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Governance Can Kill:
The Politics of Maternal Bodies in Nigeria

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“We cannot trample upon the humanity of others without devaluing our own. The Igbo, always practical, put it concretely in their proverb Onye ji onye n'ani ji onwe ya: ‘He who will hold another down in the mud must stay in the mud to keep him down.’”
― Chinua Achebe

Abstract
Maternal mortality in Nigeria is unacceptably high. The country's maternal mortality crisis occurs along regional and socioeconomic lines—the poorer northern Nigeria has a disproportionately higher maternal mortality ratio than the wealthier southern Nigeria. Most maternal deaths in Nigeria are preventable, but the country's government has not implemented rights-based laws and policies to provide services that can avert deaths. Contentious North-South geopolitics drive the governance's systemic corruption, non-transparency, and unaccountability. The author shows how Nigeria's maternal mortality crisis is not accidental or random, but political. North-South geopolitics drive Nigeria's governmental leaders to make specific choices regarding reproduction. Ultimately, these governance choices—unaccountability, underfinancing of maternal health services, and lack of gender-responsive budgeting—perpetuate Nigeria's severe and inequitable maternal mortality crisis.

Keywords: *reproduction; maternal mortality; governance; politics; Nigeria*

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Introduction

High maternal mortality in Nigeria is a global public health crisis—Nigeria, with 2.35% of the world's population,[1] alone accounts for a staggering 14 percent of the world's maternal deaths.[2] In addition, significant regional disparities in maternal mortality exist within Nigeria, particularly between the northern and southern parts of the country. The maternal mortality ratio in the North is six to ten times greater than that of the South.[3]

Most maternal deaths are preventable, in Nigeria and globally.[4] In Nigeria, technical and medical knowledge of maternal healthcare is complete and abundant.[5] Moreover, many of Nigeria's codified laws and policies rhetorically aim to reduce maternal mortality. Concrete, compelling evidence demonstrates that, when implemented, human rights-based laws and policies can reduce maternal mortality in equitable ways.[6] For example, evidence-based, transparent, and fair laws have immense potential to advance sexual and reproductive health through enabling the provision of important drugs and services.[7] However, political and economic decisions of people in power can drastically prevent the implementation of rights-based laws and policies.[8] All said, the paradox of egregious and inequitable maternal mortality in Nigeria strongly points to inadequate, unaccountable governance decisions made by those in power.

This paper shows that maternal mortality in Nigeria is largely due to "bad governance" that stems from economic and political choices made both in the capital and at the regional level. I define "bad governance" as: governance decisions and practices that 1) are demonstrably deleterious to maternal health, 2) exacerbate inequities, and 3) lack accountability. Bad governance in Nigeria has the effect of undermining rights-based

laws and policies. I argue that bad governance in Nigeria blunts the effects of national lawmaking and produces preventable and disparate maternal health outcomes between the North and South.

The methods for this paper are as follows: using academic databases and government sources, I gather traditional epidemiological data on maternal health outcomes and health services indicators. I then correlate these outcomes and indicators with specific policy and governance decisions. However, since epidemiology by itself will not completely unpack the root causes of maternal mortality, my analysis will also draw upon the literatures of health policy, sociology, anthropology, and law. In sum, through a multidisciplinary method integrating epidemiology and critical analysis, I will demonstrate how Nigeria's politics and governance drive an inequitable maternal mortality crisis.

The most important point to keep in mind throughout my exposition is: rampant unaccountability is the defining feature of Nigeria's governance. There are no enforced legal or structural mechanisms that keep government leaders accountable for their decisions. At the same time, the government's unaccountability qualifies my analyses: the state has an extreme lack of transparency regarding public records and information, especially on budgetary allocations to maternal health services.[1] Therefore, although my aim is to deploy evidence that shows Nigeria's governance is hurting maternal health, there are definitely gaps in the data on how money and resources flow from the

[1] Note that lack of transparency regarding public records and information specifically refers to the Nigerian government. Data included in this paper collected by outside sources such as the Demographic and Health Survey (USAID) or academic publications are reliable because they have transparent methods. Nigeria's government records on budgetary allocations and demographics are not reliable, and the methods for collecting this information are not transparent. None of the evidence/data I use in this paper is from Nigerian governmental records.

government to the maternal health sector. Nevertheless, my overarching aim in this paper is to map out arguments, provide available evidence, and concretize why Nigeria's governance and unaccountability has led to maternal health disparities.

Part I of this paper will introduce maternal mortality as a global public health issue and will provide a background of the Nigeria-specific maternal mortality crisis including Nigeria's demographics, geopolitics, and the epidemiology of maternal mortality disparities. Part II theorizes reproduction using the theoretic frame of *reproductive governance* along with global examples; this section also will explore the theoretical model of *intersectionality* to see how maternal health disparities are fundamentally systematic inequities. Part II will also discuss the literature and evidence that shows human rights-based laws can improve health systems and reduce maternal mortality. Finally, Part III synthesizes the paper's findings to analyze how Nigeria's bad governance undermines rights-based legislation and produces severe and inequitable maternal mortality. In essence, the first two sections will provide a snapshot of evidence and theory, and the final section will make applications to the Nigerian context.

Section One: Maternal Mortality: What Do We Know About It?

I. Maternal Mortality in a Global and Sub-Saharan African Context

A. Global maternal mortality: what progress have we made?

In recent decades, massive strides have been taken in improving global maternal health. After years of neglect, global attention to maternal mortality was reignited with the 1987 Safe Motherhood Initiative, established in order to integrate maternal health programming with primary health care.[9] In 1994, the seminal International Conference on Population and Development (ICPD) solidified international commitment for advancing

reproductive health and rights, recognizing these principles as prerequisites for sustainable social and economic development.[10] Because of the ICPD, many countries now recognize reproductive health as critical to poverty reduction. Many of the ICPD goals championed for a reduction in maternal mortality, and were incorporated in the Millennium Development Goals (MDGs) of 2000 as MDG 5.[10] MDG 5 calls for a decrease in the maternal mortality ratio by 75% between 1990 and 2015 and universal action to reproductive health during this same period.[10] International concerted efforts to reduce maternal mortality have had an impact: between 1990 and 2013, the number of maternal deaths declined by 45% worldwide.[11]

However, progress is slow. Preventable maternal mortality is still astonishingly high: every day, 800 pregnant women suffer deaths that are mostly avoidable.[11] Although the global maternal mortality ratio fell between 1990 and 2013, it has fallen at a rate of 2.5% annually rather than the 5.5% level required to meet MDG 5.[12] Maternal mortality is unquestionablly a crisis in part of poverty: ninety-nine percent of maternal deaths occur in low-income countries.[8] Even within countries, high rates of maternal deaths burden the poor, and, of all health indicators, the maternal mortality ratio has the greatest difference between the rich and the poor.[10]

Any discussion of global maternal mortality would be remiss if it did not highlight the remarkable stall in progress occurring in Sub-Saharan Africa. Sub-Saharan Africa is the riskiest region for pregnancy-related complications, and there has been scarce evidence of improvement since 1990.[12, 13] The maternal mortality ratio in Sub-Saharan Africa is more than twice the global average.[14] Stepping back to examine responses to maternal mortality in Sub-Saharan Africa reveals a sobering reality: of the

all the Millennium Development Goals, the least gains have been made towards improving maternal health in Sub-Saharan Africa.[11]

B. Maternal mortality in Sub-Saharan Africa: why are pregnant women dying?

Sub-Saharan Africa's state of maternal health is bleak. Thousands of women in the region are needlessly dying every year, many as a result of inadequate access to essential maternal health services. To compound this moral problem is the fact that effective interventions to avert maternal deaths are available, and medical knowledge in this area is widespread. The resounding question lurking behind the data, then, is: why? In a world with strong international commitment to reducing maternal maternity (MDG 5, ICPD) and abundant information for medical interventions—why are so many poor, pregnant women dying? And why is maternal health progress being made throughout the globe, but notably not in Sub-Saharan Africa?

What is immediately apparent is that pregnant women are dying in Sub-Saharan Africa because they are not receiving timely, adequate emergency obstetric care (EmOC).[15] Literature points to access to EmOC as one of the most crucial factors for preventing maternal mortality.[16] Within this access problem arise the "three delays" in achieving timely emergency care: 1) delay in decisions (made by the pregnant woman or her family) to seek care during the obstetric emergency; 2) delay in reaching an emergency obstetric facility; and 3) delay in receiving care once at the facility.[17] These three delays are due to a host of structural, financial, and system-related barriers, including low education, gender inequality, cost of transport and user fees, bad roads, inadequate referral systems, and low-quality healthcare facilities. Evidence shows that barriers to EmOC are significantly more prevalent for women in Sub-Saharan than any other region in the globe.[18]

In addition to insufficient access to EmOC, maternal health in Sub-Saharan Africa is threatened due to limited access to family planning services and information. Family planning is absolutely integral to maternal health. It includes measures such as birth spacing and contraception, which allow women to make informed decisions about their sexual and reproductive lives. Family planning has tremendous health and social benefits: reducing the number of unintended pregnancies, preventing mother-to-child HIV transmission, enhancing educational opportunities for girls and women, and reducing infant mortality.[19] Annually, family planning prevents 187 million unplanned pregnancies worldwide, including millions of abortions and unplanned births.[10] Better access to family planning could avert one-third of global maternal deaths.[10] Despite the clear benefits, there is a vastly unmet need for family planning in developing countries and specifically in Sub-Saharan Africa.[19] While Asia and Latin America tout levels of modern contraceptive use at 60-70%, Sub-Saharan Africa hovers at 25%.[19]

Moreover, a particular feature of the maternal mortality crisis in Africa is the HIV/AIDS epidemic. This is especially true of southern and eastern Africa. HIV/AIDS is an indirect and direct cause of maternal deaths. Maternal mortality is difficult to measure, and lack of complete data on maternal mortality in Sub-Saharan Africa limits efforts to quantify how the HIV/AIDS epidemic has impacted maternal mortality.[20] However, a 2013 study by Zaba et al. estimated that 25% of pregnancy-related deaths in Africa are due to HIV.[14] To reduce maternal mortality in Africa on a population-level, increasing anti-retroviral therapy (ART) coverage is essential. However, universal ART coverage of HIV-infected pregnant women must be coupled with health system strengthening, specifically the provision of antenatal, obstetric, and post-partum services.[14]

In sum, Sub-Saharan Africa's maternal mortality crisis is particularly due to a systematic absence of necessary services—EmOC, family planning services, and ART. It's difficult to believe or accept that such a dearth of necessary services is accidental. Rather, barriers to achieving progress in Sub-Saharan Africa's maternal health points to a pattern of choices: top-down, governance choices.

C. Maternal mortality in Sub-Saharan Africa: it's a political matter

In Sub-Saharan Africa, laws and policies can make these interventions—EmOC, family planning services, and ART coverage—available in meaningful ways. For example: laws that grant conditional cash transfers to pregnant women to pay for transport to EmOC facilities (minimizing the delays); laws that scale up community-based distribution of contraception and reproductive health pamphlets; policies that integrate ART delivery with antenatal care. However, it is also true that governance decisions (particularly social and economic decisions) as well as national financial practices can either support or undermine the laws and policies that facilitate these interventions. This is good and bad news. The good news is: laws, policies, and governance decisions can stop pregnant women from dying. The bad news is: current governance decisions in many Sub-Saharan African countries are very bad and deleterious for maternal health, undermining the hope offered by laws and policies.

Sub-Saharan Africa's high rates of maternal mortality are fundamentally and profoundly a political matter. When I say maternal mortality is political, I am saying that it is the result of choices—economic, social, and fiscal choices—made by government actors in the context of political contestations over power. Sub-Saharan Africa's soaring level of maternal mortality is no accident. It is a result of *structural violence*—systematic abuses perpetrated by those with political power, abuses "intimately linked to the social

conditions that so often determine who will suffer abuse and who will be shielded from harm".[21]

A stark example of how political choices translate into maternal deaths comes from Zimbabwe. In 2008, the Zimbabwean public health system collapsed. Water and sanitation services deteriorated and hospital infrastructure eroded, including the lack of essential medicines, medical supplies, and health care workers.[22] A significant decline in public-sector maternal health services occurred, delivery units closed, and many women experienced serious delays in receiving EmOC.[22] These events were a direct result of President Robert Mugabe regime's decision to politicize health for political gain.[22] In the Mugabe's vying for political power, his administration shut down hospitals and refused to provide basic health services. Mugabe's economic policies led to skyrocketing user fees that made private health services prohibitively expensive.[22] Politics, indeed, can destroy health.

The politics of maternal mortality within a country have everything to do with *political priority*, defined as the level to which political leaders grant sustained attention to an issue, enact policies and laws to address the issue, and provide resources that are commensurate with the issue's severity.[23] Essential to political priority is the question of power: who has the power to act? What groups and people are on the losing end of political priority? This paper will wrestle with these questions, attempting to deconstruct the political choices driving maternal health disparities in Nigeria.

II. Maternal Mortality in Nigeria

Maternal mortality in Nigeria is deeply a political matter. Lack of political priority manifests in governance decisions that undermine rights-based maternal health

laws and policies. I argue Nigeria's low political priority for maternal health has specific and differential impact, depending on whether you are a rich pregnant woman or poor pregnant woman in Nigeria, and then depending on where in Nigeria you are. This section provides a background for Nigeria's gross disparities in maternal mortality. The section will examine the demographics, characteristics of governance, and geopolitics of Nigeria and the epidemiology of the country's maternal mortality crisis.

A. Demographics, characteristics, and geopolitics of Nigeria

Demographics

Nigeria is the most populous country in Africa, with a population of 173.6 million people (one-sixth of Africa's total population).[24] Over the last 50 years, the country has experienced rapid population growth because of high fertility rates.[25] The country is oil-rich; oil accounts for two-thirds of the government's revenue.[26] Nigeria has a GDP of $503 billion USD, making it the largest economy in Africa, ahead of even South Africa.[27] However, Nigeria's booming economy does not benefit the majority of its residents: 80% of Nigeria's oil revenue goes to 1% of the population.[28] Despite the country's wealth, 70% of Nigerians live on less than $1 USD per day, and Nigeria ranks 153 out of 187 countries on the Human Development Index (HDI), a measure of basic human development.[29] Nigeria's wealth-development paradox is apparent in statistics such as life expectancy at birth (52.3 years), mean years of schooling (5.2), and gross national income per capita ($2,102 USD).[29] The HDI is a crude measure for human development but it masks inequality and the distribution of human development. The Inequality Adjusted HDI (IHDI) takes into account inequality—Nigeria's IDHI is 41.4% lower than its HDI, revealing sharp in-country disparities in its human development.[29]

Characteristics of governance

Nigeria's extreme wealth-development gap is shocking. The World Bank's July 2014 report asked: "How could an economy of the size and wealth of Nigeria have such high poverty rates?"[30] A contending answer is: corruption. Nigeria is perceived as one of the world's most corrupt countries; in 2014, it was ranked 135 out of 175 countries ranked from "0, clean" to "175, very corrupt".[31] Nigeria's pervasive culture of corruption has amounted in utter non-transparency regarding public records and budgetary allocations. In essence, all the research questions of this paper can be answered by the simple fact that Nigeria is so corrupt. Corruption manifests in lack of government accountability for key public responsibilities, including maternal health. However, although corruption is a crude answer to many of my inquiries, I will still map out the material effects corruption-influenced governance decisions have on maternal health. The key point I am making here is that virtually all of Nigeria's governance decisions are shaped by corruption.

Embezzlement is a defining feature of Nigeria's post-independence governance—during president Goodluck Jonathan's tenure, oil revenues did not move far past his ministers' pockets. In 2014, Nigeria's central bank governor reported that up to $21 billion of public funds had been lost due to political corruption.[30] Needless to say, corruption is a hallmark component of Nigerian politics that influences virtually all governance decisions.

Pervasive corruption in Nigeria is a manifestation of the government's extreme lack of transparency and unaccountability. Unaccountability in itself is a cause and consequence of bad governance. Lack of accountability also enables the government to not be held responsible for the country's severe inequalities, especially in maternal

mortality. Allocation of funds towards the health sector and social sector are completely opaque in Nigeria. Sadly, the Nigerian government is not interested in being held accountable for its actions, having thwarted attempts to establish a legal mechanism for accountability and transparency. For example, the country has enforced laws that prevent public access to information on government decisions and allocations.[32] Moreover, government leaders have been resistant to political action that would make public records available: in 2007, President Olusegun Obasanjo refused to sign the Freedom of Information (FOI) Bill (which had stalled in parliament for almost a decade).[33] The FOI bill was finally passed in 2011, but evidence shows that the bill is grossly underutilized.[34, 35] Ultimately, lack of transparency permits Nigeria's government leaders to be held completely unaccountable for the wealth-development paradox, and the country's severe inequalities. As stated in the introduction of this paper, Nigeria's unaccountability and non-transparency are the core basis for this paper's central claims.

Geopolitics

Nigeria is a federal constitutional republic—central government with self-governing states.[36] Its system of government was modeled after that of the United States.[36] The president's executive power is checked and balances by the National Assembly, comprised of the Senate and House of Representatives.[36]

Nigeria is composed of 36 states and the Federal Capital Territory. The country is divided into 6 geopolitical zones: North East, North Central, North West, South East, South South, and South East, and it has 774 local government areas within these zones.[37] Moreover, Nigeria is a very diverse country. It has over 250 ethnic groups, with various languages and customs.[38] The Hausa, Yoruba, Igbo, and Fulani make up 70% of the population.[39] While the Hausas and Fulani are concentrated in the North, the Yorubas and

Igbos are concentrated in the South.[39] Northern Nigeria is predominately Muslim and southern Nigeria is predominately Christian.

Nigeria's geopolitics is and has long been driven by ethnocentrism and religious tension. A fierce power struggle between the Muslim North and Christian South characterizes Nigeria's post-independence political landscape—ethno-religious violence, electoral violence, and civil unrest have become institutionalized within the country.[40] Nigeria's biggest ethnic groups—Igbo, Hausa, Yoruba—compete for political power and have historically maintained a presence in the political sphere.[41] Johnson Aguiyi-Ironsi articulated the tensions well: "kin-selective altruism has made its way into Nigerian politics, resulting in tribalist efforts to concentrate federal power to a particular region of their interests".[42]

Contentious geopolitics exacerbate the already-existing economic gap that exists between the North and South. From 1999 to 2011, Nigerian leaders informally agreed to a power-sharing system of governance, where the presidency would rotate between the North and South every eight years (two presidential terms).[38] From 1999 to 2007 southern president Olusegun Obasanjo governed and, from 2007 to 2011, northern president Umaru Musa Yar'Adua governed, until he died until 2011.[38] The North was supposed to govern until 2015 but the southern Goodluck Jonathan became president from 2011 to 2015.[38] Northern proponents were resentful by what many called a violation of the power-sharing pact.[38] Northerners feared the threat of the loss of political influence.[38] Their fear was compounded by the South's speedy economic and social progress compared to the North.[38] Both the Christian South and Muslim North seek to establish political (and cultural) hegemony in the nation—but the stakes are far higher for

the Muslim North, whose grasp at political power could spur its socioeconomic development.

The North finally regained political control in 2015 when Muhammadu Buhari won the presidential seat, beating out Goodluck Jonathan. Buhari is now under pressure to oust the country of graft, stamp out insurgent violence from the North-based terrorist group Boko Haram, and speed up the North's economic and social development.[30]

The social and economic imbalance between the South and the North is stark. For example, 49.8% of the South West's population is in the highest wealth quintile, and 1.7% is in the lowest wealth quintile **(Table 1)**. However, only 7.4% of the North West's population is in the highest wealth quintile, while 35.4% is in the lowest wealth quintile **(Table 1).** In alignment with this paper's core argument, poverty in the North is not circumstantial or abstract. Poverty in the North is the result of specific and deliberate governance decisions that stem from North-South sectarian tensions.

Table 1. Wealth quintiles: Percent distribution of the de jure population by wealth quintiles, according to residence and region, Demographic and Health Survey, Nigeria, 2013

Residence/region	**Lowest (%)**	**Second (%)**	**Middle (%)**	**Fourth (%)**	**Highest (%)**	**Number of persons**
Residence						
Urban	3.0	6.6	16.3	30.9	43.3	70,422
Rural	28.9	28.9	22.5	12.8	4.6	106,541
Zone						
North Central	11.3	21.3	32.1	20.5	14.8	27,368
North East	40.4	26.1	15.0	11.2	7.4	26,927
North West	35.4	28.7	15.9	12.7	7.4	56,512
South East	4.7	13.3	25.5	28.5	27.9	18,777
South South	0.5	10.1	25.9	32.2	31.3	19,893
South West	1.7	6.6	13.4	28.5	49.8	27,486

Economic decisions from the capital have made Nigeria's wealth to be very concentrated in the South: oil reserves are located in the South as is Nigeria's commercial hub, Lagos.[38] On the contrary, the North has a higher proportion of rural residence than the South, and these areas are mostly underdeveloped and poor.[43] As a result of economic development choices affecting the North, this region has some of the worst health and social statistics in the world.[38] Compared to the South, the North scores low on key socioeconomic indicators: literacy rates are lower in the North—the lowest literacy rates in the country are among women in the North West (26%), and the highest are among women in the South East (84%); under-five mortality is highest in the North West (185 deaths per 1,000 live births) and lowest in the South West (90 deaths per 1,000 live births); and the North West and North East zones have the highest proportion of stunted children, 55% and 42% respectively.[37] The North's lag in development can be attributed to governance decisions, specifically deindustrialization, low investment in infrastructure, and distribution decisions from taxation.[38] The North's poverty is entrenched via a pattern of national economic and political decisions.

North-South tensions manifest in Nigeria's national and regional governance. During Goodluck Jonathan's tenure from 2011 to 2015, North-South disparities intensified, and income inequality grew during the North and the South. In early 2015, southern incomes were double northern incomes.[30] One can argue that North-South tensions "blind" national governance decisions, leading to choices that favor the South's welfare over the North's. For example, policy choices from the capital have not spurred infrastructural development in the North, and this region is lacking essentials such as

public services, a reliable power grid, and investments for farming and manufacturing.[30] Even poor southern areas have much more robust resources than most areas in the North.

It is important to note that regional governance in the North is very weak, and virtually nonexistent in some areas.[44] Poor governance in the North has fueled the radicalization of Boko Haram, whose violence worsens economic and social disparities and drives away important human resources such as investors, doctors, and teachers.[44] In sum, Nigeria's inadequate regional and national governance has failed to provide the resources or strategy to stop Boko Haram.

All in all, both regionally and nationally, Nigeria has failed to organize leadership that can narrow the north-south gap. In essence, Nigeria's geopolitics show that the fiscal, economic, and political decisions made at the capital and regionally are a contentious series of competing North-South interests, but, ultimately, these decisions produce systematic abuse upon northerners through inadequate provision of social and economic resources. Nigeria's governance is not only bad, it is unequal.

Contentious geopolitics, national and regional governance, and the great chasm between the North and South's development set the stage for the shocking disparities of Nigeria's maternal mortality crisis.

Gender inequality

Social and economic inequality in both the North and South are gendered. On the World Economic Forum's 2011 global gender gap index rankings for Sub-Saharan Africa, Nigeria falls in the lower half.[45] The index measures the "magnitude and scope of gender inequalities on economic, political, and health-based criteria".[45] On the OECD Development's Social Institutions and Gender Index, Nigeria ranks "high" or "very high" on the following measures: restrictions against women in the household and family,

restrictions on female physical integrity and reproductive autonomy, son bias and devaluation of daughters, restrictions on resources and assets, and restricted civil liberties.[46]

In both the North and the South, women are not given the same opportunities as men to advance economically, politically, or socially. Nigeria is characterized by marked gender gaps in education, political participation, and economic life.[45, 46] Political power differentials are particularly disadvantageous for women because they marginalize women's issues such as maternal health. Although progress has been made in primary school education gender equality, there still remains a wide gender gap in wage and workforce.[45] In addition, healthcare access is limited for women in rural areas, especially in the North.[46] A sound base of evidence shows that women's empowerment is critical for reducing maternal mortality in Nigeria—women with "high decision-making authority" are significantly more likely to utilize maternal health care services.[47]

B. Epidemiology of Nigeria's maternal mortality crisis

Along with Somalia, Sierra Leone, the Democratic Republic of the Congo, and Niger, Nigeria is listed as one of the 10 worst places in the world to be a mother.[48] Nigeria has a maternal mortality ratio of 576 deaths per 100,000 live births (2013).[37] Although Nigeria's maternal mortality ratio fell from 800 deaths per 100,000 live births (2003) to 545 deaths per 100,000 live births (2008), progress has stagnated.[37] The percentage of deaths that are maternal deaths in Nigeria varies by age from 12% among women 45-49 to 44% among women 20-24.[37] A woman in Nigeria has a 1-in-18 chance of dying from pregnancy-related complications, in contrast to the 1-in-22 chance facing women throughout Sub-Saharan Africa.[32]

Maternal mortality in Nigeria varies significantly by region. The North, expectedly, has markedly higher maternal mortality figures than the South.[3] Maternal mortality ratios in the North are six to ten times greater than those in the South (North East: 1,549 deaths per 100,000 live births; North West: 1,025 deaths per 100,000 live births; South West: 165 deaths per 100,000 live births).[3] Thus, maternal mortality in the North is a significant driver of the national maternal mortality ratio of 576 deaths per 100,000 live births.

The leading causes of maternal mortality in Nigeria are the same as those throughout Sub-Saharan Africa—lack of EmOC, suboptimal family planning, and HIV/AIDS. Nigeria's HIV/AIDS prevalence is 4.6%, or 2.95 million infected people; the country has the second highest proportion of HIV/AIDS infections in the world.[49] As such, HIV/AIDS is a significant contributor to maternal mortality in Nigeria. A 2011 study found that HIV/AIDS accounted for 24.5% of maternal deaths in a hospital in Benin City, Nigeria (southern Nigeria).[49] HIV/AIDS contributes to maternal death via opportunistic infections such as tuberculosis, pneumonia, and malaria.[49] To my knowledge, there have been no studies or reports published on the disparities in North-South HIV-related pregnancy deaths.

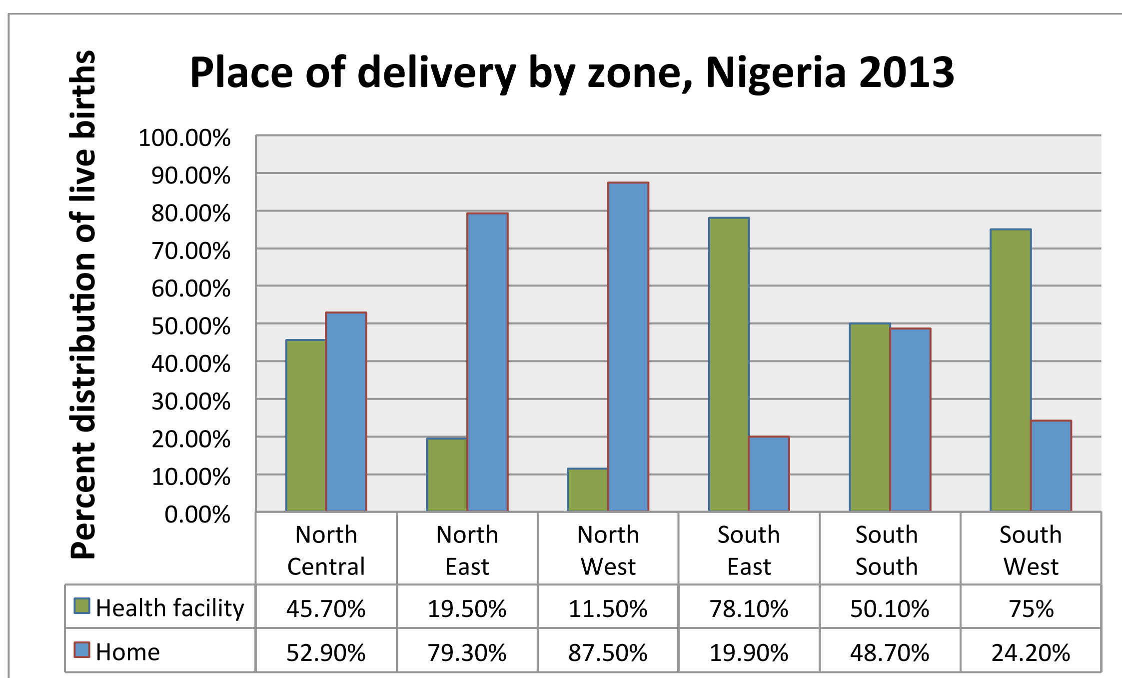
Lack of EmOC is also a major cause of preventable maternal deaths in Nigeria.[50] A 2010 study in a hospital in Benin found that the type 3 delay was the most common cause of death (61.9%), followed by the type 1 delay (28.6%).[51] Suboptimal access to EmOC is also evident because only 36% of births take place in a health facility in Nigeria, and 63% occur at home.[37] Poor access to EmOC is particularly a challenge for pregnant women in the North: the North West has the highest proportion of home

deliveries (88%) and 79% of deliveries in North East are at home **(Figure 1)**.[37] In contrast, 20% of deliveries in the South East are at home, while 24% of deliveries in the South West are at home **(Figure 1)**.[37] To make matters worse, availability of EmOC services in health facilities in northern Nigerian hospitals is very suboptimal.[52]

In addition to EmOC, quality maternal health services require the presence of a skilled birth attendant (SBA) at every birth, meaning doctor, midwife, or nurse; SBAs and EmOC are the most critical factors in preventing maternal deaths.[53] However, in the case of Nigeria, only 38% of deliveries are assisted by a SBA.[37] Moreover, while four in five deliveries in the South West and South East are accompanied by a SBA, only 12% of deliveries in the North West are accompanied by a SBA.[37]

Lastly, limited use of family planning methods is a major contributor to maternal mortality in Nigeria. Twenty-five percent of reproductive aged women in Nigeria have an unmet need for family planning.[32] The North Central zone has the highest unmet need for family planning (24%).[37] Moreover, the contraceptive prevalence among women in Nigeria is only 16%.[48] Of these women, eleven percent use a modern contraceptive method and 5% use traditional methods.[48] Male condoms are the most common modern method, even though these have a typical use failure rate of 18%.[48, 54] Contraceptive use among women varies by region: the South West has the highest levels of contraceptive use (38%), trailed by the South East (29%); the lowest levels of contraceptive use occur in the North East (3%).[37] Low contraceptive use leads to unwanted and unintended pregnancies, and one in five pregnancies in Nigeria are unintended.[55] Unintended and unwanted pregnancies increase risk of unsafe abortions and maternal death.

As stated earlier in this paper, increased access to family planning could avert maternal deaths, especially those associated with unsafe abortion. Unsafe abortion is a major driver of maternal mortality in Nigeria, and makes up 13% (possibly 30-40%) of maternal deaths based on rough estimates by experts.[56] Due to Nigeria's restrictive anti-abortion law, the majority of abortions performed in Nigeria are unsafe.[32] Poor women suffer disproportionately from unsafe abortions. While 66% of rich Nigerian women can access illegal, safe abortions, only 44% of poor Nigerian women can.[32]



	North Central	North East	North West	South East	South South	South West
Health facility	45.70%	19.50%	11.50%	78.10%	50.10%	75%
Home	52.90%	79.30%	87.50%	19.90%	48.70%	24.20%

Figure 1: Percent distribution of live births by place of delivery and zone, Data from Demographic and Health Survey, Nigeria 2013

Section Two: Theorizing: How Does Governance Kill?

III. Theorizing Reproduction: Reproductive Governance

A. Theorizing reproduction

To understand the politics of maternal mortality in Nigeria, it is useful to discuss the theoretical underpinnings of reproduction, and state governance over reproduction. This section will examine theoretical approaches to reproduction and governance. I will

first argue that reproduction is social, political, and intimately connected to power. In explaining reproduction as a political process, I will explore the theoretical frame of *reproductive governance* and global examples of this concept. Reproductive governance will later serve as an analytical tool for my argument on how Nigeria's bad governance exacerbates maternal mortality.

Reproduction is just as much a political and social process as it is a biological process. As a social process, reproduction is always historically and culturally specific, influenced by a web of gender norms, power dynamics, and medical expertise. What a society believes about reproduction is continuously and readily constructed by social actors (e.g. feminist groups), hegemonic institutions (e.g. biomedicine, technology), cultural norms (e.g. gender expectations, religion), bodies, as well as social movements and their constituencies (e.g. patient groups).

As a product of a political process, reproduction is deeply entangled with power. Political leaders use policies, cultural and religious norms, and even economic inducements as technologies of power to control and supervise the maternal body.[57] The modern state stands out for its direct (and sometimes abusive) use of power to govern maternal bodies. Historical examples of repressive governance of reproduction are evident in anti-abortion laws, sterilization laws, and laws that promote reproduction for military, slavery, or labor needs.[58]

States also assert control over reproduction to "enumerate" subjects and create social categories.[57] Many states have historically and persistently used their influence to assign value to women, oftentimes along racial or ethnic lines (e.g. sterilization of African-American mothers in 20th century United States).[59] In assigning social value to

different types of women, states can set the terms for who is "included" and who is "excluded".[57] In effect, state governance around reproduction can have differential impact on maternal bodies—providing key resources for socially "valuable" bodies and denying the same resources to socially "worthless" bodies. This claim is of particular importance to Nigerian maternal mortality: in Nigeria, sectarian North-South tensions amount in state decisions that devalue northern maternal bodies by depriving necessary health services and resources. On the other hand, state decisions favor southern maternal bodies by facilitating the provision of key health services and resources.

B. Reproductive governance and global examples

Reproduction as a political process can be captured with the concept of reproductive governance. Reproductive governance speaks of the mechanisms through which different actors—states, churches, NGOs, etc.—

> Use legislative controls, economic inducements, moral injunctions, direct coercion, and ethical incitements to produce, monitor and control reproductive behaviors and practices.[60]

Reproductive governance describes the political rationalities, or the political priorities a state holds towards reproduction in general, and toward the reproduction of specific sub-sets of its people. The term speaks to the questions scholars have been asking about the politics of reproduction—who has the power over pregnancy and its consequences?[58] Are maternal bodies a means to solve larger social problems?[58] How does state governance over reproduction produce harm, especially on socially devalued bodies? To fully tackle these questions in the Nigerian context, I will first turn to global case examples from Romania and China that effectively exemplify reproductive governance.

Although I aim to use Romania and China as examples of reproductive governance, it should be noted that Romania, China, and Nigeria all differ in their

specific modes of governance. For example, in Romania, an authoritarian regime facilitated governance practices regarding reproduction. In China, a sovereign, unitary state executed unilateral policies on reproduction. In Nigeria, a federal structure limited by a system of checks and balances (president, Senate, House of Representations) ushered forth governance decisions regarding reproduction.

The pronatalist, anti-abortion policy enforced by Romanian dictator Nicolae Ceausescu from 1966 to 1989 is a glaring example of reproductive governance.[61] Beginning in 1966, Ceausescu's policy banned all contraceptives, and outlawed abortion except under the most narrow of circumstances.[62]

Ceausescu's pronatalist policy was explicitly politicized as a tool to build a socialist state.[61] In 1986, Ceausescu stated: "the fetus is the socialist property of the whole society".[62] According to the state's ideologies, control of demographic trends was crucial to a planned economy.[61] Ceausescu's Romania tightly governed reproduction to control "the economic and social aspects of demographic development", and to manipulate family planning and achieve the ideal number of children needed for the socialist labor force.[61]

Ceausescu's population policy made the personal political. The state literally intruded into the bodies of countless Romanian women—requiring monthly gynecological exams and enforcing monthly birth quotas.[62] However, there was not wide public support for the state's pronatalist agenda. A 1989 survey revealed that most Romanian women wanted a small family size with either one or two children.[62]

Although abortion is a biological event that has direct, material effects on a woman's body, the Romanian state used its anti-abortion policy to harness maternal

bodies and fetuses as its own resources. Ceausescu's anti-abortion policy demonstrated that abortion or contraception sometimes is not a woman's individual decision, but a state's decision, based on political agendas and national interests. This policy had everything to do with choices and power. State leaders had the power to impose political choices on pregnant women's lives and bodies. Such power shows the potential abusive effects of reproductive governance.

Indeed, Ceausescu anti-abortion policy demonstrates that reproductive governance can be deeply harmful to women. In 1989, Romania had the highest maternal mortality ratio Europe had ever seen: 159 deaths per 100,000 live births.[62] About 87 percent of maternal deaths of these deaths were due to unsafe abortions.[62] In addition, unsafe abortions during the Ceausescu regime led to the infertility of up to one million women.[62]

Notably, Romania's pronatalist policy had differential impact on different types of women. Poor women endured the brunt of the anti-abortion policy.[61] Safe, clandestine abortions cost about two-months worth of salary—a sum they could simply not afford.[62] Poor women also could not afford to travel abroad for secret abortions or obtain the information required to effectively manage fertility.[61] Thus, poor women were disproportionately affected by abortion-related complications, and were most likely to suffer from maternal mortality.[61] Not only can reproductive governance produce abuse, it can also reinforce inequalities.

China's one-child policy is another example of reproductive governance gone wrong. Enacted in 1979-1980, the one-child policy stemmed from the state's attempt to achieve rapid development through population control.[63] At the policy's introduction,

China was facing rapid population growth.[64] However, rising population was not in the Chinese state's political and economic interests. According to Chinese leader Deng Xiao Ping, China's population explosion hindered the state's modernization and economic progress.[64] In 1979, Deng Xiao Ping introduced the draconian policy, which radically reduced the fertility rate from 2.66 (1979) to 1.94 (1984).[64]

The one-child policy is a harsh example of bad reproductive governance. The policy had deleterious effects: female infanticide, sex-selective abortions, and forced abortions.[64] Under the one-child policy, reproduction became political, and the maternal body became an object for the state to systematically abuse. China's reproductive governance exposed the crude power dynamics that allowed a state to so coercively control the reproductive lives of millions.

China's one-child policy (still in place) certainly reinforces income inequalities. To have more than one child, a couple must pay a fine or a "social maintenance fee" which can be as low as $7,000 USD in rural areas or as high as $20,000 USD in urban areas.[65] However, these fines clearly disadvantage the poor and benefit the rich. The wealthy Chinese can afford to pay the fines while the poor cannot. In recent news, there have been reports of poor Chinese women forced to have abortions because they cannot pay the fine.[66]

Additionally, a conversation about the one-child policy and its differential effects would be incomplete without noting how the policy exacerbates gender inequalities. Because of the policy, China is the world's most gender-imbalanced country—with a gender ratio of 117.78 boys for every 100 girls.[67] Up to today, China's reproductive governance has perpetuated the systematic discrimination against girls and women.

In sum, reproductive governance in Romania and China allow us to understand that state policies decisions around women's reproduction can be very politicized. As a result, state power over reproduction can produce harm, particularly differential harm on various types of maternal bodies.

IV. Theorizing Inequalities and Inequities: Intersectionality and How Intersectional Identities Matter for Health

To understand the root causes of Nigeria's maternal mortality disparities, I will explore theoretical approaches to health inequities; in addition, I will discuss how the critical model of *intersectionality* illuminates the inner workings of inequities: power and identity. In the final section of this paper, intersectionality will serve as an analytical tool for understanding how Nigeria's reproductive governance produces systematic and differential harm.

Scholars and experts have defined health inequalities as "health disparities between population groups defined by social characteristics such as wealth, education, occupation, racial or ethnic group, sex, rural or urban residence, and social conditions".[68] Health equity is defined as the "absence of systematic disparities in health between social groups who have different positions in a social hierarchy".[69] Equity is based on the principle of distributive justice. The concept of equity is normative, or value-based, while equality is not. In a 1992 paper, Whitehead argued that when health inequalities are "unnecessary, avoidable, or unfair," they are health inequities.[70]

I argue that systematic maternal health disparities are avoidable health inequities because they are about choices—political choices and social choices about the distribution of power, money, and resources. Daniels et al. lists four central findings from the literature on social determinants of health to support the claim that inequities are

about choices.[71] First, income-health differences are influenced by social and health policies (choices by governmental leaders).[71] Secondly, income-health gradients are influenced by a society's level of inequality.[71] Third, relative socioeconomic status is as important or even more important than absolute income in predicting health status, once a society has reached a certain threshold.[71] Lastly, there are specific psychological pathways through which inequality affects health—these pathways can be affected by policy choices.[71] Daniels' findings tell us: choices with inequitable effects are bad for health.

The concept of *intersectionality* provides a theoretical approach to the oppressive choices that underlie health inequities. The term intersectionality was coined by Kimberlé Crenshaw to capture the multiple systems of oppression that act on the social categories of race, class, gender, ability, etc.[72] In Crenshaw's words, intersectionality is meant to provoke a "discourse about identity that acknowledges how identities are constructed through the intersection of multiple dimensions".[72] Intersectionality argues that multiple social identities converge and contribute to systematic injustice and social inequality.

Intersectional scholarship emerged in response to the multiple oppressions of racism, classism, and sexism experienced by black women in the United States.[73] For a long time, black female intellectuals have called attention to their social position at the intersection of multiple systems of oppression. For example, Sojourner Truth spoke on her identity as a black female living in a classist, racist, and sexist society:

> That man over there says women need to be helped into carriages, and lifted over ditches, and to have the best place everywhere. Nobody ever helps me into carriages, or over mud-puddles, or gives me any best place! And ain't I a woman? Look at me! Look at my arm! I have ploughed and planted, and gathered into barns, and no man could head me! And ain't I a woman? I could work as much and eat as much as a man—when I could get it—and bear the lash as well! And

> ain't I a woman? I have borne thirteen children, and seen them most all sold off to slavery, and when I cried out with my mother's grief, none but Jesus heard me! And ain't I a woman?[74]

Patricia H. Collins applies intersectionality to the black female lived experience and emphasizes that oppression is not "an additive model"—the variables of gender, class, and race cannot just be summed up to arrive at a degree of oppression.[73] Rather, these categories make up "interlocking systems of oppression" part of a larger, historically created "structure of domination".[73] Social categories such as race, class, and gender operate along axes of oppression that constitute a generalized "matrix of domination".[73] Collins explains that the model of intersectionality places excluded groups in the "center of analysis" and conceptualizes all groups as holding "varying amounts of penalty and privilege".[73] For example, in the United States, white women are punished by their gender but privileged by their race.

Intersectional theory is a useful analytic approach to health disparities. Intersectionality illuminates the experiences of individuals who "live at the intersections of multiple inequalities".[75] The theoretical model also deconstructs power and privilege in social institutions, revealing the mechanisms that produce severe health inequalities. When applied to health disparities, intersectionality reveals that different groups have specific "social locations in systems of power in the health care system," and that health inequalities are not random, but are systematic and can be produced by classism, racism, gender inequality, and ethnocentrism.[75] Thus, intersectional thinking is valuable to understand health as socially constructed and rooted in the workings of power, social relations, and the distribution of resources.

Intersectionality can be applied to the socially and politically-derived categories of regional residence and ethnicity, particularly to delineate the experiences of a northern pregnant woman from those of a southern pregnant woman in Nigeria. Intersectionality allows us to conceive of maternal mortality in Nigeria as a problem explicitly about power and the way in which material resources are deprived from the oppressed in systematic ways across lines of socioeconomic status, gender, region, and ethnicity.

V. Theorizing Laws and Policies: Effective Tools for Reducing Maternal Mortality

The central claim of this paper is that rights-based laws and policies have the potential to reduce maternal mortality, but bad governance can blunt the effects of such laws. In case of Nigeria, rights-based laws and policies on the books *can* reduce maternal mortality, but this is only an ideal—bad, unaccountable governance fails to implement rights-based legislation. This section will explore literature and evidence that demonstrate, generally (not Nigeria-specific yet), the impact laws and policies can have on maternal health. Explicitly, in this section I will argue that responsive health systems are key to reducing maternal mortality. Subsequently, I will show that human rights-based laws and policies can promote responsive health systems, and as a result, reduce maternal mortality.

A. A responsive health system: how is it the key to reducing maternal mortality?

The majority of pregnant women die from direct obstetric complications such as hemorrhage, infection, eclampsia, ruptured uterus, obstructed labor, and unsafe abortion.[76] Most of these maternal deaths are avoidable—technical knowhow is widely available to treat these complications. Many obstetric emergencies cannot be predicted before they happen—thus, antenatal care and screening for risk factors have shown little value in averting maternal deaths.[77] Instead, evidence has found that to prevent a

maternal death, pregnant women need immediate access to essential medical interventions (EmOC) if emergencies develop. Medical interventions include: drugs such as magnesium sulfate to treat preeclampsia and oxytocin for severe bleeding, antibiotics, misoprostol for placental expulsion, medical supplies, and surgical equipment for cesarean sections.[78] During obstetric emergencies, SBAs must connect a pregnant woman to a strong referral system that will link her to an emergency health facility.[78] The referral system must have efficient transport and communication mechanisms to minimize or eliminate all of the three delays.[78]

Preventing maternal deaths is a complex, multifaceted process. Many things need to be in place; nothing can be forgotten, or death is imminent. Therefore, it is clear that "systems-thinking" is necessary for delivering priority maternal health services.[79] The thousands of deliveries in a country cannot be managed through isolated, vertical interventions—a holistic, system-wide approach is imperative. Systems thinking can identify where the system succeeds, breaks down, and what is needed to strengthen the overall system.[80]

There is a long-held consensus among scholars and experts that "maternal health services are dependent on the functioning of the entire health system".[81] The WHO defines a health system as all the activities whose primary purpose is to promote, restore, or maintain health".[8] A well-functioning health system is comprised of health services and service delivery, human resources, a financing mechanism, information and communication technologies, and leadership/management.[82] The resources needed for EmOC are already integrated into a health system.[77] In fact, globally, maternal mortality is an indicator of the functionality of a country's health system.[77] An example of how a

well-functioning health system can reduce maternal mortality: community-based SBAs dispense misoprostol to pregnant women in order to strengthen post-delivery contractions and expel placentas—this controls bleeding before the pregnant woman is transported to a health facility.[78] The health system is what ensures: 1) training of the SBA, 2) availability and quality of misoprostol, 3) means by which pregnant women are made aware of the need for misoprostol, and 4) transport to the health facility.

A strong base of evidence demonstrates that health systems are key to reducing maternal mortality. Campbell found that resources, organization, and management are important for maternal health service delivery.[83] A 2005 study by Parkhust et al. discovered that systems components influenced access and utilization of maternal health services and outcomes.[84] Developing countries such as Sri Lanka and Malaysia have made progress in MDG 5 by improving health systems.[77] On the other hand, erosion of health system services in Zimbabwe corresponded with increased maternal mortality.[77]

B. Human rights-based laws and policies promote responsive health systems

Laws and policies can promote responsive health systems.[7] In doing so, laws and policies can secure women's access to maternal health services. Specifically, the literature shows that **human rights-based** laws and policies can effectively promote maternal health-friendly health systems. Human rights-based laws and policies impact maternal health outcomes because they address the social and economic root causes driving these outcomes in the first place. For example, human rights-based laws and policies incorporate the principles of equality and non-discrimination, and, upon implemented, can ensure that poor women in remote areas have access to a health system's SBAs or EmOC services. This and the next section will show that human rights-based laws and policies are good for health systems and, thus, maternal health.

Because we know that in Nigeria and worldwide, maternal mortality is a crisis of inequity, human rights-based approaches have been critical for reducing maternal mortality.[85] A human rights-based approach recognizes that every person deserves a right to health. Also, the core principles of human rights approaches to health are accessibility, availability, acceptability, and quality of health services, equality and non-discrimination, and accountability.[6] Human rights-based approaches do not just focus on outcomes, but on "transforming the underlying conditions that drive distributions of disease".[85] In other words, rather than just offering technical remedies, human rights-based approaches address the root causes of maternal mortality "within and beyond health systems", including poverty and gender inequality.[85] When applied to maternal health, we see that human rights-based laws and policies promote maternal health-friendly health systems by targeting the social determinants of maternal mortality and its disparities.

It is clear that a narrow, technical-based framework to reducing maternal mortality will not work in many countries. Such an approach has not worked thus far. Maternal mortality is a human rights problem, and laws and policies must recognize this. Only then will health systems respond to the inequitable conditions that so many poor, pregnant women face. The core of maternal mortality is poverty (oftentimes governance-induced) and egregious social and economic conditions. In a dry, technical sense health systems can address maternal mortality. But in a realist sense, a human rights framework must be the driving aim of any law and policy because rights-based laws tackle the social and economic root causes of maternal deaths.

The United Nations Human Rights Council's Technical Guidance is a high-level set of guidelines to reduce maternal mortality by incorporating human rights standards

into laws and policies.[86] The Technical Guidance establishes the health system as the fundamental institution for reducing maternal deaths, and demonstrates that rights-based approaches must inform every aspect of the health system from making financing decisions to service delivery to monitoring and evaluation.[85] For example, a human rights-based approach to health systems will set budgetary allocations based on "intersecting inequalities".[85] Another example is a rights-based policy that institutes a program for training SBAs to assist in home deliveries, using mass communication campaigns to ensure accessibility for poor, marginalized women in all regions. The policy would also increase the availability of misoprostol via distribution by community health workers.

C. Impact and evidence of human rights-based approaches to promote health systems and reduce maternal mortality

There is robust evidence that human rights-based laws and policies reduce maternal mortality. Nepal is a strong example of how human rights-based laws and policies can effectively improve health systems that promote safe motherhood. Nepal suffers from one of the highest maternal mortality ratios in South Asia: estimates of the country's maternal mortality ratio range from 549 to 740 deaths per 100,000 live births.[87] Maternal mortality is a crisis of inequity in Nepal, with higher levels of maternal death occurring in impoverished regions such as mountainous and rural areas.[87] Essential medical interventions such as EmOC and SBA are inadequate for many Nepalese women—only 11% of women are accompanied by a SBA at delivery and 5% of women with life-threatening pregnancy complications have access to EmOC.[87] The Nepalese government has taken important steps to reduce maternal mortality. Over the last two decades, the government adopted clear and explicit human rights-based approaches to its

laws and policies for safe motherhood programming.[6] Nepal's National Safe Motherhood and Newborn Health – Long Term Plan (2006–2017) (NSMNH-LTP) is a major government strategy in which Nepal commits to "strength[en] women's voices and their ability to demand their rights to maternal health" and "trans[form] the distribution of power and resources that maintain inequalities across…health systems".[6] Nepal's Women's Right to Life and Health Program implements the NSMNH-LTP; through the Program, the Nepalese government aimed to address the third delay and scale up comprehensive obstetric care to districts where it was not previously available.[6] In 2000, the Program established 4 comprehensive and 4 basic EmOC centers.[6, 87] The Program was explicitly human rights-based, equity- and gender-sensitive, and targeted to women in marginalized communities.[6] Ultimately, the initiative was very effective: over a period of fours years, met need for EmOC increased from 1.9% to 16.9%, proportion of births in health facilities increased from 3.8% to 8.3%, and case fatality rate decreased from 2.7% to 0.3%.[87]

Additionally, the explicitly human rights-based Aama Surakshya Karyakram program provided free deliveries for mothers throughout Nepal and conditional cash transfers (CCT) for mothers and SBAs to "ensure the right of people for free health service utilization" as enshrined in the Constitution of Nepal.[6] Higher CCTs were given to women in poorer areas.[6] Aama Surakshya Karyakram's aim was to improve presence of SBA at deliveries. The program was successful—after 18 months, deliveries in hospital facilities increased by 19%.[6]

Along with Nepal, there is compelling evidence from other countries such as Brazil and Malawi that human rights-shaped laws and policies produce interventions that

improve health system functioning and reduce maternal mortality.[6] Sadly, Nigeria cannot make such a claim. Bad, unaccountable governance in Nigeria has failed to implement rights-based laws and policies. The consequences of this bad governance are dire: thousands of maternal lives. In the next section, I will apply the literature and evidence laid out so far in this paper to the Nigeria-specific context.

Section Three: Telling the Story of Nigeria's Bad Reproductive Governance

This final section will apply the paper's evidence and theory to Nigeria's maternal mortality crisis. In this section, I argue that in Nigeria, reproductive governance is bad, because it's 1) deleterious to maternal health, 2) produces various, inequitable impact on maternal bodies based on region, ethnicity, socioeconomic status, and gender, and 3) is held unaccountable. This section will claim that in Nigeria, reproduction is political: although Nigeria has facially good, rights-based maternal laws and policies on the books, those in power grant low political priority to maternal health, resulting in unaccountable governance decisions that undermine legislation and harm maternal bodies. This gendered disregard for care is compounded by regional and ethnic politics: all poor women face obstacles to good care, but poor women in the North face additional structural barriers.

VI. Inadequacy of Nigeria's maternal health-related laws and policies: rights on the surface, not in the substance

On the books, Nigeria has facially sound national laws and policies that have the language of human rights principles.[32] They also, rhetorically, target the current failures the country's weak health system.[32] However, because of the sheer unaccountability and non-transparency of Nigeria's governance, these laws and policies are only rights-based

on their face, not in their substance. A fundamental principle for human rights-based laws is accountability—if a governmental body is not held responsible for its actions, then implementation of rights-based laws will not happen. Nigeria's laws and policies are facially very strong with rights-based language and immense potential to reduce maternal mortality, but there are absolutely no mechanisms in the laws themselves or in the federal/judiciary system wherein government officials are held accountable for decisions. In rights-based terms, this means the laws ultimately fail because they are not fully implemented and are not the basis for holding the Nigerian government to account.

So, while I can say Nigeria has rights-based codified laws for reducing maternal mortality, the reality is, because the country's governance is very bad, these laws are impotent in practice. Thus, the ideals that I discussed in the previous section about human rights-based laws reducing maternal mortality are not currently feasible in Nigeria. In section VII, I will discuss the consequences that unaccountability and lack of implementation have on maternal bodies.

Reproductive health policies

Nigeria's reproductive health laws and policies stem from delegations and summits organized to build international commitment to reducing maternal mortality. As a United Nations member state, Nigeria signed onto achieving MDG 5 in 2000.[88] Nigeria also made international agreements to reduce maternal mortality at the 1994 ICPD Conference and the 1995 Beijing Declaration and the Platform for Action.[32] At the 2005 World Summit, world leaders (with representation from Nigeria) reaffirmed commitment to MDG 5 by improving maternal health and reducing maternal mortality.[89]

To help implement laws and policies targeted towards reducing maternal mortality, international development agencies offered Nigeria support. Over the past two

decades, Nigeria's Federal Ministry of Health received programmatic support from the United Nations Population Fund (UNFPA), World Health Organization and United Nations Children's Fund (UNICEF) to develop guidelines on quality maternal health services and design a roadmap for reducing maternal mortality.[5] In addition, Nigeria received significant donor funding from the United States Agency for International Development (USAID), British Department for International Development (DFID), the World Bank, and United Nations agencies to finance its health sector and maternal health programs.[5] The MacArthur Foundations also provided donor funds to NGOs for maternal mortality reduction.[5]

Despite bilateral and multilateral support, within Nigeria no cohesive network of political action has formed to address maternal mortality.[5] Also, lack of governmental accountability and transparency has led to misallocated and embezzled funds. Some international agencies have responded to Nigeria's lack of action—the Global Fund suspended a $50 million USD grant (for prevention of maternal-to-child HIV transmission) to Nigeria's government due to its failure to meet transparency targets.[90] However, overall, international political pressure and intra-national political priority have not been enough to hold Nigeria accountable for its health laws and policies targeted towards reducing maternal mortality.

2001 National Reproductive Health Policy and Strategy

The National Reproductive Health Policy and Strategy was passed in 2001 to address the "unacceptably high levels of maternal mortality and morbidity".[91] The policy rhetorically aims to "protect the rights of all people to make and act on decisions about

their own reproductive health" and "reduce maternal morbidity and mortality due to pregnancy, childbirth by 50% between 2001 and 2006".[91] To reduce maternal morbidity and maternal, the National Reproductive Health Policy and Strategy calls for improving availability of and access to EmOC services, increased training of reproductive health care providers, remove barriers to reproductive health services, increase sexuality and reproductive health information, and provide adequate funding for reproductive health.[91] The National Reproductive Health Policy and Strategy's language is also equity-sensitive, as it calls for compliance by "all tiers of government and individuals with all…policies and laws supporting the attainment of the highest level of reproductive health irrespective of age, sex, ethnicity, religion and socio-economic status".[91]

2004 National Policy on Population for Sustainable Development

In 2004, the Nigerian state adopted the National Policy on Population for Sustainable Development.[92] The National Policy on Population for Sustainable Development rhetorically calls for a 75% reduction in Nigeria's maternal mortality ratio from 2004 to 2015.[92] The policy explicitly names objectives for achieving this target, such as improving access to reproductive and sexual health services and strengthening maternal health programs.[32]

2007 Integrated Maternal, Newborn and Child Health Strategy

Nigeria's Ministry of Health signed on to the Integrated Maternal, Newborn and Child Health Strategy in 2007.[32] The strategy outlines an integrated approach to scaling up maternal and child health interventions through the country's health system

infrastructure. The strategy's goals rhetorically are to increase the number of deliveries in health facilities to 70% and to increase the percentage of health facilities providing EmOC to 70%.[32] Moreover, the policy's language is equity-sensitive, establishing an insurance system of free services for poor pregnant women, children, and newborns.[32]

General health sector policies

2004 Health Sector Reform Program policy

The Nigerian government has also adopted health policies that focus generally on the health sector but have implications for maternal health. The 2004 Health Sector Reform Program policy calls for the creation of primary health facilities that are connected to referral health facilities equipped with EmOC services.[32] The policy rhetorically recognizes the urgent need for improvements in Nigeria's health sector in order to reduce maternal morbidity and mortality.[32]

National Strategic Framework and Plan for Vesico Vaginal Fistula (VVF) Eradication

In 2005, the Nigeria government collaborated with the UNFPA to develop the National Strategic Framework and Plan for Vesico Vaginal Fistula (VVF) Eradication.[92] The policy's language aims to reduce the incidence of obstetric fistulas by improving the quality of maternal health services.[93]

2006 National Gender Policy

In 2006, the Nigerian government adopted the National Gender Policy, which explicitly calls for a reduction in maternal mortality by 35% or more, promotion of

gender equality and female empowerment, and "gender responsive, evidence-based health systems by 2015".[32]

1999 Constitution of Nigeria

Lastly, the 1999 Constitution of Nigeria is explicitly framed in human rights language and has theoretical implications for maternal health. The Constitution states that the objectives of state policy are to ensure social justice and distribution of "material resources...are harnessed and distributed as best as possible to serve the common good".[94] The Constitution also outlines fundamental rights, including the right to life, the right to dignity, and the right to freedom from discrimination".[32, 94]

Deficiencies in Nigeria's legal and policy framework

Although many of Nigeria's laws appear to be rights-based on their face, equity-sensitive, engendered, and oriented towards improving health systems, these laws and policies ultimately fail from lack of implementation.

Nigeria's legal system also has some deficient laws that are overtly harmful on the surface. For example, a blatant problem with Nigeria's national laws is the lack of an enforceable right to health in the Constitution.[32] The Nigerian Constitution prioritizes civil and political above social, economic, and cultural rights—the right to health is not included with other fundamental rights guarantees.[32] In addition, the Constitution's right to life clause has not made the government accountable for the country's many preventable maternal deaths.[32]

Moreover, Nigeria's restrictive abortion law is a particular deficiency of the country's legal framework. The law allows for abortion only to save the pregnant woman's life.[32] The law leads to high rates of unsafe abortion, "the single most

preventable cause of maternal death".[32] Unsafe abortions disproportionately lead to maternal deaths in poor women, especially those in the North.[32] Thus, Nigeria's abortion law is problematic because it violates the right to health and the right to non-discrimination.[32]

In sum, although theory and evidence from other countries demonstrate that rights-based laws and policies can reduce maternal mortality, such a claim cannot be made for Nigeria. The government's unaccountability and non-transparency do not allow its rights-based laws and policies to be implemented. Also, international pressure has not moved Nigeria's government towards accountability to implement potentially effective laws/policies.

While Nigeria has human rights-based laws and policies that could theoretically reduce maternal mortality and narrow the North-South disparities, in practice, lack of accountability and implementation perpetuates maternal deaths. In the next section, I will illustrate how specific reproductive governance decisions produce inequitable and deleterious impact on maternal bodies.

VII. Nigeria's governance: bad reproductive governance that produces preventable and inequitable harm on maternal bodies

A. Why is low political priority given to maternal health?

As stated earlier in this paper, oil is central to Nigeria's governance and political decisions. I argue that because of state interests in oil revenue, Nigeria grants low political priority to maternal health. The Nigerian state grants oil high political priority because it is central to the political economy—oil generates billions of dollars in revenue and gives Nigeria global economic status. As a result, low political priority is given to

maternal health and reducing maternal mortality because maternal bodies are arguably not important to the oil industry.

Low political priority for maternal health is not only motivated by the political rationality of oil, it is also motivated by gender inequality. Women do not have the same economic status as men—women are delegated to the domestic space while men are expected to be economically productive. Men run the oilrigs—in some oil companies, up to 70% of staff are men.[95] Thus, the state's political priorities are not directed towards reproduction, but towards oil revenues.

The oil-corruption nexus also explains low political priority towards maternal health. State action to reduce maternal mortality would require allocating capital and resources to the health sector—this would diminish the Nigerian leaders' corrupt practices regarding oil revenues. Financing maternal health initiatives would be costly, and it is clear the state does not want to sacrifice corruption to pay these costs. A report by the Center for Reproductive Rights found that a Federal Ministry of Health official said some men "think it's cheaper to take another wife than to save a [woman's] life".[32] Because investing in improving maternal health would be expensive and, thus, reduce the Nigerian state's culture of corruption, the state's reproductive governance becomes deeply harmful towards maternal bodies. Of course, geopolitics complicate and nuance the state's interests in oil, corruption, and gender-equality—however, I will end here with the point that Nigeria's bad reproductive governance is a result of its low political priority for maternal health.

B. Nigeria's bad reproductive governance

In Nigeria, reproduction is political. It is not accidental or random that Nigeria's maternal health policies are not adequately implemented—Nigeria's political leaders

(both nationally and regionally) make economic and political choices that favor state interests while deliberately ignoring maternal deaths, especially northern maternal deaths. Laws, policies, and judiciary systems then do not hold government leaders accountable for these choices. Earlier, I stated that reproductive governance describes the political rationalities a state holds towards reproduction in general, and toward the reproduction of specific groups of its people. Reproductive governance tells us who has the power over pregnancy and its consequences. It also tells us which pregnant women the state deems worthy and worthless.

In Romania, political leaders harnessed maternal bodies via a pronatalist policy in order to build a socialist state. Poor women suffered the most. In China, the one-child policy regulated maternal bodies to achieve the political and economic goals of modernization and development. Poor women also suffered disproportionately.

Unlike Romania's and China's, Nigeria's reproductive governance is not based on an **active** politicization of maternal health. Rather, I argue that Nigeria's reproductive governance is based on North-South geopolitics, which leads to economic and political decisions that kill pregnant women. The harmful effects of these economic and political decisions are magnified by the intersectional identities of northern pregnant women. Yes, maternal deaths in general are supremely neglected by the Nigerian state, but the worst impact of this negligence falls upon northern pregnant women who deeply suffer from state decisions that deny the provision of adequate social and economic resources. The following section will discuss how Nigeria's reproductive governance decisions has various, differential impact along gender-based, regional, ethnic, and socioeconomic lines.

C. Intersectional identities and reproductive governance

Nigeria's North-South inequalities in maternal mortality are rooted in intersectional identities: "socially [and politically] defined hierarchies" based on socioeconomic status, region, ethnicity, and gender.[8] Applying intersectional analysis to North-South disparities reveals that state-funded resources such as the health sector and maternal health services are very exclusionary for specifically northern women and, in fact, antagonistic towards their survival.[96] The dysfunction and inadequacy of state-funded maternal health resources (e.g. EmOC, family planning services, ART coverage) for northern women is a materialization of oppressive governance decisions that distribute resources according to social and political identities (poor, northern, Hausa or Fulani).

Intersectionality makes clear that this oppression does not just act along one axis: class-based oppression is not independent from region-based oppression, gender-based, or ethnicity-based oppression. A poor pregnant woman in the South experiences oppression based on her gender, class, and ethnicity, but a poor pregnant woman in the North suffers from multiple dimensions of oppression based on her gender, class, ethnicity, *and* region. Thus, simply being a "woman" or being "poor" does not predict maternal survival in Nigeria. Gender, class, ethnicity, and region must be specified in order to understand a woman's chance of surviving pregnancy.

In sum, bad reproductive governance creates grave North-South inequities in the "immediate, visible circumstances of [Nigerian women's] lives," reinforcing intersectional identities of class, region, ethnicity, and gender.[97] This analysis is the main conclusion of Nigeria's maternal health disparities—the state's bad reproductive governance creates severe maternal health inequities by systematically devaluing the

intersectional identities of northern women and depriving these women of key maternal health resources.

D. Nigeria's economic and political choices: bad, inequitable reproductive governance

This final section will map out the specific choices of Nigeria's reproductive governance and the concrete, differential consequences these choices have on maternal bodies. The specific economic and political choices this section will examine are: 1) general lack of governmental accountability; 2) non-transparency and inadequate budgetary allocations to the health sector; and 3) lack of gender-responsive budgeting.[32]

General lack of governmental accountability

As stated throughout this paper, accountability is a glaring deficiency of Nigeria's governance. General lack of accountability is deleterious to maternal health and magnifies inequities along intersectional lines. Unaccountability for the health sector stems from Nigeria's Constitution—Nigeria's national government is split between the federal, state, and local governments, however, the Constitution fails to delegate specific health sector responsibilities to each tier.[94] The absence of a clearly defined division of health-care responsibilities leads to` uncertainty about which tier of government will provide services for what level of the healthcare system.[32] As a result, no specific governmental tier is held accountable for maternal mortality.

Government unaccountability leads to an absence of mechanisms to track progress in reducing maternal health; for example, Nigeria has no system for mandatory reporting, no aggregate measures to track maternal mortality targets, and no community score cards.[92]

Lack of accountability in health-care responsibilities produces severe, inequitable maternal mortality. For instance, earlier in this paper, I showed that the North has very low availability of EmOC services—88% of deliveries are at home in the North West and only 12% of deliveries in the North West are accompanied by a SBA.[37] If implemented, rights-based laws and policies could address these inequities by increasing availability of SBAs and facilitating health facility deliveries. A law-based program that institutes training of SBAs and offers CCTs to poor, northern women would effectively reduce maternal deaths. Currently, however, it is unclear which tier of Nigeria's government is responsible for implementing the 2007 Integrated Maternal, Newborn and Child Health Strategy, which explicitly calls for increased deliveries in health facilities. It is also unclear which tier of government will implement the equity-sensitive 2001 National Reproductive Health Policy and Strategy, which could scale-up EmOC services, SBAs, and family planning services. SBAs and EmOC are only examples—lack of accountability in the health sector extends to numerous other services including ART delivery and health-system strengthening in general. Unaccountability is inscribed in Nigeria's very Constitution, enabling a culture of inaction around maternal mortality. Sadly, this culture of inaction ultimately reaps massive havoc on maternal bodies.

Contentious geopolitics exacerbates the unaccountability problem—North-South tensions in government deter efforts to establish accountability mechanisms. For example, the World Bank has noted Nigeria's resistance to stopping corruption and unaccountability.[98] It is clear that, during his leadership, Goodluck Jonathan had no incentive to stop corruption—oil-money was flowing to him and his cronies. Overall, a

series of competing North-South interests on the national governance level has resulted in perpetual unaccountability around maternal mortality, especially in the North.

Non-transparency and inadequate resource and budgetary reallocations to maternal health

Arguably the most glaring economic decision the Nigerian state has made that damages maternal health is regarding public health sector expenditure. In the 2001 Abuja Declaration on HIV and AIDS, Tuberculosis and other Infectious Diseases, Nigeria, along with other African Union heads of states, pledged to allocate 15% of its GDP to the health sector.[99] The fulfillment of this pledge has far from materialized. In 2007, Nigeria's public health expenditure was 1.4%, one of the world's lowest percentages spent on public health.[32] Nigeria's 2014 total health expenditure level is 5.3%, far below the pledged 15%.[100] Nigeria's health sector expenditure is even lower than "less-endowed" African countries such as Zambia (6.2%) and Malawi (7.2%).[32] In addition, Nigeria is currently spending 1.64% of its GDP on HIV financing, but experts say it has the capacity to do much more.[101]

Low financing of health systems has a demonstrable impact on maternal health—Nigeria's maternal health facilities are notoriously sub-standard and underequipped.[32] The UN has set standards for basic EmOC facilities (provide seven lifesaving services) and comprehensive EmOC facilities (provide caesarean delivery and blood transfusions in addition to the seven basic EmOC services).[52] 2003 estimates show that only 4.2% of Nigeria's public facilities met UN standards for basic EmOC facilities.[102] Also, underfinancing of HIV/AIDS treatment clearly compromises the linkage between ART and maternal health services for HIV-infected Nigerian women, especially in the North.[103]

In addition, Nigeria's inadequate financing has magnified inequities for northern women. A 2015 study on the quality of EmOC services in Bauchi State in northern Nigeria found that only 10.2% of facilities met UN standards for EmOC facilities.[52] Additionally, there are reports of frequent power outages at health facilities as the central power source functions at subpar standards.[32] Nigeria, and northern Nigeria especially, suffers from an acute shortage of skilled medical staff.[104] Fundamentally, Nigeria's economic decisions are deeply deleterious to maternal health, heightening maternal health inequities in the North.

Lack of transparency in Nigeria's budgetary allocations and financing facilitates inadequate resource provision to the maternal health sector. There is a dearth of information on Nigeria's specific, in-practice financial allocations for SBAs, EmOC, family planning services, or ARTs for pregnant women—I had a great deal of trouble uncovering any data in this area. Non-transparency in government spending makes it difficult to track, say, how much is being allocated to training SBAs and making misoprostol available in North West Nigeria. What's more, non-transparency makes it nearly impossible to ascertain what specific resources certain vulnerable groups need (e.g. northern pregnant women) and in what quantity.[32]

All in all, there is clearly a correlation between Nigeria's governance decisions around financing and the substandard maternal health services present in the country, especially in the North. However, my analysis in this paper is only preliminary, because the specific data on financing for EmOC, family planning services, and ART are unreliable or unavailable. Fundamentally, such non-transparency is an extension of bad

reproductive governance, and exacerbates the severity and inequity of Nigeria's maternal mortality crisis.

Lack of gender-responsive approaches and budgeting

Gender-responsive approaches are sensitive to the differential, intersectional needs of both males and females.[32, 105] Gender-responsiveness applies gender analysis to governance and ensures economic and political policies are aligned with social needs.[106] There are several studies on the association between gender empowerment and maternal health outcomes, specifically family planning use and the utilization of obstetric care services.[107] These studies have found that, empowered women are "significantly more likely to use a family planning method".[108] Moreover, meta-analysis of countries in Sub-Saharan Africa have found significant associations between female empowerment and modern contraceptive use, antenatal visits, and having an SBA accompany a delivery.[109] Corroon et al. specifically found that, in Nigeria, female empowerment within daily life is strongly linked to modern contraceptive use or delivering in a health facility.[107] This study found that female empowerment is particularly important for facilitating utilization of maternal health services in northern Nigeria.[107]

Quite simply, Nigeria has failed to mainstream gender-responsive approaches into its governance and budgeting regarding maternal health.[32] Nigeria's Secretary General of Women's Rights Advancement and Protection Alternative stated that the government's public expenditures seriously lack a gender-based perspective, leading to deprivations in women's health needs.[32] Moreover, Nigeria's governance disempowers women, evidenced by poor OECD's Gender Index scores and the unimplemented 2006 National Gender Policy. Scholars and practitioners acknowledge the gender gap in Nigeria's

governance. Nigeria has "weak legislature structures to protect the right[s] of women".[105] Also, scholars agree that the 2006 National Gender Policy is:

> Not capable of challenging the structure [of governance;] thus gender inequality and the general devaluation of women conceive within the realities of the government's macro-policy plans, including its resources allocation framework.[105]

Other than Nigeria's 2006 National Gender Policy, the only (rhetorically) gender-responsive initiative I could find in my research is the National Economic Empowerment Development Strategy (NEEDS), a wide-scale poverty reduction and economic transformation program Nigeria attempted to implement from 2003 to 2007.[110] NEEDS was explicitly designed with a gender-responsive budgeting approach—it aimed to "mainstrea[m] women's concerns and perspectives in all [its] policies and programs".[106] Under NEEDS, $161.5 million USD was allocated to the health sector,[111] including antenatal, postnatal, and family planning services.[112] However, to my knowledge, there are no evaluation studies on NEEDS' impact on women's empowerment or maternal mortality reduction—the only evaluative study I could find assessed the impact of NEEDS on the private sector.[110] It is unclear if Nigeria's government even acted upon the gender-sensitive recommendations of NEEDS. Nevertheless, what is clear is that Nigeria's governance has only marginally, if at all, addressed the gender dimensions of the country's maternal mortality crisis. As a result, there have been no indications that family planning use or SBAs in Nigeria have increased due to gender-responsive governance or budgeting—especially in the northern region. In sum, a key feature of Nigeria's reproductive governance is gender-insensitivity, which ultimately harms maternal bodies in differential ways.

Conclusion

All in all, an extensive analysis of evidence and theory leaves us deep sentiments of frustration and injustice towards Nigeria's reproductive governance practices. We can trace high-level North-South geopolitics directly to the very lives and bodies of pregnant women, especially those in the North who suffer deeply and continuously. In Nigeria, reproduction is more than just a political matter—it's an injustice and inequity matter, a matter of extreme abuse and unaccountability. The Nigerian government has shirked its responsibilities towards maternal health, leaving a gaping hole in development between the North and the South. Millions of pregnant women die daily in very avoidable ways, while oil-wealth piles atop the coffers of government leaders. The government botches decisions on gender equality, transparency, and financing, refusing to implement rights-based laws and policies and continuing a national culture of structural violence.

Progress in reducing maternal mortality in Nigeria will never be made with bad, or even subpar, governance. Government leaders must be held accountable with effective, rights-based laws that acknowledge the dignity and value of millions. While this paper does not attempt to present comprehensive solutions, it is clear that systematic accountability must be incorporated into Nigeria's governance immediately. Concrete accountability mechanisms will allow Nigeria to implement equity-sensitive laws that promote responsive health systems, and, thus, reduce maternal mortality. In addition, Nigeria's government must adhere to strict transparency practices that publicize financing and budgetary information. With public records on financing, civil society actors and the international community can mobilize and spur political priority for maternal health. Nigeria must also develop a gender-sensitive approach to its governance. Gender-responsiveness has the immense potential to transform Nigeria's maternal mortality crisis

and avert thousands of maternal deaths. In addition, although North-South politics are institutionalized in Nigeria's governance, political leaders cannot allow maternal lives to be collateral damage for these politics. In particular, political leaders should be deeply sensitive to the extraordinarily unique and intersectional identities of northern Nigerian women.

We've seen the terrible harms that can result from reproductive governance that strictly acts on state interests. It is imperative for Nigeria to develop a different way of governing—governing based on equity, justice, and accountability.

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