
SUBSTANTIVE EQUALITY AND MATERNAL MORTALITY IN NIGERIA

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1. Introduction

When women's lives are cut short or incapacitated as a result of pregnancy or childbirth, the tragedy cascades. Children lose a parent. Spouses lose a partner. And societies lose productive contributors... And as long as women remain disadvantaged in their societies, maternal and new-born health will suffer as well. But if we can empower women with the tools to take control of their lives, we can create a more supportive environment for women and children alike.¹

It is a tragedy that in the 21st century, when man has explored the moon and other planets and made significant advancement in science and technology, women should continue to die during pregnancy and childbirth. Although recent studies show a significant decline in the number of maternal deaths worldwide (Horgan et al. 2010), nonetheless, it was still estimated that 287,000 women died during pregnancy and childbirth in 2010 (WHO et al. 2012: 22). Of these estimated numbers of maternal deaths, developing countries account for 99%, that is, about 284,000 (WHO et al. 2012: 22). It has further been shown that sub-Saharan Africa is the region bearing the greatest burden of maternal deaths, accounting for nearly three-fifths (162,000) of all deaths. Moreover, the possibility of a woman dying during pregnancy or childbirth in Africa is put at about 1 in 39 compared with 1 in 3,800 in developed regions. In some countries such as Chad and Somalia, the risk of a woman dying during pregnancy and childbirth is higher at 1 in 15 and 1 in 16 respectively (WHO et al. 2012). For every one woman that dies during pregnancy or childbirth, 20 more are likely to suffer from life-long injuries (WHO 2005). On a daily basis, it is estimated that 1,000 women and girls lose their lives due to complications arising from pregnancy or childbirth (Mothers Day Every Day n.d.). Many of these women live in developing countries such as Asia and Africa. The situation is so appalling in Africa that governments were urged to declare maternal mortality a state of emergency in the region (African Commission 2008).

With about 640 deaths per 100,000 live births, Nigeria is said to have one of the highest

¹Her Majesty Queen Al Abdullah of Jordan, 'Creating a Supportive Environment for mothers and newborns', cited in UNICEF (2009: 11).

maternal mortality ratios in the world (WHO et al. 2012: 22). Equally, the likelihood of a woman dying during pregnancy or childbirth is put at 1 in 29 compared to 1 in 8,900 in Malta (WHO 2012: 34). Other poor countries such as Lesotho and Swaziland have better maternal mortality ratios than Nigeria. Nigeria is said to have the second largest number of maternal deaths after India, accounting for about 40,000 deaths during pregnancy and childbirth each year. These two countries account for one third of all maternal deaths worldwide. Sadly enough, while deaths arising from childbirth or pregnancy have almost been eliminated in developed countries, many developing countries, including Nigeria, are still grappling with the challenge of maternal mortality. Indeed, maternal mortality represents one of the most telling evidence of inequity between rich and poor countries and urban and rural areas.

The truth remains that deaths arising from childbirth or pregnancy are preventable, but most countries in developing world have not shown enough commitment to addressing this challenge. Al Abdullah asked a rhetorical question: 'How can it be that in our age of modern advances and medical miracles we are still failing to safeguard women as they perpetuate the human race itself?' (UNICEF 2009: 28). There is no reason why women should continue to die in a bid to bring forth another life. For a country like Nigeria, which is endowed with natural and human resources and regarded as the largest exporter of oil in the region, it is almost inconceivable that maternal mortality remains a great threat to the lives and health of women. Worse still, Nigeria is regarded as one of the countries that has made insufficient progress towards addressing maternal deaths with a view to meeting the target for the Millennium Development Goals (MDGs). This leaves much to be desired and merely exemplifies the little attention paid to women's health in the country.

Against this backdrop, this article examines the relevance of substantive equality in addressing maternal deaths in Nigeria. The article argues that aside from medical causes of deaths during pregnancy or childbirth, socio-cultural factors such as low status of women and lack of respect for their fundamental rights, often aggravate maternal deaths in Nigeria. While maternal deaths amounts to violations of women's rights to health and life, it is contended that the application of the concept of substantive equality, as opposed to formal equality, can be helpful in addressing some of the root causes of maternal deaths in the country. This may require the government to take some practical steps such as awareness campaigns, law reforms and gender-sensitive budgeting towards improving the health of women. The article points out that the tension between international human rights law, statutory law and customary law in a pluralist state may have serious implications for women's fundamental rights, particularly the right to health (Merry 2005). Therefore, the article argues that in accordance with its obligations under international and regional human rights instruments, the Nigerian government would need to pay more attention to promoting and protecting women's rights, including meeting their health needs.

2. The concept of Equality and Relevance for Women's Rights

The concept of equality is an important and fundamental principle essential in any democratic setting. Equality, as a 'treacherously simple concept' (Holtmaat 2004), is incapable of a precise definition. However, it is generally agreed that the notion of equality has a correlation with the principle of non-discrimination. Thus, an act of discrimination will lead to the violation of the right to equality (Shalev 2000: 38). The term 'discrimination' implies treating an individual or group of individuals differently from other members of society. While it is noted that not all discrimination will result in a violation of right, an unfair discrimination which may impugn the dignity of any individual will undoubtedly amount to a violation of right.

The classical conception of the notion of equality is often traced to Aristotle who argues that like should be treated alike and unlike in proportion to their differences (Aristotle 1976). This has given rise to a distinction between formal and substantive equality. Formal equality- often referred to as mathematical, absolute or numerical equality- merely treats every member of society in the same way without taking into cognizance their specific differences. It is aimed at promoting individual justice as the foundation for a moral claim to virtue and is dependent upon the notion that fairness requires consistent and equal treatment (Wesson 2007: 751). This type of approach is said to be blind to socio- economic disparities that may exist in every society. In other words, it does not take into cognizance the peculiar situation of vulnerable or marginalised members of society who have been historically disadvantaged either due to race, age or gender. Adherence to formal equality in the real sense does not guarantee true equality but disparity. Dworkin (1977: 37), warning Americans that sameness of treatment does not ensure true equality, opines that "we must take care not to use the Equal Protection Clause [of the 14th Amendment of the American Constitution] to cheat ourselves of equality".

The notion of formal equality is rooted in libertarianism. This idea supports the view that it is irrelevant to consider the socio-economic or physical differences in individuals in determining their access to social amenities or gain. At the centre of this argument is the fact that it is essential to retain formal equality if merit is to be maintained in a democratic society (McCrudden 1998: 543). It has further been argued that formal equality disfavours arbitrary decision processes, that is, when people or policies selectively disadvantage others based on irrelevant traits (Brest 1976: 2). In essence, the argument here is that formal equality avoids unnecessary and deficient considerations being introduced into decision-making process, thus, preventing irrational and unfair decisions, often based on uninformed criteria. In other words, formal equality is said to promote neutrality in decision-making. However, the so-called neutrality value canvassed by proponents of formal equality has been faulted as illusory and unrealistic (Fiss 1976: 135). This is because it is difficult, if not impossible, to argue that the law, legislature or

judiciary is truly neutral to all parties.

On the other hand, the notion of substantive equality implies that every individual is treated in the same manner taking into consideration each individual's peculiar circumstances. In other words, substantive equality, as different from formal equality, aims at promoting social justice and egalitarianism in a society, particularly for the marginalised or vulnerable groups (Rawls 1971). This notion recognises the diverse and complex nature of a modern democratic setting and rejects the fallacy of the 'universal individual'. According to Albertyn and Goldblatt (1998: 250), 'a commitment to substantive equality involves examining the context of an alleged rights violation and its relationship to systemic forms of domination within a society'. Unlike formal equality, which fails to recognise personal idiosyncrasies, substantive equality admits of these personal idiosyncrasies and attempts at a pragmatic approach to accommodate them. For instance, if a deaf and dumb pupil were to be enrolled in the same school with other pupils who do not have similar problems, this will amount to upholding the notion of formal equality, which will be disadvantageous to the pupil in question. A substantive equality approach to this issue will require that such a pupil be accommodated in a special school where he/she will be able to cope effectively. In essence, the substantive equality approach strives to addressing 'structural and entrenched disadvantage at the same time as it aspires to maximize human development' (Albertyn and Goldblatt 1998: 254).

An important aspect of the notion of substantive equality is that it aims towards equality of outcomes, which seeks to invest a certain moral principle into the equality approach. In essence, a substantive approach to equality may sometimes require the need for remedial actions to correct the injustice of the past or give more attention to the needs of the disadvantaged in society (Freedman 2003: 112). The non-discrimination provisions guaranteed in both the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Protocol to the African Charter on the Rights of Women (African Women's Protocol) are good examples of the notion of substantive equality. According to CEDAW, discrimination against women includes:

[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 (UN Committee on CEDAW 1980: art. 1).

States parties to the treaty are, therefore, enjoined to take steps and measures to eliminate discrimination against women within their territories. Reaffirming the language of CEDAW, the African Women's Protocol requires states to remove practices that discriminate against women and urges states parties to take all appropriate steps to

eliminate social and cultural patterns and practices that are discriminatory to women (African Union 2003: Art. 2, which drew its inspiration from CEDAW, UN Committee on CEDAW 1980: art. 2). It defines discrimination against women widely to include:

[Any] distinction, exclusion or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their mental status, of human rights and fundamental freedoms in all spheres of life (African Union 2003: art. 1).

These definitions are important in holding states accountable for failure to address cultural practices that may exacerbate maternal deaths. Apart from the fact that Nigeria has ratified both the CEDAW in 1985 and the Protocol to the African Charter on the Rights of Women in Africa in 2004, it has further ratified other human rights instruments such as the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and the African Charter. The Committee on the Covenant on Economic Social and Cultural Rights (ESCR) has noted that states are to integrate a gender perspective in policies, laws and programmes in order to advance the rights of the citizens. According to the Committee, a gender perspective recognizes that biological and socio-cultural factors play a significant role in influencing the health of men and women. It therefore urges states to proscribe discrimination in relation to health care services on various grounds including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

Also, the Human Rights Committee in its General Comment 18 has explained that equality together with non-discrimination constitutes a basic and general principle relating to the protection of human rights. In its General Comment 28, the Committee explains that all individuals are expected to enjoy the rights guaranteed in the ICCPR on an equal basis and in totality and that a state is in breach of the principle of equality whenever any person is denied the full and equal enjoyment of all rights. Thus, the Committee urges states to ensure equal enjoyment of all rights for men and women. It must be noted that 'non-discrimination and equality further imply that States must recognize and provide for the differences and specific needs of groups that generally face particular health challenges, such as higher mortality rates or vulnerability to specific diseases' (UNOCHR and WHO 2008: 7). (Please check the bibliography just before Wesson Murray)

Historically, women in different societies across the globe have been treated less than human and subjected to all forms of discriminatory practices due mainly to patriarchal traditions and customary law. The situation is even more precarious for women in a

pluralistic environment like Nigeria where statutory law operates side by side with customary or religious law. Cailleba and Kumar have argued that customary law may potentially limit human rights of women. Under patriarchy, women were denied their basic human rights and treated as less important than men (Cailleba and Kumar 2010). Moreover, they were merely assigned the roles of homemakers and child-bearers (Opara 1990; Mama 1997; Eboh 1998). Such a conservative approach was aided by the dichotomy of public and private spheres of life, which tended to shroud women's suffering and deprivation. Charlesworth et al. have contended that men have used this public/private dichotomy as a veritable weapon of women's oppression (Charlesworth et al.1991: 6131). Binion also argues that this dichotomy represents the very face of patriarchy (Binion 1995: 627). Under this dichotomy, gender roles are constructed and women's subordination to men is cemented. The result is that men are seen as the all-knowing and all-powerful dictating the 'tune of gender music'. Thus, women's ability to enjoy their fundamental rights was invariably tied to the apron strings of men as either husband or father. In essence, the public/private dichotomy undermines women's equal status in society and perpetuates discriminatory practices against women.

Under the disguise of public/private dichotomy, women and girls are not expected to freely express their sexual desires. That privilege belongs to men alone, who not only determine when to have sex but can also flaunt their sexual desires. Women and girls are expected to repress their sexual desires and remain sexually passive. An attempt to act otherwise attracts public rebuke and condemnation. This same scenario is reinforced in the case of Nigeria. In many cultures in Nigeria, it is often believed that the home is a sacred place and that whatever transpires there is not subject to public scrutiny. Therefore, women generally, and young women in particular, have been subjected to various forms of abuses, including sexual abuse by their partners, husbands, fathers or close relatives (Effah-Chukwuma and Osakwe 2000: 2). Worse still, these abuses experienced by women are regarded as 'family affairs', which must not be reported to outsiders or even law enforcement agents.

Indeed, in exceptional cases where a woman is bold enough to report an act of domestic violence to the police, the police often advise that such matters should be settled amicably as it is a 'family issue' (Effah-Chukwuma and Osakwe 2000: 2). In other words, women and girls have had to stoically bear these violations of their rights in silence. Violations of women's rights in Nigeria take different forms including denial of inheritance rights, harmful widowhood practices, early or forced marriages and lack of access to sexual and reproductive health services. Under this oppressive and hostile environment, women and girls are unable to exercise control over their sexuality. This in turn makes it very difficult for women to seek sexual and reproductive health services.

In a nutshell, the public/private dichotomy is a potential threat to the exercise of women's sexual autonomy and the enjoyment of their sexual and reproductive well-being. This is because it exposes women and girls to violence and shields them away from the

state's intervention. The fear of violence (actual or perceived) subdues women and girls and makes it difficult for them to exercise their free will or choices in sexual and reproductive health matters. Commenting on this situation, Cook and Howard have argued that developing an anti-discrimination theory can be useful in addressing the neglect of women's reproductive health and the detrimental impact of such neglect on the status of women in society (Cook and Howard 2007: 1041). Reinforcing this argument, Loenen has noted as follows:

a meaningful and convincing interpretation of the concept of discrimination starts from its historical genesis as a principle directed at protecting groups which have suffered from *structural* disadvantage, from *patterns* of exclusion, and not just from some incidental impact... Sensitive groups thus need stronger protection against classifications with a negative impact... Such an asymmetrical conception of discrimination acknowledges that harm caused by measures which disadvantage vulnerable and subordinate groups is, indeed, a greater evil which merits more suspicion than measures which disadvantage powerful and otherwise privileged groups.(Loenen1997: 407.)

The foregoing observations on the plight of women in society are critical to the discussion of maternal deaths in Nigeria. Given that deaths during pregnancy or childbirth are preventable, there is no reason why women should continue to die in the thousands every year. It has been noted that 'death on this scale is not an inevitable danger of pregnancy and childbirth-it is a preventable loss of life and the tragic result of policy decisions that too often neglect, devalue and discriminate against women' (CRR 2005: 2). As it will be discussed below, some of the causes of maternal deaths in Nigeria are rooted in socio-cultural factors such as the low status of women and lack of respect for their fundamental rights. Moreover, the failure or inability of the Nigerian government to take drastic measures to address maternal deaths in the country merely testifies to the little regard the government has for the rights and worth of women.

It must be pointed out that section 42 of the Nigerian Constitution, which deals with non-discrimination is couched in a narrow language proscribing discrimination merely on grounds of sex, race, ethnic groups, religious or political beliefs. Unlike non-discrimination provisions in most human rights instruments, the section does not include the phrase 'other status', which has been interpreted broadly by some treaty monitoring bodies. In addition, section 42 of the Nigerian Constitution can be contrasted with the equality clause in section 9 of the South African Constitution of 1996, which prohibits discrimination on various grounds including, sex, gender, pregnancy, age, marital status and sexual orientation. Despite its narrow language, it is argued that the Nigerian provision deserves a generous and purposive interpretation to address gender inequality in the country.

Moreover, it should be noted that the notion of equality is intrinsically linked to the

respect for human dignity. Therefore, failure to address the root causes of maternal deaths in Nigeria will amount to the violation of the right to dignity of women guaranteed under section 34 of the 1999 Constitution of the Federal Republic of Nigeria and other international and regional human rights instruments ratified by the country. The South African Constitutional Court in the *National Coalition of Lesbians and Gay* case has noted that ‘Dignity is a difficult concept to capture in precise terms. At its least, it is clear that the constitutional protection of dignity requires us to acknowledge the value and worth of all individuals as members of our society’.² With regard to maternal deaths, Cook et al. have noted as follows:

The failure to address preventable maternal disability and death represents one of the greatest social injustices of our times.... [W]omen’s reproductive health risks are not mere misfortunes and unavoidable natural disadvantages of pregnancy but, rather, injustices that societies are able and obligated to remedy. (Cook et al. 2001: 5)

This would imply that the Nigerian government should be held accountable for incessant loss of women’s lives during pregnancy and childbirth and is obligated to take necessary steps to address the social injustices women experience in the country on a daily basis.

3. Causes of Maternal Deaths in Nigeria

According to the World Health Organization (WHO), a maternal death is

the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes’ (WHO 1992).

As stated earlier, deaths during pregnancy and childbirth are generally preventable and have almost been eliminated in developed countries. However, maternal mortality has remained one of the leading causes of death and morbidity among women in Africa (WHO et al. 2004: 6). The reasons why women die during pregnancy are well known, and include problems such as haemorrhage (25 per cent), unsafe abortion (13 per cent), eclampsia (12 per cent), infections (16 per cent) and, obstructed labour and other direct causes (16 per cent) (WHO 2005). Although these are the general causes of maternal deaths, the reasons women die from pregnancy may differ from one country to another (CRR 2005, 2007; Hailu et al. 2009). There are also indirect causes such as HIV/AIDS, malaria, anaemia and hepatitis (20 per cent). These complications can be addressed through provisions of emergency obstetric care services. But such services are generally

²*National Coalition of Gay and Lesbians v Minister Justice South Africa*, CCT 11/98; [1999] (1) SA 6 (CC).

unavailable in poor regions. Beyond the medical reasons, other reasons for deaths during pregnancy and childbirth include the three delays- delay in reaching treatment, delay in identifying the problem and delay in getting help.

According to WHO it is estimated that 60 per cent of all deliveries take place outside health facilities and only about 60 per cent of births are attended to by skilled health care providers in developing countries (WHO 2006). In Africa, the number of deliveries attended to by skilled health care providers is even less at about 47 per cent (WHO 2006: 18). For a country like Nigeria, the number of deliveries attended to by skilled medical personnel is disappointingly put at 37 per cent, lower than the average in the region (Bankole et al. 2009: 4). More disappointingly, Nigeria is one of the countries that is struggling to reduce maternal deaths as envisaged under goal 5 of the MDGs. As earlier noted, the maternal mortality ratio in Nigeria (640 deaths per 100,000 live births) is one of the highest in the world. Deaths during pregnancy occur due to a number of socio-cultural reasons including low status of women, early marriage and a general lack of respect for women's rights. In addition, corruption, misappropriation of resources and inadequate allocation of resources to the health sector often aggravate maternal mortality in the country.

Cook et al. (2003: 217) have noted that in assessing the human rights obligations of a state as regards sexual and reproductive health, attention must be given to three important elements which include clinical care; operation of the health care system and underlying conditions including social, economic and legal conditions of observance of human rights. These elements are equally useful in accessing a state's commitment to addressing maternal deaths. The discussion in this section will focus on three of such underlying conditions that contribute to maternal deaths in Nigeria, including low status of women, lack of sexual and reproductive health autonomy and poor allocation of resources to the health sector.

Due to the patriarchal nature of the Nigerian society, women have often been subjected to various forms of discrimination and human rights abuses. Moreover, because of cultural and religious practices, Nigerian women have almost been relegated to second-class citizens and have undergone horrifying experiences. These range from dehumanising widowhood practices, denial of inheritance rights to forced or early marriage (Ewelukwa 2002: 425; Iwobi 2008: 37). In addition, in some parts of the country, women may require the permission of their husbands to seek medical attention, including antenatal care. All these erode the dignity of women and invariably contribute to high maternal deaths in the country. For instance, when a woman is denied rights of inheritance, this may limit her economic opportunities, as she is likely to lack access to personal and real property. Given that most women are economically dependent on their partners, it may be difficult for women to afford medical treatment, including antenatal care. A report has shown that the reason why most women in the rural areas do not seek antenatal care is due mainly to lack of resources (CRR 2005).

Undoubtedly, cultural practices that prevent women from inheriting from their deceased husband or father is inconsistent with the notion of equality or non-discrimination guaranteed in international, regional human rights instruments that Nigeria has ratified. Moreover, as noted earlier, the Nigerian constitution prohibits discrimination on the grounds of sex in section 42. Unfortunately, the Nigerian Supreme Court has not developed a consistent approach to addressing this challenge. An opportunity for the Court to clarify its position on this issue was missed in the case of *Mojekwu v Iwuchukwu*.³ In that case, the Nigerian Supreme Court was asked to consider the discriminatory nature of a customary practice that denies inheritance rights to a female child. The Supreme Court proceeded on the premise that customary laws were not generally discriminatory against women unless otherwise proved. Thus, the Court failed to appreciate the gender implications of customary laws for women's enjoyment of their fundamental rights. 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 custom and tradition. 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.

Generally, women in Nigeria lack adequate access to sexual and reproductive health services and are unable to exercise their reproductive autonomy due mainly to pervasive discriminatory practices against them. Because of power imbalances and the belief that women are to be seen and not to be heard, women are unable to participate in making crucial decisions relating to their sexual and reproductive well-being. The existing patriarchal tradition and the social belief that children are crowns of a woman, often make it difficult for a woman to decide the timing and number of her children. Thus, in most cases a woman may be unable to negotiate contraceptive use or seek contraceptive services without the consent of her husband or partner. A 2009 report has shown that in 2003, only one out of four women of childbearing age in the country said they were involved in making decisions relating to their sexual and reproductive health (Bankole et al. 2009: 14). In addition, young women and women in rural areas often lack adequate knowledge with regard to contraceptive services. These challenges usually contribute to high fertility rate in the country.

According to the 2008 Demographic Health Survey (DHS), the use of contraception has increased from 13 percent in 2003 to 15 percent in 2008, including a corresponding increase in the use of modern methods of contraception from 8 percent in 2003 to 10 percent in 2008 (NPC and ICF 2009). It states further that urban women are more than thrice as likely as rural women to use a method of contraception (26 and 9 percent, respectively). The DHS states further that about 20 per cent of adolescent women

³*Mojekwu v Iwuchukwu* [2004] 4 SC (Part II) 1.

(majority of whom are unmarried) have an unmet need for contraception (Allan Guttmacher Institute 2004: 6). While on average Nigerian women want large families, about 20 per cent of married women still want to limit their family size or wait for some time before their next birth, but their contraceptive needs are unmet (NPC and ICF 2009). The consequences of the above scenario are grave for women's health in the country. Low contraceptive use among women, particularly young women, can lead to high fertility rate and incidence of unwanted pregnancies. At 2008, the total fertility rate in Nigeria was estimated at 5.7 births per woman. Although this is a modest decline from previous years, nonetheless, it remains somewhat high (NPC and ICF 2009). This tends to put the lives of Nigerian women in danger since there is a correlation between high fertility rate and maternal mortality (UNICEF 2009: 32).

One of the greatest challenges to meeting the health needs of women generally and maternal health in particular in Nigeria, is the problem of inadequate allocation of resources to the health sector. Although this problem affects health services generally, the impact is felt more as regards sexual and reproductive health issues. Over the years, the Nigerian government has exhibited a flagrant disregard to lives and well-being of its citizens, especially women, through its shoestring allocation to the health sector. Government's allocation over the years to the health sector has hovered around 4-5 per cent of the annual budget (CRR and WRDC 2008: 4). Moreover, according to a World Bank Report, the country's public health expenditure as percent of (GDP) was 2.12 in 2009 as against 1.90 reported in 2008, making it one of the countries that spent the lowest percentage on the health of its people in those years (World Bank 2010). Poor funding of the health sector has led to decay in government hospitals evident by acute shortage of medical supplies such as gloves, syringes, drugs, beddings and toiletries (Durojaye and Ayankogbe 2005: 187). The poor allocation of resources to health care services needed only by women would amount to an act of discrimination. For a country that is richly endowed with various natural resources, including oil, it is embarrassing that the health sector should remain in shambles. It must be recalled that at the Abuja Declaration (2001) African governments agreed to commit at least 15 per cent of their annual budgetary allocations to the health sector. Sadly, a recent report has shown that only two countries (Rwanda and South Africa) have fulfilled this promise (WHO 2011: 2).

4. Nexus between Legal Pluralism and Maternal Deaths in Nigeria

Legal pluralism has become an essential feature of many African countries that have undergone colonialism. It is often used to describe a situation where a subject matter or issue is regulated by multiple laws, norms or forums that co-exist within the same jurisdiction (Interights 2009: 41). Oba has noted that legal pluralism is an important aspect of the Nigerian legal system (Oba 2004: 113). As a former colony of Britain, Nigeria adopts the common law legal system, which places emphasis on judicial precedent. However, in practice the country derives its sources of law from legislation,

customary laws and Shari'ah. Although Islamic law and indigenous customary laws preceded the common law system, the latter by virtue of colonialism has tended to take preeminence over the former. The adoption of these three systems together in a diverse country with different ethnic groups and religious beliefs has implications for women's rights. It should be noted that Nigeria is a federation, therefore, each component state has powers to make laws. While some statutory provisions such as the Constitution tend to give recognition to women's rights, customary laws and Shari'ah tend to perpetuate discriminatory practices against women. For instance, as noted above, the Constitution guarantees all individuals equal rights and freedoms and proscribes discrimination on grounds of sex, yet some cultural practices such as wife inheritance or primogeniture practiced in the Eastern part of the country-which denies women right of inheritance-seem to be inconsistent with the principles of non-discrimination and equality.

In addition, some provisions of Shari'ah as applicable in most parts of the northern region of the country perpetuate the low status of women. For instance, while sections 21 and 22 of the Child's Rights Act of 2003 prohibits early marriage by setting the marriageable age at 18, Islamic law (Shari'ah) applicable in the northern parts of the country allows for early marriage and prohibits adolescent girls from seeking contraceptive services. Child or early marriage is prevalent in the northern part of Nigeria as girls are married as young as 12 years or younger. When a girl is married at an early age, she is deprived the opportunity to be educated and develop mentally and physically and may be deprived of the means of livelihood. This clearly underpins the tension that may exist between statutory law and customary or religious law in a multi-cultural society like Nigeria.

The plural legal regime in Nigeria often creates confusion and uncertainty with regard to protecting women's fundamental rights and freedoms. Thus, there seems to be inconsistency and uncertainty in the application of this plural legal system. It has been noted that legal pluralism can potentially undermine women's rights to exercise free choices in matters that affect their sexual and reproductive well-being (Bond 2010: 5). The fact that maternal deaths in the northern parts of Nigeria, where Islamic law operates, are higher than any other parts of the country tends to lend credence to this assertion. Explaining the effects of the plural legal system on Nigerian women, Ewelukwa asserts:

Fundamental contradictions inherent in the legal system - the coexistence of modern, statutory laws with traditional customary laws and practices - has created a complex and confusing legal regime under which women generally are denied adequate legal protection...Not surprisingly, many of the problems which are faced today in much of Africa 'are the product of trying to piece together, in a hasty fashion, not only the different legal systems but also fundamentally different conceptions of society and the family. (Ewelukwa 2002: 446-447.)

5. The Obligations of the Nigerian Government with regard to Maternal Mortality

Under international law, a state has the three-fold obligation with respect to the right to health, including women's health needs. These include the obligations to respect, protect and fulfil the right to health of women, particularly in the context of maternal mortality. The Committee on the Covenant on Economic, Social and Cultural Rights (ESCR 2000) has noted that governments' obligations as regards the right to health include ensuring availability of timely and appropriate health care services. Access to health care services must also be guaranteed to all on a non-discriminatory basis. As noted above, Nigeria has made commitments under international and regional human rights instruments with regard to safeguarding human rights of women. In addition, the country has affirmed different consensus statements or documents such as the International Conference on Population and Development (ICPD 1995), the Fourth World Conference on Women (FWCW) also known as the Beijing Declaration (United Nations 1996), MDGs, and the Maputo Declaration on Operationalisation of Sexual and Reproductive Health in Africa and the African Union initiated a region-wide Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA).⁴ These consensus statements or documents require that states must adopt measures towards protecting the rights of women and preventing deaths during pregnancy or childbirth.

The essence of a human rights-based approach to maternal mortality is to assess whether steps and measures taken by a state are consistent with its obligations under international law. More importantly, a rights-based approach pays attention to the issue of non-discrimination in provision of services especially as regards vulnerable and marginalised groups. In other words, it is not enough for a state to recognise that maternal mortality is a challenge, but such a state will be required to adopt appropriate and concrete measures that must address the root causes of maternal death, promote women's health and well-being and address gender inequality (Freedman 2001). Thus, the Nigerian government is required to take steps, including elimination of discriminatory practices against women, towards the prevention of maternal deaths in the country. It is important to note that states are not only expected to comply with the non-discrimination principles but are also expected to ensure the implementation of those principles within the state between private actors, thus invoking both negative and positive obligations (INTERIGHTS 2011: 20).

⁴ This was launched in 2009 by African leaders. It focuses on three key areas: positive messaging; encouraging achievements and strides made in some countries in reducing maternal mortality and seeking to replicate them; and intensifying actions aimed at reducing maternal and infant mortality. The campaign aims to cut maternal mortality in countries with high rates.

Obligation to respect

The obligation to respect is often described as a negative obligation, which requires states to refrain from interfering with the enjoyment of rights. It means that states must refrain from doing anything that will prevent an individual from enjoying his/her rights. In the context of maternal mortality in Nigeria, the existence of customary laws and practices, which render women subordinate to men and expose them to sexual and reproductive ill-health, including morbidity and mortality arising from pregnancy and childbirth, could be interpreted as a breach of the obligation to respect. Despite the commitments made by the Nigerian government under international, regional and national law regarding the position of women, the status of women has not improved in the country. Moreover, the existence of a tripartite legal system in the country often compromises women's rights and makes it difficult for them to live on equal basis with men. This further perpetuates stereotypes and gives little regard to women's health and well-being. The failure of the Nigerian government to address this challenge is a breach of the obligation to respect women's rights.

In one of its Concluding Observations to Nigeria, the CEDAW Committee has expressed concern with respect to the poor attention given by the Nigerian government to the sexual health needs of women and girls (UN Committee on CEDAW 2004). The Committee has also expressed concern about the low rates of contraceptives usage leading to unwanted and unplanned pregnancies and the lack of sexuality education among young people, especially in the rural areas (UN Committee on CEDAW 2008). Therefore, the Committee has urged the government to increase women's and adolescent girls' access to affordable and accessible health care services, including sexual and reproductive health services (UN Committee on CEDAW 2004). It also urges the government to adopt adequate measures to increase knowledge of and access to contraceptive methods (UN Committee on CEDAW 2008). This seems to be in line with the Committee's observation in General Recommendation 24, 1999, where states were urged to ensure that affordable and acceptable health services, including sexual and reproductive health services, are guaranteed to women and girls (UN Committee on CEDAW 1999).

The Committee on ESCR has hinted that failure by a state to remove barriers to health care services and goods, for vulnerable and marginalized groups such as women, children, adolescents and those in rural areas, will amount to a breach of the state's obligation to realise the right to health of its citizens (ESCR 2000). In other words, physical accessibility to health care services must be assured to all women and girls, particularly those in rural areas. It should be noted that article 14 of the African Women's Protocol contains elaborate provisions relating to sexual and reproductive health of women. Article 14 guarantees all women the right to health, including sexual and reproductive health. This important article further provides that states should respect and promote a woman's right to control her fertility, decide the number and spacing of her children and choose any method of contraception (African Union 2003).

More importantly, article 14(2)(b) requires states parties to establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breastfeeding (African Union 2003). Also, the provision enjoins states parties to take appropriate measures to 'provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas' (African Union 2003: art. 14(2)(a)). The provisions of article 14 must be read together with article 2 of the Protocol, which proscribes discrimination against women in all facets of life. As noted earlier, the African Women's Protocol adopts a substantive equality approach to eliminating discrimination. Therefore, since Nigeria is a party to the Protocol, it is obligated to take adequate measures to remove all barriers, including cultural practices, to safe motherhood in the country (African Union 2003).

Furthermore, both the ICPD and the Beijing Platform identify components of the right to the highest attainable standard of reproductive health from a woman's perspective (ICPD 1995; United Nations 1996). They stress the importance of affordable, accessible and acceptable services throughout a woman's life cycle (ICPD 1995: paras 25, 223; United Nations 1996: paras. 92, 106(e)). Acceptable services include gender-sensitive standards for the delivery of quality health care services, which must meet the peculiar needs of female adolescents (ICPD 1995: paras 223, 95; United Nations 1996: paras. 103, 106(c), (g)). Bearing these comments in mind, and taking into account the challenges facing women in the country, one may argue that the Nigerian government is not doing enough to remove barriers to safe-motherhood in the country.

Obligation to protect

This duty implies that governments must take necessary steps and measures to prevent a third party from interfering with the enjoyment of the right to health. In the context of maternal mortality, it would imply a government's obligation to ensure that third parties do not interfere with women's enjoyment of their sexual and reproductive health. Thus, as shown above, the challenges of socio-cultural factors, which contribute to high maternal mortality in the country, will amount to a breach of the obligation to protect women's right to health (UN Committee on CEDAW 1999). Similarly, the negative attitudes of health care providers towards women attending antenatal care and barriers created by high cost of medical care, especially in rural areas, will constitute a breach of the duty to protect. A report has shown that women attending ante-natal care in Nigeria are sometimes forced to make unauthorised payments before they receive treatment (CRR and WARDC 2008). This often creates barriers for many women who are unable to make such payments. Thus, some of these women tend to shun treatment in public hospitals and resort to self-delivery or seeking help from untrained persons, thereby endangering their lives. In most cases, because of the poor facilities in public hospitals,

some women are forced to attend private hospitals for delivery. For some women, (especially those in rural areas) who are unable to afford this treatment, there is the likelihood of being exposed to injury or death during childbirth. This amounts to failure on the part of the Nigerian government to protect women from discriminatory practices that may result in their death.

In one of its landmark decisions involving *Alyne da Silva Pimentel v Brazil*,⁵ the CEDAW Committee has noted that 'lack of appropriate maternal health services has a differential impact on the right of life of women'. The Committee further notes that states have the obligation to guarantee all women of whatever racial, social and economic backgrounds to safe, timely, and non-discriminatory maternal health (UN Committee on CEDAW 2008). This statement of the Committee is consistent with upholding the notion of substantive equality. The Committee reinstated the principle of due diligence to hold the Brazilian government responsible for its failure to regulate the activities of health providers in the country. It then found the Brazilian government in breach of its obligation under international law to ensure safe delivery for women. The decision in *Alyne v Brazil* is a clear indication of how a rights-based approach to maternal mortality can strengthen states' accountability at the national level. It also underscores the importance of international mechanisms in enhancing accountability where national mechanisms are unreliable, inefficient or non-existent (de Mesquita and Kismödi 2012: 79). More importantly, it demonstrates how a state may be in violation of its obligation to prevent discrimination in the delivery of health care services. The fact that the services not provided are only required by women is an indication of failure to fulfil women's rights to health and prevent inequality in access to health care service.

In one of its Concluding Observations to the government of Nigeria, the CEDAW Committee has expressed serious concern 'about the persistence of entrenched harmful and cultural norms and practices, including widowhood rites and practices' and its implications for women's rights. In particular, the Committee has expressed concern about the link between harmful cultural practices and maternal deaths in the country. It therefore, urges the government of Nigeria, as a matter of priority to take decisive steps in order to address this situation (UN Committee on CEDAW 2008: paras. 336-337). These observations are consistent with ensuring gender equality and preventing women from discriminatory practices perpetrated by third parties. Indeed, they underscore the relevance of the substantive equality approach to preventing maternal deaths in the country.

Obligation to fulfill

This duty imposes obligations on a state to ensure that it has taken adequate measures,

⁵ESCR Communication No. 17/2008.

including budgetary, legislative and judicial, with respect to realising the right to health of its citizens. With regard to maternal mortality, the duty to fulfil requires a government to take steps and measures to ensure that access to sexual reproductive health services, particularly antenatal care services, are made available to women. The obligation to fulfil implies designing and implementing an appropriate legal framework that will address the incidence of maternal deaths. The Committee on ESCR, in General Comment 14, has explained that fulfilling the right to health requires a state to take a holistic approach (ESCR 2000). This will include realistic legal and policy frameworks that will assure health care goods and services to all, especially marginalised groups such as adolescents and women. Specifically, the Committee has noted that appropriate health care services must be provided to meet the peculiar needs of women.

It should be noted that the obligation to fulfil requires more than merely making laws and policies but also requires diligent implementation of those laws and policies. The Nigerian government has developed a number of policies and programmes in order to address the incidence of maternal mortality in the country. These include the National Policy on Health (FMOH 1998), the National Reproductive Health Policy (FMOH 2001), National Reproductive Health Strategic Framework (FMOH 2002), National Guidelines for Women's Health (Federal Ministry of Women Affairs 2002) and National Family Planning/Reproductive Health Policy and Standards of Practice (FMOH 2004), including a proposed bill on National Health. In addition, the government has embarked on different programmes aimed at reducing the incidence of maternal death in the country. These include a joint programme with the WHO known as the 'Making Pregnancy Safer Initiative' launched in 2001; the establishment by the government in 2001 a multi-sectoral National Safe Motherhood Committee; and the establishment in 2005 of a Presidential Task Force on Maternal Mortality aimed at ensuring the realisation of MDG 5. Despite these efforts and initiatives the maternal mortality ratio in the country has remained high. The Nigerian government has not been able to translate this myriad of policies to positive results. The major challenge remains lack of political will and inadequate allocation of resources to the health sector.

While fulfilling the right to health requires a state to commit its resources towards the realisation of health care services to all, the Committee on ESCR realises that some states, due to lack of resources, may face the challenge of immediately realising the right to health for their citizenry. However, such states are required to take progressive steps towards realising this right. On the other hand, the Committee on ESCR notes that certain obligations relating to the right to health, such as ensuring access to medicines, goods and services (including contraception), access to minimum essential food, access to shelter, housing, sanitation and safe drinking water, equitable access to health facilities and prohibition of discriminatory practices with regard to health care services are core obligations, which are not subject to progressive realization. In other words, poor states would still be expected to demonstrate that they have applied their meagre resources judiciously towards realising the right to health of their citizens. In the Committee's view,

the crucial point to consider in this respect is: whether a state is unable or unwilling (ESCR 2000).

For a country like Nigeria, which is regarded as the eighth largest oil producing nation in the world, it is almost inexcusable if not embarrassing, that the health system has become a charade due to poor funding. Despite the huge profit the country has made on sale of oil over the years, it has woefully failed to deliver a decent health care system (including sexual and reproductive health care services) to its citizens. Worst affected are vulnerable and marginalised groups such as women, children and adolescents. The government will need to allocate more resources to the health sector, especially maternal health care, in order to address the high maternal mortality ratio in the country. Certainly, the problem with Nigeria is not that of want of resources but rather a case of misplaced priorities and corruption on the part of its rulers (Nnamuchi; 2008). It has been observed that to know the priority of a state, one needs to monitor what it spends its money on (Coen et al. 2004: 12; Fathalla et al. 2006). Therefore, the Nigerian government will need to show more commitment to meeting the health needs of women by improving its allocation to the health sector, particularly sexual and reproductive health care services.

Some international and regional human right bodies have explained the importance of adopting a rights-based approach to maternal mortality. The International Human Rights Council in one of its resolutions has noted that death during pregnancy and childbirth violates women's rights to life, health, dignity and non-discrimination (Interights 2009). In the same vein, the African Commission has noted that the incidence of maternal mortality in the region is a violation of women's fundamental rights and freedoms (African Commission 2008). More importantly, the CEDAW Committee (1999) in its General Recommendation 24 has noted that failure of a state to ensure access to health care services peculiar to the needs of women will amount to discrimination.

Furthermore, the CEDAW Committee in one of its Concluding Observations to the government of Nigeria has expressed grave concern as regards the high maternal mortality ratio in the country and lack of progress on the part of the government to address this challenge. The Committee has identified factors responsible for this situation to include

unsafe abortions and inadequate post-abortion care, early and child marriages, early pregnancies, high fertility rates and inadequate family planning services, the low rates of contraceptive usage leading to unwanted and unplanned pregnancies, and the lack of sex education, especially in rural areas (UN Committee on CEDAW 2008).

Moreover, the Committee has expressed concern with regard to 'lack of access by women and girls to adequate health-care services, including pre-natal and post-natal care, obstetric services and family planning information, particularly in rural areas' (UN

Committee on CEDAW 2008). The Committee therefore, calls upon the Nigerian government to 'improve the availability and affordability of sexual and reproductive health services, including family planning information and services' (UN Committee on CEDAW 2008: para. 337). It also enjoins the government to adopt measures with a view to increasing knowledge of, and access to, affordable contraceptive methods, so that women and men can make informed choices about the number and spacing of children.

Following from the above and in the spirit of substantive approach to equality, it is clear that the Nigerian government will be required to enact appropriate laws that will remove barriers to quality sexual and reproductive health services for women and ensure non-discrimination and autonomy in reproductive decision-making to women and girls so as to guarantee safe pregnancy and childbirth (CRR 2005). Conversely the government will need to adopt measures that will facilitate access to school, for the girl-child, including knowledge on family planning services.

6. Conclusion

This article has discussed the importance of the notion of equality to advancing women's sexual and reproductive rights, particularly maternal health, in Nigeria. It has shown that the high maternal mortality in Nigeria can be attributed to entrenched patriarchal traditions, which perpetuate gender inequality and prevent women from enjoying their fundamental rights and freedom. This situation in turn prevents women from exercising their sexual and reproductive autonomy and conversely limits access health care services to them. Efforts aimed at addressing maternal deaths in Nigeria must necessarily be grounded in realising substantive equality for women in the country. Unless women are treated as human beings worthy of respect and dignity and not as second-class citizens, efforts to prevent women from dying during pregnancy and childbirth may remain ineffective. As Hunt and De Mesquita correctly noted, the principles of equality and non-discrimination require a state to ensure women's enjoyment of the right to health on the basis of non-discrimination and equality (Hunt and De Mesquita 2008: 11). States must not only take steps and measures to prevent maternal deaths but must also prioritize measures towards those at risk of maternal deaths such as women in rural areas, women living in poverty, indigenous women and young women,

While it can be said that the Nigerian governments have taken steps and measures towards addressing maternal deaths in the country, these efforts have not been met with adequate allocation of resources to the health needs of women. In particular the government has failed to commit adequate resources to meeting the sexual and reproductive health of women. Therefore, in line with the government's commitment under the Abuja Declaration and other consensus statements, there is a need for the government to increase spending on the health sector generally and sexual and reproductive health in particular. More importantly, there is a need for the adoption of

gender-sensitive budgeting, which must prioritise women's health needs in the country (Durojaye et al. 2010: 25).

In addition, there is a need for a reappraisal of the government's approach to addressing maternal deaths. This can be done through the adoption of remedial measures, which must address inequality in health care services and facilitate equal access to health care services for women, especially sexual and reproductive health services. Such measures should include properly monitored free maternal health care services for pregnant women, particularly those in rural areas. Moreover, the Nigerian government will need to enact appropriate laws that will advance women's rights and promote their sexual and reproductive autonomy. At the same time, the government will need to repeal existing customary laws and practices which have continued to perpetuate and exacerbate gender inequality and abuses of women's fundamental rights and freedoms.

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