Beyond the National Health Act: Arguing for a Comprehensive and Enforceable Maternal Care Mandate in Nigeria

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Abstract

According to the World Health Organisation (WHO) "maternal health refers to the health of women during pregnancy, childbirth and the postpartum period". This is further defined to encompass the health care dimensions of family planning, preconception, prenatal and postnatal care aiming to reduce maternal morbidity and mortality. The journey to motherhood in Nigeria remains one of the most perilous in the world. For tens of thousands of women each year, pregnancy and childbirth, universal symbols of life and hope, end in preventable deaths. Nigeria bears a staggering and disproportionate share of the global maternal mortality burden, accounting for nearly 30% of all maternal deaths worldwide. This research investigated the persistent maternal mortality crisis in Nigeria and its profound impact on the nation's developmental indices. It argued that the high rate of preventable maternal death constitutes a national emergency that is directly linked to failures within the country's legal and policy architecture. Using a doctrinal research methodology, the study conducted a critical analysis of primary legal sources, including the 1999 Constitution of the Federal Republic of Nigeria, the National Health Act (2014), and the National Health Insurance Authority Act (2022), alongside relevant international treaties to which Nigeria is a signatory. The research also drew upon secondary sources such as scholarly journals, government reports, and publications from international development partners to assess the socio-economic consequences of the crisis. A primary challenge this research identified was that the existing legal framework, while well-intentioned, is fragmented, underfunded, and largely unenforceable, failing to provide a tangible right to survival for pregnant women. This research found that the non-justiciable nature of key constitutional provisions on health and the implementation gaps in current legislation are significant barriers to progress. In response to these challenges, this research proposed the enactment of a new, standalone "Comprehensive Maternal Care Act" (CMCA). It concluded that only a bold legislative mandate can transform the right to maternal health from an aspirational principle into an enforceable reality. This research recommended the establishment of a legally guaranteed continuum of care, a strengthened primary healthcare system, robust accountability mechanisms through an independent commission, and a diversified, ring-fenced funding strategy to ensure the long-term sustainability of maternal health services in Nigeria.

1. Introduction

According to the World Health Organisation (WHO) "maternal health refers to the health of women during pregnancy, childbirth and the postpartum period".[1] This is further defined to encompass the health care dimensions of family planning, preconception, prenatal and postnatal care aiming to reduce maternal morbidity and mortality.[2] Maternal health in the context of this work thus refers to the physical, mental, psychological and physiological well-

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[1] (http:www.who.int/topics/maternal health/en)

[2] Onyemelukwe, Ifeoma & Nwankwo, Obiageli. (2014). "A Review Of The Regulatory Framework For Maternal Health In Nigeria". 10.13140/RG.2.2.15474.12480.

being of women during preconception, prenatal, pregnancy, child birth and post -partum period.[3]

The journey to motherhood in Nigeria remains one of the most perilous in the world. For tens of thousands of women each year, pregnancy and childbirth, universal symbols of life and hope, end in a preventable death. Nigeria bears a staggering and disproportionate share of the global maternal mortality burden, accounting for nearly 30% of all maternal deaths worldwide.[4] A Nigerian woman faces a 1 in 19 lifetime risk of dying during pregnancy, childbirth, or the postpartum period—a stark contrast to the 1 in 4,900 risk for a woman in a high-income country.[5] This is not merely a public health failure; it is a persistent national emergency and a grave human rights crisis that challenges the nation's commitment to the life and dignity of its citizens. Each statistic represents a woman whose death leaves behind a fractured family, motherless children, and a weakened community, perpetuating a cycle of poverty and social instability.[6]

In response to its myriad health challenges, Nigeria has established a legislative framework intended to reform the sector. The landmark National Health Act of 2014 was enacted to provide a legal structure for the regulation, development, and management of the national health system, establishing for the first time a right to a Basic Minimum Package of Health Services for all Nigerians.[7] More recently, the National Health Insurance Authority (NHIA) Act of 2022 was passed, making health insurance mandatory for all citizens and residents and establishing a Vulnerable Group Fund to subsidize care for the poorest and most marginalized, including pregnant women.[8] These legislative instruments signal a clear intent to improve health outcomes and expand access to care.

Despite the laudable ambitions of these Acts, the reality on the ground remains largely unchanged for most pregnant women. The promise of universal health coverage remains unfulfilled, with insurance enrolment still below average and the Basic Health Care Provision Fund (BHCPF) plagued by inconsistent funding and significant implementation gaps.[9] The result is a fragmented, underfunded, and ultimately unenforceable approach to maternal healthcare that fails to deliver a reliable continuum of care. This article argues that to decisively address its maternal mortality crisis, Nigeria requires a new, standalone, and robustly funded Comprehensive Maternal Care Act. Such an Act must move beyond the aspirational principles of existing legislation to create an explicit, enforceable, and fully financed mandate that

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[3] Ibid

[4] World Health Organization (WHO), UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. *Trends in Maternal Mortality 2000 to 2020*. Geneva: World Health Organization, 2023.

[5] Healthy Newborn Network. "Nigeria: Maternal and Newborn Health Country Profile." March 2024. https://healthynewbornnetwork.org/resource/2023/nigeria-maternal-newborn-health-country-profile/.

[6] Babalola, Sola, and Adeniyi Fatusi. "Determinants of Use of Maternal Health Services in Nigeria - Looking beyond Individual and Household Factors." *BMC Pregnancy and Childbirth* 1, no. 43 (2009).

[7] *National Health Act, 2014*. Federal Republic of Nigeria Official Gazette, No. 142, Vol. 101, (December 29, 2014).

[8] *National Health Insurance Authority Act, 2022*. Federal Republic of Nigeria.

[9] Onwujekwe, Obinna, et al. "Has the Basic Health Care Provision Fund in Nigeria Improved Funding for Primary Healthcare and Universal Health Coverage?" *The Pan African Medical Journal* 41, no. 165 (2022).

guarantees every pregnant woman a defined package of high-quality maternal health services, free at the point of care.

To substantiate this argument, this article is structured as follows. Section 2 will detail the scale and multifaceted nature of Nigeria's maternal health crisis. Section 3 will offer a critical appraisal of the existing legal and policy landscape, highlighting the specific inadequacies of the National Health Act and the NHIA Act. Following this, Section 4 will establish the constitutional and legal imperative for federal action. Section 5 will then outline the core provisions of the proposed "Comprehensive Maternal Care Act," focusing on a mandated continuum of care, a strengthened implementation framework, and robust accountability mechanisms. Finally, Section 6 will analyze sustainable funding strategies before the article concludes with key recommendations and a call to action.

2. **Maternal Health in Nigeria**

Nigeria is the most populous country in Africa, with approximately 214 million people, making it globally the 6th most populous nation.[10] By 2050, its population is projected to reach about 392 million, which will make it the 4th most populated country in the world.[11] However, maternal mortality remains a significant issue, with the number of deaths among pregnant women increasing over the years. Maternal care in Nigeria is structured around three levels: primary, secondary, and tertiary healthcare. Primary health centres are located in all 774 local government areas, providing antenatal care, delivery, and postnatal care. Women with complications are referred to secondary care centres managed by the states or tertiary centres managed by the Federal Government.

According to the Nigeria Demographic and Health Survey (NDHS), the maternal mortality ratio stands at 512 deaths per 100,000 live births. This means that for every 1,000 live births in Nigeria, about five women die during pregnancy, childbirth, or within two months of childbirth.[12] According to UNICEF, Nigeria has the highest number of neonatal and maternal deaths in Africa, a situation exacerbated by its large population and high mortality rates.[13] The WHO's 2019 report highlights the increasing number of maternal deaths in Nigeria, pointing to disparities in access to healthcare between the wealthy and the underprivileged.[14] This alarming statistics underlines the urgent need for continuous investment in promoting maternal and child health across the country.

In 2001, Nigeria introduced a National Reproductive Health Policy aiming to halve the national maternal death rate from 800 fatalities per 100,000 live births within five years.[15] However,

[10] United Nations Population Fund. (2017). Country programme document for Nigeria (2018–2022) (Symbol DP/DCP/NGA/3). New York: UN.

[11] Ibid

[12] Idama, Vivian, Osarhiemen, Itohanosa, Glory, Ajilora and Omolade, Akinyemi. (2024). Factors Affecting Maternal Mortality Rates in Nigeria: A Review of Challenges and Potential Solutions. Futurity Medicine. 3. 10.57125/FEM.2024.09.30.08.

[13] Ibid

[14] Ibid

[15]

even 14 years after this target date, the country has not achieved this goal. Among the maternal deaths worldwide, a significant number occur in developing countries, with a substantial portion happening in Nigeria.

2.1. **Causative factors of maternal health crisis in Nigeria.**

Maternal mortality is a major public health concern in Nigeria, with a significant percentage of deaths resulting from preventable obstetric causes. Recent research has shed light on the seriousness of this problem. According to this study, the top causes of maternal mortality include hypertension (27%), sepsis (20.6%), haemorrhage (17%), anaemia (3.2%), HIV (3.2%), and sickle cell disease (2.4%).[16]

Several factors contribute to Nigeria's maternal health crisis. Limited access to healthcare is one of these factors. Despite considerable improvements in infrastructure, many regions, particularly rural and hard-to-reach areas, still lack access to essential maternal health services like antenatal care and emergency obstetric/gynaecology care. In addition, Nigeria's health care system is often overstretched and underfunded. This is largely due to limited human resources, little or no uptake of health insurance and a lack of essential medications.[17] Primary health care facilities (PHCs), which serve as the first contact between an individual and the health system, as well as one of the three gateways for implementing the BHCPF, face challenges that limit effective delivery of their services. Economic barriers also account for the country's maternal health woes. Only 45% of women have access to financial services, limiting their ability to afford healthcare.[18]

Challenges impeding the improvement of maternal and newborn health are primarily attributed to inadequate access to quality healthcare services, poor health infrastructure, and a shortage of skilled health workers, as well as religious and sociocultural norms like early marriage and childbearing, gender inequality, and poverty.[19]

Another study emphasises the need to address delays in maternal healthcare-seeking behaviour. Delays in seeking maternal health care, reaching a healthcare facility, and receiving expert pregnancy care are identified as key factors contributing to maternal mortality. These delays are often caused by systemic challenges, such as limited access to healthcare facilities, inadequate transportation infrastructure, and a lack of awareness about the importance of prompt and specialised maternity care. Meanwhile, preterm birth complications, intrapartum events, and infections account for over 80% of newborn deaths and stillbirths.[20]

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[16] Ajegbile ML. Closing the gap in maternal health access and quality through targeted investments in low-resource settings. Journal of Global Health Reports. 2023;7:e2023070. doi:10.29392/001c.88917
[17] Ibid
[18] Maternal Health and Reproductive Justice: Bridging the Gap. https://cheld.org/maternal-health-in-nigeria/#:~:text=Despite%20considerable%20improvements%20in%20infrastructure%2C%20many%20regions%2C,care%20system%20is%20often%20overstretched%20and%20underfunded.
[19] Ajegbile ML. Closing the gap in maternal health access and quality through targeted investments in low-resource settings. Journal of Global Health Reports. 2023;7:e2023070. doi:10.29392/001c.88917
[20] Ibid

Many women opt for home births to avoid hospital fees, increasing the risks of maternal or infant death. Malnutrition is another contributory factor to the maternal health crisis in Nigeria, with anaemia affecting over 25-40% of pregnant women in Nigeria. Inadequate antenatal screening and iron-folic acid supplementation programmes worsen the condition. It is common knowledge that undernourished mothers are prone to infection, life-threatening complications, obstructed labour and would most likely have malnourished babies.[21]

2.2 The "Three Delays Model"

The causative factors of maternal health crisis in Nigeria is integrated into a model known as "The Three Delays Model".[22] This Model identifies the three groups of factors which hinder women accessing the maternal health care they need.

"The Three Delays Model" are:

a. The delay in decision to seek care. The first level of delay occurs at the house-hold or community level. The underlying factors that influence a delay in seeking preventive care or assistance during delivery occur in the community. Girls become pregnant too young. Some seek illegal abortions. Gender inequity works against empowerment of women to demand care. Some refuse antenatal care. Poverty contributes to lack of health education, adequate food and availability of health care services. Conflicting beliefs regarding supernatural causes of maternal death also contribute to delay or refusal to seek assistance from trained doctors and nurses. Financial lack in accessing Healthcare. Poor understanding of complications and risk factors in pregnancy and when to seek medical help.[23]
b. The second level of delay occurs in accessing a healthcare facility. This encompasses distance to health centers and hospitals. The availability of transportation in cases of emergency, Navigating poor and inadequate roads and infrastructure in reaching a healthcare facility. There is often no assistance for a woman in labor at night, roads are impassible and many health facilities are closed or unstaffed in the evening.[24]
c. The third level of delay is in receiving adequate health care due to Poor facilities and lack of medical supplies. Inadequately trained and poorly motivated medical staff.

[21] Maternal Health and Reproductive Justice: Bridging the Gap. https://cheld.org/maternal-health-in-nigeria/#:~:text=Despite%20considerable%20improvements%20in%20infrastructure%2C%20many%20regions%2C,care%20system%20is%20often%20overstretched%20and%20underfunded.
[22] https://www.maternityworldwide.org/what-we-do/three-delays-model/
[23] Piane, GinaMarie & Azubuike, Precious. (2023). Analyzing Maternal Mortality in Nigeria: A Qualitative Study Approach using the Three Phases of Delay. Journal of Health Promotion and Behavior. 8. 22-33. 10.26911/thejhpb.2023.08.01.04.

[24] Ibid

> Inadequate referral systems where nurses at the Primary Health Center, traditional birth attendants or family members attending a home delivery do not refer the labouring or haemorrhaging woman to the hospital in time to save her life.[25]
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> In Nigeria, the woman in labour and her family, are in most cases, asked to bring the necessities for the delivery including, hand gloves, cot-ton sponges, a wrapper to cover the woman in labor and often donated blood in case of surgical delivery. If they arrive without the items, they can be turned away from the hospital. If they don't have the money, up front, for surgery, they may be turned away. Cesarean section (CS), which is a life-saving tool in most cases is unaffordable or the women may die because the labor was not monitored according to international standards. The widespread fear of CS and familiarity with maternal deaths as a result of CS also contributes to refusal of surgical delivery.[26]

2.3. **The impact of the maternal health crisis on Nigeria's development**

The persistent maternal health crisis in Nigeria extends far beyond the confines of hospital wards and primary health centres; it casts a long shadow over the nation's entire developmental landscape. High maternal mortality is not merely a health indicator but a powerful brake on economic growth, social stability, and human capital formation. Each maternal death triggers a devastating ripple effect, dismantling families, crippling household economies, and entrenching an intergenerational cycle of poverty and disadvantage that undermines Nigeria's progress towards its national and international development goals.[27]

2.3.1. Erosion of Human Capital and Economic Productivity

The death or severe disability of a mother represents a direct and profound loss of human capital. Women are central to Nigeria's economic life, contributing significantly to household income, agriculture, and the informal economy.[28] When a mother dies, her economic contributions cease, immediately plunging the household into financial distress. Studies have shown a significant negative correlation between Nigeria's maternal mortality ratio (MMR) and its Gross Domestic Product (GDP), with one analysis suggesting that maternal mortality accounts for a substantial variance in the nation's economic growth.[29]The loss is twofold: the direct loss of a productive member of the workforce and the indirect costs associated with it, including catastrophic health expenditures that families incur in desperate attempts to save her life. The economic burden of poor maternal (preconception) health in Nigeria was estimated to

[25] Ibid

[26] Ibid

[27] Adeoye, Segun, Oluwaseyi Dolapo, and Oluwatosin Adeoye. "Maternal Mortality in Nigeria: The Unending Tragedy." *Journal of Women's Health and Development* 3, no. 2 (2020): 1-10.

[28] Adedokun, L. A., and A. A. Adeyemi. "The Economic Implications of Maternal Mortality on the Household Economy in Nigeria." *International Journal of Social Science and Humanity* 3, no. 5 (2013): 442-446.

[29] Ogunjimi, L. O., and P. F. Adebayo. "Impact of Maternal Mortality on Economic Growth in Nigeria." *African Journal of Applied Research* 11, no. 2 (2025): 605-624.

be as high as US$3.3 billion in 2020 alone, a staggering figure that highlights the immense economic cost of inaction.[30]

2.3.2. The Intergenerational Cycle of Disadvantage

The consequences of a maternal death are most acutely felt by the surviving children, creating a legacy of disadvantage that can span generations. A mother's death is the single greatest risk factor for the death of her children, especially in their first two years of life.[31] One study found that while 64 infants were born alive from 76 maternal deaths in Nigeria, a shocking 68.6% of those infants did not survive beyond five years.[32]

For children who do survive, the loss is life-altering. They are more likely to suffer from malnutrition, have lower immunization rates, and be withdrawn from school to either work or care for younger siblings.[33] This disruption to their health and education severely limits their future potential, ensuring that the poverty and vulnerability of one generation are passed down to the next. The loss of maternal care and guidance creates a void that often leads to poorer long-term health, social, and economic outcomes for the surviving children.

2.3.3. Suppression of the Human Development Index (HDI)

The Human Development Index (HDI), a composite measure of a nation's progress, is calculated based on life expectancy, education, and per capita income. Nigeria's high maternal mortality rate directly suppresses its HDI score by drastically lowering the average life expectancy for women. A high lifetime risk of maternal death means that women, on average, live shorter lives, which pulls down the national life expectancy figure—a core component of the HDI.[34] This statistical reality keeps Nigeria ranked low on global development tables, impacting foreign investment, international partnerships, and national prestige. Addressing maternal mortality is therefore not just a health or social goal; it is a prerequisite for improving Nigeria's fundamental human development profile.

2.3.4. Reinforcement of Gender Inequality

Finally, the maternal health crisis is both a cause and a consequence of deep-seated gender inequality. Societal norms that limit women's autonomy, educational attainment, and economic

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[30] Kuye, Olusesan, et al. "The Cost of Inaction on Preconception Health in Nigeria: An Economic Impact Analysis." *Global Health Action* 17, no. 1 (2024).

[31] Hogan, Margaret C., et al. "Maternal Mortality for 181 Countries, 1980–2008: A Systematic Analysis of Progress Towards Millennium Development Goal 5." *The Lancet* 375, no. 9726 (2010): 1609-1623.

[32] Nigeria Health Watch. "An Unseen Grief: Maternal Mortality's Impact on Infants and Children." November 30, 2024. https://articles.nigeriahealthwatch.com/an-unseen-grief-maternal-mortalitys-impact-on-infants-and-children/.

[33] Babalola, Sola, and Adeniyi Fatusi. "Determinants of Use of Maternal Health Services in Nigeria - Looking beyond Individual and Household Factors." *BMC Pregnancy and Childbirth* 9, no. 43 (2009).

[34] United Nations Development Programme (UNDP). *Human Development Report 2023/2024: Breaking the Gridlock: Reimagining Cooperation in a Polarized World*. New York: UNDP, 2024.

independence are key drivers of poor maternal outcomes.[35] When a woman cannot make decisions about her own body or health, when she lacks the financial resources to pay for transport or care, and when her life is valued less than that of a man, she is more likely to die in childbirth. In turn, the crisis reinforces these inequalities. High rates of maternal death are used to justify restricting women's roles to the domestic sphere, limiting their participation in public life and leadership. It becomes a tragic, self-fulfilling prophecy where the perceived risk of motherhood is used to curtail a woman's potential, thereby ensuring the cycle continues.

3. **The Legal and Policy Framework of Maternal Care in Nigeria**

The legal and policy framework for maternal health in Nigeria is a complex web of domestic legislation, national policies, and international commitments. While these instruments express a clear intent to protect and promote the health of mothers, a critical analysis reveals significant gaps in implementation, enforcement, and funding that undermine their effectiveness. This section provides a detailed appraisal of this framework.

3.1 The Domestic Legal Framework

3.1.1 The 1999 Constitution of the Federal Republic of Nigeria (as amended)

The Constitution is the supreme law of the land, and its provisions are the ultimate source of legal authority. The right to health, including maternal health, is primarily located in Chapter II: Fundamental Objectives and Directive Principles of State Policy.

- Section 17(3)(d) explicitly states that "The State shall direct its policy towards ensuring that... there are adequate medical and health facilities for all persons."[36]
- Section 17(3)(f) adds that "children, young persons and the aged are protected against any exploitation whatsoever, and against moral and material neglect."[37]

The primary challenge with these provisions is their legal status. Section 6(6)(c) of the Constitution renders the entire Chapter II non-justiciable, meaning that citizens cannot bring a legal action against the government for failing to uphold these principles.[38] This has been consistently affirmed by Nigerian courts, effectively reducing the constitutional right to health to a mere policy objective rather than an enforceable legal right.[39] This fundamental flaw means that while the state has a moral and political duty to provide for maternal health, it lacks a legally compelling one under its own highest law.

[35] Center for Health, Ethics and Law in Development (CHELD). "Maternal Health and Reproductive Justice: Bridging the Gap." April 28, 2025. https://cheld.org/maternal-health-in-nigeria/.

[36] *Constitution of the Federal Republic of Nigeria, 1999 (as amended).*
[37] Ibid
[38] Ibid
[39] *Okogie v. Attorney-General of Lagos State* (1981) 2 NCLR 337.

3.1.2 The National Health Act, 2014

The National Health Act (NHA) is the most significant piece of legislation directly addressing health rights in Nigeria. Its purpose is to provide a framework for the regulation, development, and management of a national health system.

- Section 1(1) establishes a right for every Nigerian to a Basic Minimum Package of Health Services. This package is meant to cover a range of services at the primary healthcare level, which would logically include essential maternal care.[40]
- Section 3 obligates all citizens to participate in a health insurance scheme, laying the groundwork for what would become the NHIA Act.[41]
- Section 11 establishes the Basic Health Care Provision Fund (BHCPF), the Act's primary financing mechanism. It stipulates that at least 1% of the Consolidated Revenue Fund of the Federal Government, along with contributions from other sources, be dedicated to the BHCPF. This fund is intended to finance the Basic Minimum Package of Health Services, with 50% allocated to the National Health Insurance Scheme for this purpose.[42]

Despite its promise, the NHA's impact has been limited by inconsistent and insufficient funding of the BHCPF and a lack of clarity and enforcement regarding the precise contents of the "Basic Minimum Package."[43]

3.1.3 The National Health Insurance Authority (NHIA) Act, 2022

This Act repealed the previous National Health Insurance Scheme (NHIS) Act and sought to accelerate the drive towards Universal Health Coverage (UHC).

- Section 1 makes health insurance mandatory for all Nigerian citizens and legal residents.[44]
- Section 25 establishes the Vulnerable Group Fund, which is intended to pay for the insurance premiums of vulnerable persons, a category that explicitly includes pregnant women, children under five, and the indigent.[45]

The NHIA Act is a significant step forward in principle. However, its success is contingent on the effective funding and administration of the Vulnerable Group Fund. With a vast number of Nigerians falling into the vulnerable category, the financial resources required to cover their premiums are immense, and the mechanisms for identifying and enrolling these individuals are still developing.

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[40] *National Health Act, 2014*. Federal Republic of Nigeria Official Gazette, No. 142, Vol. 101, (December 29, 2014).
[41] Ibid
[42] Ibid
[43] Onwujekwe, Obinna, et al. "Has the Basic Health Care Provision Fund in Nigeria Improved Funding for Primary Healthcare and Universal Health Coverage?" *The Pan African Medical Journal* 41, no. 165 (2022).
[44] *National Health Insurance Authority Act, 2022*. Federal Republic of Nigeria.
[45] Ibid

3.1.4 The Nigerian Labour Act, 1971

This Act provides the primary statutory protections for employees, including maternity leave.

- Section 54 grants a female employee the right to twelve weeks of maternity leave (six weeks before and six weeks after confinement) with at least 50% of her normal wages. It also protects her from termination on account of her pregnancy.[46] This provision, while important, is outdated and falls short of the International Labour Organization's (ILO) recommended minimum of 14 weeks. Furthermore, it only applies to the formal sector, leaving the vast majority of women working in the informal economy unprotected.

3.2 The International Legal Framework

Nigeria is a signatory to numerous international and regional treaties that create a binding obligation to protect and promote the right to health, including maternal health. Under international law, these commitments are not merely aspirational.

3.2.1 The International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966

- Article 12 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[47] The UN Committee overseeing the ICESCR has clarified in its General Comment No. 14 that this right includes "the creation of conditions which would assure to all medical service and medical attention in the event of sickness," explicitly mentioning the need for the reduction of stillbirth-rate and infant mortality and the provision of health care for mothers before, during, and after childbirth.[48]

3.2.2 The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979

- Article 12 obligates states to "take all appropriate measures to eliminate discrimination against women in the field of health care" and, specifically, to "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."[49]

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[46] *Labour Act (Cap L1 LFN 2004).*

[47] United Nations. *International Covenant on Economic, Social and Cultural Rights*. Adopted December 16, 1966.

[48] UN Committee on Economic, Social and Cultural Rights (CESCR). *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)*. E/C.12/2000/4, August 11, 2000.

[49] United Nations. *Convention on the Elimination of All Forms of Discrimination against Women*. Adopted December 18, 1979.

3.2.3 The African Charter on Human and Peoples' Rights (Banjul Charter), 1981

- Article 16 states that "Every individual shall have the right to enjoy the best attainable state of physical and mental health," and obligates State Parties to "take the necessary measures to protect the health of their people."[50]Unlike the Nigerian Constitution, the African Charter has been domesticated and is an enforceable part of Nigerian law.[51]

3.2.4 The Protocol to the African Charter on the Rights of Women in Africa (Maputo Protocol), 2003

This is one of the most progressive international instruments on women's rights. Nigeria ratified it in 2005.

- Article 14(1) provides a comprehensive right to health for women, which includes sexual and reproductive health.
- Article 14(2) is particularly explicit, obligating states to take appropriate measures to:
    - **(a)** Provide adequate, affordable and accessible health services... to women;
    - **(b)** Establish and strengthen existing health and nutritional services for women, especially during pregnancy and while breastfeeding.[52]

The challenge with these international instruments is one of domestication and implementation. While Nigeria is bound by them on the international stage, and the African Charter is directly applicable in court via its domestication, there is often a significant disconnect between these legal obligations and the lived reality of Nigerian women seeking maternal healthcare.

4. **The Proposed "Comprehensive Maternal Care Act": Core Provisions**

This section outlines the foundational pillars of a proposed new federal law, the "Comprehensive Maternal Care Act" (CMCA). This Act is designed to supersede the ambiguities of existing legislation by creating an explicit, enforceable, and fully-funded right to maternal healthcare for every Nigerian woman. The cornerstone of the CMCA is the legal guarantee of a comprehensive and integrated continuum of care, provided free at the point of access to every pregnant woman, irrespective of her location, income, or insurance status. These services shall be legally defined as an enforceable right.

Part A: Pre-natal Care

a. **First Trimester Registration:** Every pregnant woman is entitled to register her pregnancy at a designated Primary Health Centre (PHC) within the first trimester, at no cost.

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[50] Organization of African Unity. *African Charter on Human and Peoples' Rights ("Banjul Charter")*. Adopted June 27, 1981.
[51] *Abacha v. Fawehinmi* (2000) 6 NWLR (Pt. 660) 228.

[52] African Union. *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*. Adopted July 11, 2003.

b. **Comprehensive Antenatal Services:** A minimum of eight (8) antenatal check-ups as recommended by the World Health Organization (WHO), which must include:
   i. Essential screenings for hypertension, gestational diabetes, HIV, and anemia.
   ii. Provision of required immunizations (e.g., Tetanus Toxoid).
   iii. Guaranteed access to routine nutritional supplements, particularly Folic Acid and Iron.
   iv. Structured health education on birth preparedness, nutrition, danger signs, and family planning.

Part B: Childbirth

a. Skilled Birth Attendance: Every birth must be attended by a skilled and certified health professional (a doctor, nurse, or midwife). Home births attended by traditional birth attendants shall only be permissible where a formal link to a PHC for emergency referral is established and documented.

b. Access to Emergency Obstetric and Newborn Care (EmONC): Every Local Government Area (LGA) must have at least one designated 24/7 Comprehensive EmONC facility and four Basic EmONC facilities, fully equipped and staffed to manage complications, including performing caesarean sections and blood transfusions.

Part C: Post-natal Care

a. **Mandatory Postnatal Check-ups:** A minimum of four postnatal check-ups for both mother and baby within the first six weeks after birth, including at least one home visit by a community health worker within the first 48 hours.

b. **Mental Health Screening:** Universal screening for postnatal depression and other perinatal mental health conditions, with a clear and funded pathway for referral and treatment.

c. **Family Planning Services:** Provision of comprehensive family planning counseling and services to all women in the postnatal period, allowing them to make informed choices about birth spacing.

Part D: A Strengthened Implementation Framework

a. **Primacy of the Primary Health Centre (PHC):** The Act shall legally designate the PHC as the non-negotiable cornerstone and primary entry point for all maternal health services. Every political ward must have at least one fully functional PHC that meets the minimum standards defined in this Act.

b. **Funded Referral Pathways:** The Act will establish a mandatory, funded transport and communication system linking every PHC to its designated Basic and Comprehensive EmONC facilities. The cost of emergency transportation shall be fully covered by the state.

c. **Mandated Minimum Standards:** The Act will empower a regulatory body to set and enforce legally binding minimum standards for all designated facilities, including:

i. **Staffing:** At least one full-time, certified midwife per PHC; 24/7 presence of doctors and anesthetists at CEmONC facilities.

ii. **Equipment:** A mandated list of essential equipment, including delivery kits, resuscitation equipment, and reliable electricity and clean water.
iii. **Drug Availability:** An "Essential Maternal Medicines List" must be fully stocked at all times, with a zero-tolerance policy for stockouts.

Part E: Accountability and Enforcement

a. **Independent Maternal Health Commission (IMHC):** The Act will establish an independent commission with the power to investigate maternal deaths, monitor compliance with the Act's provisions, conduct facility audits, and publish annual performance reports on all states and LGAs. The IMHC shall have the power to recommend sanctions and prosecute cases of criminal negligence.
b. **Citizen-Led Accountability:** The Act will legally empower and fund Ward Health Committees (WHCs) to act as community-level watchdogs. These committees will have the right to access facility records, conduct social audits, and formally report grievances to the IMHC.
c. **Grievance Redress and Legal Penalties:** The Act will create a clear, simple, and free mechanism for women and their families to report service failures. It will also establish strict legal penalties, including fines and potential imprisonment, for health administrators and officials found guilty of willful neglect, diversion of funds, or failure to comply with the Act's provisions.

Part F: Sustainable Funding

The current 1% allocation from the Consolidated Revenue Fund to the BHCPF is fundamentally insufficient to achieve the comprehensive mandate of this proposed Act. The fund is overstretched, covering all aspects of primary healthcare, not just maternal services.

To ensure the long-term sustainability of the CMCA, the Act will establish a diversified and ring-fenced funding model.

a. **The National Maternal and Child Health Levy:** A dedicated levy will be imposed on specific goods and services, with all proceeds ring-fenced exclusively for the CMCA. Potential sources include:
i. A 1% levy on all telecommunications service charges (voice and data).
ii. A 5% excise tax on all sugar-sweetened beverages.
iii. A 2% levy on profits after tax for all banking, insurance, and oil and gas companies operating in Nigeria.
b. **Mandatory Budgetary Allocation:** The Act will mandate that a minimum of 15% of the annual federal budget be allocated to health, in line with the Abuja Declaration. It will further stipulate that at least 25% of this health budget must be dedicated to the implementation of the CMCA at the federal, state, and local levels.
c. **Regulated Public-Private Partnerships (PPPs):** The Act will provide a framework for structured PPPs focused on service delivery and infrastructure upgrades. These

partnerships will be strictly regulated by the IMHC to ensure they prioritize health outcomes and patient safety over profit, with clear performance metrics and clauses that allow for contract termination in cases of non-performance.

5. **Conclusion and Recommendations**

Nigeria stands at a critical juncture. The nation's staggering maternal mortality rate is not an immutable tragedy but a direct consequence of a legal and policy framework that, despite its intentions, remains inadequate, fragmented, and largely unenforceable. The National Health Act and the NHIA Act, while foundational, have failed to create a tangible, enforceable right to survival for pregnant women. The devastating impact of this crisis on Nigeria's economic productivity, human capital, and overall development index constitutes a clear and present threat to its future.

This article has argued that the cycle of preventable death can only be broken through bold, decisive legislative action. The proposed "Comprehensive Maternal Care Act" (CMCA) offers a detailed blueprint for such action. By establishing a legally guaranteed continuum of care, strengthening the primary healthcare system, mandating robust accountability mechanisms, and creating a sustainable, ring-fenced funding structure, the CMCA moves beyond aspirational goals to create a system of duties and consequences. It transforms the right to maternal health from a non-justiciable principle into a concrete, measurable, and enforceable reality.

This research concludes with an urgent call to action. The Federal Government of Nigeria, through the National Assembly, must prioritize the drafting and enactment of this or a similar legislative instrument. The legal community must champion the cause of justiciability for health rights. Civil society must mobilize to demand accountability, and international partners must align their support behind this transformative agenda. The cost of inaction is measured in the lives of mothers, the futures of children, and the developmental potential of a nation. The time for incremental adjustments has passed; the moment for a generational legislative mandate has arrived.