Domestic and International Perspectives" eds. (Routledge, 2020) at 232-233.

[685] Egede, Edwin, 'Bringing Human Rights Home: An Examination of the Domestication of Human Rights Treaties in Nigeria,' (2007), 51:2 *Journal of African Law* 249-284.

[686] Treaty (Making Procedure, etc.) Act 2004, CAP T 20, LFN 2004.

[687] Although the section refers to any treaty with any country, the interpretation by the Supreme Court is that the section applies to all international bilateral or multilateral treaties which include human rights treaties. See. Ibidapo v Lufthansa Air (2005) 5 NWLR (Pt 919) 342. Constitution of the Federal Republic of Nigeria (Promulgation) Act. 7 See also items 26 and 31 of the Exclusive Legislative List contained in the second schedule of the 1999 constitution.

[688] See section 12(2) of the 1999 Constitution.

[689] [1997] 4 NWLR (Part 498) 124 at 150. For UK practice see J H Rayner v Department of Trade and Industry [1990] AC 418 at 550.

[690] (1990)7 NWLR 507. The case was followed by several other cases, See Abacha v Fawehinmi(infra).

Beyond ratification, treaties must be domesticated to make them enforceable. Nigeria has ratified the ICESCR and CEDAW but has failed to integrate these treaties into her domestic legislation. The non-domestication of these treaties by Nigeria pursuant to section 12, amounts to a violation of Nigeria's international obligations especially the provisions of the Vienna Convention on the 1969 Law of Treaties, which require States Parties to comply with the provisions of treaties they have entered into in good faith under the principle of *pacta sunt servanda.* The reliance of Nigeria on its domestic provisions to evade implementing these treaties would seem contrary to the spirit of the treaties, and lack of political will to guarantee implementation of their provisions and the rights arising therefrom. The legislature puts them beyond the reach of ordinary citizens and refuses to accord the instruments the desired legal status. Nigeria's legal regimes comprise both domestic laws and treaties voluntarily entered and ratified by the country.[691] The country's approach to application of human rights treaties is contrary to Nigeria's commitment to implement treaties, especially the distinction being made between social, civil and political rights, since it relies on its domestic laws to avoid its obligations.[692] As noted by the CESCR in its General Comment No. 9 on the Domestic Application of the Covenant:

> The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.[693]

Experts argue that the non-domestication of the treaties in accordance with domestic requirements violates international law.[694] For the treaties to be legally binding on Nigeria, it must domesticate them. Nigeria has not domesticated the treaties, therefore it is not legally bound by their provisions.[695] Nigeria has obligations under the ICESCR and CEDAW to

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[691] Egede, Edwin, *supra* note 685 at 251.
[692] Vienna Convention on the Law of Treaties 1969, art. 26 on the principle of *pacta sunt servanda.*
[693] CESCR, General Comment 9, The Domestic Application of the Covenant (Nineteenth session, 1998), U.N. Doc. E/C.12/1998/24 (1998), para. 10.
[694] Odinkalu, CA 'The impact of economic and social rights in Nigeria' in Gauri, V & Brinks, D (eds) *Courting social justice: judicial enforcement of social and economic rights in the developing world* (Cambridge 2008); Centre for Reproductive Rights & Women Advocates Research and Documentation Centre Broken promises: human rights, accountability and maternal death in Nigeria (2008) 17.
[695] Egede, *supra* note 685 at 249-284.

respect, protect, and fulfil the enumerated rights in similar manners as obligations under civil and political rights.[696] The obligation to fulfil requires States to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of such rights. Thus, the failure of Nigeria to provide essential primary health care to those in need amounts to a violation under these instruments.[697] The only exception to non-fulfilment of socioeconomic rights by a state is a "proven lack of resources"[698]. Nigeria is the biggest oil exporter in Africa, with oil revenues accounting for over 80% of the government revenue.[699]

Despite Nigeria's vast resources, its incidence of maternal death is one of the worst in the world. The governments have failed to prioritise pregnant women's health especially as the country has fallen short of meeting up its obligation in terms of minimum budgetary allocation to healthcare sector as well as the failure to put maternal healthcare infrastructure in place in both urban and rural areas despite the high rate of maternal deaths. Therefore, Nigeria has an obligation to respect and adhere to the provisions of the treaty, and to pursue policies that do not detract from the Covenant and should strive to progressively realize health rights within its territory through the judicious use of available resources in the light of its high maternal mortality .

Even with domestication of human rights treaties, socio-economic rights have been declared to be non-enforceable. Nigeria has domesticated the African Charter, the Protocol Establishing the African Court on Human and Peoples' Rights pursuant to section 12(1) of the 1999 Constitution, and this is the only treaty that has been so enacted. The Charter contains an integrated regime of rights including economic, social, cultural, civil, and political rights.[700] The application of the African Charter in Nigeria was considered in the case of *Fawehinmi v.*

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[696] International Commission of Jurists (ICJ), *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, 26 January 1997, available at: http://www.unhcr.org/refworld/docid/48abd5730.html Guideline 6.
[697] Ibid. Guideline 6.
[698] CESCR General Comment 14.
[699] National Population Commission (NPC) (Nigeria) & ORC Macro, Nigeria Demographic and Health Survey 2003 at 2 (2004).
[700] C. A. Odinkalu, Implementing economic, social and cultural rights under the African Charter on Human and Peoples' Rights. In Malcolm Evans & Rachel Murray, *The African Charter on Human and Peoples' Rights: The system in practice 1986–2000* (2002) 178.

*Abacha.* [701] The Supreme Court upheld the Court of Appeal's decision that the rights provided in the Charter are enforceable through court processes deploying the rules of procedure of Nigerian courts.[702] However, the same court has also held that in the scheme of obligations and entitlements, the African Charter is below the Nigerian Constitution, and conflicts between the two instruments must be resolved in favour of the Constitution.[703] The posture of the Supreme Court, it has been argued, means that the Charter, even though it has been domesticated, cannot introduce justiciable rights that the Constitution has declared non-justiciable. In this case, the Supreme Court of Nigeria has sought to reify the supremacy of the Constitution against all other laws, including international human rights instruments, alongside those that have been domesticated. This is contrary to art of constitutionalism and confirms the failure of justices of the Supreme Court to appreciate the importance of international human rights jurisprudence to social rights.[704] This perhaps explains why human rights litigation in Nigeria has relied mostly on domestic provisions, and in some cases, the domesticated African Charter.[705]

The mode of reception and implementation of health treaties limits the effectiveness of maternal health laws in Nigeria. The approach to international reproductive health obligations in the country, coupled with socio-economic and cultural factors, greatly impacts the realization of effective maternal health.[706] As a signatory to a number of international conventions on maternal health,[707] the government when confronted with its failure to meet certain human rights standard, unjustifiably claims that these treaties are unenforceable and not part of laws in Nigeria. This non-recognition has had negative effect on maternal mortality cases in Nigeria as it confronts litigants with the unenforceability challenge with no regard for the robust international jurisprudence on maternal health. This conclusively establishes that the combined effect of the non-enforceability of the right to health in Nigeria justified by the non-ratification and domestication of treaties affect the right to health under the Constitution. This approach to the right to health has contributed to the poor governance of maternal health in Nigeria.

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[701] (2000) 6 NWLR (part 660) 228.
[702] Ogugu v. State, [1996] 6 *Nigeria Weekly Law Reports* (Pt. 316) 1, 30–31.
[703] Fawehinmi v. Sani Abacha [2000] *Nigeria Weekly Law Reports* (Pt. 660) 228.
[704] Art. 60 African Charter. See SERAC v Nigeria, (*supra*).
[705] See the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, LFN 2004.
[706] Odunsi & Adewole, "*Domestication and Reception" supra* note 684 at 234.
[707] CEDAW, ICESCR, ACHPR and Maputo Protocol.

Ratification and domestication 'veils' require reforming domestic Nigerian jurisprudence on the non-enforceability of socioeconomic rights as it is crucial to ensure accountability from the government regarding maternal health policies. Domestication of socioeconomic rights related treaties like the ICESCR and CEDAW should be expressed with a strong emphasis on their reasonable and effective implementation. Mere domestication of treaties although may not automatically translate to decline in maternal deaths, these treaties have legal and institutional mechanisms, including treaty bodies jurisprudence, for the enforcement of the rights which policy makers must concretely embrace. Domestic courts have the power to bridge the gap and enforce the right to health, thereby providing essential remedies and protections for individuals. They can play a vital role in realizing the right to health, through their interpretation and application of constitutional provisions and existing laws.

Despite the little progress in the implementation of the African Charter in Nigeria, landmark decisions such as *SERAC*, have established precedents in the application of socioeconomic rights. The Charter and the Women's Protocol made therefrom, are now understood as a viable legal framework for enforcing the right to health and indeed maternal health in Nigeria. The strict compliance with international decisions by governments in Nigeria is however beyond the scope of this thesis.

### 4.2 Constitutionalising the right to health in Nigeria

Constitutionalizing the right to health has become a global trend, with numerous countries recognizing and implementing health as a fundamental right in their national constitutions.[708] This chapter explores the case of Nigeria, arguing that the country should also adopt a constitutional right to health. Drawing upon the experience of South Africa as a comparative example, Chapter Six of this thesis dwells on the potential benefits and challenges of

[708] Kinney E, Clark B. Provisions for health and health care in the constitutions of the countries of the world. (2004)37 *Cornell International Law Journal* 285-355; Backman G, Hunt P, Khosla R, *et al.* Health systems and the right to health: an assessment of 194 countries. (2008)372 *Lancet* 2047-2085; Heymann S, Cassola A, Raub A, Mishra L. Constitutional rights to health, public health and medical care: the status of health protections in 191 countries. (2013) 8 *Glob Public Health* 639-653.

constitutionalizing the right to health in Nigeria. I examine its implications for the protection and promotion of the health and well-being of its citizens.[709]

The rationale for undertaking a discussion of the constitutionalisation of the right to health for the prevention of maternal death lies in the fact that failings in the delivery of healthcare services to women often result in maternal deaths. Constitutionalisation would also attempt to subject public health policies, laws and powers exercised by state organs to constitutional procedures and norms.[710] This approach will therefore improve maternal health outcomes and ensure that women exercise their right to be healthy, and thus avoid unnecessary deaths. It also enables us to identify and address the disparities that characterise access to healthcare services in Nigeria as well as the underlying disadvantage and discrimination that prejudice women and affect their reproductive capacity.

What impact does the constitutionalisation of the right to health have on the health and well-being of societies? As observed by Barak-Erez, denying constitutional status to social rights has a disproportionate effect on women, who are in general poorer, more vulnerable than men, and who carry the burden of caring for their dependent relatives.[711] Kavanagh brushes aside objections to the constitutionalisation of the right to health and makes a case that the right to health can make a difference for health outcomes.[712] First, constitutionalizing health can benefit the overall wellbeing of a country's population.[713] Secondly, by operating as an institution in the national political economy of health, it sets the appropriate actors, venues, and actions in health policy with significant effect on the policy agenda and the eventual distribution of resources.[714] Constitutionalisation of health improves health aggregates, including by significantly improving the wellbeing of the poor and marginalized segments of

[709] M Kavanagh Constitutionalising health: rights, democracy and the political economy of health policy (2017) iii; Dissertation University of Pennsylvania; https://repository.upenn.edu/edissertations/2863 (accessed on 20 August 2021).
[710] Petra Dobner and Martin Loughlin "The Twilight of Constitutionalism?" Oxford Scholarship Online: May 2010 (accessed on 15 June 2021)
[711] D Barak-Erez 'Hermeneutics: feminism and interpretation' in B Baines, D Barak-Erez & T Kahana (eds) Feminist *constitutionalism: global perspectives* (2012) 95.
[712] Kavanagh *supra* note 709 at 17.
[713] Kavanagh *supra* note 709 at 17.
[714] Kavanagh *supra* note 709 at 17.

a society, even as it may do less for those with higher incomes, bringing equity benefits along with overall improvements.[715]

Young argues that the entrenchment of a justiciable right to health can produce beneficial outcomes.[716] She argues that whether countries adopt a limited or expansive approach to health rights, the results are dependent on the aggregation of four variables: doctrinal arrangements i.e. whether jurisdictions are supportive of content-heavy, core, substantive rights, or procedural obligations.[717] In addition, there is a need to determine whether they are supportive of access to courts with viable remedies. Also, there can be a consideration for financing arrangements i.e. how to arrange profit-seeking incentives for efficiency and non-health-related interests. The civil society configurations are important consideration as well.[718] Although, some experts claim that providing constitutional protections to health rights leads to middle-class and wealthy individuals using the courts to ensure access to costly, non-critical treatments, which takes money away from providing care to the most vulnerable or marginalized in a society.[719] Undoubtedly, there are jurisdictions with strong access to health services without a constitutionally or statutorily entrenched right to health. A common feature of these systems including countries like Canada and United State of America, is a state social security program and policies strengthened by other rights in several human rights instruments.[720] Where the political will exists for the provisions of social and public goods, it requires limited need for implementation of a constitutional and statutory right to healthcare. However, in emerging democracies such as Nigeria, the political-will is absent partly due to the insensitivity of a government and its limited financial ability. This makes the enforcement of health rights challenging for ordinary citizens. Hence, there is a need for a constitutionally

[715] Kavanagh *supra* note 709 at 16-17.
[716] Katharine G. Young. "The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa". (2013): 26:1 *Harvard Human Rights Journal* 179-216.
[717] Ibid.
[718] Ibid 179, 180.
[719] Pedro Santos "Beyond Minimalism and Usurpation: Designing Judicial Review to Control the Misenforcement of Socioeconomic Rights (2019) 18 *Wash University Global Stud Law Review* 493
[720] A typical example is the Canadian legal system. For example, the Canadian Health Act provides for access to health but, it does not grant a right to health although its implementation is influenced strongly by the Canadian Charter of Rights and court decisions on various aspects of the right to health. See Eldridge v British Columbia [1997] 3 SCR 624; Chaoulli v Quebec [2005] 1 SCR 791, 2005 SCC 35 held that a prohibition of private health insurance violates the right to life and security of persons under the Quebec Charter of Human Rights and Freedoms.

guaranteed right to health as adopted in South Africa. The justifications for incorporating and enforcing the right to health in its constitution are convincing and compelling. It has enabled the marginalized groups such as women, to bring cases before the courts for vindication, which in turn results in positive influence on state maternal health policies and programmes, especially toward pregnant women. To what extent has the Nigerian Constitution reflected this objective of making social rights and right to health enforceable within its legal structure? This next section turns to the status of the right to health under the 1999 Constitution of Nigeria.

### 4.3 Right to Health as Fundamental Objectives and Directive Principles in Nigeria

A good starting point on the capacity of government through laws and policies to guarantee health equity would be to examine Nigeria's constitutional provisions relating to the right to health. The 1999 Constitution of Nigeria provides among other things that the state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.[721] This provision is in the Chapter II of the Constitution, which is non-justiciable.[722]

While the provision in the 1999 Constitution of Nigeria acknowledges the state's responsibility to ensure adequate medical and health facilities for all, it falls short of explicitly recognizing the right to health as a justiciable and an enforceable right. To guarantee the right to health in Nigeria, there is a need for constitutional reforms that explicitly recognize and protect the right to health, provide mechanisms for its enforcement, and ensure accountability in the provision of healthcare services. This may involve incorporating specific language that recognizes the right to health and outlining the duties and obligations of the state in fulfilling this right, as well as establishing effective mechanisms for redress in case of violations. By implication, provisions of Chapter II are mere aspirations that the Nigerian government aims to deliver to its citizens without a binding obligation on the state. Citizens tend to rely on international instruments that guarantee similar rights to enforce these provisions especially where the Nigerian governments have ratified and domesticated same as in the case of the African Charter[723].The Charter forms part of the laws in force in the country, and guarantees every person the right to enjoy the best attainable state of physical and mental health in article 16. In

[721] Section 17(3)(d).
[722] Section 6(6)(c).
[723] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1990. Section 1.

assessing Nigeria's compliance with its obligations under the African Charter, it is relevant to determine the status of the Charter and indeed international human rights instruments in Nigeria's domestic jurisdiction.

Pursuant to its domestication, the Charter is an Act of the Federation and a subject for enforcement. Thus, citizens who have claims of violation of rights guaranteed under African Charter can approach domestic courts or tribunals to enforce their rights. In many instances, the African Charter has been relied upon by domestic courts to enforce human rights violations including right to health.[724] Consequently, the absence of justiciable right to health in the Nigerian Constitution does not relieve government of its legal obligations to ensure that preventable maternal deaths do not occur. Indeed, the right to health guaranteed in article 16 of the African Charter being a domestic law has the force of law in Nigeria and unlike the provisions of Chapter II, it is judicially enforceable.

The provisions of the African Charter on Human and Peoples' Rights Ratification and Enforcement Act [725] have a force of law in Nigeria and shall be given full recognition, effect and be applied by all authorities and persons exercising legislative, executive or judicial powers in Nigeria. By virtue of section 1 of the Act, the African Charter is enforceable in Nigeria. Thus, article 16 of the African Charter, which guarantees the right to health,[726] is enforceable in Nigeria and should be applied by the government.[727] The provisions of the section can be interpreted by Nigerian courts to give effect to the reproductive rights of women, maternal health services as well as implement the interpretive guides and comments made pursuant to the Charter. The decisions of the African Commission on the rights are also applicable as guides. While the domestication of the African Charter in Nigeria is a positive step towards recognizing the right to health, it is important to note that the Charter has a

[724] Fawenhinmi v Abacha (*supra*)
[725] African Charter Enforcement Act (Nigeria).
[726] African Charter, art. 16.
[727] The African Commission on Human and Peoples' Rights held that the Nigerian government violated the right to health (Article 16) of the African Charter in the case Social & Economic Rights Action Center v. Nigeria, Communication No. 155/96, African Commission on Human Rights (2001), available at http://www1.umn.edu/humanrts/africa/ comcases/155-96.html (finding government oil exploration activities had caused a number of negative health impacts including reproductive problems)

subordinate status in the interpretation of the Constitution[728] by the domestic courts in Nigeria. Therefore, if the Constitution does not explicitly recognize the right to health and impose positive obligations on the government, solely relying on the domesticated African Charter may not fully guarantee the comprehensive protection and enforcement of the right to health in Nigeria. In spite of this, the reality for women in Nigeria is that access to health services, particularly sexual and reproductive health, remains abysmal and has grave implications for preventable maternal death. This amounts to a failure of Nigeria's constitutional framework in realizing the right to health and consequently, predisposing pregnant women to maternal mortality. Despite socio-economic rights being subject of progressive realization under international law, Nigeria needs to show that it is taking concrete positive steps within the limits of its available resources to realize these rights. This is most especially the immediate 'minimum obligations' which are essential, such as primary health care including maternal health, that governments is required to provide within the framework of the ICESCR and African Charter.

The 1979 Constitution introduced Chapter II provisions on Fundamental Objectives into the Nigerian constitutional law jurisprudence, a corollary for non-justiciable socioeconomic rights.[729] The foundation for the introduction of the principle is not unconnected to the years of military rule in Nigeria. During the constitutional debates of 1978 which led to the enactment of 1979 Constitution, an argument has been put forth for a constitution that prioritizes civil and political rights while neglecting socioeconomic rights. The outcome however does not meet the yearnings and aspirations of Nigerians. Proponents of this view argue "that if the state may not be able to provide free education at all levels, right to a job, shelter and free medical care, these should not be justiciable rights".[730] They base their position on the financial demands of social rights for the state and the huge budgetary consequences compared to civil and political rights.

The above narrative reinforces Karl Klare's position that "For present purposes it is enough to note that the very existence of this debate shows that rights discourse is socially constructed,

[728] SERAC *supra*.
[729] Akande, Jadesola, The Constitution of the Federal Republic of Nigeria, (London: Sweet § Maxwell, 1982), 13.
[730] Eze, Osita, Human Rights in Africa: Some Selected Problems, (Lagos: Macmillan Publishers, 1984), at 32

that conceptions of rights are embedded within and framed by particular political and social visions."[731] Contrary to these assertions, it is important to recognize that civil and political rights not only entail negative imposition of obligations on the state but also require positive action to ensure their effective enjoyment.[732] This approach, which I extensively discuss in chapter five of the thesis, draws inspiration from the Indian legal framework and emphasizes the need for an expansive interpretation of rights that encompasses both civil and political as well as socio-economic rights.[733] The conventional negative/positive dichotomy is no longer tenable as it is unsound.[734] This is also in line with an international law approach emphasizing the interdependence and indivisibility of all human rights: be they civil, cultural, economic, political, or social rights.[735] It is now also settled that civil and political rights require considerable budgetary expenditure.[736]

The provisions of Chapter II of the 1999 Constitution includes fundamental obligations of government, people, political objectives, economic objectives and social objectives.[737] Specifically, Section 17 of the Constitution provides as follows:

(1) The State social order is founded on ideals of Freedom, Equality and Justice,
(2) In furtherance of the social order- (a) every citizen shall have equality of rights, obligations and opportunities before the law; …
(3) The State shall direct its policy towards ensuring that- … (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; (d) there are adequate medical and health facilities for all persons.

Despite the provisions allowing both the federal and state governments in Nigeria to enact laws and fornulate policies pertaining to the health sector, these efforts fall short of imposing

[731] Klare, Karl E. 'Legal Theory and Democratic Reconstruction: Reflections on 1989', (1991) 25:1 University of British Colombia Law Review 69-103, at 97
[732] M. Langford "The justiciability of Social Economic Rights: From Practice to Theory" In Social Rights Jurisprudence: Emerging Trend in International Comparative Law" Edited by Malcom Langford (Cambridge University Press) 2008.
[733] Ibid.
[734] Shue, Henry, Basic Rights: Subsistence, Affluence and U.S. Foreign Policy, (Princeton, New Jersey: Princeton University Press, 1980), 51.
[735] K Krause & M Scheinin 'The Right not to be discriminated against: the case of social security' in T Orlin, A Rosas & M Scheinin (eds.) *The jurisprudence of human rights law: an interpretive approach* (2000) 255.
[736] Langford supra note 732 above.
[737] See sections 13–17 of the Nigerian Constitution 1999 (as amended).

positive obligations for ensuring effective judicial enforcement.[738] This places the crucial matter of healthcare at the discretion of executive policies, potentially exacerbating inequalities across different states. The right to health has not generated real attention from the Nigerian governments at all levels. While successive governments have made attempts to address the standard and quality of health services in the country, there remains a pressing need for comprehensive legal frameworks that guarantee equitable access to healthcare and enforce the right to health for all Nigerians.

Judicial decisions in Nigeria relating to the right to health are almost nonexistent due to its non-justiciable nature. The few cases on right to health originated from adjudication upon justiciable civil and political rights, and legislation relating to Chapter II provisions of the Constitution. The development of Nigerian jurisprudence on socioeconomic rights has been hampered by their non-justiciable nature. Section 6(6)(c) of the 1999 Constitution of the Federal Republic of Nigeria states that:

> The judicial powers vested in accordance with the foregoing provisions of this section… (c) shall not, except as otherwise provided by this Constitution, extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or any judicial decision is in conformity with the FODPSP set out in Chapter II of this Constitution.

The Nigerian governments have always relied on the non-justiciability of these rights to object to cases that come before the courts, seeking to enforce the rights provided for in Chapter II of the Constitution.[739] Hence, this is likely an objection a government[740] would confront with a claim to enforce a violation of the right to health arising from a maternal death. Indeed in *WARDC v AG Federation & Ors,* a case I reviewed earlier, relating to maternal death in a Nigerian hospital, the defendant challenged the suit on grounds that the right to health is not

[738] J Odikpo and E Durojaye "Litigating Health Rights Issues: The Nigerian Experience" in Litigating the right to health in Africa: challenges and prospects (edn.) Ebenezer Durojaye (2015)141-156 at 146.
[739] The Court of Appeal of Nigeria, in an action challenging the constitutionality of the abolition of private primary school by the government of Lagos State, held that no court has "jurisdiction to pronounce any decision as to whether any organ of government has acted or is acting in conformity with the "FODPSP" and that the role of the judiciary is limited to interpreting general provisions regarding the observance of the provisions of chapter II. See. Archbishop Anthony Olubunmi Okogie & 6 Others v. Attorney-General of Lagos State, (1981) Nigeria Constitutional Law Reports 337.
[740] Archbishop Okogie & 6 Others v. A.G. Lagos State (1981) Nigeria Constitutional Law Reports 337.

justiciable in Nigeria.[741] But a constitutionally guaranteed right to health would empower the Nigerian judiciary to subject government policies to accountability tests, and Nigerian citizens would benefit from an added layer of judicial evaluation of public policies to promote their general welfare. This is available to maintain a cause of action against the government for maternal deaths resulting from their actions and/or omissions.

Although, the domesticated African Charter has been applied to the right to health in Nigeria, its application has been limited. [742] In a few decided cases, the right to health care provisions have been utilized by prisoners for a secondary relief, based upon a primary civil liberty claim.[743] Civil liberties have been employed by the judicial system to incorporate medical treatment of prisoners under the custody of prison authorities in Nigeria.[744] In 2003, a Federal High Court ruled and mandated the Federal Government of Nigeria by article 16(2) of the African Charter on Human and Peoples' Rights to provide medical care to four prisoners who are HIV positive.[745] These decisions suggest that Nigerian courts are definitely well equipped to evaluate whether socioeconomic policies of a government comply with the requirements under a proposed constitutional amendment transforming non-justiciable Chapter II provisions of the 1999 Constitution into justiciable socioeconomic rights. Nigerian courts have a remarkable record of jealously guiding existing justiciable civil and political rights provisions under Chapter IV of the 1999 Constitution.[746]

[741] WARDC v. A.G & ors. *supra* note 25.
[742] Section 12; The Constitution of the Federal Republic of Nigeria 1999.
[743] Festus Odafe & 3 Others vs. AG Federation & 3 Others, Suit No. FHC/PH/CS/680/2003.
[744] Abacha v. The State [2002] 5 Nigeria Weekly Law Reports, 761; State v. Bamaiyi [2001] 8 Nigeria Weekly Law Reports, 715.
[745] Ishmael Azubuike & 3 Ors. v. Attorney-General of the Federation & 3 Others, unreported Suit No. FHC/PH/CS/679/2003 cited in Odinkanlu, Chidi Anselm, 'The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights', in Gauri, Varun and Brinks, Daniel M. (eds.), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World, (Cambridge: Cambridge University Press, 2008), 183- 223 at 214.
[746] Abacha v. Fawehinmi (2000) 6 Nigeria Weekly Law Reports (Pt. 660) 228 S.C.; Shugaba Darman v. Federal Minister of Internal Affairs (1981) 2NCLR 459; Bishop Olubunmi Okojie v. Attorney-General of Lagos State (1981) 1 Nigeria Constitutional Law Reports 218; Attorney-General Imo State v. Ukaegbu (1981) 2 Nigeria Constitutional Law Reports 568; Governor of Lagos State & Others v. Chief Odumegwu Ojukwu & Another (1986) 1 Nigeria Weekly Law Reports (Part 18) 621.

### 4.4 Argument for Justiciability of Socio-economic Rights

Experts who oppose the enforcement of socio-economic rights argue that democratic principles of separation of powers can be contradicted if courts adjudicate on government policies and programmes, a task reserved for the representatives of the people, thus breaking the equilibrium of functions between the various branches of government and which has bearing on democratic legitimacy, and checks and balances.[747] In their opinions, matters involving the allocation of resources should be left to the political authorities rather than the courts.[748] Normatively, they argue, that judges lack institutional legitimacy and capacity as well as proper remedies to address violation of these rights.[749] Gerard argues that "if Social Rights are made justiciable and are vindicated by the courts, the result will tend to distort the traditional balance of the separation of powers between the judiciary and other branches of government in that more power will flow to the judiciary"[750].

According to Kaase, arguments raised in opposition and for judicial enforcement of social rights are manifold.[751] The separation of powers in a democratic government requires that the judiciary in performing its functions, restrain itself from intruding on the governmental functions assigned to other branches of government[752]. In addition, the implementation of socio-economic rights, is viewed to be costly, since the understanding of this class of rights is that the state oblige to protect welfare of its citizens.[753] The consequence of not treating social rights as imposing positive obligations on governments to provide health facilities is that Nigerian public hospitals are grossly underfunded, cost of private medical care alternative is unaffordable to the average citizens and available health facilities are not properly managed,

[747] M. Langford "The Justiciability of Social Rights" *supra* note 98 at 5; Liebenberg, Sandra, Socio-Economic Rights: Adjudication under a Transformative Constitution, (Claremont, South Africa: JUTA, 2010), 118.
[748] For arguments on non-justiciability of Socio-Economic Rights, see generally Christiansen C.E., , (2007), 38 Columbia Human Rights Law Review 321, Vile M., Constitutionalism and the Separation of Powers (Oxford; Clarendon Press, 1967), 13, Hogan G., "Directive Principles, Social Rights and the Constitution", , Vol. (2001), 36 Irish Jurist 174 at 189, Villiers B.D., "Social Rights" in Van Wyk, J. Dugard B. de Villiers and D. Davis (eds). Rights and Constitutionalism – The New South African Legal Order (Oxford: Clarendon Press, 1996) 529 at 606.
[749] Langford "The Justiciability of Social Rights" *supra* note 98 at 5.
[750] Langford "The Justiciability of Social Rights" *supra* note 98 at 10.
[751] Kaase T.F., The Justiciability of Social Rights Myth or Reality? Oct. (2010) 1:1 Human Rights Review (Ahmadu Bello University, Zaria).
[752] Ibid at 2.
[753] Okeowo A.O., Economic, Social and Cultural Rights: Rights or Privileges? (Law Legends & Company) Chapter VI 114 – 154 at 130

which has resulted in a comatose state of maternal health infrastructure.[754] In Nigeria, after confronting transportation hurdle of locating health-care institutions, a recurring issues in rural areas, pregnant women encounter challenges of long waits and absence of basic sanitary consumables, electricity, and first-aid equipment especially in public hospitals.[755]

Proponents for restriction of the judiciary interference in non-justiciable socioeconomic rights further argue that, while the respective jurisdiction of the various branches of government should be clear, courts are already involved in a considerable range of matters which have bearing on government spending. The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts is arbitrary and incompatible with the principle that human rights are indivisible and interdependent.[756] It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in a society.[757] Weeson argues that it is well-established that this dichotomy is overstated.[758] Courts are well equipped to adjudicate the constitutionality and soundness of government's socioeconomic policies.[759] The same competencies required in adjudication of civil and political rights that implicate budgetary expenditure also apply to socioeconomic rights.[760] Moreover, the debate over the relative ease of the judicial remedies in civil and political rights, as opposed to the constraints of applying resource allocation implications of adjudicating socioeconomic rights, is addressed by CESR and it directly implicates the constitutional legitimacy and capability of courts to adjudicate over

[754] See the Concluding Observations of the Committee on Economic, Social and Cultural Rights on Nigeria's 1996's Report on ICESCR, E/C.12/1/Add.23 of 13th May, 1998 paragraph 28.
[755] CRR, "Broken Promises" *supra* note at 8.
[756] Langford "The Justiciability of Social Rights" *supra* note 98.
[757] http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G98/148/36/PDF/G9814836.pdf?OpenElement (accessed on April 22, 2020) para. 10.
[758] M Wesson 'Disagreement and the constitutionalisation of social rights' (2012) 12 *Human Rights Law Review* 225.
[759] The courts have established record of guarding existing civil and political rights under its constitutions. Abacha v. Fawehinmi (2000) 6 NWLR (Pt. 660) 228 S.C.; Shugaba Darman v. Federal Minister of Internal Affairs (1981) 2NCLR 459; Bishop Olubunmi Okojie v. Attorney-General of Lagos State (1981) 1 NCLR 218; Attorney-General Imo State v. Ukaegbu (1981) 2 NCLR 568; Governor of Lagos State & Others v. Chief Odumegwu Ojukwu & Another (1986) 1 NWLR (Part 18) 621.
[760] Ibid.

socioeconomic rights.[761] Therefore, the non-justiciability of ESCR in Nigeria remains a confusing aberration considering the huge deposit of natural resources in the country[762].

Notwithstanding the unprecedented judicial and academic attention that social rights have received in recent years, the nature of the obligations imposed by these rights remains unclear. These issues are related because in the absence of a reasonably clear account of what social rights entail, it is difficult to sensibly address concerns regarding their constitutionalisation.[763] However, Langford argues that economic and social rights appear to have been partly rescued from controversies over legitimacy, legality and justiciability, and in many jurisdictions, have been accorded a more prominent place in discourse advocacy and jurisprudence.[764] The indivisibility, indissolubility and interdependency of human rights under international law are now accepted norms.[765] Subjecting social rights to constitutional regulation maintains that since the degree of their implementation always depends on current and constantly changing economic situations, the matter should thus be a subject of statutory legislation.[766] Langford argues that many of the concerns about justiciability, in fact relate to the nature of claims advanced by vulnerable groups to positive measures from governments, rather than to the social and economic nature of the right being claimed. If courts exhibit a systemic preference for claims challenging government interference, and a reluctance to engage with claims to positive measures of protection, they invariably exclude critical issues of injustice and inequality from judicial review and thereby entrenching systemic patterns of exclusion.[767]

When rights are brought before the courts for adjudication, they prompt an examination and interaction with the policies of the government. The literature on judicial politics challenges the legitimacy and utility of courts as actors in policy issues, such as health.[768] This challenge

[761] CESR General Comments 9.
[762] Okonjo-Iweala, supra note 98 at 66; Obiajulu Nnamuchi, 'Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria' (2008*) 52:1 Journal of African Law*, 4.
[763] Wesson, *supra* note 734 at 223.
[764] Langford M "Justiciability of Social Rights" *supra* note 98 at 40.
[765] World Conference on Human Rights, Vienna 1993.
[766] Banaszak, B 'Constitutionalisation of social rights – necessity or luxury? (2012) 66 *Persona & Derecho* 22.
[767] M Langford "The Justiciability of Social and Economic Rights: An Updated Appraisal" the Human Rights Consortium, Belfast, Northern Ireland (2007), 7-8. See C. Scott, 'The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights', (1989), 27 *Osgoode Hall Law Journal* 769, 779-790.
[768] Kavanagh *supra* note at 709.

extends the question of the court's political legitimacy to its competence in the determination of applying competing policy options. In countries like South Africa, where social rights are already constitutionalized, the debate focuses more on how to give effect to the provisions of the constitution. If civil and political rights can be legitimately protected, there is little normative basis on which we can exclude social rights.[769] Once a right is made justiciable by the constitution, state action often determines whether the right has been violated and the sort of remedy that courts may be able to provide.[770] From the above, it can be safely concluded that courts in the fulfilment of their constitutional responsibilities, have an important role to play in the implementation of socioeconomic rights. The establishment of a judicial structure for the enforcement of economic, social and cultural rights is an important function of a constitution. Constitutional recognition and judicial enforcement of the right to health can go a long way in improving the health and well-being of women, as it establishes their health considerations in general with a particular consequence for maternal mortality..

### 4.5 The Judiciary's Role in Promoting the Right to Health in Nigeria

When initiating a case in the court of law to vindicate human rights, the "requirement of permissibility" must be satisfied.[771] The issue of *locus standi* is the most important one for the claimant.[772] On the other hand, understanding of this may help the public authority whose decisions are being challenged to determine whether the claim will be accepted or not.[773] The ease of access to the court is crucial for the enforcement of human rights. Applicants whose socio-economic rights have been violated in recent times have always tended to file human rights actions against the Nigerian governments in regional courts, such as the African Commission on Human and Peoples Rights and at the Economic Commission for West Africa States Court of Justice, more than domestic courts within Nigeria.[774] This is justified by the

[769] M Khosla 'Making social rights conditional: lessons from India (2010) 8 *International Journal of Constitutional Law* 741.
[770] Ibid.
[771] Odinkalu, *supra* note 96.
[772] Adesanya v. President, [1982] 1 NCLR, 231
[773] T. Ogowewo, "The problem with standing to sue in Nigeria" (1995) 9 *Journal of African Law* 39; See, T. Ogowewo "Wrecking the law: How Article III of the Constitution of the United States led to the discovery of a law of standing to sue in Nigeria", (2000) 26 *Brooklyn Journal of International Law* 527.
[774] Odinkalu C "Courting Rights" *supra* note 96 at 602.

continuous non-justiciability of enforcement of social economic rights under the domestic jurisdiction and a highly restrictive approach to standing to sue in the Nigerian courts.

The Nigerian Supreme Court case of *Abraham Adesanya v. President of the Federal Republic of Nigeria* has become the definite authority on right of access to court or *locus standi* in Nigeria. The precedent established by the case requires an applicant to disclose an interest which is personal to him, before such an individual can be granted *locus standi* in a court of law in Nigeria.[775] The decision has effectively limited the opportunity for public interest litigation or class actions in Nigeria.[776] Almost all international treaties related to social economic rights recognize the principle of *locus standi* and highlight the importance of securing it in the national legislation.[777] Each state is entitled to extend the capacity to bring court proceedings. Public interest litigation in India and class action in South Africa have utilized socioeconomic rights litigation to improve accountability mechanism in resources allocation by their governments. The South African Constitution enables broad access to court and a more relaxed *locus standi*, as opposed to Nigeria's Constitution. Nigerian courts, unlike Indian and South African courts, have been very traditional in granting access to court, and a nexus entailing personal interest must be the foundation of any claim filed in a court. The Nigerian Supreme Court has always maintained the supremacy of the Nigerian Constitution over domestic legislation and treaties entered into by the Nigerian State.[778] This is premised on the supremacy provisions of Section 1 of the 1999 Constitution. The doctrinal approach and the procedural challenges preclude public interest actions[779] for violations of rights such as in the case of maternal health, and represents a major obstacle to the enforcement of socioeconomic rights in Nigeria.

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[775] [1981] 1 NCLR, 358

[776] Ogowewo, Tunde I. 'Wrecking the Law: How Article III of the Constitution of the United States led to the Discovery of a Law of Standing to Sue in Nigeria', (2000-2001)26 Brooklyn Journal of International Law 527-590; Ogowewo, Tunde I. 'The Problem with Standing to Sue in Nigeria', (1995), 39:1 *Journal of African Law* 1-18.

[777] S Gloppen, 'Litigating as a Strategy to Hold Governments Accountable for Implementing the Right to Health' (2008) 10 Health and Human Rights 21; See B Hough, 'A Re-examination of the Case for a Locus Standi Rule in Public Law' (1997) 28 Cambrian Law Review 83–104.

[778] SERAC *supra*.

[779] Litigants must disclose "personal interest" in the subject matter of the proceedings which is over and above that of the general public. This interest is difficult to prove where the alleged violation or governmental inactions similarly affects other members of the public. Chinonye Obiagwu & Chidi Anselm Odinkalu, Nigeria: Combating legacies of colonialism and militarism. In Abdullahi An-Na'im (ed), Human rights under African constitutions: Realizing the promise for ourselves (2002), 211.

There are two important court cases dealing with the African Charter and socioeconomic rights as provided in Chapter II provisions of the Fundamental Objectives of the 1999 Constitution. *The Social and Economic Rights Action Centre (SERAC) and the CESR v. Nigeria* and *Abacha v Fawehinmi.* The case of *SERAC v Nigeria* is significant in situating the African Charter within the Nigerian legal system. The communication brought before the Commission alleged violations of socioeconomic rights in Nigeria, particularly in relation to oil drilling activities in Ogoniland. The Nigerian government admitted to the violations and indicated remedial actions being taken, including the establishment of the Ministry of Environment and the Niger Delta Development Commission. The Commission evaluated Nigeria's obligations to respect, protect, promote, and fulfill both civil and political rights and socioeconomic rights, focusing on healthcare and environmental obligations. The Commission referred to Article 16 of the African Charter, which guarantees the right to the best attainable state of physical and mental health, and Article 24 which affirms the right to a favorable environment. The Commission emphasized that fulfilling these rights requires inclusive social policies informed by inputs from affected communities. [780]

Secondly, in *Abacha and Others v. Fawehinmi*,[781] The African Commission establishes that upon domestication, the Charter becomes binding on state members and enforceable in domestic courts. The case is significant for the recognition of socioeconomic rights in Nigeria. Although the case specifically dealt with the arbitrary arrest and detention of the human rights lawyer Chief Gani Fawehinmi, the Supreme Court examined the African Charter on Human and Peoples' Rights and its incorporation into the Nigerian law. The court held that when a treaty is enacted into a law by the National Assembly, such as the African Charter, it becomes binding and must be upheld by the courts. The Charter grants rights and obligations to citizens and should be meaningfully enforced . The court acknowledged that many of the rights and obligations in the Charter are already enshrined in the Nigeria's Constitution. Notably, the court focused on civil and political rights enshrined in Chapter IV of the Constitution, without

[780] (2001) AHLR 60 (ACHPR 2001); The African Commission focused on the healthcare and environmental obligations of Nigeria, as a treaty member of both the ICESCR and the African Charter. The Commission held that Nigeria violated international law regarding its failure to hold transnational non-state actors directly responsible for human rights violations.
[781] (2001) AHLR 172 (NgSC 2000)

explicitly addressing non-justiciable socioeconomic rights outlined in Chapter II on FODPSPs. The Charter gives to citizens of member states rights and obligations, which are to be enforced by their courts, if they must have any meaning.[782]

It is very instructive that the Court refers to Chapter IV, which deals with Fundamental Human Rights relating to civil and political rights, however the Court makes no reference to the application of the provisions of Chapter II on FODPS, relating to non-justiciable socioeconomic rights. Nevertheless, the Court lays down the hierarchical status of the Nigerian Constitution vis-à-vis treaties, especially the African Charter that being a statute with an international status. It is presumed that the legislature does not intend to breach international law, but the Charter is not superior to the Constitution.[783]

During the Sovereign National Conference of 2014 convened by the former President Goodluck Jonathan, a major recommendation of the Committee is that socio-economic rights should be included as justiciable rights in the Constitution.[784] The Conference recommends the merging of the provisions Chapter II (on socioeconomic rights) and IV (fundamental human rights) of the 1999 Constitution (as amended). This makes Chapter II justiciable under our law. It also prescribes that the African Charter be incorporated into the Constitution.[785] The Conference also recommends the establishment of a Constitutional Court vested with jurisdiction over issues relating to the enforcement of fundamental human rights in the Constitution, similar to the approach in South Africa. [786] These recommendations if implemented can positively transform legal and judicial challenges affecting maternal health in Nigeria. Unfortunately, the reports of the Conference have been ignored by successive governments over the years despite the abysmal maternal mortality reputation of the country.

There is often a tendency in the constitutionalisation debate on health to lay much emphasis on legal enforcement. Rather, constitutionalisation should be seen more as an ethical

[782] Ibid. at paragraph 14
[783] Ibid. at paragraph 15
[784] The National Conference 2014: Final Draft of Conference Report (August 2014), 564.
[785] Ibid, at 564.
[786] Ibid, at 724.

framework for public policy and decision-making in health governance.[787] Given the important connection between women's equality and health, constitutionalisation must look beyond incorporating rights to the development of implementable health, environmental and economic policies and initiatives which will not only have health as its core but also the overall wellbeing and development of women. Hence, the significance of statutory and policy treatment of healthcare responsibilities under national constitutions especially in a federal structure like Nigeria, is to be viewed from an equality perspective and identification of discriminatory and specific health system needs of the different communities for which they are being developed.

### 4.6 Legal and other Constitutional Challenges under the Nigerian Legal System: Governmental Responsibility for Health Care in Nigeria's Three-Tier Federal System.

Governance decisions can either support or undermine the laws and policies that facilitate effective state interventions. The causes of maternal deaths in Nigeria are multifaceted and extend beyond medical and socio-cultural factors. They are intricately tied to an imbalance structure of healthcare responsibilities, which highlights the urgent need for Nigeria to prioritize and undertake comprehensive reforms.[788] The structure of the primary healthcare system which encompasses maternal health as presently constituted has deleterious effects on maternal health and thereby undermining positive prospects for laws and policies.[789]

Nigeria operates a federal constitution; hence the division of constitutional responsibilities amongst the three tiers of government, namely the Federal, State and Local governments. Considering Nigeria's three-tier system of governance, the 1999 Constitution places most health matters on the concurrent list, thereby authorizing the three tiers of government to share responsibilities on matters regarding health.[790] The 1988 National Health Policy and Strategy to Achieve Health for all Nigerians (1988 National Health Policy) is the Nigeria's first

[787] M Kavanagh, *supra* note 709.
[788] CRR, "Broken Promises" *supra* note 8.
[789] Enifome Eto "Government Policy and Initiatives on Maternal Mortality Reduction in Nigeria" South Dakota State University, Thesis and Dissertation. (2016). 14.
[790] Id. at 11, sec. 5.1

comprehensive health policy document.[791] It sets a target of "health for all citizens by the year 2000",[792] and recognizes primary health care as defined[793] in the 1978 Declaration of Alma-Ata as an integral part of the policy.[794] It states that the minimum level of primary health services must include "maternal and child health care, including family planning."[795] The Policy provides for a health-care system with three levels of care: primary, secondary, and tertiary.[796] It assigns responsibility for providing primary health care to the local governments, "with the support of State Ministries of Health"; secondary health care to the state governments; and tertiary health care to the federal government.[797]

The revised National Health Policy of 2004 retains the provisions of the 1988 Policy on the division of healthcare responsibilities among the three tiers of government.[798] Although, the new policy acknowledges that the maternal mortality rate in Nigeria is among the highest in the world[799] and aims to "create an enabling environment for appropriate action and provides the necessary impetus and guidance to local initiatives in all areas of reproductive health."[800] It includes the reduction in maternal morbidity, unwanted pregnancies, and perinatal and neonatal morbidity and mortality; reducing gender imbalance in matters of sexual and reproductive health; and promoting research on reproductive health issues.[801] It also includes provisions and strategies for achieving these goals, such as "equitable access to quality reproductive health services," building the reproductive health capacity of providers, "ensuring availability of appropriate materials for effective reproductive health services," and undertaking necessary research to address "emerging issues in reproductive health."[802] Despite the acknowledgments and recognition that there is absence of a clear constitutional mandate

[791] Federal Ministry of Health (Nigeria), National Health Policy and Strategy to Achieve Health for All Nigerians, (1988),1.
[792] Ibid. at 1, sec. 1.1
[793] Declaration of Alma-Ata; International Conference on Primary Health Care, Alma-Ata, USSR, Sept. 6-12, 1978, at 1, paras. VI, VII.
[794] Nigeria, National Health Policy and Strategy to Achieve Health for All Nigerians, at 7, sec. 3.3 (1988).
[795] Ibid. at 9, sec. 4.3(d).
[796] Ibid. at 12, sec. 5.5
[797] Ibid. at 12-13, sec. 5.5(a)-(c).
[798] Federal Ministry of Health (Nigeria), Revised National Health Policy, at 9-10, sec. 4.6 (2004).
[799] Ibid. at 2, sec. 2.
[800] Ibid. at 32, sec. 6.9(1).
[801] Okpani, A. I., & Abimbola, S. Operationalizing universal health coverage in Nigeria through social health insurance. (2015). 56:5, *Journal of the Nigeria Medical Association,* 305–310.
[802] Ibid. at 32-33, sec. 6.9(3), 6.10.

for health, the document provides for primary health obligations to be provided at the local government level[803] and leaves uncertain the functions of the federal and state governments on maternal health.[804] The constitutional gaps have obstructed the ability of the government to fulfil its responsibility to provide quality maternal health care.[805] This leads to the conclusion that the governance of the primary health system is not comprehensive and without adequate implementation procedure. Hence, the reason why the National Health Act in 2014 was enacted.[806] It is argued that passing of the NHA would address this gap in the Constitution, including maternal health regulation.[807]

### 4.7 The National Health Act 2014 (NHA)

The National Health Act can play a vital role in advancing the realization of the right to health in Nigeria. By aligning its provisions with the legislative power vested in the National Assembly, the Act provides a pathway for enforcing and promoting the right to health in the country. Under the Nigerian jurisprudence, the enactment of an Act of parliament pertaining to a non-justiciable right,[808] offers an alternative legislative mechanism and can potentially render the fundamental objectives justiciable.[809] Therefore, this analysis presents a promising opportunity for realizing the right to health through subsidiary legislation enacted by the National Assembly. The enactment of the National Health Act thus signals the intention of the national legislature to make the right to health justiciable in Nigeria. The right to health in Nigeria can be secured through the National Health Act, 2014. Despite the provisions of Section 6(6)(c) on the non-justiciability of the right to health, the Nigerian 1999 Constitution provides a pathway for making justiciable and enforcing the provisions of Chapter II. Section 4(2) which empowers the National Assembly to enact laws aimed at realizing the provisions of the Exclusive List set out in Part I of the Second Schedule to the Constitution,[810] includes

[803] Ibid.
[804] Ibid at 7.
[805] Ibid at 14
[806] Ibid at 15; National Health Act, 2014, Act No. 8 of 2014. It was signed into law on October 31 2014.
[807] Nigeria, Health Sector Reform Programme 2004 at 15 (2005)
[808] Attorney-General of Ondo State v. Attorney-General of the Federation (2002) 9 N.W.LR. Part 772, pp. 222-474.
[809] Ibid.
[810] Specified in Part I of the Second Schedule to the Constitution (the Exclusive Legislative List), under item 60(a), is the authority of the National Assembly to do legislate on several matters, including the "establishment and regulation of authorities for the Federation or any part thereof . . . [t]o promote and enforce the observance of the "Fundamental Objectives" under Chapter II of the Constitution.

making laws to render justiciable the provisions of Chapter II. In *Attorney-General of Ondo State v. Attorney-General of the Federation & 35 Ors,*[811] the Supreme Court's position is that the non-justiciability status of the provisions of Chapter II could be vested with justiciability through the enactment of a statute.

The provisions of the Act can transform maternal health in Nigeria to measure up to national obligation in compliance with international human rights law. By effective application of the provisions of the Act, Nigeria can significantly improve maternal health and reduce mortality rates, irrespective of the non-existence of a constitutional right to health. Although, the Act does not define health to broadly encompass the provisions of ICESCR, its definition is quite similar to article 12 of ICESCR. Section 1(1)(c) NHA states that the goal of the statute is to "provide for persons living in Nigeria the best possible health services within the limits of available resources."[812] Best possible health may be interpreted in a manner to encompass the international approach of guaranteeing the best attainable health status, under the various international human rights instruments on health including the African Charter. The Act imposes an obligation on the Nigerian government to "protect, promote, and fulfil the rights of the people of Nigeria to have access to health care services."[813] This obligation resonates with and amounts to a codification of two important provisions on health services under international human rights law i.e. article 12(2) and CESR General Comments No. 14: to respect, fulfil and protect the right to health. The statute represents a laudable effort on the part of the government to use legislative process in the direction of its international obligation.

But improving the health of citizenry under the Act is subject to available resources. This is similar to "progressive realization", and echoes the minimum core obligation available under the ICESCR and the African Charter. The obligation requires that the Nigerian government must take reasonable legislative and other measures, within its available resources, to achieve progressive realisation of the right to health. It also imposes a duty upon the government to continually review its policies to ensure that the achievement of the right is progressively realized. In other to further the goal of meeting the minimum requirements of health for every

[811] A.G Lagos v A.G Fed (*supra*).
[812] Section 1 NHA
[813] Section 1(1)(e).

Nigerian, section 3(3) provides that "Nigerians shall be entitled to basic minimum package of health services"[814] and "… all Nigerians shall be entitled to a guaranteed minimum package of services."[815] The Act has no definition for the basic minimum package, a major criticism against the Act. The provision of the Act satisfies the requirement imposed upon states parties by the ICESCR[816], regarding minimum core obligation.[817] The development of a basic minimum package comprising ideally essential, cost-effective interventions, to which every Nigerian must be entitled by law regardless of income, class, ethnic group, health status, gender, or location. Most relevant for maternal health is the provision that "no healthcare provider, health worker or health establishment person shall be denied of emergency medical health treatment for any reason." It criminalizes such act with fine and imprisonment, or both.[818]

The Act also focuses on women's financial and economic status with respect to maternal health in Nigeria. It recognizes the economic challenges confronting women and the adverse impact of out-of-pocket payment on vulnerable populations and makes provision for their protection. The Act establishes the "Basic Health Care Provision Fund."[819] The aim is that the Fund would be utilized to finance strategic sectors of the health system, including provision of health services, training of health personnel, provision of drugs, supporting social health insurance and emergency medical treatment,[820] all of which are essential to realizing the attainment of maternal health projection in the country. With the regrettable state of maternal health in Nigeria and the attendant loss of lives of pregnant women, it remains unthinkable that the Fund is yet to be utilized for establishing a free national maternal health program as required.[821]

The Act also fails to provide equitable framework for realizing the goal of equality in accessing health services and goods, especially for vulnerable groups. The protection of vulnerable

[814] S. 3(3) NHA
[815] Section 3(4) NHA Act.
[816] Ibid. Section 15(3) (restating the entitlement of citizens to "basic minimum package of health services)
[817] N. Obiajulu "Securing the Right to Health in Nigeria under the Framework of the National Health Act" (2019) 37:3 *Medicine and Law* 477 – 532.
[818] Section 20 of the NHA 2014.
[819] NHA, *supra* note 27, S.11 (1), (2).
[820] Section 11(3) which stipulates that money from the fund will be allocated to fund basic healthcare package specified in the Act.
[821] Yakasai, *et al.* "Free maternity services in Kano State impact of free maternity services in Kano State Nigeria." (2012) 29:1 Tropical Journal of Obstetrics and Gynecology 18-21.

populations is key to intersectional approach and an essential part of the right to health under international law. Poor and marginalized pregnant women continue in a cycle of poverty and impoverishment due to cost of health services in form of out-of-pocket expenses, limited health facilities and expensive health care in Nigeria, especially in urban areas. In addressing the inequality, the NHA merely empowers the Minister of Health to prescribe conditions under which some categories of people may be eligible for exemption from payment for health care services at public health establishments.[822] The Minister is to consider the needs of vulnerable groups such as women, children, older persons, and persons with disabilities.[823]

The Minister is yet to make any specific regulation relating to poor rural pregnant women in both the southern and northern regions of Nigeria, despite that they are regarded as vulnerable groups and require specific protection.[824] In line with intersectional approach, obligations and requirements contained in the General Comment 14, the Act fails to address specifically maternal health[825] and participation of the citizenry in health-related decision making at the community, national and international levels.[826] Although, it may be argued that from the general thrust and language of the Act, the expansive provision of the statute is enough to cover sexual and reproductive right of pregnant women.[827]

The Act also fails to address the seeming division of responsibilities between the three tiers of government regarding primary healthcare which maternal health is an integral part of, other than the responsibility for tertiary health care which is vested in the Federal Government.[828] There is no stipulation, anywhere in the statute, as to which level of government is responsible for secondary and primary health care services. Despite similar omission by the National Health Policy to define these functions, the Act fails to capture in a concrete sense the roles of the different organs of the state. Disappointedly, the NHA being a substantive national

[822] Ibid. section 3(1).
[823] Ibid. section 3(2)(d).
[824] WHO "Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division: World Health Organization; 2014.
[825] General Comment No. 14, supra note 6 at paras. 14, 16, 21, 23, 34, 36, 44.
[826] Ibid at 11.
[827] Section 27.
[828] NHA, *supra* note 27, S. 2(1)(i) (entrusting the responsibility of ensuring the provision of tertiary and specialized hospital service to the Federal Ministry of Health)

legislation misses the opportunity to address the anomaly.[829] Allocation of responsibilities regarding the different tiers of health care delivery is an important aspect of protecting primary healthcare, especially for maternal health. But the NHA fails to address such a critical subject. The consequences of the lopsided constitutional responsibilities for maternal health can be grave. It includes inability of the federal government to effectively pressure the other levels of government to implement their policies and fulfil their healthcare obligations. It is recommended that a constitutional amendment to healthcare responsibilities can deliver the much-needed reform for maternal health, although amendment involves a lengthy lawmaking process requiring a political will.

### 4.8 Constitutionalising Gender Equality in Nigeria

The constitutionalization of gender equality in Nigeria is a crucial endeavor that requires the active involvement of the judiciary. Courts play a significant role in advancing social and gender equality by interpreting laws and undertaking judicial review of state actions.[830] In fulfilling their responsibility, the courts must remain mindful of the constitutional values and principles that underpin society's interests, including dignity, equality, and justice.[831] This is significant in the context of maternal health, where the promotion of gender equality is essential for ensuring women's access to adequate healthcare services and addressing the unique challenges they face.

The Constitutional right to equality and non-discrimination in Nigeria falls under Chapter IV of the Constitution. So, any person who wishes to enforce his/her right, she/he must do so in the High Court of a state. Since most High Courts are located in urban centres and local government headquarters in the states, this presents a challenge of access to justice for disadvantaged poor women living in rural areas, who may not be able to afford the services of a legal practitioner because of the cost implications. Another factor that militates against the ability of rural women who labour under entrenched patriarchal structures, is lack of knowledge of constitutional rights to which they are entitled.

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[829] Revised National Health Policy 2004, *supra* note 30, Chapter 2.
[830] D Barak-Erez 'Hermeneutics: feminism and interpretation' in B Baines, D Barak-Erez & T Kahana (eds) Feminist constitutionalism: global perspectives (2012) 97.
[831] Y Olomojobi "*Human rights on gender, sex and the law"* Princeton (2013) 30.

The determination of how Nigerian courts have fared in the promotion of gender equality necessitates an examination of how they have handled cases seeking to enforce the right to equality and non-discrimination. Courts are enjoined to adopt innovative approaches to judicial reasoning like social context analysis (important in demonstrating the disadvantage or vulnerability of women and girls), balancing competing rights, substantive equality interpretation of constitutional provisions relating to equality and the intersectionality of multiple forms of discrimination, which can go a long way towards advancing gender justice.[832]

In the past, Nigerian courts had been timid in enforcing the right to equality and non-discrimination guaranteed by the Constitution . This is reflected in the earlier decisions of the courts on the issue. The Supreme Court of Nigeria had in the case of *Nezianya v. Okagbue*[833] and *Mojekwu v. Iwuchukwu,*[834] upheld a discriminatory customary laws preventing women inheriting intestate properties. Although the court declared the practices to be discriminatory, it went further to state that not all customary laws discriminate against women. Durojaye states that in making such a declaration, the court fails to appreciate the gender implications of customary laws for women's enjoyment of their fundamental rights.[835] According to him, this approach of the Court is not only faulty, but also fraught with danger, especially when one bears in mind that men have almost always determined customs and traditions.[836] While it is true that not all cultural practices are inimical to women's health and enjoyment of their fundamental rights, it is not in contention that some cultural practices perpetuate gender inequality and are potentially threats to women's rights.[837] However, more recent pronouncements indicate that the courts have risen from the clutches of customary laws to strike down any customary law provisions that discriminate against women's right to property inheritance. In *Ukeje v. Ukeje*[838], the Supreme Court appears to have put the matter to rest when it held that such a law which disinherits a daughter or a wife purely on the basis of her gender is void by reason of being inconsistent with section 42 of the 1999 Constitution (as

[832] 'Gender equality and women's empowerment: constitutional jurisprudence' UN Women (2017) 55.
[833] (1963) All NLR 352.
[834] (2004) SC (part II) 1.
[835] E Durojaye, *supra* note 117 at 114.
[836] Ibid.
[837] Ibid.
[838] (2014) All FWLR.

amended). While the evolving jurisprudence of Nigerian courts in relation to gender equality is encouraging, the limitations imposed by the constitutional guarantee of equality in a formal sense, prevents them from undertaking a social context analysis of cases where the court is called upon to advance substantive gender equality like the South African Constitutional Court. Legislation alone cannot guarantee total reform, the Nigerian courts must therefore exhibit a proactive disposition to pregnant women's plight and refuse to continue age-long traditions that are harmful to their health. Several complex social and legal factors that prevent judicial activism around customary law in Nigeria are rooted in the country's diverse cultural and legal landscape. It ranges from constitutional recognition of customary law, its diversity,[839] and lack of codification. To promote judicial activism around customary law in Nigeria, there is a need for comprehensive legal reforms, increased legal education and training for judges and legal practitioners, and a delicate balancing act between respecting cultural diversity and upholding human rights principles. Efforts to codify customary law and establish clear guidelines for its application can also enhance legal certainty and consistency in judicial decisions. Additionally, empowering women and marginalized groups to access formal justice systems can help address gender bias and discrimination in customary practices.

### 4.9 Guaranteeing of formal rather than substantive equality

The Constitutional guarantee of formal rather than substantive equality has a negative effect on maternal health in Nigeria. The right to equality and freedom from discrimination are entrenched in the Nigerian Constitution and particularly provided for in Chapter IV of the Constitution, which is expressly declared to be subject of judicial examination and capable of being enforced.[840] Specifically, section 42 guarantees the right to freedom from discrimination.[841] As earlier discussed, this provision prohibits either the conferment of privilege or advantage as well as the imposition of disabilities or restrictions simply on any of the grounds listed in the section.[842] The inclusion of sex and other grounds in the list of the prohibited grounds evinces an intention by the framers of the Constitution to ensure that no

[839] Nigeria has over 371 ethnic groups with each having distinct customary practices. Full list of all 371 tribes in Nigeria, states where they originate' *Vanguard* 10 May 2017. https://www.vanguardngr.com/2017/05/full-list-of-all-tribes-in-nigeria-states-where-they-originate/ (accessed on 20 October 2022).
[840] Nafiu Rabiu v. The State (1981) 2 NCLR 293.
[841] Section 42 of the 1999 Constitution (as amended).
[842] BO Nwabueze, *supra* note 661 at 452.

individual (man or woman), young or old, rich or poor suffers any disadvantage on the basis of their sex or status. Thus, any deprivation or disadvantage suffered as a result of any law, policy or practical application of same, by a citizen on account of his or her sex runs contrary to the express provisions of the Constitution. The 1999 Constitution does not allow the state to regulate or inhibit this right on any grounds whatsoever. As Nwabueze puts it:[843]

> The absolute character of the prohibition results partly from its rigid and precise wording and partly from the fact that the provision is completely withdrawn from the power of the state to regulate fundamental rights in the interest of defence, public safety, public order, public morality, public health or the protection of the rights and freedom of others, both in normal times and during an emergency.

On a superficial level, the non-derogable nature of the right to freedom from discrimination under the 1999 Constitution would appear to underline the commitment of the Nigerian state to respect and protect this expressly guaranteed constitutional right. However, a critical examination of the provision shows that it guarantees equality in its formal sense and not in a substantive manner.[844] Substantial equality goes beyond recognising the equality of everyone. It identifies differences among groups of people with long standing goal of greater understanding, which is the goal of intersectionality theory.[845] Having regard to the analysis of formal and substantive equality, the provision of the Nigerian Constitution will not yield substantive equality to women. It adopts a traditional approach to equality, which sees equality as a system of formal rules. Substantive models of equality emphasize the importance of considering social and cultural practices and institutions that may result in seemingly neutral rules having discriminatory impacts on certain groups.[846] In practice, this means going beyond formal equality and taking proactive measures to address systemic inequalities and barriers faced by marginalized communities. In the context of maternal mortality in Nigeria, substantive equality entails recognizing that maternal health outcomes can be significantly affected by cultural norms, traditional practices, and institutional factors.[847] For example, in

[843] Ibid.
[844] Ibid at 455; E Durojaye 'Substantive equality' supra note 117 at 112.
[845] Bernard C & Hepple B "Substantive Equality" (2000) 59 Cambridge Law Journal 562-585.; Clifford J "Equality". In Shelton D (ed), The Oxford Handbook of Interntional Human Rights Law, Oxford University Press, (2013) 420-25.
[846] E Durojaye 'Substantive equality' supra note 117 at 112.
[847] Ibid.

some regions of Nigeria, there might be prevailing cultural beliefs that discourage women from seeking timely and appropriate maternal healthcare, such as antenatal care or skilled birth attendance. These practices, rooted in deep-seated traditions, could lead to delayed or inadequate medical interventions during childbirth, thereby contributing to higher maternal mortality rates. A substantive approach to addressing this issue would involve targeted interventions to challenge and transform these cultural norms.[848] It would include community engagement and sensitization programs to raise awareness about the importance of maternal health and promote gender equality in decision-making regarding healthcare.[849]

Additionally, substantive equality would address institutional factors that hinder access to quality maternal healthcare for disadvantaged groups. This may include insufficient healthcare facilities, limited availability of trained healthcare professionals in remote areas, and financial barriers that prevent women from accessing essential maternal health services. A substantive approach would seek to improve the overall healthcare infrastructure, invest in training skilled birth attendants, and implement policies to remove financial barriers, ensuring that all women, regardless of their socioeconomic status or geographical location, have equal access to maternal health services. The formal approach homogenizes the experience of pregnant women in Nigeria by developing a uniform programme and policy as discussed earlier, to address maternal mortality in the country despite the disparities in the maternal mortality ratio across the regions. Women in Nigeria continue to suffer oppression and suppression, which arises from the patriarchal nature of the society as well as cultural and religious practices. Substantive models of equality take into account the social and cultural practices and institutions that can cause a facially neutral rule to have a systematically discriminatory effect.[850]

Despite its narrow language, the Nigerian Constitution deserves a generous and purposive interpretation to address gender inequality in the country.[851] While this may be so, it would however have been much better to expressly provide for substantive equality in the

[848] C Albertyn 'Substantive equality and transformation in South Africa' (2007) 23 *South Africa Journal on Human Rights* 257.
[849] Ibid.
[850] SH Williams 'Equality, representation, and challenge to hierarchy: justifying electoral quotas for women' in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 57-58.
[851] E Durojaye, *supra* note 117 at 111.

Constitution, rather than place our hope for progressive interpretation at the disposition of a judge. The non-incorporation of a substantive equality provision in the Nigerian Constitution represents a missed opportunity to provide a basis for redressing the subjugation and disadvantage to which pregnant women have been, and continue to be subject to, which in some cases result in preventable maternal death. The guarantee of substantive equality in Nigeria would require not only an amendment of the formal equality provision for a substantive one, but also to add a proviso to the constitutional recognition of personal religious and customary rights that make them subject to Chapter IV of the Constitution which deals with fundamental rights.

### 4.10 The challenges of multiculturalism

The multicultural nature of Nigeria and its legal system remains a challenge for maternal health. Nigeria is a diverse, multi-ethnic and multi-cultural and religious society. Consequently, the country is faced with challenges relating to how to balance and reflect the various minority identity and majority differences in cultural values. The role of rights is important in achieving meaningful dialogue for the realisation of equality and non-discrimination within different communities. Multiculturalism is "the state of a society or the world containing many cultures that interact in some significant way with each other".[852] It captures the importance of addressing the challenge for effective governance of the legal, socio-cultural and religious factors affecting health for instance. Multiculturalism can be understood in the Nigerian context as a strategy for the political management or protection of the country's multi-ethnic reality including the imbrication of this with religious differences, especially along ethno-regional lines.[853] A policy of multiculturalism tests the limits of accommodation and interrogates the state's own ideology and its adherence to principles of equality and religious freedom.[854] The idea of critical multiculturalism is aimed at better understanding how pluralist democracies like Nigeria can formulate a policy that respects group difference while upholding equality and fairness.[855] It therefore follows, that it remains

[852] Amy Gutmann, "The Challenge of Multiculturalism in Political Ethics," (1993)22:3 Philosophy & Public Affairs 171.
[853] Wale Adebanwi "Contesting Multiculturalism: Federalism and Unitarism in Late Colonial Nigeria" in (2018) 56:1, *Commonwealth and Comparative Politics* 40-64.
[854] V Narain 'Critical multiculturalism' in B Baines, D Barak-Erez & T Kahana Feminist *constitutionalism: global perspectives* (2012) 384 at 377.
[855] Ibid at 377.

crucial to engage minority and secondary voices in the process of accommodating dialogue on their differences.[856] In proposing a solution to the problem. Narain argues that:

> Multiculturalism has to be imagined in a way that brings a fresh perspective to rearticulating women's rights, a perspective that crafts meaningful responses to women's exclusion from equal citizenship and that evaluates the potential of constitutional rights as the legitimate arena in which to reclaim women's selfhood.[857]

Although, it remains a challenge for policy makers, to craft a policy of multiculturalism that can respond to difference among groups while retaining an understanding of the universal forms of equality and freedom from discrimination; to refocus attention on and to reinstate women's equality in the negotiations between minority groups or communities and the state, in the accommodation of their differences.[858] In tackling minority women's vulnerability, any analysis of the accommodation of group difference must take into cognizance the diversity within the group.[859] Addressing multiculturalism is an integral aspect of intersectionality that represents intra-group differences as important as those between groups, since it is possible for individuals and groups within a dominant groups to be simultaneously oppressed and privileged.[860]

The challenges arising from the interplay of cultural, ethnic, and religious factors in Nigeria result in the interpretation of statutory provisions that often align with customary laws. This has led to the perpetuation of harmful practices such as considering women as property subject to inheritance, favoring male children for inheritance purposes, and requiring women to seek male permission for employment and reproductive health decisions. The Court of Appeal in Nigeria has held that these practices violate the express constitutional provisions which guarantee the right to freedom from discrimination.[861] Some theorists have proposed a theory of accommodation of group differences in resolving the challenge, i.e. to what extent such

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[856] Ibid at 377
[857] Ibid at 378.
[858] Ibid at 391.
[859] Ibid at 387.
[860] See E Durojaye & S Nabaneh *supra* note 107.
[861] *Mojekwu v. Mojekwu* (1997) 7 NWLR pt. 512, (where the Court of Appeal declared a custom that allowed only male children to inherit their fathers property unconstitutional), See also *Muojekwu v. Ejikeme* (2000) 5NWLR pt. 657; *Ukeje v. Ukeje* SC.224/2004 (decided 14 April 2016; *Ihemedu v. Uwazie & Ors* Suit No: HAM/13/2017(Unreported) per Agugua J.

theory satisfies group interests as well as accommodate minority interests within the larger group. To address these challenges, it is crucial to reform existing laws and policies to promote gender equality, ensure women's autonomy in reproductive health choices, and challenge discriminatory customs that undermine women's rights. This can be achieved through legal and judicial reforms to foster a more inclusive and equitable society that respects the rights and dignity of individuals and groups.

It is crucial to emphasize that the majority of the challenges concerning women's reproductive rights and maternal health in Nigeria revolve around cultural and religious factors that permeate both public and private domains, and are within the purview and responsibilities of the state legislatures. Hence, the need to address the challenge of multiculturalism since it is a major issue in the policy regulation in the country.[862] The challenge of multiculturalism in the domestic constitutionalisation of rights flowing from international constitutional law in plural states like Nigeria is a real one. As a practical example, despite the ratification and domestication of the United Nations Convention on the Rights of the Child as the Child's Rights Act, many states in the predominantly Muslim Northern part of the country have either not passed the state versions or passed versions that have been watered-down[863]. One prominent contentious issue being the legal age of marriage, which is set at eighteen years under the Act, as against the Islamic injunction of 'on-set of puberty'.[864] This is despite the contribution of girl-child marriages to the high level of maternal mortality in the country.[865] In addition, Nigeria ratified CEDAW in 1985 without reservation and signed its optional protocol in 2000, which was ratified in 2004. As a state party, Nigeria is obliged to implement the Convention's provisions by using all appropriate means to eliminate all forms of discrimination against women[866]. Nigeria has not till date passed any enabling legislation to domesticate the Convention, which has greatly hindered the observance and application of its provisions. The non-domestication has been linked to the diverse cultural and religious values that can be implicated by the Convention, especially maternal health care needs.

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[862] S Williams 'Democratic theory, feminist theory, and constitutionalism: the challenge of multiculturalism' in B Baines, D Barak-Erez & Tsvi Kahana *Feminist constitutionalism: global perspectives* (2012) 396.
[863] Enyinna Nwauche, "Child Marriage in Nigeria: (Il)Legal and (Un)Constitutional" (2015) 15 African Human Rights Law Journal 421 at 423.
[864] Ibid.
[865] Ibid.
[866] CEDAW, *supra* note 83 at art. 2.

Contrary to its undertaking to adopt legislative and other measures to give effect to the rights and freedoms guaranteed under its Constitution, several constitutional provisions, as well as other laws, practices and policies still contain discriminatory provisions, including the continued criminalisation of abortion,[867] which is a reproductive health need of women only. Fraser challenges the exclusion of private issues or interest from public discussion, arguing that for a multiculturalism policy to respond to discrimination and disadvantage, it must recognise the way in which social inequality limits the possibility of free dialogical engagement.[868] Its absence results in a limitation of political participatory constitutional rights which are fundamental for the advancement of women's equality.

The difficulty is that accommodation of the minority culture by the larger society sometimes results in serious harms to vulnerable groups within the minority culture, and the vulnerable group most at risk of being hurt is women.[869] Minority rights and freedom must be protected in the balancing process,[870] especially the effect on personal laws of such groups since they are not achievable without infringing on their right to religion and cultural values[871]. Williams 'dialogic, democratic approach' calls for internal dialogue within the minority culture to strengthen their voices[872]. One approach is the interpretation of the legal order i.e., the constitution accommodating of such views especially in a geographically concentrated ethno-cultural-linguistic groups. [873] That way, the rules and regulations guiding the groups must be made to comply with the minimum threshold established by the constitution for all. Evidence suggests that beyond regional disparities across north and south, intra group differences exist in the rate of maternal death ratio especially in a multi-cultural, multi-ethnic and religious society like Nigeria. To address intra-group differences affecting maternal or pregnant women in communities in Nigeria, concrete and diverse legal and social solutions are required. It is

[867] Sections 228, 229 and 230 of the Criminal Code for Southern states of Nigeria and Sections 232, 233 and 234 of the Penal Code for Northern States of Nigeria criminalise the procuration of an abortion.
[868] N Fraser 'Rethinking the public sphere: a contribution to the critique of actually existing democracy' (1990) 25/26 Social text, 566, 77.
[869] S Williams 'Democratic theory, feminist theory, and constitutionalism: the challenge of multiculturalism' in B. Baines, D Barak-Erez & Tsvi Kahana *Feminist constitutionalism: global perspectives* (2012) 393.
[870] Ibid at 396.
[871] Ibid at 192.
[872] Ibid at 393.
[873] Ibid at 393.

crucial to ensure that the rules and regulations guiding various cultural and ethnic groups align with the minimum constitutional standard established for all citizens.[874] This requires active engagement with community leaders and elders to promote awareness of constitutional rights and gender equality principles.[875] Sensitization programs should be conducted to challenge harmful traditional practices and beliefs that negatively impact maternal health outcomes. By fostering an understanding of the constitutional framework and human rights principles, communities can work towards eliminating discriminatory practices and ensuring equitable access to maternal healthcare services.[876]

It is essential to implement targeted policies and interventions to address regional and intra-group disparities in maternal death ratios. Tailored healthcare programs should be developed to meet the specific needs of different communities, considering cultural and religious factors.[877] Local healthcare facilities need to be adequately equipped and staffed to provide quality maternal healthcare services. This can be achieved through increased investment in healthcare infrastructure and the training of skilled healthcare professionals, especially in under-served areas.[878] In addition, financial barriers to maternal healthcare access must be addressed, with the provision of subsidies or health insurance schemes to support pregnant women from economically disadvantaged backgrounds.

### 4.11 The public/private division under the Constitution

The division of powers empowering the state to regulate the public sphere while limiting its ability to regulate the private sphere has been a long-standing feature of many national constitutions. The idea behind this division is to allow people some privacy in certain areas of life, and to enable minority groups practice their religion and culture while belonging to the majority group. Culture affirms an individual's and group's choice, autonomy and identity.[879]

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[874] S. Benhabib 'Beyond interventionism and indifference: culture, deliberation, and pluralism' (2005) *Philosophy & Soc. Criticism* 31(7) 756

[875] AM Tripp 'Conflicting agendas? Women's law and customary law in Africa' in in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 193.

[876] A. Vakulenko 'Gender and international human rights law: the intersectionality agenda' in S Joseph & A. McBeth (eds.) *Research handbook on international human rights law* (2010) 196.

[877] M. Dechka 'Is culture a taboo? Feminism, intersectionality, and culture talk in law' (2004) 16 *Canadian Journal of Women and the Law* 14, 16.

[878] Ibid.

[879] V Narain 'Critical multiculturalism' in B Baines, D Barak-Erez & Tsvi Kahana *Feminist constitutionalism: global perspectives* (2012) 385.

In the quest to respect group identity, difference becomes the basis for discrimination, demonstrating the usefulness of contextualisation and historicisation strategies in situating identities within certain political and social formations.[880] This is more evident in plural and multicultural societies, and experience has however shown that often the most serious forms of discrimination are those that women encounter in the private sphere.[881] Woodhouse is of the view that the public/private division is no longer sacrosanct in contemporary political and constitutional discourse.[882]

Despite the contention, the Nigerian Constitution maintains the public/private division. It delineates the items in the exclusive legislative list, granting the Federal Government legislative powers over certain areas, The Constitution includes issues relating to the formation, annulment and dissolution of marriages other than marriages under Islamic law and customary law, including matrimonial causes relating thereto,[883] while the states exercise subsidiary powers over residual matters.[884] The effect of these provisions is a tacit recognition of Islamic and customary laws as a part of the corpus of laws that are in force and applicable to different parts of the country.[885]

The continued recognition and institutionalisation of Islamic and customary laws in the administration of justice system, and judicial structures are largely responsible for the continued oppression of women within the Nigerian legal system, and which have implication for women's autonomy and reproductive health decision making.[886] These discriminatory practices, such as forced or child marriage are backed by influential state legislations, stamped

[880] Ibid at 391.
[881]B. Baines & R Rubio-Marin 'Towards a feminist constitutional agenda' in B Baines & R Rubio-Marin (eds) *The gender of constitutional jurisprudence* (2005) 10.
[882]B. Woodhouse 'The constitutionalisation of children's rights: incorporating emerging human rights into constitutional doctrine' (1999) 2 *Journal of Constitutional Law* 23.
[883] Item 61, Exclusive Legislative List, Second Schedule to the Constitution of the Federal Republic of Nigeria 1999 (as amended).
[884] Both levels of government exercise concurrent powers over items in the concurrent legislative list. In the event of a conflict however, the federal law prevails. See. Part 11, Second Schedule of the Constitution of the Federal Republic of Nigeria, 1999 (as amended).
[885] Section 260, 262, 275, 277 and 282 of the Constitution of the Federal Republic of Nigeria 1999. Similar provisions are contained in the Constitution regarding the application of Sharia and Customary Court of Appeal of states of the Federation including Abuja.
[886] A. Diala & B. Kangwa 'Rethinking the interface between customary law and constitutionalism in sub-Saharan Africa' (2019) *De Jure Law Journal* 189-206.

by the courts, and enforced by law enforcement agents.[887] Since intersectionality theory seeks to strengthen the tools for addressing discrimination and oppression, which lie at the heart of health inequalities, it provides a framework to question existing structures and traditional practices which, at times, serve to reinforce inequality. The customary law provisions, rooted in culture and religion, flagrantly disregard the principles of intersectionality, failing to acknowledge and address the diverse and interconnected forms of discrimination experienced by women. By prioritizing patriarchal forces in the formulation of religious and customary laws, they perpetuate gender-based inequalities and subject women to discrimination, disadvantage, and subjugation, directly impacting their overall well-being and maternal health.[888] The discriminatory practices surrounding maternal mortality in Nigeria, such as forced or child marriage, are not only socially sanctioned but also supported by influential state legislations, upheld by the courts, and enforced by law enforcement agencies. [889] These practices run counter to even formal equality provisions of the Nigerian Constitution of 1999[890], which guarantee equal rights and protections for all citizens, regardless of gender. Additionally, these provisions contradict the theory of intersectionality adopted in explaining maternal mortality, as they fail to recognize the complex and interconnected forms of discrimination experienced by women.[891] By prioritizing patriarchal forces in the formulation of religious and customary laws, these provisions perpetuate gender-based inequalities and deny women their personal autonomy and dignity.[892] This directly impacts women's overall well-being and maternal health, which hinders their access to essential healthcare services.

The operation of the courts' jurisdiction, especially in cases related to personal laws, further compounds the violation of women's rights.[893] These legal systems disregard the principles of intersectionality, as they do not consider the multiple layers of discrimination experienced by

[887] Ibid.
[888] M. Becker, "Patriarchy and Inequality: Towards a Substantive Feminism" (1999) 1:3 University of Chicago Legal Forum 21 at 23.
[889] Section 277 of the constitution grants the Sharia Court of Appeal the right to decide questions of personal law for Muslims, including the validity or dissolution of a marriage, guardianship, inheritance, and succession.
[890] Section 42 of the 1999 Constitution of Nigeria.
[891] Nwabueze, supra note 661.
[892] Durojaye, *supra* note 117.
[893] Narain, *supra* note 854 at 379; Catharine MacKinnon, "Sex Equality under the Constitution of India: Problems, Prospects, and Personal Laws" (2006) 4 International Journal Constitutional Law at 187.

women from various cultural, religious, and social backgrounds.[894] Instead, they reinforce traditional practices and customs that perpetuate gender-based discrimination and restrict women's choices and capabilities.[895] An intersectional approach seeks to address such systemic barriers and dismantle oppressive structures that contribute to health inequalities. However, these customary law provisions, rooted in culture and religion, do not acknowledge or address the diverse forms of discrimination women face, thereby impeding progress towards achieving gender equality and improved maternal health outcomes in Nigeria.[896]

It has been observed that Muslim women are subject to discrimination in the family, which is regulated by religious personal laws.[897] Religious personal laws are specific legal provisions derived from religious doctrines that govern personal matters such as marriage, divorce, inheritance and guardianship, within a particular religious community.[898] In contrast, state laws that enforce religious rules refer to legislation adopted by the government based on religious principles, which may extend beyond personal matters to govern societal and public affairs.[899] While religious personal laws specifically apply to family-related issues and are based on religious teachings, state laws enforcing religious rules may have a broader impact on a society.[900] Therefore, while there might be some overlap between religious personal laws and state laws enforcing religious rules, they differ, as the former pertains to personal family matters within a religious community, and the latter encompasses a wider range of legal measures influenced by religious beliefs and applied to society as a whole.[901] In the context of women's reproductive rights in Northern Nigeria, understanding the distinction between these legal frameworks is vital for assessing how Islamic religion affects women's rights and advocating for gender equality and reproductive justice. Certain Islamic laws discriminate on

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[894] Ibid.
[895] Ibid.
[896] E. Durojaye 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism* 111.
[897] Riffat Hassan, "Feminist Theology: The Challenges for Muslim Women" (1996) 5:9 Critique: Journal for Critical Studies of the Middle East 53.
[898] Mackinnon, *supra* note 893 at 198.
[899] Philip Ostien & Albert Dekker, "Shari'ah and National Law in Nigeria" in Jan Otto, ed, Shari'ah Incorporated: A Comparative Overview of the Legal Systems of Twelve Muslim Countries in Past and Present (Leiden: Leiden University Press, 2010) at 578.
[900] Taiwo, EA, "Justifications, Challenges and Constitutionality of the Penal Aspects of Shariah Law in Nigeria" (2008) 17:1 Griffith Law Review 187; Weimann, Gunnar, "Divine Law and Local Custom in Northern Nigerian zinā Trials" (2009) 49:3&4 Die Welt des Islams 451.
[901] Ibid.

the basis of both religion and gender. The religious personal laws are justified under the right to religious freedom and the state's commitment to protecting group life.[902] Since the state is precluded from regulating this sphere, many of the rules developed and enforced therein do not engender gender equality. For instance, Islamic law enjoins Muslims to give birth to as many children as possible to enlarge the Muslim community, without considering the burden on Muslim women and their capabilities to give birth, a clearly discriminatory practice.[903] In the South the preference for male child remains a point of tension with negative implications for women.[904] Thus, the rights of women to exercise control in the personal sphere is essential for their ability to exercise associated rights and guarantee effective maternal health in Nigeria.

The challenge presented by the division of public/private sphere is therefore how to craft a policy of multiculturalism that can respond to difference among groups, while retaining an understanding of the universal forms of equality and freedom from discrimination; to refocus attention on and to reinstate gender equality in the negotiations between groups and the state in the accommodation of the differences.[905] For example, Muslim women's groups can play a crucial role in advocating for women's maternal health rights within their communities.[906] These groups can work to raise awareness about maternal health issues, denounce harmful practices, and promote gender equality in decision-making regarding healthcare.[907] They can also collaborate with healthcare providers and government agencies to ensure that maternal health services are culturally sensitive and make provision for inclusiveness. One effective solution could be to train more Muslim women as professionals in the maternal care area.[908] This would not only increase the number of healthcare providers from similar cultural backgrounds but also create a supportive environment for pregnant women to receive care that

[902] Narain *supra* note 854 at 379.
[903] Ezeilo, J. 'Towards a cross-cultural approach to women's human rights' in Ezeilo, J et al (eds) *Sharia implementation in Nigeria: issues and challenges on women's rights and access to justice* (WACOL & WARD-C 2000).
[904] Ibid.
[905] Ibid at 391.
[906] M. Dechka 'Is culture a taboo? Feminism, intersectionality, and culture talk in law' (2004) 16 *Canadian Journal of Women and the Law* 14, 16.
[907] Ibid.
[908] Kylea Liese and Angela B Maeder "Safer Muslim motherhood: Social conditions and maternal mortality in the Muslim world" (2018)13:5 Global Public Health 567-581; Mondal N A et al., "Has Muslim Got Benefited from the National Health Mission? A Situational Analysis of Maternal Health Services in India". (2020) 30:5 Ethiop J Health Sci. 785-794; Akseer N, Kamali et al., "Status and drivers of maternal, newborn, child and adolescent health in the Islamic world: a comparative analysis" (2018) 14:391 *Lancet.* 1493-1512.

aligns with their religious and cultural beliefs. It would help bridge the gap between healthcare providers and the communities they serve, fostering trust and better communication in maternal healthcare services.[909]

In this context, Irving's call for substantive protection of equality, [910] Barak-Erez's advocacy for asking "the woman question," [911] and Benhabib's emphasis on a deliberative model of democracy', all become relevant. [912] These theoretical frameworks advocate for women's participation in collective decision-making, the incorporation of women's perspectives into policy development, and the recognition of non-state dimensions in addressing multicultural challenges. By embracing these principles, Nigerian authorities can foster an inclusive approach to maternal health that respects cultural diversity while ensuring women's reproductive rights and well-being are protected and advanced. By incorporating such solutions, the government can take significant strides towards reducing maternal mortality rates in Nigeria, particularly among diverse cultural and religious groups.

In reconciling feminism and multiculturalism, care must be taken not to arrive at a solution in which one trumps the other, but to ensure a solution that integrates the principles of both concepts for symbiotic coexistence that yields an egalitarian society. Multiculturalism therefore, has to be imagined in a way that brings a fresh perspective to re-articulating women's rights, a perspective that crafts meaningful responses to women's exclusion from equal participation, and that evaluates the potential of constitutional rights as the legitimate arena in which to reclaim women's self-hood.[913]

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[909] Dhakal S. *et al.,* "Skilled Care at Birth among Rural Women in Nepal Practice and Challenges" (2011) 29:4 Journal of Health Population and Nutrition 371-378.; BR Pokhrel, P Sharma, B Bhatta, B Bhandari, N Jha. Health seeking behavior during pregnancy and child birth among Muslim women of Biratnagar, Nepal (2012) 14:2 Nepal Medical College Journal 125-128; A Singh, DV Mavalankar, R Bhat. Providing skilled birth attendants and emergency obstetric care to the poor through partnership with private sector obstetricians in Gujarat, India, (2009) 87:12 Bulletin of the World Health Organization 960-964.

[910] H Irving 'More than rights' in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 77.

[911] D Barak-Erez 'Hermeneutics: feminism and interpretation' in B Baines, D Barak-Erez & T Kahana (eds) Feminist *constitutionalism: global perspectives* (2012) 95.

[912] S Benhabib 'Beyond interventionism and indifference: culture, deliberation, and pluralism' (2005)31:7 *Philosophy & Soc. Criticism* 756 cited in V Narain at 389.

[913] Narain, *supra* note 854 at 378.

It must be stated however that in the context of Nigeria, there appears to be limited opportunities for women to participate in this dialogical process, the reason being that the structures for the determination of minority rules totally exclude women's participation.[914] Thus, rules that promote gender equality needs to be either formulated outside of these patriarchal structures, and this is where the constitutionalisation of gender equality principles becomes imperative to develop standardised principles to guide the conduct of both majority and minority communities; or reform the structures to ensure participation of women in the decision-making process especially on important matters as health. To address issues of maternal deaths, the divisions between public and private spheres as constituted remains a potential threat to women's reproductive and sexual autonomy and must be addressed within existing constitutional parameters. [915] Experts argue for the eradication and for intervention of the state in the private sphere to protect the vulnerable within the settings.[916] They argue that the recognition by the constitution of religious and cultural laws and its consignment to private spheres threatens the capacity of women to attain their reproductive autonomy.[917] Since, the religious and customary practices of majority of Nigerian societies are misogynistic in orientation, thereby subjugating women to men and undermining their personal autonomy. It is important to emphasise that the dichotomy must be abolished considering its effect on women's maternal health, by subjecting discriminatory laws to scrutiny, especially laws on minorities to access basic standards of equity, natural justice and gender equality principles.[918]

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[914] Formulation and interpretation of Islamic rules are undertaken by the Council of Ulamas (Body of Islamic law scholars, who are regarded as guardians of the law with responsibility for its interpretation and reform) in the northern part of Nigeria – a body with no female representation. Nasir M. B. "Islamic Schools, the Ulama, and the State in the Educational Development of Northern Nigeria (2011) 33Religious Elites in the Development Arena 2-3; Clarke, P.B., *West Africa and Islam*, London, Edward Arnold (Publishers) Ltd(1982); Umar, M.S., *Islam and Colonialism: Intellectual Responses of Muslims of Northern Nigeria to British Colonial Rule*, Leiden, Netherlands, Koninklijke Brill NV (2006).

[915] E Durojaye, *supra* note 117 at 111.

[916] See MacKinnon, *Toward a Feminist Theory of the State* (Harvard University Press, 1989); See also Cheryl Hanna, 'The Paradox of Hope: The Crime and Punishment of Domestic Violence' (1998) 39(5) *William & Mary Law Review* 1505, 1538.

[917] Durojaye, *supra* note 117 at 112.

[918] This requirement is also inline with the principles of repugnant to natural justice, equity and good conscience applicable under Nigeria law and applied by the judiciary for declaring unconstitutional such practices. See, *Mojekwu v. Mojekwu* (1997) 7NWLR pt. 512, (where the Court of Appeal declared a custom that allowed only male children to inherit their fathers property unconstitutional), See also Mojekwu v. Ejikeme (2000) 5 NWLR pt. 657.

### 4.12 Absence of affirmative action and gender quota

The absence of affirmative action and gender quotas in Nigeria perpetuates gender inequalities and directly impacts the realization of the right to health, particularly in relation to maternal mortality[919]. Without adequate representation and inclusion of women in decision-making processes, policies addressing maternal health may not adequately address the specific needs and challenges faced by women.[920] An intersectional approach recognizes the unique experiences of women from different socio-economic, cultural, and ethnic backgrounds, and the absence of affirmative action limits the effectiveness of such an approach in addressing the intersecting factors that contribute to maternal mortality.[921]

Affirmative action policies and gender quota promote substantive equality by actively addressing the specific challenges and discrimination faced by pregnant women in Nigeria, going beyond the limitations of formal equality.[922] While formal equality treats everyone the same way under the law, it may fail to account for the unique socio-economic, cultural, and institutional barriers that pregnant women encounter in accessing quality maternal healthcare.[923] In contrast, affirmative action initiatives aim to level the playing field by providing targeted support and opportunities for marginalized groups, including pregnant women.[924] For instance, implementing gender quota in healthcare leadership positions can increase the representation of women in decision-making roles, ensuring their voices are heard in policy making processes.[925] Similarly, affirmative action policies can allocate resources and services to areas with higher maternal mortality rates, particularly in regions with significant socio-economic disparities.[926] By prioritizing substantive equality through affirmative action, Nigeria can effectively address the maternal health challenges faced by pregnant women and promote more equitable access to essential healthcare services, leading to improved maternal

[919] N Toyo 'Issues and contentions in the debate around affirmative action in Nigeria's constitutional reforms' in O Igbuzor & O Bamidele (eds.) *Contentious issues in the review of the 1999 constitution* (2002) 121.
[920] Ibid.
[921] Stephan Klasen & Anna Minasyan, "Affirmative Action and Intersectionality at the Top: Evidence from South Africa" (2021) Industrial Relations of Economy and Society 2.
[922] N Toyo 'Issues and contentions in the debate around affirmative action in Nigeria's constitutional reforms' in O Igbuzor & O Bamidele (eds.) *Contentious issues in the review of the 1999 constitution* (2002) 121.
[923] Nwabueze, supra note 661; Freedman *supra* note 132.
[924] Toyo, *supra* note 922 at 122.
[925] SH Williams 'Equality, representation and challenge to hierarchy: justifying electoral quotas for women' in SH Williams (ed) *Constituting equality: gender and comparative constitutional law* (2009) 9.
[926] Ibid.

health outcomes. A recent study offers data to support that female empowerment in politics has a direct effect on maternal mortality level.[927] It finds that women statistically prioritise policies aimed at improving female conditions at a higher rate than their male counterparts. Hence, female empowerment contributes to Sustainable Development Goals by the UN, including reducing maternal mortality[928] and increasing the number of women in government.[929] In addition, the principle of affirmative action is not alien to the Nigerian Constitution. Indeed, the Constitution contains salient provisions that seek to ensure the need to balance the distribution of employment among the various states of the federation. Specifically, section 153(c) of the Constitution provides for the establishment of the Federal Character Commission and provides for its composition and powers. Membership of the Commission consists of a chairman and one person to represent each of the states of the Federation and the Federal Capital Territory, Abuja. With a view to giving effect to the provisions of section 14 (3)[930] and (4)[931] of the Constitution, the Commission is empowered to:

(a) Work out an equitable formula subject to the approval of the National Assembly for the distribution of all cadres of posts in the public service of the Federation and of the States, the Armed Forces of the Federation, the Nigeria Police Force and other government security agencies, government owned companies and parastatals of the States;
(b) Promote, monitor, and enforce compliance with the principles of proportional sharing of all bureaucratic, economic, media and political posts at all levels of government;

[927] A Yamin 'Suffering and powerlessness: The significance of promoting participation in rights-based approaches to health' (2009) 11 *Health and Human Rights* 6.
[928] Sustainable Development Goals 3.1.
[929] Sustainable Development Goals 5.5.
[930] The composition of the Federal Government of the Federation, or any of its agencies and the conduct of its affairs shall be carried out in such a manner as to reflect the Federal character of Nigeria and the need to promote national unity and also to command national loyalty, thereby ensuring that there should be no predominance of persons from a few states or from a few ethnic or other sectional groups in that government or in any of its agencies. S.153 Constitution of Federal Republic of Nigeria LFN 2004.
[931] The composition of the government of a state, a local government council, or any of the agencies of such government or council or such agencies shall be carried out in such manner as to recognise and the conduct of the affairs of the government or council the diversity of the people within its area of authority and the need to promote a sense of belonging and loyalty among all the peoples of the federation. Ibid at section 153.

(c) Take such legal measures, including the prosecution of head or staff of any Ministry or government body or agency which fails to comply with any federal character principle or formula prescribed or adopted by the Commission; and

(d) Carry out such other functions as may be conferred upon it by an Act of the National Assembly.

The practical application of this provision is that recognition is given to the equality of result (equitable representation of all states of the federation and Abuja) rather than the equality of opportunity and certainly have negative effect on women's health rights. The inclusion of this provision in the Constitution is aimed at addressing minority ethnic group interests as again that of vulnerable groups such as pregnant women.[932] There is a lot to suggest that the application of the 'federal character principle' (Sec.14 (3) of the 1999 Constitution) has increased resentment in certain areas and produced entrenched dominance of certain groups over others. In a way, it does seem that rather than reverse perceived imbalances, the federal character principle may have created new alienated, non-targeted and prioritised "Federal Character" subjects at the expense of transformation goals, especially efficiency and effectiveness of the Nigerian state.[933] It is however disheartening to observe that the affirmative action principle applied under this Constitution in relation to ethnic and state differentiation is not extended to differentiation on the grounds of sex or other status recognized under section 42 as well as by the CEDAW.[934] The absence of the extension can be rationalised based on the history and has largely favoured men over women and focused mainly on national interests and stability. Thus, gender based affirmative action is a recent innovation, and not in national interest. [935] This amounts to a reinforcement of gender stereotypes and patriarchy that has become ingrained in the societal ways of life of all the ethnic groups that make up the country, which is reinforced by both cultural and religious practices over the years. The marginalisation of women is reflected in political, economic and social structures of the Nigerian society.

[932] Minorities Commission Report (1958) 505, 97 cited by Nwabueze *A constitutional history of Nigeria* (1982) 39.
[933] N Toyo, *supra* 922 at 126.
[934] Ibid at 137.
[935] K Shettima 'Engendering Nigeria's third republic' (1995) 38 *African Studies Review* 61 – 98.

The Beijing Declaration and Programme of Action gave rise to agitations by women's groups across the country for the adoption of affirmative action, demanding for a 30% representation of women in both elective and appointive positions.[936] While this campaign has yielded marginal results, the position of women in Nigeria remains appalling. It must be stated however, that merely increasing representation through certain measures and actions may not deal with the problems of inequality arising from entrenched discrimination over a long period of time. A conscious, strategic, and incremental affirmative action programme is what is required to redress the inequalities of the past and promote the evolution of an egalitarian society built on equality and non-discrimination norms in all spheres of societal life. This approach will be in line with the theory of intersectionality and can have significant effect on maternal health laws and policies to be introduced and implemented by the federal and state governments in Nigeria.

The real challenge for affirmative action on the basis of gender is how to integrate gender equity goals into the structures, policies and practices of the state in a sustainable way.[937] In effect, for gender-based affirmative action to be worthwhile in Nigeria, it is important to challenge the status quo and confront the structures of the society as well as the character of the state, which fosters the imbalances that exist.[938] One major step towards challenging the status quo reflected in the existing structures of the society is to reform the country's constitution to consciously recognise the inferior status of women, and make clear provisions aimed at redressing this gender injustice. This will undoubtedly involve the removal of provisions in the Constitution that discriminate against women and integrating provisions that not only seek to redress the injustices of the past, but also contain affirmative action provisions that promote gender equality and recognise the reproductive and sexual autonomy of women.

Despite the developments across the African region regarding affirmative action, the lack of political will on the part of the legislature is apparent and requires more than legislative reform to address the deeply rooted entrenched hierarchical social norms between men and women in Nigeria.

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[936] Fourth World Conference on Women, Beijing, 15 September 1995, A/CONF.177/20.
[937] S Clayton & F Crosby *Justice, gender and affirmative action* (1992) 11.
[938] Toyo, *supra* note 922 at 134.

On the 1st of March 2022, the National Assembly in Nigeria rejected five (5) gender equality bills[939], seeking to alter the provisions of the Constitution to guarantee equality for women. The rejection has once again brought to the fore the need to revamp and purge our democratic system of recondite bias and to consistently challenge the systemic discrimination against women, and as a matter of urgency stop the oppression being perpetuated in the patriarchal society. [940] Bill 35 seeks to provide for a special seat for women in the National and State Assemblies. It provides for additional 111 seats in the National Assembly. Bill 68 seeks the inclusion of at least ten per cent (10%) affirmative action in favour of women in Ministerial Appointments. Unfortunately, they were rejected by the male-dominated National Assembly. The rejection reinforces the attitude of Nigerian legislature's unchanging attitude towards issues of women and may have multiplier effect on women beyond maternal health. The bias of lawmakers derived from the social imbalance continues to limit and exclude women's participation, particularly disregarding their perspective on critical matters that affect the gender. They claim that these bills violate constitutional right to freedom of religion guaranteed under the Constitution. This is an institutionalised discrimination by ethno-religious bodies that vote against these bills. It has far-reaching effects for women's health and can further drive negative outcomes for maternal mortality in Nigeria.

A significant contribution of my thesis is the important role of the courts in transforming health services, especially through constitutional guarantee of the right to health and provisions that make health equity attainable. I argue that a constitutional guaranteed right to health in Nigeria assures citizens of government commitment to transform maternal health, which guarantees equality and empowers court to enforce collective and individual claims. The Courts must focus on endorsing, overseeing and evaluating the effectiveness of maternal health policies rather than being burdened with the content of constitutional guarantees of the right. The failure of the state

[939] The bills are: 1. Bill to "provide for special seat for women in the National and State Assembly",2. Bill to "expand the scope of citizenship by registration"; 3. Bill to "provide for affirmative action for women in political party administration"; 4. Bill to "provide criteria for qualification to become an indigene of a state in Nigeria" and; 5. Bill to "give women a quota in the federal and state executive councils or ministerial and commissionership seats".

[940] Funmi Falana "Condemnation of the National Assembly's rejection of bills seeking gender equality" March 2022), Condemnation of the National Assembly's rejection of bills seeking gender equality (vanguardngr.com) (Accessed on May 15, 2022).

to realize the right to health cannot be justified on the philosophical nature of the right to health, but on the failure of the government to channel resources and capacity to properly implement effective intersectional policies. It also emphasizes the urgent need to domesticate and implement international human right treaties on the right to health to guarantee equality as well as implement effective intersectional policies, allocate resources and implement comprehensive measures to ensure the realization of women's right to health. By shifting from formal to substantive equality, we can address the unique challenges faced by women in different contexts, including the detrimental impact of harmful customary laws. By embracing substantive equality over formal equality, Nigeria can tackle the discriminatory impact of harmful customary laws on women. The judiciary's active role in upholding women's rights to equality and non-discrimination is vital in endorsing and evaluating maternal health policies.[941] For instance, the shift to substantive equality could involve judicial activism in cases where discriminatory customary laws perpetuate gender-based inequalities in access to maternal healthcare.[942] Through landmark decisions, the judiciary can challenge these harmful practices and ensure that women's reproductive rights are protected and upheld.[943] Additionally, the judiciary's evaluation of maternal health policies can be guided by an intersectional approach, taking into account the diverse and interconnected forms of discrimination experienced by women from different cultural and socio-economic backgrounds. This comprehensive understanding will lead to more effective policies that address the specific challenges faced by women in different contexts, promoting equitable access to maternal healthcare and improving maternal health outcomes in Nigeria.

### 4.13 Conclusion

In conclusion, Nigeria is faced with a multitude of challenges in achieving gender equality in healthcare. To overcome these obstacles, crucial reforms are needed, the country must ammend provisions of the Directive Principles of State Policy under its Constitution to attain justiciable rights status, including the domestication of international treaties and the enactment of

[941] United Nations Population Fund (UNFPA), Maternal Health, http://www.unfpa.org/swp/2004/english/ch7/page3.htm (last visited May 12, 2008).
[942] Paul Hunt & Judith Bueno De Mesquita, University of Essex Human Rights Center, Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health 3 (2007), available at http://www.unfpa.org/upload/lib_pub_file/750_ filename_reducing_mm.pdf
[943] Durojaye, *supra* note 117.

statutory reforms to effectively implement healthcare provisions. The country must address the complexities of multiculturalism within its legal system and reform the division of healthcare responsibilities. Embracing substantive equality over formal equality, particularly in the judicial interpretation of the right to health, is essential. An intersectional approach is necessary to ensure positive obligations and entitlements, particularly for marginalized populations. Furthermore, constitutional provisions that uphold harmful customary laws must be reformed, and the judiciary should play a proactive role in upholding women's right to equality and non-discrimination. It is imperative for the Nigerian courts to overcome self-imposed constraints and deliver justice to the impoverished and marginalized masses who are deprived of their socioeconomic rights, including the right to health.

The existing constitutional framework must be creatively altered and interpreted to give meaningful effect to maternal health purposes, while simultaneously addressing the failings of the healthcare system and social issues that impact maternal health outcomes. To effect the necessary change, a multi-faceted approach is required. Firstly, legal reforms must creatively reinterpret the existing constitutional framework to prioritize maternal health purposes and protect women's reproductive rights.[944] This could involve amending laws to explicitly recognize and enforce women's right to access quality maternal healthcare services without discrimination.[945] Secondly, the healthcare system must be strengthened through increased investment in infrastructure and the provision of essential maternal health services. Additionally, social issues such as gender inequality, poverty, and lack of education must be addressed through targeted interventions, empowering women and improving their overall well-being.[946] In a synergy of legal reforms, healthcare system improvements, and social interventions, Nigeria can foster an environment that genuinely prioritizes maternal health which can lead to improved maternal health outcomes and enhanced reproductive rights for women. An examination of the experiences of India and South Africa in the next chapters will shed light on the prospects and challenges of achieving better health outcomes, gender equality, the right to health, and the prevention of maternal deaths. By undertaking these reforms and

[944] Nussbaum, M 'India, sex equality, and constitutional law' in Baines, B & Rubio-Marin, R (eds) *The gender of constitutional jurisprudence* (Cambridge 2005).
[945] Ngwena, C.& Durojaye, E, *supra* note 107.
[946] R Cook, B Dickens & M Fathalla *Reproductive health and human rights: integrating medicine, ethics, and law* (2003) 398.

addressing the identified areas of concern, Nigeria can pave the way for improved healthcare and greater gender equality, leading to better maternal health outcomes for all women.

## CHAPTER FIVE

## Constitutionalizing Maternal Health: The Indian Socioeconomic Rights Approach

### 5.0 Introduction

Engaging comparative method of analysis, I examine the possible options of incorporating maternal health within a constitutional framework and judicial structure, by discussing legal, social and cultural factors affecting maternal health. This chapter focuses on one of the two parallel regimes of socio-economic rights under national constitutions. The Indian approach of interpreting socioeconomic rights implicates justiciable civil and political right to life.[947] Socio-economic rights, in India like Nigeria, are subject of non-justiciable Fundamental Objective and Directive Principles ("FODPSP"). I examine how India has negotiated the limitations of a constitutional tradition strongly opposed to constitutionalized socioeconomic rights, using judicial activism to read civil and political rights into it to realize socio-economic right to health. Although, it is difficult to impose or transplant[948] the approach on Nigeria, the goal of functional comparative method is to analyse laws, policies and doctrines in this context.[949] As a country with the highest maternal mortality in the world, the Indian jurisdiction has also adopted a progressive interpretation of the right to non-discrimination provision in its constitution and established different initiatives and programs to address the issues of inequality with positive effect on social, economic and political spheres. These approaches have led to improvement in the statistics of its maternal health. I examine landmark maternal cases from India regarding the violation of the right to life, dignity and non-discrimination, and how the court's approach to discrimination in these cases have resulted in more positive treatment of maternal deaths in an intersectional way. I juxtapose the Indian experience with that of Nigeria, where socioeconomic rights are not justiciable as well, but are also listed as "FODPSPs" or "DPSP"[950] . I argue that Nigeria can benefit equally from the experiences of India through the expansion of the constitutionally guaranteed right to life to encompass a right

[947] This regime aligns with most of the Western world including countries like USA, Canada, in the claim that socioeconomic rights are 'no more than pious wishes' but can be given effect when interpreted to advance other justiciable civil and political rights.
[948] Ralf on Comparative Law at 3.
[949] Konrad Zweigert's comparative functionalism regarded as the most fruitful, perhaps the only method of comparative law See John Reitz, 'How to do Comparative Law', (1998) 46 *American Journal of Comparative Law* 617, 620-623.
[950] Referred to as Directive Principles of State Policies (DPSPs) in the Indian Constitution.

to healthcare and its determinants. I conclude that despite doctrinal limitations of justiciability, and judicial precedents that determine the disposition of the Nigerian judiciary recognition of socioeconomic rights as directive principles under its constitution, Nigerian policymakers and judiciary can learn from the Indian courts approach of reading civil and political rights to realise socio-economic rights under its constitution.

Comparative law seeks to explain differences between legal systems towards the goals of transparency, judicial accountability and control that are guaranteed in each system, albeit by different means.[951] The rationale for the comparative approach lies in the fact that constitutional norms developed by some national jurisdictions may be adopted by other states with similar legal system and traditions. The choice of India is informed by its shared similar features with Nigeria as a common law country, and its constitutional provisions of non-justiciable fundamental objectives. Although the judicial decisions of foreign jurisdictions and statutory provisions even if similar, are not legally binding as precedents and laws, [952] the Nigerian Court of Appeal has held that such decisions carry some measure of weight and persuasive effect.[953]

The chapter is divided into four parts. The first part looks at maternal health disparities in India, the nature of social inequality and discrimination resulting in the worse maternal mortality globally, as well as causes of maternal health disparities. The second part examines the socioeconomic rights under the Indian constitution through the doctrine of fundamental objectives and directive principles of state policy. I also examine how the Indian courts through a critical analysis of case laws, have interpreted political and civil rights that implicate the fundamental objectives to positively influence policies and compel the legislature and executive to implement programmes that have significant bearing on health matters. I examine the socio-economic, judicial and political peculiarities of Nigeria with the aim at explaining the divergent outcomes of the social rights in Nigeria despite its similarities of the fundamental objectives with India. The third part examines the judicial enforcement of socioeconomic rights. Also, it examines how maternal death have been prevented through right to life with its

[951] Mitchel de S.-O.-L'E. Lasser, Judicial Deliberations (2004), 362.
[952] *Inspector General of Police v All Nigeria People's Party* (2008) CHR 131at 142 (CA).
[953] Ibid.

implications for the right to health. In the fourth part of this chapter, the social factors affecting maternal health are discussed and intersectional discrimination is examined through landmark cases alongside their significance on maternal health enforcement in India and the subsequent intersectional policies and programmes implemented, particularly in the context of preventable maternal deaths. I conclude that despite factors affecting the Nigerian judiciary in applying socioeconomic rights as directive principles under its constitution, Nigerian policymakers and judiciary can learn from the Indian courts approach of reading civil and political rights to realise socio-economic rights under its constitution.

## 5.1 Health Care System in India

Each comparative jurisdiction has different features, but important similarities exist between India and Nigeria which makes my analysis suitable. This includes the federal structure of the health system in India. The division of healthcare responsibilities makes healthcare services the responsibility of the state governments but with the accommodation of influence of the central government to intervene by way of implementation of programmes and policies across the country in relation to items listed in the concurrent legislative list of the Indian Constitution. The central government initiate health policy and general planning framework for health. Pursuant to the division of legislative powers and policy framework, the central government has had several positive and significant influence on the health sector in the country through constitutional means, including maternal healthcare .[954]

In this chapter, my focus is not on the potential limitations of adopting the judicialized approach. Instead, I emphasize the immense potential for addressing maternal mortality through a comprehensive and tailor-made approach for Nigeria. The aim is to shed light on the critical treatment of the right to health as Directive Principles of State Policy (DPSPs) through civil and political rights, and the underlying determinants that shape health outcomes. By doing so, valuable insights can be gleaned by the Nigerian legal system drawn parallel with the experiences of India. Although as regards maternal health, the policies have seen a reduction

[954] The Constitutional provisions (Schedule 7 of article 246) are classified into three lists, including a concurrent list which both centre and states can operate but with the overriding power remaining with the centre.

in the maternal mortality ratio in the country, the progress is not even as disparities remain across the regions of the country,[955] as discussed below.

### 5.1.1 Maternal Health and Regional Disparities in India

India still accounts for about one-fifth of the global maternal deaths[956] despite the steady decline in the rate of the mortality in the country. There are large inter-state and intra-state disparities, reinforcing the fact that the maternal health in India is a crisis of inequality.[957] The disparities are not only from different states, but also between different economic groups within these states, particularly placing the odds against rural and poor mothers[958]. Despite the strides in India in the policies and strategies for curbing sustaining an effective maternal health for a considerable decline in the Maternal Mortality Ratio in India, it remains unacceptably high.[959] Regional and rural-urban differences in health statistics are also based on economic status and continue to dominate reality in Indian society.[960]

### 5.1.2 Causes of Maternal Health Disparities in India

The discussion in Chapter Three emphasizes how social factors are integrated into the institutional framework to address policies related to maternal mortality, shedding light on the causes of disparities in maternal death rates, particularly in the context of Nigeria. Most of maternal death disparities are because of inequality, and generally associated with the social

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[955] Banerjee, S., John, P., & Singh, S. 'Stairway to death: Maternal mortality beyond numbers', (2013) 48:31 *Economic and Political Weekly* 123–30.

[956] Hunt P. UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Mission to India, United Nations General Assembly, 15 April 2010. UN Doc. No.A/HRC/14/20Add.2.

[957] Joe, W *et al.* 'Maternal Mortality in India: A review of trends and patterns', Institute of Economic Growth, Working Paper No. 353, (2015) 2.

[958] Montgomery, A.L, Ram, U., Kumar, R. & Jha, P. 'Maternal mortality in India: Causes and healthcare service use based on a nationally representative survey'. (2014) 9:1, 4.

[959] Singh P. K. "India has achieved groundbreaking success in reducing maternal mortality. New Delhi: WHO Regional Director South-East Asia; 2018; Maternal Mortality Ratio variation, ranging from 300 in Assam to 61 in Kerala.

[960] India's MMR was estimated to have 178 maternal deaths per 100,000 live births. In 2010, 19 per cent of the 287,000 maternal deaths estimated worldwide took place in India. Disparities in maternal health indicators occur between the more urban South and West, and less developed and mostly rural Central, East, and Northeast of India. 68 percent of the population resides in rural areas in 2014. See, Jithesh V. "Social Determinants of Maternal Deaths and Maternal "Nearmisses" in Wayanad District, Kerala: A Qualitative Study. Working Paper no. 3. Trivandrum: Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology; (2012), 2, 13; Das, A. 'The challenge of evaluating equity in health: Experiences from India's maternal health program', in S. Sridharan, K. Zhao, & A. Nakaima (eds.), Building Capacities to Evaluate Health Inequities: Some Lessons Learned from Evaluation Experiments in China, India and Chile. New Directions for Evaluation, (2017) 91–100.

determinants of health such as poverty, education, as they affect the marginalised and vulnerable in the society. India maternal mortality crisis is also a gender inequality issue, as women and girls continue to face major health problems due to discrimination against them.[961] Studies have demonstrated the connection between maternal health and their social determinants.[962] The systematic discrimination against women especially those from the lower castes who suffer for their social status as prescribed by culture, tradition, and religion remains a contributing factor. Women from lower castes suffer poor health and social exclusion, resulting from the extreme social gradient due to the unequal distribution of power, income, goods and services.[963] In addition, the prevalence of child marriage and early pregnancy are major contributors to maternal mortality in India as well.

Similarly, maternal mortality levels are significantly influenced by socio-cultural, health, and demographic factors.[964] Generally, these aspects of the societal structure can be reasonably captured by different similar variables, such as general social and economic inequalities, female literacy rate, caste system, and cultural issues as child marriage and contraceptive use.[965] In using a comparative method, my research ensures that the different forms in which women experience discrimination within the countries are not universalised. It is difficult to capture all the different forms of discrimination that affect maternal health within these jurisdictions; thus the focus is on poverty, child marriage and cultural and religious factors. Although the public health system in India is well structured, it fails to meet even customary service standard.[966] Education, wealth, socioeconomic marginalisation, and urban against rural

[961] Singh P, Rai R, Alagarajan M, Singh L. "Determinants of maternity care services utilization among married adolescents in rural India". *PLoS One.* (2012), 7.
[962] Sanneving *et al.* Inequity in India: The case of maternal and reproductive health. (2013) 6:19, *Global Health Action* 145; Vora *et al.* Maternal health situation in India: A case study. (2009), 27 *Journal Health Population Nutrition* 184-201.
[963] Arokiasamy P & Pradhan J. Maternal health care in India: access and demand determinants. *(2013*),14:373 *Prim Health Care Res Dev.* 93.
[964] Although, several important initiatives have been rolled out under the Reproductive and Child Health (RCH) programme and National Rural Health Mission (NRHM).
[965] Thiem, 'Human dignity and gender inequalities' in Duwell, M et al (eds) *The Cambridge handbook of human dignity: interdisciplinary perspectives* (Cambridge 2014).
[966] Das, A. 'The challenge of evaluating equity in health: Experiences from India's maternal health program', in S. Sridharan, K. Zhao, & A. Nakaima (eds.), Building Capacities to Evaluate Health Inequities: Some Lessons Learned from Evaluation Experiments in China, India and Chile. New Directions for Evaluation, (2017) 91–100.

living are major determinants of whether or not a woman receives maternal health services in India.[967]

The comparative method emphasizes difference, it does not give us criteria for evaluation and it provides powerful arguments against unification. Thus, my research does not set criteria for evaluation of laws and policies neither does it seek their unification of laws. To evaluate an approach is to engage in a 'better law comparison', the better of several laws within a jurisdiction despite the context is that which fulfills law's function better than the other. I use the yardstick of maternal mortality reduction as a measure of evaluation. India remains a major example for developing countries regarding how the policy makers and the courts have sought to utilize civil and political rights to incorporate socioeconomic rights, and use the various underlining determinants of health to address the menace of maternal mortality. The Indian jurisdiction has addressed the determinants of health including the rights to education, economic status, and other determinants such as poverty, by creatively interpreting those fundamental rights which have implications for the denial of socio-economic rights.[968] This is aimed at correcting social inequality in the country, despite the non-justiciable nature of socioeconomic rights in its Constitution.

## 5.2 Legal Framework for Right to Health and Non-Discrimination in India- The CEDAW and ICESCR

In this section, I discuss the key international instruments that India has ratified but not domesticated, and which have however been applied by its courts in ameliorating the challenges pregnant women face. This is particularly relevant for the Nigerian legal system considering its similar posture towards these instruments. In 1994 India ratified the CEDAW with several reservations relating to issues such as child marriage. In fact, the country states that it is not legally bound to implement the Convention throughout the country. The reservations are largely due to conflict with religious and cultural values of the country. It has also not ratified the Optional Protocol of the CEDAW. Therefore, India is not bound by the

[967] Ibid.
[968] Arokiasamy P & Pradhan, *supra* note 963.

requirement of regular reporting, and this is why there are several reports pending and due for submission by the country to the supervisory committees under the Convention.[969]

As a dualist state, India as a party to the Convention, has elevated the ICESCR provisions affecting the right to health to a superior state as against the local enactments. This guarantees the right to the highest attainable standard of health.[970] Pursuant to the ratification, the Indian legislature has enacted laws giving effect to some of its treaty obligations and these laws are in turn enforceable by the courts. The Indian Supreme Court has viewed the DPSP which contains many provisions of the ICESCR including health as being complementary, and that neither part is superior to the other. Even though the jurisprudence with respect to these rights in India has been ground-breaking, the non-implementation of court decisions by state authorities remains a challenge.[971] International treaties to be applicable in India, must be domesticated by separate local legislation. Since none of the international human rights treaties have been incorporated into domestic laws in India as in Nigeria, both the ICESCR and CEDAW have only persuasive significance and can be used at the discretion of the courts.[972] For instance, the courts have on several occasions used the ICESCR and CEDAW in conjunction with other rights guaranteed under its constitution and these are discussed in the subsequent subsections of this chapter.[973] The Indian courts' proactive approach to international law showcases significant flexibility in implementing the right to health and non-discrimination provisions within the Indian legal framework, even in the absence of their local legislative transformation as mandated by international law. This contrast highlights the potential benefits of a more assertive judicial stance by Nigeria, towards treaty implementation

[969] Center for Reproductive Rights 'Maternal Mortality in India: Using International and Constitutional Law to Promote Accountability and Change'. (2008) (Accessed: 10 October 2021)
[970] India has submitted its combine 2nd, 3rd, 4th & 5th periodic report to UN in October 2006. The reports are available at http:/ / www.ohchr.org
[971] S Muralidhar 'Implementation of court orders in the area of economic, social and cultural rights: An overview of the experience of the Indian judiciary' paper presented to the First South Asian Regional Judicial Colloquium on Access to Justice, New Delhi, 1-3 November 2002 http://www.ielrc.org/content/w0202.pdf (accessed 21 May 2021).
[972] Ravi Duggal "Right to Health and Health Care Theoretical Perspectives" in Healthcare Case Law in India: A Reader" Centre for Enquiry into Health and Allied Themes (Delhi, 2007), 6.
[973] See. *Vishaka v State of Rajasthan,* writ petition number 666-70 of 1992, quoted in Toebes, 1998. A case on sexual harassment at the workplace, the Supreme Court invoked the CEDAW and Beijing Declaration stating that – Any international convention not inconsistent with the fundamental rights and in harmony with its spirit must be read into these provisions to enlarge the meaning and content thereof, to promote the object of the constitutional guarantee.

in ensuring the realization of rights. The implementation of treaty provisions regardless of transformation is similar to "welfare approach" adopted in the developed countries like USA and Canada, and offers important guidance to courts in interpreting provisions of similar treaties to address critical issues such as maternal mortality in Nigeria.

### 5.2.1 Prevention of Maternal Death through Civil and Political Rights Framework

Much of the success of the Indian court on maternal health lies in the interpretation of civil and political rights to life under its constitution to give effect to the underlying socioeconomic determinants of health. Undoubtedly, the right to life is the most important right guaranteed by international human rights laws and national constitutions.[974] It has the status of *jus cogens*, peremptory norms of international law from which no derogation is permitted. Without this right, all other rights are rendered meaningless. Since the right to life is guaranteed both under international law and national constitutions and considering its importance, international law imposes positive duties and obligations for states parties to adopt any appropriate laws or other measures in order to protect life from all reasonably foreseeable threats, including from threats emanating from both private persons and state entities.[975] This positive duty also requires states to take appropriate measures to address the general conditions in a society. This may arise as direct threats to life or impediments that prevent individuals from enjoying their right to life with dignity. Also, it may develop strategic plans for advancing the enjoyment of the right to life, which may comprise measures to prevent harmful practices, and for improving access to medical examinations and treatments designed to reduce maternal and infant mortality.[976]

The Indian jurisdiction has demonstrated a proactive approach in utilizing civil and political rights to address and prevent maternal deaths. By recognizing the inherent value of these rights and their interplay with maternal health, the Indian courts have played a pivotal role in promoting accountability and safeguarding women's lives. For instance, the Supreme Court of India, in the landmark case of *Parmanand Katara v. Union of India*[977], affirms the duty of

[974] General Comment No. 36 on article 6 of the ICCPR on the right to life CCPR/C/GC/36 30 October 2018 para 2. This general comment replaces earlier general comments No. 6 (16th session) and 14 (23rd session) adopted by the Committee in 1982 and 1984, respectively.
[975] General Comment No. 36, para 18.
[976] General Comment No. 36, para 26.
[977] Parmanand Katara v. Union of India (1989) Air 2039, 1989 Scr (3) 997.

hospitals to provide immediate medical assistance to pregnant women in emergency situations. This decision emphasizes the positive obligation of the state to protect the right to life and ensure access to healthcare services for pregnant women. This illustrates how the Indian legal system has harnessed civil and political rights to impose positive obligations to actively prevent maternal deaths.[978] Citizens may bring actions against states for violations of its constitutions including related rights that affect such civil rights. Certainly, lessons abound from the jurisprudence of the Indian Supreme Court on how it adopts a collective reading of the entire constitution to protect other rights incidental to the right to life. Thus, a purposive interpretative strategy by the courts can be an avenue for constitutionalising the prevention of maternal death.

### 5.2.2 Enforcing Right to Health through civil and political rights in Nigeria

Civil and political rights are justiciable and represent a significant avenue for the prevention of maternal deaths in Nigeria. The Nigerian Constitution guarantees the right to life under section 33, and provides that every person has a right to life, and no one shall be deprived intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence for which he has been found guilty in Nigeria.[979] The provision of section 33 although framed to address intents for violation of the right, falls short of imposing positive obligations on the state and also for culpability in criminal cases as well as in civil cases. This constitutional approach is a model adopted by the Indian Courts. According Khlosa, it requires that civil actions can give rise to constitutional rights violation.[980] Thus, negligent actions and omissions which result in maternal deaths can violate constitutionally guaranteed rights and can impose positive duties on a state regardless of the intent requirement under the Nigerian Constitution.

The Nigerian courts have, to a limited extent, recognized the right to health in cases involving the right to liberty and the right to life.[981] By drawing on the provisions of the African Charter and Chapter II of the Constitution, the courts have acknowledged the importance of ensuring access to healthcare for individuals in detention whose health is deteriorating, to uphold their right to life.[982] While these decisions reflect a positive development in protecting the right to

[978] General Comment No. 36, para 26.
[979] Section 33(1) Constitution of Federal Republic of Nigeria.
[980] M Khosla *supra* note 769 at 754.
[981] Abacha v. Fawehinmi (2000) 6 NWLR (Pt. 660)
[982] Festus Odafe & 3Others v. Attorney General of the Federation & 3 Others, Suit No. FHC/PH/CS/680/2003.

health, the broader recognition and enforcement of the right to health in Nigeria's legal framework is yet to be fully realized. The courts have held that arrested persons are entitled to bail on ground of ill health, In the case of *Mohammed Abacha v. The State*[983], the Supreme Court of Nigeria held, that "whatever the stage at which bail is sought by an accused person, ill-health of the accused is a consideration weighty enough to be reckoned as special circumstances'.[984] In *Festus Odafe & 3 Others vs. AG Federation & 3 Others*, the Nigerian Federal High Court relies on Art 16 of the African Charter on Human and Peoples' Rights rather than Nigeria's Constitution to protect right to health.[985] The court upheld the right to health of the HIV prison detainees' applications when it held that the prison administrators are unable to cater for their welfare. It held that the Charter imposes a duty on the state to take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick, regardless of their status. Regarding the application of the right to health as a positive right, cost of providing health care and the requirement of progressive realization argument before the court, the court held while it acknowledges the undue burden on the public purse of providing such right: 'A dispute concerning socio-economic right such as right to medical attention requires a court to evaluate state policy and give judgment once it is consistent with the Constitution'. The court then held that statutes must be complied with and that the government has responsibility to all inmates in a prison regardless of the nature of the offences in every instance.[986] These decisions reflect trends in some Nigerian courts to reconcile and interpret constitutional and statutory provisions on health to uphold the obligations of the state to respect, protect, promote, and fulfil the enjoyment of the right. The Indian jurisdiction offers important lessons through its judiciary active role in enforcing socioeconomic rights in form of DPSPs that implicate the civil and political rights particularly the right to life, in constitutionalising maternal health in Nigeria. Having domesticated the

[983] Abacha v. The State [2002] 5 Nig. Weekly L. Reps. 761; State v. Bamaiyi, [2001] 8 Nig. Weekly L. Reps., 715

[984] According to the court special circumstances include: ill-health of the accused which is infectious or contagious or poses a real hazard to other occupants of the detention facility or prison; the prison or government authorities do not have access to medical facilities required to treat the accused or suspect; the allegations of ill-health are supported by positive, cogent, and convincing medical report issued by an expert in the field of medicine in which the accused suffering from the ill-health is referable. See also Federal Republic of Nigeria v. Danjuma Ibrahim & 5 Others, Federal High Court, Charge No. FCT/HC/CR/79/2005, In re: Motion No. M/4717/2005.

[985] Unreported, Suit No. FHC/PH/CS/680/2003, Judgment of Honorable Justice R. O. Nwodo, of February 23, 2004.

[986] Festus Odafe, *supra* at 13.

African Charter which embodies all categories of both civil, political rights and socioeconomic rights in a single document, this empowers citizens to bring claims for enforcement under the Charter in Nigeria. This assumes that when the right to health is constitutionalised, it will result in positive outcomes and reduce maternal mortality in Nigeria.

### 5.2.3 Socioeconomic Rights under Indian Constitution-Directive Principles of State Policy

The jurisprudence of the Indian judiciary in socioeconomic rights has been a subject of significant attention among human rights scholars.[987] In the realm of maternal health, India presents a unique context where the intersection of civil and political rights plays a crucial role in shaping policies and interventions. However, it is equally important to examine the impact of socioeconomic rights, as enshrined in India's fundamental objectives and directive principles, and their jurisprudence in addressing maternal health disparities. India like Nigeria is a former British colony. It gained independence in 1947, following several decades of British colonial rule. The countries also have a chapter on the Directive Principles of State Policies in their constitutions,[988] which embodies the non-justiciable socio-economic rights provisions and justiciable civil and political rights.[989] Socioeconomic rights requires the state to pursue socio-economic justice.[990] The Preamble of the Indian Constitution seeks to guarantee the welfare of citizens on an equal basis of social platform balance under article 21 of the Constitution on the right to life, personal liberty, and the right to equality under article 14. These principles are reflected in both Part III and Part IV of the Constitution where rights and dignity of the individual are protected. Hence, social and economic justice are interpreted to include access to healthcare facilities and emergency maternal healthcare services. Like

[987] See generally: R Abeyratne 'Socioeconomic rights in the Indian Constitution: towards a broader conception of legitimacy (2014) 39 *Brooklyn Journal of International Law* 71; N Menell 'Judicial enforcement of socioeconomic rights: a comparison between the transformative projects in India and South Africa (2016) 49 *Cornell International Law Journal* 723-743; M Khosla 'Making social rights conditional: lessons from India (2010) *International Journal of Constitutional Law* 739-765.

[988] Part IV, chapter 37.

[989] Art. 37 (provides directive principles shall not be render enforceable by any court of India) the Constitution of India. See. De Villiers, Bertus, 'Directive Principles of State Policy and Fundamental Rights: The Indian Experience', (1992) 8 *South African Journal on Human Rights* 29-49, 2; Sharma, Gokulesh, Human Rights and Social Justice: Fundamental Rights vis-à-vis Directive Principles, (New Delhi: Deep and Deep Publications, 1997), 48.

[990] Many of the provisions in Part IV correspond to the provisions of the ICESCR. The Constitution of India, full text available at the website of the Ministry of Law and Justice (Legislative Department), India: http://lawmin.nic.in/olwing/coi/coi-english/coi-indexenglish.htm (accessed on February 22, 2021).

Nigeria, the Constitution expressly bars the courts from enforcing the provisions of part IV, but it admits that the 'principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws'.[991] Part III empowers the Supreme Court to enforce human rights under article 32.[992]

The concept of directive principles was inspired by India in the Nigerian constitutional development.[993] Chapter II of the Nigerian Constitution contains the DPSPs which are not subject to judicial enforcement pursuant to Section 6(6)(c).[994] Despite these similarities in the constitutional framing, the Indian judiciary has been quite progressive in giving effect to the socioeconomic rights provisions of the constitution, including the right to health.[995] This calls for a review of some decisions of the courts in India to determine what lessons Nigeria can learn from the Indian experience in the advancement of socioeconomic development, particularly in the area of health and general human well-being, as prerequisite conditions for the realisation of better living condition for the citizenry.[996]

In a landmark case, the Supreme Court of India held that 'In building up a just social order it is sometimes imperative that the fundamental rights should be subordinated to directive principles',[997] a decision that transformed the Indian approach to directive principles. Subsequently, the Indian courts have sought to utilize civil and political rights to incorporate socioeconomic rights. The DPSPs are therefore seen as aids to interpret the constitution and

[991] Ibid.
[992] Article 226 extends this right to the High Courts. Id. art. 226.
[993] See J Akande "The Constitution of the Federal Republic of Nigeria 1979 with Annotations" (1982, Sweet & Maxwell) 13; "Report of the committee on Fundamental Rights and Directive Principles of state policy and press freedom" (1976) II The Report of the Constitutional Conference Containing the Resolutions and Recommendations 105.
[994] "The judicial powers vested in accordance with the foregoing provision of this section: shall not, except as otherwise provided by this constitution, extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in chapter II of this constitution." Section 6 Constitution of Federal Republic of Nigeria.
[995] Ibe Stanley "Beyond justiciability: Realising the promise of socio-economic rights in Nigeria" (2006) *African Human Rights Law Journal* 236.
[996] See generally: R Abeyratne 'Socioeconomic rights in the Indian Constitution: towards a broader conception of legitimacy (2014) 39 *Brooklyn Journal of International Law* 71; N Menell 'Judicial enforcement of socioeconomic rights: a comparison between the transformative projects in India and South Africa (2016) 49 *Cornell International Law Journal* 723-743; M Khosla, supra note 769 at 739-765.
[997] Keshavananda Bharati v. State of Kerala (1973) 4 SCC 225.

more specifically to provide the basis, scope and extent of the content of fundamental rights.[998] According to Bhatia *et al*., the right to life constitutional provision has been extended to incorporate socioeconomic rights of nutrition and health care, work and shelter, regardless of their non-justiciable nature under the constitution.[999]

### 5.2.4 The Indian Experience in Enforcing Directive Principles

The Supreme Court in India has striven to concretize in real terms the wordings of the "Directive Principles of State Policy," exhorting the Indian state to realize socioeconomic rights. Its first step was to simplify access to courts by poor litigants through the public interest litigation concept. The Court then expanded the ambit of justiciable fundamental rights of civil and political rights, especially the right to life, to entail provisions of health care. I argue that Nigeria has much to learn from the Indian constitutional experiences, where there are ongoing conscious efforts by the judiciary, executive, and legislature to improve accountability in maternal health through the instrumentality of the constitution as well as international treaties.

Beginning with the *Maneka Gandhi v. Union of India*, the Supreme Court introduced an interesting approach of interpreting socio-economic rights, by expanding the guarantee of the right to life in article 21 to include a whole gamut of socio-economic rights.[1000] Overruling *A.K Goplan v State of Madras*[1001] on the exclusiveness of fundamental rights, the Supreme Court added that the right to life provision of article 21 has an added substantive requirement.[1002] It added that a 'procedure' under article 21 of the Constitution cannot be arbitrary, unfair, oppressive, or unreasonable of justness, fairness, and reasonableness, and its future decisions links it with environmental, nutrition, emergency health care, legal aid, and labour rights.[1003]

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[998] Ibid. Mathew J. para. 1714 at 881.

[999] Courts in India have developed a strong jurisprudence to expand the scope of section 21 of the Constitution to include livelihood and other related protections such as health, food etc. See. Maneka Gandhi v. Union of India, AIR 1978 SC 597, 623–624; Mehta v. Union of India, (1991) SC 420; Olga Tellis v. Bombay Municipal Corporation, AIR 1986 SC 180; Bhatia *et al.*, "Pro-Poor Policies and improvement in maternal health outcomes in India" (2021) 21, *BMC Pregnancy and Childbirth* 389.

[1000] In Francis Coralie Mullin *v* Union Territory of Delhi 1981 (1) SCC 608, the Supreme Court held that the right to life includes the right to live with human dignity and all that goes along with it.

[1001] AIR 1950 SC 27.

[1002] Sripati, Vijayashri 'Constitutionalism in India and South Africa: A Comparative Study from a Human Rights Perspective, (2007), 16 Tulane Journal of International and Comparative Law 49-116.

[1003] Kothari, Jayna, 'Social Rights Litigation in India: Developments of the last Decade', in Barak-Erez, Daphne and Gross, Aeyal, M. (eds.), Exploring Social Rights: Between Theory and Practice (Hart Publishing: Oxford and Portland, Oregon, 2007), 171-192.

The decision in the case has significantly influenced the enforcement of socioeconomic rights in India and this case has been described as the turning point of the Supreme Court decades of formalist approach, where the Court expands the rights of citizens against the state rather than limiting them.[1004] Drawing on a range of directive principles for interpretive guidance, the Court found that the right to life would include the right to livelihood.[1005]

Lower courts in India have not largely embraced this expansion of individual rights.[1006] It is not surprising that much of the literature that paints a positive view of India's judiciary is focused on the Supreme Court. The Supreme Court's broad interpretation of civil and political rights in India has played a crucial role in effectively enforcing socioeconomic rights to health, including the supervision of maternal health policies and programs, resulting in significant positive impacts at the national level.[1007] The court has subjected maternal policies to judicial scrutiny through exercising supervisory jurisdiction of state policies particularly the NRHM and JSY[1008], across the states of the Indian federation. The court mandated states to establish similar policies for vulnerable and poor women in these communities regardless of the financial constraints.[1009] This has resulted in increased access to maternal care and concomitant reduction of maternal deaths in India.[1010] However, Sudarshan cautions against placing the greater burden of social transformation on the judiciary, but rather, members of civil society, legislative, and executive institutions must collectively bear the burden of eradicating poverty, while courts can alleviate democratic shortfalls.[1011] He claims that it only benefits elites and

[1004] Bhatia, Gautam. "The Supreme Court's Right to Privacy Judgment – X: Conclusion: The Proof of the Pudding". *Indian Constitutional Law and Philosophy*. (Accessed on 18 May 2021).
[1005] Khosla, *supra* note 769 at 747.
[1006] Muralidhar, supra at note 971.
[1007] Dunn *et al.,* "The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality" (2017) 17, *BMC Pregnancy and Childbirth* 367; Center for Reproductive Rights, Maternal mortality in India: Using international and constitutional law to promote accountability and change (2008) 13-21.
[1008] National Rural Health Mission (NRHM) and Janani Suraksha Yojana (JSY) are maternal health Initiatives introduced in India to address social factors resulting in low access to maternal services discussed later in this chapter.
[1009] Indian SC mandate establishing policies on maternal health.
[1010] The JSY was associated with a significant reduction in maternal mortality ratio with an average of 8.5% per year compared to 5.8% in non JYS states. See Nandita S et al., "Janani Suraksha Yojana and the Maternal Mortality ratio in India: a national representative case control study" (2017) Lancet.; Animesh *et al.,* "Effect of JSY on maternal and neonatal mortality: an Indian longitudinal cross-sectional study" (2017) BMC Public Health.
[1011] Ibid. at 163-165.

the middle class who can afford to contest the social rights if they are threatened.[1012] The multiplier effect of these decision can be felt through class action by civil societies and few elite groups who can act on behalf of the poor and marginalized in the society, to secure their rights and entitlements.[1013] One major justification exists for the support of this position, India like Nigeria, does not guarantee a public welfare package for citizens like developed countries. Thus, in the absence of a justiciable right to health which can empower individual claims against the state, the approach of the Indian courts reassures the poor masses that maternal health policies which falls below national minimum standard, and which violates fundamental rights like life, dignity and discrimination, will be subjected to judicial review and enforcement. It offers hope of a better maternal health programs and policies from the state governments in a federal political structure like Nigeria.

It is important to analyse the Supreme Court of India's jurisprudence and review case-laws on social and economic rights on specific rights over which the Court has deployed this approach that has implications for maternal mortality and other rights such as the right to education, health, speedy trial, equal wages, and provision of shelter. I adopt a comparative method as my focus to analyse similar laws and constitutional provisions and critique them contextually while seeking for a unified goal of addressing maternal mortality.[1014] The Indian Supreme Courts jurisprudence sets the stage for a functional comparative analysis adopted in this thesis, which seeks to recommend judicial and legal doctrines to be applied by the Nigerian courts in the light of similar constitutional structures such as DPSPs, and established judicial hierarchy under both constitutions. One of the key rights in this regard is the Right to Health, which has incidental implication for this research work.

### 5.3 Nigerian Courts and Social Rights Challenges

A significant challenge of the Nigerian judiciary is treating social rights as being fundamental to the realization of the idea of equality. Enforcing human rights as a norm in Nigeria is complicated by a number of factors, [1015]such as *locus standi*, doctrine of judicial precedents,

[1012] Ibid.
[1013] Ibid. at 154.
[1014] Michaels, Ralf, The Functional Method of Comparative Law. (OUP, 2006) 339-382.
[1015] L. Pedro, Jurisdiction of courts in Nigeria: Materials and cases, Lagos State Ministry of Justice Law Review Series, (2006), 1.

judicial attitude to technicalities and timidity in expanding socioeconomic rights, and these compound the maternal mortality crisis in Nigeria. To effectively address enforcing socio-economic rights, it is essential to have a proactive judiciary as in India that engages in purposeful interventions and promotes a strong human rights culture, particularly through the robust interpretation of civil and political rights.[1016] The Nigerian courts are yet to extricate themselves from the self-imposed restraints in delivering justice to the poor and marginalised masses who are deprived of their socioeconomic rights, including the right to health. The courts have, through restrictive doctrine, discouraged litigation on economic and social rights. The judiciary's culture of public law litigation and enforcement make it impossible to develop any coherent socioeconomic analytical framework. This makes it difficult to adopt the Indian approach for several reasons. The unacceptable maternal death statistics can also be attributed to the several years of uninterrupted military rule in Nigeria, between 1983 to 1999. The draconian nature of the military rule has serious implications on legal and institutional mechanisms for socio-economic accountability. The period witnesses suspension of substantial parts of the constitution of the country including the provision of justiciable Chapter Four. The military administrations rule by decrees and edicts. These oust the jurisdictions of courts to entertain matters or actions challenging any actions of the military that amount to violations or abuse of rights guaranteed under the Constitution. [1017] This abolition of democratic rule in Nigeria resulted in national and state policies being made by few individuals whose only credentials are attainment of top hierarchy in their career.

This mindset also impacts the country's judiciary, leading to a more passive approach. While some judges have embraced a more active stance, their numbers remain limited.[1018] The ousting of the court's jurisdiction challenges the independence of the judiciary. According to Eso (JSC retired), on the need for the active role of the judges, he says:

> It would be tragic to reduce judges to a sterile role and make an automaton of them. I believe it is the function of judges to keep the law alive, in motion, and to make it

[1016] See T. Ogowewo, "Self-inflicted constraints on judicial government in Nigeria", (2005) 49:1, *Journal of African Law* 39, 46–53.
[1017] See for instance Decree 2 and Decree 4 1984.
[1018] There are cases in which the courts deployed judicial activism despite military rule to protect the rights of individuals and groups guaranteed under the constitution and various international human rights treaties that Nigeria has ratified. See. *Transbridge Trading Company Ltd v. Survey International Ltd* (1986) 4NWLR (PT. 37) 576 at 596-7

> progressive for the purpose of arriving at the end of justice, without being inhibited by technicalities, to find every conceivable, but acceptable way of avoiding narrowness that spells injustice. Short of being a legislator, a judge, to my mind, must possess an aggressive stance in interpreting the law.[1019]

This situation likely explains the court's passive approach in contrast to India, where such challenges are absent. The CESR has strongly noted that in Nigeria[1020], the enjoyment of economic, social, and cultural rights is hindered by the absence of the rule of law, military governments[1021], and the negative attitude of the government towards human rights.[1022] While it may be argued that these concerns are no longer defensible due to Nigeria's return to democratic rule, the failure to deliver adequate maternal health services and the courts' consistent stance that Chapter II provisions are not justiciable suggest otherwise. According to Odinkalu, litigating the right to health in Nigeria remains a great challenge due to several factors including an unfriendly legal regime, the high cost of litigation and delays in the justice system.[1023]

### 5.4 Right to Health and the Indian Supreme Court

The right to health is widely acknowledged as a less contentious right within the Indian jurisdiction, deemed justiciable in terms of its recognition as a part of the right to life, yet it falls short of enforceability.[1024] The financial implications required to enforce the right for individual claims continue to be a barrier to enforcing the right to health even in developed countries like US and Canada.

Courts globally generally exhibit a cautious approach when granting individual access to the right to health.[1025] Article 47 of DPSPs provides for the duty of the state to improve public health services. However, the Court has always recognised the right to health as being a vital

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[1019] *Transbridge case supra at* 597.
[1020] CESR Concluding Observations supra note 323 at para 3 in L Holmstrom (ed) *Concluding Observations of the UN Committee on Economic, Social and Cultural Rights* (2003).
[1021] Ibid at para. 4.
[1022] Ibid at para. 5.
[1023] Odinkalu, *supra* note 694 at 183.
[1024] S. Muralidhar, India: The Expectations and Challenges of Judicial Enforcement of Social Rights, in Social Rights Jurisprudence: Emerging Trends in International and Comparative Law (M. Langford ed., 2008) 102, 114.
[1025] Ran Hirschl *et al.*, Economic and Social Rights in National Constitutions (2014) 62:4 American Journal of Comparative Law 1043-1098.

part of the fundamental right to life and liberty.[1026] This broad approach was a subject of interpretation in the case of an agricultural labourer who suffered injury following a fall from a moving train.[1027] He was refused medical treatment by several government hospitals for lack of required facilities. The Supreme Court declared that his right has been violated and ordered the Government of West Bengal to pay him compensation for the loss suffered.[1028] In addition, the Court directed the Government formulate a scheme for primary health care with a reference to treatment of patients during an emergency.[1029]

In *Consumer Education and Research Centre v. Union of India*[1030], the Supreme Court, in a public interest case, also determined the right to health of workers from exposure to harmful substances resulting in injury in the workplace. The Court ordered the state to provide compulsory health insurance for every worker as enforcement of the worker's fundamental right to health. It also has delivered several decisions on other health related issues such as drugs and medicine,[1031] the rights of the mentally ill,[1032] and the minimum standards of care to be observed in mental hospitals.[1033] In the area of the right to health, the conceptual framework has not been difficult to evolve with the Court readily recognising it as a part of the enforceable right to life.[1034] The identification of emergency medical care as a core right has been a useful yardstick to evaluate the extent of state obligations. It should be possible to contend that the health policy priorities of the state will have to be tailored to meet these specific minimum obligations. Therefore, entitlement to healthcare must be ensured by developing specific statutes, programs and services. This approach has also affected the interpretation and the approach to underlining issues affecting maternal health since majority of the rights could have implications for the right to life of citizens. The social determinants of health have then become part of important consideration for court decisions. The courts have held that where individuals

[1026] See Francis Coralie Mullin, *supra* note 818.; Paramanand Katara v. Union of India (1989) 4 SCC 286
[1027] Paschim Banga Khet Majoor Samity v. State of West Bengal (1996) 4 SCC 37.
[1028] Ibid at 40.
[1029] Ibid at 40.
[1030] (1995) 3 SCC 42.
[1031] Vincent Pannikulangura v. Union of India (1987) 2 SCC 165; Drug Action Forum v. Union of India (1997) 6 SCC 609; All India Democratic Women Association v. Union of India (1998) 2 SCALE 360.
[1032] Sheela Barse v. Union of India (1993) 4 SCC 204
[1033] Rakesh Chandra Narayan v. Union of India, (1991) Supp. (2) 626, 1989 Supp (1) SCC 644, 1994 Supp. (3) SCC 478; Supreme Court Legal Aid Committee v. State of Madhya Pradesh (1994) 5 SCC 27; 1994 Supp. (3) SCC 489
[1034] Paschim Banga case (*supra*).

lack social factors that determine health, denied emergency maternal health care that threatens pregnant women, it amounts to violation of a core aspect of the right to life under article 21 of the constitution, and the courts have obligations to declare such actions and failure of the state to have violated women's right as in *Paschim* case.

The landmark decision of the court in *Paschim Banga Khet Mazoor Samity v. State of West Bengal & Anor,*[1035] establishes the core minimum of the right to health especially for poor pregnant women in India. The plaintiff challenged his refusal of emergency treatment at several state hospitals for lack of medical resources and equipment. The Supreme Court in finding that his right to life was violated, held that the right to access adequate emergency services and treatments are essential to the enjoyment of the right to life, and that the state cannot justify the refusal to provide such services on grounds of lack of financial resources. The Court ruled that welfare policy is the primary duty of the government, and it means provision of adequate medical facilities for its people. The government discharges this obligation by running hospitals and health centres to provide medical care to those who need it. It is no doubt that financial resources are needed for providing these facilities. But at the same time, "it cannot be ignored that it is the constitutional obligation of the state to provide adequate medical services to the people and the state must do whatever is necessary for this purpose has to be done"[1036]. The Court upholds the right to access essential medicines is also an area of 'core minimum obligations', and that has proved a fertile ground for courts to uphold claims with helth implications. This has improved the nature and quality of decisions which mandate the states to provide comprehensive, creative, preventive, promotional and rehabilitative health services and proper nutrition to all the people of India.

Although, this justification of the state raises the democratic legitimacy and institutional capacity as observed in *State of Punjab v. Ram Lubhaya Bagga,*[1037] where the Supreme Court has recognized that "provisions of health facilities cannot be unlimited"[1038]. It states that such provisions are subject to constraints of finance. It is argued that no country has unlimited

[1035] (1996) (4) SCC 37
[1036] Ibid.
[1037] (1998) SC 1703
[1038] Ibid.

resources to spend on any of its projects.[1039] The Court through a liberal interpretation extends the view of article 21 to right to health as a fundamental human right and it encompasses more than life and mere existence, to rights that ensure its meaningful status.[1040] Thus, the government cannot maintain reliance on financial constraints to deny citizens their right to life if broadly interpreted by the courts.[1041] The implication of these restraints would limit governments' capacity to put minimum measures to guarantee the rights to health of especially vulnerable women, which would amount to a violation of their right to life.

Despite the financial implications, courts have upheld certain rights to be non-derogable through the application of international law. In the case of *Mohd Ahmed v Union of India*[1042], the court held that the right to health falls within the ambit of the right to life guaranteed under Article 21 of the Indian Constitution, and emphasized that the financial implications should not hinder the realization of this right[1043]. The court's analysis drew on General Comments 3 and 14 of CESCR, which emphasize the non-derogability of state obligations relating to the right to health[1044]. In particular, the court held that the core obligation of providing essential primary health care services is non-derogable, highlighting the state's duty to ensure access to basic healthcare for all individuals[1045].

The Court have not been deterred in extending the realization of the right to life to include other socioeconomic rights even despite limits of economic capacity for development of a state.[1046] In the case of *Unnikrishnan J.P. v. State of Andhra Pradesh,*[1047] the Court held that since the right to life cannot be complete and meaningful without giving education to citizens, it is regarded as an integral part of the right to life. It expressly approved of the claim of the applicants, and refused to accept the non-enforceability of the DPSPs and the margin of appreciation claimed by the state for its progressive realisation. According to the Court in

[1039] Ibid.
[1040] Ibid.
[1041] Ibid.
[1042] 7279/2013 (2014), paras. 43, 67 and 69.
[1043] For a comparative overview, see O. Ferraz, 'Between Abdication and Usurpation: Social Rights in the Courts of Brazil, India and South Africa', in O. Vilhena, U. Baxi, and F. Viljoen, Transformative Constitutionalism: Comparing the Apex Courts of Brazil, India and South Africa (2013).
[1044] General Recommendation 3 and 14 of CESCR.
[1045] Ibid
[1046] Ibid. at 693. Note the concurring opinion of Justice Mohan especially at 694, 714-715, and 719.
[1047] (1993) 1 SCC 645.

*Mohini Jain v. State of Karnataka*[1048], the right to education could be interpreted to include reproductive health education, information on contraceptive and other health related information. Illiteracy significantly limits a person's ability to access, understand and apply health-related information. Several studies have documented that the quality of health services improve as women's education levels increase, and they concurrently demand higher quality care.[1049] This is significant for maternal health in Nigeria as there exists social restrictions on educational exposure of women and girls in several regions of the country to sexual education, especially the northern region.[1050] Educational exposure increases independence among women; extending right to education to the right to life and as a core of the right to health as in India will have positive impact of highlighting the needed sexual information and cultural issues preventing such information and ultimately their autonomy.

### 5.5 Enforcement of Socioeconomic Rights under the Right to Life in India

The Indian courts offer substantial flexibility in the enforcement of rights through public interest litigation. The history of the judicial activism in India perhaps explains the indifference of the executive towards judicial decisions and has led to the issuance of mandatory court orders requiring supervision and timelines by the machinery of adjudication in Indian courts.[1051] Hence, the development of the concept of "Epistolary Jurisdiction" by the Indian judicial process. It seeks to make judicial process accessible to the poor and socially disadvantaged in the society. For instance, in *Consumer Education & Research Centre v. Union of India,*[1052] a public interest petition outlines health hazards faced by workers in the asbestos industry. After examining the dangers of exposure to its harmful components, the Supreme Court held that employers had a constitutional responsibility to provide for safe working conditions.[1053] Article 21 read with Articles 39(e), 41, and 43, was interpreted to

[1048] (1992) 3 S.C.C. 666.
[1049] Sunitha Ganiger "Women's Health care and Education in Rural India through and Innovative Cultural Competency Model: A sociological Analysis, (May 2012) 1:4, *Golden Research Thoughts* 1-4. 1.
[1050] James Dwyer, "The Children we Abandon: Religious Exemptions to Child Welfare and Education Law as Denials of Equal Protection to Children of Religious Objectors" (1996) 74 *North Carolina Law Review* 1420.
[1051] Ibid.
[1052] (1995) 3 S.C.C. 42.at 70.
[1053] Ibid at 72.

include "protection of the health and strength of the worker", and guarantee the right to health and medical care.[1054]

The Supreme Court in *Education & Research* case reasons that the court is willing and able to impose a higher level of judicial review in compelling the government to fulfil its constitutional responsibility through a reading of the DPSPs into the right to life under article 21 of the Constitution. Without this approach to interpretation, of what value are the DPSPs if the executive were allowed to ignore them in the implementation of laws and policies? Although the approach of the court has been argued, delved into resource allocation issues which is within the powers of the executive, and the judiciary lacks institutional capacity for adjudication thereof. But this view has been countered as demonstrated by decisions emerging from several jurisdictions including courts in India.[1055] It is argued that where a state policy is inconsistent with constitutional obligations, the court have constitutional powers to give appropriate orders notwithstanding that it may amount to intrusion. These are constitutional intrusions and can be accommodated within the framework of separation of powers.[1056]

A major lesson Nigeria can draw from the Indian Courts enforcement of socioeconomic rights and especially maternal health is the emphasis it places on non-derogable nature of the right to life. Regardless of a constitutional language or classification of the right to health, the fundamental nature of right to life cannot be compromised. Thus, Nigerian courts in exercising their judicial functions over socioeconomic rights must take this into consideration in arriving at their decisions when these rights affect the right to life. The Indian Court has proactively given effect to and enforce rights regarded as Directive Principles despite the clear and express provisions of Article 37 of its Constitution, providing that these rights "shall not be enforceable by any court," by construing into the Fundamental Right to life a right to "live with human dignity", and expanding that substantive standard to include rights protected by the Directive

[1054] Ibid at 70.
[1055] See Mazdoor Samity v State of West Bengal (1996) 4 SCC 37; See also Parmanand Katara v Union of India AIR 1989 SC 2039; Stote of Punjab and Others v Mohinder Singh AIR 1996 SC 2426; and Mahendra Pratap Singh v State of Orissa AIR (1997) Ori 37.
[1056] Obiajulu, *supra* note 292 at 4.

Principles.[1057] They have created a legal pathway that elevates the right to health as justiciable right and offers the protection required for vulnerable groups in the society.

In addition, the Indian Court addresses the jurisprudential argument over democratic legitimacy objections to judicial enforcement of social rights. [1058] Since both the legislature and executive arms of government are elected by the general populace, sovereignty, and by extension, legitimacy can be said to reside in the people. As Abeyratne observes, the Indian Court's activism and proactive role in the enforcement of social rights reassures citizens that the Court would hold their elected officials to account for the implementation and realisation of their constitutional mandates.[1059] The Court has ensured accountability by enforcing the socioeconomic obligations enshrined in the Constitution without unduly interfering with democratic decision making.[1060] As stated earlier, the courts approach favors enforcing social rights as a collective right requiring the state to implement policies and programs granting individual claims to the rights.

Khosla finds justification for this unique conception in the *Olga Tellis case*. He states that although *Olga Tellis* recognizes a right to livelihood, there is no elaboration on the content of this right.[1061] The case involves homeless and pavement dwellers who are residing on a public property. The state's decision to evict them and repatriate them to their respective places of origin was challenged in a court. The petitioners argued that they could not be evicted unless the state provides them with an alternative accommodation.[1062] The central question in *Olga Tellis* involves the scope of Article 21. The court reasoned that the right to life include right to livelihood and that their eviction without a replacement for their dwelling place is unconstitutional.[1063] The Court considered, first, whether such eviction would be legal, and secondly, whether resettlement must be provided in replacement of such eviction. This case is

[1057] N Menell 'Judicial enforcement of socioeconomic rights: a comparison between the transformative projects in India and South Africa (2016) 49 *Cornell International Law Journal* 740.
[1058] Frank I. Michelman, The Constitution, Social Rights, and Liberal Political Justification, in Exploring Social Rights: Between Theory and Practice 21–24 (Daphne Barak-Erez & Aeyal M. Gross eds., 2007)
[1059] R Abeyratne 'Socioeconomic rights in the Indian Constitution: towards a broader conception of legitimacy (2014) 39 *Brooklyn Journal of International Law* 71.
[1060] Menell, *supra* note 1057 at 737.
[1061] Khosla, M 'Making social rights conditional: lessons from India (2010) 8 *International Journal of Constitutional Law* 741.
[1062] (1985) 3 S.C.C. 545.
[1063] Ibid.

widely quoted as exemplifying the use of civil and political rights to advance social rights, but it is also criticized due to its failure to provide for the right to resettle. The case provides for no individualized right to shelter, and that the state has no obligation to provide for that. The focus is on ensuring that a proper procedure for eviction is followed as against enforcing social rights of dwellers.[1064] While the case specifically deals with the right to housing for homeless dwellers, the principles established can be extended to other social rights, such as maternal health. By prioritizing social rights, including access to healthcare, the court's focus on ensuring a proper procedure for eviction. It emphasizes the need for a comprehensive and rights-based approach to addressing societal challenges.[1065] In the context of maternal health, this approach calls for not only ensuring proper procedures for addressing housing issues but also prioritizing access to quality healthcare services for pregnant women. The principles from the Grootboom case can guide efforts to advance the right to health and maternal health by emphasizing the importance of proactive and comprehensive measures to address social disparities and promote equitable access to essential healthcare services for all, including pregnant women.[1066]

The next section discusses the approach of India to discrimination under its national legal framework. I consider the extent to which the country has sought to address gender inequality as well as social inequality in realizing the socioeconomic right to health.

### 5.6 Non-Discrimination in India and Maternal Mortality

In India, the substantive equality approach has been evident in the courts' jurisprudence on maternal health.[1067] One specific example is the case of *Paschim Banga Khet Mazdoor Samity v. State of West Bengal,* where the court recognized the need for targeted measures to address the vulnerabilities faced by pregnant women working in the agriculture sector.[1068] The court

[1064] Khosla *supra* note 769 at 747.
[1065] P. de Vos, 'Grootboom, The Right of Access to Housing and Substantive Equality as Contextual Fairness', (2001) 17 *South African Journal on Human Rights,* 258– 276; see also T. Roux, 'Legitimating Transformation: Political Resource Allocation in the South African Constitutional Court', (2003), 10 *Democratization* 92–111, at 97.
[1066] M. Wesson, 'Grootboom and beyond: Reassessing the socio-economic rights jurisprudence of the South African Constitutional Court', (2004) 20 *South African Journal of Human Rights,* 284– 308.
[1067] Shenoy, D., "Courting Substantive Equality: Employment Discrimination Law in India", 2013, available at: http://www.kentlaw.iit.edu/Documents/Institutes%20and%20Centers/ILW/Jackson%20Louis%20Writing%20Competition/Shenoy_EmploymentLawIndia.pdf.
[1068] Paschim *supra* note 1027.

acknowledged that women in this profession are particularly disadvantaged due to their economic and social conditions, which can adversely impact their maternal health outcomes.[1069] In the case, the court ordered the state government to provide better healthcare facilities and essential maternal health services for these women, taking into account their unique challenges and needs.[1070]

Nigeria can learn from the Indian courts' approach in this case by recognizing and addressing the specific vulnerabilities faced by pregnant women in different contexts within the country. By adopting a substantive equality approach, Nigeria's judiciary can focus on the targeted measures and affirmative action needed to address the historical disadvantages and systemic barriers that impact maternal health outcomes for women, particularly those from marginalized and disadvantaged backgrounds.[1071] This may involve developing and implementing policies that prioritize maternal healthcare access for vulnerable groups, such as women in rural areas, with low socio-economic status, and from minority communities. By adopting a substantive equality lens, Nigeria can promote equitable access to maternal health services and improve overall maternal health outcomes for all women, irrespective of their social and economic circumstances. This goes beyond viewing the right to health as a mere platform for basic human rights, emphasizing the state's positive obligations to implement inclusive policies and affirmative actions for vulnerable individuals within the community. India has sought to address the different structural and social factors affecting maternal mortality through addressing the well-established mutually interlocking discrimination at multiple levels and in different forms.[1072]Although, there are several other factors responsible for the social inequality, this section specifically discusses gender and inequality, the concept of child marriage and age of marriage[1073], which have direct implications for maternal health. It also examines recent cases dealing with maternal mortality in India and the courts approach to intersectional discrimination in this regard, to draw lessons for Nigeria.

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[1069] Ibid.
[1070] Paschim *supra* note 1027 at 37, 38.
[1071] R Cook et al 'Advancing safe motherhood through human rights' WHO/RHR/01.5, Geneva: World Health Organisation (2001) 28. Durojaye, *supra* note 117.
[1072] Nussbaum, M 'India, sex equality, and constitutional law' in Baines, B & Rubio-Marin, R (eds.) *The gender of constitutional jurisprudence* (Cambridge 2005).
[1073] Krieger, N. 'Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination', International Journal of Health Services, (1999) 29:2, 295-352.

### 5.6.1 Gender Inequality and Indian Jurisprudence

The Indian courts' jurisprudence on gender inequality and maternal mortality offers valuable lessons from a comparative perspective for Nigeria, considering the socio-economic, cultural, and women's low social status in a patriarchal society. Nigeria can draw inspiration from the Indian approach, which recognizes the role of law in addressing these complex challenges by emphasizing substantive equality, addressing socio-economic disparities, challenging discriminatory cultural norms, and promoting women's empowerment.[1074] By incorporating these lessons, Nigeria can enhance its efforts to combat discrimination and improve maternal health outcomes for women.

The relatively high mortality rates of pregnant women are a reflection of gender inequality and unequal gender relations.[1075] Despite the guarantee of equality under the Indian Constitution, women are discriminated against on several grounds, which affect their reproductive rights including maternal health rights.[1076] The subordinated position of women in the society and huge importance attached to motherhood is also largely responsible and leaves women with limited or no bargaining power and decision making capacity regarding their health, the spacing and number of children to be borne by a woman.[1077] Also, the preference for sons over daughters for property status and economic reasons are largely responsible for the gender discrimination with negative consequence for maternal mortality.[1078] India is a highly patriarchal society, and women's bodies and reproductive capacities are regarded as publicly 'owned', with the decision-making power vested in families or other social kin groups.[1079]

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[1074] N Menell, 'Judicial enforcement of socioeconomic rights: a comparison between the transformative projects in India and South Africa (2016) 49 *Cornell International Law Journal* 740.

[1075] Montgomery *et al.,* "Maternal mortality in India: causes and healthcare service use based on a nationally representative survey. (2014),9:1, *PloS One* 2-3.

[1076] Ibid at 4.

[1077] Joe, *et al.,*'Maternal Mortality in India: A review of trends and patterns', (2015) Institute of Economic Growth, Working Paper No. 353, Available at: http://www.iegindia.org/upload/publication/Workpap/wp353.pdf (Accessed: 17 July 2022)

[1078] Sen, Amartya "Many Faces of Gender Inequality". (2001), 18:22 *Frontline, India's National Magazine*. 1–17; Milazzo, A. (2014) 'Why are Adult Women Missing? Son Preference and Maternal Survival in India', World Bank Policy Research, Working Paper No. 6802.

[1079] Maya Unnithan "What Constitutes Evidence in Human Rights-Based Approaches to Health? Learning from Lived Experiences of Maternal and Sexual Reproductive Health" (2016) 17:2 *Health and Human Rights* E45-E56, 52.

Apart from social and cultural inequalities which 'force' women to bear children, they are further disadvantaged by economic status and educational attainment.[1080]

The Indian courts have treated international instruments like the CEDAW[1081], as critical in the decisions of the courts, especially in the absence of a specific regulation in the country on gender equality. In *Vishaka v. State of Rajasthan,*[1082] a ruling on provisions affecting women in the workplace, the court declared that the provisions of the CEDAW, to which India is a state party, are binding and enforceable in India.[1083] The court referred to article 11 of the CEDAW, which calls on states to eliminate discrimination in the workplace, to support its decision that the need for safe working environment for women is an extension of non-discrimination provision. The Indian judiciary through the *Vishaka case* has proactively used international law to strengthen women's rights through the balanced application of the CEDAW and domestic laws, to fill the legislative vacuum. This questions the validity of age-long patriarchal cultures and laws that affect women, including their maternal health.[1084]

The Constitution of India contains provisions on non-discrimination in article 14, guaranteeing the right of equality and freedom from sexual discrimination.[1085] Specifically, article 14 of the Constitution requires that 'the State shall not deny to any person equality before the law or equal protection of the law within the territory of India'[1086]. While article 15 (1) also requires that 'the State shall not discriminate against any citizen on the grounds only of religion, race, caste, sex, place of birth or any of them'.[1087] In addition, article 15 (2) guarantees that 'no

[1080] Human Rights Watch 'Hidden Discrimination: Caste discrimination against India's untouchables'. (2007) Available at: https://www.hrw.org/report/2007/02/12/hidden-apartheid/caste discrimination-against-indias-untouchables (Accessed: 20 July 2021)
[1081] India had ratified the Convention with two declarations and a reservation on grounds of conflict with personal laws of India. They are the declarations on Article 5 and 16, and a complete reservation on article 29. It holds that these provisions would be taken care of in conformity with its policy of non-interference in the personal affairs of any Community without its initiative and consent. http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm
[1082] (1997) 6 SCC 241
[1083] *Supra.*
[1084] Sidra Dhawan, "Application of CEDAW by the Indian Judiciary: Proactive Role in Enabling the Progress of Women's Rights in India" (2022) 5 *Int'l JL Mgmt & Human* 886.
[1085] Article 14 and 15, Indian Constitution; Kannabiran, K., Tools of Justice: Non-Discrimination and the Indian Constitution, Routledge India, (2012) 337.
[1086] Article 14 India constitution.
[1087] Similarly, article 16 which guarantees equality of opportunity in matters of public employment, article 21 which guarantees the right to life and article 22 which guarantees protection against arrest and detention in certain cases are enforceable only against the State.

citizen shall, on grounds only of religion, race, caste, sex, place of birth or any of them be subject to any disability, liability, restrictions or condition with regard to public utilities or establishments … enforceable even against other persons, including associations, firms or corporations'.[1088] Article 16 on additional grounds of descent and residence also creates exceptions to the principle by favoring some sections and classes who need special protection.[1089] These provisions grants formal equality which support existing patriarchal structures in the society, like section 42 of the Nigerian Constitution. However, the Court has also interpreted the provisions of article 14 and 15(4) of the Constitution which prohibit discrimination on several grounds to provide affirmative action and special treatment for the socially and educationally disadvantaged in the country.[1090]

Notwithstanding the status of the CEDAW in India, the courts have creatively interpreted the provisions of the treaty to be applicable and issued binding guidelines pending the enactment of specific status for regulation of the systemic discrimination against women.[1091] This approach is commendable especially for addressing economic and social issues affecting the marginalised pregnant women who are more prone to maternal deaths. In addition, the incorporation of the affirmative action in the reading of the provisions of the Constitution for socially underprivileged and women in public spheres has relevance to addressing the participation of women especially in the development of maternal health law and policies.[1092] The approach of the Indian courts to gender inequality and maternal health demonstrates a significant divergence in the interpretation and application of international law, constitutional provisions, and statutes pertaining to gender equality. This approach provides valuable insights for the Nigerian judiciary, particularly in light of the rejection of gender equality bills by the

[1088] M.C. Mehta v. Union of India (1987) 1 SCC 395, the principle of absolute liability of a corporation to compensate for the loss and injury caused on account of its hazardous activity was recognised. The legal position was explained with reference to the constitutional framework of article 21, as its connotation.

[1089] Part IV A of the Constitution, which was inserted by the 42nd Amendment in 1976, sets out, in article 51A, fundamental duties which, among others, require every citizen of India 'to promote harmony and spirit of common brotherhood amongst all the people of India transcending religious, linguistic and regional or sectional diversities; to renounce practices derogatory to the dignity of women' See. Article 51A (e) of the Constitution of India.

[1090] See. Indra Sawhney v. Union of India, 1992 (Supp) 3 SCC 217, (Cf. State of Kerala v. N.M. Thomas, (1976) 2 SCC 310).

[1091] Nussbaum, *supra* note 1072 at 109.

[1092] The affirmative action sanctioned by article 14 of the Indian Constitution is implemented by various governments and refers to as reservation policy for addressing inequalities against different groups. See Banerjee, A. & Somanathan, R. 'The political economy of public goods: Some evidence from India', (2006) 82 *Journal of Development Economics* 287-314.

National Assembly in Nigeria. To embrace this reform, Nigeria needs to foster a judicial environment that recognizes the importance of gender equality, encourages proactive interpretation of laws, and promotes the protection and advancement of women's rights in relation to maternal health.

### 5.6.2 Child Marriage and Maternal Mortality in India

Like Nigeria, the prevalence of child marriage in India is justified on cultural, religious grounds, and out of economic necessity.[1093] Evidence suggests young girls from poor families are almost twice more likely to be married at a young age than women from wealthy families in India.[1094] As discussed earlier in Chapter three, young pregnant girls are susceptible to several health challenges such as obstetric fistulas, VVF, and even death, because they have not attained required physical maturity.[1095] As in Nigeria, ideological conflict of universalism and cultural relativism reflects a dilemma in India and it is responsible for the non-implementation of the provisions of the CEDAW dealing with traditional practices and cultural beliefs. The Indian government has taken a proactive step by implementing conditional cash transfer initiatives like *Apni Beti Apna Dhan* (ABAD), which provides financial support to mothers upon the birth of a baby girl, thereby incentivizing delaying a child marriage. These initiatives demonstrate a strong commitment to addressing the relationship between child marriage and maternal mortality while promoting gender equality and empowering women.[1096] Within three months of a girl child birth, the government provides a saving bond; a form of financial incentive for young girls to stay in school and out of marriage, which is redeemable once she turns 18, given that she is not yet married.[1097] Although, it is estimated that despite the national law limiting the age of marriage, 47%[1098] of young girls marry before the age of

[1093] Annie Bunting, "Stages of Development: Marriage of Girls and Teens as an International Human Rights Issue" (2005) 14:1 *Social & Legal Studies* 17-38.

[1094] UNICEF "Reducing child marriage in India: A model to scale up results*",* available at https://www.unicef.org/india/reports/reducing-child-marriage-india (Assessed on 7 December 2021); "Ending Child Marriage: A profile of progress in India". *UNICEF DATA*. 12 September February 2021.

[1095] See earlier discussion in Chapter 3 & 4 of this thesis on the effect of maturity on women and girls' health including VVF.

[1096] The ABAD program was introduced in October 1994 to improve parents' perceived value of daughters by offering them economic incentives. Upon the birth of a daughter, mothers are entitled to a monetary award of Rs. 500 (approximately $11) within 15 days of each birth, to cover post-delivery needs.

[1097] UNFPA, Country program action plan, 6, (2013).; Rao, M. G., & Choudhury, M. Health care financing reforms in India. National Institute of Public Finance and Policy working paper. (2012).

[1098] The percentage varies according to states. e.g Rajasthan (65.2 percent), Uttar Pradesh (58.6 percent), Madhya Pradesh (57.3 percent) and Bihar (69 percent).

18.[1099] Evidence suggests that the introduction of this initiative has reduced the number of married children as their level of education increases,[1100] especially early child education or compulsory education as in the case of Nigeria.[1101]

The India's Prohibition of Child Marriage Act of 2006 offers statutory intervention aimed at redressing the age-long practice in recognition of its contribution to maternal mortality, unlike the CRA in Nigeria.[1102] Under the 2006 Act, the legal age of marriage for girls is 18 years and for boys 21 years.[1103] It also makes provision for incentives for restricting child marriage since a major factor for such rampant practice is poverty.[1104] It puts in place economic incentives to prevent child marriage under the *"our daughters, our wealth"* program, with positive outcomes. [1105] As discussed earlier in Chapter Four in this thesis, although Nigeria has similar initiatives including CRA provisions to address child marriage, the pluralist nature of the Nigerian legal system, constitutional validation of customary and Islamic marriages[1106] have limited the application of the CRA's provisions since they make its adoption discretionary for states in the federation, thereby questioning the effectiveness of the statutory intervention.[1107] The detailed analysis of the historical, legal and cultural issues surrounding child marriage in Nigeria is beyond the scope of this thesis. The existence of pluralist system and lack of political will on the part of both federal and state governments in Nigeria remain a challenge to effective regulation. This has resulted in several failed attempts at protecting the rights of girls in Nigeria despite their vulnerability to maternal deaths from early pregnancy in the Muslim dominated northern region especially. The residual nature of child rights under the Constitution and

[1099] UNFPA. Country program action plan, 6. (2013). (Assessed on 20 May 2021)
[1100] Adhikari R. K. "Early Child Marriage and Child Bearing: Risks and Consequences. In Bott S, Jejeebhoy S, Shah I, Puriet C eds. Towards adulthood: Exploring the sexual and reproductive health of adolescents in South Asia, WHO (2003), 62-6.
[1101] Olaide A *et al.,* "Child marriage and maternal health risks among mothers in Gombi, Adamawa State, Nigeria: Implications for mortality, entitlements and freedoms" (2016) 16:4, *African Health Sciences* 986.
[1102] See the application of the Child Rights Act 2003 in Nigeria discussed in chapters Three and Four of the thesis.
[1103] Section 2 of the Act.
[1104] See UNICEF, Child Protection from Violence, Exploitation and Abuse, (UNICEF, 2016), online: https://www.unicef.org/protection/57929_58008.htm
[1105] Are Economic incentives enough to prevent Child Marriage? Findings from Haryana, India, https://www.girlsnotbrides.org/economic-incentives-enough-prevent-child-marriage-findings-haryana-india/ (assessed on January 20, 2020). The program grant funds to parent in a special account for every girl that remains unmarried before the age of 18years and for subsequent years towards her education.
[1106] Section 277 of the Constitution of Nigeria.
[1107] E. Nwauche, "Child Marriage in Nigeria: (Il)Legal and (Un)Constitutional" (2015) 15 *African Human Rights Law Journal* 421, 423.

strong religious inclination can make the adoption of the Indian approach difficult. A constitutional amendment to the residual list under the 1999 Constitution[1108] will limit the regional or state control over child marriage in a more centrally controlled legislation which can be invigorated by already domesticated CRC, CRA and African Charter on the Rights and Welfare of the Child (ACRWC).[1109]

### 5.7 Intersectional Discrimination, Maternal Death and Indian Courts

I contextualise the effect of socioeconomic factors affecting pregnant women in accessing proper maternal health services using the intersectional approach adopted in India to address such issues through examination of two landmark cases. In *Laxmi Mandal case,* [1110] the High Court in India upheld rights of two pregnant women relating to maternal health *(Shamti Devi and Fateema)* and held that their exclusion from healthcare and social services is a violation of their rights under the Constitution. Shamti, a poor Indian women died from premature birth complications which originated from her lack of access to necessary care.[1111] She was refused medical care because she had no identity card to establish her eligibility for free maternal health service. The delay in accessing emergency care for weeks resulted in a complication and her subsequent refusal to continue medical care after that ultimately culminated to her death. Shamti refused to attend pre-natal care for fear of facing similar experience in the hospital. She went into labor at home without any skilled attendant and ultimately died from the complication.

Fateema, a homeless pregnant woman with underlying ailments, anemia, epilepsy and other conditions which made her vulnerable and at risk while pregnant, visited several public health facilities and was denied access to public health services and other corresponding social program by the government.[1112] Being homeless, Fateema gave birth in public glare under a tree in a dehumanizing manner. The court found that both women denial of public services to

[1108] S. 277 of the Constitution of Federal Republic of Nigeria 1999.
[1109] African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49 (entered into force 29 November 1999).
[1110] *Laxmi Mandal v. Deen Dayal Harinagar Hospital & Others & Jaitun v. Maternal Home MCD, Jangpura & Others* ("*Laxmi Mandal*") W.P.(C) Nos. 8853 of 2008.
[1111] *High Court on its own Motion* v *Union of India* Writ Petition 5913/2010.
[1112] Fateema case (*supra*)

which they were entitled to, amounted to a violation of their right to life guaranteed under the Indian Constitution, and health as a prerequisite to enjoying the former.[1113] The *Laxmi* case in India holds significant relevance to both the right to non-discrimination and the right to life, as it addresses the intersectionality of reproductive rights, and healthcare access. Nigeria can learn valuable lessons from this case in terms of the need for comprehensive legal and policy frameworks that prioritize the protection and empowerment of women, including addressing discriminatory practices in ensuring access to reproductive healthcare. The Court relied on the decision in *Paschim* where the Supreme Court of India declared that the right to life includes obligations of the state to provide timely medical treatment needed to preserve life[1114]. The barriers such as education, socioeconomic status and the caste system, to accessing the necessary health services amount to discrimination. The decision in *Laxmi Mandal* and the nature of intersectional discrimination such as in *Alyne*, reinforce the need for states to treat the right to health in a positive manner and implement programs to address maternal health issues in India, and serves also as influence on how the state can use a constitution to support maternal health rights by holding government accountable.[1115]

The Court held that the denial of any woman access to emergency healthcare on the ground that they are unable to demonstrate that they are below poverty line and proven eligibility status, is unconstitutional[1116]. The case resulted in the National Rural Health Mission (NRHM) appropriate medical staff training initiative and maternal death audits in the country. Pursuant to the decision, the Union of India has taken significant steps to address the issue, including the implementation of a comprehensive program to conduct audits of all maternal deaths at both community and medical facilities. Additionally, it has initiated high-level discussions between the state and central governments to ensure effective collaboration in tackling this critical issue. It is argued that the decision created positive outcomes considering that the Chief Justice of New Delhi in a Public Interest Litigation in the *Shanti Devi* instituted a case by the court on its own to intervene and seek accountability in the case of maternal death of a

[1113] Ibid.
[1114] Ibid.
[1115] The decision has further influenced another maternal health decision in *Premlata v. Government of NCT Delhi W.P*. (C) 7687/2010 & CM APPL 6265/2011 and the case of *Sandesh Bansal v. Union of India* (PIL) W.P. 9061/2008 whose decisions addressed accountability for the high levels of maternal deaths in India and the effect of poverty and poor healthcare funding on maternal mortality.
[1116] Shanti Devi (*supra)*.

homeless woman.[1117] The Shanti case has significantly affected the ability of litigants to seek accountability for violations of the right to life as well as economic and social factors affecting pregnant women. This reinforces the intersectional nature of maternal deaths in the Indian society.[1118] For instance, in a recent case, in *Sandesh Bansal v Union of India*,[1119] the Court ordered the immediate implementation of the National Rural Health Mission in the state of Pradesh with a focus on strengthening infrastructure, timely access to maternal services and skilled personnel.[1120] Despite the reluctance of some state high courts in India to embrace as a general rule, the jurisprudence of reading the interdependence of civil and political rights into the right to health for maternal health purposes, the decision in *Shanti Devi* laid a strong foundation for lower courts to implement 'minimum' program for pregnant women as evident in *Sandesh Bansal.* This reflects the significant development and the important active supervisory role of the Supreme Court in upholding women rights in India. This decision assures citizens that not only are court capable of giving orders that establish rights regales of financial constraints, but also can exercise supervisory role on effective implementation of such order, an important lesson for Nigerian courts.

### 5.8 Intersectional Policy and Maternal Mortality in India

Another interesting development in India lies in the approach to addressing underlying social factors affecting women's access to maternal health services on grounds of residence and economic ability. As discussed earlier in Chapter Two of the thesis, adopting an intersectional approach to health does not only focus on realising the right to health through the courts, but includes addressing economic and systemic challenges[1121] through evolving policies such as the National Rural Health Mission and the cash transfer initiatives to support women living below poverty line. These initiatives are briefly discussed below.

[1117] *High Court on its own Motion* v *Union of India* Writ Petition 5913/2010.
[1118] Kaur, J 'The role of litigation in ensuring women's reproductive rights: an analysis of the Shanti Devi judgement in India' (2012) 39 *Reproductive Health Matters* 21-30, 21.
[1119] (PIL) WP 9061/2008.
[1120] Kaur, *supra* note 1118 at 25.
[1121] Anthias and Yuval-Davis, *supra* note 135 at 63, 65.

### 5.8.1 National Rural Health Mission - Rural Health Initiative

Despite progressive court decisions and intersectional initiatives in India, the poor state of health facilities can be attributed to systemic challenges such as inadequate infrastructure, resource allocation, and limited capacity in the healthcare system. [1122] These factors hinder the effective implementation of maternal health policies and contribute to disparities in access to quality healthcare services for women, particularly those in marginalized communities.[1123]

Das writing on the states of Indian health system and the geographical disparities, observes that "in context of maternal care, three services, high-quality delivery services, referral services, and life-saving emergency obstetric care services are still not universally available in all districts".[1124] The unavailability of maternal health services across some regions especially in the rural region, expose rural women as against their urban counterpart to increased risks of complications during pregnancy.[1125] Even when the facilities are present and available, they are concentrated in the urban areas. This is particularly important because evidence suggests maternal mortality can be reduced when economic and financial barriers are addressed.[1126]

The urban and rural disparities resulted in the introduction of the National Rural Health Mission (NRHM), a government policy seeking to address the challenges like transportation, cost of necessary drugs, and essential medicines[1127], faced by the rural poor women in India.[1128] The initiatives cover a range of health determinants such as immunizations, nutrition, and reproductive healthcare as well as provision of free ambulatory services and deliveries for pregnant women in public facilities in these regions. This eliminates the economic barriers

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[1122] Duggal, Ravi "Healthcare in India: Changing the Financing Strategy", (2007). 41:4 *Social Policy & Administration* 386–394.

[1123] Montgomery, *et al.,* 'Maternal mortality in India: Causes and healthcare service use based on a nationally representative survey'. (2014) 9:1.

[1124] Das, A. 'The challenge of evaluating equity in health: Experiences from India's maternal health program', in S. Sridharan, K. Zhao, & A. Nakaima (eds.), Building Capacities to Evaluate Health Inequities: Some Lessons Learned from Evaluation Experiments in China, India and Chile. New Directions for Evaluation, (2017) 91–100. 96.

[1125] Jeffery, P. & Jeffery, R. 'Only when the boat has started sinking: A maternal death in rural north India', (2010) 71:10, *Social Science and Medicine* 1711–1718.

[1126] Sidney, *et al.,* 'Out of pocket expenditures for childbirth in the context of the Janani Suraksha Yojana (JSY) cash transfer program to promote facility births: who pays and how much? Studies from Madhya Pradesh, India', (2016) 15:71 *International Journal for Equity in Health* 1-11.

[1127] Singh, *et al*. Barriers to safe motherhood in India. New York, NY: Guttmacher Institute, (2009). 21-23.

[1128] Umesh Kapil & Panna Choudhury "National Rural Health Mission (NRHM): Will it Make a Difference?" (2005) 42 *Indian Pediatrics* 783.

against pregnant women.[1129] According to Gupta *et al.*, the initiative has had positive effect on the utilisation of maternal health services.[1130] By focusing specifically on maternal health needs of vulnerable citizens especially rural women, the initiative introduced an intersectional approach to maternal health in India since the link between poverty and maternal health is established.[1131] Guaranteeing some of the underlying determinants under the initiative on a national scale resulted in improved access to maternal health services for several women in rural regions who bear the larger proportion of maternal mortality and thus resulting in reduction in maternal deaths. Reforms that target underlying economic, and infrastructural factors affecting maternal health are more likely to result in increased access and consequently positive health outcome for women.

### 5.8.2 Janani Suraksha Yojana (JSY): Cash Transfer Initiative

India has also introduced cash incentives to promote institutional delivery among poor pregnant women i.e the *Janani Suraksha Yojana* (JSY), a safe motherhood intervention under the National Health Mission.[1132] To ensure that pregnant women have adequate access to maternal health services, the initiative seeks to compensate pregnant women living below poverty line for attending the recommended number of prenatal visits, delivering in a health facility, and receiving postpartum care.[1133] Under the initiative, eligibility restrictions require that recipients be at least 19 years old and have no more than two births.[1134] According to Vora, economic barriers are responsible for the low utilisation of healthcare services by women who are majorly residents in rural areas where health facilities are not readily accessible and where available expensive, as evidence reveals that states like Kerala and Tamil Nadu where health facilities are readily available and women are financially capable, have consistently recorded

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[1129] Hunter *et al.,* The Effects of Cash Transfers and Vouchers on the use and quality of maternal care services: a systemic review. (2017), PLOS One. 12:3.
[1130] Gupta *et al.,*"Demand side financing in Health. How far can it address the issue of low utilization in developing countries? 2010; Prinja *et al.,* "Universal Health Insurance in India: Ensuring equity, efficiency, and quality". (2012) 37:3, *Indian Journal of Community Medicine* 142–9.
[1131] Ibid.
[1132] Sidney *et al.,* "Out of pocket expenditures for childbirth in the context of the Janani Suraksha Yojana (JSY) cash transfer program to promote facility births: who pays and how much?" Studies from Madhya Pradesh, India', (2016) 15:71, *International Journal for Equity in Health* 1-11.
[1133] Singh *et al.,* 'How Affordable is Childbearing in India? An Evaluation of Maternal Care Expenditures', (2016) 16:4, *Newborn and Infant Nursing Reviews,* 175-183. Available at: http://www.sciencedirect.com/science/article/pii/S1527336916300939# (Accessed: 14 August 2021); Singh, *et al.,* Barriers to safe motherhood in India. New York, NY: Guttmacher Institute, (2009). 21-23.
[1134] Sidney, *supra* note 944 at 3-4.

low maternal mortality rates and serve as role models for the rest of the country.[1135] In Kerala, most women are highly educated and live in urban areas with excellent infrastructure, allowing women to easily travel to health facilities.[1136] The initiative has been applauded on ground of its intersectional approach to maternal health, as it seeks to eliminate specific challenging economic barriers for a set of women i.e poor pregnant women, as well as targeting rural women.[1137]

The approach shifts the focus on the right to health from a negative approach to imposing positive obligations on the state to providing maternal healthcare services regardless of the classification of rights under its Constitution.[1138] Hence failure to provide safe and accessible maternal health services including adequate funding, violates the rights to health and equality protected by international human rights law.[1139] The Nigerian state must not only provide health service, such services must be geographically and economically accessible to all women especially the marginalized. It must adopt a proactive and inclusive approach to health services, recognizing that accessibility and availability are fundamental rights using the discrimination provisions in section 42 as well as civil and political right to life under section 33. Although the right to health may not be justiciable in Nigeria, the government can still fulfill its obligations by enacting comprehensive legislation and implementing policies that prioritize equitable access to healthcare, particularly for marginalized populations.

## 5.9 Prospects and Challenges to the Application of Indian Integrative Approach of Enforcement of Socioeconomic Rights in Nigeria

Do the similarities that exist between the Indian and Nigerian constitutional structures and provisions make for possible enforcement of socioeconomic rights by the courts in Nigeria? It is important to consider that despite lessons that Nigeria can learn from the Indian creative methods of overcoming the hurdle of justiciability in the enforcement and realization of

[1135] Vora *et al,*. "Maternal health situation in India: a case study" (2009), *Journal of Health, Population and Nutrition*, 186.
[1136] Ibid at 198.
[1137] Yuval-Davis, N. 'Intersectionality and Feminist Politics', (2006) 13:3 *European Journal of Women's Studies* 193-209.
[1138] O Afulukwe-Eruchalu & E Durojaye 'Developing norms and standards on maternal mortality in Africa: lessons from UN human rights bodies' (2017) 1 African Human Rights Yearbook 82-106 at 89.
[1139] See General Comments 22 on the Right to sexual and reproductive health (article 12 ICESCR).

socioeconomic rights, several challenges are abound in the case of Nigeria in respect of the same set of rights. The jurisprudence of the Indian Supreme Court through the adoption of a communal reading of the provisions of civil and political rights serve as a template of strengthening the right to health. However, in order to effectively address the issue of maternal deaths and ensure access to justice, the courts in Nigeria should play a proactive role by interpreting these rights in a purposive manner and adopting a more inclusive approach to standing in public interest litigation. This approach presents valuable opportunities for indirectly advancing the cause in maternal health and incorporating the issue of maternal deaths into the constitutional framework .

### 5.9.1 Indivisibility of Civil/Political and Socioeconomic Rights

Most significant lesson from the analysis of the Indian approach to socioeconomic rights is the emphasis on the indivisibility of fundamental rights on one hand, and directive principles on the other hand. The accomplishment of the Indian Supreme Court in realizing socioeconomic rights through civil and political rights, is attributed to its emphasis on this. This is achieved by the Court's innovative expansion of the right to life to include guarantees of the basic determinants of the rights concerned, including health, education, food, etc. The court's approach is to infuse the non-justiciable directive principles into justiciable rights through adopting a broad interpretation which includes the enforceable right to life under article 21 of the Constitution.[1140] As stated earlier, an important lesson from the approach is that a constitutional language does not necessarily determine nor guarantee enforcement of socio-economic rights.[1141] Although, both India and Nigeria have similar constitutional structure especially with regard to the doctrine of DPSPs, but the jurisprudence of the Nigerian courts have taken a different path as they have rejected claims seeking the interpretation of social rights to implicate civil and political rights, especially with respect to obligations of the governments.

[1140] Circle of Rights: Economic, Social and Cultural Rights Activism 'Justiciability of ESC rights: The Indian experience' University of Minnesota Human Rights' Resource Centre https://www1.umn.edu/humanrts/edumat/IHRIP/circle/justiciability.htm (accessed 7 June 2016).
[1141] Albertyn, C 'Substantive equality and transformation in South Africa' (2007) 23 *South Africa Journal on Human Rights* 257.

According to Ibe, India presents an interesting discourse with respect to the justiciability of socioeconomic rights as the Indian Supreme Court has creatively made them enforceable through its emphasis on the interrelatedness of human rights.[1142] He argues that lessons from countries such as India suggest clear linkages can and should be established between civil and political rights, which are justiciable, and socio-economic rights which are not.[1143] This approach establishes that social justice is mostly suitably initiated by the judiciary as against the legislators, or the drafters of a constitution.[1144] The Nigerian courts have failed to embrace the indivisibility and interdependence of the right to health with other civil and political rights such as the right to life and dignity, considering the insistence on inadequate resources[1145]. This has remained a major concern for policy makers and courts which must make difficult and tough choices including prioritizing healthcare services for different categories of the citizenry, rural and urban settlers, the young and old, the rich and poor.[1146]

### 5.9.2 Judicial Activism

The role of functional comparative law and judicial decisions across jurisdictions is instrumental in understanding and analyzing the effectiveness and impact of legal principles and practices in different legal systems. The objects of this are often reflected in judicial decisions as a reaction to real life situation in different legal systems. These must be understood in the light of their function in any given society.[1147] Indeed, comparative scholars sometimes recognize this when they focus on what the courts do in fact, as opposed to what they say they are doing. Beyond legal creativity, there is the need for some level of judicial activism by courts to achieve equitable outcomes for perceived rights infractions, particularly with (in)actions of government institutions and their personnel.[1148] Courts have long been recognized as the last hope of the ordinary citizen, and they have served as a check against

[1142] S Ibe 'Beyond Justiciability: Realising the promise of socio-economic rights in Nigeria' (2007) 7 AHRLJ 233.
[1143] Ibid, at 234.
[1144] J Berger 'Litigating for social justice in post-apartheid South Africa' in V Gauri & DM Brinks (eds.) Courting social justice: Judicial enforcement of social and economic rights in the developing world (2008) 57-58.
[1145] L Munro, '"The Human Rights-based Approach to Programming": A Contradiction in Terms?' in S Hickey and D Mitlin (eds) Rights-based Approaches to Development: Exploring the Potential and Pitfalls (Kumarian Press 2009) 187, 197–201.
[1146] Ibid.
[1147] Basil Markesinis, 'Case Law and Comparative Law: Any Wider Lessons?', (2003) 11 *Eur. Rev. Priv. L.* 717.
[1148] Ibid, at 234-5.

excesses of the state. They have also been instrumental in enforcing the supremacy of the constitution in India.[1149] According to experts, the lack of enforcement of socioeconomic rights in some jurisdictions does not conform to the nature of the right, rather it shows lack of competence or unwillingness of the adjudicating body to entertain such claims.[1150] The interrelationship between rights lies in how they are expressed institutionally. This relates to establishment of functioning institutions to promote and guarantee socioeconomic rights and making them have the same force of implementation like the civil and political rights model.[1151]

The role of judicial activism in constitutional democracies, particularly in the interpretation of socio-economic rights, cannot be overstated.[1152] The Indian courts' jurisprudence exemplifies the potential for substantial changes in domestic law and policy, promoting pro-poor programs and facilitating access to justice through public interest litigation. [1153] Embracing such activism in Nigeria could empower the courts to address socio-economic rights[1154], including the right to health, and provide appropriate remedies[1155] for the health needs of vulnerable individuals, particularly pregnant women.[1156] While comparative constitutional approaches seem not to conform with the ideals embraced by Nigerian courts, recognizing positive outcomes in other jurisdictions can inform and enhance a judicial tendency to promote socio-economic rights in some peculiar social and historical contexts.[1157] The low level of accountability for socio-

[1149] S. Muralidhar, supra note 971 at 102.
[1150] Economic, Social and Cultural Rights – Handbook for Human Rights Institutions (2005) Office of the United Nations High Commissioner for human Rights accessed 8 June (2016) 26.; The CESCR has noted in its general comment 3 that the appropriate means by which states can realise their socio-economic obligations goes beyond legislative measures to include judicial and quasi-judicial measures in case of violation.
[1151] D J Whelan, 'Untangling the indivisibility, interdependency and interrelatedness of human rights' (2008) Working Paper 7 Economic Rights Working Paper Series Human Rights Institute, University of Connecticut 5.
[1152] FAR Bennion "Statutory interpretation: codified, with a critical commentary", London: Butterworths, (1984), 50.
[1153] Muralidhar supra note 971.
[1154] V Gauri and D Brinks, Courting Social Justice: Judicial Enforcement of Socioeconomic Rights in Developing World (Cambridge University Press 2010).
[1155] See *Fertilizer Corporation Kamager Union v Union of India* 1981 AIR (SC) 344 where it was held that restrictive rules on locus standi are in general inimical to the growth of the law. Also, turning away a litigant with a good cause just because he has not been sufficiently affected personally could mean that some government agency is left free to violate the law.
[1156] See examples in Center for Reproductive Rights Maternal mortality in India: Using international and constitutional law to promote accountability and change (2008) 13-21.
[1157] Liebenberg, Sandra, Socio-Economic Rights: Adjudication under a Transformative Constitution, (Claremont, South Africa: JUTA, 2010), 118

economic rights protection in Nigeria, particularly the right to health, is of concern in a society grappling with widespread poverty, unemployment, and alarmingly high maternal mortality rates[1158]. The dire circumstances faced by pregnant women, who struggle to meet their basic needs and experience preventable maternal health issues, further exacerbate the challenges in seeking legal recourse[1159]. The cost of litigation and the uncertainty surrounding the enforcement of court judgments against the state make it highly improbable for these vulnerable individuals to rely on the courts as a viable avenue for justice.

Although, the civil society groups can play an important role in mobilising and organising the poor and deprived populations, especially through public interest litigation, with a view to engaging the government where necessary, for prevention of avoidable deaths.[1160] There remains procedural hurdle of *locus standi* to be crossed in Nigerian courts. Morka argues, in this regard, that poverty eradication warrants the evolution of 'processes that enable the poor and other marginalised groups, communities or nationalities, to participate in both envisioning and shaping outcomes on matters that concern them'.[1161] The normative human rights framework and legal argument cannot be effective unless we deal with these complicating factors as part of a wholistic approach to protection of rights. Regardless of the jurisdictional differences of both Nigeria and India, analysts emphasize the role of institutions, both legal and non-legal, even doctrinally different ones, are comparable if they are functionally equivalent, if they fulfill similar functions in different legal systems.

### 5.9.3 Locus Standi and right to sue

The Indian approach of broadening the requirement of standing has made a significant contribution to the enforcement of socio-economic rights. This provides valuable lessons for Nigeria. It is important as it has the implication of allowing the most marginalized members

[1158] Hunt, P., Nowak, M. and Osmani, S., 'Human Rights and Poverty Reduction: A Conceptual Framework', Office of the High Commissioner for Human Rights, Geneva. (2003),

[1159] See S Amadi 'Programmatic and conceptual paralysis in protecting and promoting economic, social and cultural rights in Africa' http://www.communitylawcentre.org.-za/projects/Socio-Economic-Rights/conferences/samuel_amadi_ paper.pdf (accessed 12 June 2022).

[1160] See Obiora Okafor, Modest Harvests: On the Significant (but Limited) Impact of Human Rights NGOs on Legislative and Executive Behaviour in Nigeria, (2004) 48 Journal of African Law 23 ; See P.O. Agbese, "The state versus human rights advocates in Africa: the case of Nigeria", in E. McCarthy-Arnolds, D.R. Penna, and D.J. Cruz Sobrepena (eds.), Africa, Human Rights and the Global System: The Political Economy of Human Rights in a Changing World, Westport, CT, (1994), 167.

[1161] Ibid.

of the society who lack the required resources to enforce their violated rights to access the symbolic citadel of justice to assert the protection of their inalienable rights. Despite criticism of the lack of systemic implementation[1162], the Indian jurisdiction has been applauded for proactively defending the rights of the poor and marginalized,[1163] especially through established several programmes and policies to address poverty and geographical factors affecting pregnant women in the country. Most importantly, these policies have transformed to positive effect by reducing maternal mortality in the country.[1164]

The Indian courts have also been proactive in reviewing maternal health policies and exercise supervisory role for such policies.[1165] The court has also mandated policies aimed at allocating resources to assist disadvantaged communities,[1166] as well as the implementation of existing ones . In a case, the court establishes timelines for the completion of policies,which it enforces through interim orders[1167] to include the marginalized in the society.[1168] The Supreme Court of India has also implemented procedural changes, which allows (and encourages) public interest organizations to file petitions on behalf of disadvantaged groups to hold the government accountable for large-scale violations of fundamental rights.[1169] As stated earlier, the Nigerian judiciary can adapt this approach in implementing judicial reforms to institutional technicalities which has remained an important tool in the hands of defendants and the state for challenging maternal health cases as seen in the case of *WARDC v A.G Federation* discussed earlier.[1170] If the requirement of standing to sue is relaxed, similar maternal health actions will be subjected to constitutional and judicial scrutiny, thereby ensuring accountability.

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[1162] Ravi Duggal "Right to Health and Health Care Theoretical Perspectives" in Healthcare Case Law in India: A Reader" Centre for Enquiry into Health and Allied Themes (Delhi, 2007), 6.
[1163]Upendra Baxi, "Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India", (1985), 4:107 Third World Legal Studies
[1164] Bhatia *et al.,* "Pro-Poor Policies and improvement in maternal health outcomes in India" (2021) 21 *BMC Pregnancy and Childbirth* 389.
[1165] Muralidhar, *supra* note 971 at 102.
[1166] Ibid at 102.
[1167] See PUCL v. Union of India, Writ Petition (Civil) No. 196 (2001) (India).
[1168] The courts have petitioned on its own in several cases seeking to extend maternal health programmes to the poor who are excluded for its programs. See *High Court on its own Motion* v *Union of India* Writ Petition 5913/2010.
[1169] See, Morcha v. Union of India, (1984) 2 S.C.R. 67 (India).
[1170] WARDC *supra* note 674.

A critical examination of the Nigerian judicial system reveals the self-imposed restraints, such as the stringent requirement of standing to sue (locus standi), which pose significant obstacles to the effective protection of socioeconomic rights, including the right to health. Moreover, the onerous interlocutory processes that often extend to the Supreme Court before substantive issues can be addressed on their merits further contribute to the challenges faced by individuals seeking to enforce their rights. It is imperative to dismantle these barriers and create a more accessible and efficient framework that facilitates the realization of socioeconomic rights for all.

Unbundling undue technicalities has the tendency to further ease the burden of the poor while improving the inclination of the court towards speedy dispensation of justice.[1171] There exist similar legal challenges in the enforcement of human right decision especially those that requires huge public expenditure such as always the case with regard to provision of health infrastructure.[1172] Each of these features constitutes stumbling blocks limiting the enforcement of decisions in maternal mortality cases by the court system in Nigeria. Despite the possibility of applicants seeking enforcement of social rights through other constitutional rights such as rights to life, dignity and discrimination[1173] which reflect the dominant judicial engagement on rights infringements, still very few cases are filed explicitly to enforce the right to health.[1174] A more active judiciary as in India, enforcing social rights through civil and political rights could act as the important push to propel the executive and legislative arms of government from their apathetic attitude to the 'rights of the poor', vulnerable pregnant women and redress the state lack of commitment to fulfill its obligations.[1175]

The Nigerian judiciary can adapt this approach in addressing Nigeria's peculiar maternal health crisis, by relaxing the requirement of standing to sue for civil societies and NGOs. Relaxing the doctrinal requirement of 'personal interest' needed to bring claims for socioeconomic rights have proven to be a major obstacle enforcement of rights including to maternal health in

[1171] T. Ogowewo, "The problem with standing to sue in Nigeria", (1995) *Journal of African Law* 9:39;
[1172] Mmuozoba, C. U. Quest for justice beyond fair trial: Provisions of the Sheriffs and Civil Process Act as metaphor for injustice, (2007) 5:1, *Nigerian Bar Journal* 79, 90, 91.
[1173] Odinkalu, *supra* note 694 at 190-191.
[1174] Odinkalu, *supra* note 694 at 184.
[1175] See P Farmer Pathologies of power: Health, human rights and the new war on the poor (2003).

Nigeria, and reduces the number of maternal health cases filed in courts since the requirement requires the applicant to show that she has suffered more than other members of the public, which can be difficult to prove in cases involving maternal services especially in rural areas. In a recent case, the court in *Ohakosim v COP Imo* holds that the Fundamental Rights Enforcement Procedure (FREP) 2004 Rules aimed at ensuring speedy dispensation of justice in fundamental human rights cases under Chapter IV of the Constitution are applicable to rights guaranteed under the African Charter. By extending the rules to the Charter, the court offers an opportunity required to enforce the right to health including maternal health in Nigerian courts. Although, it is doubtful whether the apex court would adopt this approach in light of the judicial precedents.

### 5.9.4 Application of International Human Rights Law

#### 5.9.4.1 Indian Interpretation Model for International Instruments

The Indian court's proactive treatment of international human rights treaties by the courts regardless of domestication is instructive. As a dualist state, India is yet to domesticate ICESCR and CEDAW and its protocols. As seen in the *Vishaka case*, the courts have creatively applied the principles of the Conventions progressively and expansively to include socioeconomic factors in resolving cases of discrimination pending the enactment of the Equality (Prohibition of Discrimination) Bill, 2021.[1176] Evidence suggests that India has experienced lower maternal mortality rate and more consistent improvement in maternal health indicators than Nigeria due to the State obligation to provide the minimum core of the social right.[1177] It is important to point to the need for Nigeria to domesticate the ICESCR and the Optional Protocol to the ICESCR to offer an added layer of protection for women's health right in Nigeria. This allows individuals and groups whose right to health are violated to access international accountability mechanism in the form of the CESR.

As examined in Chapter Four of this thesis, the 1999 Constitution of Nigeria, the domesticated African Charter and relevant health statutes offer prospect for enforcing the right to health in Nigeria. These statutes create rights, obligations, or institutional procedures in enforcing health

[1176] The Bill drafted by CLPR is pending passage by the Indian Legislative which cover 27 characteristics or ground of discrimination. See, Center for Law & Policy Research "Equality Bill 2021: Takes a New Step in Addressing Discrimnation, Recognising intersectionality & Promoting Equality" (2021), 1-3.
[1177] Bhatia *et al., supra* note 999 at 390.

rights. However, the Nigerian courts approach of limiting the domesticated African Charter including the realization of the right to health to the extent permitted by the legislature, constitutes a serious impediment[1178] and has negative effects on litigants seeking remedies for violation of maternal health in the country. The domesticated African Charter is also a subject of the constitutional provision on FODPSPs, with an implication of contradicting the spirit of "ratification and domestication" regarding it. . This is especially important for the rather depressingly low record of the government's compliance with judgments of local and regional courts, and decisions of international human rights bodies.[1179]

**5.10.4.2 Preventing maternal death and the right to life under the Nigerian Constitution**

Since the various causes of maternal death are preventable and avoidable and can be easily addressed, it can be argued that the constitutional provisions in section 33 of the Nigerian Constitution is contrary to the state obligations under the ICCPR, which requires states, 'to take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity.'[1180] Despite these provisions, the Indian jurisprudence reads these provisions to align with provisions of the constitution to guarantee the right to life to realise other rights. This offers important lessons for the Nigerian jurisdiction. The Nigerian courts as in India can proactively interpret these provisions to hold the governments accountable to their constitutional and international responsibilities, which include 'to preserve, protect and defend the Constitution of the Federal Republic of Nigeria,'[1181] and 'to strive to preserve the FODPSPs'.[1182] Therefore, a purposive interpretative strategy by the Nigerian courts can be an opportunity for constitutionalising the prevention of maternal death. As stated earlier in Chapter Four of the thesis, Nigeria has ratified ICCPR and African Charter as a domestic law. They have construed

[1178] See, art 2 of the Optional Protocol to the ICESCR and art 5 of the Protocol to the African Charter on the establishment of the African Court on Human and Peoples' Rights under the African system, however, there still remains the issue of whether the Nigerian government would be willing to implement the decisions of such agencies, especially as it is yet to ratify the Optional Protocol to the ICESCR.

[1179] E. I. Ogunlana "Human Rights Violations in Nigeria: A Study of Government's Non-Compliance with Court Orders." (2021) 5:2 *European Journal of Human Rights Law and Policy* 1-18. Low record of compliance with court decisions

[1180] General Comment 36, *supra* para 26.

[1181] Seventh Schedule to the Constitution of the Federal Republic of Nigeria

[1182] Oaths of Office of the President, Vice President, Governor, Minister, Commissioner or Special Adviser, Seventh Schedule to the Constitution of the Federal Republic of Nigeria.

their provisions restrictively to exclude the application of these instruments to human right cases brought before them. The court must go beyond the legal status of these instruments and be intentional in realising the primary essence of court in the administration of justice. The role of the court would be defeated if such instruments are not given purposeful interpretation to protect citizens lives and health.

In sum, the Indian courts have risen to the occasion in ensuring that the government respects and promotes the foundational values of the Constitution, and have given juridical impetus to the provisions of the Directive Principles. Its interpretative practice appears to allay the concerns of opponents of the more active role of courts of socioeconomic rights on the legitimacy and competence of the courts to do substantial justice in the enforcement of socioeconomic rights.[1183]

Given the circumstances, it is imperative that Nigerian courts take lessons from the Indian Supreme Court. The Indian courts activism is highly commendable and recommended since it recognizes the failure of the other branches of government to fulfil their constitutional obligations and as such the court must step into fill such a vacuum. This recommendation brings to the fore the importance of firm judicial presence in human rights arena, especially in relation to the court's role as an arbiter of socio-economic rights disputes. Therefore, a more proactive judicial role ought not to be challenged but encouraged to deliver public goods and development required in a developing economy like Nigeria where thousands of pregnant women continue to lose their lives in the midst of abundant resources. The similarities that exist between the Indian and Nigerian constitutional structures and provisions go to show that the enforcement of the right to health by the Indian courts can also be applied in Nigeria. The challenge therefore is for the Nigerian courts to extricate themselves from the self-imposed restraints and deliver justice to the poor and marginalised masses who are deprived of their socioeconomic rights, including the right to health.

Finally, it is important to point to the need for Nigeria to domesticate the, CEDAW ICESCR and the Maputo Protocol. Asides the juridical value of the treaties, these treaties have become significant for advancing women's interest including pregnant women as well as stimulating

[1183] O Motta Ferraz "Health Inequalities, rights and courts: The social impact of the judicialisation of health" in A Yamin & S Gloppen (eds) *Litigating Health Rights: Can courts bring more justice to health?* (2011) 76-102; Biehl *et al.,* 'Judicialisation of the right to health in Brazil' (2009) 373 *The Lancet* 2182-84.

government and civil society interests to demand protection of women's rights. In the absence of such domestication, the Nigerian judiciary can seek the realization of the provisions through judicial application of the provision of these treaties in interpreting right to health as the Indian courts have done in the case of *Shanti Devi* where the court applied the interpretation of the ICESCR in interpreting the minimum obligations to include the right to health. This allows individuals and groups whose socio-economic rights are violated to access international accountability mechanism in the form of the Committee on Economic, Social and Cultural Rights. It advocates consistent use of public interest litigation to promote legal reforms and "grant victims access to effective remedies and make Chapter II of the 1999 Constitution and applicable treaties a living and daily reality for the disadvantaged and vulnerable sector of the population."[1184] But these will count for nothing unless the government plays its own part "by making sure that decisions and judgments of courts relating to economic and social rights are fully and effectively implemented." A multi-sectorial approach focusing on eliminating the various factors adversely affecting the underlying determinants of health remains the most important approach to improving maternal health in Nigeria. This is especially important for the rather depressingly low record of the government's compliance with judgments of local and regional courts, and decisions of international human rights bodies.[1185]

The non-justiciability of the right to health emboldens the Nigerian state in its failure to prioritise health. Although making the right justiciable might not necessarily have impact on guaranteeing welfare of the people, as argued by many scholars, it is not incontestable that constitutional guarantees make rights more compelling than litigating mere aspirations. Therefore, a judicial interpretation of enforceable civil and political rights provisions can mobilise the government to provide essential services for maternal health in the present challenging situation needs to be given adequate consideration. One benefit of this has begun to emerge in the positive impact that intersectional policies have had on women's experience in countries like India and South Africa on the treatment of the right to health.

[1184] Odinkalu, *supra* note 694 at 184-5.
[1185] Ogulana, *supra* note 1179 at 2-3.

## 5.11 Conclusion

In India, socioeconomic rights including right to health are regarded as fundamental objectives as the case in Nigeria. However, Indian courts have built up a formidable body of jurisprudence to extend the scope of the right to life to livelihood and related protections. This is in their interpretation of Section 21 of the Indian Constitution. The Indian Supreme Court has treated the violation of the right to life as affecting the right to health, which is fundamental to all human beings under article 21 of the Constitution. In contrast, the right to health in Nigeria is regarded as non-justiciable and often denied enforcement on the ground of non-availability of adequate resources. Although similar framework exists through civil and political rights, the courts are yet to adopt this approach in its application to maternal health despite similar approach to right to liberty under the Nigerian law. With respect to the right to health in particular, the Nigerian judiciary after a period of uncertainty under military governments, is yet to adopt a positive outlook to right to health, despite the negative implications it has for maternal health. The passivity on the part of courts in Nigeria, has in the past, contributed to executive inaction, and court orders have repeatedly been disobeyed by the government. Additionally, reforms aimed at addressing inequalities affecting women, such as child marriage, economic insufficiency or poverty must be implemented as in India. The Nigeria courts' passivity in the past has contributed to executive inaction, with government orders being repeatedly disobeyed. Therefore, it is imperative for the Nigerian judiciary to adopt a proactive stance, and ensures the protection of maternal health and the enforcement of policies that promote substantive equality and prioritize the well-being of women.

# CHAPTER SIX

## Constitutionalizing Maternal Health – South African Transformative Approach

### 6.0 Introduction

In this chapter, I examine another possible approach available to Nigeria for constitutionalizing maternal health. This involves the application of justiciable right to health and equality under the Transformative South African Constitution, to advance maternal health initiatives. The rationale for the comparative approach lies in the capacity to apply constitutional norms developed by other jurisdictions with similar legal system and traditions. I examine the social rights jurisprudence of Nigeria and South Africa with a view to highlighting the variations in the constitutional provisions on enforceability of socioeconomic rights and the effect they may have on the realization of effective maternal health. In doing so, I advance three arguments relating to both the study of social rights adjudication and the effects of the enforcement of the right to health in Nigeria. First, I argue for the recognition of a constitutional right to health in Nigeria, like South Africa. Second, I highlight the crucial role of the judiciary in developing social rights jurisprudence, including the application of reasonableness test and minimum core standard derived from international treaty body like the CESCR. Lastly, the thesis explores the courts' approach to equality, particularly in cases involving marginalized individuals, emphasizing the importance of a proactive and inclusive judicial system.

Comparing South African Constitutional Court and Nigeria Courts jurisprudence on socio-economic rights is difficult because these courts are the products of different sociocultural, political and legal factors. The functional approach requires the following steps: identify a shared social problem, find and describe the 'legal' and 'extra-legal' solutions that arise in relation to the problem in each system, identify similarities and differences between the solutions, build a conceptual language capable of discussing all the cases, find explanations for similarities and differences in the wider context and, critically and normatively evaluate the findings.[1186]

Hence, the functional approach is very suited to macro and micro-level research as maternal health is a socio-legal problem which the nature of reforms require. A major difference is that

[1186] Zweigert and Kötz, *supra* note *109* at 32–47.

Nigerian Constitution lacks justiciable socio-economic rights, which explains why courts have consistently rejected enforcement of such rights. A comprehensive analysis of various factors is necessary to elucidate the disparities between these countries and draw valuable insights for addressing socioeconomic rights, particularly the right to health.

Zweigert and Kötz, acknowledge that the solutions to this particular problem may not necessarily be 'legal', but may be produced by 'extra-legal' norms and institutions.[1187] This includes the judicial attitude to rights, the institutional mechanism for the enforcement of these rights, and the constitutional structure for the realization of socioeconomic rights. I argue that to effectively adopt the South African approach requires an appraisal of South Africa's judicial, institutional, and constitutional structures as well as transformative constitution distinctiveness, since its goal is to address apartheid historical inequality[1188]. Several countries have socioeconomic rights with similar texts, but the Constitutional Court's jurisprudence promotes the consideration of a context-specific approach in enforcing socioeconomic rights, taking into account the unique circumstances of the country.[1189]

This chapter is arranged in three parts: the first offers a background to the constitution of South Africa and a description of the socio-political situation in the country to the extent that it constitutes the contextual background to the discussion. The second offers a jurisprudential analysis by examining the decisions of the Constitutional Court in dealing with the right to health. The third focuses on the treatment of right to equality[1190] and intersectionality application as well as lessons for Nigeria in constitutionalising maternal health. The chapter concludes that the Nigeria judiciary with the benefit of constitutional justiciable right to health, can transform maternal health progressively through fostering intersectional and maternal policy initiatives.

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[1187] Zweigert & Kotz, supra note 109. Petra Mahy "The functional approach in comparative socio-legal research: reflections based on a study of plural work regulation in Australia and Indonesia" (2016) 12:4 *International Journal of Law in Context* 420–436.

[1188] See Preamble to the 1996 Constitution of South Africa.

[1189] Eric Christainsen "Exporting South Africa's Social Rights Jurisprudence, (2007) *Loyola University Chicago International Law Review* 29 at 37-38.

[1190] In South Africa, the right to equality is considered both a civil and political right as well as a socioeconomic right. The Constitution of South Africa guarantees the right to equality in Section 9, which encompasses both the prohibition of unfair discrimination based on various grounds (civil and political aspect) and the promotion of substantive equality and the elimination of socioeconomic disparities (socioeconomic aspect).

## 6.1 The Transformative Constitution of South Africa[1191]

While there are many arguments against the functional comparative approach, especially regarding the 'constructed' nature of social problems and the artificial 'stripping back of context', the ideas resonate with the core themes explored in this work, reinforcing their relevance and applicability to the research findings. I deal with this by presenting a brief background to the South Africa's[1192] 1996 Constitution to avoid the challenge of generalisation of problems for comparative purpose. I evaluate the approach of the Constitutional Court introduced in South Africa to address issues of socioeconomic rights.

This approach is crucial because despite the eradication of colonialism and its attendant suppression and the collapsed apartheid regime, the country still grapples with profound health inequality, highlighting the need for effective measures to address this ongoing issue.[1193] It is still a deeply divided and unequal society with racial-economic discrimination.[1194] Before 1994, South Africa did not enjoy justiciable socioeconomic rights like Nigeria. This resulted in a complex problem of structural inequality in the country. The apartheid regime was characterized by wide-spread socio-economic deprivations and inequality in access to public goods.[1195] Serious racial discrimination also existed in the country; the white minority had better access to public goods as against the majority black.[1196] Hence, the South Africa Constitution is a product of popular liberation movement.[1197] The resulting inequality from these regimes necessitated the inclusion of economic, social and cultural rights in the 1996

[1191] The 'Transformative Constitution' of South Africa is built on the doctrine of transformative constitutionalism, which aims to engender the "culture of rights" includes an endorsement of socioeconomic rights and substantive equality. It is generally referred to the process of using values set by constitutional framework of a state to usher change in the social, legal, economic and political system. See. Langa P "Transformative Constitutionalism (1998) 14 South Africa Journal of Human Rights 1.

[1192] Frankenberg G, Comparative Law as a Subversive Discipline. (1985) *17 Journal of Legal Pluralism and Unofficial Law* 24-27. Legrand P & Munday R, Comparative Legal Studies and the Theory of Reflexive Law in Reimagination of Comparative Law Hart Publishing, (2003) 3-34.

[1193] H. van Rensburg & A Fourie "Inequalities in South African health care" South African Medical Journal (1994), 84: 95-99; Price M. "The consequences of health service privatisation for equality and equity in health care in South Africa". (1988); 27: *Social Science Medicine* 703-716.

[1194] Ruff B *et al.,* "Reflections on health-care reforms in South Africa" (2011), 32 *Journal of Public Health Policy*. 184-92.

[1195] Dommisse J. "Health and health care in post-apartheid South Africa: a future vision" (1988) 80:3, *Journal of National Medical Association*, 325-33.

[1196] Steytler, N., 'Local government in South Africa: Entrenching decentralised government' in Steytler, N., (ed.) The place and role of local government in federal systems (2005) Konrad-Adenauer-Stiftung, 183 – 212, at 184.

[1197]Eric C. Christiansen, Using Constitutional Adjudication to Remedy Socio-Economic Injustice: Comparative Lesson from South Africa, (2008) 13 *UCLA Journal of International Law & Foreign Affairs* 369, 378– 81

Constitution of South Africa which is aimed at advancing the socio-economic needs of the poor, in order to uplift their human dignity.[1198]

The Constitution and the jurisprudence of the Constitutional Court in enforcing these rights are significant. It adopts models of socioeconomic rights which offer comparative lessons for how these rights may be implemented in varying jurisdiction including Nigeria.[1199] It emphasizes the importance and different roles of the judiciary in a constitutional democracy of highly unequal society like Nigeria. The constitutional guarantee and protection of socioeconomic rights from abstract rights to substantive equality is an indication of the idea of transformation agenda of the society.[1200] It is the evidence of the state commitment to guarantee the social wellbeing of citizens and establish an equal society regardless of the social status of its members. I argue that guaranteeing social rights is essential to the reconstruction and development of a democratic South Africa, and can protect the interests of the most disadvantaged members of the society.[1201] There is a perception that the inclusion of these rights would achieve the equitable redistribution of resources and social services including healthcare services.[1202] Despite arguments for and against its inclusion at the drafting stages of the constitution and the final stage of the negotiation process, the Committee includes a comprehensive list of socioeconomic rights in the constitution as justiciable rights despite objections.[1203]

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[1198] Liebenberg, S., 'South Africa's evolving jurisprudence on socio-economic rights: An effective tool to challenging poverty?' (2002) 2 Law, Democracy & Development, 159 – 191, 160.

[1199] See infra, sub-section 6.5 of this Chapter.

[1200] P. de Vos, 'Grootboom, "The Right of Access to Housing and Substantive Equality as Contextual Fairness", , (2001), 17 *South African Journal on Human Rights* 258– 276; T. Roux, "Legitimating Transformation: Political Resource Allocation in the South African Constitutional Court", (2003), 10, *Democratization* 92–111, 97.

[1201] Petition of the Ad Hoc Committee for the Campaign on Socio-Economic Rights presented to the Constitutional Assembly (19 July 1995), in Sandra Liebenberg and Karisha Pillay (eds.), Socio-economic Rights in South Africa: A Resource Book (Cape Town: Community Law Centre, University of the Western Cape – The Socio-Economic Rights Project, 2000), 19–20.

[1202] Sunstein, Cass, 'Against Positive Rights: Why social and economic rights don't belong in the new constitutions of post-Communist Europe', (1996) 2 *East European Constitutional Review,* 35-38 at 36.

[1203] Haysom, Nicholas, 'Constitutionalism, Majoritarian Democracy and Socio-Economic Rights', (1992), 8 *South Africa Journal on Human Rights* 451-463 at 455-456; Mureinik, Etienne, 'Beyond A Charter of Luxuries: Economic Rights in the Constitution', (1992), 8 *South Africa Journal on Human Rights* 464-474.

## 6.2 Social Rights – Judicial, Institutional and Constitutional Context

A comprehensive understanding of the social, judicial, and constitutional contexts in Nigeria and South Africa is vital when employing the functional comparative method. Recognizing the importance of the context is crucial because attempting to compare entities that are fundamentally dissimilar or incomparable would yield limited meaningful insights. For my research to be effective and valid, I set common parameters to evaluating the problem of constitutionalising maternal health in South Africa and Nigeria. For Zweigert and Kötz[1204], one should not begin a comparison with legal categories that are likely to be based on home jurisdiction preconceptions, but rather legal solutions are said to be comparable if they relate to the same social problem. The legal system of every society faces essentially the same problems and solves these problems by quite different means though very often with similar results.[1205] The different solutions that arise from the same social problems are said to be 'functional equivalents'. Although maternal mortality is more pronounced in Nigeria than in South Africa, the underlying social issues are the same, in this way, through isolating the social problem, the complexity of contextual differences between the countries is reduced to focus on common point of entry of different legal systems.[1206] The section begins by outlining the right to health in South Africa and the different elements and boundaries i.e judicial attitudes to rights, institutional structures and constitutional context. They serve as parameters to evaluating the prospects for reforming the treatment of the right to health in South Africa towards addressing maternal health in Nigeria.[1207]

Transformative Constitution recognizes right to health in South Africa as a fundamental socioeconomic right. It also includes provisions in various international human rights instruments.[1208] It encompasses not only access to healthcare services but also includes the broader social determinants of health, such as access to clean water, sanitation, housing, and a healthy environment.[1209] The Constitutional Court of South Africa has played a crucial role in

[1204] Zweigert, Kötz and Weir *supra* note 109 at 34.
[1205] Zweigert, Kötz and Weir *supra* note 109 at 34, 35.
[1206] Valcke A., Adams, M., & Bomhoff, J. The architecture of postnational rulemaking in the administrative sphere. In postnational rulemaking Oxford University Press (2014) 95-137.
[1207] Zweigert, K., Kötz H., & Weir T. Introduction to Comparative Law, Oxford University Press (1998) 35.
[1208] Section 27 1996 Constitution of South Africa.
[1209] See Sandra Liebenberg, 'The value of human dignity in interpreting socio-economic rights', (2005), 21 South African Journal on Human Rights 1–31.

interpreting and enforcing the right to health, particularly in addressing systemic health disparities and ensuring equitable access to healthcare for all.[1210] Its jurisprudence provides a robust framework for addressing maternal mortality and improving maternal health outcomes in the country.[1211] By examining the South African experience in the judicial, institutional and constitutional contexts, this thesis seeks to draw valuable lessons and insights that can inform efforts to enhance the right to health and combat maternal mortality in Nigeria.

### 6.2.1 Judicial Attitude to Rights

The judicial approach to rights in South Africa is radically different from Nigeria's, especially as it relates to socioeconomic rights. To understand comparative context for the development and treatment of social rights jurisprudence, it is important to situate the pre-existing judicial norms that explains the present approach of the courts and legal reasoning on these rights.

Generally Nigerian judges adopt a formalist approach to interpretation of rights[1212] i.e the 'strict' interpretation of the law, and have not been known to give decisions beyond the application of popular legal principle to the letters of the law.[1213] Nigerian judges, often displaying a conservative stance, demonstrate a tendency to prioritize internal considerations over external influences or persuasion, particularly in cases concerning socio-economic rights, where their decision-making affects the well-being of citizens. Although, such conservative judicial attitudes have been subject of criticisms, an overwhelming opinion seems to suggest that a better approach is a balance between the formalist approach and the attitudinal one, which considers that judges must take into account, the political, social and economic environments in deciding cases before them.[1214] Internalized norms determine judicial decision. It properly situates and defines judges' roles to enable them operate effectively within

[1210] The Constitutional Court has developed a robust jurisprudence in dealing the right to health including several landmark cases such as TAC and Soobramoney on the interpretation of the right to health and the obligations of the state; S. Liebenberg, 'Social and Economic Rights: A Critical Challenge' in S. Liebenberg (ed.), The Constitution of South Africa from a Gender Perspective (Cape Town: The Community Law Centre in association with David Philip, 1995), 79–96.
[1211] O. Ezekika *et al.*, The implementation of a maternal Health project in South Africa: Lessons for taking mHealth innovations to scale" (2022) 14:7 African Journal of Science 1798-1812.
[1212] See, Whittington, Keith "Once More Unto the Breach: Post-Behavioralist Approaches to Judicial Politics". (2000), 25: 2 *Law & Social Inquiry* 601-634; See also, Danziger et al., "Extraneous Factors in Judicial Decisions". Proceedings of the National Academy of Sciences, (2011), 108:17, 6889–92.
[1213] Odinkalu, *supra* note 694.
[1214] Whittington, *supra* note 1212 at 603-604.

a political system, without making them slaves to judicial precedent and procedure, where the necessity requires[1215].

In Nigeria, there is a need to protect the institution of the judiciary considering the political climate. The quality and education of judges in the country account for its rigid disposition in adjudicatory role. The selection and appointment of judges in the country has been criticized as lacking in merit and based on executive patronage, considering the diverse nature of law enforcement.[1216] The executive generally appoints judicial officers, and in most cases on the basis of geo-political and other political considerations.[1217] This appointment process results in filling the majority of the Appeal Courts seats with old and incompetent judges[1218], who are generally not knowledgeable in human rights law and without requisite legal practice experience nor international exposure in other areas of civil law. The implication is that these set of judges determine the direction and norms of judicial interpretation in the country, without much innovation in terms of adopting modern trends of legal theory and development, especially for social rights.

By contrast, although South Africa adopts a formalist approach to rights, judges are relatively amenable to the consideration of public policy and the process of balancing compared to the Nigerian judges.[1219] The relatively young, diverse and vibrant judges selected from a rank of senior practitioners in the country, tend to adopt progressive reasoning in decision over rights, with the aim of realising post-apartheid equal society.[1220] These factors predispose South African judges to addressing issues of social rights adjudication in a more pragmatic approach, which balances the role of courts and the necessity to achieve equality goal of the

[1215] Ibid.
[1216] C Odinkalu "Judicial Independence 62years after Nigeria's Independence, The Guardian 3 October 2022.
[1217] Ibid.
[1218] There have been justices including Appeal Court and the apex court, accused of taking bribes from litigants or the executive officials especially in election petition cases. For instance, past Supreme Court justices and members of Judicial Service Commission are currently being investigated for corruption and fraud by the Economic and Financial Crimes Commission (EFCC). See. See. Ise Oluwa Ige "Supreme Court under probe over alleged N2.2billion" Vanguard August 11, 2022; A. Akintade "EFCC probes Supreme Court Secretary GamboSaleh over N10billion loot, federal racketeering" Gazette Ng August 4, 2022.
[1219] Evan Rosevear "Social rights interpretation in Brazil and South Africa" (2018) 5:3, *Curitiba* 149-183.
[1220] Ibid.

transformative constitution.[1221] The judicial attitude towards social rights in Nigeria and South Africa, while influenced by both individual judges and the overall culture of adjudication, demonstrates a notable difference. South African courts have shown a greater openness to considering public policy implications in their approach to social rights, providing a more progressive and dynamic framework for protecting and promoting these rights,[1222] compared to the conservative tendencies observed in Nigeria.[1223]

Considering the above, Nigerian judges are less likely to apply progressive attitudes to the interpretation of rights. The interpretation of social rights and enforcement of socioeconomic rights in that instance are likely not to be in a manner to give effect to the rights beyond the negative connotation which is traditional to civil and political settings. Extending the notion of positive rights obligations to socioeconomic rights requires a radical change in the nature and attitudes of the judges, both at the high courts of states and the apex court in the country.[1224] In doing so, rather than challenging the fundamental assumptions about the nature of law as a separate, technical entity with objective answers, judges incorporate the right to health into the existing rights which are absolute and capable of independent enforcement.[1225] Given the above observations, a natural reaction to these arguments is that the Nigerian Supreme Court is not likely to endorse enforceability of socioeconomic rights through the court in the nearest future. However, there have been instances in the direction of adoption of progressive thinking by some high court judges in their decisions.[1226] These have limited effects in addressing the institutional problems of passivism in the Nigerian judiciary.

[1221] The first South African Court was presided by Arthur Chaskalson, co-founder of the Legal Resources Center and Ismael Mahomed, the first non-White judge in South Africa and popular racial inequality activist during apartheid, Albie Sachs.
[1222] Lester, L., and O'Cinneide, C., 'The effective protection of socio-economic rights' in Cottrell, J., and Ghai, Y., (eds.) Economic, social and cultural rights in practice: The role of judges in implementing economic, social and cultural rights (2004) *Interights* 17-22.
[1223] Odinkalu, *supra* note 694 at 184.
[1224] Ibid at 185.
[1225] In chapter five, I discussed the tendency of Nigerian courts to interpret the right to health in the light of right to liberty of persons under section 34 of the 1999 Constitution. But their reluctance to interpret the right fails to impose positive duty on the government that is capable of independent enforcement.
[1226] Odafe's case *supra*, and Mojekwu's case *supra* note 85.

### 6.2.2 Institutional Structures

In contrast to Nigeria, where the existing judicial structure during the dictatorial regimes was retained to adjudicate over both civil, political rights as well as the fundamental objectives in Chapter II, the South African Constitutional Court; a special court was created with the jurisdiction on purely constitutional matters and with the mandate to preserve the South African Constitution, enhance dignity, and substantive equality through the recognition of civil and political and socio-economic rights in a single document .[1227] In South Africa, the institutional structures for the enforcement of social rights are relatively well-established and robust.[1228] The Constitutional Court, as the apex court, plays a crucial role in interpreting and safeguarding social rights through its progressive jurisprudence including support for public interest litigation of social rights[1229]. The South African Human Rights Commission also serves as a vital institution for monitoring and promoting the realization of social rights.[1230] The institutional frameworks for social rights enforcement are comparatively weaker in Nigeria but, they face similar challenges, which complicate the difficulties faced by the marginalized and vulnerable populations in accessing justice and enjoying their social rights.

#### 6.2.2.1 Implication of Hierarchy of Courts in Nigeria

In Nigeria, there are restraints on lower courts by the doctrine of binding precedents in socioeconomic rights matters.[1231] The extant procedural problems of the court remain a major obstacle to realizing the enforcement of socio-economic rights.[1232] The 1999 Constitution confers authority on the High Court, Court of Appeal and the Supreme Court to interpret and enforce the provisions of the Constitution.[1233] These courts are also vested with the judicial power to rule on all matters relating to the constitutionality of legislations, with the power to

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[1227] South African Constitution, Chapter. 2, Sections. 9-10 (adopted May 8, 1996).
[1228] See Jeffery, H., 'The new politics of economic and social rights' in Karin, A., and Mihyo, P., (eds.) Responding to the human rights deficit, essays in honour of Bas de Gaay Fortman Kluwer Law International (2003) 61 – 72, at 67.
[1229] Jason Brickhill "Public Interest Litigation in South Africa, Juta (ed.) Jason Brickhill (2018); Sabel, F., and Simon, H., 'Destablization rights: How public interest litigation succeeds' (1999) 113 Harvard Law Review 1 – 83.
[1230] Liebenberg, S., 'Violations of socio-economic rights: The role of the South African Human Rights Commission' in Andrews, P., and Ellman, S., (eds.) The Post-apartheid Constitutions: Perspectives on South Africa's basic law, Witwatersrand University Press and Ohio University Press (2001) 405 – 443.
[1231] Ibid.
[1232] See Tunde I. Ogowewo, Self-inflicted constraints on judicial government in Nigeria, (2005) 49:1, *Journal of African Law* 39, 46–53.
[1233] Nwabueze, *supra* note 661.

make final decision resting with the Supreme Court.[1234] In exercising the power granted under the Constitution, the Supreme Court has held that the exercise of all powers whether legislative, executive or judicial, must be traceable to the highest law of the land, the Constitution,[1235] as interpreted by the apex court. In addition to the undue reliance on judicial precedents which affects the enforcement of socio-economic rights by lower courts in interpreting the law, the court ought to be guided by the spirit and object of the Constitution, which includes a balanced legal analysis.[1236] One major challenge for a highly populated country is the delay experienced in the judicial system.[1237] This results in delay in adjudication of interlocutory applications and substantive human rights cases.[1238] An important aspect of the Nigerian legal system that affects the enforcement of social rights regardless of the justiciable nature of social and economic rights are procedural issues for the enforcement of rights. Here, I consider two issues: jurisdiction or standing to sue and complex nature of interlocutory appeals.

In South Africa, the procedure for social rights enforcement has characteristic robust and comprehensive framework that enables their effectiveness.[1239] The country's constitutional jurisprudence and legal system have established mechanisms such as direct access to courts, justiciable rights, and a proactive approach to public interest litigation, which together expedite the process and ensure meaningful remedies for violations of social rights[1240]. This streamlined approach contrasts with the often protracted and convoluted process in Nigeria,[1241] which hinder the enforcement of social rights by various institutional and procedural challenges, including limited access to justice, bureaucratic bottlenecks, and a more formalistic approach to judicial interpretation.

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[1234] Sections 230 and 233, Constitution of Federal Republic of Nigeria.
[1235] Section 1(3) Constitution of Federal Republic of Nigeria.
[1236] See. Rosevear, *supra* note 1219 at 149-150.
[1237] Human rights cases are subordinated to 'political cases' such as election petitions. The precedence is given to them and they are speedily tried. This is occasioned by a constitutional amendment requiring speedy disposal of 180days. See. Constitutional Amendment Act. However, the opposite is the disposition of the court to human right matters, which are often delayed.
[1238] The 36 states of Nigeria and the FCT (Abuja) have one high court each and federal high courts is different geopolitical zones serving several states. See. Lawal Pedro, 2006. Jurisdiction of courts in Nigeria: Materials and cases, Lagos State Ministry of Justice Law Review Series, 1.
[1239] Sunstein, C., 'Suing government: Citizen remedies for official wrongs. By Peter Schuck' Book review (1983) 92 Yale Law Journal 749 – 761
[1240] Viljeon, *supra* note 1343
[1241] Odinkalu, *supra* note 694.

#### 6.2.2.2 Judicial Procedure for Rights

Before the examination of substantive matters, litigants in Nigerian courts, as a matter of law and procedure, may challenge the jurisdiction of courts over a particular issue as a preliminary issue. Such challenge may go as far as the Supreme Court.[1242] This gives room for the defendant in human rights cases to challenge the justiciability of socioeconomic rights as a matter of jurisdiction.[1243] The legal effect is that such challenge suspends, delays, and redefines the substantive legal issues in dispute in these proceedings and can work hardship and legal uncertainty for applicants seeking justice.[1244] Another major obstacle is the failure of the government to obey court decisions, including Supreme Court's. For instance, the Sheriff and Civil Process Act[1245] requires the consent of the Attorney General of Federation or States before levying of a state properties for judgment settlement. There is customary refusal of such consents, which often frustrate litigants' efforts[1246] and erode "…public confidence in the judicial process."[1247] These factors constitute major, self-inflicting, and institutional obstacles for the enforcement of socio-economic rights jurisprudence in Nigeria.

### 6.2.3 Constitutional Context for Socioeconomic Rights

Although the historical contexts of Nigeria and South Africa differ, both countries have constitutional provisions on socioeconomic rights that emerged in response to periods of an authoritarian rule. This parallel provides a compelling basis for comparison, as it allows for an examination of the legal frameworks and the approaches taken to ensure the realization of socioeconomic rights in these contexts. The apartheid regime of South Africa was racist and the military rule in Nigeria ushered in alteration of the democratic constitution. In fact the background to subsequent constitution in Nigeria imposes the thought of that undemocratic era, and without the due consultation and participation of the Nigerian people.[1248] The

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[1242] Constitution of the Federal Republic of Nigeria, 1999, secs. 233(2)(a) & (b) & 241(1)(b)&(c)
[1243] Pedro, *supra* note 1015 at 1.
[1244] Cases on human rights and other matters in Nigerian courts are known to take decades before settlement. For example, in Amadi v. NNPC [2000] 10 Nig. Weekly L. Reps. (Pt. 675) 76, the interlocutory appeal to the Supreme Court took thirteen years to resolve, at the end of which the case was remitted back to the High Court for trial.
[1245] Sheriffs and Civil Process Act, Cap. 407, Laws of the Federation, 1990, sec. 84(1),(3).
[1246] See. Mmuozoba, C. U. Quest for justice beyond fair trial: Provisions of the Sheriffs and Civil Process Act as metaphor for injustice, (2007) 5:1, *Nigeria Bar Journal* 79, 90.
[1247] Ibid at 91.
[1248] Chinonye Obiagwu & Chidi Anselm Odinkalu, "Nigeria: Combating legacies of colonialism and militarism". In Abdullahi An-Na'im (ed.), Human rights under African constitutions: Realizing the promise for ourselves (2002), 211.

emerging South African constitution on the other hand represents a 'negotiated' bill of rights, designed to bring about both symbolic and substantive transformation and to foster stable, inclusive democracies. In doing so, it emphasizes the importance of holding state actors accountable and defending individuals via the inclusion of extensive bills of rights and assigning their protection to strong, independent judicial branches.[1249] In the following two subsections, I briefly outline the development of the social rights jurisprudence in each country, emphasizing the right to health and its enforcement in these two jurisdictions below.

### 6.3 Social Rights Jurisprudence of the Constitutional Court of South Africa

The South African Constitution recognizes the importance of constitutional adjudication of social rights and their enforcement. It creates the Constitutional Court as the highest court in the country on constitutional matters, and it is limited to deciding only constitutional issues.[1250] Cases involving inequality and discrimination on different grounds and on the violation of justiciable socio-ecomonic rights have been brought before the Constitutional Court.[1251] Over the years, the Court has through its jurisprudence developed criteria for guaranteeing equality and realizing of social rights. Several of the Constitutional Court decisions are clear examples of how the application of constitutional principles could enhance the validity of laws, policies, and programs adopted in relation to health.[1252] The intersection of equality rights and socioeconomic rights offers much unexploited potential to challenge inequalities in access to health resources and services.

In assessing the performance of the Constitutional Court in delivering on the promise of social equality and justice transformation envisioned by the Constitution, Albertyn states that:

> Substantive equality is an important mechanism of legal and social change, but that it has seldom been applied in a manner that is fully 'transformatory'. While courts can be powerful institutions for achieving social inclusion, this had tended to occur within clearly defined institutional, doctrinal and normative boundaries that limit

[1249] Albertyn, *supra* note 167 at 257.
[1250] Haysom, *supra* note 1203 at 451.
[1251] See Harksen v. Lane NO and Others 1997 (11) BCLR 1489 (CC), See also, Hoffmann v. South African Airways 2000 (11) BCLR 1211 (CC)
[1252] Mizikenge, D., 'Minister of Health and Others v. Treatment Action Campaign: Its implications for the combat of HIV/AIDS and the protection of economic, social and cultural rights' (2003) 19 East African Journal of Peace and Human Rights 174 – 193.

> the possibilities of fundamental shifts in power relations in society.[1253] In addition, some of the cases on gender equality show the difficulties of developing an idea of difference that is not tied to disadvantage. In both *Hugo* and *Masiya*, the Court has tended towards a protective attitude concerning women's disadvantage (the burdens of motherhood and gender based violence) which, although defensible, demonstrates the difficulties of articulating a more egalitarian world based on an affirmation of gender difference, and thus reinforces stereotypical ideas of women as mothers or victims. One of the most important indicators of a transformative approach is the extent to which equality judgments contribute to the dismantling of systemic inequalities and the establishment of new norms and conditions.[1254]

Jagwanth and Murray examine several cases dealing with gender inequality in South Africa and other socio-economic rights issues that have implications for women. They state that:

> It is clear that judicial enforcement of the equality rights of women has been limited. The problem is exacerbated by the fact that the courts have generally applied the equality provision in cases involving relatively privileged groups. The cases suggest that those people who would benefit most from the protection of the equality provision – indeed those whom the provision was specifically designed to protect-have not used it: women and other disadvantaged groups are not reaching the courts. The institutional obstacles that are being faced by disadvantaged groups seeking to secure rights through the courts are of course not unique to South Africa and are a feature of rights litigation in many other parts of the world, including Canada and the United States. In South Africa, however, the problem is compounded by the high level of poverty and illiteracy among black rural women and by the inadequacy of funding, state or otherwise, for human rights education and constitutional litigation.[1255]

The South African Constitution contains substantive equality as well as the provisions of the Equality Act aimed at addressing the inequality experienced by women. It has adequate provisions for both legislative and institutional structures with the goals of promoting gender equality and advancement of the course of women.[1256] However, they are yet to be achieved due to several existing factors: economic and political challenges beyond the reach of the Constitutional Court.[1257]

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[1253] Albertyn *supra* note 167 at 273.
[1254] Albertyn *supra* note 167 at 273.
[1255] Jagwanth, S & Murray, C 'Ten years of transformation: how has gender equality in South Africa fared?' (2002) 14 *Canadian Journal of Women and Law* 256at 291.
[1256] R Manjoo 'South Africa's National Gender Machinery' (2005) *Acta Juridica* 253.
[1257] Ibid at 270.

Despite the shortcomings, the South African constitutional framework for effective achievement of transformation, offers lessons for Nigeria in the transformation of health and gender equality. The incorporation of the transformative approach enhances the 'constitutional opportunity structures' that guarantees substantive equality for women, considering the age-long oppression, subjugation and disadvantage experienced by them.[1258] The approach also aligns with Nigeria's international obligations under both the ICESCR, CEDAW, African Charter and Maputo Protocol provisions discussed earlier in Chapter Three.

Thus, I examine the jurisprudence of the Constitutional Court on socioeconomic rights through the analysis of cases determined by the court which have implications for the right to health especially the right to emergency healthcare service needed by pregnant women, as well as housing rights and equal access to healthcare services generally. Specifically, four important cases are considered by the Constitutional Court (*Soobromoney, TAC and Grootboom*)[1259], with bearing on application of social rights, and importantly *Khosa* case[1260] on the intersection between social rights and equality. A brief description of these cases will assist in outlining the context for the application of the South African approach.

## 6.4 Constitutionalising the Right to Health in South Africa

In this section, I evaluate the most significant socioeconomic decisions of the South African Constitutional Court and the jurisprudence of the court regarding the right to emergency healthcare and equality as it relates to access to health. This section will analyse four of the first set of cases considered by the Court, and how the court has engendered positive outcomes.

### 6.4.1 Emergency Healthcare

The first case before the Constitutional Court in which a private individual seeks to enforce constitutional socioeconomic rights[1261] is *Soobramoney v. Minister of Health, Kwazulu*

[1258] H Irving 'More than rights' in SH Williams (ed) *Constituting equality: gender equality and comparative constitutional law* (2009) 85.
[1259] Soobramoney case (1998) (1) SA 765 (CC); TAC (2002) (5) SA 721 (CC); Grootboom 2000 (11) BCLR 1169 (CC); (2001) (1) SA 46 (CC) Infra.
[1260] (2004) (6) BCLR 596 (CC) Infra.
[1261] Dennis Davis, Socio-Economic Rights in South Africa: The Record After Ten Years, 2 New Zealand Journal of Public International Law 47, 48 (2004) (quoting Albie Sachs, Advancing Human Rights in South Africa xi (1993)).

*Natal.*[1262] The claimant needed kidney dialysis, but due to limited number of dialysis machines and inadequate medical consumables , patients were ranked and given priority on the basis of likelihood of survival. Soobramoney's heart ailment was used to eliminate him from the pool of those who were being considered for kidney dialysis. The claimant challenged the hospital policy prioritizing curable cases for publicly funded dialysis treatment at the expense of terminal cases. The Court ruled that due to lack of available resources, the government cannot be compelled to provide health care for *Soobromoney.*[1263] According to the Court, the right to health is dependent on the availability of adequate resources, and that on a rational basis the decision of the government was justified on account of limited resources.[1264] It held that the denial of treatment of the claimant did not amount to a violation of the right to emergency health services guaranteed under the Constitution.[1265]

The case highlights the court's deference to policy choices made by the executive branch of government. The court refused to subject the policy decision of the government to scrutiny especially at it relates to the availability of dialysis machine for *Soobramoney.*[1266] The implication of the decision justifies the utilitarian philosophy of prioritizing the life of an individual for the greater good of the society.[1267] Rather than requiring the expansion of the dialysis program and treatment in such an emergency situation by the government, the Court instead justified the exclusion on the ground of insufficient resources.[1268] The Court felt it would not have been implementing socio-economic rights, but rather interfering in the executive's power in the allocation of more resources for health sector in the country. The decision has been criticized on the basis that the decision seemed to indicate that the constitutional right to health held little force against policy-making or resource allocation

[1262] 1997 (12) BCLR 1696 (CC) 8.
[1263] Soobramoney, *supra* note 1259 at paras. 36 and 37.
[1264] Brand, Dannie, 'Socio-Economic Rights and Courts in South Africa: Justiciability on a Sliding Scale', in Coomans, Fons, (ed.), Justiciability of Economic and Social Rights: Experiences from Domestic Systems', (Antwerpen: Intersentia, 2006), 207-236, at 227.
[1265] Davis, *supra* note 1261.
[1266] Soobramoneey, *supra* note 1259 at para. 8.
[1267] Lehmann, Karin, 'In Defense of the Constitutional Court: Litigating Socio-economic Rights and the Myth of the Minimum Core,' (2006-2007), 22, *American University International Law Review* 163-197 at 193-197.
[1268] Ibid.

considerations.[1269] The court was reluctant to impose positive obligation on the state. It adopted a restrictive interpretation of the right to health despite the wider reach of the provision of the Constitution. The case emphasizes that healthcare rights must be approached from human rights interdependence perspective. The state must strike a balance between valid health entitlements and competing rights of others in the light of state resources. This decision may however be justified on the ground that the intervention required was an expensive kidney dialysis which falls within tertiary health service in Nigeria as indeed in South Africa, as opposed to baseline 'minimum primary health care' which states are obligated to provide under international human rights law. More importantly, most maternal health care problems in Nigeria are essential and emergency healthcare which the state have obligation to provide on a holistic basis.

### 6.4.2 An Innovative Perspective to Social Rights

The Constitutional Court steps backwards from its utilitarian justification in the earlier case in the claims in *Grootboom*[1270]. This deals with the right to housing guaranteed under the Constitution.[1271] In the celebrated case, the Constitutional Court introduced the concept of reasonableness into socioeconomic rights jurisprudence.[1272] Irene Grootboom commenced the action with 510 children and 390 adults who were homeless and on the government waiting list for housing.[1273] As a temporary measure, the applicant moved to a private land and built temporary shelters on the land. The shelters were demolished upon an eviction order of court by the landowners. The Constitutional Court reiterates that sections 39, 231 to 235 of the Constitution obliges the Court to take into consideration international law principles and guidance especially when these principles are binding on South Africa.[1274]

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[1269] D. Moellendorf, 'Reasoning about Resources: Soobramoney and the Future of Socio-economic Rights Claims', 14 *South African Journal on Human Rights* (1998): 327; C. Ngwenya, 'The Recognition of Access to Health Care as a Human Right in South Africa: Is it Enough?', (2000) 5 *Health and Human Rights* 33.
[1270] Grootboom *supra* note 1259.
[1271] Right to Housing is guaranteed under Article 26 of the Constitution.
[1272] Dugard, Jackie & Roux, Theunis, 'The Record of the South African Constitutional Court in Providing an Institutional Court for the Poor: 1995-2004', in Gargarella, Roberto; Domingo, Pilar and Roux, Theunis (eds.), Courts and Social Transformation in New Democracies: An Institutional Voice for the Poor? (Aldershot: Ashgate, 2006), 107-125, at 114-116.
[1273] 2000 (11) BCLR 1169 (CC).
[1274] Ibid at para. 26.

The Court proceeds to examine the concept of minimum core obligations of General Comment 3, paragraph 10 of 1990, by the CESR Committee developed from a decade of considering state reports submitted on norm clarification role and contents of the ICESCR.[1275] According to the Court Per Yacoob, J., he concludes that "Minimum core obligation is determined by generally having regard to the needs of the most vulnerable group that is entitled to the protection of the right in question" and argued further that, "it is in this context that the concept of minimum core obligation must be understood in international law"[1276] He further highlights reasons the Constitutional Court could not apply the minimum core approach despite the positive appraisal of the concept in the case. He argues that the Constitutional Court lacks the informational capacity of the ICESCR to evaluate what amounts to minimum core in determining the right to housing in the South African Constitution.[1277]

The Court adds substantive limits to this deference for reasonable policy choices and directed the government to implement coherent policies aimed at progressive realization of a constitutional right within the state available resources. This is contrary to the Court submission in *Soobramoney.* According to the Court, it is not possible to determine the minimum threshold for the progressive realisation of the right of access to adequate housing without first identifying the needs and opportunities for the enjoyment of such a right. These will vary according to factors such as income, unemployment, availability of land and poverty. It argues that the government housing program violates this obligation since it fails to prioritize those living in such conditions or crisis situation such as in the case of *Grootboom*.[1278]

The Court also reasons that the housing needs of rural and urban dwellers will be different, although the needs are ultimately depending on economic, political, and historical circumstances of the country. In essence, it is difficult and complex to determine the minimum core obligations for the progressive realization of the right to access adequate housing without a comprehensive data on the needs and prospects of enjoying the right. It is argued that since the Court suffers from deficiency of information, as against those reports available to the

[1275] Ibid at para. 31.
[1276] Ibid at para. 31.
[1277] Justice Yacoob in Grootboom, *supra* note 1259, para. 32.
[1278] Ibid. at para. 99(2)(b)

ICESCR, it could not establish what amounts to minimum core in the case.[1279] It must be noted, courts are not well disposed towards upholding judicial doctrines from a comparative constitutional law standpoint, especially where there are comparative equivalents within the home jurisdiction. I recognise that the reasonableness doctrine is country specific, the minimum core equivalence can be found within the jurisprudence of the ICESCR which Nigeria is a signatory.

Regardless of domestication, the Nigerian courts can embrace the application of the 'minimum core' in its decisions. This case thus serves as an administrative model of socio-economic rights and by implication conferring powers on the court to command the governments to devote more resources than it otherwise would, and establish priority for those in dire need without mandating individual claims, as long as there is a social problem at hand. Such approach is in line with Weber's intersectional approach that these discriminations are socially constructed and are reinforced by state policies which negates their legal and policy obligations to provide effective maternal health services. It is important for cases of maternal health in Nigeria where the high maternal deaths are alarming and requires sustainable interventions through different reforms from states. This includes long and short-term diversification of social and economic policies and the prioritization of focus on needs of citizenry especially the vulnerable poor rural women.

### 6.4.3 Access to Healthcare – The TAC Case

An important case in the jurisprudence of the South African socio-economic rights approach is the interpretation of access to healthcare under the provisions of section 27 of the Constitution in *the Minister of Health and Others v. Treatment Action Campaign and Others (No. 2).*[1280] It represents a good example of a case where a government has been held accountable for its obligation to realise the right to health generally. This certainly impacts maternal health. The South African government restricted the provisions of a vital drug, Nevaripine (NVP), a drug for the prevention of mother-to-child transmission of the HIV virus, to some selected research health centers, raising concerns from efficacy to lack of resources.[1281]

[1279] Ibid. para. 32.
[1280] (2002) AHLR 189 (SACC 2002)
[1281] See, Ngcobo, Sandile, South Africa's Transformative Constitution: Towards an Appropriate Doctrine of Separation of Powers' (2011) 22:1 *Stellenbosch Law Review* 37-49 at 46.

The Constitutional Court rejected these positions and held that there were adequate supplies of the drug to cover all health centers and the failure of the South African government to provide it widely in public care institutions for the purpose of preventing mother-to-child transmission of HIV is unreasonable and amounts to a violation of the right of access to healthcare in section 27 of the South African Constitution, 1996.

This decision in *TAC case* undoubtedly exemplifies the argument that the right to health imposes a positive obligation on a state to take appropriate measures and steps, in order to ensure access to life-saving medication for its citizens.[1282] A positive right approach to sexual and reproductive rights is determined by how State Parties make budgetary allocation and how resources are distributed within a state. The CESCR in General Comment No 14 describes the obligation to eliminate discrimination against women as requiring significant positive measures involving allocations of resources and strategies pursued over time.[1283] It argues that the 'availability' of reproductive health services depends on resource allocation.[1284]The Court through the case addresses the minimum core requirement test, the government health policy, and the right to access to health care services which a country must fulfil. It compares the provision of the minimum core in *Grootboom* case and refers to General Comment 3 of ICESCR, Para 10[1285] which provides that while state resources must be taken into consideration, states must have minimum obligation to provide basic component of the rights under the Convention including primary healthcare, otherwise the reason for the Convention would be defeated. State must demonstrate it has prioritised the use of available resources especially for the vulnerable in the society.[1286]

The Court analyses the minimum core principle and the difference in the concepts under the ICESCR and the South African Constitution, relying on the Court's decision per Judge Yacoob analysis in Grootboom in paragraph 33 in relation to the reasonableness test.[1287] The Court

[1282] M Heywood 'South Africa's Treatment Action Campaign: Combining Law and Social Mobilisation to Realise the Right to Health' (2009) 1 *Journal of Human Rights Practice* 24.
[1283] B Porter, 'The Crisis of Economic, Social and Cultural Rights and Strategies for addressing it' in J Squires et al (eds.) The Road to a Remedy: Current Issues in the Litigation of Economic, Social and Cultural Rights (University of New South Wales Press 2005) 43.
[1284] Ibid.
[1285] TAC, *supra* note 1259 at para. 26.
[1286] Ibid at para. 37.
[1287] Ibid at para. 27.

establishes that in light of the measures required by the state under section 26(2) of the Constitution, the obligation must be considered not as an independent right, to a minimum core of the right of access to housing under section 26(1).[1288] The Court argues that a purposive interpretation of the provisions of section 26 and 27 as well as its decisions in both *Soobramoney* and *Grootboom* would lead to the conclusion, that even though it is difficult for everyone to be covered by the core service immediately, the state must provide reasonable access to the rights under section 26 and 27 of the Constitution in a progressive manner.[1289] It holds that South Africa has an obligation to take reasonable measures progressively to eliminate or reduce the large areas of severe deprivation or simply eliminate inequality in the society, and that the courts will guarantee that the democratic processes are protected while ensuring accountability, responsiveness and openness, as the Constitution requires in section 1.[1290]

The Court emphasizes deference of executive policy decisions regarding efficient utilization of public revenues in the cases before it as regards its institutional capacity to determine the absence of adequate resources, what amounts to minimum core of the right to access to health care just as it faced in *Grootboom* with regards to right to housing.[1291] The Court must strike the balance in deferring the ability of the other organs of government to make effective allocation of limited resources and the Court's ability to influence such decisions for the purpose of the larger society over individual claims and demands.[1292]

The Court consequently through the TAC case defers to both the legislative and executive organs in the making of socio-economic policies of government and reverses the opportunities of applying the minimum core concept developed to assess the policies of the government to make it accountable. It further rules that section 27(1) of the Constitution does not give rise to a self-standing, enforceable, and independent positive right irrespective of the considerations

[1288] Ibid at para. 34.
[1289] Ibid at para. 35.
[1290] See: Sandra Liebenberg, 'The Judicial Enforcement of Social Security Rights in South Africa: Enhancing Accountability for the Basic Needs of the Poor' in Eibe Riedel (ed.), Social Security as a Human Right: Drafting a General Comment on Article 9 ICESCR – Some Challenges (Berlin: Springer– Verlag, 2007), 69–90.
[1291] TAC, *supra* note 1259 at para 36, 37.
[1292] TAC, *supra* note 1259 at para. 37

listed in section 27(2) of the Constitution[1293], and that the two subsections must be read conjunctively to determine the scope of the positive rights that citizens have against the state in enforcing such rights.[1294] The rights under subsections (1) and (2) are limited to accessing healthcare services that the state has obligation to provide in relation to the content of the rights in Section 27(1) & (2).[1295] In assessing the government policy on health using the reasonableness test, the Court holds the policy to be unreasonable and inflexible and violate the rights of mothers and children. [1296]

The Court then orders the government to remove the restrictions on the availability of Nevirapine and subjects its administration on each mother to medical superintendent.[1297] However, the Court refrains from assuming a supervisory jurisdiction on the revised policy for consistency with the Constitution.[1298]

The case is particularly significant for the right to health in South Africa and Nigeria can learn several important lessons from it. First, contrary to the constitutional and important powers of the courts to define the contours of fundamental rights and values, [1299] the Court refuses to define what the right to health entails and limits the content to availability of resources. It requires that any policy of the state must be subject of constitutional standard of reasonableness doctrine and compliant with constitutional obligations. [1300] Moreso, the Court is very specific in terms of remedy ordered in the case including the drug to be administered.[1301] Second, the health rights litigation may be initiated by few individuals, but the outcome of the decision may impact positively on the lives of hundreds of people.[1302] The decision in the case is influenced by the effect of the lack of alternative treatment on poor mothers who cannot afford the drugs. The court finds the state policy not to be intersectional as in *Shanti Devi* (*India*) and

[1293] Ibid. para. 39
[1294] Ibid.
[1295] Ibid at para. 39.
[1296] Ibid at para. 80.
[1297] Ibid at para. 135, 129.
[1298] Ibid.

[1299] Liebenberg, Sandra, Socio-Economic Rights: Adjudication under a Transformative Constitution, (Claremont: JUTA, 2010), at 176.
[1300] Ngcobo, *supra* note 1281 at 46, 47.
[1301] Liebenberg, *supra* note 1157 at 86.
[1302] Durojaye, *supra* note 117 at 3.

*Alyne cases (Brazil)* where discrimination on social status are the issues. It holds that although individuals lack positive right to health claims but recognises the right to access for individual to state programmes without discrimination. The court evaluation of the government policy concludes that it denies different categories of mother especially poor women in public hospital access to essential vaccine. Third, it emphasises the significance of the state positive measures like in Nigeria, despite limited resources to adopt a holistic approach to the larger needs of a society rather than to focus on the specific needs of individuals within it.

### 6.4.4 Right to Equality and Social Security

A significant aspect of intersectionality is that it is highly sensitive to geographical, social and temporal locations of individuals and collective actors 'translocality', i.e ways in which social divisions have different meanings and with different effect within different space. The decisions of the Constitutional Court in *Khosa and Others v. Minister of Social Development and Others, Mahlaule and Others v. Minister of Social Development*,[1303] reflect the importance of intersectional theory in addressing maternal health rights as it demonstrates the intersection between socioeconomic rights and right to equality. The former case offers important lesson for Nigeria as it exemplifies how equality rights and socio-economic rights can mutually reinforce each other to substantiate how a government policy and programme may unreasonably or unfairly exclude a particular group from socioeconomic program and how a court ruling can mandate their inclusion.[1304]

The case of Khosa concerns the constitutional challenge of exclusion of the applicants from the social assistance scheme under the provisions of the Social Assistance Act 1992.[1305] The scheme specifically designates social grants for the elderly and welfare benefits for dependent children, ensuring targeted support for these vulnerable groups. However, the operational scope of the scheme is restricted to South African citizens, as emphasized in the Khosa case, despite Khosa's permanent resident status in South Africa.[1306]. The state in the case argues that including the applicants in the social assistance scheme would impose financial burdens on the

[1303] 2004 6 SA 505 (CC).
[1304] Liebenberg, *supra* note 1157 at 87.
[1305] Act 59 of 1992.
[1306] Khosa, *supra* note 1260 at 62.

state and discourage self-sufficiency amongst non-citizens.[1307] It further argued that even if it had the obligation to include the applicants, it is unable to fulfil such obligation on the ground of limited resources.

The Constitutional Court holds that exclusion of the applicants from the social assistance scheme on the ground of lack of resources is not justified.[1308] This is because their inclusion will only lead to a very small proportional increment, two percent, in the entire social grants budget.[1309] It states that the impact of the denial on the life and dignity of the groups affected far outweighs the financial burden and immigration reasons offered by the state.[1310] The Constitutional Court states that there is a difficulty in applying section 36(1) of the Constitution to the socio-economic rights entrenched in sections 26 and 27 because these sections contain an internal limitation which qualifies the rights.[1311] The state's obligation in respect of rights provided under section 26 and 27 of the Constitution goes further than to take reasonable legislative and other measures within its available resources to achieve the progressive realisation of the rights.[1312] It entails an equality principle[1313]. The concept of reasonableness is through a purposive formula, employed by the Court, to give a broader meaning to the word "everyone" contained in section 27(1) of the Constitution of South Africa with regard to social security benefits, to encompass not only citizens but also permanent residents.[1314] The Court is of the view that section 36 can only have relevance if what is 'reasonable' for the purposes of section 36(1) is different from what is 'reasonable' for purposes of sections 26 and 27.[1315] According to Justice Mokgoro:

[1307] Ibid at paras, 60 and 63.
[1308] Ibid at para. 52.
[1309] The state estimated that extending the benefits to qualifying permanent residents would lead to an increase of between R 240 million and R 672 million in the social assistance budget. Such a minimal increment in the budget could not justify their exclusion.
[1310] Khosa, *supra* note 1260 at para. 82.
[1311] See Soobramoney, *supra* note 1259, paras. 11, 28; Grootboom, *supra* note 1259 at para. 38; TAC *supra* note 1259 at para 39.
[1312] See Grootboom where the court defined "progressive realisation" to mean that provisions of the rights could not be realised immediately. But must be interpreted to achieve the goal of the Constitution is that the basic needs of all in our society be effectively met and the requirement of progressive realisation means that the State must take steps to achieve this goal. (para. 45)
[1313] Khosa, *supra* note 1260 at para. 52.
[1314] Ibid at paras. 86–98.
[1315] Khosa, *supra* note 1260 at para. 83, 105.

> The socio-economic rights in ss. 26 and 27 of the Constitution are conferred on 'everyone' by ss.(1) in each of those sections. In contrast the State's obligations in respect of access to land apply only to citizens. Whether the right in s27 is confined to citizens only or extends to a broader class of persons depends on the interpretation of the word 'everyone' in that section. The applicants relied on s25 of the Constitution, as well as various other rights in the Bill of Rights to argue that 'everyone' in s27 included non-citizens and therefore also (for the purposes of this case) permanent residents.[1316]…This Court has adopted a purposive approach to the interpretation of rights. Given that the Constitution expressly provides that the Bill of Rights enshrines the rights of 'all people in our country' and in the absence of any indication that the s27(1) is to be restricted to citizens as in other provisions in the Bill of Rights, the word 'everyone' in this section cannot be construed as referring only to 'citizens.'[1317]

The Court emphasizes the importance of context in evaluating the policy of government regarding socio-economic rights. It states that but for their lack of citizenship, permanent residents would not be excluded from the social scheme and would enjoy their right to social security.[1318] In considering whether that exclusion is reasonable, it is relevant to have regard to the purpose served by the social security scheme, the impact of the exclusion on permanent residents and the relevance of the citizenship requirement for that purpose.[1319] It is also necessary to have regard to the impact that this has on other intersecting rights. Where the right to social assistance is conferred by the Constitution on 'everyone' and permanent residents are denied access to this right, the equality rights entrenched in section 9 of the Constitution are directly implicated.[1320] The Court holds that the government act of denial of permanent residents is unreasonable and orders the inclusion of "or permanent resident" to be the operative word in the relevant section. [1321] The approach taken by South Africa in the Khosa's case holds significant relevance for Nigeria's efforts to address inequality in accessing maternal health. Drawing from this case, Nigeria can learn the importance of recognizing and addressing intersecting forms of discrimination faced by vulnerable individuals, particularly women, to ensure their right to health. By adopting a comparable approach that prioritizes the

[1316] Ibid at para. 46.
[1317] Ibid at para. 47.
[1318] Ibid at para. 49.
[1319] Ibid at para. 49.
[1320] Ibid at para. 49.
[1321] "Reading in the words 'or permanent resident' after 'South African citizen' in s3(c) and 'or permanent residents after 'South African citizens' in s4(b)(ii) offers the most appropriate remedy as it retains the right of access to social security for South African citizens while making it instantly available to permanent residents." Ibid. at paragraph 89.

state's responsibility to implement proactive measures and comprehensive policies, particularly in relation to marginalized groups such as rural and poor women, a stronger and more inclusive framework can be established. This approach can work towards reducing maternal health disparities and ensuring equitable access to quality maternal healthcare services for all women, irrespective of their socio-economic and cultural background.

### 6.5 The Development of the Reasonableness Test and the Minimum Core

As evident from the above discussed cases, the Constitutional Court displays undue deference to the executive and legislative branches when it refuses to employ the golden opportunity in Grootboom,[1322] to define and limit the minimum requirements for enforcing the right to housing. The Court argues that it does not have sufficient information to determine the extent of the minimum requirement to enforce the right, a task best suitable for the executive which deals with government policies.[1323] Although the Court rejects the minimum core doctrine as enunciated by the CESCR Committee in General Comments 3, the practical implication of the Courts' position reflects an endorsement of the CESCR's minimum core obligation to govern the right to health care which is justiciable under its Constitution.[1324]

Considering the difficult questions and diverse interests and needs required, the Court is likely to face in determining the minimum core in Grootboom, it opted to apply a reasonableness test of the South African government's housing policy in relation to "the right to have access to adequate housing." There are those who need land; others need both land and houses; yet others need financial assistance.[1325] There are difficult questions relating to the definition of the minimum core in the context of a right to have access to adequate housing, whether the minimum core obligation should be defined generally or with regard to specific groups of people.[1326] This is a test which seeks to assess whether the measures taken by the government in the realization of the right to housing under section 26 are reasonable.[1327] This implies that

[1322] 2000 (11) BCLR 1169 (CC).
[1323] Ibid at para. 33.
[1324] Young, Katherine, Constituting Economic and Social Rights, (Oxford: Oxford University Press, 2012), 80.
[1325] *Grootboom*, *supra* note 1259 at para. 33.
[1326] Ibid at para. 44.
[1327] Ibid at para. 38.

there may be cases where it may be possible and appropriate to adopt the content of a minimum core obligation to determine whether the measures taken by the State are reasonable.

The Constitutional Court exercises the deference without exercising supervisory jurisdiction on the executive and legislative branches of government in the application of the reasonableness doctrine of the Court.[1328] The Constitutional Court in the *TAC case* outlines its reasonableness formula thus:

> Courts are ill-suited to adjudicate upon issues where court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the courts, namely, to require the state to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determinations of reasonableness may in fact have budgetary implications, but not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance.[1329]

The reasonableness doctrine and the minimum core has been argued empower the Court to implement equitable policies through interpreting constitutional rights and enforcing socio-economic rights without usurping the powers of policy makers, but rather subject the policies to proper evaluation.[1330] Although the approach, if taken to the extreme, may be dangerous for social rights by imposing a standard for review with contextualizing the different rights involved. [1331] The Court rejection of the minimum core in Grootboom is thus, justified on the ground that it does not possess capacity and the extent of information available to the ICESCR on the minimum core content of access to housing for example, and finds it difficult to aggregate the diverse needs of the right.[1332] By developing the reasonableness test for enforcing socioeconomic rights, the courts implicitly recognize the doctrine of separation of powers

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[1328] Wesson, Murray, 'Grootboom and Beyond: Reassessing the Socio-economic Jurisprudence of the South African Constitutional Court, (2004), 20 *South African Journal on Human Rights* 284- 308.
[1329] TAC supra note 1081 at para. 38.
[1330] Bilchitz, David, 'Giving Socio-economic Rights Teeth: The Minimum Core and its Importance, (2002), 119 *South African Law Journal* 484-501.
[1331] Liebenberg, Sandra & Goldblatt, Beth, 'The Interrelationship between Equality and Socio-economic Rights under South Africa's Transformative Constitution,' (2007), 23 *South African Journal on Human Rights* 335-361, at 355; Ackerman, Bruce, 'The New Separation of Powers,' (2000), 113:3 Harvard Law Review 633-729, at 724-725.
[1332] Bilchitz, David, "Poverty and Fundamental Human Rights: The Justification and Enforcement of SocioEconomic Rights", (Oxford: Oxford University Press, 2007), 197-200.

which requires that the courts refrain, due to institutional incapacity[1333], from making orders that interfere with the functions of other branches of government given the expertise and complexities involved.[1334] However, the role of the court, as envisaged by the test, is a restrained, constructive and focused evaluation of the measures and reasonableness of government constitutional obligations.[1335]

Similarly, the Court rejects the minimum core approach of the ICESCR Committee in the TAC case.[1336] It refuses to define the contents of a minimum core of right of access to health care, and other incidental rights under section 27(1) and 27(2). While the Court rejects the doctrine, its approach is simply to deny individuals the opportunity to bring claims for its enforcement on the basis of consideration or institutional implementation of these rights.[1337] As stated in TAC, the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them.[1338] It is a tool to test the extent of the reasonableness of the government program to implement these rights. The Court in the case finds no justification to exhibit deference to the other branches of government. The government restrictions placed on the provision of Nevirapine, a drug for the prevention of mother-to-child transmission of the HIV virus affect a fundamental right, right to health. Adopting a legal standard of minimum core of the ICESCR will only serve to limit the ability of the Court in extending the implementation of social rights which must be guided within historical, political and social context.[1339] Moreover, the rejection of the minimum core can be argued, is deliberate in favour of the reasonableness concept, since the minimum core existed before the transformative constitution.[1340] A test of reasonableness integrates the idea behind

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[1333] Id, per Sachs J at para 58; TAC, supra note 1259 at para 37.
[1334] Lehmann, Karin, 'In Defense of the Constitutional Court: Litigating Socio-economic Rights and the Myth of the Minimum Core,' Vol. 22, (2006-2007) 22 *American University International Law Review* 163-197 at 193-197.
[1335] See Bate J in Cheranci v Cheranci (1960) NRNLR 24. 125; See Minister of Health v Treatment Action Campaign No. 2 (TAC) 2002 (5) SA 721 at paras 98 and 99; Soobramoney, supra note 1213 at para 29.
[1336] Bilchitz, David, "Towards a Reasonable Approach to the Minimum Core: Laying the Foundations for Future Socio-economic Jurisprudence," *South African Journal on Human Rights*, (2003), 19, 1- 26.
[1337] Compare this justification for rejection of a standing right to health in developed countries like USA and Canada where the courts have interpreted the right to life to exclude positive right to health by individuals. See, C M Flood and A. Gross, Litigating the Right to Health: What can we learn from a Comparative Law and Health Systems Approach (2014) 16:2 *Health and Human Rights* 62-68.
[1338] Liebenberg, *supra* note 1157 at 335-36.
[1339] Soobramoney, *supra* note 1213 at para. 16; Grootboom, *supra* note 1192 at para. 43; Khosa, *supra* note 1260 at para. 49
[1340] Sections 26(2); 27(2); 29(1)(b).

the minimum core content and goes beyond it. "However, reasonableness review must incorporate substantive factors such as the interpretation of the relevant socioeconomic right, and a detailed, contextual assessment of the impact of the denial of the right on the complainant group."[1341] It considers all the various mechanisms of socioeconomic rights, alongside the Constitutional mandate of reasonableness.[1342]

South Africa ratified the ICESCR in 2015. The provisions of the Convention have influenced the interpretation and enforcement of socio-economic rights under its Constitution. Notwithstanding the ratification, it appears the Constitutional Court is not likely to follow the jurisprudence of the CESCR on socio-economic rights as demonstrated by rejection of the minimum core obligation, an approach similar to the Constitutional Court's to the ratified African Charter.[1343] Consequently, the lack of ratification and domestication has not prevented some countries in realizing the goals of enforcing social and economic rights under the treaty as it is the case with Nigeria. Thus, every right should be interpreted contextually to give effect to its purpose by advancing one of the core values of the Transformative Constitution rather than to establish some core or minimum content of a right as opposed to setting minimum standard to be applied to every right enunciated by the CESCR.[1344] This minimum core can also serve to limit genuine attempts by states to improve the enjoyment of rights if the minimum has been fulfilled, thereby impeding development and encouraging governmental inaction[1345].

Despite the reasonableness approach, the Court still requires sufficient information to determine what would amount to minimum core obligation in any context under the

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[1341] Liebenberg, Sandra, 'Socio-economic Rights: Revisiting the Reasonableness Review/Minimum Core Debate,' in Woolman, Stu and Bishop, Michael (eds.) Constitutional Conversations, (Pretoria: Pretoria University Press, 2008), 303-329, at 327-328.

[1342] Brand, Danie, 'The Minimum Core Content of the Right to Food in Context: A Response to Rolf Künnemann,' in Brand, Danie and Russell Sage (eds.) Exploring the Core Content of Socio-economic rights: South Africa and International Perspectives, Pretoria: Protea Book House, (2002), 99-108.

[1343] V., Frans, International Human Rights Law in Africa, (2nd ed.) (Oxford: Oxford University Press, 2012), 539.

[1344] V., Frans, 'Children's Rights: A Response from a South African Perspective,' in Brand, Danie and Russell Sage (eds.) Exploring the Core Content of Socio-economic rights: South Africa and International Perspectives (Pretoria: Protea Book House, 2002), 201-206, 205; Young, Katharine, 'A Typology of Economic and Social Rights Adjudication: Exploring the Catalytic Function of Judicial Review,' (2010), 8:3 International Journal of Constitutional Law 385-420.

[1345] Van Bueren, Geraldine 'Alleviating Poverty through the Constitutional Court,' (1999) 15 *South African Journal on Human Rights* 52-74, at 59; van Bueren, Geraldine, 'Of Floors and Ceilings: Minimum Core Obligations and Children,' in Brand, Danie and Russell Sage (eds.) Exploring the Core Content of Socio-economic rights: South Africa and International Perspectives (Pretoria: Protea Book House, 2002), 183-200.

Constitution.[1346] It further formulates a multi-layer test for determining the reasonableness of the government policies with regards to housing in *Grootboom*; it states first that the measures must establish a coherent public housing programme directed towards the progressive realisation of the right of access to adequate housing within the state's available resources; second, the programme must be capable of facilitating the realisation of the right; third, that the detailed contours and content of the measures to be adopted are primarily a matter for the legislature and the executive arms, which must ensure that the programs are reasonable. The Court holds that these reasonableness test must be fulfilled by the state in any challenge seeking the enforcement or violation of section 26 of the Constitution. The question will be whether the legislative and other measures taken by the state are reasonable, thereby subjecting government policies and programs to proper scrutiny. This translates to greater social effect in the society. It is important to emphasize that the Court in Grootboom did not grant individual remedies to the claimants, which reinforces the approach of enforcing socio-economic rights progressive realization for the betterment of the society over individual litigants. According to section 27(2), the state is required to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights in section 27(1). This significantly questions the idea that courts can serve as significant institutions for deliberation concerning the meaning and implications of constitutional rights.[1347] Nevertheless the Constitutional Court when confronted with claims for its failure to implement social rights, applies the standard of reasonableness doctrine which requires the South African government to prove that its policies and programs are geared toward attaining its socioeconomic constitutional obligations. The relevance of the reasonableness test and minimum core approach, holds valuable lessons for Nigeria in addressing maternal health issues. Despite criticisms, Constitutional Court provides a comprehensive framework for assessing the reasonableness of socio-economic rights obligations, including the right to health[1348]. By employing a reasonableness test, which considers factors such as available resources and progressive realization, South Africa has provided a practical and flexible approach to

[1346] Ibid at para. 33.
[1347] Liebenberg, *supra* note 1157 at 176.
[1348] Durojaye, supra note 117; Shelton, D., Remedies in international human rights law (1999) Oxford University Press.

balancing the right to health with resource constraints.[1349] In addition, the Constitutional Court's recognition of ICESCR and its application of the minimum core concept demonstrates the importance of adopting international human rights standards to guide the fulfillment of socio-economic rights.[1350] Nigeria can benefit from adopting a similar approach, recognizing the ICESCR as a guiding framework and embracing the development of judicial concept similar to the reasonableness test to ensure effective implementation and protection of the right to health in the country. This would help in addressing the persistent challenges of resource allocation and address disparities faced by Nigerian women in accessing adequate maternal healthcare services.

### 6.6 Right to Health in Nigeria

The right to health in Nigeria presents a stark contrast to the South African approach, with significant challenges hindering its effective realization.[1351] Unlike South Africa, Nigeria is yet to formally recognize the right to health as justiciable, limiting the avenues for seeking legal remedies for violations.[1352] The Nigerian courts have shown reluctance in being proactive in entertaining arguments that when interpreted broadly with justiciable provisions like right to equality will mean that the right to health requires positive obligations from the government.[1353] Instead, resource constraints arguments often prevail, leading to insufficient protection of this fundamental right.[1354] Furthermore, existing opportunities to guarantee the right to health in Nigeria, such as the African Charter, the National Health Act, and undomesticated international treaties like the ICESCR and CEDAW, have encountered resistance and lack of effective implementation.[1355]

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[1349] See Liebenberg, S., 'Enforcing positive socio-economic rights claims: The South African model of reasonableness' in Squires, J., Langford, M., and Thiele, B., (eds.) The road to a remedy: Current issues in the litigation of economic, social and cultural rights (2005) Australian Human Rights Centre and Centre on Housing Rights and Eviction 73 – 88; see Bilchitz, D., 'The right to health care services and the minimum core: Disentangling the principled and pragmatic strands' (2006) 7 ESR Review 2 – 6.
[1350] Bilchitz, D., 'The right to health care services and the minimum core' *supra* note.
[1351] Durojaye, *supra* note 117.
[1352] S. I. Nwatu 'Legal Framework for the Protection of Socio-Economic Rights in Nigeria' 10 *Nigerian Juridical Review* (2011-2012) 46.
[1353] Durojaye, E 'Substantive equality and maternal mortality in Nigeria' (2012) 65 *Journal of Legal Pluralism* 111.
[1354] Obiajulu Nnamuchi, 'Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria' (2008*) 52:1 Journal of African Law*, 4.
[1355] Odinkalu, *supra* note 694.

To address these shortcomings, Nigeria can draw important lessons from the South African approach. Recognizing the right to health as justiciable would provide a legal foundation for holding the government accountable to its obligations.[1356] The Nigerian courts need to adopt a more proactive stance in interpreting and enforcing socio-economic rights, including the right to health, by embracing the principles and concepts developed by the South African Constitutional Court.[1357] By doing so, Nigeria can establish a robust framework for the realization of the right to health, including the implementation of positive obligations, despite resource constraints.[1358] Additionally, domesticating and effectively implementing international human rights instruments, such as the ICESCR and CEDAW, would further strengthen the protection of the right to health in Nigeria.[1359] These steps are essential to address the persistent challenges faced by Nigerian women in accessing adequate maternal healthcare services and to ensure the fulfillment of their right to health.

### 6.7 Constitutionalising gender equality in South Africa

As stated earlier, the transformative constitution of South Africa is informed by the idea of tackling racial inequality and inhumane apartheid policy.[1360] To achieve such substantive equality and in order to attain the transformative agenda, the idea must be grounded in constitutional values.[1361] Thus, substantive equality has been identified as a foundational value the new Constitution seeks to achieve. This is evident through its deliberate engagement and the progressive evolution of jurisprudence in the application and interpretation of constitutional provisions, demonstrating a commitment to substantive equality in South Africa.[1362] For instance, the equality provision in the South African Constitution is found in section 9(3)&(4) and provides as follows:

> (3) The state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, ***pregnancy***, marital status, ethnic or social

[1356] S. I. Nwatu 'Legal Framework for the Protection of Socio-Economic Rights in Nigeria' 10 *Nigerian Juridical Review* (2011-2012) 46.
[1357] Odinkalu, *supra* note 694 at 191-2.
[1358] Ibid.
[1359] Nwatu, *supra* note 96 at 46-47.
[1360] S. Liebenberg, 'Needs, Rights and Transformation: Adjudicating Social Rights in South Africa', (2006), 17 *Stellenbosch Law Review* 5–36.
[1361] C Albertyn, *supra* note167 at 257.
[1362] K Govender 'The developing equality jurisprudence in South Africa' (2008)107 *Michigan Law Review* 120.

origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth.

(4) No person may unfairly discriminate directly or indirectly against anyone on one or more grounds in terms of subsection (3). National legislation must be enacted to prevent or prohibit unfair discrimination.

The section prohibits unfair discrimination on grounds of unlimited criteria including *"pregnancy".* This sub-Section is considered to have bolstered the rights of pregnant women in South Africa, and this can have positive effect on maternal health. The provision imposes positive obligations on both state and non-state actors under the constitution. [1363] Thus acts and omissions which violate women's reproductive rights may be deemed discriminatory especially where such acts are contrary to the equality spirit of the constitution seeking to redress age-long discrimination against women. Thus, the provision is in line with recent international human rights approach to guaranteeing reproductive and sexual equality, such as under the ICESCR[1364], CEDAW[1365] and African Charter.[1366]

It is also important to note that right to equality and socio-economic rights are complementary.[1367] The intersection between right to equality and social-economic rights is subject of interpretation in the *Khosa* case. The Court's decision is explicitly based on the intersection between equality right and the right to social security. Section 9 of the Constitution provides for the equality clause and has been argued must be read to complement the provisions of section 27.[1368] In defining 'extra-legal', they include practices that supersede or bypass legislation and judge-made law as well as the unwritten rules of practice. They explain that a social problem in one place may have legal solutions, while, in another, it may be solved by a

[1363] Jagwanth & Murray *supra* note 1255 at 258.
[1364] Art. 2(2) of ICESCR on guarantee of equality in the application of the convention.
[1365] CEDAW *supra* note 83 art. 2, 3 and 24.
[1366] African Charter, *supra* note 92 art 2.
[1367] S. Liebenberg, 'Social and Economic Rights: A Critical Challenge' in S. Liebenberg (ed.), The Constitution of South Africa from a Gender Perspective (Cape Town: 1995), 79-96.
[1368] C Ngwena "The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?" (2000) 5:1 Health and Human Rights 26-44; M Langford "The Justiciability of Social Rights: From Practice to Theory" (2008) eds, M Langford; Social Rights Jurisprudence: Emerging Trend in International Comparative Law (Cambridge University Press) 1, 5.

custom or social practice.[1369] Similar to the objectives of intersectional theorists,[1370] the provisions of section 27 aim at securing both formal and substantive equality and prevent factors such as gender, race, and other similar factors to serve as barriers to public services including health as well as social factors such as income and geographical location are eliminated. [1371] It therefore confers not only a negative right, under which the state or individuals should refrain from interfering with an individual's right to secure health care services without justification, but also a positive right to receive health care from the state.[1372] Indeed, women's rights advocates also support the constitutional protection of socio-economic rights on the basis that it would advance substantial gender equality in South Africa.[1373] Although these cases are not exactly equality cases, the refusal of the government to make provisions for the poor and less privileged can be understood as an equality violation.[1374] These cases are at the intersection of the substantive concepts of equality and socioeconomic rights under the Constitution. Hence, they explore the realization of the right to health and other socioeconomic rights as an essential part of the equality agenda of the Constitution.

In contrast, Nigeria's constitution embraces a more formal approach to gender equality under Section 42, which lacks the substantive provisions present in the South African constitution.[1375] Despite the longstanding discrimination experienced by Nigerian women on a daily basis, various bills seeking to adopt measures similar to provisions of section 9(2) of South Africa above have been rejected.[1376] This disparity underscores the need for Nigeria to prioritize the constitutionalization of gender equality, particularly in addressing maternal health disparities. By enacting comprehensive legislation and adopting the judicial principles of substantive

[1369] Zweigert and Kötz, *supra* note 109 at 35.
[1370] Crenshaw, *supra* note 26; Collins, *supra* note 100.
[1371] Liebenberg, *supra* note 1157 at 79–96.
[1372] Ngwena, *supra* note 107.
[1373] Liebenberg, *supra* note 1157 at 80-81.
[1374] The Constitution also established the Commission for Gender Equality, empowered to promote, educate, monitor, and lobby for gender equality and to "promote respect for gender equality and the protection, development and attainment of gender equality,[1374] as well as institutional mechanisms aimed at achieving equality for women such as the South African Human Rights Commission under the Constitution, Office on the Status of Women (OSW). The OSW has also established provincial offices in the Offices of the Premiers. See. S. 184 Constitution; P Andrews 'Striking the rock: confronting gender equality in South Africa' 3 *Michigan Journal of Race and Law* 330.
[1375] Nwabueze, supra note 661.
[1376] Yomi Kazeem, "Nigerian lawmakers voted down a women equality bill citing the bible and sharia law" (20 April 2022), online: https://qz.com/africa/639763/nigerian-lawmakers-voted-down-a-women-equality-bill-citing-the-bible and-sharia-law/.

equality, Nigeria can ensure that women's rights are protected and that they have equal access to quality maternal healthcare services.

### 6.8 Implications of the different approaches to right to health

The judicial approach in South Africa to socioeconomic rights has attracted a great deal of attention, especially in the area of health litigation. The analysis shows a positive view of constitutionalizing health through justiciable constitutional provisions. According to Durojaye, a key driver of South Africa's success in the treatment of maternal health issues is the courts' interpretation in *TAC* case, which gives force and effect to the principles underlying the universal minimum health coverage including pregnant women's, regardless of social standing or wealth.[1377] Smith notes that the emerging trend in the right to health interpretations have extended to provisions of medicine and other basic health determinants, which is exemplary.[1378] In addition to these transformative decisions, institutional measures have also been put in place to ensure accountability within the health care system in South Africa, flowing from the rulings ordering government to implement measures for the marginalized where established that they are proportionately affected notwithstanding the general concerns of limited resources.

The South Africa decisions have had a positive effect on maternal health and general health system through its transformative decisions. A number of empirical studies support this claim through the 'reasonableness' doctrine insofar as the government have complied with the putting minimum measures in place within the constraints of resources through increased health expenditures. This has generally addressed the major health challenges within the country.[1379] The decision in TAC is efficiently and effectively implemented and have had positive effect on maternal health and wellbeing of pregnant women, albeit indirectly since individual claims are not readily guaranteed without creating a floodgate of actions. Generally, there is a consensus

[1377] E Durojaye "The Relevance of Health Rights Litigation in Africa" In Litigating the Right to Health in Africa: Prospects and Challenges (Edn.) by Durojaye Ebenezer, Routledge (2015) 3; M Heywood, 'South Africa's Treatment Action Campaign: Combining Law and Social Mobilisation to Realise the Right to Health' (2009) 1 *Journal of Human Rights Practice* 14, 24.

[1378] A Smith 'Equality constitutional adjudication in South Africa' (2014) 14 *African Human Rights Law Journal* 615.

[1379] Ngwena, C, 'Scope and Limits of Judicialisation of the Constitutional Right to Health in South Africa: An Appraisal of Key Cases with Particular Reference to Justiciability' (2013) 14 *R. Dir. Sanit., Sao Paulo* 43-87.

that the South African Constitutional Court decision may have effected a significant structural change and played a critical role in affecting health policy in South Africa.

## 6.9 Prospects and Challenges of South African Constitutional Approach of Enforcement Socioeconomic Rights in Nigeria

In examining the constitutional approach to the right to health in South Africa, this chapter highlights compelling arguments for Nigeria to adopt a similar framework. Firstly, the constitutional guarantee of social rights, alongside the establishment of specialized constitutional courts, provides a strong foundation for the realization and development of effective remedies for violations of the right to health. Secondly, the Constitutional Court's adoption of an intersectional approach, considering social inequality and discrimination, offers valuable insights into addressing the complex challenges relating to healthcare access and maternal health in Nigeria. Lastly, the role of international treaties and their constituent instruments in shaping the jurisprudence on the right to health underscores the importance of aligning Nigeria's legal framework with the global standard, which enhances the protection of individuals' health rights and strengthening the country's commitment to improving maternal health outcomes.

### 6.9.1 Constitutional Guarantee of Social Right

The approach of the Constitutional Court in South Africa serves as a compelling defense against the argument that socio-economic rights have no place in a constitution. [1380] It demonstrates the efficacy and importance of incorporating such rights into the constitutional framework.[1381] Considering the acknowledgment of the indivisibility and interdependence of all human rights under international law, socioeconomic rights like civil and political rights deserve constitutional protection.[1382] Ngwena argues that the approach to socioeconomic rights in South Africa establishes the impossibility of realizing the rights through constitutional means without

[1380] Proponents argue that a constitution should protect "negative" rights, not "positive" rights. Constitutional rights should be seen as individual protections against the aggressive state, not as private entitlements to protection by the state. See, e.g., Colleen M Flood *et al.*, Charter rights & Health care funding: a typology of Canadian rights litigation" (2010) *Ann Health Law* 2; Scott, Constitutional Ropes of Sand or Justiciable Guarantees?, (1992); 141 *University of Pennsylvania Law Review* 1; Symposium, Socio-economic Rights, (1992) 8, *South African Journal of Human Rights* 451.

[1381] C. R. Sunstein, "Social and Economic Rights? Lessons from South Africa" (John M. Olin Program in Law and Economics Working Paper No. 124, 2001), 1.

[1382] Opinion of the Economic and Social Committee on the Citizens' Europe, 23 September 1992 (Opinion 1037) para 1.2.3.

considering the immediate political and social inequality in a society.[1383] The functional approach advocated by Zweigert and Kötz provides a valuable framework that enables me to address the issue of justiciable right to health within a multicultural society, focusing on practical legal solutions for specific social problems. [1384] This approach allows me to stay within the realm of legal analysis, avoiding the need to delve into extensive sociological research, while still recognizing and acknowledging the broader social phenomena associated with the problem at hand.[1385] The apartheid regime in South Africa creates a deep inequality on race, sexism, economic and political grounds, and it is responsible for the health disparities in the society including terrible maternal health indices.[1386] In *Grootboom*, the Constitutional Court requires the government to develop and fund a reasonable program by which a significant number of poor people are given access to emergency housing. Despite the limited resources, the Court in *Soobramoney, Grootboom and TAC* recognizes the positive obligation on the state to guarantee such rights under section 26 and 27, and develops a model for its actualization by refusing the provisions of these rights on demand and to individuals.[1387] This approach is in direct opposite to trends in some countries where the right to health focuses on granting individual remedies as opposed to protection of the public health. In Columbian[1388] *tutela* actions[1389] for example, the court rulings impact only the parties involved although the sheer volume of claims ultimately has a systemic effect thereafter.[1390]

Considering the general resource constraints in granting every individual the right to health to the highest available standard, states have rejected the constitutional approach and deny individuals as bearers of such right.[1391] Ferraz argues that, in Brazil, granting individual remedies

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[1383] C Ngwena "The Recognition of Access to Health Care as a Human Right in South Africa: Is It Enough?" (2000) 5:1 *Health and Human Rights* 26-44.
[1384] Legrand & Munday, *supra* note 1192 at 292.
[1385] Brand, R. A., Comparative Law, Oxford: Oxford University Press (2007) 410.
[1386] Ibid.
[1387] Scott, *supra* note 1380 at 8.
[1388] Pedro Santos, *supra* note 719 at 493; Thomas & Flood, Putting Health to Rights (2015) 1 CJCCL 47-78 at 61.
[1389] Tutela is a form of immediate protection against public authority of legal rights without the need for lawyers and formal filing of action, but by way of the individual or third parties petitioning or verbal submission to a judge, a fast access tool for fundamental rights which must be decided within 10days. See. Patrick Delaney "Legislating for Equality in Colombia: Constitutional Jurisprudence, Tutelas, and Social Reform" (2008), 1, *The Equal Rights Review* 50 at 54.
[1390] Thomas & Flood, *supra* note 1388 at 61.
[1391] Michael Da Silva "International Right to Health Care: A Legal and Moral Defense" (2018), *Michigan Journal of International Law* 346.

in cases involving right to health have the implication of neglecting the poor in the allocation of scarce health care resources redistribution under the regressive principle of 'to each according to their ability to litigate.'[1392] He notes that while health rights litigation has increased over the years in Brazil, it is becoming clear that the main beneficiaries of these decisions are the middle class citizens and not necessarily the vulnerable and marginalised groups who often experience violation of their health rights.[1393] It is however important to note that, beyond the impact of addressing access to maternal care services, health system improvements and changes, subjecting the right to health to litigation can inspire transformation of social norms[1394] and play a critical role in supporting domestic programs and campaign designed to improve access to reproductive health care and reduced maternal mortality.[1395] It can be used to empower women and minority groups to achieve broader political and social change.[1396] According to a recent study, the reduction in deaths from non-pregnancy related infections and the success of the HIV anti-retroviral treatment programme in pregnancy as a result of compliance of government to the Constitutional Court judgement in the TAC case, have been hailed as the main reason for the decline in the Maternal Mortality Ratio in South Africa in the past few years.[1397] This reflects a positive aspect of the constitutional right to health, since it gives the Constitutional Court an opportunity to further develop and interpret policies aimed at substantive equality in conjunction with the legislative and executive arms of the government.

To what extent can the Nigerian courts, governmental bodies, and other stakeholders successfully navigate the complex normative, political, cultural and institutional terrains involved in constitutionalising the right to health and other socioeconomic rights? The inclusion of these rights among the justiciable ones raises a number of concerns. This is especially

[1392] Thomas & Flood, *supra* note 1388 at 52; O. Ferraz, "Th e Right to Health in the Courts of Brazil: Worsening Inequities?" (2009) 11:2 *Health & Human Rights* 33; O. Ferraz, "Harming the Poor through Social Rights Litigation: Lessons from Brazil" (2011) 89:7 *Texas Law Review* 1643.
[1393] Ferraz O.M. 'Brazil-Health Inequalities, Rights and Courts: The Social Impact of Judicialisation of Health in in S Gloppen & A. Yamin (eds.) Litigating Health Rights: Can Court bring more Justice Health? (Harvard: Harvard Law School 2011) 79-80.
[1394] Flood *et al.,* supra note 1380 at 3.
[1395] Dunn *et al.,* "The Role of Human Rights litigation in improving access to reproductive healthcare and in achieving reductions in maternal morality" (2017) 17 *BMC Pregnancy and Childbirth* 367.
[1396] Ibid at 368; Flood *et al., supra* note 1380 at 2.
[1397] National Committee on Confidential Enquiries into Maternal Deaths. Saving Mothers 2014-2016: Seventh triennial report on confidential enquiries into maternal deaths in South Africa. Pretoria: National Department of Health South Africa; (2018).

regarding the appropriateness of the role of the court with respect to social and economic development in a constitutional democracy.[1398] While it might be established that it is unlikely to arrive at a consensus on roles of the court in the enforcement of socioeconomic rights, the concerns apply equally to other areas of constitutional adjudication. But the constitutional recognition of socio-economic rights while not necessarily the panacea to all problems derived therefrom, it gives room for judicial intervention in holding the government accountable in implementing measures to compel their execution for the benefit of the people, as seen in the South African cases of *TAC and Grootboom.*[1399] Therefore, it is recommended that Nigeria considers adopting a similar constitutional approach, particularly the right to health cases, to empower the judiciary and ensure the effective realization of maternal health of pregnant women. Experts argue that justiciable right to health provides, in the case of Nigeria, an avenue for seeking judicial remedies for violations of such rights without justiciability hurdle under section 6(6)(c) of the 1999 Constitution.[1400] In their opinion as well, section 13 of the Constitution may be deployed by the courts since they have a general power to give effect to the provisions of the Constitution including the provisions of Chapter II.[1401] Akande argues otherwise, her objection rests on the widely acknowledged argument of limited resources, contending that the enforcement of Chapter II provisions of the Constitution would impose substantial financial burdens on the government. However, it is essential to critically examine the underlying assumptions and explore alternative approaches that prioritize the realization of socioeconomic rights within the available means and resources.[1402] This is the case in most advanced countries, like Canada, UK and US, as socioeconomic rights are not constitutionally recognized due to their financial implications, yet basic and core minimum rights are guaranteed.[1403] It is difficult to sustain the paucity of resources and funding argument for an oil rich country like Nigeria,[1404] as

[1398] Flood et al, *supra* note 1380; Haysom, Nicholas, 'Constitutionalism, Majoritarian Democracy and Socio-Economic Rights', (1992), *8 South Africa Journal on Human Rights* 451-463 at 455-456.
[1399] *TAC*, *supra* note 1259 and *Grootboom supra* note 1259.
[1400] Ferraz, *supra* note 1393 at 54; S Ibe, *supra* note 1142 at 233.
[1401] C. Onyemelukwe 'Access to Anti-retroviral Drugs as a Component of the Right to health in International Law: Examining the Application of the Right in Nigerian Jurisprudence' (2007) 7 *African Human Rights Law Journal* 446.
[1402] See J. Akande, The Constitution of the Federal Republic of Nigeria 1979 with Annotations (Sweet & Maxwell 1982) 13.
[1403] Ibid.
[1404] Nigeria is the 13 largest oil producer in the world and largest economy in Africa by GDP. See CIA The World Factbook (CIA 2017) accessed 28 December 2017. Alex Enumah 'EU Withdraws Financial Support for Nigeria, Says Country Not Poor' (Thisday Newspapers Jun 2017) accessed 18 August 2021.

the core minimum and non-derogable obligations under ICESCR may be guaranteed progressively, including basic maternal healthcare services.[1405]

### 6.9.2 Role of Special Constitutional Court on Social Rights

The Constitutional Court of South Africa has effectively debunked the objections to the realization of socioeconomic rights through a constitution, demonstrating the judiciary's capacity to implement and provide appropriate remedies through judicial review of state actions, omissions, and interpretations of such rights. The Court has successfully enforced the establishment of programs by other branches of government, and still maintains a balanced application of the principle of separation of powers. This exemplifies the judiciary's ability to ensure accountability and uphold the socioeconomic rights of individuals, while respecting the constitutional framework and promoting the overall well-being of the society.[1406] This demonstrates that justiciable socioeconomic rights is a means to challenge the government to effectively and efficiently implement such rights and involve the people in the decision-making process. In addition, it brings to light, as Viljoen argues, that effective implementation as a part of the issue of justiciability is to ensure that the formulation of the government policies and strategies realise socioeconomic rights. They must be reasonably formulated and implemented based on their constitutional obligation.[1407]

The approach of reading equality provisions into section 9 of the Constitution to create a platform for upholding socioeconomic rights as it has been done in the case of section 27 of the South Africa Constitution, supports the indivisibility and interdependence of human rights as espoused in the jurisprudence. It affirms the contention that civil and political rights under international and domestic constitution implicate socio-economic rights and must be protected as positive rights. It also counters the argument that socioeconomic rights are too polycentric to be realized and are determined by will of the political class.[1408] Afterall, the overall importance of a constitution lies in its being an enabling instrument, which must necessarily be underpinned by other legal instruments and policies.

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[1405] Obiajulu Nnamuchi, *supra* note 292 at 2-3.
[1406] Eze, Osita, Human Rights in Africa: Some Selected Problems, (Lagos: Macmillan Publishers, 1984), at 32.
[1407] Viljoen, *supra* note 387 at 576.
[1408] E. Mureinik, 'Beyond a Charter of Luxuries: Economic Rights in the Constitution', (1992) 8 *South African Journal on Human Rights* 464–474.

A constitutional amendment, while important, may not be sufficient to guarantee positive health outcome.[1409] Procedural and doctrinal restraints from Nigerian courts must be addressed to achieve effective enforcement of socioeconomic rights. According to Odinkalu, the Nigerian courts have failed to mobilise justiciable Chapter IV rights to create a vibrant human rights culture and develop positive values in the Nigerian human rights jurisprudence.[1410] To translate the constitutional social rights to positive outcome, it must be protected in the manner contemplated under international human rights legal regime, where the Nigerian government is required to "respect, protect and fulfil" these rights, including adopting an intersectional approach of treating them as imposing a positive duty on the state to provide these services, eliminate discriminatory laws based on the interpretation offered by various treaty bodies like the CESR and CEDAW on the holistic and comprehensive approach to encompass the determinants of health and other ancillary issues. For example, compliance with such obligations would, for instance, imply higher budgetary allocations to health, education, social security and job creation.

Besides, there are several other factors which also inhibit the adoption of a constitutionalized social right as applicable in South Africa. The constitutional approach in South Africa is built on the transformative agenda based on a guaranteed equality.[1411] These factors are both within and without the operation of the courts, as the interpretations of the discrimination provisions under section 42 of the 1999 Constitution might have untoward consequence for all social rights, particularly health. This includes favourable consideration of abolition of laws and cultural factors that violate women's rights: abortion rights, discriminatory cultural and religious laws affecting women's health in different regions of the country. The Nigerian Supreme Court in *Mojekwu v. Iwuchukwu*[1412] offers some rare glimmer of hope regarding the application of the principle of non-discrimination and doctrine of natural justice, equity and good conscience to discriminatory customary laws that target women[1413]. In *Mojekwu v. Iwuchukwu*[1414], the claimant instituted an action seeking an order of court declaring a customary law that precludes female

[1409] Odinkalu *supra* note 694 at 190.
[1410] Odinkalu *supra* note 694 at 184.
[1411] Albertyn, *supra* note 167 at 257.
[1412] (2004) SC (part II) 1.
[1413] See also Mojekwu v. Ejikeme (2000) 5 NWLR pt. 657.
[1414] (2004) SC (part II) 1.

children from inheriting the estate of their late father who dies intestate. Despite declaring the custom to be discriminatory, the court further establishes that not all customary laws discriminate against women. While it is true that not all customs are detrimental to women's interest including their health, several of these customs violate women's rights.[1415] According to Durojaye, such declaration fails to appreciate the gender implications of customary laws in enjoying of fundamental human rights. Such declaration is dangerous considering that most customs are determined by men who are the gatekeepers of custom and tradition in these communities. The courts' approach in dealing with culture and its impact on women's rights, particularly in relation to their health, has been selective and reluctant to strike down custom that contribute to discrimination against women. While it is acknowledged that not all custom are harmful to women's interests, it is important to recognize that many custom do violate women's rights. Failing to appreciate the gender implications of customary laws and their impact on women's fundamental human rights is a concerning oversight. It is crucial to address this issue as custom is often determined by men, who act as gatekeepers of tradition within these communities, thereby further perpetuating gender inequality and hindering women's rights to health and well-being. The Supreme Court of Nigeria has demonstrated a commendably progressive approach in the case of *Ukeje v. Ukeje,* [1416] wherein it declares a law that unjustly disinherits women solely based on their gender as void due to its inconsistency with Section 42 of the 1999 Constitution, which prohibits discrimination. This landmark decision signifies the Court's recognition that such discriminatory practices are fundamentally incompatible with constitutional principles. Moreover, the Court's perspective on the application of this ruling appears to indicate its expectation for Nigerian courts to universally uphold and apply the principles of non-discrimination established within the Constitution. This marks a significant step towards ensuring gender equality and challenging long-standing gender-based biases in the legal system. Moreso, the advancement of women rights requires legislative provisions and institutional structures to promote and protect gender equality.

[1415] E Durojaye *supra* at 117.
[1416] (2014) All FWLR.

### 6.9.3 Constitutional Court & Intersectionality

The adoption of intersectionality by the Constitutional Court holds immense potential for addressing the critical issue of maternal mortality and in advancing substantive equality.[1417] Coupled with its commitment to going beyond constitutional frameworks and embracing intersectionality, the court offers a compelling example of how to actively address discrimination and ensure justice for marginalized communities. By embracing these lessons, Nigerian courts can foster a more inclusive and effective judicial system that guarantees substantive equality and delivers justice to those most in need within a society. In a recent decision of *Mahlangu and Another v Minister of Labor and Others*[1418], the South African Constitutional Court recognizes that beyond broader economic hazards that workers may be exposed, the health and safety of certain racialized and vulnerable women workers must be viewed from perspectives of equality and dignity. The case concerns the constitutional challenge to the Compensation for Occupational Injury and illness Act (COIDA), which precludes domestic workers who are predominantly black women, employed in private homes from making claims to the Compensation Fund in cases of illness, injury, disablement, or death at work. For the first time, the Court expressly recognizes a theory of intersectional discrimination and moves forward its own jurisprudence on indirect discrimination, infusing the right to social security, dignity and in retrospective application of an intersectional analysis.

The application of intersectionality as a guiding principle in the case of *Mahlangu and Another v Minister of Labor* showcases the South African courts' profound commitment to upholding constitutional rights.[1419] The judgment not only emphasizes the significance of international law[1420] but also recognizes the necessity of adopting a broad national and international approach when addressing discrimination against domestic workers.[1421] The Court decisively concludes that the exclusion of domestic workers is irrational, arbitrary, and inexplicable[1422], failing to

[1417] Shreya Atrey "Beyond discrimination: Mahlangu and the use of intersectionality as a general theory of constitutional interpretation" International Journal of Discrimination and the Law (2021) 21(2) 168–178.at 172;
[1418] (2020) ZACC 24.
[1419] Shreya Atrey, supra note 1417; See Minister of Finance v. Van Heerden [2004] ZACC 3 [27].
[1420] The court held that the exclusion of the categories of women and workers cannot be justified under international law conventions, including the International Covenant on Economic, Social and Cultural Rights (ICESCR).
[1421] *Mahlangu supra* at para. 42
[1422] See Victor AJ in *Mahlangu* case at para 72 in interpreting the provisions of sections 9(1) and 9(3) of the Constitution of South Africa.

consider the specific needs of the most vulnerable members of the society, particularly black women[1423], who face compounded vulnerabilities due to intersecting forms of mistreatment based on race, sex, gender, and class. This landmark case affords the Constitutional Court the opportunity to interpret the provisions of section 9(3) of the South African Constitution on discrimination and section 10 on dignity, and to address indirect discrimination through the lens of intersectionality, setting a significant precedent for future cases. [1424]

*Mahlangu* case shows that the Court goes beyond that in fact and recognises intersectionality not just as a part of discrimination model, but also as a part of general constitutional law framework, using it as a theory of constitutional interpretation in adjudication.[1425] The decision also reasserts the goals of transformative constitutionalism as "undoing gendered and racialized poverty," and insists that an intersectional and historic lens is essential to the achievement of structural and systematic transformation.[1426] The decision of the Constitutional Court of South Africa in Mahlangu's case has the potential to serve as a template for Nigerian courts to employ intersectionality as an interpretive framework in discrimination and human rights cases, especially for poor pregnant women. The Nigerian courts must go beyond legal limits and parameters to implement legal solutions for social problems. It requires courts to take a substantive-equality approach to addressing the multiple forms of discriminatory practices against pregnant women in the society. The provisions of equality under section 42 of the 1999 Constitution and the CEDAW on multiple discrimination, can broadly be interpreted to include harmful traditional and religious practices which impair pregnant women from enjoying their rights. This is Crenshaw's most significant contribution, that any effort to address inequities in health of people must address power imbalance and empower disadvantaged people to participate in decision making that affects their well-being.[1427]

[1423] *Mahlangu supra* at para. 106
[1424] *Mahlangu supra* at para. 75
[1425] Shreya Atrey, *supra* note 1417 at 168.
[1426] *Mahlangu supra* at para. 195.
[1427] WHO Commission on Social determinant of health 'Closing the gap in a generation: Health equity through action on the social determinant of health' (2008) http://reposi tory.essex.ac.uk/9714/1/participation-right-highest-attainable-standard-health.pdf (accessed 5 March 2019).

### 6.9.4 Implementation of International and National Obligations

The introduction of a substantive and transformative provision in the Constitution enhances the 'constitutional opportunity structures' that guarantees basic capabilities for all, bearing in mind long periods of subjugation and disadvantage experienced by women. The approach provides the impetus for government institutions to undertake social context analysis in deciding maternal health policies. This is also in consonance with the countries' obligations under the African Charter, ICESCR and CEDAW. The approach affords Nigeria the opportunity to develop constitutional and socio-economic rights jurisprudence and accountability mechanisms around the right to health. This has been achieved in South Africa despite non-ratification and non-domestication of the ICESCR and CEDAW[1428]. The approach of treating of substantive equality under its constitution as against formal equality and the enactment of the Equality Act, assists the court in treating equality and non-discrimination cases with utmost priority despite constitutional limitation clauses. Also, an innovative strategy under the 1996 Constitution like the Constitutional Court for human rights cases and the establishment of a Commission for Gender Equality which is empowered to "promote respect for gender equality and the protection, development and attainment of gender equality" are some of cues that has relevance to the Nigerian maternal health situation.[1429] Such constitutional and independent institution seeking gender equality in the context of deep historical gender inequality and violence against women assist in mainstreaming, including monitoring and periodic reporting obligations, and making visible the specific reproductive health issues confronting women and girls.

If indeed socioeconomic rights become immediately justiciable in Nigeria today, there would still be no guarantee of its enforcement as its implementation could become a major issue. Although Nigerian mere 'paper' commitments to its international and local obligations is a far measure from the requirement to realizing positive health outcomes, but it raises hope in the quest to addressing women's maternal health challenges. Perhaps this presents a veritable platform to request for demonstration of a further political enthusiasm to match the urgency and importance of the situation.[1430] A show of deliberate expenditure of some political capital in this

[1428] Section 39(1)(b) in interpreting the Bill of Rights enjoin courts to prefer any reasonable interpretation consistent with international law. See. S v Makwanyane (1995) (3) SA 391 (CC) at 35.
[1429] Andrews, P 'Striking the rock: confronting gender equality in South Africa' 3 *Michigan Journal of Race and Law* 330, 331.
[1430] Manjoo, *supra* note 1256 at 270.

direction is a sure way of offsetting the imbalance in the system. The significant disparity in budgetary allocation for healthcare in Nigeria has led to a dire situation where the majority of health facilities in the country are in poor conditions and predominantly located in urban areas. This poses grave challenges for the rural population, which constitutes a significant portion of the country's residents. The problem starts with the current insufficient allocation of a mere 5% of the budget to healthcare, which is grossly inadequate to meet the needs of the population. Urgent action is required to raise the budgetary allocation to the agreed minimum regional threshold of 15%, as set forth in the Abuja Declaration.[1431] This step is crucial to address the glaring inequities and ensure that adequate healthcare services are accessible to all, irrespective of their geographical location or socioeconomic status.

The South African constitutional approach gives Nigeria the opportunity to develop and treat social rights and indeed right to health in the context of the political, social and historical challenges of maternal mortality and social inequality in the country, as well as afford the courts greater discretion in developing standards and practices, and potential of developing remedies with implications for policies choices and reforms.[1432] The above discussion presents Nigeria array of opportunities for judicial, institutional and structural reforms from the South African constitutional approach to socio-economic rights and maternal health challenges.

Understanding the context of my research through a comparative law approach, provides a valuable insight into the strength and weaknesses of how different countries or regions have implemented policies and programs related to maternal health and how these policies have affected health outcomes. It helps inform Nigeria to develop more effective maternal health policies and programs. I realize that legal approach can be applied to transform health as well as the social, cultural and religious environment in Nigeria. My thesis lays emphasis on the role of courts in enforcing socio-economic rights and the justiciable right to health. While acknowledging the inherent limitations of a justiciable right to health, it is crucial to address these concerns that have been extensively discussed by scholars. This recognition underpins my

[1431] WHO The Abuja Declaration: Ten Years On (WHO 2011) accessed 30 January 2018.
[1432] E Durojaye, *supra* note 117 at 105; C Ngwena & E Durojaye (eds.) 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights: an introduction' in C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 4.

proposal for the amendment of the 1999 Constitution to explicitly include the right to health, along with the enactment of supportive health statutes. By taking this step, we can strengthen the legal framework and provide a solid foundation for promoting and safeguarding the health and well-being of all individuals within the country. It is imperative that we proactively address these issues and ensure that access to quality healthcare is not only protected but also actively promoted as a fundamental human right.

## 6.10 Conclusion

In Nigeria, the attitude of courts to rights, to institutional and legal mechanisms for realising socioeconomic right under the constitutions are important considerations which will have bearing on the outcome of the constitutionalisation process. The Constitutional Court, while interpreting the transformative South African Constitution, wherein socioeconomic rights are justiciable, made some ground-breaking decisions in relation to health care, housing, and social security. It formulated a reasonableness test doctrine in evaluating the effectiveness of the various programmes that the government had designed to implement socioeconomic rights including healthcare programs. Socioeconomic rights are embedded in the South African Constitution to facilitate accountability of government's socioeconomic policies in order to fulfil the transformative goals of the national Constitution. Undeniably, the reasonableness doctrine of the Constitutional Court has led to improved accountability of the South African government in the crafting of inclusive and responsive socioeconomic policies. As the experience of South Africa shows, justiciable socioeconomic rights can transform healthcare challenges. In the light of myriad of challenges confronting pregnant women, it is imperative to strongly recommend the adoption of a justiciable right to health in the Nigerian Constitution. The courts in Nigeria should embrace a more proactive stance in enforcing socioeconomic rights and remain open to drawing on well-reasoned foreign jurisprudential approaches. The courts and policymakers could learn much from the Constitutional Court's socio-economic decisions. This subjects the government policies to constitutional scrutiny as well as evolving institutional and judicial approach to realizing socio-economic rights in Nigeria. Justiciable right is not a stand-alone remedy, when added to existing policy of addressing gender inequalities, socio-economic mechanisms, will transform maternal health challenges in Nigeria.

# CHAPTER SEVEN

## Conclusions and Recommendations

### 7.0 Introduction

This thesis has explored the multifaceted challenges of maternal mortality in Nigeria, with a particular focus on regional disparities and the intersectional nature of discrimination against pregnant women across various social, economic, religious, and geographical lines. Woven through the chapters are examination and presentation of key arguments. Chapter 1 establishes the existing legal regime for addressing maternal rights in Nigeria, highlighting its limitations. Chapter 2 emphasizes the need for an intersectional approach in understanding and addressing maternal health issues. Chapter 3 critically analyzes the factors contributing to regional disparities in maternal mortality and their violations of national and international human rights provisions. Chapter 4 sheds light on the limitations of socioeconomic rights and the power of judicial review in realizing women's rights in Nigeria.

Chapter 5 delves into the Indian approach, which entails interpreting civil and political rights, such as the right to life, to effectively realize social rights particularly the right to health. By incorporating intersectional policies and adopting a more inclusive approach to standing, Nigeria can draw valuable lessons from this framework. This chapter showcases the potential for Nigeria to prioritize and protect maternal health, regardless of the constitutional status of the right to health. In Chapter 6, the focus shifts to the transformative constitution of South Africa, which highlights the power of justiciable socioeconomic rights, national policies, and international regulations in addressing the unique challenges faced by pregnant women in Nigeria. The South African model demonstrates how rights-based approach to health can bring about positive change and advance the well-being of individuals. By embracing similar principles, Nigeria can pave the way for meaningful progress in ensuring maternal health and improving overall healthcare outcomes. These chapters underscore the importance of considering diverse approaches and leveraging existing legal frameworks to confront the pressing issues surrounding maternal health in Nigeria. The thesis also explores the institutionalization of discrimination and the non-domestication of human rights treaties, which have significantly affected the well-being of pregnant women in the country.

The findings of this thesis reinforce the urgent need for a reform. I recommend that Nigeria adopt a mixed approach to realize an effective maternal health framework, encompassing constitutional, statutory, and judicial reforms. Recognizing the justiciable right to health, addressing intersecting socio-cultural factors, and ensuring accountability through policy implementation are crucial steps. The thesis underscores the importance of subjecting socioeconomic rights to enforcement, as it grants the courts the power to set policy priorities, ensure legislative commitment, and hold the government accountable. Additionally, the proactive interpretation of justiciable constitutional provisions, employing an intersectional framework, can address gender inequalities and deliver justice for pregnant women.

In conclusion, this thesis provides a comprehensive analysis of the challenges surrounding maternal mortality in Nigeria, examining legal, social, and cultural factors. It underscores the need for effective implementation of international human rights treaties, constitutional recognition of rights, and proactive judicial interpretation. By implementing the recommendations put forth in this thesis, Nigeria can make significant strides in reducing preventable maternal deaths and promoting the overall well-being of pregnant women. It underscores the need for effective implementation of international human rights treaties, constitutional recognition of rights, and proactive judicial interpretation. I conclude that a mixed approach for realising effective maternal health remains an ideal way, whether they are constitutionally justiciable or amenable to enforcement as aspirational goals of states is generally reflected in how the states adopt principles and policies aimed at realizing the socio-economic rights of citizens. By subjecting socio-economic rights to enforcement, the approach grants unlimited access to the courts, empowering them to shape policy priorities and secure legislative commitment. By embracing this approach, citizens, particularly the vulnerable and marginalized members of society, are provided with a crucial opportunity to hold the government accountable for the implementation of policies. This enables them to seek redress and demand transparency in the government's actions, ensuring that the rights and needs of all citizens are safeguarded. To address the current gaps in the legal framework, I make three recommendations: constitutional, statutory, and judicial reforms. In exploring the role of the constitution and policies in addressing health inequality and the intersection of socio-cultural

factors, I discuss recognising justiciable right to health in achieving effective maternal health as well as other factors that affect the realisation of quality health and gender inequality.

## 7.1 Summary of findings

### 7.1.1 The relevance of intersectionality theory in addressing healthcare access for maternal health

The main argument put forth in this thesis is the application of the theory of intersectionality to address the disparities in maternal health and mortality in Nigeria. Chapter 2 of my thesis explores the theory of intersectionality, which provides a critical framework for understanding how social identities intersect to shape individual experiences of privilege and oppression. By considering various social categories such as race, gender, sexual orientation, socio-economic status, and disability, intersectionality analyzes the interlocking systems of privilege and oppression that contribute to health inequality. I argue that intersectionality offers a reliable approach to addressing health inequality and seeks socio-economic justice, while aligning with human rights obligations and constitutional guarantees.

Although, the theory of intersectionality has faced criticism for lacking a clear definition and for not addressing whether all identities are intersectional or if only multiple marginalized subjects possess an intersectional identity. Nonetheless, the thesis maintains that when viewed from the perspectives advocated by scholars like Crenshaw, intersectionality provides a robust approach to addressing health inequality and maternal mortality. It encompasses structural, political, and representational intersectionality, and recognizes the importance of human dignity, equality, freedom entitlements. This approach aligns with human rights obligations and constitutional guarantees. By exploring the social and cultural factors that significantly impact women's health in the country, this chapter emphasizes the need for comprehensive and inclusive strategies to improve maternal health outcomes. It underscores the complexities and interconnections between different aspects of women's lives and highlights the urgency of addressing these factors to reduce maternal mortality rates.

The theory of intersectionality, when applied to maternal health in Nigeria, offers a valuable framework for understanding and addressing the disparities in death rates across regional lines in Nigeria. While recognizing the criticisms and challenges associated with the theory, the

thesis contends that intersectionality provides a reliable approach to promoting socio-economic justice and aligns with human rights obligations and constitutional guarantees. The practical analysis conducted in Chapter 3 highlights the significance of adopting an intersectional approach and emphasizes the need for comprehensive strategies to improve maternal health outcomes in Nigeria.

Urgent government interventions are crucial to address the disparities in maternal healthcare access for marginalized groups. A comprehensive approach focusing on improving educational and socioeconomic status across all categories and regions can effectively reduce equity gaps. By tackling these broader social determinants of health, we can expect barriers like seeking permission for healthcare and financial constraints to diminish, to ensure a more accessible, equitable, and all inclusive maternal healthcare system. An imperative conclusion emerges from this research, highlighting the necessity of considering multiple factors that influence maternal mortality rates in Nigeria. Empowering women through education emerges as the most effective strategy to enhance maternal health and elevate women's status in a society.[1433] This finding unequivocally demonstrates the direct relationship between maternal mortality and women's educational status.[1434] Educated women are more inclined to seek antenatal and postnatal care, as well as opt for institutional deliveries, leading to a significant reduction in maternal mortality rates. Evidence from other developing countries further solidifies the need for intersectionality in maternal mortality regulation.[1435] Socio-economic and demographic factors, such as education, employment, income, urban residence, access to services, maternal age, number of live births, and women's household position, are crucial determinants of maternal healthcare indices . Addressing these factors collectively is indispensable in tackling the maternal mortality crisis in Nigeria.

A complete restructuring of the current national healthcare services with a focus on the peculiarities of people from different regions including an integration of traditional and alternate methods of maternal care would be intersectional in this respect. Since maternal

[1433] Engel J *et al.,* Nepal's Story Understanding improvements in maternal health. Development Progress Case Study Summary March (2013).

[1434] Mayor S. Pregnancy and childbirth are leading causes of death in teenage girls in developing countries (2004) 328, BMJ 1152.

[1435] Jackson TP, Hanson K. Financial incentives for maternal health Impact of a national programme in Nepal, (2012) 31 *Journal of Health Economics* 271-284.

health is multidimensional, healthcare personnel and infrastructure should be integrated based on needs, with social services across different communities, policies, and activities to support the full range of necessary prevention, promotion, and optimization activities.[1436] Thus, the government must prioritize women from lower socio-economic backgrounds in community interventions, offering schemes for partial funding, community payment schemes, insurance programs and social insurance options. These measures can significantly enhance women's access to maternal healthcare services and, consequently reduce maternal mortality rates. Only through a comprehensive and intersectional approach can Nigeria effectively combat the pressing challenge of maternal mortality.

### 7.1.2 Nigeria's commitment to its human rights treaty obligations

The significance of Nigeria's compliance with international human rights treaties, particularly in relation to maternal health and women's sexual and reproductive rights cannot be overemphasized. As discussed in various chapters, including Chapter 4[1437], Nigeria has ratified treaties such as the ICESCR and CEDAW, which impose obligations on the country to respect, protect, and fulfill these rights. However, the non-domestication of these treaties into national law has limited the ability of citizens to seek enforcement of their rights in local courts, resulting in a lack of compliant laws and policies. This failure to fulfill international obligations has led to ongoing violations of international law, particularly in the area of maternal health. Therefore, I argue that Nigeria must demonstrate a clear commitment to its international treaty obligations by ratifying, domesticating, and implementing relevant treaties and protocols.

I analyze the limitations of socioeconomic rights as non-justiciable and directive principles of state policy in Nigeria in Chapter 4 of the thesis. This analysis highlights the obstacles that hinder the realization of women's rights, specifically in the context of maternal health. The thesis advocates for an empowered judiciary that can subject government policies on socioeconomic rights to objective scrutiny. By allowing the courts to play a more active role in reviewing government actions, the chapter emphasizes the importance of legal mechanisms in promoting women's health and rights. Furthermore, the thesis explores additional legal

[1436] Halfon *et al*., Quality of Preventive Healthcare for Young Children: Strategies for Improvement, Commonwealth Fund Publication (2005) No. 822.
[1437] See Chapter 4 at section 4.5.

challenges that impede the realization of these rights within the Nigerian legal system, including the need to address multiculturalism and the necessity of reforming cultural and religious laws to achieve substantive equality.

The non-domestication of these treaties limits the enforcement of rights in domestic courts, leading to ongoing violations and inadequate laws and policies. Nigeria must show a clear commitment to fulfilling its international obligations by ratifying, domesticating, and implementing relevant treaties. My thesis underscores the significance of an empowered judiciary in advancing women's health and acknowledges the limitations of socioeconomic rights in this context. It delves into the legal complexities within the Nigerian system, including the challenges posed by multiculturalism, and emphasizes the necessity of reforms to attain substantive equality in the realm of maternal health. By shedding light on these critical aspects, the thesis aims to strengthen the discourse on improving maternal healthcare and promoting gender equity in Nigeria.

### 7.1.3 Constitutional and legal framework for right to health

I argue that Nigeria has not adequately addressed the challenges of maternal health and the right to health in its legal system, despite its commitments locally and internationally. In Chapter Four, it is argued that Nigeria's Constitution, as the supreme law of the land, empowers the state to promote a healthy population through provisions such as the right to health, equality, and non-discrimination. [1438] However, these rights have been viewed from a negative perspective, rather than a positive one that imposes duties on the government to provide adequate healthcare services for pregnant women. By adopting a positive rights approach and treating the right to health as justiciable, the judiciary can hold the government accountable for making provisions to reduce maternal complications and avoidable deaths, especially among the poor and vulnerable. Lessons from South Africa's transformative constitution and the Constitutional Court's jurisprudence on health inequality confirm the relevance of adopting a justiciable and positive rights angle in addressing maternal health challenges.

[1438] Chapter 4 at page 112.

The incorporation of "directive principles" into a constitution signifies a commitment to upholding its integrity and necessitates constitutional review to observing such principles. [1439] The preamble of the Nigerian Constitution outlines its aspirations and methods for achieving socio-economic rights. When a state enshrines human rights in its constitution, it assumes an ongoing responsibility to fulfill both negative and positive obligations to secure those rights. By treating the right to health as a directive principle, despite ongoing inequality and discrimination faced by women in maternal health, Nigeria violates the spirit of its Constitution and its international commitments to dignity, equality, and justice. This violation is compounded by governance shortcomings related to women's sexual reproductive rights and the lack of health infrastructure, particularly in rural areas.

I examine the limitations of socioeconomic rights as non-justiciable and directive principles in Nigeria, illustrating how these limitations hinder the realization of women's rights, specifically in the context of maternal health. I emphasize the importance of an empowered judiciary that can subject government policies on socioeconomic rights to objective scrutiny, I also analyze other legal challenges within the Nigerian legal system, including multiculturalism and the need to achieve substantive equality through reforms of cultural and religious laws.

Nigeria needs to address the challenges of maternal health and the right to health by adopting a justiciable and positive rights approach. The Constitution should be interpreted to impose positive duties on the government to provide adequate healthcare services for pregnant women. The incorporation of directive principles should be reviewed, as their treatment as non-justiciable provisions contradicts the spirit of the Constitution and has negative implications for the country's international commitments. An empowered judiciary and legal mechanisms are crucial in promoting women's health and rights, while addressing other legal challenges, such as multiculturalism and the need for substantive equality through reforming cultural and religious laws.

[1439] See. Chapter 4 on 4.5 on Fundamental objective and Directive Principles FODPSP and Right to Health.

### 7.1.4 Judicial attitude to realising socio-economic rights

The main argument of this thesis is that Nigeria can learn valuable lessons from the judicial attitudes towards the right to health in India and South Africa, considering the significant maternal mortality rates in Nigeria. In Chapters Five and Six, a comparative analysis of models for realizing social rights under national constitutions is provided. The analysis reveals that holistic intersectional approaches, coupled with a vibrant judiciary, play significant roles in ensuring the realization of social rights. The experiences of India and South Africa provide valuable insights for Nigeria to address maternal justice.

While the Constitution provides substantive content, the role of the judiciary in interpreting its provisions is crucial. [1440] However, the thesis establishes that although the courts in Nigeria have developed jurisprudence on civil and political rights, they have failed to extend such treatment to social and economic rights, including the right to healthcare. [1441] According to Odinkalu, '…the law has failed so far to be an instrument for stimulating demand for healthcare or ensuring accountability for non-availability of healthcare'.[1442] The courts have employed narrow exclusionary rules of standing to sue (i.e *locus standi*) and interlocutory appeals, resulting in prolonged delays in court proceedings and limited enforcement of economic and social rights. [1443] Additionally, the apex court in Nigeria has interpreted the domesticated African Charter and other international human rights treaties as subordinate to the Constitution, limiting their enforceability in domestic courts. [1444]

The court's position is based on the application of Section 6(6)(c) of the Constitution, which renders the provisions of Chapter II, containing social rights including health, unenforceable in Nigerian courts. This approach is justified by arguments of limited resources and the progressive realization of social rights, contrary to international human rights law. [1445] However, opportunities exist to bypass the effect of Section 6(6)(c) through national laws that

[1440] See Chapter 5 and 6.
[1441] Notwithstanding the jurisprudence of civil and political rights, there are challenges in the implementation and enforcement of civil and political rights in Nigeria. See. S Ebobrah 'The future of economic, social and cultural rights' (2007) 1 *Review of Nigerian Law and Practice* 109 118; S. I. Nwatu 'Legal Framework for the Protection of Socio-Economic Rights in Nigeria' (2011-2012) 10 *Nigerian Juridical Review* 4.
[1442] CA Odinkalu, *supra* note 694 at 209.
[1443] Ibid at 218.
[1444] *Peter Nemi v. Attorney General of Lagos State* (1996) NWLR (part 452) 42.
[1445] Section 17(3)(c).

signal the state's commitment, although these attempts have been feeble thus far. [1446] In India, a communal reading of civil and political rights has been interpreted to give effect to socioeconomic rights, recognizing their interdependence and interconnectedness.

The comparative analysis of the collective application of the right to health through policies in India and South Africa reveals challenges and opportunities for advancing the right to health through collective action[1447]. Courts are reluctant to intervene if a government policy exists that is seen as a fair means of progressively realizing the right to health, even if individuals do not receive the associated benefits. Furthermore, the diversity of judicial institutional structures and mechanisms makes it difficult to assume universal incorporation of apex court decisions into lower court decisions. While court decisions have the potential to redistribute resources and introduce significant policy changes, they may also impact the incentives of policymakers in resource allocation, potentially neglecting the needs of the most vulnerable in a society.

In Chapter five, my thesis analyses the capacity of Indian courts to adjudicate health policies that violate justiciable civil and political rights to life. By showcasing the effectiveness of non-justiciable fundamental objectives and crafting remedies to achieve those objectives, the thesis demonstrates that Nigeria can achieve similar objectives regardless of the status of the right to health under its Constitution. My thesis highlights the potential for leveraging different approaches to socioeconomic rights recognition and realization based on a country's unique social, cultural, institutional, and historical backgrounds.

I argue that Nigeria can learn from India and South Africa's judicial attitudes towards the right to health in addressing maternal challenges. Adopting a holistic and intersectional approach, with an empowered judiciary, can play a significant role in realizing social rights, including maternal justice. The interpretation of constitutional provisions, bypassing limitations, and recognizing the interdependence of rights are important steps. While challenges exist, leveraging different approaches and lessons from other jurisdictions can contribute to the advancement of the right to health in Nigeria, improving the well-being of women, and reducing maternal mortality.

[1446] Section 17(3)(d).
[1447] See Chapters 5 and 6.

### 7.1.5 Discrimination in access to healthcare services for women

The discrimination in access to maternal healthcare services in Nigeria, influenced by legal status, cultural and religious norms, and institutional structures, violates the equality provisions of international and national statutory provisions. [1448] Chapter 3 explores the problem of maternal mortality as a central issue in the struggle for women's equality in Nigeria. It establishes that women face discrimination in the exercise of their sexual and reproductive rights, which sometimes lead to maternal deaths, despite the existence of numerous national and international treaties addressing women's sexual agency.

Discrimination affects certain groups of women, particularly the poor, rural, and other vulnerable women, impeding their access to healthcare services and significantly impacting their physical, psychological, and mental health.[1449] To address these disparities, the government should adopt a comprehensive approach that caters specifically for the unique needs of these marginalized groups. Additionally, legal restrictions on abortion and the stigma attached to contraceptives and unwanted pregnancies also infringe upon women's right to sexual and reproductive rights, pushing them towards unsafe practices and making unsafe abortion a leading cause of avoidable maternal death in Nigeria.

I examine in Chapter 3 the economic, religious, cultural, and geographical factors contributing to disparities in the maternal mortality ratio across different regions of Nigeria. I critically analyze the extent to which these factors violate both national and international human rights standards. By uncovering the underlying causes of these disparities, the chapter emphasizes the urgent need for targeted interventions and policy reforms to address the systemic challenges faced by pregnant women in various regions of the country.

The discrimination and barriers faced by women in accessing maternal healthcare services, along with the economic factors exacerbating these issues, require constitutional obligations to be imposed on the government to remove these barriers and provide accessible, culturally

[1448] Chapter three examines the several factors affecting women autonomy over their sexual and reproductive rights including maternal health.
[1449] R Cook, B Dickens & M Fathalla *Reproductive health and human rights: integrating medicine, ethics, and law* (2003) 398.

acceptable, and quality maternal health services. By addressing these issues comprehensively, Nigeria can work towards reducing maternal mortality rates and ensuring the fulfillment of women's sexual and reproductive rights. I highlight the discriminatory practices and institutional structures that impede women's access to maternal healthcare services in Nigeria. By addressing legal restrictions, stigma, economic barriers, and regional disparities, the government can take significant steps towards ensuring equality and improving maternal health outcomes. The findings underscore the urgent need for targeted interventions, policy reforms, and the enforcement of constitutional obligations to provide accessible and quality maternal health services that meet the unique needs of all women in Nigeria.

### 7.1.6 Culture and Maternal Health in Nigeria

Addressing the role of culture, particularly harmful customary and religious practices sanctioned by constitutional provisions as customary laws, is crucial for an effective policy framework for maternal health in Nigeria. Chapter 4 delves into the coexistence of different legal systems, such as customary law and Sharia law, which interpret culture differently in the Southern and Northern regions of Nigeria, respectively. This has significant implications for state policies and often negative consequences for women and girls, especially within rural communities. [1450]

The operation of international human rights instruments and mechanisms to address the cultural aspects of maternal health is uncertain due to the lack of political will and constitutional restrictions that uphold these cultural practices in Nigeria. The evident incapacity to challenge discriminatory provisions, including the rejection of gender bills by the National Assembly[1451], perpetuates the denial of sexual and reproductive health rights, thereby reinforcing institutional subordination of women. [1452] The power structures controlling women's sexuality and reproduction are deeply rooted in societal norms, making legal reforms essential at both federal and state levels to identify and rectify discriminatory cultural and

[1450] Lila Abu-Lughod, "Do Muslim Women Really Need Saving? Anthropological Reflections on Cultural Relativism and its Others" (2002) 104:3 *American Anthropologist* 783-791.
[1451] Yomi Kazeem, "Nigerian lawmakers voted down a women equality bill citing the bible and sharia law" (20 April 2022), online: https://qz.com/africa/639763/nigerian-lawmakers-voted-down-a-women-equality-bill-citing-the-bible and-sharia-law/.
[1452] Julie Ada Tchoukou, "Religion as an ideological weapon and the feminisation of culture in Nigeria: a critical analysis of the textuality of violence through the legal regulation of child marriages" (2020) 24:10, 1525.

religious practices such as child marriage, female genital mutilation (FGM), and purdah, all of which significantly contribute to maternal mortality in Nigeria. In Chapter 4, I explore the limitations of the CRA and CEDAW which hinder the realization of women's rights, particularly in the context of maternal health and how constitutional provisions sanction these practices. To promote women's health and rights, the thesis advocates for a constitutional reform of the legislative competence to address multiculturalism and achieve substantive equality through reforms in cultural and religious laws.

The coexistence of different legal systems and the use of culture by policymakers to perpetuate discriminatory provisions hinder the implementation of maternal rights within communities. To overcome these challenges, legal reforms are necessary to identify and rectify discriminatory cultural and religious practices that contribute to maternal mortality. By addressing these issues, Nigeria can strive towards achieving equitable and improved maternal health outcomes for all women.

### 7.1.7 Regional disparities in the access to maternal health services

Regional disparities in access to maternal health services in Nigeria, particularly between rural and urban areas and the Southern and Northern regions, are influenced by complex social, economic, religious, cultural, and geographical factors. Chapter 3 extensively explores these factors and establishes their impact on the maternal mortality ratio in different regions of the country.[1453] Women across regions face discrimination based on various factors. Poor women experience differential treatment due to their socioeconomic status, while Northern Muslim women are affected by Islamic obligations that influence their decision-making power, including choices related to reproductive health. These regional disparities in the provision of social amenities, infrastructure, and maternal health services contribute to differential harm experienced by women in different regions. In rural areas, where healthcare facilities and professionals are inadequate, and financial difficulties pose barriers to access, there is a higher maternal death rate. This disparity directly infringes upon the human rights of pregnant women to access healthcare, which often lead to complications and avoidable deaths.

[1453] See Chapter 3 above.

The Nigerian government has neglected its responsibilities towards maternal health, resulting in a significant development gap between urban and rural regions. Despite the country's abundant natural resources, millions of pregnant women continue to die daily in avoidable circumstances. The government's failure to address structural inequalities, implement transparency measures, promote gender equality, and allocate adequate financing have perpetuated this disparity. The absence of rights-based laws and policies further exacerbates the situation. Chapter 3 critically examines the economic, religious, cultural, and geographical factors that contribute to disparities in the maternal mortality ratio across rural-urban and Southern-Northern regions of Nigeria. It assesses the extent to which these factors violate national and international human rights standards. By uncovering the underlying causes of these disparities, this chapter underscores the urgent need for targeted interventions and policy reforms to address the systemic challenges faced by pregnant women in different regions of the country.

In conclusion, this thesis highlights the significant impact of regional disparities on access to maternal health services in Nigeria. It identifies the complex interplay of social, economic, religious, cultural, and geographical factors that perpetuate these disparities. The thesis emphasizes the urgent need for interventions and policy reforms to address these challenges and ensure equitable access to maternal healthcare across all regions of the country. By understanding and rectifying the underlying causes, Nigeria can work towards reducing maternal mortality and upholding the human rights of pregnant women.

## 7.2 Recommendations

Having considered the need to adopt an intersectional approach as well as the role of the constitution in the attainment of reproductive justice in the country, this thesis offers a number of recommendations. The recommendations if implemented will ensure that different aspects of women’s rights are addressed, especially as they affect different groups of women particularly the poor marginalised who bear greater burden of social inequality. This thesis makes specific and general recommendations. It identifies the constitutional, statutory and judicial recommendations required for government institutions and organisations to effectively tackle the high maternal deaths in the country.

### 7.2.1 Constitutional and Statutory recommendations

This thesis presents a series of robust and compelling recommendations to effectively address maternal mortality in Nigeria. These recommendations, grouped under different subheads, cover crucial aspects that need urgent attention. First and foremost, constitutional amendments are vital to protect and uphold women's reproductive rights as justiciable and enforceable rights. By recognizing and affirming these rights within the constitution, the government can create a strong legal framework to safeguard maternal health. The vital process of domesticating international treaties is imperative to synchronize national laws with global human rights standards. This necessitates the integration of pertinent provisions into domestic legislations, ensuring their robust implementation, and holding the government accountable for fulfilling its obligations. It also entails creating an enabling environment for NGOs to operate freely and contribute significantly to the advancement of human rights and justice.[1454] Additionally, the positive provisions outlined in the National Health Act of 2014 should be fully implemented to enhance the quality and accessibility of maternal healthcare services across the country.

Moreover, judicial reforms are crucial for advancing reproductive justice. By empowering the judiciary to play an active role in enforcing social and economic rights, particularly the right to maternal healthcare, the courts can contribute significantly to reducing maternal deaths. This requires a shift from narrow interpretations and exclusions to a more inclusive and progressive approach that considers the intersecting factors impacting women's access to healthcare services. Adopting these comprehensive recommendations encompassing constitutional amendments, domestication of rights, implementation of the National Health Act, and judicial reforms, Nigeria can make substantial strides in addressing maternal mortality. These measures will contribute to the realization of reproductive justice and the overall well-being of women, especially those who are marginalized and bear a disproportionate burden of social inequality.

[1454] C Ngwena & E Durojaye (eds) 'Strengthening the protection of sexual and reproductive health and rights in the African region through human rights: an introduction' in C Ngwena & E Durojaye (eds) *Strengthening the protection of sexual and reproductive health and rights in the African region through human rights* (2014) 4.

### 7.2.2 Legislative Amendments

Legislative amendments play a pivotal role in Nigeria's federal system, where different levels of government hold legislative responsibilities that can have detrimental effects on women's health and maternal well-being. This is particularly concerning as certain legislative provisions have perpetuated discrimination against women. Without crucial legislative amendments, especially at the national level, the realization of recommendations aimed at improving women's health will face significant challenges. Therefore, it is imperative for the federal legislature in Nigeria to undertake specific amendments to advance women's rights and address the pressing issues surrounding maternal health. The following amendments are therefore required from the federal legislature in Nigeria.

### 7.2.3 Amendment seeking to make the right to health justiciable

In order to address the scourge of maternal mortality in Nigeria and to make sexual and reproductive rights available and accessible to pregnant women, this thesis recommends that the relevant provisions of the Constitution need to be amended to make the right to health and access to healthcare justiciable under the 1999 Constitution. This will show Nigeria's commitment to keep its international law obligations arising from ratified but undomesticated treaties such as the ICESCR, CEDAW, and implementation of African Charter and the Maputo Protocol. This is a way to ensure that Nigeria is held legally accountable within its Constitution. This will serve to also eliminate the barriers to litigating health rights imposed by the non-justiciable provisions of Section 6(6)(c) of the Constitution in relation to the provisions of Chapter II of the 1999 Constitution. As discussed in Chapter Four and Six of the thesis, the mere justiciability of the right to health does not automatically guarantee adequate protection of the rights as seen in several developed countries. When the right to health is justiciable under a constitution, citizens are able to hold governments accountable by actions against it for failure to provide both preventive and emergency services that women require.[1455] This will introduce the needed rights-based approach to maternal health, in resolving the disturbing maternal mortality menace in Nigeria.[1456] In addition, making the right to health justiciable empowers individuals and groups by providing a framework for accountability on the part of the government as it is the case in South Africa. A justiciable social right has enabled the courts

[1455] CRR, 'Broken promises" *supra* note 8 at 58.
[1456] N Daniels *Just health: meeting health needs fairly* (2008) 323.

to make the state accountable for its socioeconomic policies.[1457] Nigeria has great lessons to learn from the South African constitutional example.

### 7.3.4 Domestication of international human rights treaties

To achieve the reforms suggested in this thesis, international human rights treaties that deal with right to health and other socioeconomic rights which are determinants of the right to health like the ICESCR, must not only be ratified but also domesticated in Nigeria in accordance with the provisions of Section 12 of the 1999 Constitution. The refusal to domesticate these treaties has hampered the ability of citizens to take the advantage of mechanisms of the treaties to seek justice before Nigerian courts. Although, two treaties which affect the right to health, i.e. the African Charter[1458] and the Child's Rights Act,[1459] have been domesticated in Nigeria, the domestication of ICESCR, CEDAW and the Maputo Protocol will go a long way in showing renewed commitment of the Nigerian governments to the promotion and protection of the rights of women, which when violated, may result in preventable maternal death. One of the major challenges for the implementation of this recommendation is the insufficient institutional framework and capacity to implement these treaties. The Nigerian government lack the resources and infrastructure necessary to effectively implement these treaties, including adequate legislation, monitoring and reporting mechanism, and judicial systems that are equipped to enforce the treaties' provisions. Addressing these challenges will require a multifaceted approach that involves creating awareness, strengthening institutional capacity, and addressing cultural barriers.

### 7.3.5 Constitutional increase of quota for women's participation in governance

Recognizing the political under-representation of women as a crucial element of the intersectional approach, this thesis emphasizes the need for urgent action to address this persistent issue. In Nigeria, women continue to be excluded from key decision-making processes, resulting in low representation in legislative and policy-making bodies. Cultural and religious justifications further perpetuate this gender imbalance, evident in the infamous

[1457] Ngcobo, Sandile, South Africa's Transformative Constitution: Towards an Appropriate Doctrine of Separation of Powers' (2011), 22:1, *Stellenbosch Law Review* 37-49, 46.
[1458] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, laws of the Federation 2004.
[1459] Child's Rights Act 26 of 2003 (*supra*).

remarks by then Nigeria's President Buhari's dry but telling humour that women "belong to the other room", that is the bedroom. This comment undermines women's roles and participation in governance.[1460] To effectively implement the recommended reform strategies for achieving gender equality, a constitutional expansion and inclusion of women in parliamentary bodies must be prioritized. This entails a constitutional amendment by the Nigerian legislature to establish gender quotas that can rectify the current inequitable system.[1461] Additionally, revisiting rejected gender bills and embracing on a policy of gender mainstreaming will facilitate the appointment of women to executive, judicial, and other state institutions. However, addressing deep-rooted patriarchal system and cultural attitudes that hinder women's participation necessitates comprehensive efforts to shift societal norms and practices, alongside legislative support, resource allocation, and institutional backing to create an enabling environment for women's political engagement. By rectifying the under-representation of women, Nigeria can foster more equitable societies, strengthen democracy, and ensure a more inclusive policy dialogue on issues that profoundly impact women's lives.

### 7.3.6 Preventing maternal death through civil and political right to life

As discussed in Chapter Five, under international human rights instruments as well as the national constitution, the right to life remains the most important right upon which several other rights depend, including the right to health. The 1999 Constitution guarantees these rights. Protecting this right suggests that the Nigerian government must not only prevent arbitrary and unjustified taking of lives, but also adopt positive processes to guarantee the right to life as well as taking steps to prevent unnecessary maternal mortality in the country. However, the express provision of the section fails to capture circumstances where acts and omissions such as where the state fails in their positive duty, which result to death such as in the case of maternal health. Although a significant aspect of this recommendation is the central role of the judiciary in using judicial powers to interpret human rights as interrelated; creating a link through judicial reasoning ensures interdependence and accord legal protection to women. Despite such needed intervention, a constitutional amendment to include such provision will empower the courts to adopt an interpretation of the right to life to include failure

[1460] Sede Alonge, "My wife belongs in the kitchen'- President Buhari isn't helping Nigeria" (17 October 2016).
[1461] J Nedelsky, *supra* note 22 at 47.

of governments to provide facilities and measures that lead to maternal death, as obtainable in the Indian jurisprudence.

### 7.3.7 Repeal all gender discriminatory laws and eliminating gender stereotypes

Women in Nigeria are regarded as subordinate and as having a second-class status in relation to men. They are expected to seek permission in decision making even when it relates to their sexual health. Some cultural practices and religious tenets also play a key role in perpetuating the age-long subjugation and deprivation of women. Different comprehensive reports, studies and investigation have been conducted on the various discriminatory laws affecting women's rights in Nigeria.[1462] I believe that the different tiers of government in the country should make concerted efforts to amend, repeal, and make policies to eliminate specific laws and policies that contribute to denial of women's reproductive autonomy. In Nigeria, the violation of women's right to equality is perpetuated by various laws, including customary, religious, and state practices. These practices, such as purdah and the preference for male children, are deeply ingrained in the society and prevalent across different regions. In the northern part of Nigeria, the cultural practice of multiple pregnancies by a single woman further exacerbates the challenges faced by women in attaining gender equality. Such amendments are compliant with the country's international obligations under several international human right treaties, that states should eliminate discriminatory laws that affect women and girls.

An essential requirement of the CEDAW is the obligation it imposes on state parties to eliminate harmful traditional practices based on the idea of the inferiority or the superiority of either of the sex, or on stereotyped roles for men and women.[1463] These stereotypes are evident in the various forms of discrimination experienced by women within personal laws restricted to the private sphere,[1464] and which have been identified by this thesis. To address health inequality, these stereotypes must be tackled to ensure an improvement in maternal health and negative consequences on women's reproductive autonomy. Effective sensitization is required by the government to achieve this standard, and to complement this is the domestication of

[1462] Nigeria's 6th Periodic Report of State Parties to CEDAW, CEDAW/C/NGA/6, PP 13 & 19.
[1463] Article 5(a).
[1464] See L. Forman and J A Singh, The Role pf Rights and Litigation in assuring more equitable access to healthcare in South Africa" in the right to health at the Private/public divide: A global comparative study (Cambridge: Cambridge University Press) (2014).

relevant women's rights treaties and law such as the CEDAW and the CRA. This is to give voice and empower individuals, minority and vulnerable groups, and for the public to challenge violation of these rights.[1465]

### 7.4 Reform of division of healthcare responsibilities among tiers of government

An important aspect of the reforms needed to address maternal health is the appropriate delineation of primary healthcare responsibility under the Constitution. As a federal state, division of responsibilities for health is a concurrent matter between the federal and state governments. However, while the Constitution provides for the powers and responsibilities of each tier of government, it is silent over specific powers and responsibilities for health care, especially maternal health care. The omission is not surprising given the fact that the Constitution envisages health care as a mere objective to be aspired to as provided in s.17(3)(d) (1999). Since there is no immediate obligation of the different levels of government, there is no obvious need to clarify the nature and extent of their responsibilities.[1466] This omission has resulted in overlaps and uncertainty regarding the division of these obligations, which has enabled each level to abdicate their healthcare duties and responsibilities. I therefore argue that amending the various provisions of the constitution relating to allocation of responsibilities of the different tiers of government will positively address the maternal health challenges. I am by no means suggesting that merely addressing the responsibility issue is likely to eradicate high maternal death ratio, national and state policies must be holistic in its approach to be effective. To truly address the maternal health, the state must do more than elimination of barriers to maternal health to addressing several regulatory gaps that could potentially compromise the health of pregnant women. The different tiers of government must collaborate to set national policy strategies and goals for eradicating maternal mortality in the country, including identifying which tier has clearly defined responsibility for maternal health.

### 7.5 Evolving Judicial Strategies for Proactive Decision Making

Recommendations aimed at establishing a proactive judiciary and ensuring the protection of socioeconomic rights, particularly the right to health, are crucial for improving maternal health

[1465] S Williams 'Democratic theory, feminist theory, and constitutionalism: the challenge of multiculturalism' in B Baines, D Barak-Erez & Tsvi Kahana *Feminist constitutionalism: global perspectives* (2012) 393.
[1466] CRR "Broken Promises" at 8.

outcomes in Nigeria. Drawing lessons from South Africa where principles of reasonableness, minimum core, and substantive equality, indivisibility and interdependence of right have been embraced, Nigerian courts must adopt a proactive approach to interpreting laws and adjudicating disputes relating to constitutional violations. Overcoming the challenges of justiciability and non-domestication of relevant treaties, the courts possess the institutional capacity and legitimacy to make pronouncements on socioeconomic rights and maternal health as the case in India. By following the Indian public interest litigation and broader interpretation of civil and political rights as well as South African approach, the courts can effectively uphold the right to equality, non-discrimination, dignity and right to life of women in the context of maternal health. Public interest litigation, supported by the Fundamental Rights Enforcement Procedure (FREP) Rules 2009 made by the Chief Justice of Nigeria pursuant to section 46(3) of the Constitution, can be a powerful tool to hold the government accountable for violations and ensure the realization of citizens' rights[1467]. To achieve a proactive judiciary, initiatives such as judicial training and education, adequate funding for infrastructural development, and safeguarding judicial independence are essential. These reforms, accompanied by the strategic involvement of civil society organizations[1468], will promote judicial activism, encourage the protection of socioeconomic rights, and ultimately advance maternal health in Nigeria.

### 7.6 Applying intersectionality theory to maternal health

As stated earlier in this thesis, women experience different forms of discrimination depending on their social status and identity, and reforms must target these specificities to address the regional maternal mortality disparities in Nigeria. Maternal health in Nigeria must be approached from an intersectional perspective considering the different experiences of women across the regions in the country. The differential harm resulting from the present approach to maternal health amounts to a violation of several human rights guaranteed by the Constitution. An intersectional perspective is thus required in the conception of rights and mechanisms to address the violation, development and implementation of maternal health policies in Nigeria. An intersectional approach views the different rights not from the mere point of view of negative duties, but rather as those which states must take positive steps to actualise albeit

[1467] C. Odinkalu, *supra* note 694 at 188.
[1468] Obiora Okafor, Modest Harvests: On the Significant (but Limited) Impact of Human Rights NGOs on Legislative and Executive Behaviour in Nigeria, (2004) 48 *Journal of Africa Law* 23.

progressively.[1469] It also helps us to recognise the interplay of multiple forms of discrimination against women that ultimately leads to preventable death.[1470]

Discrimination against pregnant women in Nigeria is determined by age, religion, language, socio-economic status, geographical location, birth, or other status. Nigerian governments both at the national and state levels must address the ways in which any instances of discrimination on other grounds affect women in a particular way.[1471] Addressing maternal mortality in Nigeria from an intersectional approach will not only address the discrimination that different women suffer within the healthcare settings, it will also help the state in designing region, status specific and equitable strategy to addressing maternal mortality[1472], thereby eliminating both remote and immediate causes of maternal deaths in the communities.

## 7.7 Essential Recommendations for Holistic Maternal Health Reform in Nigeria

While this thesis focuses on constitutionalizing maternal health as a right to health in Nigeria and socio-cultural factors impacting maternal health, there are several general recommendations that are required to holistically reform maternal health policies and regional disparities in the country. These recommendations include political prioritization of maternal health, increased funding for healthcare, and the removal of user fees. The sections will briefly discuss these recommendations and their importance in addressing the maternal health crisis in Nigeria. Future research can also explore ways in which these general recommendations can be engaged as instruments for realizing maternal health transformation in Nigeria.

### 7.7.1 Political Prioritization

Mere legislation cannot address maternal mortality without necessary commitments by the executive arm of government, especially where there is a need for budgetary priority for primary healthcare, building of infrastructure and institutions. It provides an important link and cohesion required for policy reforms and effectiveness. The Nigerian elites and political

[1469] S. Fredman *Human Rights transformed: positive rights and positive duties* (2008) 178.
[1470] M Dechka 'Is culture a taboo? Feminism, intersectionality, and culture talk in law' (2004) 16 *Canadian Journal of Women and the Law* 14, 16.
[1471] HRC General Comment No. 28, Equality of Rights between Men and Women (Article 3 ICCPR) UN Doc CCPR/C/21/Rev.1/Add.10 (29 March 2000) 30.
[1472] Alwazzan L, Rees CE. Women in medical education: views and experiences from the Kingdom of Saudi Arabia. (2016) 50:8 Med Educ 852-865.

class must treat the problem of maternal mortality as a national problem requiring urgent attention which requires legislative, executive and judicial collaborations.[1473] Beyond making laws addressing the lopsided division of responsibilities for maternal health that has resulted in all tiers abdicating their health responsibilities and formulating policies which the government have largely retained on paper. Nigeria governments at the state and local levels must increase budgetary allocation to health facilities especially for the poor and the rural residents. The disparity in maternal mortality across the regions in the country especially in the Northern regions of the country is a manifestation of the lack of political will on the part of the state governments of the region coupled with the national government's poor dispositions in this respect. The Nigerian governments must declare maternal health as a national health issue just as it did with HIV/AIDs, Ebola disease and Corona virus (Covid-19) pandemic. This will assist in bringing to focus the high rate of maternal mortality in the country and a need for reforms.

Nigeria's National Reproductive Health Policy and Strategy of 2001 replaces the 1994 Maternal and Child Health Policy when it became clear that the existing policy places greater emphasis on child health than maternal health.[1474] The new policy was developed to address a number of concerns, including the "unacceptably high levels of maternal and neonatal morbidity and mortality". The Nigerian government therefore must put in place legislative, executive and institutional measures required to give maternal health a holistic solution. My position is that both national and state governments understand the peculiarities of their regions regarding women's health and have the means to address maternal mortality and develop policies in their regions without adverse implications or interference with their constitutional responsibilities.

### 7.7.2 Removal of User Fees

The introduction of user fees in public facilities in Nigeria constitutes serious barriers to obtaining quality maternal health care, resulting in women either not seeking care or being denied essential services when they are unable to pay the accompanying fees.[1475] Sadly, some

[1473] J Shiffman & S Smith 'Generation of political priority for global health initiatives: a framework and case study of maternal mortality' (2007) 370 *The Lancet* 1370-79.
[1474] CRR "Broken Promises" *supra* note 8.
[1475] CRR "Broken Promises" *supra* note 8.

women are detained for failure to pay for maternal healthcare services until they offset their medical bills, which further discourages women from seeking maternal care. The state health institutions seem oblivious of liability incurred under international obligations for ceasing medical treatments post-delivery and denying health services in the states owned facilities including during emergencies, for vulnerable poor women, and cases that point to this fact occur daily in such facilities. The introduction of user fees and its effect on poor uneducated and rural women, amount to discrimination against women because only women need maternal health. The United Nations recommends that states assess the gender impacts of revenue-raising measures, including user fees.[1476] The CEDAW Committee has also interpreted its discrimination provision to include a duty to eliminate such barriers, such as high fees that limit women's access to health-care services. It is recommended that user fees be eliminated in the government health facilities. Financial requirements and other economic challenges faced by women in seeking maternal health care especially poor women in rural areas, should be phased out.

### 7.7.3 Increased Funding for Healthcare

Nigeria, a significant stakeholder in the WHO, has committed to allocating a minimum of 15% of its national budget to healthcare, as outlined in the 2001 Abuja Declaration. This commitment reflects the country's dedication to improving healthcare services and addressing public health challenges.[1477] One of the obvious manifestations of improved political will to addressing the problem of maternal mortality is increase in the budgetary allocation to healthcare in general and maternal health in particular. In 2020, the Federal Government of Nigeria claimed that the required threshold remains mere aspiration for countries and a tall order. In 2021, Nigeria allocated an abysmal 4.5% up from 4.4% in 2020 to health, contrary to the African threshold. I argue that an increase in the budgetary allocation to the health sector, backed by effective implementation, will improve general primary healthcare and maternal health outcomes for women, and be consistent with Nigeria's constitutional obligations. Greater funding can facilitate enhanced access to health products and services for women. The state must take on the responsibility of refining its regulatory framework to provide a

[1476] United Nations, Financing for gender equality and the empowerment of women, Report of the Secretary General, para. 88(d), U.N. Doc. E/CN.6/2008/2 (2008).
[1477] Abuja Declaration, 27 April 2001 OAU/SPS/ABUJA/3.

comprehensive approach to maternal health in Nigeria. Without adequate commitment through increased budgetary allocation to health of women, maternal mortality will remain a public health challenge.

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