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MATERNAL HEALTH AS A JUSTICIABLE RIGHT IN NIGERIA AND AFRICA

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ABSTRACT: *Amala Okafor's legal and policy analysis reframes maternal health in Nigeria and Africa as a justiciable right, confronting one of the continent's most glaring indicators of systemic governance failure, public health neglect, and legal under-enforcement. In Nigeria, which bears a disproportionate share of global maternal deaths, the crisis stems not from inevitable tragedy but from preventable causes rooted in weak institutions, chronic underfunding, socio-cultural barriers, and critically, the absence of enforceable accountability mechanisms. Unlike developed nations where maternal mortality often reflects mere systemic fragmentation within otherwise robust frameworks, Africa's challenge reveals deeper structural deficiencies that demand urgent rights-based intervention. Okafor argues affirmatively that state failures to deliver accessible, adequate, and timely maternal healthcare constitute clear violations of constitutionally enshrined socio-economic rights, statutory obligations under frameworks like Nigeria's National Health Act, and regional human rights instruments such as the African Charter on Human and Peoples' Rights. By synthesizing domestic jurisprudence with continental precedents, the analysis charts a transformative pathway: elevating maternal health from vague policy aspiration to concrete legal entitlement through strategic litigation, judicial benchmarks, and multi-stakeholder accountability. Recommendations emphasize mandatory health budget allocations (at least 15% of national spending), citizen-led enforcement suits, and governance innovations to halve Africa's 200,000+ annual maternal mortality burden. Ultimately, Okafor positions maternal health as Africa's moral and developmental imperative, urging policymakers to wield legal muscle over goodwill to save lives and build equity.*

KEYWORDS: Maternal, Health, Right, Africa, Nigeria.

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INTRODUCTION

Maternal mortality in Nigeria and across Africa stands as one of the most damning and persistent barometers of systemic governance collapse, chronic public health underinvestment, and glaring legal inaction. While developed nations grapple with maternal deaths primarily through coordination failures within largely functional healthcare ecosystems—where robust funding, trained personnel, and emergency response systems mitigate risks—the African reality exposes far more foundational fractures. Here, the crisis is anchored in crumbling institutions lacking basic capacity, perennially inadequate budget allocations (often below the Abuja Declaration's 15% threshold), entrenched socio-cultural obstacles like gender biases and rural isolation, and above all, the profound absence of binding legal mechanisms to hold governments accountable. In Nigeria, these failures manifest starkly: women die from eclampsia, postpartum hemorrhage, and obstructed labor in facilities without oxygen, blood, or skilled attendants, while preventable infections claim lives that basic protocols could save.

Nigeria's burden is staggering, accounting for roughly 20% of global maternal deaths despite comprising just 2.6% of the world's population—rates hovering around 814 deaths per 100,000 live births, per recent WHO estimates, far exceeding sub-Saharan averages. What renders this catastrophe morally indefensible is its overwhelming preventability: over 80% of cases, according to Lancet analyses, stem from addressable gaps in antenatal care, skilled birth attendance, and emergency obstetric services. This persistence compels a pivotal legal interrogation: does the state's chronic failure to ensure accessible, quality, and timely maternal healthcare infringe upon justiciable rights to life, health, and human dignity? This analysis answers resoundingly yes, repositioning maternal mortality not as tragic happenstance but as a rights violation actionable in courts. Drawing from Nigeria's 1999 Constitution (Sections 17, 33, and the socio-economic rights in Chapter II, increasingly justiciable via SERAP precedents), the National Health Act 2014 (mandating emergency care), and regional pillars like the African Charter on Human and Peoples' Rights (Articles 14-16, domesticated via Cap A9 LFN 2004), it constructs a robust framework. African Court and Commission jurisprudence—such as Purohit v. Gambia on health rights—bolsters domestic cases like Femi Falana's suits against federal health neglect. Together, these forge a litigation pathway: class-action suits enforcing minimum service standards, judicial orders for budget ring-fencing, and mandatory reporting on maternal mortality ratios (MMRs). By litigating benchmarks (e.g., <70 deaths/100,000 by 2030 per SDG 3.1), advocates can compel systemic overhaul—transforming maternal health from elusive policy rhetoric into an ironclad legal entitlement, with multi-stakeholder duties cascading from federal executives to local councils. This rights-based pivot promises not just halved MMRs but equitable governance rebirth across Africa.

This study adopts a doctrinal legal research methodology. It is based mainly on constitutional provisions, statutory instruments, judicial decisions and regional and international human rights instruments that have relevance to the rights of the mother in Nigeria and Africa. Both primary (Constitution of the Federal Republic of Nigeria 1999 as amended, National Health Act 2014, African Charter on Human and Peoples' Rights, case law and secondary (scholarly literature, policy documents, reports of international organisations, public health data) sources are explored. The study examines the extent to which maternal mortality can be considered a violation of legally protected rights and considers how strategic litigation can be used as a tool to achieve accountability and enhance maternal outcomes.

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Structural Determinants of Maternal Mortality

Maternal mortality in Nigeria cannot be understood solely through a legal lens; it is deeply intertwined with structural and socio-economic realities.

A. Financial Barriers

Nigeria's healthcare system is heavily reliant on out-of-pocket payments.[1] For many women, the cost of antenatal care, delivery, and postnatal services is prohibitive, leading to delayed or absent medical intervention.

B. Infrastructure and Human Resource Deficits

Many healthcare facilities lack basic equipment, medications, and trained personnel.[2] Rural areas are particularly affected, with limited access to skilled birth attendants.

C. The "Three Delays" Framework

The persistence of maternal mortality is often explained through the "three delays" model:[3]

- Delay in deciding to seek care;
- Delay in reaching a healthcare facility;
- Delay in receiving adequate care upon arrival.

Each of these delays reflects systemic failures that can, and should, be addressed through legal and policy reforms.

All these delays reflect that maternal mortality is not only a medical fact, but also a symptom of failure of the governance system as a whole. These barriers continue to exist, highlighting the need for more thorough legal and policy measures to close these gaps in institutions that threaten pregnant women.

Constitutional Foundations: Expanding the Right to Life

A. Section 33 and the Evolution of Judicial Interpretation

Section 33 of the Constitution of the Federal Republic of Nigeria guarantees the right to life.[4] Traditionally, this provision has been interpreted narrowly, focusing on protection against unlawful or arbitrary deprivation of life.

However, Nigerian courts have, in certain instances, adopted a more expansive approach, recognizing that the right to life encompasses conditions necessary for meaningful human existence.

[1] WHO, Global Health Expenditure Database (2023)

[2] Federal Ministry of Health, National Strategic Health Development Plan (2018)

[3] Thaddeus S and Maine D, 'Too Far to Walk: Maternal Mortality in Context' (1994) Social Science & Medicine

[4] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 33

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A pivotal illustration is found in Gbemre v. Shell, where the Federal High Court held that environmental degradation that threatens human survival constitutes a violation of the right to life.[5] This decision is doctrinally significant because it shifts the right to life from a purely negative obligation (i.e., the state must not kill) to a positive obligation (i.e., the state must take steps to preserve life).

Similarly, in Attorney-General of Ondo State v. Attorney-General of the Federation, the Supreme Court affirmed that constitutional provisions may impose enforceable duties on government actors where public welfare is implicated.[6]

Applying this reasoning to maternal health, it becomes arguable that a healthcare system that fails to prevent foreseeable maternal deaths, particularly where such deaths arise from lack of basic medical care, constitutes a breach of the constitutional right to life. Maternal mortality, in this sense, is not merely a health outcome but a constitutional failure.

B. The Challenge of Non-Justiciability and Its Circumvention

A major obstacle to enforcing socio-economic rights in Nigeria lies in Chapter II of the Constitution, which contains directive principles of state policy but is rendered non-justiciable under Section 6(6)(c).[7] These provisions include obligations relating to health and welfare, yet courts cannot ordinarily enforce them.

However, this limitation is not absolute. Nigerian jurisprudence has demonstrated that where socio-economic concerns intersect with enforceable fundamental rights, courts may intervene.[8] This doctrinal opening becomes even more significant when considered alongside the domesticated African Charter.[9]

The African Charter:

A Direct Legal Basis for Maternal Health Claims

A. Domestication and Legal Status

The African Charter on Human and Peoples' Rights occupies a unique position within Nigerian law. By virtue of its domestication, it has the force of statute and is directly enforceable in Nigerian courts.

In Abacha v. Fawehinmi, the Supreme Court affirmed that the Charter is binding and can be invoked to enforce rights contained therein.[10] This decision effectively bridges the gap created by the non-justiciability of Chapter II.

[5] *Gbemre v Shell Petroleum Development Company Nigeria Ltd and Others* (2005) AHRLR 151 (NgHC 2005)

[6] Attorney-General of Ondo State v Attorney-General of the Federation (2002) JELR 42378 (SC)

[7] Constitution of the Federal Republic of Nigeria 1999 (as amended), s 6(6)(c)

[8] Chidi Odinkalu, 'The Impact of Economic and Social Rights in Nigeria' (2004)

[9] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act Cap A9 LFN 2004

[10] Abacha v. Fawehinmi (2000) 6 NWLR (Pt 660) 228

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B. Article 16 and the Right to Health

Article 16 of the African Charter guarantees the right to health and obligates states to take necessary measures to protect the health of their people.[11] Unlike the Nigerian Constitution's socio-economic provisions, this right is enforceable.

Maternal mortality, therefore, can be framed as a violation of Article 16 where the state fails to provide:

- Adequate healthcare facilities;
- Access to skilled medical personnel;
- Essential maternal health services.

Additionally, Article 4 (right to life) and Article 5 (right to dignity) reinforce this framework, creating a multi-layered rights basis for challenging systemic failures in maternal healthcare.[12]

Statutory Framework

The National Health Act and Its Limitations

A. The Promise of the National Health Act 2014

The National Health Act represents a significant legislative effort to regulate Nigeria's healthcare system.[13] It establishes the Basic Healthcare Provision Fund (BHCPF), which is designed to finance essential health services, including maternal and child health.[14]

The Act envisions:

- Improved access to primary healthcare;
- Financial risk protection for vulnerable populations;
- Strengthened healthcare infrastructure.

B. Implementation Failures and Accountability Gaps

Despite its progressive framework, the Act suffers from serious implementation challenges:[15]

- Inadequate Funding: Allocations to the BHCPF are often insufficient or inconsistently released.

[11] African Charter on Human and Peoples' Rights 1981, Article 16

[12] ibid Articles 4 and 5

[13] National Health Act 2014

[14] ibid Section 11

[15] World Bank, Nigeria Health Financing Report (2018)

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- Weak Oversight: There are limited mechanisms to ensure that funds are properly utilized.
- Fragmented Governance: Coordination between federal, state, and local governments remains poor.
- Lack of Enforceability: Individuals cannot easily compel compliance with the Act's provisions.

These deficiencies undermine the Act's effectiveness and contribute to persistent maternal mortality.

Litigation as a Mechanism for Systemic Change

A. The Potential of Strategic Litigation

Strategic litigation offers a powerful tool for transforming maternal health outcomes. By framing maternal deaths as violations of constitutional and human rights, litigants can compel state accountability and drive policy reform.[16]

Such litigation can seek:

- Declaratory relief establishing state obligations;
- Injunctive orders compelling improvements in healthcare delivery;
- Compensation for victims and their families.

B. Comparative African Jurisprudence

Comparative African jurisprudence offers valuable pointers on the justiciability and enforcement of socio-economic rights, especially health rights. In recent years, courts in every region and country across the continent have moved away from understanding socio-economic rights as policy goals. Rather, they have acknowledged that governments have legally binding responsibilities to do what is reasonable to ensure the health and welfare of their citizens.

In *Purohit and Another v The Gambia*, the African Commission on Human and Peoples' Rights found that the African Charter's Article 16, on the right to health, places positive duties on states to ensure that everyone has access to adequate healthcare services, and to safeguard vulnerable groups against situations that are likely to compromise human dignity and wellbeing.[17] The Commission expressed the importance of a state creating sufficient healthcare systems; otherwise, it may be breaching the Charter. The case was about mental health services, but its reasoning is relevant to maternal health and the lack of facilities, skilled staff and accessibility of services are resulting in preventable deaths.

A more direct link between maternal death and state accountability was discussed in *Center for Health, Human Rights and Development (CEHURD) and Others v Attorney General of*

[16] Alicia Ely Yamin, Power, Suffering and the Struggle for Dignity (UPenn Press 2016)

[17] *Purohit and Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003).

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Uganda.[18] The case had been sparked by the deaths of two women during childbirth caused by poor maternal health services. The case was initially rejected based on the political question doctrine, but ended up before the Supreme Court of Uganda, which ruled that claims of violations of constitutional rights due to poor maternal care were justiciable and could be considered by the courts. It was a pivotal ruling that overturned a previous decision to block judicial review of healthcare failures by governments and establishes courts as a guardian of rights in healthcare.

This gives additional support to judicial enforcement of socio-economic rights through the jurisprudence of the South African Constitutional Court. *Minister of Health v Treatment Action Campaign (No 2)*[19] has ordered the government to increase access to antiretroviral medicine to prevent mother-to-child transmission of HIV. The Court ruled that government policies in the area of health rights should be reasonable, and that courts could examine whether public authorities have met their constitutional responsibilities. The ruling had ruled that a lack of resources does not automatically absolve governments of responsibility when lives are at stake.

Together, these decisions have established a greater judicial consensus in Africa that the right to health has binding implications for the states. They also show that courts can be a catalyst for changing the way systems function in providing health care. In Nigeria, comparative jurisprudence serves as a persuasive tool in the recognition of maternal death not only as a public health problem but also as a legal problem and violation of the rights to human dignity, health and life. These precedents could thus be referenced in Nigerian courts to help develop a stronger rights-based approach to maternal health litigation.

Policy and Legal Reform

Towards a Rights-Based Framework

A meaningful response to maternal mortality in Nigeria and across Africa requires more than declaratory commitments; it demands a deliberate shift towards a rights-based framework anchored in enforceability, accountability, and institutional coherence. Such a framework must operate simultaneously at constitutional, statutory, institutional, and administrative levels, ensuring that maternal health is not treated as a discretionary policy objective but as a binding legal obligation.

A. Constitutional Reform and Interpretation

At the constitutional level, reform need not necessarily begin with formal amendment, although that remains a long-term objective. More immediately, the judiciary must adopt a progressive and purposive interpretation of existing fundamental rights provisions.

The right to life under Section 33 should be expansively construed to encompass access to essential maternal healthcare, particularly in circumstances where death is preventable and attributable to systemic deficiencies.

[18] *Centre for Health, Human Rights and Development (CEHURD) and Others v Attorney General* Constitutional Appeal No 1 of 2013 (Supreme Court of Uganda, 19 August 2020).

[19] *Minister of Health and Others v Treatment Action Campaign and Others (No 2)* 2002 (5) SA 721 (CC).

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Nigerian courts have already demonstrated the capacity for such interpretive evolution, as seen in Gbemre v. Shell Petroleum Development Company Nigeria Ltd., where environmental harm was held to implicate the right to life. Extending this reasoning to maternal mortality would not represent a doctrinal departure, but rather a logical progression in constitutional jurisprudence.

In addition, there is a pressing need to revisit the doctrine of non-justiciability under Section 6(6)(c) of the Constitution. While traditionally seen as a barrier to enforcing socio-economic rights, courts can, and increasingly do, circumvent this limitation by linking such rights to enforceable civil and political guarantees.

Maternal health, when framed through the lenses of life, dignity, and equality, fits squarely within this evolving jurisprudential approach.

Furthermore, the judiciary must assume a more assertive role in enforcing health-related rights. This includes granting declaratory and injunctive reliefs that compel government action, as well as recognizing state liability in cases of systemic neglect. Judicial reluctance to intervene in policy matters should not extend to situations where inaction results in preventable loss of life.

B. Strengthening Statutory Enforcement

While constitutional interpretation provides the normative foundation, statutory reform is essential for operational effectiveness. The National Health Act 2014, though progressive in design, requires significant strengthening to ensure enforceability.

First, the Act should be amended to include clear, justiciable obligations on government authorities at all levels. Currently, many of its provisions are framed in aspirational terms, lacking the binding force necessary to compel compliance. Introducing enforceable duties, especially in relation to maternal and primary healthcare, would enable individuals and civil society organizations to hold the state accountable through legal action.

Second, there is a need to introduce penalties for non-compliance. Government agencies that fail to implement statutory mandates, particularly those relating to the Basic Healthcare Provision Fund, should be subject to administrative sanctions and, where appropriate, legal liability. Without consequences, statutory obligations risk remaining merely symbolic.

Equally important is the need to enhance transparency in fund allocation and utilization. The persistent opacity surrounding healthcare funding undermines both efficiency and public trust. Legal provisions mandating periodic disclosure, independent audits, and public access to financial data would significantly improve accountability and reduce mismanagement.

C. Institutional and Financial Reforms

Legal and policy reforms must be matched by tangible improvements in institutional capacity and financial commitment. One of the most critical challenges facing maternal healthcare in Nigeria is chronic underfunding. Increasing budgetary allocation to the health sector is therefore not merely a policy preference but a legal and moral imperative.

Greater investment should be directed towards primary healthcare infrastructure, which serves as the first point of contact for most women, particularly in rural areas. Strengthening these

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facilities would significantly reduce delays in accessing care and improve overall maternal outcomes.

In addition, there must be sustained investment in the training, recruitment, and retention of healthcare professionals. The shortage of skilled birth attendants remains a major contributor to maternal mortality. Addressing this requires not only increased training capacity but also improved working conditions, remuneration, and incentives to retain personnel within the public health system.

Institutional reforms should also focus on improving coordination between federal, state, and local governments. The current fragmentation of responsibilities often leads to inefficiencies and service gaps. Establishing clearer lines of accountability and enhancing intergovernmental collaboration would contribute to a more coherent healthcare system.

D. Data, Monitoring, and Accountability

A rights-based approach to maternal health must be underpinned by robust systems for data collection, monitoring, and accountability. Reliable data is essential for identifying gaps, measuring progress, and informing policy decisions.

To this end, there is a need to establish comprehensive and standardized data collection systems that capture maternal health indicators across all regions. Such systems should be integrated into national health information frameworks and supported by adequate funding and technical capacity.

In addition, the law should mandate public reporting of maternal health outcomes, including mortality rates, causes of death, and disparities across socio-economic and geographic groups. Transparency in this regard not only facilitates oversight but also empowers civil society and the media to hold authorities accountable.

Finally, the creation of independent oversight bodies is crucial for ensuring sustained accountability. These bodies should be vested with investigative and supervisory powers, enabling them to monitor compliance with legal and policy obligations, conduct audits, and recommend corrective measures. Their independence must be guaranteed to prevent political interference and ensure credibility.

CONCLUSION

Maternal mortality in Nigeria and Africa represents a profound failure of law, policy, and governance. The persistence of preventable deaths is not merely a reflection of limited resources but of inadequate legal enforcement and institutional accountability.

By grounding maternal health in constitutional and human rights frameworks, and by leveraging both domestic and regional legal mechanisms, it is possible to transform the current paradigm. Maternal health must be recognized not as a discretionary policy objective but as a binding legal obligation that the state is duty-bound to respect, protect, and fulfill.

Only through such a reconceptualization can Nigeria and Africa begin to address the systemic failures that continue to cost countless women their lives.

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