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Litigation: A Strategy for Enhancing Accountability in Women Reproductive Health Right in Nigeria

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Abstract

High maternal mortality ratio serve as objective indicator to the poor condition of women's health in any country and point to multiple violations of wide range of human rights. Reproductive health care is very fundamental to a women's wellbeing, since a major burden of diseases in women are related to their reproductive functions, and the way in which society treat or mistreat women. Although, regional and international human rights mechanisms are increasingly framing maternal mortality as human rights issues and crafting laws and commitments that take this framework into accounts, far too many preventable maternal deaths and injuries continue to occur, Nigeria continues to have a high maternal mortality ratios despite recent statistics that point to global reduction in the number of maternal deaths and maternal mortality ratio. This work contends that Nigeria government and other actors should be held accountable for failing to implement human rights obligation and making safe motherhood reality for women in Nigeria. It advances litigation as a key strategy. It assesses how international, regional and national human rights laws and initiatives could be developed to promote accountability vis-a-vis the role of national human rights institution in ensuring accountability for poor maternal health outcomes, using case law from other jurisdiction, it concludes by reiterating that governments must implement pertinent human rights obligations in order to effectively address the prevalence of maternal mortality and morbidity in Nigeria territory.

Keywords*: litigation, reproductive health, accountability, childbirth, maternal mortality, morbidity*

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Introduction

Complications with pregnancy and childbirth constitute a major cause of mortality and morbidity for women in Nigeria. Since the adoption of the Programme of Action of the International Conference for Population and Development, 1994 and the Platform for Action of Beijing Declaration, 1995 governments and civil society advocates can claim many achievements in working towards the ultimate goal of reproductive health and rights of women.[1] Even though progress might have been made has been uneven as maternal mortality is still very high in developing countries like Nigeria, therefore more remains to be done in the context of the post-2020 development agenda and the new Sustainable Development Goals that is succeeding the Millennium Development Goals.

Sometime in 1993 World Bank report ranked maternal mortality as the primary health problem in young adult women in developing countries, accounting for 18% of the total disease burden Women who die in the prime period of their lives, as mother's whose deaths have major health and social impacts on their families. Maternal Mortality should be viewed as only the tip of the iceberg of maternal morbidity and acute or chronic suffering. For every maternal death, there are many women who survive serious illness with continued suffering and incapacity such as through problems associated with obstetric fistulae. A woman in Nigeria (emphasizes mine) goes through the journey of pregnancy and childbirth burdened with a heavy luggage of social injustice, which she accumulated as a girl not considered being her brother is equal as a woman denied control of her fertility, and as a pregnant mother whose interest as a woman are considered by her family, community and even healthcare providers to be secondary to the interest of her foetus.[2]

Common direct causes of maternal mortality are hemorrhage, eclempsia, high blood pressure, obstructed labour, infections, unsafe abortion.[3] These direct factors are mostly sustained by underlying political and socio-economic factors which create obstacles that limit women's access to maternal healthcare.[4] Obstacles such as, high user fees and informal fees, bad roads, long distances and lack of reliable transportation to hospital, inadequately equipped and staffed hospitals generate circumstances that daily expose pregnant women to unnecessary disability and death[5]. Additional obstacles such as inadequate access to family planning and restrictive laws on abortion.[6] Again, cultural belief also increase women's expose to maternal mortality and morbidity. These obstacles constitute or point to violation of human rights guarantees. Although regional and international human rights laws and mechanisms are increasingly framing maternal mortality and morbidity as human rights issues far too many preventable deaths and injuries continue to occur in Nigeria. As it stands, Nigeria continues to have one of the highest level of maternal mortality in the world in spite of recent statistic that point to global reduction.[7]

[1] N.I. Aniekwu, Reproductive Health Law. A jurisprudential Analysis of Gender Specific Human Rights for the African Region, 2011 Benin City, Ambik Press 2011.
[2] World Bank Development Report: Investing is Health (New York: Oxford University Press, 1993, p. 223.
[3] Onyema Afulukwu Eruchalu, Accountability for Non-fulfillment of Human Rights Obligations: - A key strategy for Reducing maternal mortality and disability in strengthening
[4] Ibid
[5] Ibid
[6] See S. 220-230 of the Criminal Code that criminalizes abortion except to save the life of the mother in Nigeria
[7] WHO, Trends in Maternal Mortality: 2010-2029 available at: http://apps.who.int/risi/bitsdream/10665/44874/1/9789241/56363eng.pdf access 29th November 2022.

According to WHO 2022 recent statistics, maternal mortality ratio in the world corresponds to ratio 216 maternal death per 100,000 live births and to a 1-in-180 time risk for pregnancy related death for each girl entering her childbearing years.[8] In all, South Sudan is the top country by maternal mortality ratio in the world. As at 2022, South Sudan ekes out just above Chad for the world's highest maternal mortality rate of 1,150 death for every 100,000 live births[9]. While the top 5 country in respect of this includes Chad, Sierra Leone, Nigeria and Central African republic. No doubt, high maternal deaths that occurred in 2022 took place in developing world of sub-Sahara Africa and southern Asia. However, maternal deaths in the sub-region were HIV related. According to WHO's findings, sub-Saharan Africa accounts for 62% of global maternal death attributed to HIV/AIDS of which Nigeria is among these countries, and this shows the magnitude of the problem.[10]

It is not just the loss of women's lives that is the outcome of failure for Nigerian government to provide affordable, accessible and quality health care services for women to assure safe motherhood, with each maternal death, many more women are rendered seriously ill and often permanently disabled. These injuries which include damage to reproductive organs, severe anemia, postpartum disability (such as obstetric fistula) chronic pain and infertility, carry serious physical, emotional and mental health, social and economic consequences for affected women and jeopardize the well-being of their children and other family members. There are also economic implications at the individual family as well as wider community levels.

Meaningful control over whether to become a mother is absolutely fundamental to the realization of women's reproductive health and socio-economic wellbeing. A human right to reproductive health means little if women with unwanted pregnancies are implicitly compelled to either become mothers or to have recourse to unsafe abortion services.[11] Reducing Nigeria's high Maternal Mortality Ratio requires holding accountable all actors who have corresponding obligations to preserve women's health and human rights. The government which is the primary duty bearer of human rights obligations under national, regional and international laws has a three-fold legal obligation to respect, protect and fulfill all constitutional and human rights provision.[12] Generally, States' obligation to respect human rights requires them to refrain from interfering with its enjoyment. The obligation to protect imposes a duty on the States to take steps to prevent private actors from interfering with the enjoyment of human rights guarantee. While the obligation to fulfill and compels state to undertake legislative, judicial, administrative and other appropriate measures to ensure the realization of human rights.[13] Impunity for the non-fulfillment of human rights commitment by Nigerian government sustains preventable maternal mortality and morbidity. Therefore, litigation on violations is an important strategy for reducing these deaths and injuries, in Nigeria maternal health care system as it gives room and promote accountability

[8] Maternal Mortality – An Overview/Science direct available at .sciencedirect.com accessed 9th November 2022
[9] Ibid
[10] The triple threat of pregnancy, HIV Infection and malaria available at <bmcpregnancychildbirth.biomedcentra.com> accessed 9th November, 2022.
[11] Rebecca J. Cook, Bernard M. Dickens, Mahmond I. Fathalla, Reproductive Health and Human Rights: Integrating Medicine, ethic and law (Oxford 2003), 23.
[12] Onyema Afulukwu-Eruchalu, "Accountability for non-fulfillment of Human Rights Obligation: A key strategy for reducing maternal disability in sub-saharan African, in strenghtening the Protection of Sexual and Reproductive Health and Rights in African Region, ed. Charles Ngwena & Ebenezer Durojaye (South Africa: PULP, 2014).
[13] Onyema Afulukwu-Eruchalu, "Accounting for Maternal Health Care and Services in Nigeria" Centre for Reproductive Rights, in International Federation of Gynaecology and Obstetrics, available at http://onlinielibraryWiley.com/doi/10.1002/ijgo.12108pdf accessed 29th November 2022.

by government institutions. Thus the principal indicator of mortality amongst women of reproductive age is the maternal mortality ratio which is the number of maternal deaths per 100,000 live births. In 2021 multiple Indicator Cluster by UNICEF, on 16th August 2022 result reveal that Nigeria made little progress in some sectors. Child mortality decreased from 1 in 8 to 1 in 10 children (Mics 2021).[14] Notwithstanding, there are huge urban/rural and zonal disparities on the maternal mortality ratio. For instance, it has been shown that maternal mortality is more and higher in the rural area than in the urban area. However, according to the Programme of Action of the ICPD, all births should be assisted by trained persons, preferably nurses and midwives, but at least trained birth attendants.[15] The underlying causes of maternal mortality and morbidity should be identified and attention should be given to the development of strategies to overcome them. Programmes and education to men's support for maternal health and safe motherhood should be developed.

What is Reproductive Health and Reproductive Right?

Reproductive health has been defined as:

> a state of complete physical, ,mental and social well-being in all matters relating to the reproductive system and to its functions and process, reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safety through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.[16]

Reproductive Rights

Proceeding from the definition of reproductive health in paragraph 72 of the ICPD:

> reproductive rights are defined as: certain human rights, that are already recognized on national laws, international human rights and other relevant United Nations documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination coercion and violence as expressed in human rights documents, the exercise of this right; they should take into account the

[14] 2021 multiple Indicator Cluster Survey – Unicef: available at www.unicef.org>nigeria>reports
[15] International Conference on Population and Development ICPD available at www.unfpa.org accessed 29th November 2022.
[16] International Conference for Population and Development Programme of Action, 1994 para 7.2 see also the platform for Action and Beijing Declaration, 1995 para 94.

> needs of their living children and their responsibilities towards the community.[17]

Reproductive rights include:

> The right of all couples and individuals to decide freely and responsibly the number and spacing of their children with accessible and available means of contraceptive; the right to have the information, education and means to do so; the right to safe abortions under specific circumstances and conditions; the right to be free from violence, the right to be protected from HIV/AIDS and other STDs affecting the sexual and reproductive health of individuals and the right to safe motherhood.[18]

An Insight into Health Care in Nigeria

Nigeria has been said to operate a three tier national health care system. Health and other related matters, fall under the concurrent legislative lists of the National and State House of Assembly with each state exercising control over health system development, organization and control.[19] Under the constitution both the National and State Houses of Assembly have authority to review and pass legislative bills on matters relating to health and various houses committees facilitate the passing of legislation. Through these structures, various interest groups can lobby for the passage of legislation of interest. All three tiers of government are involved in health delivery.[20] Primary health care is basically the responsibility of the local government councils and communities, while the state and federal governments provide secondary and tertiary health care and facilities. The National Council of Health, chaired by the Minister of Health and comprised of the Minister of Health, Minister of State for Health and State Health Commissioners is responsible for the development of national guidelines and the implementation of the National Health Policy.

Nigeria participated actively at the ICPD and Beijing Conferences, as well as in many of the follow-up review Conferences by the United Nations, including the Beijing + 5 in 2000, ICPD + 10 in 2004, the ICPD + 15 in 2009 and the Beijing + 10 reviews. Nigeria was among the 179 nation states that approved the historic programme of Action which emanated from the ICPD. By being a signatory to the above documents, the Nigerian State is obliged to incorporate and implement the provisions of international and regional instruments and conventions that protect women's reproductive health. The issue here is, to what extent has Nigeria comply and implemented the provisions of these instruments and conventions?

Assessment of Maternal Mortality in Nigeria

Nigeria has one of the highest maternal deaths in the world. According to UNICEF, the latest figures in 2021 show a maternal mortality rate of 576 per 100,000 live births, and it is the fourth highest on earth.[21] Each year, approximately 262,000 babies die at births and it is the world second highest national total. These, infact are even underestimated since mortality

[17] Ibid
[18] Ibid
[19] N.I Anieku, Reproductive Health Law: A Jurisprudential Analysis of Gender Specific Human Rights for the African Region., University of Benin, 2011 p 84
[20] Ibid
[21] Situation of women and children in Nigeria UNICEF available at www.unicef.org>nigeria?situation accessed on 10th November 2022

figure as high as 3,000 occur in some areas without accurate civil registration system, while some are pregnancies complications which are life threatening requiring emergency obstetrics care.[22]

According to Statistics on 19th September 2019 from World Health Organization (WHO) in its report, trends in maternal mortality: 200-2017, every day in 2017, approximately 810 women died from preventable causes related to pregnancy and child birth. While between 2000 and 2017, the maternal mortality ratio (MMR) number of maternal deaths per 100,000 live births dropped by about 38% worldwide.[23] In all, 94% of all maternal death occur in low and lower middle income countries, while maternal mortality is unacceptably high and about 295,000 women died during and following pregnancy related. The sub-Saharan Africa and southern Asia accounted for approximately 80% (254,000) of the estimated global maternal deaths in 2017. However, the overall maternal mortality ratio (MMR) in less developed countries declined by just under 50% by UNICEF Report.[24]

Be it as it may, Nigeria estimated to have adult life time risk of 1 in 29. However, statistics from the previous years showed that a woman in Nigeria had a 1 in 8 life time risk of dying in childbirth or from pregnancy related causes in 2016 but the recent result in 2021 reveal that some progress has been made, that is now 1 in 10 children in Nigeria.[25]

Though Nigeria made progress in meeting goal 5 of the Millennium Development Goals, it is quite insignificant when compared with the magnitude of the problem. In view of the Sustainable Development Goals that succeeded the MDGs, there is a wakeup call on the government and other stakeholder to take issues of women's reproductive health rights seriously to enable them go through pregnancy and childbirth successfully, especially in rural area of the country.

Causes of High Maternal Mortality in Nigeria

The causes of maternal mortality are usually medical, although social economic and cultural factors to a large extent could influence same. For instance:

1. Health system laws and policies that affect availability, accessibility, acceptability and quality of reproductive health services. Some examples of such laws obstructing women's access to health information and care, such as the criminalized abortion law; laws and practices that entrench subservient roles for women than brothers or husbands. Health systems laws and policies that restrict women's reproductive choices. Health practices that infringe on patient's privacy and confidentiality.

2. Underlying social, cultural, legal, economic and religious causes e.g. child marriage, poverty, ignorant illiteracy.

3. Child marriage, poverty, ignorant, illiteracy, gender inequality, harmful traditional practices that disinherited widows and the girl child etc. Other factors are delay in seeking help in problems related to pregnancy and child birth, lack of skilled personnel, poor health services, infrastructure and equipment, especially in rural areas and declining socio-economic status of Nigeria. The rights-based approach to

[22] Ibid
[23] Maternal Mortality World Health Organization – available at www.who.int>... detal access on 14th November 2022
[24] Number of maternity deaths word Bank. available at worldbank.org>SHMMR.DTHS
[25] 2021 MICS-Unicef available at www.Unicef.org?Nigeria>report accessed 25th November 2022

addressing the determinants of reproductive health issue to the context of maternal mortality in Nigeria is therefore imperative in the present circumstance.

Failure to fulfill human rights standards application to Maternal Mortality and Morbidity

Several human rights guarantees, such as the rights to life, health, equality non-discrimination and information are pertinent to safe motherhood.

United Nations and regional treaty monitoring bodies (TMBs) charged with interpreting these guarantees have developed their context to clarify States obligations.[26] These standards taken together constitute a yardstick for measuring the sufficiency of steps taken by States to reduce maternal mortality and morbidity. They impose legally-enforceable obligation on States for which they could be held accountable.

International, Regional and National Human Right's Framework on Reproductive Health Right

i. Right to Life

At the international level, states who are signatory have a legal obligation to protect the right to life guaranteed under the International Covenant on Civil and Political Rights (ICCPR).[27] In keeping with this obligation states parties are required to make necessary efforts to increase life expectancy which goes beyond their obligation to merely refrain from taking any action that would violate the right to life and instead imposes a positive compliance with relevant treaties have not only expressed concern about high MMR, but have highlighted their causes.[28]

TMBS have confirmed that the lack of access to emergency obstetric care and other reproductive health services escalates the risk of material death. They have also reiterated that barriers to access to reproductive healthcare, including costly treatment expenses with regards to pregnancy and poor access to antenatal services increase women's risk of Maternal Mortality and Morbidity.[29] They therefore mandated states to reduce maternal death rates by providing sufficient resource allocations, enhancing women's access to maternal healthcare services, providing skilled attendants during delivery, developing awareness, raising campaigns on the importance of family planning and providing antenatal care.[30]

At the regional level, the African Charter on Human and People's Rights (African Charter) and the protocol to the African charter on Human and People's Right guarantees the right to life and that every woman shall be entitled to respect for her life.[31] The African commission on Human and People's Rights (African Commission), charged with monitoring states'

[26] See International Covenant on Civil and Political Rights. International Covenant on Social, economic and cultural Rights and the Convention on the Elimination of all forms of discrimination against Women, the African Charters of Human and People's Rights, Protocol of the Rights of Women in Africa

[27] 31 Art 6 International covenant on civil and political rights.

[28] See Conclusive observations on the Human Rights Committee on Zambia para 18, UN DOC CPR/CZMB/CO/3, 2007.

[29] See conclusive observation of the Human Right committee on Mali, para 14, UN DOC CCPR/CO/77/MLI 2003; concluding observation of the CEDAW Committee on Burundi, para 36 UN DOC CEDAW/C/BDI/CO/4 2008

[30] Ibid

[31] Protocol to the African charter on Human and People's Rights on the Rights of Women in Africa at 4 (1) 32, 11 July, 2003. Art 4 African charter.

implementation of both the African charter and the African Women's protocol has expressed concern at the high occurrence of maternal death, for instance, in Nigeria has been mandated to adopt suitable measures to reduce maternal death.[32]

At the National level the constitution guarantees the right to life under chapter four, 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 of which he has been found guilty in Nigeria.[33] Therefore it is an injustice for a woman to die of a preventable maternal death when trying to bring another to life.

There is well-documented evidence to show that government have not taken adequate action to protect the right to life of women in this regard, a wide range of political and socio-economic factor as well as financial, institutional and infrastructural barriers such as long distances to hospitals, bad roads and a lack of reliable transportation, which they have a duty to address and which still contribute to preventable material deaths,[34] as a result Nigeria continues to account for a very high material deaths.

ii. Right to Health

The right to health is entrenched in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) article 12 of Convention on the Elimination of all forms of Discrimination against Women (CEDAW). The UN committee on economic, social and cultural rights (ESCRC) which oversees states compliance and implementation has elaborated that the right to health includes a right to maternal and reproductive health services, including access to family planning, pre- and post natal care, and emergency obstetric care.[35] It further stated that fulfilling the right to health requires the governments guarantee to all the availability, accessibility, and acceptability and of quality. CEDAW obliges states to ensure that women access service in connection with pregnancy, confinement and post-natal period.[36] Also the African charter obligates states to guarantee every individual the right to health[37] and mandate them to ensure that this includes access to medical attention during sickness, likewise the African women protocol requires states to promote women's right to health, specifically recognising that this includes their sexual and reproductive health and stresses that the rights calls for the provision of adequate, affordable and accessible health services.[38] Art 14(2) (c) charges states to legalize medical abortion in cases of sexual assault, rape, incest or where woman's mental or physical health is at risk, or the life of the woman or the foetus is at risk.

At the national level chapter 2 of the constitution of Nigeria guarantee right to health. Beautiful as these provisions, they are without "legal teeth" as they are mere directive principles of government. However, it is important to note that the African charter[39] and the African women protocol have been ratified by Nigeria, which means the provisions are applicable and enforceable in Nigeria territory. Thus, becoming fertile ground for litigation by Human rights group or individual on behalf of the victims whose Health Right must have

[32] Concluding observation of the African commission on Human and people's rights on the 3rd periodic report of the federal republic of Nigeria, 55th session para. 24 2008
[33] The constitution of the Federal Republic of Nigeria sec 33, 1999 (as amended)
[34] see centre for Reproductive Rights claiming our rights: surviving pregnancy and childbirth in Mali 2003.
[35] Economic, Social and Cultural Rights Committee General Comment 14
[36] Convention on elimination of all forms of discrimination against women.
[37] Art 16 African Charter
[38] Art 14 African protocol
[39] The Constitution of the Federal Republic of Nigeria, 1999 (as amended)

been violated for example, the case of *Women Research and Documentation Centre (WARDC) v. LUTH, Hospital Medical Director, Attorney General Lagos State and Ministry of Health Lagos State* in Lagos which is still pending in court is very instructive.

iii. Right to Non-discrimination

The right to non-discrimination and information is provided for by article 2(1) of ICCPR. It mandates states to guarantee all individuals the rights in the covenants without distinction of any kind such as race, colour or sex. Article 26 of ICCPR also requires states to make certain that all persons are equal before the law and are entitled without any discrimination.[40] CEDAW prescribe discrimination specifically in the field of healthcare.[41] At the regional level both the African charter[42] and African women protocol[43] require state to eliminate discrimination against women. At the national level the constitution provides for non-discrimination.[44]

The obligations imposed by the right to non-discrimination are immediate and transcend beyond the right in which other rights are fulfilled.[45]Its immediate nature requires that even the poorest states with the least resources fulfill this right instantaneously, particularly for the most vulnerable amongst them. The far-reaching nature of obligation under this right means that all other rights must be guaranteed on an equal basis of all. Accordingly, barriers that prevent women from accessing maternal healthcare services which only women enjoy need not be violated on non-discrimination basis of sex and sexuality.

iv. Right to Information

At the international level the rights to information is protected by ICCPR and states to guarantee women the right to decide on the number, spacing of their children and to have access to the information required to exercise this right. Clarifying the connection between this right and maternal health CEDAW Committee has stated that low access to information on family planning heightens women susceptibility to maternal mortality.[46] Also the CRC Committee requires states to make available to adolescents information on contraceptives and to access high quality health care services. It is important to note that all the international and regional guarantees rights discussed in the article are all justiceable at those levels and compel state government to uphold them. However, in spite of these provisions Nigeria continues to have one of the highest level of maternal deaths in the world. A number of global efforts aimed at addressing the problem from human rights perspectives outline not just the actions government must take in the realization, but government have had sufficient time to implement the requisite human rights standards, which it has failed to do. Despite the sense of urgency behind this effort, Nigeria government has persistently failed to uphold its obligation. For instance, in the UN Millennium Development Goals with goal 5 targeting reducing maternal mortality with 85% by the year 2020, at the end Nigeria is one of the countries that couldn't meet the target. In the new Sustainable Development Goal, goal 3 requires maternal health to be reduced to 70 per 100,000 life birth by 2030. There's therefore

[40] This right is further guarantee by the convention on the right of the child
[41] Art 12 CEDAW
[42] Art 18(3) African charter
[43] Art Z African women protocol
[44] See s. 42 Constitution of the Federal Republic of Nigeria 1990 (as amended)
[45] ESCR Committee General comment 20. non-discrimination in economic, social and cultural rights, UN DOC E/C 12/GC/20 2009.
[46] Convention on the Elimination of all forms of discrimination against women committee's general comment 18

need to make a concerted effort to hold government accountable for not fulfilling their commitments in reducing maternal mortality in Nigeria, which can be achieved through proper and constructive litigation by Human Right groups or individual on behalf of the victims.

Nigeria Policies on Maternal Health

To ensure these constitutional human rights provisions are operational, the National Health Policy and Strategy to Achieve Health[47] for all Nigerians identifies the reduction of maternal mortality and morbidity as one of its main objectives and provides strategies to achieve this. They include improving equitable access to reproductive health services and ensuring that materials required to provide such services are available. Likewise, the National health Act[48] prohibits the refusal of emergency treatment to a person for any reason, and requires healthcare institutions to disseminate information in health care facilities regarding available services, complaints procedures and rights and duties of both users and healthcare providers. The Act further mandates health institutions to display in a visible place, and regularly keep patients informed about, the procedures for laying complaints about how they were treated in a healthcare facility, and to investigate any such complaint. it classifies reproductive health services as "Essential Service", and aims to ensure that complete disruption of services due to industrial disputes does not occur in public facilities. The pertinent question is, to what extent has healthcare service provider comply with these policies?

Litigation as Strategy for Securing Accountability for Preventable Maternal Mortality

Nigeria must understand that various forms of accountability strategies for violation of the right to health in general and specifically for preventable maternal death exist. One of such strategies is litigation. This could be brought individually or human rights bodies/institutions on behalf of the victim family. Emerging and pending decisions on maternal mortality and morbidity show that court and other quasi-judicial bodies are decisively compelling states to fulfill their commitments. Though the case analyzed in this article came from other regions, the underlying circumstances are similar to those faced by women in Nigeria. As such, they identify and suggest windows of opportunity for litigating comparable cases in Nigeria and could also be relied on as persuasive precedents especially in international courts of which decisions and judgment binds on Nigerians and its governmental institutions.

A Review of Case law on Reproductive Health Right in Foreign Jurisdiction

Alyne da Silva Pimentel v. Brazil[49]: In a historic decision delivered by the CEDAW Committee in August 2011, states' obligations to ensure women adequate access to maternal health services, as a fundamental right, has been clearly affirmed.

On 11 November 2002, Alyne, a Brazilian woman of African descent who was then six months pregnant with her second child, went to a local health centre to complain of vomiting and severe abdominal pain. The doctor she consulted did not perform any tests, and sent her home with vitamins. She returned two days later, still having severe pain, and only then did the doctors admit her and established the absence of a foetal heartbeat. Alyne had a stillbirth but, against prevailing medical standards which prescribe that surgery should be performed urgently to ward off any bleeding or infection; she did not receive surgery for over 14 hours.

[47] National Health Policy of 1998, 2004, 2016 and 2020
[48] National Health At of 2015, Sections 20, 24 and 30.
[49] Communication No. 17/2008 CEDAW/C/49/D/17/2008.

After surgery, she had severe hemorrhage and low blood pressure, yet the doctors did not decide to transfer her to a hospital with better equipment facilities until her condition had worsened. When they did attempt a transfer, only one hospital – a municipal hospital – had space. The local health centre did not own an ambulance and the municipal hospital, which owned only one, would not use it to facilitate the transfer. Alyne's family attempted but was unable to arrange for a private ambulance. During the resulting eight-hour delay in getting her to the municipal hospital, she fell into a coma. When she was eventually transported to the municipal hospital, her medical records were not sent along. Ultimately, Alyne was left in the hallway of an emergency room in the municipal hospital until she died on 16 November 2002. 21 hours later, her daughter was five years old at the time. Due to the undue delays in obtaining a remedy in Brazil, substantiated through evidence that women who belong to vulnerable groups in Brazil, such as those who are poor and those who are of African descent, stand little chance of obtaining a remedy in the courts, the case was initiated before the CEDAW Committee in 2007. The main claims were that the government of Brazil had violated Alyne's rights to life, health and legal redress, guaranteed by its Constitution as well as international human rights treaties, including CEDAW. The claims highlighted the poor quality of care at an inadequately-equipped health centre, the delay in recommending a referral, the lack of space at better-equipped hospitals, the lack of reliable transportation to effect the transfer, the failure to transfer her medical records along with her to ensure appropriate and timely care, and the lack of access to emergency obstetric care as the main factors that caused her death.

In its decision, the CEDAW Committee determined that Alyne died principally due to the low-quality care she received. It also found that Brazil had violated Alyne's right to health under article 12 of the Convention. Responding to the government's assertion that it could not be held responsible for the actions of a private health institution, the Committee emphasized that governments could not relinquish their responsibilities by outsourcing medical services. Instead, they must supervise and regulate the health practices and policies of private health facilities. It also found that Brazil had violated Alyne's right to access to justice guaranteed in article 2(c), due to the delays and ultimate lack of redress. It further determined that the government had failed in its obligation to exercise due diligence in ensuring that private healthcare providers deliver sufficient care as provided for in article 2(e) of the Convention. It also held that Alyne's right to non-discrimination, defined by article 1, had been violated.

The Committee mandated Brazil to provide reparation to Alyne's family, including financial compensation commensurate with the gravity of the violations against her and to ensure women's rights to safe motherhood and affordable access for all women to adequate emergency care. It further urged the government to provide adequate professional training for health workers, especially on women's reproductive health rights, including quality maternal treatment during pregnancy and delivery, as well as timely emergency obstetric care. It also urged Brazil to provide effective remedies for violations of women's reproductive rights, to make certain that health centres respect reproductive/healthcare standards, to punish providers who violate women's reproductive rights, and to implement a national law aimed at reducing maternal mortality and morbidity.

The case, the first of its kind to be brought before any international TMB, clearly confirms governments' duty to address preventable maternal death. It also establishes state responsibility for private healthcare facilities, has far-reaching implications for women in Nigeria.

Conclusion

Reproductive health rights continue to be the major issues in many countries. Even though maternal mortality has reduced globally, there are still many countries where women face unacceptable risks of death whenever they go through pregnancy, labour and delivery. This article reveals a number of factors intercept for women high maternal mortality in Nigeria, which ranges from direct medicals to legal and social-cultural norms.

The target to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030 under Sustainable Development Goal cannot be met without fully protecting, promoting respecting and fulfilling the right of all women to access reproductive, maternal health care and services.[50]

Despite the high incidence of preventable maternal mortality and morbidity in Nigeria, and the various violations of human rights which they constitute, accountability for these violations remains elusive. There is yet no single decision holding government or any other actor responsible, and yet there is clear evidence that failure to implement relevant human rights standards sustain the factors and barriers that fuel those unnecessary death and injuries. As such Nigeria government has not only failed to implement relevant reproductive health rights standards, but has also not suffered any consequences for its failure.

Until the government is held accountable and compelled to implement and monitor measures towards eliminating the obstacles to safe motherhood, women in Nigeria will continue being exposed to serve risks during pregnancy and childbirth. Moreover, international, regional and other commitments aimed at reducing maternal mortality and morbidity will have limited impact in Nigeria if government do not accept their role in sustaining the problem and undertake to eliminate them. Although litigation may require time and resources, it has proved to be an effective strategy for holding states accountable and compelling them to take action to prevent future deaths.

Recommendations

1. Advocates must now develop strategies for successful litigation and the implementation of decisions while considering the foil range of factors-political and socio-economic, as well as the resulting barriers, financial, infrastructural and institutional which must be addressed, as they consider intersecting issues that increase women's risk of preventable maternal death, such as HIV, Covid-19 and poverty.

2. Advocates will need to think strategically to surmount likely obstacles, such as inadequate data collection and maintenance systems, difficulties with obtaining consent to litigate, procuring relevant evidence from health facilities which may have an interest in not providing them, and long delays in obtaining judgment from a court.

3. Advocate should look beyond the obvious facts of a case to obtain the full picture. For instance, although the case of maternal mortality did not implicate inadequate access to family-planning services as a direct cause of poor maternal health outcomes, the number of children already born might suggest that inadequate access to family-planning methods played a role.

[50] Legal Grounds Reproductive and Sexual Rights in Sub-Saharan African Courts, volume III, (South Africa: Pretoria University Law Press) 2017.

4. Finally, while the forum of litigation might pose a challenge, particularly when domestic remedies are either non-existent or have been exhausted, maternal mortality and morbidity cases could be taken before international and regional courts or bodies. Apart from holding government liable, government could be made to pay reparation and compensation because it is crucial to ensure that justice is done.

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