AN EXAMINATION OF THE PROTECTION OF WOMEN'S RIGHT TO HEALTH UNDER INTERNATIONAL LAW: A CASE STUDY OF NIGERIA.

BY

Ifeyinwa Stella KECHERE
LLM/LAW/06759/2009-2010

SEPTEMBER, 2015

AN EXAMINATION OF THE PROTECTION OF WOMEN'S RIGHT TO HEALTH UNDER INTERNATIONAL LAW: A CASE STUDY OF NIGERIA.

BY

Ifeyinwa Stella KECHERE
LLM/LAW/06759/2009-2010

A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF LAWS DEGREE-LLM

DEPARTMENT OF PUBLIC LAW,
FACULTY OF LAW,
AHMADU BELLO UNIVERSITY, ZARIA
NIGERIA

SEPTEMBER, 2015

DECLARATION

I declare that the work in this thesis entitled: AN EXAMINATION OF THE PROTECTION OF WOMEN'S RIGHTS TO HEALTH UNDER INTERNATIONAL LAW: A CASE STUDY OF NIGERIA has been carried out by me in the department of private law. The information derived from the literature has been duly acknowledged in the text and a reference list provided. No part of this thesis has been previously presented for another degree or diploma at this or any other institution.

Ifeyinwa Stella KECHERE	.....	.....
Name of Student	Signature	Date

CERTFICATION

This thesis entitled: AN EXAMINATION OF THE PROTECTION OF WOMEN'S RIGHTS TO HEALTH UNDER INTERNATIONAL LAW: A CASE STUDY OF NIGERIA by Ifeyinwa Stella KECHERE meets the regulations governing the award of the degree of Master of Laws-LL.M of the Ahmadu Bello University Zaria and is approved for its contribution to knowledge and literary presentation.

Prof. J.A.M Audi	.....	.....
Chairman, Supervisory Committee	Signature	Date
Dr. M.A Madaki	.....	.....
Member, Supervisory Committee	Signature	Date
Dr. K. M Danladi	.....	.....
Head, Department of Public Law Ahmadu Bello University, Zaria.	Signature	Date
Prof. K. Bala	.....	.....
Dean, School of Postgraduate Studies Ahmadu Bello University, Zaria.	Signature	Date

ACKNOWLEDGEMENTS

To God be the glory for the successful completion of this course. My profound gratitude go to my supervisors Prof. J.A.M Audi and Dr M.A Madaki for their diligence, patience and understanding. I am greatly indebted to them.

I thank and appreciate my husband Mr Isaac Kechere for his support and encouragement. I also appreciate my wonderful children, Ogechi, Arthur and Donald for their understanding without which this work would not have been possible.

I thank Mrs Mary Ijoye for helping in the type setting and production of this work. I appreciate every other person who one way or another gave me a helping hand or word of encouragement during the course of this programme.

May God bless you all.

DEDICATION

This is work dedicated to God Almighty who makes all things possible and to my family for their love and support.

TABLE OF CONTENTS

Pages

Title Page -- -- -- -- -- -- -- -- -- i

Declaration -- -- -- -- -- -- -- -- -- ii

Certification page -- -- -- -- -- -- -- -- iii

Acknowledgement -- -- -- -- -- -- -- -- iv

Dedication -- -- -- -- -- -- -- -- -- v

Table of Contents -- -- -- -- -- -- -- -- vi

Table of Cases -- -- -- -- -- -- -- -- -- x

Table of Statutes -- -- -- -- -- -- -- -- xi

Abstract -- -- -- -- -- -- -- -- -- xii

CHAPTER ONE
GENERAL INTRODUCTION

1.1 Background to the Study -- -- -- -- -- -- 1

1.2 Statement of the Research Problem -- -- -- -- -- 4

1.3 Empirical Research Questions -- -- -- -- -- 5

1.4 Aims and Objectives of the Research -- -- -- -- -- 5

1.5 Scope and Limitation of the Research -- -- -- -- 6

1.6 Justification -- -- -- -- -- -- -- -- -- 6

1.7 Research Methodology -- -- -- -- -- -- 8

1.8 Literature Review -- -- -- -- -- -- -- 8

1.9 Organizational Layout -- -- -- -- -- -- 11

CHAPTER TWO
CONCEPTUAL CLARIFICATION OF KEY TERMS

2.1 Human Rights -- -- -- -- -- -- -- -- 12

2.2 Right to Health -- -- -- -- -- -- -- 16

2.3 Women -- -- -- -- -- -- -- -- 17

2.4 Women's Right -- -- -- -- -- -- -- 17

2.4.1 Right to Reproductive Health -- -- -- -- -- -- 18

2.4.2 Right to Maternal Health -- -- -- -- -- -- 19

CHAPTER THREE
LEGAL FRAME WORK FOR THE PROTECTION OF WOMEN'S RIGHT TO HEALTH

3.1 Analysis of International Frame Work for the Protection of Women's Right to Health -- -- -- -- -- -- -- 22

3.1.1 Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), 1979 -- -- -- -- -- 22

3.1.2 International Convention on Economic, Social and Cultural Right (ICESCR), 1966 -- -- -- -- -- -- -- 24

3.1.3 International Convention on Civil and Political Right (ICCPR), 1966-- 26

3.1.4 Convention on the Right of the Child (CRC), 1989 -- -- -- 27

3.1.5 African Charter on Human and People's Right (ACHRP), 1981 -- 28

3.1.6 Protocol to the African Charter on Human and People's Rights, 2003-- 29

3.1.7 Universal Declaration of Human Right (UDHR), 1948 -- -- 34

3.2 Analysis of Domestic Frame Work for the Protection of Women's Right to Health in Nigeria -- -- -- -- -- -- -- 35

3.2.1 Constitution of the Federal Republic of Nigeria, 1999 (as amended)-- 35

3.2.2 Labour Act, 2004 -- -- -- -- -- -- -- 37

3.2.3 Criminal Code, 2004 -- -- -- -- -- -- -- 38

3.2.4 Child's Right Act, 2003 -- -- -- -- -- -- 40

3.2.5 Matrimonial Causes Act, 2004 -- -- -- -- -- 43

CHAPTER FOUR

EMPERICAL RESEARCH ON THE PROTECTION OF WOMEN'S RIGHT TO HEALTH IN NIGERA

4.1 Research Design -- -- -- -- -- -- -- 44

4.2. Area of the Study -- -- -- -- -- -- -- 44

4.3 Population/Participants in the study -- -- -- -- -- 45

4.4 Method of Data Collection and Analysis -- -- -- -- 45

45 Ethical Issues -- -- -- -- -- -- -- -- 46

4.6 Presentation of Result and Data Analysis -- -- -- -- 47

4.6.1 Research Question One -- -- -- -- -- -- 47

4.6.2 Research Question Two -- -- -- -- -- -- 48

4.6.3 Research Question Three -- -- -- -- -- -- 49

4.6.4 Research Question Four -- -- -- -- -- -- 59

CHAPTER FIVE

CHALLENGES TO THE PROTECTION OF WOMEN'S RIGHT TO HEALTH IN NIGERIA

5.1 Legal Challenges -- -- -- -- -- -- -- 67

5.2 Socio-Cultural Challenges -- -- -- -- -- -- 69

5.2.1 Female Genital Mutilation -- -- -- -- -- -- 69

5.2.2 Delivery by untrained traditional birth Attendants -- -- -- 71

5.2.3 Early girl child marriage -- -- -- -- -- -- 72

5.2.4 Preference of male children -- -- -- -- -- -- 73

5.2.5 Harmful widowhood practises -- -- -- -- -- 73

5.3 Economic Challenges -- -- -- -- -- -- -- 74

5.4 Lack of political will -- -- -- -- -- -- -- 75

5.5 High rate of illiteracy -- -- -- -- -- -- -- 76

CHAPTER SIX

SUMMARY AND CONCLUSION

6.1	Summary -- -- -- -- -- -- -- --	77
6.2	Findings -- -- -- -- -- -- -- --	78
6.3	Recommendations -- -- -- -- -- -- --	79
	Bibliography -- -- -- -- -- -- -- --	81
	Appendix -- -- -- -- -- -- -- --	83

TABLE OF CASES

	Pages
Abacha vs Fawehinmi (2006) 6 NWLR Pt 660 at 228 -- -- --	69
Agbakoba vs Director SSS (1994) 6 NWLR Pt 351-- -- -- --	69
Akinnubi vs Akinnubi (1997) 2 NWLR Pt 144 -- -- -- --	73
Asika vs Atuanya (2008) 17 NWLR PT 117 at 484 -- -- -- --	74
Mojekwu vs Mojekwu (1997) 7 NWLR Pt 512 at 283 -- -- --	73
Paschim Banga Khet Mazdoor Samtg vs State of West Banga (1996) 4 SCC 37--	35
RTNACHPN vs MHWUN (2008) 2 NWLR Pt 1072-- -- -- --	69
Ukeje vs Ukeje (2014) LPELR SC -- -- -- - -- --	74
Uko vs Iro (2008) FMLR Pt 129 at 1454 -- -- - -- --	73
Uzoukwu vs Ezeonu (1991) 6 NWLR Pt 200 p. 708-- -- -- --	36

TABLE OF STATUTES

Pages

Abolition of Harmful Traditional Practises against Women and Children Law, 2001 of Ebonyi State -- -- -- -- -- -- -- 42

African Charter on Human and People's Rights, 1981 -- -- -- --4, 7, 30

Child's Rights Act, 2003 -- -- -- -- -- -- -- 40, 68

Constitution of the Federal Republic of Nigeria 1999 (as amended)-- --3,7,28,35,69

Convention on the Elimination of all forms of Discrimination against Women (CEDAW), 1979 -- -- -- -- -- -- -- -- 4, 6, 21, 22

Convention on the Rights of the Child (CRC), 1989 -- -- -- -- 7, 27

Criminal Code Act, 2004 -- -- -- -- -- -- -- 3,38,68

Girl-Child Marriage and Female Circumcision (Prohibition) Law, 2000 of Cross River State -- -- -- -- -- -- -- -- 41

International Convention on Civil and Political Rights (ICCPR) ,1966-- -- 25, 26

International Convention on Economic, Social and Cultural Rights (ICESCR), 1966 ---- -- -- -- -- -- -- -- -- -- 7, 16, 25

International Convention on Population and Development (ICPD),1994 -- -- 7, 17

International Planned Parenthood Federation Charter, 1996-- -- -- 13

Labour Act, 2004 -- -- -- -- -- -- -- -- 37

Marriage Act, 2004 -- -- -- -- -- -- -- -- 43

Matrimonial Causes Act, 2004 -- -- -- -- -- -- 43

Penal Code, 2004 -- -- -- -- -- -- -- -- 38, 67

Police Act, 2004 -- -- -- -- -- -- -- -- 38

Protocol to the African Charter of Human and People's Rights, 2003-- 4, 7, 17, 28,30

United Nations Fourth World Conference on Women, 1995 -- -- -- 17

United Nations World Conference of Human Rights, 1993-- -- -- 17

Universal Declaration of Human Rights (UDHR), 1948-- -- -- 1, 3, 13, 16, 34

World Health Organization Constitution -- -- -- -- -- -- 1, 17

ABSTRACT

Every individual is entitled to the full protection of their rights because they are human beings. Men and women also experience health challenges but because women go through some biological and social processes that carry health risks like pregnancy and child birth they require adequate health care to be able to fulfil these roles. The research aimed to examine women's right to health as a neglected issue that leads to maternal and infant mortality; to examine women's right to health as a fundamental human right whose importance is such that no derogation should be encouraged and also to explain how socio-cultural practises contribute to abuse of women's right to health. The main objective of the research is to show that the Nigerian legal system has not been able to capture the extent of women's right to health under several international Conventions that Nigeria is a party to. In line with these aims and objectives, questionnaire and interview survey was administered on health professionals and women, hospitals were also visited in order to determine how lack of healthcare facilities and personnel affect the status of women's health in Nigeria. The methodology used in the research is both empirical and doctrinal. The research observed that there is a plethora of international and national laws and instruments that aim at protecting women's right to health but lack of political will on the part of government and cultural beliefs hinder the enforcement of some of these laws. An analysis was made of the international and domestic legal framework for the protection of women's right to health in Nigeria, the challenges militating against the protection of these rights were discussed and recommendations were proffered that Nigeria should be willing to perform its obligations under the international convention to which she is a party including the Protocol to the African Charter on Human and Peoples' Rights in Africa also known as the Maputo Protocol, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), International Convention on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC) et cetera. Judicial Activism should be encouraged in Nigeria. The right to health should be treated as an extension of the right to life as has been done in India. This is because the provisions of Chapter 11 of the Indian Constitution are pari materia with Chapter 11 of the Nigerian Constitution on Fundamental Objectives and Directive Principles of State Policy.

CHAPTER ONE

GENERAL INTRODUCTION

1.1 Background to the Study

Men and Women are entitled to the full protection of their rights because they are human beings.[1] At its most basic level, "human rights" are safeguarded prerogative granted because a person is alive.[2] This means that all human beings have rights by virtue of human species membership. A right, therefore is a claim to something (by the right holder) that can be exercised and enforced under a set of grounds or justifications without interference from others. The subject of right can be an individual or a group, and the object is that which is being laid claim to as a right.[3] Human rights are, therefore, those rights that every human being possesses and is entitled to enjoy by virtue of being a human being.

Health has been defined by World Health Organization (WHO) "as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity".[4] The preamble to the Constitution of the World Health Organization also proclaims that "the enjoyment of the highest attainable standard of living is one of the fundamental rights of every human being without distinction of races, religion, and political belief, economic or social conditions".[5]

---

[1]Okagbue, I. (1996) *Women's Rights are Human Rights*. Nigerian Institute of Advanced Legal Studies, Lagos p.1.
[2] Oyedele, O.S (2006) ,Women's Rights in Africa: Myth or Reality, *University of Benin Law Journal*, Vol. 9(1) p.28.
[3] Ibid.
[4] World Health Organization, *Preamble to the Constitution the World Health Organization* (1948) adopted by the International Health Conference on July 1946. Opened for signature on July 22 1946, and entered into force on 7th April, 1948.
[5] Ibid.

Right to health as a fundamental human right was declared by the Universal Declaration of Human Rights (UDHR)[6]. Women's right to health has been declared as human right at Beijing, China.[7] At the Conference, delegates from 189 countries committed themselves to upholding the equal rights and inherent dignity of women through the adoption of the Beijing Declaration. The Declaration called on governments to implement measures to eliminate discrimination and violence against women and girls, recognize women's rights as human rights; and within this context, control all aspects of their health and fulfil their responsibilities to respect women's human rights and humanitarian law.[8]

Women and men share many similar health challenges, but the differences are such that women deserve particular attention. They experience conditions that have negative impact on their wellbeing. Some of these are pregnancy and childbirth which are not diseases, but are biological and social processes that carry health risks and require health care. Throughout human history, pregnancy and child bearing have been major contributors to the health problem and disability among women. Maternal Mortality (the death of women during pregnancy, delivery or the post partum period) is a key indicator of women's health status.[9] This indicator is very high in Nigeria, as it has been observed that over the past three and half decades, Nigeria has progressively shown one of the most abysmally poor reproductive health indexes in the world.[10] Women's health should not be a problem only to women themselves. It is crucial to the health of the children they bear and their fitness for their roles both in the home and in public life. This underscores

[6] United Nations, Universal Declaration of Human Rights (1948), Art. 25.
[7] United Nations, (1995) , Fourth World Conference on Women in Beijing-China, September, 4-15.
[8] Amnesty International, (2005*) Stop Violence Against Women*, Amnesty International Secretariat, London, p.22.
[9] World Health Organization (2009), *Today's Women and Health Evidence, Tomorrow's Agenda*, WHO Press, Geneva, p.40.
[10] Ladan, M.T (2007), *Law and Policy on Health ,HIV-AIDS, Maternal Mortality and Reproductive Rights in Nigeria*, Faith Printers and Publishers, Zaria, p.89.

the importance of providing sound healthcare for women as an investment not just for the present but also for the continuity of future generation. From the above, it is crucial that the underlying social and economic determinants of women's health, including education and employment, are important for the survival, growth and development of children.

Culture in Nigeria is a major culprit that adversely affects women's health. This manifests in various forms ranging from Female Genital Mutilation, early/child marriages, forced marriages, widowhood practices, unsafe traditional delivery practices, the preference of male children to female children, violence against women, et cetera. They contribute to the poor health index of the Nigerian women. The preference of male children to female children has direct impact on the psychological state of such female children as can be seen in this folksong**: "**why did you come oh girl? When we wished for a boy? Take a jar and fill it from the sea, may you fall into it and drown**"**[11] The song shows the resentment of the girl child in some parts of Africa and Nigeria. The resentment places a heavy burden on the socio-economic and psychological well being of women in Nigeria.

Notwithstanding all these, there are many International and National legislation and safeguards on women's right to health. In Nigeria, the Constitution[12] did not make express provisions for ensuring the right to health but under Chapter II, it provides for the social objectives of government. Chapter IV[13] on Fundamental Rights also provides for the right to life and right to the dignity of human person. The Labour Act[14]and the Criminal Code[15] also make provisions to guarantee women's right to health.

There are several international instruments on Women's right to health, urging state parties to ensure the provision of such rights in their National Laws and to uphold

[11] Oyelade, O.S,. op. cit. p.1.
[12] Constitution of the Federal Republic of Nigeria, *(CFRN)* 1999 (as amended).
[13] Ibid, S.33 and 34.
[14] Labour Act Cap L1, Laws of the Federation of Nigeria, 2004, S.54.
[15] Criminal Code Act Cap C38 LFN, 2004. Chapter21 and part V.

the observance and protection of such rights. Some of these instruments include, but not limited to, the United Nations Universal Declaration of Human Rights (UDHR)[16], United Nations Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)[17], African Charter on Human and Peoples Rights,[18] which has been ratified and domesticated by Nigeria; International Covenant on Economic, Social and Cultural Rights,[19] Maputo Protocol on the Rights of Women in Africa[20]. All these are considered in details in the course of the work.

1.2 Statement of the Research problem

Women suffer many health challenges especially during their reproductive years. Some of these challenges are not diseases but biological and social processes that carry health risks and require healthcare. Culture-based practices lead to poor health condition of women example, female genital mutilation, unhealthy widowhood practices, violence against women, early child marriage, certain traditional beliefs, et cetera. Lack of health care facilities and personnel at the grassroots, dearth of modern medical equipment and procedure is another problem militating against the actualization of women of right to health. There are National and International legislation that aim at protecting and safeguarding women's right to health, but the problem lies in implementation and lack of political will on the part of government to pursue policies and programmes advancing women's rights to their logical conclusion.

This thesis, therefore, is a research into the question, whether or not the non domestication of international conventions relating to women's right to health to which

[16] United Nations, Universal Declaration of Human Rights (1948).
[17] United Nations Convention on the Elimination of all Forms of Discrimination against Women (1979).
[18] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap. A9 Laws of the Federation of Nigeria, 2004.
[19] 1966.
[20] A protocol to ACHPR adopted in Maputo, Mozambique on 11th July, **2003** and came into force, 2005.

Nigeria is signatory is a major cause or contributory to the non existence of the right to health for women in Nigeria.

1.3 Empirical Research Questions

a. Do women suffer from health challenges during their reproductive years that are not necessarily disease based but biological and social processes that carry health risks and require health care?

b. Are there culture based practices that contribute to the poor health status of women in Nigeria?

c. How does lack of health care facilities and personnel especially at the grass roots affect the status of women's health in Nigeria?

d. What are the components of women's right to health and how do they affect maternal mortality in Nigeria?

1.4 Aims and Objectives of the Research

1.4.1 Main objective

To show that the Nigerian legal system has not been able to capture the extent of women's right to health under several international Conventions that Nigeria is a party to.

1.4.2 Specific objectives

a. To study the extent to which Nigeria has been able to measure up to international standards in terms of domestication of International Conventions on women's right to health to which Nigeria is signatory.

b. To explain how socio-cultural practises contribute to the abuse of women's right to health.

c. To show that non-domestication of International Conventions on women's right to health and non-provision of punitive measures against the abuse of these rights in Nigerian National Laws is a major reason for the persistent practise of harmful cultural practises in Nigeria against women.

1.5 Scope and Limitation of the research

This research focuses on the applicability of International Conventions on women's right to health in Nigeria. It examines the effect of non-domestication of International Conventions on women's right to health in Nigeria. It further examines the effect of negative socio-cultural practises on women's right to health by gathering information from experienced experts in the field of women's health. It seeks to find out the extent to which International Conventions on women's right to health have been able to protect women in Nigeria.

The limitation faced in the course of this research is insecurity. The researcher could not travel to many parts of the country to carry out the empirical research because of insecurity problems prevalent in the country. Another limitation is lack of funds to travel extensively in order to gather information and materials for the work.

1.6 Justification

Nigeria is a party to numerous International Convections that protect women's right to health like the United Nations Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)[21] International Convention on Civil and

[21] United Nations CEDAW (1979) adopted by United Nations GENERAL Assembly in 1979.

Political Rights (ICCPR),[22] International Convention on Economic, Social and Cultural Rights (ICESCR),[23] Convention on the Rights of the Child (CRC),[24] African Charter on Human and Peoples' Rights (ACHPR),[25] The Protocol to the African Charter on Human and Peoples' Rights[26] among others, but only the ACHPR have been domesticated. The Protocol to the African Charter on Human and Peoples' Rights which make very specific provisions on women's right to health in Article 14 has not been domesticated. The non-domestication of these International Conventions to make them applicable in Nigeria as part of our National Laws as provided by section 12 of the constitution [27] have made them ineffective in the protection of women's right to health in Nigeria.

Following from these lack of protection, many women die in pregnancy and child birth in Nigeria as indicated by the maternal mortality ratio which is 576 to every hundred thousand live birth [28]These deaths are preventable if government live up to their responsibilities towards its citizens by providing healthcare and putting adequate legislation in place to punish those that abuse women's right to health. This research is also necessary to show that socio-cultural practises like female genital mutilation, child/early marriages, negative widowhood practises as problems that violate women's right and, therefore, women need protection by application, enforcement and implementation of legislation and policies on the issue.

[22] ICCPR adopted by United Nations General Assembly in 1966 and entered into force in 1976.
[23] ICESCR adopted by United Nations General Assembly in 1966 and entered into force in 1976.
[24] CRC adopted by United Nations General Assembly in 1989 and entered into force in 1990.
[25] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap. A9 Laws of the Federation of Nigeria, 2004.
[26] This Protocol was adopted in Maputo Mozambique in 2003 and entered into force in 2005.
[27] Constitution of the Federal Republic of Nigeria, 1999 (as amended).
[28] National Population Commission (NPC) [Nigeria] and ICF International (2014*) Nigeria Demographic and Health Survey 2013*. Abuja, Nigeria and Rockville Mary Land USA, NPC and ICF International.

1.7 Research Methodology

The methodology for this research is both doctrinal and empirical. Primary and secondary sources of information are used in the research. The primary sources of doctrinal research include International Conventions, the Nigerian Constitution, the Penal Code, the Criminal Code, the Labour Act, the Marriage Act, the Child Rights Act. The secondary sources include books, journals, articles and the internet. For the empirical research method, questionnaire and interview survey was administered on health experts like doctors, nurses, midwives and female patients and women generally.

1.8 Literature Review

There are many writings on human rights generally and on women's rights in particular.

Rebecca Cook, Bernard Dickens and Mahmoud Fathalla[29] are of the view that, the right to health is an inclusive right which contains both freedoms and entitlements. The freedoms includes the right to control one's health and body including sexual and reproductive freedoms, and the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection that provides equality of opportunity for people to enjoy the highest level of health. The health care system has obligations to people's right to health. It has the obligations to respect, protect and fulfil the right to health. It has to respect and protect the freedoms and fulfil the entitlements embodied in the human right to health. According to them,[30] reproductive health is special, maternity is not a disease, it means the propagation of our species. It is a risky business which women undertake. Women

[29] Rebecca Cook et al (2006) *Reproductive health and human Rights integrating medicine, ethics and law,* Oxford University Press, New York, p.37.
[30] Ibid p. 57.

have a right to be protected when they go through risks for survival of our species. They are of the view that reproductive and sexual ill-health do not occur in a vacuum, but are conditioned by combine laws and values[31]

Some other writers have advocated that socio-cultural factors contribute to the denial of women's right to health. According to Eze[32] in spite of Article 18(3) of the African Charter which provides that states should ensure the elimination of every discrimination against women and also ensure the protection of the rights of women and the child stipulated in International Declarations and Conventions, women are still being discriminated against in social, political, economic and cultural fields. From the view of Adebayo[33], there are certain age long socio-cultural practices that hinder women from fully enjoying their rights. He identifies these as cultural practices and attitudes passed from one generation to another which have been powerful obstacles to women's enjoyment of their human rights.

Enemuo[34] identifies another practice which infringes on women's right as early girl/child marriage which also denies her opportunity to acquire education and sellable skills that will have direct impact on her economic status, and will ultimately limit her ability to take care of her health. In the words of Rebecca Cook,[35] women's health is often compromised not by lack of medical knowledge, but by infringements on women's human rights. These take the form of female genital mutilation, rape, lack of access to family planning and reproductive health education, etc

[31] Ibid p. 4.
[32] .Eze, O. (1984) *Human Rights in Africa: Some Selected Problems*, Nigeria Institute of International Affairs, Lagos, p.149.
[33].Adebayo, A. (1989) *African Women in Development, Selected Speeches*, United Nations Economic Commission for Africa, Addis Ababa, p.44.
[34] Enemuo, F.C (1999), Gender and Women Empowerment, in Remi Anifowose and Francis (ed), *Elements of Politics*, Lagos, Malt house, Lagos, p.227.
[35] Cook, R J and Fathalla M.F (1996), *Advancing Reproductive Rights Beyond Cairo and Beijing*, International Family Planning Perspective, 22, p 115.

According to Bogecho, D[36] for a woman to die from pregnancy and childbirth is a social injustice, such deaths are rooted in women's powerlessness and unequal access to finances, education basic health care, employment and other resources. Today, after decades of struggle, the right to health has finally been articulated in international treaties and is slowly being implemented as a human right in few countries.

Omoyemen Odigie Emmanuel[37] is of the view that adequate maternity leave is important to enable the Woman's body to recover after delivery but a study of the Nigerian Workplace has revealed that "a gap is identified between law and practice with wide patterns of protection resulting in some women enjoying good benefits, while others are wholly or partly unprotected within the Nigeria workplace." According to him, by virtue of the Protocol to the African Charter on Human and people's Rights, Nigeria women are guaranteed the right to health including sexual and reproductive rights among other rights, and the obligation of the Nigerian government having ratified the protocol includes enactment of appropriate legislation to protect women's rights to health. He mentioned the patriarchal structure of the Nigerian society and failure of government to domesticate this protocol as serious hindrance to the realization of Women's Rights in Nigeria.

Asikia Ige[38] is of the view that the health status of the Nigerian Women has been affected by a general lack of access to qualified personnel and adequate health facilities especially in rural areas. According to him, the Situation Analysis on Children and Women carried out by the United Nations Children's Fund (UNICEF) and the Federal

[36] Bogecho , D (2004) Putting it to Good use : The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health, *Law, Social Justice and Global Development Journal (*LGD) (1) p,3.
[37] Omoyemen Odigie-Emmanuel (2010) "Assessing Women's Rights in Nigeria Washington, DC *Foreign Policy in Focus*, retrieved from http://www.FPIF.org/articles/assessing – Women's -Rights-in-Nigeria assessed on 14th February, 2013.
[38] Asikia , I. (2012) Women and the Right to Health in Nigeria: The Intersections, *British Journal of Arts and Sciences.* British Journal Publishing inc retrieved from http://www.bjournal.co.uk/BJASS.aspx.

Government of Nigeria shows disparity between Urban and Rural dwellers. For example, trained hospital personnel assist in delivering only 60% of urban babies and 29% of rural babies while traditional birth attendants (TBAS) delivered 46% of rural and 22% of urban children. The report identifies inadequate pre-natal care whereby pregnancies that are at risk are not quickly identified, thus, mothers in the rural towns are at higher risk of maternal death.[39]

According to Okagbue,[40] the issue of women's rights has not been given serious consideration under international human rights instruments. He is of the view that some of the myopia on the human rights instruments on women no doubt stem from the overwhelming male composition of the structure of the international legal order, therefore "women's Concern" are relegated to a limited category because men generally are not the victims of sex discrimination, domestic violence and sexual denigration as well as negative cultural practices that affect women's health.

1.9 **Organisational Layout**

This Thesis comprises of six chapters. Chapter one deals with general introduction of the work and consists of background to the study, statement of the research problem, Aim and objectives scope and limitation of the research, justification for the research, research methodology and literature review. Chapter two deals with conceptual clarification of key terms like health, human rights, right to health, maternal health and women's right to health. Chapter three is an analysis of international and domestic legal frame work for the protection of women's right to health.

[39] Aina, O.I (2003) *General Overview of the Status of Women in Nigeria* in Abiola A.O (ed) Women Advocates Research and Documentation Centre Lagos.
[40].Okagbue, I. op. cit p.1

Chapter four is a presentation and analysis of empirical data collected in the course of the research. Chapter five discusses the challenges to the protection of women's right to health in Nigeria. While chapter six presents the summary, finding/observation and recommendations made.

CHAPTER TWO

CONCEPTUAL CLARIFICATION OF KEY TERMS

2.1 Human Rights

In its simplest form Human rights are those rights that every human being possesses and is entitled to enjoy by virtue of being human. They are in-born and accompany every human being at birth. Human Rights are those rights set out in the Universal Declaration of Human Rights (UDHR)[1]. They are basic rights and freedoms that all people are entitled to regardless of nationality, sex maternal or ethnic origin, language or other status. These rights as stated by the UDHR include Right to life[2] Freedom from slavery and Servitude[3] Freedom from torture or cruel, inhumane or degrading treatment[4] Right to marriage and to found a family[5] Right to Health[6]

Human rights are basic standards which all human beings are entitled. They concern fundamental freedoms and humanity[7] Human rights stem from the notion that all human beings are born equal and, therefore, have an equal right to enjoy dignity and security.[8] These ideas arose in the 17th and 18th Centuries during the enlightenment and influenced philosophers such as Locke, Montesquieu Rousseau. Initially the concept of human rights applied domestically and did not have a place in international sphere. It was only towards the end of the 18th Century and the beginning of the 19th Century that concern for individual rights filtered into the international system.[9] An example of this

[1] Adopted by United Nations General Assembly on December 10, 1948.
[2] United Nations UDHR, Art. 3.
[3] Ibid, Art. 4.
[4] Art. 5.
[5] Art .25.
[6] Art. 25.
[7] International Planned Parenthood Federation Charter (IPPF) (996), Regent's College, Inner Circle Regent's Park London, United Kingdom p.1.
[8] Alson, P and Steiner, H.J. (1996) International Human Rights Context*: Law, Politics and Morals* pp.113, 115.
[9] Alson, P and Steiner, H.J. (1996) International Human Rights Context: *Law, politics and Morals* , p.114.

occurred in the 19th century when slavery and slave trade was abolished in Europe and United States.

Later, following both World wars, international human right was formally entrenched within the United Nations Treaty Systems. The United Nations Charter[10] was the first international document to formally give voice to the human rights movement after the Second World War. The Charter laid out the United Nations basic purpose of securing peace. In 1948 the U.N. General Assembly Adopted the Universal Declaration of Human Rights[11]

Pillai and Wang[12] defined human rights as a loosely organized set of formal and informal rules, codes and norms which protect individuals against groups and organizations that threaten the survival and dignity of human persons.

At the 1993 World Conference on Human Rights[13] member states of the U.N agreed that the human rights of Women should be integrated into all aspects of human rights work of the organization. They further declared that:

> The human rights of women and the girl-child are an inalienable, Integral and indivisible part of universal human rights. The full and equal participation of women in political, civil, economic, social and cultural life at national, regional and international levels and the eradication of all forms of discrimination on grounds of sex are priority objectives of the international community[14]

Several theoretical approaches have been advanced to explain how and why the concept of human rights developed. One of the oldest Western philosophies on human

[10] UN Charter signed on June 26, 1945, entered into force 24, October 1945.
[11] Universal Declaration of Human Rights, UN General Assembly Resolution 217 A(III) U.N Doc A(810) 1948).
[12] Pillai, V and Wang. L(1999), *Women's Reproductive Rights in Developing Countries India*, Gaungp Zheu p.3.
[13] United Nations World Conference on Human Rights,(1993) Vienna Austria.
[14] Vienna Declaration and Programme of Action Part 1 para. 18.

rights is that they are a product of a natural law[15]. Some proponents of the natural law school include John Locke Hugo Grotius and Aristotle. Natural law theories base human rights on "natural" moral, religion or even biological order that is independent of transitory human laws or traditions.

Human Rights are considered the offspring of natural rights which themselves evolved from the concept of natural law. Natural law, which played a dominant role in Western political theory for centuries, is that standard of higher - order morality against which all other laws are adjudged[16]. To contest the injustice of human made law, one was to appeal to the greater authority of God or natural law. Eventually, this concept of natural law evolved into natural rights. This change reflected a change in emphasis from society to individual. Whereas natural law provided a basis for curbing excessive state power over society, natural rights gave individuals the ability to pews claims against the government[17].

John Locke, in his second Treatise on government [18] described a "state of nature" prior to the creation of society in which individuals fended for themselves and looked after their own interest. In this state,, each person possess a set of natural rights including the right to life, liberty and property.

Locke argued in his writing[19] that certain rights self-evidently pertain to individuals as human beings (because these rights existed in the hypothetical "state of nature" before mankind entered civil society). These rights include rights to life, liberty (freedom from arbitrary rule) and property: Upon entering civil society, humankind

[15] Wikipedia: Philosophy of human rights retrieved from https://en.wlkpdia .org/philosophy _of human _rights# Natural rights.
[16] Globalization 101 : Origin of Human Rights retrieved from www. Globalization 101.org/human _rights vs – Natural Rights.
[17] Ibid.
[18] Locke, 1690.
[19] Locke, Glorious Revolution (1688:89)

surrendered to the state pursuant to 'social contract' only the right to enforce these natural rights and not the rights themselves and that the state's failure to secure these rights gives rise to responsible, popular revolution[20].

In contrasts to Natural Law School of Thought, the Positivist School, believe that there are no natural rights rather human exist solely because of laws. These laws are positive or national laws (the written law of a given society at a particular time) and applies to the citizen of a given nation or society. Those who adhere to legal positivism believe that there can be no higher law than a nation's positive law. The Positivists believe that whether a law is 'bad' or good is irrelevant. The law is the law and must be obeyed until it is changed through a legitimate law making process to prevent anarchy[21] Hobbes and Humme are among the greatest proponents of legal positivism.

2.2 **Right to Health**

The Universal Declaration of Human Rights states that **"**Everyone has a right to a standard of living adequate for the health and well being of himself and his family"[22]

The preamble to the World Health Organization's (WHO) Constitution also declares that "It is one of the fundamental rights of every human being to enjoy the highest attainable standard of Health" The International Covenant on Economic and Social Cultural Rights (ICESCR)[23] further defined the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental Health"**.** It also says that states must take steps to ensure "the creation of conditions

[20] Burns H. W. *Human Rights* retrieved from www. Britannica.com./topic/human rights/natural-law-transformed-into-natural rights accessed 16th July 2015
[21] Cross, F and Miller, R.(2014) *The Legal Environment of Business: Text and Cases,* USA, Cengage Learning Stamford USA p.4 retrieved at https://books.google.com.ng/books ISBN = 1305142942.
[22] United Nations UDHR Art. 25.
[23] United Nations ICESCR (1966) Art. 12.

which would assure to all medical services and medical attention in the event of sickness".

In line with the World Health Organization's definition of Health as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity"[24] and in keeping with international covenants as regards the right to health, states have obligation to make health care available and affordable to all its citizens irrespective of socio-economic status.

2.3 **Women**

The protocol to the African Charter on Human and Peoples' Rights defined women as persons of female gender including girls.[25]

2.4 **Women's Right to Health**

Women's Right to Health is a fundamental human right as have been declared at Beijing in 1995[26]. The Declaration called on governments to implement measures to eliminate discrimination and violence against women and girls, recognize women's rights as human rights; and within this context control all aspects of their health and to fulfil their responsibilities to respect women's human rights under international law.

Pregnancy and child birth are major contributors to the health problem and disability among women, it is for this reason that women need special health care especially during their reproductive years. Women's right to Health include: right to reproductive health and right to maternal health.

---

[24] World Health Organization, *Preamble to the Constitution the World Health Organization* (1948) adopted by the International Health Conference on July 1946. Opened for signature on July 22 1946, and entered into force on 7th April, 1948.

[25] Protocol to the African Charter on Human and Peoples' Rights (2003) Art. 1(K).

[26] United Nations World Conference of Women (1995).

2.4.1 **Right to Reproductive Health**

Reproductive Health was defined by International Convention on Population and Development (ICPD)[27] as "a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes". This implies the provision of healthcare systems that will make reproduction safe for women. It includes provision of prenatal and ante-natal services, drugs, healthcare procedures, reproductive health education that are available and affordable to all women even at the rural areas.

The Convention on the Elimination of all Forms of Discrimination against Women[28] specified the rights to health for women explicitly, stating that it includes healthcare-services related to family planning, pregnancy, child birth and the post natal period. In 1999 the CEDAW Committee[29] further commented that states must **"**eliminate discrimination against women in their access to health care services, through their life cycle.

The Beijing platform defined **"**Women's reproductive health' to include a satisfying and safe sex life, capacity to reproduce, and the freedom to decide if, when and how to do so"

According to Bogecho[30] from the definition of reproductive health set out by the ICPD, it is clear that women's reproductive health does not exist in vacuum. In order for good reproductive health to be a realistic possibility, important economic and political conditions must be met. Such conditions include provision of affordable health care

[27] United Nations International Conference on Population and Development (1994).
[28] United Nations CEDAW (1981).
[29] CEDAW Monitoring Committee.
[30] Bogecho, D (2004) Putting it to Good Use: The International Covenant on Civil and Political rights and Women's Right to Reproductive Health (1*) Law, Social Justice & Global Development Journal* GD) p.5.

services, adequate remuneration of health care providers, incentives for health care providers working in rural areas, adequate and functional referral centres, e.t.c.

Health advocates and human right scholars have argued that health is a socially produced good that needs a combination of Civil and Political Rights (the right to decide the number and spacing of children) and economic and social rights (the availability of contraceptives and safe and affordable health services) to attain the highest standard of sexual and reproductive health.[31].

The 1998 report by the World Health Organization (WHO) on safe motherhood explains that empowering women and guaranteeing them their human rights will improve their reproductive Health.[32] Women's reproductive health depends on the enforcement of their human Rights because the concept of health is not simply a biological process of individual responsibility but the attainment of the highest standard of sexual health depends greatly on social, economic and political factors like availability of health facilities, availability and affordability of health services, economic empowerment of women, political will on the part of government to make laws that promote women's reproductive rights, e.t.c.

2.4.2 **Right to Maternal Health**

Proper care during pregnancy and delivery is important for the health of both the mother and the baby and is an indicator of both maternal and child health in the society.[33]. The health care that a woman receives during pregnancy, at the time of delivery, and soon

[31] Pillai, Vijayan K and Wang, (1999*) Women's Reproductive Rights in Developing Countries*, p.3.
[32] Family Care International and Safe Motherhood Inter Agency Group (2002) Safe Motherhood: A matter of Human Right and Social Justice in Bogecho, D (2004), Putting it to Good Use: The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health (1) *Law, Social Justice and Development Journal (LGD)* p.5.
[33]National Population Commission (2008) Nigeria Demographic and Health Survey (NDHS) Abuja National Population Commission and ICF Macro, Maryland p. 125.

after delivery is important for the survival and well being of both the mother and the child.

According to WHO[34] maternal health refers to the health of women during pregnancy, child birth and postpartum period. While motherhood is often a positive and fulfilling experience, but for too many women, it is associated with suffering, ill-health and even death. A woman dies from complications in childbirth every minute that is about 529,000 each year, the vast majority of them in developing countries. A woman in sub-Saharan Africa has a 1 in 16 chance of dying in pregnancy or childbirth[35]. This is a social injustice. Every woman has a right to maternal health which includes ante-natal care, education on safe motherhood, maternal nutritional programmes, adequate delivery assistance, post natal care and family planning.

The major objective of ante-natal care is to ensure optimal health outcomes for the mother and the baby. Ante-natal care from a trained provider is important to monitor the pregnancy and reduce morbidity risks for the mother and child during pregnancy and delivery. Antenatal care provided by a skilled health worker enables:

a. Early detection of complications and prompt treatment (e.g. detection of sexually transmitted infections);

b. Prevention of diseases through immunization and micronutrient supplementation;

c. Birth preparedness and complication readiness; and

[34] WHO Health topics = Maternal Health retrieved from http://www.who.int/topes/maternal-health/en accessed 24th October 2011.

[35] Unicef , MDG goal of Improving Maternal Health by 2015 retrieved from http://www.uncef.org/mdg/index_maternalhealth.htm.

d. Health promotion and disease prevention through health messages and counselling of pregnant women.[36]

The Convention on the Elimination of all forms of Discrimination against Women (CEDAW) affirms this by stating " Notwithstanding the provisions of paragraph 1 of this article, state parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period granting free services where necessary as well as adequate nutrition during pregnancy and lactation" [37].

Further affirming this position CEDAW Committee General Recommendation[38] provides that:

> State parties should include in their reports how they supply free Services where necessary to ensure safe pregnancies, childbirth and Post-partum periods for women. Many women are at risk of death or disability from pregnancy- related causes because they lack the funds to obtain or access the necessary services, which include ante-natal, maternity and post natal services. The Committee notes that it is the duty of state parties to ensure Women's right to safe Motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.

Nigeria is a party to CEDAW and, therefore, has an obligation to respect and abide by its provisions but it is unfortunate that maternal mortality due to poor maternal health is still high in Nigeria. According to the 2008 Nigeria Demographic and Health Survey[39] the maternal mortality ratio is 545 maternal deaths per 100,000 live births while in the 2013 NDHS the maternal mortality ratio is 576 maternal deaths per 100,000 live births.

[36] Nigeria Demographic and Health Survey (2008) National Population Commission Abuja p.125.
[37] CEDAW, Art. 12(2).
[38] CEDAW General Recommendation 24 paragraph 27, 20th Session 1999.
[39] Nigeria Demographic and Health Survey (2008) National Population Commission Abuja p.238.

CHAPTER THREE

LEGAL FRAMEWORK FOR THE PROTECTION OF WOMEN'S RIGHT TO HEALTH

Women health status is affected by complex biological, social and cultural factors which are interrelated and can only be addressed in a comprehensive manner. The need to protect women's right to health has been recognized by the international community. This has led to the provision for such protection in a number of multi-lateral treaties which are considered in this chapter. Nigeria has also put in place in addition to international treaties it has ratified and domesticated, some other legislation aimed at protection of women's right to health.

3.1 Analysis of International Framework on Women's Right to Health

3.1.1 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)[1]

This was adopted by the United Nations General Assembly in 1979 and is often described as an international bill of rights for women. It provides that

> State parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning Notwithstanding the provisions of paragraph1 of this article, State parties shall ensure to women appropriate services in Connection with pregnancy, confinement and the post-natal Period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. [2]

[1] United Nations CEDAW (1979).
[2] Art. 12.

The Committee of CEDAW[3] in its General Recommendation[4] elaborated on the provision of Article 12 above at its Twentieth Session in 1999[5] it states:

> State parties compliance with article 12 of the Convention is central to the health and well-being of women. It requires States to eliminate discrimination against women in their access to health care services, throughout their life cycle, particularly in the areas of family planning, pregnancy, confinement and during post-natal period[6]

State parties are encouraged to report on their health legislation, plans and policies for women with reliable data disaggregated by sex on the incidence and the severity of diseases and conditions hazardous to women's health and nutrition and on the availability and cost effectiveness of prevention and curative measures[7]

The Convention also states in its General Comment[8] that measures to eliminate discrimination against women are considered inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women.

The Committee has made recommendations regarding the provision of adequate information to women and adolescent girls on the issues of HIV/AIDS and other sexually transmitted diseases.[9]

The Committee also urged State parties to implement a Comprehensive National Strategy to Promote Women's health through their lifespan. This includes interventions aimed at both the prevention and treatment of diseases and conditions affecting women. They should place a gender perspective at the centre of all policies and programmes affecting Women's health and should involve women in the planning, implementation

[3] An expert body established in 1982 to watch over the progress made by the convention in State parties to the convention.
[4] Art. 21 of the Convention empowers the Committee to make general recommendations addressed to State parties based on reports and information received from state parties..
[5] General comment No. 24.
[6] Ibid, No 24(2).
[7] General comment 24(9).
[8] Ibid, 24(11).
[9] Ibid, 24(18).

and monitoring of such policies and programmes and in the provision of health services to women.[10]

Many women are at risk of death or disability from pregnancy related causes because they lack funds to obtain or access the necessary services, which include antenatal, maternity and post-natal services. The Committee on CEDAW notes that it is the duty of State parties to ensure Women's right to safe motherhood and emergency obstetric services and they should allocate to these services the maximum extent of available resources.[11] State parties are urged to provide frees services to women in order to ensure safe pregnancies, childbirth and post-partum periods.

CEDAW also provides that [12]

> State parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women that they participate in and benefit from rural development and, in particular shall ensure to such women the right to have access to adequate health care facilities, including information, counselling and services in family planning..

This recognizes the need for rural women to be provided with adequate health care facilities. The rural areas especially in Nigeria lack infrastructure like good roads, electricity, health centres, e.t.c. and so health workers do not like to dwell there. This provision urges government and personnel that by giving incentives to health workers posted to rural areas for them to stay there and work thereby reducing maternal mortality.

3.1.2 **International Convention on Economic, Social and Cultural Rights (ICESCR)**

This is a multilateral treaty adopted by the United Nations General Assembly on 16th December, 1966 and came into force from 3rd January 1976 and is explicit about the

[10] General Comment No. 24(29) & 31(a).
[11] Ibid, 24 Para. 17.
[12] Art. 14(2).

right to health and states that "The State parties of the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[13].

The steps to be taken by the State parties to the present covenant to achieve the full realization of this right as provided by General Comment 14 shall include those necessary for:

a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
b. The improvement of all aspects of environment and industrial hygiene;
c. The prevention, treatment and control of epidemic, endemic, occupational and other disease;
d. The creation of conditions which would ensure to all medical service and attention in event of sickness.[14]

The Covenant further states that **"**Special protection should be accorded to mothers during a reasonable period before and after childbirth. During such period, working mothers should be accorded paid leave with adequate social security benefits" [15]. These are provisions to safeguard Women's right to health particularly as it pertains to reproductive rights.

The Committee on International Covenant on Economic, Social and Cultural rights[16] in this General Comment No 14[17] states that[18]

[13] United Nations ICESCR Art. 12.
[14] General Comment 14 ICESCR, E/C.12/2000/4.
[15]Ibid, Art. 10 (2).
[16] The Committee that monitors issues arising from the implementation of the ICESCR.
[17] E/C.12/2004/4, Twenty-Second Session, General, 25th April – 12 May 2000.
[18] General Comment 14(14).

> The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child (art.12(2)(a) may be understood as requiring measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.

General Comment 14(9)[19] states that "the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health". Article 12(c) provides that "All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, that is respectful of culture of individuals, minorities peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned"

3.1.3 **International Covenant on Civil and Political Rights (ICCPR)**

This was adopted by the United Nations General Assembly[20] on 16th December, 1966 and entered into force on the 23rd day of March 1976. It provided that **"**Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life" [21].

The Committee on the ICCPR[22] in its General comment provides that[23]

> The right to life enunciated in article 6 of the Covenant has been dealt with in all States respectfully. It is the supreme right which no derogation is Permitted even in time of public emergency which threatens the life of the Nation (art.4). However, the Committee has noted that quite often the Information given concerning article 6 was limited to only one or other aspect of this right. It is a right which shall not be interpreted narrowly.

[19] ICESER, General comment 14(9).
[20] Resolution 2200 4(XXI), 16th December, 1966.
[21] Art. 6 (1).
[22] Committee that monitors the implementation of ICCPR.
[23] General Comment 6.

In relation to Women's Right to Health following the wider interpretation envisaged by this Covenant it is an infringement or a woman's right to life for a woman to die in child birth as a result of non-availability or non-accessibility of adequate health care facility.

This is further elaborated in Article 6(5)[24] which states:

> Moreover, the Committee has noted that the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot be properly understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for State parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.

3.1.4. **Convention on the Rights of the Child (CRC)**

This Convention was adopted by the United Nations General Assembly in November, 1989[25] and entered into force in 1990. It makes specific provisions relating to the right of Women to Health as follows:

> 1. State parties shall recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services[26]

2. State parties shall pursue full implementation of this right and in particular, shall take appropriate measures;

a. To diminish infant and child mortality;

b. To ensure appropriate pre-natal and post-natal health care for mothers; and

c. To develop preventive health care, guidance for parent and family planning education and services.

---

[24] General Comment 6(5).
[25] Adopted by the U.N. General Assembly by Resolution 44/28 of 20th November, 1989.
[26] Art. 24(1).

This article urges State parties to provide adequate facilities for care of Women during pregnancy and after childbirth. These include drugs ante-natal care/education and adequate nutrition.

3.1.5 **African Charter on Human and Peoples' Right (ACHPR)**

This is a regional treaty which was adopted by the Organization of African Unity[27]. It provides in Article 16(1) that "Every individual have the right to enjoy the best attainable state of physical and mental health "State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick" It goes further to state in Article 18 (2)[28] **"**The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of women and the child as stipulated in International declarations and conventions".

The Charter, in addition to calling for the protection of the rights of women, including their right to Health also urges State parties to ensure the protection of these rights as already spelt out in the numerous International Declarations and Conventions that abound. The good news is that the African Charter on Human and Peoples Rights have been ratified and domesticated in Nigeria in accordance with Section 12 of the Constitution[29]

This means that the Provisions of the African Charter is enforceable in Nigeria as a domestic law[30]. Nigeria is, therefore, under obligation to promote the rights of women

[27] Adopted 27 June, OAU Doc. CAB/LEG/67/3 rev.5, 21 1.r.m. 58(1982) entered into force 21 October, 1986.
[28] Ibid, Art. 18 (2).
[29] S.12 CFRN 1999 (as amended).
[30] African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, CAP A9 Laws of the Federation of Nigeria, 2004.

including the right to health as stipulated in this Charter by ensuring full implementation at the national level.

3.1.6 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa

This protocol was adopted in Maputo Mozambique in July 2003. It entered into force on the 25th November, 2005. It is also known as the Maputo Protocol. The Protocol made provisions for the protection of women's right to Health in Article 14 which is on Health and Reproductive Rights. It provides as follows:

1. State parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:

a. the right to control their fertility;

b. the right to decide whether to have children, the number and the spacing of children;

c. the right to choose any method of contraception;

d. the right to self protection and to be protected against sexually transmitted infections. This is right to protect oneself against HIV/AIDS;

e. the right to be informed of one's own health status and that of one's husband, particularly if he is infected with sexually transmitted diseases, including HIV/AIDS;

f. the right to have family planning education.

2. States parties shall take all appropriate measures to:

a. Provide health services to women in hospitals and health centres. These hospitals and health centres should not be far from their villages or places of residence and the cost should be affordable;

b. establish and strengthen existing pre-natal delivery and post-natal health and nutritional services for women during pregnancy and while they are breast feeding

c. Protect the reproductive rights of women by authorizing the right to a medical abortion when the pregnancy she carries is the result of rape or when continuing with the pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus[31].

Unfortunately this protocol has not been domesticated by Nigeria even though it has been ratified. The campaign for its domestication has been on with a lot of resistance from religious groups. The Catholic Bishops Conference of Nigeria have rejected the move and argued that it "aims at not only opening the door for the legalization of abortion, but even demanding that the state should provide for abortion"[32] According to the Bishops, the entire Article 14(2) (c) is totally unacceptable and must be expunged from the protocol before Nigeria can consider its domestication.

On the other hand, Ogedengbe Boma[33] explaining the sprit behind the contentious Article 14(2) (c), as it relates to Nigeria that in her experience spanning 40 years in practice and from evidence – based documentation of the Society of Obstetricians and Gynaecologists of Nigeria (SOGON), "Nigeria has a high rate of unsafe abortion among her young women of reproductive age group which is often between 15 and 25 years**".** She is of the view that evidence based studies have shown that unsafe abortions accounts for about 15 -20 percent of maternal deaths in Nigeria and other developing countries. She argued that if Nigeria is able to stop women dying from unsafe abortion it would get rid of about 20 percent of maternal mortality. She made a case for permissible abortion

[31] Art. 14(2) (c) of the Protocol to the ACHPR.
[32] Shokunbi, Y. (2010) Nigeria: Of Pope's shift on Condon and Women's Reproductive and Health Rights, *Daily Independent* December 4, accessed from All African.Com July 12 , 2011 .
[33] Chairman Pro-Abortion Care Network in Nigeria (PAC-Net) and Consultant Obstetrician and Gynaecologist , Lagos University Teaching Hospital (LUTH) .

for victims of rape, persons who have diseases that is incompatible with pregnancy, as the mother could actually die from the disease, person carrying abnormal babies and situations where pregnancy threatens the life of the mother and baby, "such women are entitled to safe procedure and this safe (medical) procedure should be provided by practitioners who have been trained to do it and not by quacks" [34].

Nigeria has only domesticated the African Charter on Human and Peoples' Rights ACHPR out of all these International Conventions, providing Women's Right to Health though it has ratified all the Conventions. It can be argued that by Article 18 of the ACHPR which Nigeria has domesticated, these other Conventions can be made applicable in Nigeria as Article 18 ACHPR provides that: "The state shall ensure the elimination of every discrimination against women and ensure the protection of the rights of the Women and the Child as stipulated in International declarations and conventions" Nigeria having domesticated this law is bound to enforce it as its National Law.

The African Commission on Human and People's Rights[35] in its Resolutions on Addressing Maternal Mortality in Africa[36]declares that "Preventable Maternal Mortality in Africa is a violation of right to life, health and dignity of women in Africa" and therefore calls upon African Governments to individually and collectively address the issues of maternal mortality in accordance with the recommendations.

That state parties to the African Charter on Human and Peoples' Rights should:

1. Meet their obligations under the Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases In particular:

i. Allocate 15% of their National budget to the health sector in accordance with the Declaration;

[34] Shokunbi, Y. note 32
[35] The Commission that monitors the issues arising from the implementation of the ACHPR
[36] ACHPR/Res. 135(XXXXIIII) OS: Resolution on Maternal Mortality in Africa. 44th Ordinary Session held in Abuja from 10 24 November, 2008

ii. Ensure that market based economic reforms including privatization do not take away the responsibility of the state to fulfil the right to health;

iii. Ensure that health reforms policies and programmes should make adequate considerations of the right of poor and rural women to access basic healthcare as enshrined in the protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa;

.iv Further ensure that access to ante-natal and obstetric services as much as practicable be free, available and accessible;

2. Adopt human right based approaches in the formulation of country programmes and strategies to reduce maternal mortality in Africa. In particular to:

i. Ensure participation of women and civil society in the formulation, implementation, monitoring and evaluation of policies and frameworks aimed at addressing maternal mortality.

ii. Take all appropriate measures including positive discrimination in providing funds for specific programmes and projects to secure maternal health.

iii. Provide a well staffed and equipped maternity centres in rural areas.

iv. Employ and retain skilled health personnel and birth attendants at rural and semi-urban areas.

v. Train and retain health workers in emergency obstetric care.

vi. Develop community based emergency transport system to cushion the effect of delays in getting medical attention.

vii. Develop adequate training curriculum for the education of women and girls on the rights to reproductive health.

3. Include in their periodic reports under article 62 of the African charter:

i. The general state of maternal health, including the level of mortality and morbidity and challenges faced in implementing related program.

ii. Policy and institutional measures taken to give effect to the provisions of article 14 of the African charter on the right to the best attainable state of physical and mental health for women.

iii. Budgetary and institutional measures dedicated to securing maternal health.

.iv Other programs and activities undertaken to secure maternal health with results.

4. Consider the declaration on the state of maternal health in Africa as a continental emergency and take appropriate regional actions.

5. To those member states of the African Union that have not already done so, to urgently ratify the protocol to the African Charter on Human and Peoples Rights on the Rights of women in Africa.

6. To member states that have already ratified this protocol to immediately undertake measures for domestication, including amendment of internal laws to conform with the provisions of the protocol.

7. To develop programmes aimed at drawing attention to the negative impact of maternal mortality on women in Africa and future generations.

8. To Civil Society Organization in Africa to work in collaboration and develop partnerships to:

i. Conduct research on maternal mortality in respective African countries;

ii. Work in collaboration with governmental agencies to develop effective country strategies for securing the right to maternal health;

iii. Ensure the participation of communities and women groups in the framework of programs aimed at reducing maternal mortality;

iv. Monitor the implementation of programs aimed at reducing maternal mortality;

v. Advocate for the ratification and domestication by African states of the protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in African without reservations.

This recommendation is laudable and exhaustive, if carried out diligently, will eradicate to a great extent, the abuse of women's Right to Health.

3.1.7 **Universal Declaration of Human Rights UDHR)**

The Universal Declaration of Human Rights (UDHR) is greatly agreed to be the foundation of international human rights law[37]. It has achieved the status of customary international law jus cogens that guide all nations. Together with the International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social and Cultural rights, they form the International Bill of Human Rights.

Article 25[38] states:

1. Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing, medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability widowhood, old age or other lack of livelihood in circumstances beyond his control.

2 Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

This Article has recognized the need for motherhood to be given special care like pre-natal and post-natal care, adequate nutrition during pregnancy and while bread-

[37] Adopted by United Nations General Assembly on 10th December, 1948.
[38] UDHR, Art. 25 (1).

feeding, family planning education, adequate immunization for mothers and their children, etc.

3.2 Analysis of Domestic Framework on Women's Right to Health in Nigeria

3.2.1 **Constitution of the Federal Republic of Nigeria**[39] is the grundnorm, that is, the supreme law of the land. It does not make explicit provisions for the protection of women's right to health, but such right can be adduced from some of its provisions.

Section 33(1)[40] provides that: "Every person has a right to life, 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". This can be interpreted as protection of the right to health and by extension women's right to health. In protecting the right to life the government is under obligation to provide adequate health facilities for all especially women and children as have been spelt out in a plethora of International Conventions on the right to health. Therefore, a situation where women die in pregnancy and childbirth of preventable causes is a clear violation of their right to health and life.

In the Indian Case of *Paschim Banga Khet Mazdoor Samitg v. State of West Banga*[41] The Supreme Court of India held that the right to life protected by Article 21 of the Indian Constitution was breached when various government hospitals denied a complainant emergency treatment for head injury. Here, the right to life was used to protect health.

Section 34(1)[42] Constitution of the Federal Republic of Nigeria 1999 (as amended) provides that

Every individual is entitled to respect for the dignity of his person and accordingly:

[39] Constitution of the Federal Republic of Nigeria 1999 (as amended).
[40] CFRN (as amended).
[41] (1996) 4 SCC 37.
[42] CFRN (1999) as amended.

a. no person shall be subjected to torture or to inhuman or degrading treatment;

b. no person shall be held in slavery or servitude; and

c. no person shall be required to perform forced or compulsory labour.

In the case of *Uzoukwu vs Ezeonu*[43]*a*n Enugu Court of Appeal defines "Inhuman treatment" as characterizes any act "without feeling for the suffering of the other".

Following from this argument, it is inhuman treatment for women to be dying of pregnancy and childbirth related causes. It shows that the governments whose duty is to ensure adequate care for women do not feel for the women in their suffering to bring forth children.

Section 37 of the 1999 Constitution[44] provides that for the right to private and family life. It states that "The privacy of citizens, their homes, correspondence, right to telephone conversation and telegraphic communication is hereby private and guaranteed and protected". This right to private and family life includes the right to marry, found a family and decide when and the number of children to have. It also includes a right to make informed choice about family planning and contraception. Under Chapter II on Fundamental Objectives and Directive Principles of State Policy, Section 14(2)(b)[45] provides that "the security and welfare of the people shall be the primary purpose of government----" This can be interpreted to mean that health and well being of the people shall be the primary purpose of government. Section.17 (3) (C) provides that **"**the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused" (d) There are adequate medical and health facilities for all persons. All these are allusions to the citizen's right to health. The provisions of Chapter II of the Constitution even though not justiceable serves as a roadmap to government on its responsibilities to the people.

[43] (1991) 6. NWLR pt 200 p. 708 at 764-788.
[44] CFRN 1999 (as amended).
[45] Ibid, S. 14 (2) (b).

3.2.2 **Labour Act**

The Labour Act[46] provides in Section 54 as follows: In any public or private industrial or commercial undertaking or any branch thereof, a woman:

a. shall have the right to leave her work if she produces a medical certificate given by a registered medical practitioner stating that her confinement will probably take place within six weeks;

b shall not be permitted to work during six weeks following her confinement;

c. if she is absent from her work in pursuance of paragraph (a) or (b) of this sub-section and had been continuously employed by her then employer for a period of six months or more or immediately prior to her absence, shall be paid not less than fifty percent of the wages she would have earned if she had not been absent; and

d. shall in any case, if she is nursing her child, be allowed half an hour twice a day during her working hours for the purpose.

This is a clear protection of women's right to maternal health. Subsection 5 goes further to provides that **"**child**"** includes both a legitimate and illegitimate child; but in practice this laudable provision is not adhered to, single mothers are denied of their right to maternity leave as is provided for under this Section and most women in the private sector even though covered by this provision are not given maternity leaves for up to 12 weeks as provided. It is noteworthy to state, that the Federal Government of Nigeria has extended the maternity leave for women in its employment to 4 months, that is 16 weeks. This is commendable. Private sector establishments are hereby encouraged to do same.

Some legislation, however, depart from the Labour Act in prescribing the scope of reproductive rights of women in Nigeria[47] For example, Police Regulation 127, made

[46] Cap. L1, LFN 2004.
[47] Ladan, M.T. A paper presented at a - One day Stakeholders Forum on Reproductive Health in Nigeria, Tahir Guest Palace Hotel Kano – Nigeria, April 20, 2006.

under the Police Act[48] states that "an unmarried Police Officer who becomes pregnant shall be discharged from the force, and shall not be re-listed except with the approval of the Inspector General"

This provision violates the rights of unmarried women in the police force and is contrary to Section 42 of the Constitution and, therefore, to the extent of its inconsistency should be declared null and void. Section 55 of the Labour Act prohibits women from night work with the exception of Nurses and women holding managerial positions who are not ordinarily engaged in manual labour. This is to enable women do their duties as wives and mothers to their children. Section 56 prohibits women from underground work as this is usually hazardous.

3.2.3 **Basic Criminal Legislation that protects Reproductive Right of Women in Nigeria - Criminal Code and the Penal Code**

The Criminal Code Act,[49] in Chapter 21 provides for offences that touch on the reproductive health and rights of women and girls. Section 218 provides that:

> Any person who has unlawful carnal knowledge of a girl under the age of thirteen years is guilty of a felony and liable to imprisonment for life, with or without canning. Any person who attempts to have unlawful carnal knowledge of a girl under the age of thirteen years is guilty of a felony and is liable to imprisonment for fourteen years with or without canning.
> A prosecution for other of the offences defined in this section of this Code shall be begun within two months after the office is committed.
> A person cannot be convicted of either offence defined in this section of the Code upon the uncorroborated testimony of one witness.

This is aimed at protecting the reproductive organs and rights of women/girls from sexual abuse as unlawful carnal knowledge of girls can lead to diseases and infections which can affect the functionality of the reproductive system.

[48] Cap. P22, LFN 2004.
[49] Cap. C38, LFN, 2004.

However, the requirement of corroboration of the evidence of the victim and time limitation within which to commence an action has whittled down the scope of protection it otherwise seeks to provide.

Section 219 provides for the offence of Householder permitting defilement of young girls on his premises.

Section 221 deals with defilement of girls under sixteen and above thirteen, and of idiots.

Section 222 deals with indecent treatment of girls under sixteen years.

Section 222 (A) (B) and (C) deals with the seduction or prostitution of a girl under sixteen years.

The protection under the Criminal Code does not extend to married adolescents by virtue of section 6 of the Criminal Code which provides that "unlawful carnal knowledge**"** means carnal connection which takes place otherwise than between husband and wife. This provision makes marriage a defence for the sexual abuse of young girls who have not attained the age of majority.

Section 357 provides for the offence of rape again time limitation and corroboration is required and marriage is also a defence as a man by the provisions of the act cannot be liable to the rape of his wife.

Sections 228 – 230 deals with attempts to procure abortion.

Section 232 of the Penal Code[50] provides that "whoever voluntarily causes a woman with child to miscarry shall if such miscarriage be not caused in good faith for the purposes of saving the life of the woman be punished with imprisonment for fourteen years"

Under Nigeria law, interfering with pregnancy no matter how early this takes place is regarded as criminal unless such interference is undertaken in good faith to preserve the mother's life. One school of thought view this as a protection of the unborn

[50] Cap P3, LFN, 2004.

child while another sees it as an interference with a woman's right to privacy and freedom to decide when and when not to have a baby.

3.2.4 **Child Right Act, 2003**

The Child Right Act[51] provides under S. 13(1) that "a child is entitled to enjoy the best attainable state of physical, mental and spiritual health".

Section 13(2) above provides that: Every Government, parent, guardian, institution service, agency, organization or body responsible for the care of the child shall endeavour to provide for the child the best attainable state of health.

Section 13(3) provides for responsibility of every government in Nigeria which shall:

a. Endeavour to reduce infant and child mortality

b. Ensure the provision of necessary medical assistance and health care services to all children with emphasis on the development of primary health care.

c. Ensure appropriate health care for expectant and nursing mothers.

For the purpose of this Act "a child is a person under the age of 18 years. By implication adolescent girls are ensured of their right to health by these provisions.

Section 21 prohibits child marriage that is marriage to a person under the age of 18 years. It also prohibits and punishes betrothal under section 22 and 23.

Section 31 prohibits sexual intercourse with a child. A person who contravenes this provision is liable on conviction to imprisonment for life[52]. It is immaterial that the offender believed the girl to be above the age of eighteen or that the sexual intercourse was with the consent of the child[53]

These provisions are laudable, with regard to the health consequences of offences provided for; such as Vesico Vaginal Fistula (VVF), sexually transmitted disease, HIV,

[51] Child Right Act which came into force in 2003. Cap C14, LFN, 2004.
[52] S. 31 (2).
[53] S. 31(3)(a)and(b).

high incidence of maternal mortality as a result of "child mothers" whose reproductive organs are not yet developed. Also noteworthy is the physiological and psychological trauma of such child victims. The Child Rights Act unfortunately did not provide for the abolition of female genital mutilation.

Some States have however enacted laws prohibiting the practice of FGM such states include, Lagos, Osun, Ondo, Ogun, Ekiti, Bayelsa, Edo, Cross River, Rivers and Ebonyi.

This is a welcome development and a step in the right direction more so, when from the 2008 NDHS, these states from the South West, South East and South-South geopolitical zones have the highest prevalence of FGM.

The Girl-Child Marriage and Female Circumcision (prohibition) Law, 2000 of Cross River States that[54]

> "Upon the commencement of this Law, no person shall circumcise or mutilate the genital organ of any female, whether or not her consent is obtained".
> Any person who:
> Performs the operation of female circumcision of female genital mutilation
> (a) Offers herself for circumcision or genital mutilation
> (b) Coerces, entices or induces any person to undergo female circumcision or genital mutilation; or
> (c) Allow any female who is either a daughter or ward to be circumcised or have the genital organ mutilated;
> Is guilty of an offence and shall on conviction be liable to a fine of not less than Ten Thousand Naira or to imprisonment not exceeding 2 years for a first offender and to imprisonment not exceeding 3 years without an option of fine for each subsequent offence.
> "Any person who contravenes the provisions of this law, may be arrested without a warrant and taken without delay to the nearest police station where he may be granted bail until he is brought before a magistrate's court for trial".

[54]Law No. 2 of 2000, S. 3

This law makes it an offence for both the victim, the person who carried out the circumcision and the parents or guardian of the victim who has been circumcised to have engaged in Female Genital Mutilation/Circumcision.

In Ebonyi State, the House of Assembly has enacted A Law to Abolish Harmful Traditional Practices Against Women and Children[55] which defines Harmful Traditional Practices" to include[56]

(a) "Any Traditional or Customary practices", of a scandalous or disgraceful nature which amount to a failure to observe the fundamental human rights of a woman or any child "which allows for a female genital mutilation or circumcision".

(b) The law went on to define "Circumcision" as "the act of cutting off the clitoris of a female; and "mutilation" as "any cutting, incision, damage of any or all of the female sex organ".

(c) This definition is broad and encompasses all the types of female genital mutilation practiced in Nigeria.

(d) The Ebonyi State law in Section 3 abolished and utterly declared unlawful all harmful traditional practices which hitherto[57] have been practiced before the commencement of law including FGM. It is also an offence to prevent any person from exercising any right accruing to him or her, or to molest, obstruct or injure any person by reason of his having exercised any right under the law. Any person who encourages either by spoken or written or by any visible representation or otherwise incites or encourages any person to practice any harmful traditional practices in whatever form is guilty of an offence and upon conviction is liable to a fine not exceeding Two Thousand naira or to an imprisonment for a term not exceeding five years.

[55] Law No. 10 of 2001
[56] Ibid S. 2
[57] S.3(i) (ii) (iii) Law No. 10 of 2001.

(e) Deprivation of any right relating to marriage, acquisition of inheritance title e.t.c by reason of any harmful traditional practice is an offence and upon conviction the offender is liable to a fine of Two Thousand Naira or to imprisonment for a term not exceeding five years.[58]

(f) This law is made not withstanding any custom or tradition of any community or people in Ebonyi State.[59]

By this provision, it is no excuse that the practice is a custom or tradition handed down from generation to generation. These kinds of pro-active legislation are what is required by all states in Nigeria to be able to eradicate female genital mutilation in the country.

3.2.5 **Marriage Act and Matrimonial Causes Act**

Section 18 of the Marriage Act[60] provides for the requirement of parental consent if a party contracting the marriage is under the age of 21 years not being a widower or widow. This presupposes that the prescribed age of marriage is 21 years and above. However, the requirement of parental consent for parties less than 21 years for a valid marriage tends to give approval to child marriage as parents can consent to the marriage of their under aged children.

The Matrimonial Causes Act[61] did not stipulate the age of marriage but rather used the phrase "marriageable age". Section 3(1) (1) (e) of the Act provides that "a marriage shall be void if anyone of the parties is not of a marriageable age". Despite the lacuna in this law, it is submitted that Section 3(I) (I)(e) of the MCA and Section 18 of the MA seek to prevent the negative Health Consequences of girl-child marriage.

[58] Ibid S. 6
[59] S. 3
[60] Cap. M6, LFN, 2004.
[61] Cap M7. LFN, 2004

CHAPTER FOUR

EMPIRICAL RESEARCH ON THE PROTECTION OF WOMEN'S RIGHT TO HEALTH IN NIGERIA

4.1 Research Design

This research will employ mainly the Qualitative Research Design. This type of Research is carried out when a researcher wish to understand meanings, describe and understand experiences, ideas, beliefs, values and such intangibles. As opposed to quantitative method that is highly statistical, qualitative method of gathering information focuses on describing a phenomenon in a deep, comprehensive data. This is generally done by administering interviews; open ended questions on focus groups. In most cases, a small number of participants take part in this type of research because to carry out such research endeavour requires many resources and much time. The advantage of this type of research method is that in using open ended questions, in the interviews, researchers understand how individuals are doing, what their experiences are, and recognize important outcomes of interest that do not surface when surveyed with pre-determined questions like the use of questionnaires. The quantitative method is also used to complement the qualitative method.

4.2 Area of the Study

The research is based on some selected hospitals in the Federal Capital Territory, Abuja. Data from the Nigeria Demographic and Health Survey, 2008[1] and 2013[2] which conducted Health Survey throughout Nigeria is also used.

[1] National Population Commission, Abuja (2008) *Nigeria Demographic and Health Survey*. NPC and ICF Macro, Calverton Maryland U.S.A.
[2] National Population Commission (NPC) [Nigeria] and ICF International (2014*) Nigeria Demographic and Health Survey 2013*. Abuja Nigeria and Rockville Mary Land USA, NPC and ICF International.

4.3 **Population/Participants in the Study**

Participants in this study are health experts in selected hospitals in the Federal Capital Territory, Abuja who have a wealth of experience on the subject matter. These include doctors, gynaecologists, nurses and midwives who deal with the health of women, giving them pre-natal and post-natal care. In this capacity, they see a large number of women populations on daily basis and also have a good understanding of the health care system. Women that make use of these healthcare facilities are also included in the research.

4.4. **Method of Data Collection and Analysis**

The primary and secondary means of data collection are used in this study. The primary means of data collection is based on interviews of Health professionals who are experienced on the subject matter and the administration of questionnaire on both the health experts and patients.

The Descriptive research design which is a form of qualitative design is used in data collection. It aims at collecting data on and describing in a systematic manner, the characteristics, features or facts about a given population. This is interested in describing certain variables in relation to the population. Usually descriptive surveys are concerned with description of events as they are.

Qualitative research design is a descriptive, non-numerical way of research.[3] It cannot be measured in a conventional sense as it takes place in actual and everyday setting not in a Laboratory. It investigates the way people react, live and manage their

[3] Brain, W. (2000) *Dissertation skills for business and management students*, Seng Lee Singapore, p. 28.

daily lives.[4] Simple percentage frequency as well as simple descriptive statistics are used to analyze data collected.

4.5 **Ethical Issues**

The UK's Economic and Social Research Council (ESCR),[5] a governmental body, which funds and supports independent, high quality research, has outlined six core principles which describe the type of ethical protection contemporary research should provide to enhance the rights of research participants.

According to the report, a research that is conducted in a professional and ethical manner must ensure and uphold "integrity, honesty, confidentiality, voluntary participation, impartiality and avoidance of personal risk to the individual and social groups"

In keeping with these ethical principles, the researcher sought and obtained the approval of the Federal Capital Territory Health Research Ethics Committee (see appendix I) whose duty it is to scrutinize every health related research in the Federal Capital Territory to ensure ethical compliance. The right to participate in this research was voluntary. Participants were at liberty to do so. They were duly informed about the nature of the research through the Participant Information Sheet (see appendix II) and the consent secured through the Informed Consent Form (see appendix III) also administered before the survey. The researcher also sought and obtained the consent of the Federal Capital Territory Hospital Management Board to administer interview and questionnaire survey on her employees (see appendix IV) This was done in order to ensure that no aspect of the research violate their right to privacy. The confidentiality of participants is highly maintained. Their personal data is no where revealed throughout the research. The Informed Consent Forms signed by them will be stored for a period of time in a secured place after which they will be destroyed.

---

[4] Ibid. p.29

[5] Economic and Social Research Council (ESCR2012), Research Ethics Framework, Swindon, UK, ESCR. Publishing, pp 23-26 retrieved from http://www.gold.ac.UK/media/ESRCReEthicsframetcm6-11291.pdf accessed 17 August, 2 2013.

4.6 Presentation of Result and Data Analysis

4.6.1 Research Question One

Do women suffer from health challenges during their reproductive years that are not necessarily disease based but biological and social processes that carry health risk and require health care?

On this question the researcher interviewed healthcare professionals. A total of twenty (20) doctors, twenty midwives (20) and twenty (20) nurses were interviewed. The researcher used the interview survey for this question, in order to understand in depth the views of the experts and not limit them to pre-determined answers in the case of questionnaires survey. There was almost a consensus in the affirmative to the question.

All twenty midwives answered in the affirmative, nineteen nurses answered in the affirmative with one having a different view, eighteen doctors answered in the affirmative, totally agreeing with the assertion, while two differed slightly. As shown in the table, graph and chart below.

Table 4.1 Reproductive challenges requiring health care

S/NO	Professionals interviewed	agreed	objected
A	Doctors	18	2
B	Midwives	20	0
C	Nurses	19	1
	Total	57	3

Figure 4.1 Reproductive challenges requiring health care

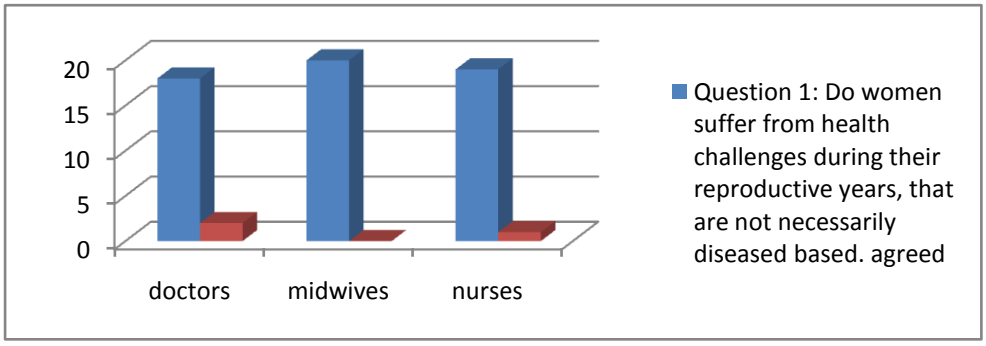


TABLE 4.1B Participants in the study

	Professional	Total response in percentage
1	Doctors	30.00
2	Midwives	33.33
3	Nurses	31.67
4	Objections	5.00
	Total	100.00

A total of 95% of the health care professional interviewed are of the view that the health challenges faced by women during their reproductive years are not diseases on their own but consequences of their pregnancy and in most cases these challenges are overcome with good ante-natal, safe delivery and post natal care. The other 5% are of the view that some of the health challenges can be termed diseases because of them are actually very serious like pregnancy induced hypertension and the likes.

4.6.2 **Research Question Two**

Are there culture based practices that contribute to the poor health status of women in Nigeria?

Nigeria is a multi ethnic and multi cultural state, this question investigates whether there are culture based practices that contribute to the poor health status of women in Nigeria. The interview survey is also used to answer this, as it has to do with the way of life of the different ethnic groups in Nigeria. It needs in depth discussion and not predetermined options that restricts the answers to be obtained.

As in research question one, twenty nurses, twenty doctors and twenty midwives were interviewed and their response is shown in the table below.

TABLE 4.2 Response of Professional on cultural practises

S/NO	Professionals interviewed	agreed	objected
A	Doctors	20	0
B	Midwives	20	0
C	Nurses	20	0
	Total	60	0

The finding was that all agreed with the assertion, that there are culture based practices that contribute to the poor health status of women health in Nigeria like early girl child marriage, female genital mutilation, some traditional superstitious beliefs and practices, etc. These will be discussed in details in the next chapter.

4.6.3 **Research Question Three**

How does lack of health care facilities and personnel especially at the grass root affect women's health in Nigeria?

The researcher designed two sets of questionnaires, one for women (patients) (Appendix v) and another for health care professionals (Appendix VI). The researcher sent out four Hundred questionnaires on this question to female patients, three hundred and sixty were returned out of which thirty eight is declared invalid because they were not properly filled, leaving a total of three hundred and twenty two valid questionnaires. Therefore 80.5% of the returned questionnaires are valid.

The researcher concentrated the research on public health institutions because from the result obtained it is evident that most women patronize public health care institutions.

Question two, Appendix V was answered as follows: In which of these categories does your health care institution belong? Two hundred and ninety two (292) female

patients responded to belonging to public healthcare institutions, while thirty (30) were of private health care institutions. This is shown in the table below.

TABLE 4.3 Category of health Institution

S/NO	CATEGORY OF HEALTH INSTITUTION	RESPONSE
1	**Public health care institution**	**292**
2	**Private health care institution**	**30**
	Total	**322**

More respondents use public health institution because they are more affordable than the private therefore is within their means from the result, a total of 91% of the respondents use public health care institution while 9% use private health care institutions.

Question Five (5) Appendix V: How would you rate facilities and infrastructure in your health care institution?

The Options provided were:

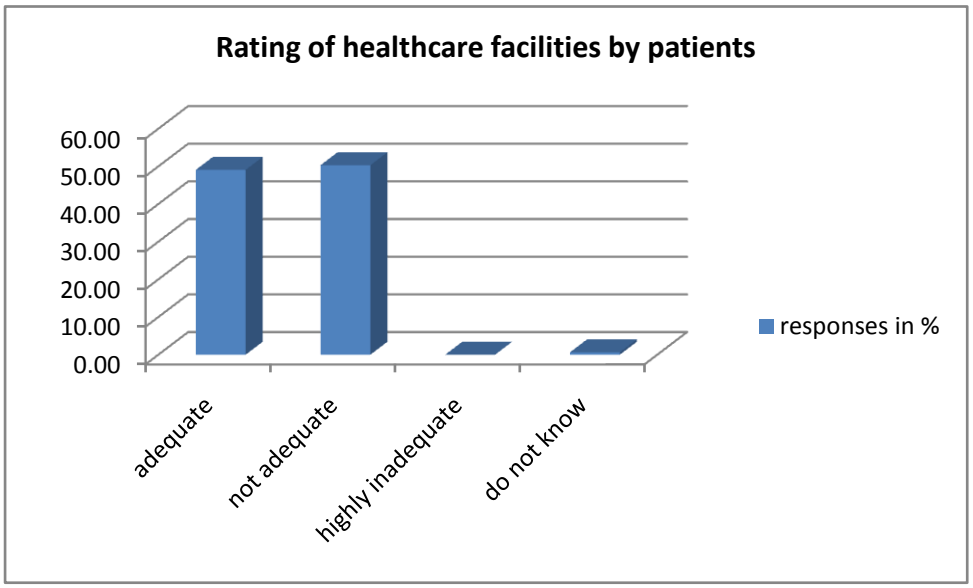
A. **Adequate**
B. **Not adequate**
C. **Highly inadequate**
D. **Do not know.**

A total of one hundred and fifty eight respondents answered adequate, while a hundred and sixty two patients answered inadequate, two respondents answered do not know, as presented in the table below.

TABLE 4.4 Rating of facilities and infrastructure in healthcare institutions

S/NO	RATNG	RESPONSE	RESPONSE IN %
1	Adequate	158	49.0683
2	Not Adequate	162	50.3106
3	Highly Inadequate	0	0
4	Do not know	2	0.62112
	Total	322	100

FIGURE 4.2 Rating of health care facilities by Patients



As can be seen from the table and figure 50% of patients that use [public health care institutions are of the opinion that health faculties are not adequate 49% said they are adequate while 1% said they do not know.

Question six (6) Appendix Five (5):- In relation to patients' population how sufficient are health care professionals in your health care institution?

A. **Highly sufficient**

B. **Sufficient**

C. **Insufficient**

D. Highly insufficient

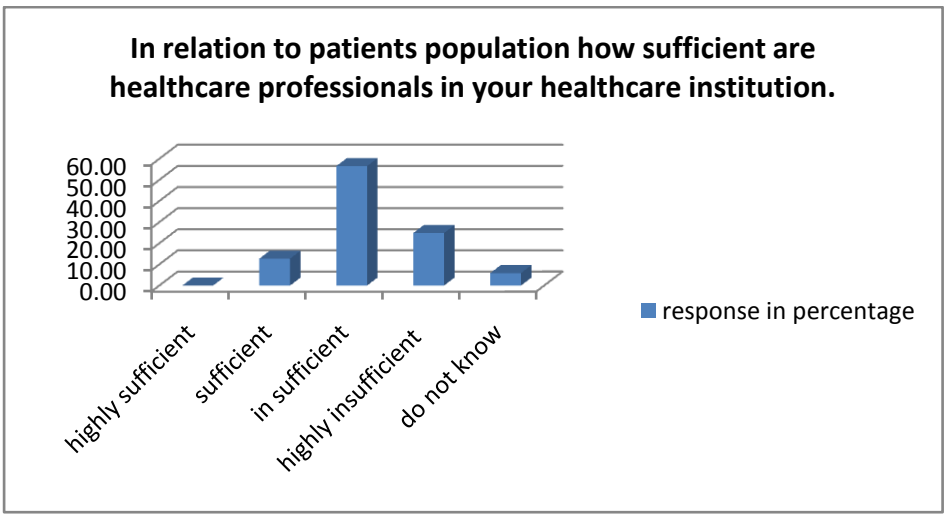
E. Do not know

A hundred and eighty two (182) answered insufficient, while eighty (80) answered highly insufficient, forty one (41) sufficient and nineteen (19) did not know. This is presented in the table and graph below.

TABLE 4.5 Response on sufficiency of health care professionals

PATIENTS VIEW	RESPONSE	RESPONSE IN PERCENTAGE (%)
Highly sufficient	0	0.00
Sufficient	41	12.73
Insufficient	182	56.52
Highly insufficient	80	24.84
Do not know	19	5.90
Total	322	100.00

4.3 Response on sufficiency of health care professionals



56% of respondents answered that health care professionals are insufficient 24% said they are highly insufficient while 12% said they are sufficient and 5.9% were undecided. It can be concluded that health care professionals are insufficient in public health care institutions.

Question Seven (7) Appendix Five (5): On the average how much time do you spend on each maternal care visit to your health care institution?

A. **Below two hours**

B. **Two to three hours**

C. **Three to four hours**

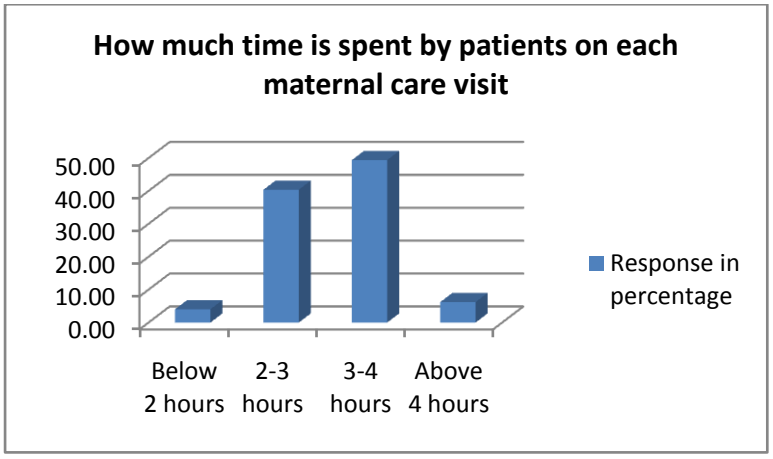
D. **Four hours and above**

Thirteen respondents answered below two hours, while a hundred and thirty said two to three hours, a hundred and fifty nine persons answered three to four hours, while nine answered above four hours. This is presented in a tabular and graphic form below.

TABLE 4.6 Time spent on each hospital attendance

TIME SPENT BY EACH PATIENT	REPONSE	RESPONSE IN PERCENTAGE (%)
Below 2 Hours	13	4.04
2 – 3 Hours	130	40.37
3-4 Hours	159	49.38
Above 4 Hours	20	6.21
Total	322	100

FIGURE 4.4 Time spent on each hospital attendance



49% of respondents spent 3 – 4 hours on each hospital attendance, 40% spent 2 -3 hours, 6 % spent above 4 hours. A situation where patients spent up to 4 hours on routine antenatal care visit reinforces they assertion that there is insufficient of health care professionals and infrastructure in public hospitals in Nigeria.

Appendix VI was administered on health care professionals. A total of two hundred (200) questionnaires were given out to this category of participants, a hundred and eighty two (182) were returned out of which six (6) were invalid because they were not completely filled, leaving a total of a hundred and seventy eight (178) valid questionnaires. Therefore, 89% of the questionnaires returned were valid.

Question two (2) Section A, Appendix VI: - In which of these categories does your health care institution belong to Public or private?

A hundred and forty one (141) belong to public health care institution while thirty seven (37) belong to private ones.

TABLE 4.7

Responses of health care professionals on category of health institution

Which of the health care institutions do you belong	Response in %	Response
public	79.21	141.00
Private	20.79	37.00
	100.00	178.00

79% of health care professionals interviewed work in public health care institution while 20.79% work in private health care institution.

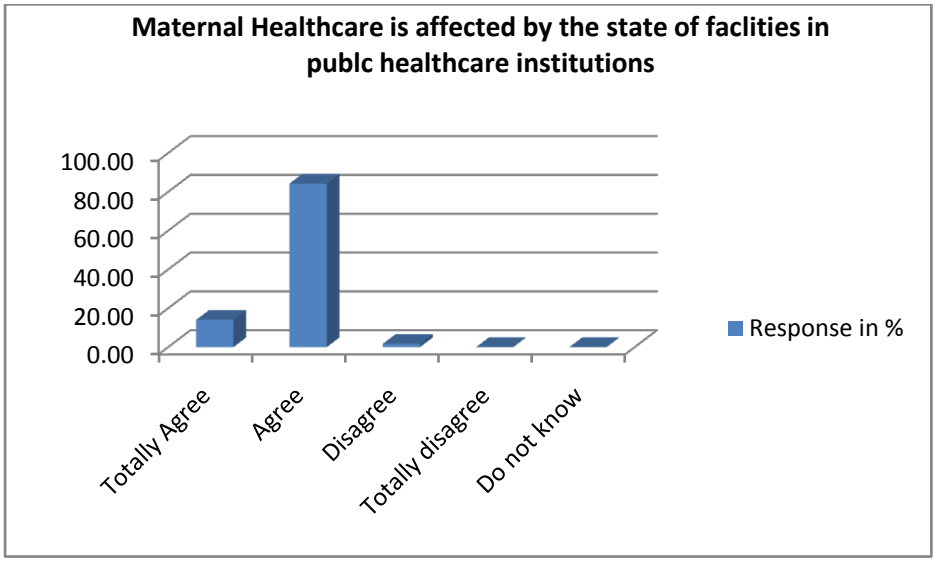
Question five (5) Section B Appendix VI: - Maternal healthcare delivery is affected by the state of facilities and infrastructures in public healthcare institutions?

A. Totally agree
B. Agree
C. Disagree
D. Totally disagree
E. Do not know
F. A hundred and fifty three (153) respondents agreed with this, while twenty five (25) respondents totally agreed. This is represented below in table 4.8 and figure 4.5.

TABLE 4.8 Effect of facilities in public health care institutions on maternal health

Maternal health care is affected by the state of facilities in public health care institutions	Response in %	Response
Totally Agree	14.04	25.00
Agree	84.27	150.00
Disagree	1.69	3.00
Totally disagree	0.00	0.00
Do not know	0.00	0.00
Total	100.00	178.00

Figure 4.5 Effect of facilities in public health care institutions on maternal health



84% of respondents agreed that maternal health care is affected by state of facilities in public health care institution, 14% totally agreed while 1.69% disagreed. From the researcher's experience this assertion is a true representation of the situation as one can find out that even delivery couches and beds are not enough to say the least in most public hospitals.

Question six (6) Sections B Appendix VI: - There are inadequate facilities and infrastructures in public healthcare institutions in FCT.

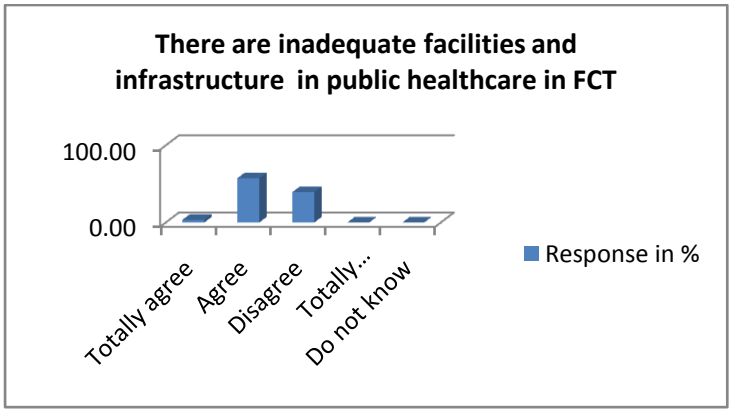
a. Totally Agree
b. Agree
c. Disagree Totally disagree
d. Do not know

Six (6) respondents totally agreed, a hundred and two (102) agreed, while seventy (70) disagreed; this is illustrated below in tabular and graphical forms.

TABLE 4.9 Adequacy of infrastructure in public healthcare institutions (Response by health care professionals)

There are inadequate facilities and infrastructure in public health care in FCT	Response in %	Response
Totally agree	3.37	6
Agree	57.30	102
Disagree	39.33	70
Totally disagree	0.00	0
Do not know	0.00	0
Total	100.00	178

FIGURE 4.6 Adequacy of infrastructure in public healthcare institutions (Response by health care professionals)



57% of health care professionals agreed that infrastructure is inadequate in public health care institutions 3.37% totally agreed while 39% disagreed.

Question seven (7) section B Appendix VI:- In relation to patient population there are insufficient healthcare professionals in public health institutions in the FCT?

A. **Totally Agree**

B. **Agree**

C. **Disagree**

D. **Totally disagree**

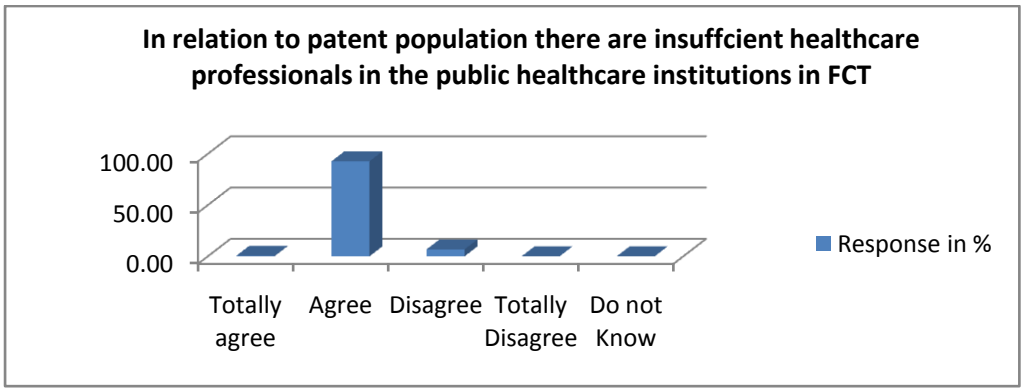
E. **Do not know**

A hundred and sixty five (165) respondents agreed while twelve (12) respondents totally disagreed with this assertion. This is represented below in table 4.10 and graph 4.7.

TABLE 4.10 Response on sufficiency of health care professionals by health care professionals.

In relation to patient population there are insufficient healthcare professionals in the public health care institutions in FCT	Response in %	Response
Totally agree	0.56	1
Agree	92.70	165
Disagree	6.74	12
Totally Disagree	0.00	0
Do not Know	0.00	0
Total	100.00	178

FIGURE 4.7 Adequacy of infrastructure in public healthcare institutions



Question 4, Section A, Appendix VI: - On the average how many patients do you attend to in a day?

A. 1-5

B. 6-10

C. 11-15

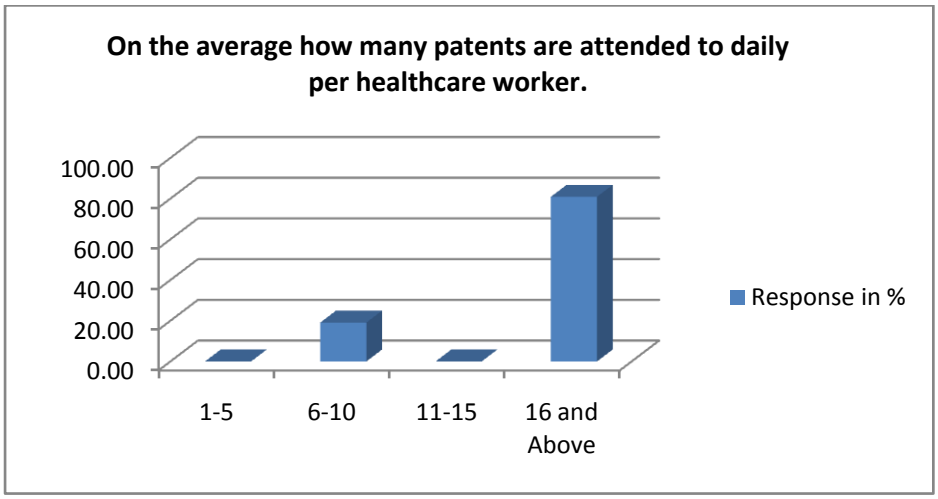
D. 16 and Above

A hundred and forty four respondents answered sixteen (16) and above, while thirty four (34) answered six (6) to ten (10) patients in a day, this is presented in the table and graph below.

TABLE 4.11 Percentage of patients attended to daily per health care worker

On the Average how many patients are attended to daily per health care worker	Response in %	Response
1-5	0.00	0
6-10	19.10	34
11-15	0.00	0
16 and Above	80.90	144
Total	100.00	178

Figure 4.8 Percentage of patients attended to daily per health care worker



4.6.4 Research Question Four

What are the components of women's right to health and how do they affect maternal mortality in Nigeria.

This question sought to find out the components of women's right to health, from the perspective of women and healthcare experts. The following question was posed to women.

Question seven (7) Appendix five (5): Women's right to health includes the following

- Pre-natal care
- Safe Delivery

- Post-natal care
- Family planning
- Health education

Options include the following:

A. Agree
B. Partially Agree
C. Disagree
D. Do not know

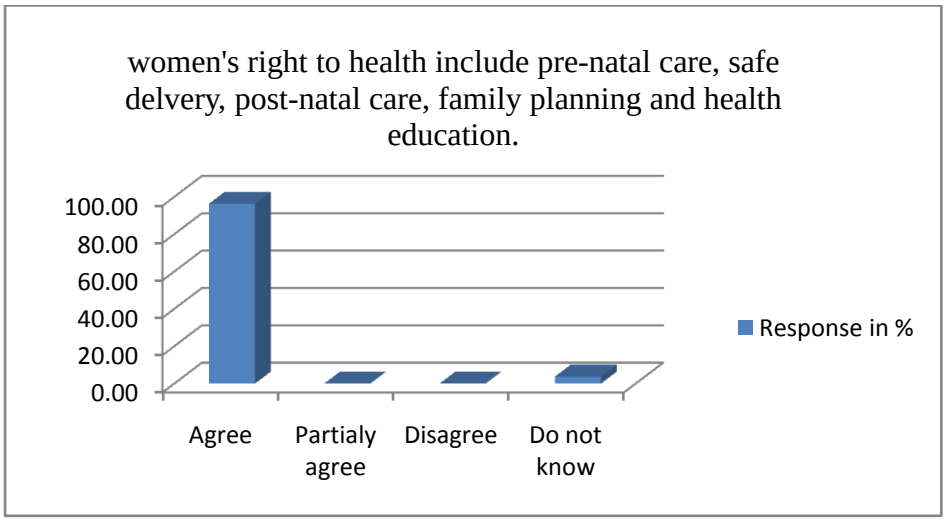
Three hundred and ten (310) respondents agreed with the assertion while twelve (12) respondents do not know, as represented in the table and graph below.

TABLE 4.12 Components of women's right to health (patient's perspective)

women's right to health include pre- natal care, safe delivery, post natal care, family planning and health Education (women's perspective)

Options	Response in %	Response
Agree	96.27	310
Partially agree	0.00	0
Disagree	0.00	0
Do not know	3.73	12
Total Respondents	100.00	322

FIGURE 4.9 Components of women's right to health (patient's perspective)



Question eight (8) section B Appendix VI same as question seven (7) Appendix V, was administered on healthcare professionals, and they all answered in the affirmative.

Question Eight (8) Appendix V: Which of these services does your hospital provide free for maternal care patients?

A. Pre-natal care

B. Delivery

C. Post-natal care

D. Family planning

E. Health Education

F. All of the above

G. None of the above

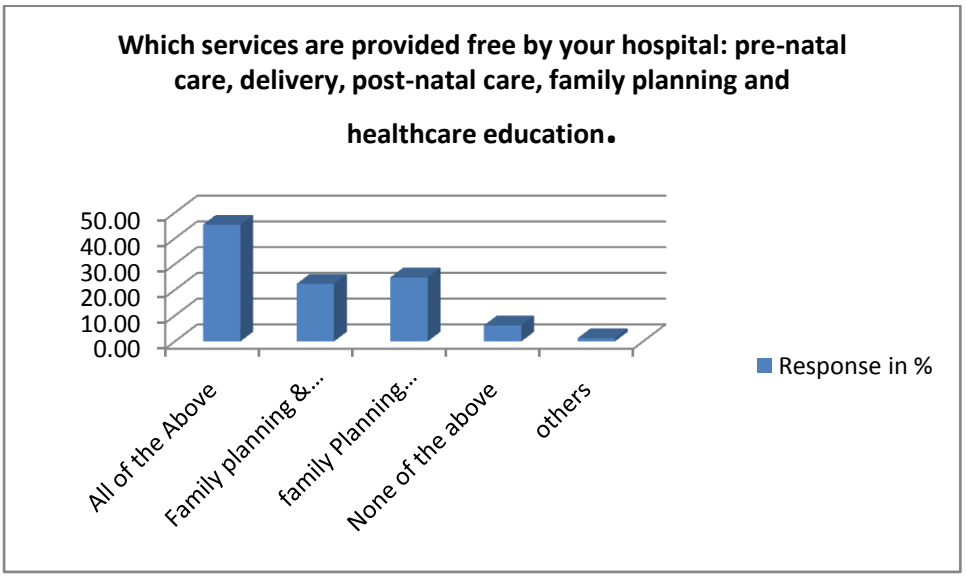
H. Others please indicate.

A hundred and forty six (146) respondents answered all of the above, seventy two (72) answered D and E, while eighty respondents answered A, D and E, and twenty (20) answered G, while four (4) in addition to F included tetanus injection and immunization, as shown in the table below.

TABLE 4.13 Free Provision of health care services
Which services are provided free by your hospital: pre-natal care, Delivery, post natal care, family Planning and Health education?

Options	**Response in %**	**Response**
All of the Above	45.34	146
Family planning & Health Education	22.36	72
family Planning Health Education& Pre-natal care	24.84	80
None of the above	6.21	20
others	1.24	4
Total Respondents	100.00	322

FIGURE 4.10 Free Provision of health care services



Question ten (10) Appendix V: Patients were asked how satisfied they were with the maternal healthcare services they received at the healthcare facility they used or attended.

The options provided were:

A. Highly Satisfied

B. Satisfied

C. Not satisfied

D. Do not know

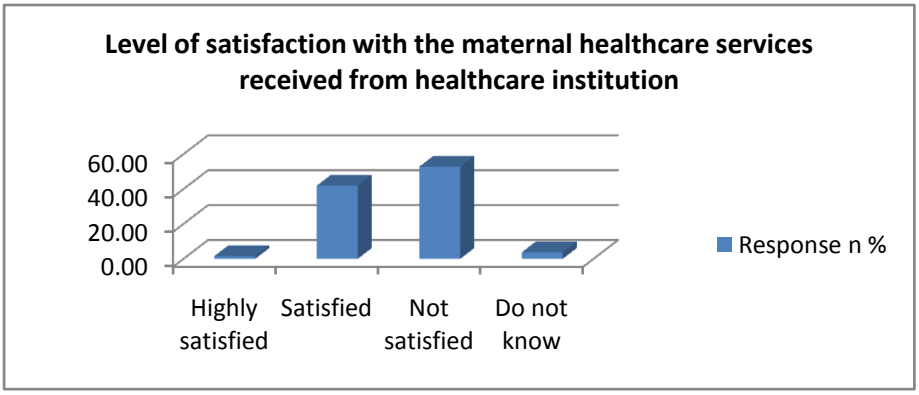
A hundred and thirty five (135) respondents were satisfied with the maternal services provided by healthcare facility they attended, while a hundred and seventy respondents (170) were not satisfied, twelve (12) respondents did not know, and five (5) respondents were highly satisfied with the service they received.

This is illustrated in the table and graph below.

TABLE 4.14 Level of satisfaction with health care services

Options	Response in %	Response
Highly satisfied	1.55	5
Satisfied	41.93	135
Not satisfied	52.80	170
Do not know	3.73	12
Total Respondents	100.00	322

FIGURE 4.11 Level of satisfaction with health care services



Question nine (9) Section B Appendix VI focused on healthcare professionals, and they were asked. Which of these services does your hospital provide to maternal care patients free?

The following where the options provided

A. Per-natal care

B. Delivery

C. Post-natal care

D. Family planning

E. Health education

F. All of the above

G. None of the above

H. Others please indicate

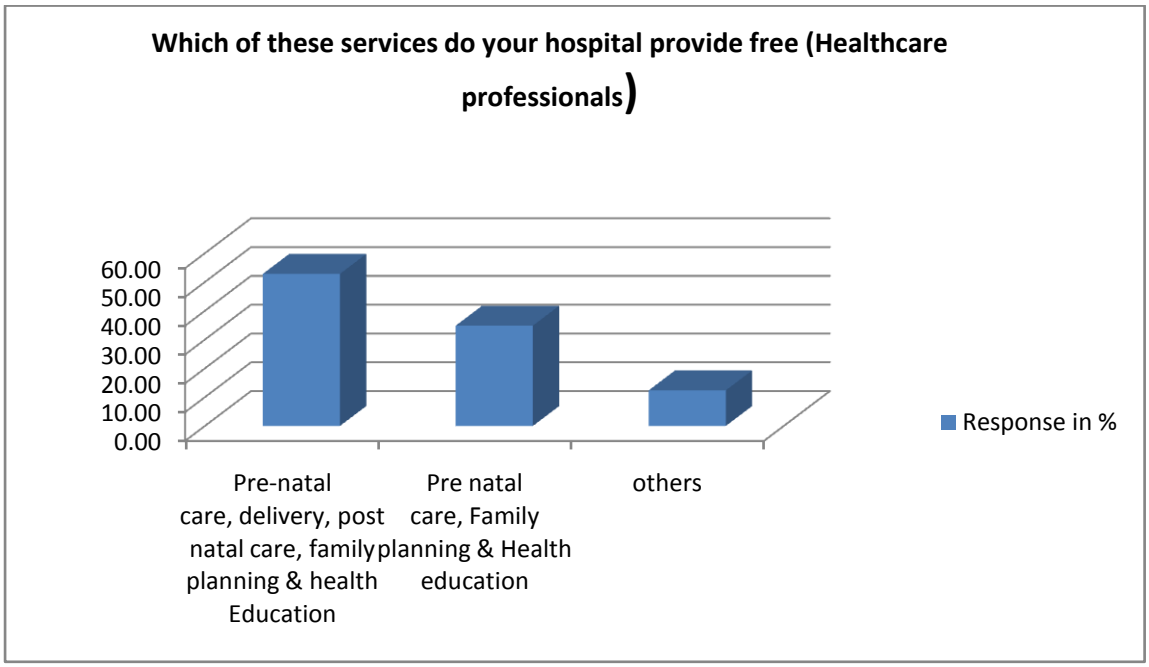
Ninety Four (94) respondents answered F (all of the above), six (6) opted for A, D and E, while twenty two (22) respondents included immunization and tetanus injection. This is shown and illustrated in the table and graph below.

TABLE 4.15 Response on free provision of health care service by health care professionals

Which of these services do your hospital provide free (Health care professionals)

options	Response in %	Response
Pre-natal care, delivery, post natal care, family planning & health Education	52.81	94
Pre natal care, Family planning & Health education	34.83	62
others	12.36	22
Total Respondents	100.00	178

FIGURE 4.12 Response on free provision of health care service by health care professionals



Question eleven (11) Section B Appendix VI: The Healthcare professionals were asked how free access to healthcare services as mentioned in question nine (9) above affect maternal and child mortality in their hospitals. Below were the options provided:

A. Significantly increase the rate of maternal and child mortality

B. Significantly reduce the rate of maternal and child mortality

C. Have no effect on the rate of maternal and child mortality.

D. Do not know.

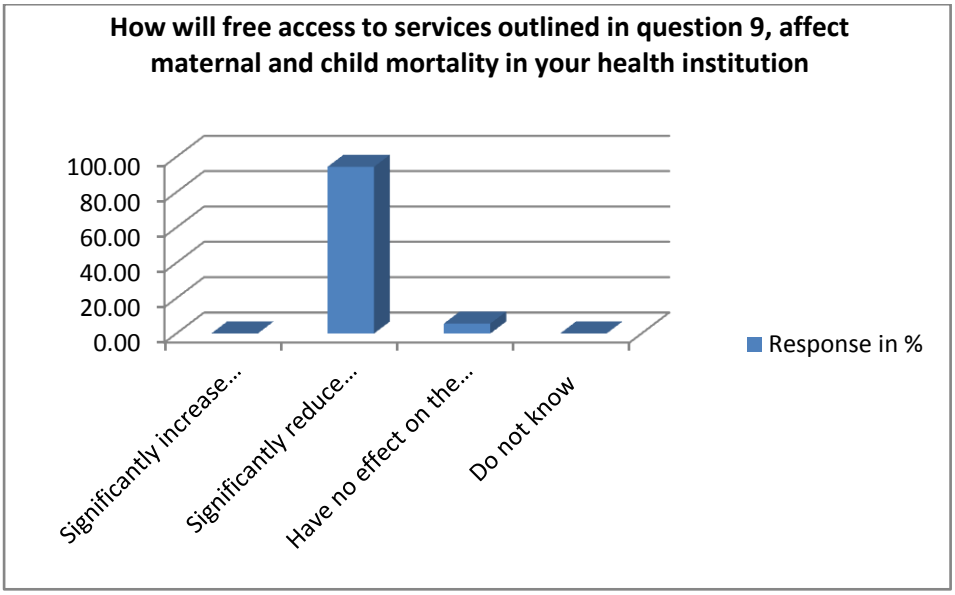
A hundred and sixty eight (168) answered B, that is it would significantly reduce the rate, while ten of the healthcare professionals questioned answered C, been of the opinion that it had no effect on maternal and child mortality.

This is presented below in a tabular and graphical form.

TABLE 4.16 Effect of free medical services on maternal and child mortality. How will free access to services outlined in question 9, affect maternal and child mortality in your health institution.

Options	Response in %	Response
Significantly increase the rate of maternal and child mortality	0.00	0
Significantly reduce the rate of maternal and child mortality	94.38	168
Have no effect on the rate of maternal and child mortality	5.62	10
Do not know	0.00	0
Total respondents	100.00	178

FIGURE 4.13 Effect of free medical services on maternal and child mortality.



CHAPTER FIVE

CHALLENGES TO THE PROTECTION OF WOMEN'S RIGHT TO HEALTH

5.1 Legal Challenges

The Constitution of the Federal Republic of Nigeria, 1999 [1] as the grundnorm does not have express provision on the right to health. One can only infer the right to health in section 17 which states that "the State social order is founded on the ideals of freedom, equality and justice. In furtherance of the social order section 17 (3) (d) provides "the State shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons".

This is a blanket provision which does not adequately address the issue of health. Moreover this provision is found in Chapter II of the constitution under the Fundamental Objectives and Directive Principles of State Policy which are non justiceable. They only serve as a road map to the government on its responsibilities to the people.

Section 232 of the Penal Code [2]which criminalizes abortion in Nigeria does not take into consideration the risk of unsafe abortion which result in the high incidence of death of women in the hands 'quacks' who illegally procure abortion for these women. This is not withstanding the fact that the Protocol on the Right of Women in Africa provides the ability of a woman to make her own decisions regarding her body and her reproductive life because the adequate protection of her reproductive life is key to

[1] CFRN (1999) as amended.
[2] Cap. P3, LFN 2004.

improving a woman's health[3]. This Protocol though ratified by Nigeria has not been domesticated.

The tripartite application of the Nigerian Constitution, Customary law and Islamic law in Nigeria often creates a conflict in the regulation of the lives of the citizens. A person can choose to be guided by Customary or Islamic law for example in the area of marriage. Both laws are acceptable in Nigeria and person is so bound by either law which is often in conflict with the constitution. Example can be seen in the law on rape. Section 218 of the Criminal Code[4] provides for unlawful carnal knowledge of a girl under the age of 13. The same Criminal Code in section 6 provides that 'unlawful carnal knowledge' means carnal connection otherwise than between husband and wife. This makes marriage a defence for sexual abuse of young girls who have not attained the age of majority. The Child Rights Act[5] provides that 'no person under the age of 18years is capable of contracting a valid marriage and accordingly a marriage so contracted is null and void and of no effect whatsoever". This is in conflict with Islamic and customary laws that allow for the marriage of girls under the age of 18years provided that the parents of such girls consent to the marriage. In actual fact, most Nigerians prefer to be bound by their customs in issues regarding their personal lives and in most cases these customs are in conflict with the constitution.

There are many international instruments that provide for the protection of women's right to health[6] which have been signed and ratified by Nigeria but because Nigeria practises the dualist system of incorporation of international law into National

[3] Asika, I; (2012) Women and the Right to Health in Nigeria, *British Journal of Arts and Social Science*. British Journal publishing Inc. retrieved from http//www.bjournal.co.uk/BJASS.aspx assessed on October 1, 2014.
[4] Cap. C38 LFN, 2004.
[5] Cap. C14, LFN, 2004.
[6] as discussed in chapter three

Laws, these instruments are not applicable in Nigeria until they are domesticated as required by section 12 of the constitution[7] This position is reinforced by the following cases *Abacha vs Fawehinmi*[8] *Agbakoba vs Director SSS*[9] *and RTNACHPN vs MHWUN*[10]

5.2 **Socio-Cultural Challenges**

These are cultural practises that contribute to the poor health status of women in Nigeria but are accepted by the people as their way of life and they include:

5.2.1 Female Genital Mutilation (FGM)/Female Circumcision /Female Genital Cutting- These terms are used interchangeably. The Western Feminists preferred to use Female Genital Mutilation because they do not practise it and therefore see it as a very negative act while the African feminists use female circumcision or female genital cutting because it is a culturally accepted practise in Africa. Female Genital Mutilation (FGM) is defined by World Health Organization (WHO) as all procedures which involve the partial or total removal of the external female genitalia and/or injury to the female genital organs, whether for cultural or any other non-therapeutic reasons [11] FGM has no known health benefits. On the contrary, it is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissues interfere with the natural functioning of the body and cause several immediate and long-term consequences.[12] FGM is an unhealthy traditional practise inflicted on girls and women worldwide. It has been identified as a violation of human rights which is deeply rooted in cultural beliefs and perceptions over decades and

[7] CFRN 1999 (as amended).
[8] (2006) 6 NWLR pt 660 at 228.
[9] (1994) 6 NWLR pt 351 at p 1.
[10] (2008) 2 NWLR pt 1072 p. 575 at 587.
[11] World Health Organization (1998) *Female Genital Mutilation: An overview* retrieved from: http//:apps/who.int/dsa/cat98/fgm book.htm# 16 accessed 10th June 2013.
[12] World Health Organization, *Sexual and Reproductive Health: Classification of Female Genital Mutilation* www.Who.int./reproductivehealth/topics/fgm/overview/en accessed March 16th 2014.

generations. FGM is widely practised in Nigeria and with its large population the number of FGM cases in the country is quite high.

There are so many beliefs that are attributed to the significance of FGM in Nigeria, for instance, in the Northern parts of the country, it is believed that FGM makes girls more fertile and aids easy delivery. Among some Igbo tribes, a female is not regarded as a woman until she undergoes female genital mutilation. All these are myths as the WHO has reported that women who undergo circumcision stand greater risk of complications at child birth and there is no health benefit derivable from FGM[13] .

According to the 2008 Nigeria Demographic and Health Survey, almost all the ethnic groups carry out this practice[14]. This is mostly done at infancy. From the report, 88.8% of women/girls between the ages of 15 – 19 years were circumcised before their first birthday and according to the 2013 NDHS[15] 82% of circumcised women in Nigeria were circumcised before age five. This goes to show that FGM is done mostly at infancy. This procedure is mostly carried out by traditional circumcisers with unsterilized instruments like razor blade and knives thereby increasing the risk of transmission of HIV/AIDS. From the survey, South-West Nigeria has the highest rate of female genital mutilation of 53.4% followed by the South-East with 52.8%, South-South 34.2%, North-West 19.6%, North-Central 11.4% and North-East 2.2% [16] see appendix VII. The reasons mostly given for this practise include preservation or cultural heritage, cleanliness/hygiene, social acceptance, better marriage prospects, to curb a woman's sexual appetite thereby

[13] World Health Organization, *Sexual and Reproductive Health: Classification of Female Genital Mutilation* www.Who.int./reproductivehealth/topics/fgm/overview/en accessed March 16th 2014.
[14] National Population Commission (2008*) Nigeria Demographic and Health Survey* ICF macro Calverton Maryland USA p.301.
[15] National Population Commission (NPC)[Nigeria] and ICF International (2014*) Nigeria Demographic and Health Survey* 2013. Abuja, Nigeria and Rockville Mary land USA, NPC and ICF International p. 351.
[16] Ibid p. 300; see Appendix VI.

preventing premarital sex and encouraging faithfulness to partner, religious approval, et cetera.

The health consequences of this practise are very devastating and include; severe pain, heavy bleeding, shock, fracture or dislocation due to restraints, injury to adjacent tissue of urethra, vagina, perineum and rectum, pelvic inflammatory disease, risk of contracting infectious disease such as HIV and Hepatitis B and even death. The long term consequences include painful intercourse, painful and difficult labour fistulae formation – VVF or RVF, cysts and abscess of genital, loss of normal sexual function, pelvic infections, recurrent urinary tract infections, difficulty passing urine et cetera. All these can be avoided by the elimination of female genital mutilation which according to WHO has no benefits whatsoever.

Other cultural practises that contribute to the poor health of women in Nigeria include the poor delivery by untrained traditional birth attendants.

5.2.2 Delivery by Untrained Traditional Birth Attendants

According to the 2008 NDHS, thirty five percent (35%) of births in Nigeria are delivered in a health facility. Twenty percent (20%) of these deliveries occur in public sector facilities. Fifteen percent (15%) occur in private sector facilities. Three in five births (62% percent) occur at home[17] compared with the 2013 NDHS,[18] thirty six percent (36%) of births in Nigeria are delivered in health facility, twenty three percent (23%) occur in public sector facilities, thirteen percent (13%) in private sector facilities while sixty three percent (63%) occur at home. Most of these home deliveries are taken by

[17] National Population Commission (2008) *Nigeria Demographic and Health Survey* ICF macro Calverton, Maryland U.S.A.

[18] National Population Commission (NPC)[Nigeria] and ICF International (2014) *Nigeria Demographic and Health Survey 2013.* Abuja, Nigeria and Rockville Mary land USA, NPC and ICF International p. 351.

Traditional Birth Attendants (TBA) who are not trained in the gynaecological procedures. The consequence of this is high rate of maternal and infant mortality. They also use unsterilized instruments thereby resulting in high rate of transfer of infectious diseases like HIV/AIDS, Hepatitis etc. There is also this belief that delivery through caesarean section is a sign of weakness on the part of the mother, or that it is not in ones lineage to delivery through C. S, therefore these women in the course of trying to have normal vaginal deliveries develop serious complications resulting to death of mother and child or serious deformities should they survive. Increasing the percentage of births delivered in health care facilities is an important factor in promoting women's health as it will reduce the number of deaths arising from complications of pregnancy and child birth

5.2.3 Early Girl-Child Marriage

The marriage of under-aged girls can lead to serious health consequences for such girls during child birth due to under-developed pelvis. This can result to Vesico Vaginal Fistula (VVF) or Recto virginal (RVF) which in addition to serious health consequences also have serious social consequences for these girls. VVF occurs when blood supply to the tissues of the vagina and the bladder is restricted during prolonged obstructed labour. The tissues die between these organs, forming holes through which urine can pass uncontrollably. RVV, however, occurs in a similar way to VVF but the holes form between the vaginal and rectum leading to uncontrollable leakage of faeces. According to health experts interviewed, the pelvis of these girls is underdeveloped and cannot stand the pressure exerted by the foetal head in trying to come out through the birth canal. This force thereby interrupts the flow of blood to the nearby tissues of the mother's pelvis resulting either VVF or RVF.

5.2.4 Preference of Male Children

The belief that a male child is superior to a female, and that every family needs to propagate its name by a male child, has caused women to continue having children to the detriment of their health in the quest to have male children for their husbands in order to secure their place in their homes even when it is not safe for them to continue with pregnancy and childbirth.

5.2.5 Harmful Widowhood Practises

In some parts of Nigeria, a woman is forced to drink the water used to bathe the dead husband to prove her innocence at the death of her husband. In some parts she is inherited by the husband's brother and continues to bear children by him forcefully. In the case of *Akinnubi vs Akinnubi*,[19] the court held that a widow under intestacy forms part of the estate if her deceased husband and, therefore, can neither inherit nor be appointed as a co-administrator. This led to a lot of emotional and psychological problems for the woman. She can also contact serious sexually transmitted diseases like HIV/AIDS, syphilis e.t.c. Customs that discriminatorily disinherit women either as mothers, wives and daughters under intestacy is expressly discriminatory[20] This is mostly practised in the Eastern part of the country. This practise has been held to be illegal. In the case of *Mojekwu vs Mojekwu*[21]the Court of Appeal pronounced that "oliekpe" custom that disinherits women in absence of surviving sons in intestacy discriminatory and repugnant to natural justice, equity and good conscience. In *Uko vs Iro*[22] the court held unequivocally derogatory customs and practises which deprive women of constitutionally

[19] (1997) 2 NWLR pt 144.
[20] Okeke, U. *P A case for the enforcement of Women's Right as Human Rights in Nigeria* retrieved from http://www.wunrn.com/ assessed 10th October, 2014.
[21] (1997) 7 NWLR pt 512 at 283 .
[22] (2002) FMLR pt 129 at 1454.

guaranteed rights as illegal. In *Asika vs Atuanya*[23] the Court of Appeal held that disinheriting a woman of her late father's property under Onitsha customary law is discriminatory under the African Charter on Human and Peoples Rights which has been domesticated and is applicable in Nigeria. In *Ukeje vs Ukeje*[24] the Supreme Court held that the Igbo native law and custom which disentitled a female from inheriting in her late father's estate is in conflict with Section 42 (1) (a) and (2) of the 1999 Constitution (as amended) a fundamental right provision guaranteed to every Nigerian and therefore void. According to the Court, no matter the circumstances of birth of a female child, such a child is entitled to an inheritance from her late father's estate.

5.3 **Economic Challenges**

In developing countries especially in Africa to which Nigeria belongs, economic resources are scarce in comparison to competing developmental needs. For this reason, the government do not allocate resources to the health care sector to meet its needs. The African Commission in its resolution extensively provides for the obligation of African government as it relates to the protection of women's right to health (as discussed in chapter three of this work under the African Charter on Human and Peoples Rights) but government will always give the excuse of lack of funds.

On the part of the women, poverty is a major factor that militates against the protection of their health. Most women in Nigeria are on the peasant level and do not have the resources to take care of their health. According to Bogecho[25] for a woman to die from pregnancy and child birth is a social injustice. Such deaths are rooted in women's powerlessness and unequal access to finances, education, basic health care,

[23] (2008) 17 NWLR pt117 at 484.
[24] (2014) LPELR (SC).
[25] Bogecho , D (2004) Putting it to Good use : The International Covenant on Civil and Political Rights and Women's Right to Reproductive Health, *Law, Social Justice and Global Development Journal* (LGD) (1) p.3.

employment and other resources. The education of male child in priority to females and early marriage of the girl child prevent her from acquiring the needed education and skills that will economically empower her to take care of herself.

Access to loans in Nigeria is based on collateral which in most cases are landed properties and this is not within the reach of most women in Nigeria and therefore lack of capital hinders them from engaging in meaningful businesses that will enhance their economic power. This will in turn empower them to adequately take care of themselves. This can be seen in the result of the 2013 NDHS[26] on the place of delivery of women. From the result, ninety three percent (93.1%) of women in the lowest wealth quintile give birth at home while 19 percent (19.1%) of women in the highest wealth quintile give birth at home. This shows that the more economically empowered a woman is, the more likely she is to take care of her health.

5.4 **Lack of Political Will**

This is another factor that hinders the protection of women's right to health. The government do not have the will to put appropriate laws and policies in place for the protection of women's right to health. There is a plethora of international instruments and conventions that provide for the protection of these rights to which Nigeria is signatory (as discussed in chapter three) but the non-domestication of these make them unenforceable in Nigeria. These instruments have laudable provisions for the protection of women's right to health but women in Nigeria cannot go to court to enforce them. It is only the African Charter which has been domesticated without its protocol which made extensive provisions for the protection of women's right to health. Government is hereby

[26] National Population Commission(NPC)[Nigeria] and ICF International (2014) *Nigeria Demographic and Health Survey 2013.* Abuja, Nigeria and Rockville Mary land USA, NPC and ICF International p. 124.

reminded that by acceding to these conventions and treaties, they have a moral obligation at least to deviate from the aims of such international instruments.

5.5. **High Rate of Illiteracy**

Illiteracy is high in Nigeria especially among the female population[27]. This contributes to the abuse of women's right to health because of some beliefs that are held to be beneficial to women but in actual fact are not of any benefit but rather harmful like female genital mutilation. As a result of illiteracy, some rural women prefer to have their children with traditional birth attendants thereby exposing themselves to health risks that otherwise would have been prevented if they accessed health care facilities.

[27] National Population Commission(NPC)[Nigeria] and ICF International (2014) *Nigeria Demographic and Health Survey 2013.* Abuja, Nigeria and Rockville Mary land USA, NPC and ICF International p.15.

CHAPTER SIX

SUMMARY FINDING AND RECOMMENDATIONS

6.1 **Summary**

In this work efforts have been made to show that women's right to health is a fundamental human right as have been established by numerous international treaties and conventions. It has also been established that pregnancy is a biological and social process that require healthcare and that the death of a woman during childbirth is a social injustice and an infringement of women's right to health.

There is no express provision of the right to health in the Nigerian Constitution but this can only be inferred from other provisions (as discussed in chapter three). There are lots of international legal instruments that provide for women's right to health but they are not enforceable in Nigeria because they have not been domesticated in Nigeria as required by the constitution

Negative cultural practises are a major culprit in the abuse of women's right to health. Some of these cultural practises include female genital mutilation/cutting which ranks highest because it cuts across every tribe in Nigeria. Others include early girl-child marriage, harmful widowhood practises, delivery by untrained birth attendants among others. There are insufficient infrastructure and healthcare personnel in public healthcare institutions in Nigeria especially at the grassroots. Haemorrhage is the greatest cause of maternal mortality in Nigeria which rate is at 576 maternal deaths per 100,000 live births.

The African Charter on Human and People's Right (ACHPR) has been domesticated in Nigeria as provided by Section 12 of the Constitution and therefore is now applicable as a national law. It provided for the right of an individual to enjoy the best attainable state of physical and mental health. The optional protocol to the ACHPR

which made categorical provisions on women's right to health has been ratified but not yet domesticated.

6.2 **Findings**

The following findings have been made in this research;

1. Nigeria has not measured up to international standards and best practises with respect to women's right to health in its legal system.
2. Nigeria is a signatory to a number of International Conventions providing for the protection of women's right to health, especially the protocol on the African Charter on Human and Peoples Rights (the Rights of Women in Africa) which specifically made elaborate provisions on Women's Right to health as discussed in chapter three, but has not domesticated these Conventions to make them applicable in Nigeria.
3. The non provision of the right to health in the Nigerian Constitution and non domestication of international instruments that provide for women's right to health do not leave Nigerian women with adequate safeguards against the abuse of their right to health.
4. Culture based practises contribute to the poor health status of women in Nigeria, which include female genital mutilation/female genital cutting/female circumcision, early childhood marriage, harmful widowhood practise, preference of male to female children, the belief that delivery through caesarean section is a taboo, et cetera. All these practises have serious health consequences for women and are serious infringements on their right to health.

6.3 **Recommendations**

Women's right to health have been established as a fundamental human right that should be upheld. In view of the findings made in this study, the following recommendations are suggested:

1. Nigeria should be willing to perform its obligations under the international convention to which she is a party including the Protocol to the African Charter on Human and Peoples' Rights in Africa also known as the Maputo Protocol, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), International Convention on Economic, Social and Cultural Rights (ICESCR), Convention on the Rights of the Child (CRC) et cetera.
2. Negative cultural practises that infringe on women's right to health should be outlawed. The Penal and Criminal Codes should be amended to criminalize these practises and severe punishment spelt out for offenders. These practices include FGM early girl child marriage, harmful widowhood practices, delivery by untrained traditional birth attendants et cetera.
3. The right to health has been established as a fundamental human right and therefore should be enshrined in the Nigerian Constitution in order to empower women and other Nigerians to hold government accountable for negligence in the provision of health infrastructure and personnel that will help to improve and protect women's health. There should be public awareness and enlightenment on women's right to health and the negative consequences of the abuse of this right. This will empower women to demand for the protection of their right to health.
4. Judicial Activism should be encouraged in Nigeria. The right to health should be treated as an extension of the right to life as has been done in India. This is

because the provisions of Chapter 11 of the Indian Constitution are *pari materia*[173] with Chapter 11 of the Nigerian Constitution on Fundamental Objectives and Directive Principles of State Policy.

[173] Similar.

BIBLIOGRAPHY

A. Books

Adebayo, A. (1989) *African Women in Development, Selected Speeches*, United Nations Economic Commission for Africa, Addis Ababa.

Aina, O.I (2003*) General Overview of the Status of Women in Nigeria* in: Abiola A.O (ed) Women Advocates Research and Documentation Centre, Lagos.

Amnesty International, (2005*) Stop Violence Against Women*. Amnesty International Secretariat, London.

Brain, W. (2000) *Dissertation Skills for Business and Management Students*, Seng Lee Singapore.

Cook, R. Et al (2006) *Reproductive health and human rights integrating medicine, ethics and law,* Oxford University Press, New York.

Enemuo, F.C (1999) *"Gender and Women Empowerment",* in Remi Anifowose and Francis (ed), *Elements of Politics,* Lagos, Malt house, Lagos.

Eze, O. (1984) *Human Rights in Africa: Some Selected Problems*, Nigeria Institute of International Affairs, Lagos.

Ladan, M. T (2007) *Law and Policy on Health, HIV-AIDS, Maternal Mortality and Reproductive Rights in Nigeria,* Faith Printers and Publishers, Zaria.

National Population Commission, Abuja (2008) *Nigeria Demographic and Health Survey*. NPC and ICF Macro, Calverton Maryland U.S.A.

National Population Commission (NPC) [Nigeria] and ICF International (2014*) Nigeria Demographic and Health Survey 2013*. Abuja Nigeria and Rockville Maryland USA, NPC and ICF International.

Okagbue, I. (1996) *Women's Rights are Human Rights*. Nigerian Institute of Advanced Legal Studies, Lagos.

Pillai, V and Wang. L (1999) *Women's Reproductive Rights in Developing Countries* India, Gaungp Zheu.

World Health Organization, *Preamble to the Constitution of the World Health Organization* (1948) adopted by the International Health Conference on July 1946. Opened for signature on July 22 1946, and entered into force on 7th April, 1948.

World Health Organization (2009), *Today's Women and Health Evidence, Tomorrow's Agenda*, WHO Press, Geneva.

B. Journals

Alson, P and Steiner, H.J. (1996) International Human Rights Context*: Law, Politics and Morals.*

Oyedele, O.S (2006) Women's Rights in Africa: Myth or Reality, *University of Benin Law Journal*, Vol. 9 (1).

Shokunbi, Y. (2010) Nigeria: Of Pope's shift on Condon and Women's Reproductive and Health Rights, *Daily Independent* December 4, assessed from All African.Com July 12, 2011.

C. Internet Materials

Asikia Ige (2012) Women and the Right to Health in Nigeria: The Intersections, *British Journal of Arts and Sciences.* British Journal Publishing inc. retrieved from http://www.bjournal.co.uk/BJASS.aspx.

Economic and Social Research Council (ESCR2012), *Research Ethics Framework*, Swindon, UK, ESCR Publishing, PP 23-26 retrieved from http://www.gold.ac.UK/media/ESRCReEthicsframetcm6-11291.pdf accessed 17th August, 2013.

Okeke, U. *P. A case for the enforcement of Women's Right as Human Rights in Nigeria* retrieved from http://www.wunrn.com/ assessed 10th October, 2014.

Omoyemen Odigie-Emmanuel (2010) "Assessing Women's Rights in Nigeria Washington, DC *Foreign Policy in Focus*, retrieved from http://www.FPIF.org/articles/assessing – Women's -Rights-in-Nigeria assessed on 14th February, 2013.

Unicef, MDG goal of Improving Maternal Health by 2015 retrieved from http://www.uncef.org/mdg/index_maternalhealth.htm.

Globalization 101 : Origin of Human Rights retrieved from www. Globalization 101.org/human _rights vs – Natural Rights.

Burns H. W. *Human Rights* retrieved from www. Britannica.com./topic/human rights/natural-law-transformed-into-natural rights accessed 16th July 2015

Cross, F and Miller, R.(2014) *The Legal Environment of Business: Text and Cases*, USA, Cengage Learning Stamford USA p.4 retrieved at https://books.google.com.ng/books ISBN = 1305142942.

Wikipedia: Philosophy of human rights retrieved from https://en.wlkpdia .org/philosophy _of human _rights# Natural rights.

APPENDIX IX

LIST OF TABLES

Pages

Table 4.1. Reproductive challenges requiring Health Care -- -- -- 47

Table 4.1b Participants in the Study -- -- -- -- -- -- 48

Table 4.2 Response of Health Professionals on Cultural Practises -- -- 49

Table 4.3 Category of Health Institutions -- -- -- -- -- 50

Table 4.4 Rating of Facilities and Infrastructure in Health Care Institutions-- 51

Table 4.5 Patients Response on Sufficiency of Health Care Professionals-- -- 52

Table 4.6 Time spent on each Hospital Attendance -- -- -- -- 53

Table 4.7 Response of Health Care Professionals on Category of Health Institutions -- -- -- -- -- -- – -- -- 54

Table 4.8 Effect of Facilities in public Health Institutions on Maternal Care-- 55

Table 4.9 Professionals Response on Adequacy of Infrastructure in Public Health Institutions -- -- -- -- -- -- -- -- 56

Table 4.10 Response on Sufficiency of Health Care Professionals -- -- 58

Table 4.11 Percentage of Patients attended to daily per Health Care Worker-- 59

Table 4.12 Component of Women's Right to Health -- -- -- -- 60

Table 4.13 Free Provision of Health Care Services -- -- -- -- 61

Table 4.14 Level of Satisfaction with Health Care Services -- -- -- 63

Table 4.15 Response of Professionals on Free Provision of Health Care Services- 64

Table 4.16 Effect of Free Medical Services on Maternal and Child Mortality-- 65

APPENDIX X

LIST OF FIGURES

Pages

Figure 4.1 Reproductive Challenges requiring Health Care -- -- 47

Figure 4.2 Rating of Health Care Facility by Patients -- -- -- 51

Figure 4.3 Response on Sufficiency of Health Professionals -- -- 52

Figure 4.4 Time spent on each Hospital Attendance -- -- -- -- 53

Figure 4.5 Effect of Facilities in public Health Institutions on Maternal Care-- 55

Figure 4.6 Response of Professionals on Adequacy of Infrastructure in Public Health Institutions -- -- -- -- -- -- 57

Figure 4.7 Response of Patients on Adequacy of Infrastructure in Public Health Institutions -- -- -- -- -- -- -- 58

Figure 4.8 Percentage of Patients attended to daily per Health Care Worker-- 59

Figure 4.9 Component of Women's Right to Health -- -- -- 60

Figure 4.10 Free Provision of Health Care Services -- -- - -- 62

Figure 4.11 Level of Satisfaction with Health Care Services-- -- -- 63

Figure 4.12 Response of Professionals on Free Provision of Health Care Services-64

Figure 4.13 Effect of Free Medical Services on Maternal and Child Mortality-- 66