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RESEARCH ARTICLE

The Right to Health in Nigeria and Its Impact on Citizens' Access to Medical Care

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Abstract

The socio-economic and productive strength of every nation is determined by the health (the physical, mental and psychological wellbeing) of its people. To guarantee this, the constitutions of some countries, including Nigeria, provide for the right to health, and have framed institutional and policy systems to operationalize and realize this goal, as one of the major objectives of governments. However, despite this great intention on paper, the realization of good healthcare for most of the citizens of this country is still a mirage, despite legal and policy interventions in the form of human rights. The question is, can a rights-based approach to healthcare facilitate or guarantee the realization of this normative claim through access to medical care? This article contends that mere legal and policy frameworks that guarantee the right to health do not automatically engender access to good medical care, as there are hurdles to cross beyond the "limit of available resources".

Keywords: Right to health; rights-based approach to health; access to medical care; regulating health insurance; Nigeria

Introduction

Nigeria's healthcare indicators are considered to be some of the worst on the African continent, as its 3.2 per cent annual population growth is not supported by the economic development that should sustain it.[1] The country is also plagued by the large number of citizens who have been stricken by diseases such as malaria, tuberculosis and HIV/AIDS, among others – it has one of the highest global rates of HIV/AIDS infection.[2] Similarly, in 2018 the country reported a general mortality rate of 67 deaths per 1000 live births and an under-five mortality rate of 132 deaths per 1000 live births – in summary, more than 1 out of 8 live births die before their fifth birthday.[3] The situation is further aggravated by lack of access to skilled birth attendants. Only 43 per cent of births are assisted by skilled medical attendants; unskilled providers such as traditional birth attendants assist in 20 per cent of deliveries, while 11 per cent of births receive no assistance.[4] It is important to note that relatives of pregnant women assist in 22 per cent of deliveries,[5] exposing the infants and the mother to health hazards due to the unskilled handling of birth by such persons.

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1 USAID "Global health: Nigeria", available at: <https://www.usaid.gov/nigeria/global-health> (last accessed 13 November 2020).

2 Ibid.

3 National Population Commission and the DHS Program "Nigeria demographic and health survey, 2018" at 163 and 178, available at: <https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf> (last accessed 13 November 2020).

4 Ibid.

5 Ibid.

In the same vein, more than half of women in Nigeria (52%) report at least one problem associated with accessing healthcare for themselves.[6] The least common problem women face in accessing healthcare is getting permission to go for treatment (11%), and the most common one is getting money for treatment (46%), among others.[7] Generally, some of the impediments to accessing healthcare prevalent in the country include medical negligence from healthcare providers and medical personnel, insufficient diagnostic and therapeutic equipment and other medical facilities, the manufacture and distribution of adulterated drugs, insufficient funding of the healthcare system and inadequate remuneration of the health-sector workforce, among other things. All these challenges make the realization of the right to health and access to affordable and effective medical services impracticable, especially to the majority of the Nigerian population that is plagued by poverty. The already gloomy state of the mental, physical and social wellbeing of the country's people is further worsened by poverty, as the country has the highest number of poor people per capita in the world. Forty per cent of the Nigerian population, about 83 million people, lives below its poverty line of NGN 137,430 (USD 381.75) per year.[8] With the disconsolate state of the healthcare system, the situation of which is further worsened by poverty, access to health services becomes an issue for serious consideration and adversely impairs the development of a nation, as the state of healthcare facilitates or impedes development.[9] Ralph Waldo Emerson also emphasized the primacy of health to the social and economic security of a people when he theorized that "the first wealth is health".[10] Considering the ever-increasing health challenges faced by the growing Nigerian population and the semi-permeable (i.e. not universal) channel for access to healthcare services at primary, secondary and tertiary levels,[11] does the rights-based approach to health hold any value in addressing these challenges? This article attempts a response to the debate on the primacy of the right to health as a platform for the realization of population health necessary for social and economic development in the country. The issue of healthcare and rights of access to good healthcare services has been a consideration since the historical development of the healthcare system currently in operation in the country.

Background to the development of the healthcare system in Nigeria

In Nigeria, before the influences of foreign civilizations on the country's healthcare systems, the over-200 ethnic groups had separate traditional healthcare and medical systems which catered for the sick. The system of traditional healing and medical practices comprised "herbalists, divine

6 Ibid.

7 Id at 182.

8 The World Bank "Nigeria releases new report on poverty and inequality in country", available at: <https://www.worldbank.org/en/programs/lsms/brief/nigeria-releases-new-report-on-poverty-and-inequality-in-country> (last accessed 13 November 2020).

9 RN Nwabueze "The legal protection and enforcement of health rights in Nigeria" in C Flood and A Gross (eds) *The Right to Health at the Public / Private Divide: A Global Comparative Study* (2014, Cambridge University Press) 371, available at: <https://www.cambridge.org/core/books/right-to-health-at-the-publicprivate-divide/legal-protection-and-enforcement-of-health-rights-in-nigeria/89F1254C207397DF8460AABA81415678> (last accessed 10 November 2022).

10 RW Emerson "Power", available at: <https://emersoncentral.com/texts/the-conduct-of-life/power/> (last accessed 18 November 2022).

11 Primary healthcare clinics are usually found in local communities, and the personnel are responsible for the treatment of simple ailments like malaria, typhoid, headaches and other minor health challenges. They are usually operated by health technicians, nurses and other medical health workers in small hospitals. The secondary level has medical doctors, pharmacists, laboratory scientists and nurses, among others, and treatments are done based on medical examination; prescription medicines are also given by family doctors (general medical practitioners) after medical tests and other examinations have been done. The tertiary level of healthcare is referral-based when the services of specialist medical doctors and other practitioners are required. This is usually based on a referral from the secondary-care centres.

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healers, soothsayers, midwives, spiritualists, bone-setters, mental health therapists and surgeons".[12] This deep-rooted and widespread practice and acceptance of these traditional healing systems of healthcare is still recognized and practised alongside the western system, over 150 years after the introduction of the latter into people's cultures and civilizations.[13]

Western-style medical care and facilities, which kick-started the establishment of hospitals in the late 1880s in Abeokuta, Onitsha and Calabar, were brought into the country by missionaries as a tool to further their evangelistic mission and the conversion of the locals to the Christian faith.[14] Generally, besides provision of healthcare, the Church, and particularly the Catholic Church, has a history of championing the right to healthcare, based on its teachings on the dignity of the human person and social justice.[15] This paradigm sponsored the nature of their intervention in the medical practices already in operation in Nigeria. With the advent of colonialism shortly after, the colonial authorities merged and controlled healthcare services in the country.[16] The colonial authorities directed and determined the nature of medical services that were accessible, as they provided the facilities and staff.[17] The western-style healthcare services were mainly accessible to inhabitants of urban settlements, especially the personnel of the colonial administration.[18] This semi-permeable access to healthcare, lacking universal coverage and characterized mainly by a privileged access structure, was not sustainable. The influence of this system on the development of the healthcare system has been quite overwhelming, as the current practice still retains the same feature – access by the small portion of the population that can afford the out-of-pocket payment system; only about 30 per cent of urban-based youths and of women have been enrolled on the national health scheme.[19]

After Nigeria gained independence in 1960, the post-independence healthcare system showed that the country "has effectively inherited the colonial model of health [care] based on privileged access to care".[20] The case of Nigeria was consistent with the power-sharing structure in federal settings, where sub-regional governments had power to create differing regulatory systems on the same issue. For instance, the Eastern regional government's "Policy for Medical and Health Services" indicated that the aim was to provide universal healthcare services. This policy prioritized the provision of medical services in rural areas, as the urban centres had already been fairly covered; the rural healthcare services would be in the form of small hospitals of 20 to 24 beds, superintended by a medical officer who would also oversee the operations of dispensaries, maternal and child welfare clinics and the sanitation-related workforce. The policy further mandated local governments to contribute to the development and maintenance of such rural services, with grants from the regional government.[21]

The 1970s were characterized by "prosperous oil boom years which began shortly after the end of the Nigerian civil war in 1970 [and] coincided with a rapid expansion in the health facilities …

12 A Scott-Emuakpor "The evolution of health care systems in Nigeria: Which way forward in the twenty-first century" (2010) 51/2 *Nigerian Medical Journal*, available at: <https://www.nigeriamedj.com/text.asp?2010/51/2/53/70997> (last accessed 13 January 2020).

13 Ibid.

14 RA Schram *A History of the Nigerian Health Services* (1971, Ibadan University Press), quoted in ibid.

15 MA Glendon "The forgotten crucible: The Latin American influence on universal human rights idea" (2003) 16 *Harvard Human Rights Journal* 27, cited in J Tobin *The Right to Health in International Law* (2012, Oxford University Press) at 21–22.

16 M Bull "Medical services in Nigeria, 1954–55" (Oxford Development Project report), quoted in Scott-Emuakpor "The evolution", above at note 12.

17 Ibid.

18 Schram *A History*, above at note 14, quoted in Nwabueze "The legal protection", above at note 9 at 374.

19 National Population Commission "Nigeria demographic and health survey", above at note 3 at 48.

20 OS Alubo "Power and privileges in medical care: An analysis of medical services in post-colonial Nigeria" (1987) 24 *Social Science and Medicine* 453, quoted in Nwabueze "The legal protection", above at note 9 at 374.

21 Scott-Emuakpor "The evolution", above at note 12.

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Every bed in government hospitals was filled, and there were long queues at the Out-patient departments."[22] The prosperous economy of this period had a positive impact on the infant mortality rate, thanks to access to medical care at affordable rates.[23] This system of healthcare delivery was prevalent in the country, and this period was considered the "glorious days" of the Nigerian healthcare system; there was not a serious change until the early part of the 1980s.[24] In this period, medical services were offered for free to civil servants and members of their families, and those who did not fall under this category accessed healthcare services at discounted rates.[25]

However, the oil glut and the plunging of the price of oil during the early to mid-1980s made it impracticable for the military government to continue with this policy; hence the Structural Adjustment Programme (SAP) was introduced to curb public reliance on government for free social services, including medical care.[26] The fall in the price of oil, which formed over 90 per cent of the country's exports, and the newly introduced SAP system resulted in an increase in the cost of medical services and drastically reduced the number of people who could access them.[27] The practically free access to healthcare in the 1970s and early 1980s was due to the government's budget subsidy of about 90 per cent of the cost of healthcare services in the country, and this constituted a heavy burden on the public purse which could not be sustained after the fall in the price of oil.[28] The government had to give part of this burden to private citizens, most of whom were unable to carry it. This led to a proliferation of private-sector healthcare service providers, with a large reduction in the number of people who could access their services due to their high charges.[29] The state of the private-sector investors in the country's healthcare industry in the 90s was described by Ogunbekun, Ogunbekun and Orobaton thus:

> "The persistently low quality and inadequacy of health services provided in public facilities has made the private sector an unavoidable choice for consumers of health care in Nigeria. Ineffective state regulation, however, has meant little control over the clinical activities of private sector providers while the price of medical services has, in recent years, grown faster than the average rate of inflation."[30]

This situation continued into the 1990s and the early 2000s, a key feature being the promulgation of the National Health Insurance Scheme aimed at bridging access to medical care through contributions from both employees and employers. But despite that, only about 3 per cent of people aged 15 to 49 have health insurance cover.[31]

Considering the above unsavoury developments regarding privileged access to medical care in the country, the need to view care through the lens of human rights arose, and whether human rights language (the right to health and the rights-based approach to healthcare) holds the key to

22 IO Orubuloye and JB Oni "Health transition research in Nigeria in the era of the Structural Adjustment Programme" (1996) supplement to 6 *Health Transition Review* 301 at 302, available at: <https://openresearch-repository.anu.edu.au/bitstream/1885/40194/2/Orubulo6.pdf> (last accessed 10 November 2022).

23 IO Orubuloye and JC Caldwell "The impact of public health services on mortality: A study of mortality differentials in a rural area of Nigeria" (1975) 29/2 *Population Studies* 259.

24 I Mohammed "Academics, epidemics & politics: An eventful career in public health" (2007) 42, quoted in Nwabueze "The legal protection", above at note 9 at 375.

25 Ibid.

26 Orubuloye and Oni "Health transition research", above at note 22 at 303.

27 Ibid.

28 IO Ogunbekun "Which direction for health care in Nigeria?" (1991) 6 *Health Policy & Planning* 254 at 255, quoted in Nwabueze "The legal protection", above at note 9 at 375.

29 Ibid. See also I Ogunbekun, A Ogunbekun and N Orobaton "Private health care in Nigeria: Walking the tightrope" (1999) 14/2 *Health Policy and Planning* 174.

30 Ibid.

31 National Population Commission "Nigeria demographic and health survey", above at note 3.

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addressing this concern is another issue altogether. The right to health as encapsulated under the International Covenant on Economic, Social and Cultural Rights (ICESCR) entails "the right of everyone to the enjoyment of the highest attainable standard of mental and physical health".[32] The UN Committee on Economic, Social and Cultural Rights' General Comment no 14 expounded the boundaries of the right (based on the rights-based approach to healthcare) thus:

> "The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health."[33]

The clarification in the above General Comment strengthened the claim that the right depends on a tapestry of varied yet interconnected rights without which it has no meaning. The rights-based approach to healthcare is a conscious amalgamation of related rights that further the realization of the substantive right to health in the context of modern ideas of health and access to healthcare services. It is framed on the premise of the right to health and "in rights to various underlying determinants of health"[34] usually captured in national constitutions and statutes to safeguard the highest attainable standard of health.[35] The rights-based approach similarly mainstreams some human rights principles, like non-discrimination in terms of access and equality, stakeholder participation in decision-making, and accountability through access to remedies.[36] This is far from the limited context of the right to health, *simpliciter*, which has witnessed some shifts since the early 1990s.[37] Furthermore, the rights-based approach considers the right to health as central – "but other rights need to be present too".[38]

On the theoretical underpinnings of the right, Hunt has opined that the conceptual and operational contours and contents of the right to health are becoming clearer, and there is a strong case that the right to health makes a contribution to a human rights-based approach by way of its distinctive features, such as availability, accessibility, acceptability and quality (AAAQ), progressive realization, maximum available resources, and international assistance and cooperation. However, this valuable contribution is unlikely to be realized unless the right to health, including its distinctive features, is explicitly recognized and consistently applied.[39] The whole essence of this approach is to mainstream the human right to health as a core component of the rights-based approach to healthcare. This is because any rights-based approach that "implicitly makes the right to health its component [rather than its nucleus] would lack credibility and legitimacy".[40] The beauty of this approach is that it addresses health-related harms as human rights violations, and

32 International Covenant on Economic, Social and Cultural Rights, art 12(1), resolution adopted by the UN General Assembly, 16 December 1966 (which came into force on 3 January 1976), res 2200A(XXI).

33 UN Committee on Economic, Social and Cultural Rights, General Comment no 14: The Right to the Highest Attainable Standard of Health (11 August 2000), UN doc E/C 12/2000/4, para 3, available at: <https://apps.who.int/disasters/repo/13849_files/o/UN_human_rights.htm> (last accessed 18 November 2022).

34 LO Gostin and BM Meier "The origins of human rights in global health" in BM Meier and LO Gostin (eds) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (2018, Oxford University Press) 25.

35 LO Gostin and BM Meier *Global Health Law* (2014, Harvard University Press).

36 General Comment no 14, above at note 33.

37 Paul Hunt "Interpreting the international right to health in a human rights-based approach to health" (2016) 18/2 *Health and Human Rights Journal*, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5394996/pdf/hhr-18–1 09.pdf> (last accessed 4 May 2022).

38 T Murphy *Health and Human Rights* (2013, Hart Publishing).

39 Hunt "Interpreting", above at note 37 at 117.

40 Ibid.

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international law has presented a global standard by which to frame government responsibilities and measure health policies, lifting it from the level of political aspiration to legal accountability.[41]

Furthermore, the General Comment no 14 of the Committee on Economic, Social and Cultural Rights emphasizes the inviolability of the AAAQ elements in the operationalization of the right:[42]

- Availability entails the adequate provision of functional public healthcare facilities, goods, services and programmes. With Nigeria's population of about 200 million people, abject poverty, polluted air quality and insecurity naturally impact adversely on the budget for health. In the light of this, healthcare policies reflect the country's limited funds, as even when funds are released, "corruption and government bureaucracies perforate the effectiveness of the target intervention".[43]
- Accessibility means that health facilities, goods and services are within reach of everyone in a state. Accessibility is in four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility. In Nigeria, barriers to access are prevalent, especially pertaining to non-affordability and poverty on the part of women, who constitute about 70 per cent of the poor.[44]
- Acceptability means that health facilities and services are required to relate to medical ethics, are "culturally appropriate" and are considerate of gender and life-cycle expectations. Even where health facilities are available, cultural and religious inhibiting factors are another major hurdle. These include a rejection of family planning and a boycott of polio vaccines in northern Nigeria, due to cultural and religious beliefs, especially in the Muslim-majority northern part of the country.[45]
- Quality means health facilities and services must be scientifically and medically suitable and of good quality.[46]

Addressing the problems of AAAQ inherent in the Nigerian public healthcare system would require financial resources, human capital (a skilled workforce) and buy-in from community and religious leaders and consumers of medical services for effective redress of these challenges. Budgetary provision alone would not be sufficient to address the AAAQ principles. The Federal Government of Nigeria has attempted using the contributory health insurance scheme to overcome barriers to the AAAQ principles,[47] but this has not had much success, as a mere 5 per cent of the population is

41 Gostin and Meier *Global Health Law,* above at note 35 at 21.

42 World Health Organization "The right to health" (fact sheet), available at: <https://www.ohchr.org/sites/default/files/Documents/Issues/ESCR/Health/RightToHealthWHOFS2.pdf> (last accessed 17 May 2022).

43 E Otu "Geographical access to healthcare services in Nigeria – A review" (2018) 10/1 *International Journal of Integrative Humanism* 18, available at: <https://www.researchgate.net/publication/330263101> (last accessed 17 May 2022).

44 MN Onah and V Govender "Out-of-pocket payments, health care access and utilisation in south-eastern Nigeria: A gender perspective" (2014) 9/4 *Plos ONE* at 4 and 8, available at: <https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0093887&type=printable> (last accessed 18 November 2022).

45 AA Adefalu et al "Qualitative exploration of factors affecting uptake and demand for contraception and other family planning services in North-West Nigeria" (2019) *African Journal of Reproductive Health* 63 at 67–68, available at: <https://www.ajol.info/index.php/ajrh/article/view/193156> (last accessed 17 May 2022); I Ghinai "Listening to the rumours: What the northern Nigeria polio vaccine boycott can tell us ten years on" (2013) 8/10 *Global Public Health: An International Journal for Research, Policy and Practice*, available at: <http://dx.doi.org/10.1080/17441692.2013.859720> (last accessed 17 May 2022).

46 Ibid.

47 This was done by promulgating the National Health Insurance Scheme Decree no 35 (1999), with the goal of ensuring that every Nigerian has access to quality healthcare at an affordable cost. See A Ibiwoye and IA Adeleke "Does national health insurance promote access to quality health care? Evidence from Nigeria" (2008) *The Geneva Papers on Risk and Insurance – Issues and Practice* 219, available at: <https://link.springer.com/content/pdf/10.1057/gpp.2008.6.pdf> (last accessed 18 May 2022).

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covered under the scheme and about 70 per cent still funds their healthcare needs from out-of-pocket spending.[48]

In the context of Nigeria, this right, whether viewed traditionally as the right to health or broadly through the lens of the rights-based approach to healthcare, has its foundation in international law, hence this article will examine it from its foundational underpinnings under that law as well as from its cascading influence on municipal law.

The right to health under international law

The preamble to the Constitution of the World Health Organization contextualizes its idea of health to entail

> "a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of all human beings without distinction as to race, colour, and religion."[49]

Historically, the right to health was conceived in the 20th century, with its earliest mention in the World Health Organization Constitution of 1946,[50] shortly before its passive recognition in article 25(1) of the Universal Declaration on Human Rights which provides that "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services".[51] This was fortified by the ICESCR, article 12(1) of which recognized "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[52] This article further imposes on state parties the duty of providing the required structure for the realization of the right, which includes provision for the reduction of infant mortality and for the healthy development of the child; the improvement of hygiene; the prevention, treatment and control of epidemics and other diseases; and working out conditions for quick medical attention in the event of sickness.

The provisions of ICESCR article 12(1) appear to be most comprehensive, as it sets the details of the spectrum of state parties' responsibilities towards their people. These range from a preventive approach through action on hygiene, regard for children, the most vulnerable group, and access to a "medical service … in the event of sickness".[53] The approach adopted in this instrument is commendable as it covers several elements of the right that every legal or policy framework on the right to health should reflect. In addition, General Comment no 14 is framed in the language of the broad (rights-based) approach to healthcare, inclusive of other rights, including access to medical services.[54]

48 GO Alawode and DA Adewole "Assessment of the design and implementation challenges of the National Health Insurance Scheme in Nigeria: A qualitative study among sub-national level actors, healthcare and insurance providers" (2021) 21/124 *BMC Public Health* 1, available at: <https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889–020–10133–5.pdf> (last accessed 18 May 2022). See also YA Adebisi et al "Assessment of health budgetary allocation and expenditure toward achieving universal health coverage in Nigeria", available at: <https://brieflands.com/articles/jhrt-102552.html> (last accessed 17 May 2022).

49 The Constitution of the WHO was adopted by the International Health Conference, New York, 19–22 June 1945 and opened for signature on 22 July 1946 by the representatives of 61 states; available at: <https://www.who.int/about/governance/constitution> (last accessed 18 November 2022).

50 AM Gross "The right to health in an era of privatisation and globalisation: National and international perspectives" in D Barak-Erez and AM Gross (eds) *Exploring Social Rights: Between Theory and Practice* (2007, Hart Publishing) 293.

51 Universal Declaration of Human Rights (1948), General Assembly res 217A(III), UN doc A/RES/3/217A.

52 ICESCR, above at note 32.

53 Ibid.

54 General Comment no 14, above at note 33.

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Similarly, the African Charter on Human and Peoples' Rights (the African Charter), which was developed as a regional response to egregious human rights abuses perpetrated by some post-independence African political leaders,[55] provides in article 16 that:

> "1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State Parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[56]

The immediate enjoyment of this right has been doubted by eminent scholars and considered to be on the same level as mere fundamental objectives and directive principles of state policy under chapter 2 of the Constitution of the Federal Republic of Nigeria 1999 (as amended), which by its nature is not justiciable. But the sting of this argument has been watered down by the position of the African Commission on Human and Peoples' Rights in *Social and Economic Rights Action Centre (SERAC) v Nigeria*, where the Commission stated that "there is no right in the African Charter that cannot be made effective".[57] In addition, *Purohit and Moore v The Gambia,* determined by the African Commission, shows great promise on the extent of the duty of the state parties under the African Charter on mental health, disability and other rights associated with the right to "best attainable health" provided for under the Charter.[58] The African Commission found the Gambia in violation of articles 16 (the right to best attainable health) and 18(4) (the right of the aged and disabled to "special measures of protection in keeping with their physical and moral needs"), among others. The position of the Commission, based on the necessity of the rights-based approach, is plausible as it sets the agenda for state parties' accountability for rights violations in relation to healthcare, whether for the vulnerable or for the generality of the people. The Commission further sounded a word of caution on the "justification" of limits on available resources:

> "[M]illions of people in Africa are not enjoying the right to health maximally because … of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full enjoyment of this right. Therefore … the African Commission would like to read into Article 16 the obligation on part of States party to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources, to ensure that the right to health is fully realised in all its aspects without discrimination of any kind."[59]

Unfortunately, though, as of 2017, 14 years later, the decision of the African Commission had not been complied with by the Gambian government in relation to the repeal of the Lunatics Detention Act, which the Commission found to be in violation of the African Charter.[60]

In the case of Nigeria, as the African Charter has been domesticated, it has the force of law and is on the same pedestal with any enactment of the Nigerian National Assembly.[61] To deepen the

55 OU Umozurike "The African Charter on Human and Peoples' Rights" in G Alfredsson (ed) *The Raoul Wallenberg Institute Human Rights Library* (vol 2, 1997, Martinus Nijhoff Publishers) quoted in Nwabueze, "The legal protection", above at note 9 at 383.

56 OAU doc CAB/LEG/67/3 rev 5, 21 ILM 58 (1982), adopted 27 June 1981, entered into force 21 October 1986.

57 African Commission on Human and Peoples' Rights, case no Achpr/Comm/A044/1 (27 May 2002).

58 Comm no 241/2001 (2003), available at: <https://www.globalhealthrights.org/wp-content/uploads/2014/09/Purohit-and-Moore-v.-The-Gambia.pdf> (last accessed 11 May 2022).

59 Id, para 85.

60 VO Ayeni "State compliance with and influence of reparation orders by regional and sub-regional human rights tribunals in five African states" (PhD dissertation, University of Pretoria, 2018) at 407, available at: <https://repository.up.ac.za/bitstream/handle/2263/68311/Ayeni_State_2018.pdf?sequence=1&isAllowed=y> (last accessed 11 May 2022).

61 Domesticated as African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, cap A9, Laws of the Federation of Nigeria, 2004.

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discussion on the right, this article contends that the right to life guaranteed by the 1999 Constitution (as amended) has no meaning if adequate healthcare is not provided and access to it is not realizable. Being a signatory to the above instruments, Nigeria is under obligation to promulgate municipal legislations that recognize such a right and to set up a system that facilitates its realization, especially in times of emergencies or a pandemic like COVID-19.

There is a consensus that among the vulnerable, women and children are the most adversely impacted by war;[62] the COVID-19 pandemic, especially, has been described using a "war" analogy, and so has HIV/AIDS.[63] In recognition of the non-inclusivity of the peculiar harms vulnerable groups, including women and children, are exposed to, international human rights treaties such as the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW)[64] and the Convention on the Rights of the Child, among others, were entered into. Nigeria has ratified the CEDAW instrument but has not yet domesticated its provisions, about 30 years after becoming a signatory.[65] It also signed and ratified the Optional Protocol of CEDAW in 2000 and 2004 respectively[66] – the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol), which is reputed to be the most progressive international treaty on women's rights.[67] Article 2(1)(b) of the Maputo Protocol mandates state parties to combat all discrimination against women through appropriate legislative, institutional and other measures. The protocol makes further provision in article 14 on the reproductive rights of women.[68]

The non-domestication of the CEDAW instrument in Nigeria means that its provisions cannot be validly given effect to by Nigerian courts.[69] Worthy of note, though, is the National Policy on Women, which is guided by the provisions of CEDAW and its operational protocol which sets out to mainstream gender equality as a globally recognized development strategy.[70] As relating to

62 LE Nagle "How conflict and displacement fuel human trafficking and abuse of vulnerable groups: The case of Colombia and opportunities for real action and innovative solutions" (2013) 1/2 *Groningen Journal of International Law* 2.

63 The French president, Emmanuel Macron, described it as "a war against the invisible enemy". See "Addresse aux Français du président de la République Emmanuel Macron" (16 March 2020), quoted in A Spadaro "COVID-19: Testing the limits of human rights" (2020) 11/2 *European Journal of Risk Regulation* 1 at footnote 1; M Gagnon and D Holmes "Governing masses: Routine HIV testing as a counteroffensive in the war against HIV-AIDS" (2008) *Policy, Politics, & Nursing Practice*, available at: <https://journals.sagepub.com/doi/abs/10.1177/1527154408323931> (last accessed 17 May 2022).

64 CEDAW was adopted in 1979 and came into effect in 1981. Nigeria became a signatory to it in 1985; see Federal Ministry of Women Affairs and Social Development "National Gender Policy Federal Republic of Nigeria: Situation Analysis/Framework, 2016", available at: <https://nigerianwomentrustfund.org/wp-content/uploads/National-Gender-Policy-Situation-Analysis.pdf> (last accessed 10 May 2022).

65 OC Okongwu "Are laws the appropriate solution: The need to adopt non-policy measures in aid of the implementation of sex discrimination laws in Nigeria" (2020) 21/1 *International Journal of Discrimination and the Law* 33, available at: <https://journals.sagepub.com/doi/pdf/10.1177/1358229120978915> (last accessed 10 May 2022).

66 Id at 34.

67 Adopted by the Second Session of the Ordinary Assembly of the Africa Union in Maputo, Mozambique on 11 July 2003 and entered into force in 2005, available at: <https://au.int/sites/default/files/treaties/37077-treaty-charter_on_rights_of_women_in_africa.pdf> (last accessed 18 May 2022); LA Obiora and C Whalen "What is right with Africa: The promise of the protocol on women's rights in Africa" (2015) 2 *Transnational Human Rights Review* 153, available at: <https://digitalcommons.osgoode.yorku.ca/cgi/viewcontent.cgi?article=1017&context=thr> (last accessed 18 May 2022).

68 These include the right to control one's fertility; whether to have children or not; the number of children and their spacing; the choice of which contraception to use; protection against STIs, including HIV/AIDS; the right to be informed of one's health status and one's partner's; and family planning education. State parties have the duty to fulfil the rights by taking mandatory measures to provide affordable and accessible health services, including information, education and communication, especially to rural women; pre-, during, and post-pregnancy medical care; and authorizing medical abortion in rape, health-challenging situations, etc.

69 The Constitution of the Federal Republic of Nigeria 1999 (as amended), sec 12 makes domestication by the National Assembly mandatory for any international law ratified by Nigeria to have the effect of law in the country. See also the Supreme Court's decision in *MHWUN v Minister of Health and Productivity and Others* [2008] SC 201/2005 10.

70 Federal Ministry of Women Affairs "National Gender Policy", above at note 64, para 1.1.

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the health of women, this policy supports the creation of an inclusive environment for fighting HIV/AIDS, STIs and differential impacts, and the removal of barriers for accessing reproductive health services, especially family planning and STIs, and maternal care at the primary healthcare level.[71] But beyond the capacity of the above instruments to influence policymakers on women's rights, they are not able to compel compliance. Similarly, Nigeria ratified the Convention on the Rights of the Child in 1991 and domesticated it in 2003, to operationalize its provisions and that of the African Union Charter on the Rights and Welfare of the Child 1990.[72] Among Nigeria's 36 states, 25 have so far domesticated the Act, while the remaining 11 Muslim-majority northern states have not yet done so, hence eroding the prospect of the realization of the right on a national scale which drove the ratification of the instrument by the federal government in the first place.[73]

On the theoretical and philosophical horizon, there is no interdisciplinary consensus in the fields of international relations, international human rights law, medical ethics and health law and policy on whether the right to health is an imperative deserving a place on the human rights table. Even among the adherents to the school of thought that supports the recognition of such right, there is a variegation of opinions on its nature, its normative content, the duty imposed by it and its enforceability, among others. It has even been contended that this disputed right lacks coherence, definability, political viability, economic sustainability and justiciability – the combination of these elements being necessary for the recognition of a new right under international law.[74] Galtung and Wirak, for instance, have argued in this regard that human needs should not form the basis for the recognition of a new right, including the right to health, because unlike needs that are inherent in people, human rights are seen as existing between them.[75] To them, human rights and human needs (even in the form of freedom) are "two different kinds of things" and not a special type of need. This argument, however, is a hard pill to swallow, as human rights history is replete with human needs forming the fulcrum of agitations for, and subsequent recognition of, new rights in the global search for liberty and peace, whether under the French Declaration of the Rights of Man and of the Citizen, the Magna Carta, the US Declaration of Independence, or the formation of the UN in 1945, among others. The body of human rights has even been drawn to address public health concerns like HIV/AIDS, in recognition of the need for a healthy population and workforce.[76] As Norman Daniels theorized, the right to health constitutes a "*special* social good" which holds high value and attraction, as "it fully justifies the case for prioritising HCJ [healthcare justice] needs over other needs, and may thus provide a firm basis for the HRTH [human right to health] talk".[77] The question should rather be, what human need is deserving of being accorded a human rights status under international law? Especially when viewed in terms of other surrounding concerns regarding the content of such a right, the feasibility of its justiciability and theoretical

71 Id, para 4.3.9.

72 Child Rights Act 2003; UO Okoye "Knowledge and awareness of the child's rights act among residents of a university town in Enugu State, Nigeria" (2011) 2/10 *Educational Research* 1595, quoted in Okongwu "Are laws the appropriate solution", above at note 65 at 30.

73 Id at 36.

74 Tobin, *The Right to Health*, above at note 15 at 1. Upendra Baxi has raised more areas that are usually deserving of consideration: all questions about human rights raise familiar concerns regarding their origins, authorship (the debate over human rights as gifts of "the West to the Rest"), reach (universality v cultural specificity), etc. See U Baxi "The place of the human right to health and contemporary approaches to global justice: Some impertinent interrogations" in J Harrington and M Stuttaford (eds) *Global Health and Human Rights: Legal and Philosophical Perspectives* (2010, Routledge) 12.

75 J Galtung and AH Wirak "On the relationship between human rights and human needs" (1977) 8/3 *Bulletin of Peace Proposals* 251, available at: <https://www.jstor.org/stable/44480606> (last accessed 13 October 2021).

76 DP Fidler "Fighting the axis of illness: HIV/AIDS, human rights, and U.S. foreign policy" (2004) 17 *Harvard Human Rights Journal* 99; JM Mann "Human rights and AIDS: The future of the pandemic" (1999) *Health and Human Rights* 216.

77 N Daniels *Just Health Care* (1985, Cambridge University Press) 56, quoted in Baxi "The place", above at note 74 at 20.

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underpinnings, among other issues, this has always been the old path to finding a new route to a new right under international law.

Furthermore, in expressing her own concerns regarding the lack of interdisciplinary consensus and a viable theoretical foundation to the right, Jennifer Roger has stated that "[o]ne would be hard pressed to find a more controversial or nebulous human right than the 'right to health'".[78] She further argues that while activists, non-governmental organizations and scholars have made undeniable advancements in promoting a human rights-based approach to health, "the question of a philosophical and conceptual foundation – a theory – for the right to health has fallen through the cracks that emerge from an interdisciplinary intersection of medical ethics, international relations, international human rights law, health policy, health law, and public health law".[79] This genuine concern should give room for dialogue and scholarly research on the viability of this right, even as efforts are being made to work out its multidisciplinary philosophy and conceptual foundation, rather than a total discountenance of the need and viability of the right.

Though the development of this right under international law has been long and agonizing, its recognition (either as hard or soft law) has become widespread. Legal instruments, including the Universal Declaration of Human Rights, the International Covenant for Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination 1965, the Convention on the Elimination of All Forms of Discrimination against Women 1979 and the Convention on the Rights of the Child 1989, have in one way or another recognized this right as constituting part of the body of international human rights, whether as soft or hard law.[80] Similarly, several regional instruments have recognized the right in the same vein. These include the African Charter on Human and Peoples' Rights 1981[81] and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 1988.

The Committee on Economic, Social and Cultural Rights' adoption of the content of the right has also lifted the hurdle on the interpretative challenges that impeded its recognition as a substantive right.[82] It recognized that the whole gamut of article 12 of the ICESCR captures the following:

a) The right to health is closely connected to and depends on the foundation provided by the right to food, housing, work, education, human dignity and life, among other things, as an integral premise for its fruition.
b) It is not synonymous with the right to be healthy; it entails the freedom to control one's body (in the form of sexual and reproductive freedom, etc.) and freedom from interference (in the form of torture, non-consensual medical treatment, etc.).

78 J Roger "Toward a theory of a right to health: Capability and incompletely theorized agreements" (2006) 18/2 *Yale Journal of Law & the Humanities* 273, available at: <https://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1313&context=yjlh> (last accessed 9 October 2021).

79 Ibid.

80 Universal Declaration of Human Rights, above at note 51; ICESCR, above at note 32; International Convention on the Elimination of All Forms of Racial Discrimination, art 5(e)(iv), resolution adopted by the UN General Assembly, 1965, res 2106(XX); CEDAW, arts 11.1(f) and 12, resolution adopted by the UN General Assembly, 1979, res 34/180; Convention on the Rights of the Child 1989, art 24.

81 Art 16. To further emphasize its applicability as legislation that forms part of Nigerian law, the Court of Appeal, while relying on the Supreme Court's decision in *Abacha v Fawehinmi*, held that "[b]y the Act, the African Charter constitutes part of the laws of Nigeria which must be upheld by all courts in Nigeria. The African Charter is also given recognition by Chapter IV of the Constitution of the Federal Republic of Nigeria, 1999 as well as the Fundamental Rights (Enforcement Procedure) Rules enacted pursuant to section 46(3) of the Constitution which is one of the ways to enforce the right guaranteed by the African Charter and Chapter IV of the Constitution" ([2000] 6 NWLR (Pt 660) 228).

82 General Comment no 14, above at note 33.

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c) The concept of "the highest attainable standard of health" in article 12 of the Covenant entails consideration of the biological and socio-economic base of the individual and state parties' limits of available resources.
d) It is an "inclusive right" that thrives on the availability of the determinants of health, including access to safe and potable drinking water, adequate sanitation, a healthy environment, health-related education and information, and the right to participate in decision-making on health-related issues, and so on.
e) Access to healthcare as a primary component of the right has four overlapping principles: non-discrimination and equal treatment, physical accessibility, affordability and access to information on health matters.

The above and more form the wide scope of the contents of the substantive right to health under international law, as conceived by the ICESCR. The General Comment has been critiqued, however, for lacking any philosophical grounding necessary for a right to health.[83] To analyse this in the Nigerian context, the key question would be whether the expansive interpretative possibilities of the right's content are preconditions for its recognition or are mere guiding principles for its implementation; or whether they are capable of being coalesced into a congruous whole in the pursuit of the realization of the right to health. If they are a precondition for the recognition and realization of the right, then Nigeria is certainly not ripe for its recognition. And if the country is not ready for it, how can the government be compelled to bear the burden of setting up the infrastructure and system for affordable access to healthcare before the emergence of the rights system? Similarly, is the notion of the limit of available resources a decoy deployed by public officials to evade accountability regarding their duty to provide hard infrastructure (institutions) and soft infrastructure (an enforceable legal framework) and the human capacity required for the realization of the right? Paragraphs 30 to 34 of the Comment would appear to have foreseen the possibility of some state parties hiding under the canopy of limited resources to avoid taking the steps necessary for the realization of the right in the future. To safeguard this, paragraph 33 of the Comment imposes a tripod of obligations on state parties to respect, protect and fulfil the right.[84]

In addition, the right to life is merely the icing; the real cake is what is captured in the second- and third-generation rights, including the right to healthcare, a clean environment, food, etc., on which it stands, as conceptualized under the rights-based approach to health.[85] Where citizens can readily and inexpensively access food, clean water and medical care, among other things, the claim of the right to life has a better meaning. Realistically, the majority of people from first-world countries have a higher life-expectancy ratio than the majority of the third-world population, who have difficulty accessing safe and potable water, functional and affordable medical care, good air quality, and so on. This means the value of the right to life (as a political and civil right) should be measured in terms of the realization of the rights to food, clean drinking water, access to effective medical services in times of sickness, a clean and liveable environment, etc. (which belong to the second and third generations of human rights) as an indivisible whole. In endorsing the community reading of all human rights claims, the Vienna World Conference on Human Rights recognized in its declaration that "[a]ll human rights are universal, indivisible and interdependent and interrelated".[86] This is in line with the derivative approach to the interpretation of constitutions

83 Roger "Toward a theory", above at note 78 at 274.
84 General Comment no 14, above at note 33.
85 Second-generation rights speak of social and economic rights, such as the right to healthcare, education, etc., while third-generation rights refer to collective claims, for instance, the right to a clean environment, sustainable development, and so on.
86 Vienna Declaration and Programme of Action adopted by the World Conference on Human Rights in Vienna on 25 June 1993, available at: <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx> (last accessed 8 October 2021).

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mainly adopted by Indian courts, as shown in *NG Thirumulpad v Union of India and Others*, which has found its way into the Nigerian judicial system.[87] For instance, in *Jonah Gbemre v Shell and Others*, the judge of the Federal High Court held that the right to life and the dignity of the human person guaranteed under sections 33 and 34 respectively of the 1999 Constitution of the Federal Republic of Nigeria (as amended) inevitably include the right to a clean, pollution-free and healthy environment. He further stated that the continuous flaring of associated gas by Shell during their oil operations and production in the applicant's community was a "gross violation of their fundamental right to life (including healthy environment)".[88]

Without sounding overconfident about the infallible viability of the right, it is however generally acknowledged that its implementation in the face of dwindling public resources has caused some frustration to policymakers, who are confronted with the reality of scarce resources vis-à-vis the realization of the right.[89] But this challenge can be overcome if conscious policy, legal, judicial, budgetary and other indices are marshalled for the attainment of this goal.

The legal and policy framework for the right to health in Nigeria

Considering the unpleasant state of human health and the numerous impediments to accessing good healthcare services in Nigeria, the government has made attempts through a legal framework to address this challenge, especially using the right-to-health approach. In a top-down development of this right, advancements in the international arena have provided the underpinning framework for the recognition of the right in the country, first as a constitutional aspirational goal and policy and subsequently as a statutorily recognized and enforceable right. Section 17(3) of the Constitution contextualizes it, saying that the state's policy shall prioritize "the health, safety and welfare of all persons in employment [which] are safeguarded and not endangered or abused" and that "there are adequate medical and health facilities for all persons".[90]

However, the executable potency of the right was initially sapped by section 6(6)(c) of the same Constitution, which makes matters taxonomized under chapter 2 (to which the right to health belongs) non-justiciable. This has arguably been redressed by the National Health Act, which has provided the operative legislation for the recognition of the right to health in Nigeria, beyond its being considered a mere policy issue. In *Attorney General of Ondo State v Attorney General of the Federation and Others*, the apex court held on the enforceability of chapter 2 of the Constitution that "it is incidental or supplementary for the National Assembly to enact the law that will enable the ICPC [Independent Corrupt Practices Commission] to enforce the observance of the fundamental objectives and directive principles of state policy".[91] This judicial pronouncement gives vigour to the enforceability of rights recognized under chapter 2 of the 1999 Constitution (as amended).

Furthermore, the issue of discrimination and denial of healthcare to not just women and children but another vulnerable group was in issue in *Odafe and Another v Attorney General of the Federation*, where the denial of access to medical treatment to prison inmates in Nigeria with HIV/AIDS was held to amount to the infringement of their right to the dignity of the human person and the right to health under the African Charter, and that the inmates were entitled to the right to medical treatment while in detention.[92] In a similar matter, in *Georgina Ahamefule v*

87 [1997] 2 SCC 267.

88 Suit no FHC/B/CS/53/05 (14 November 2005).

89 L Munro "The human rights-based approach to programming: A contradiction in terms?" in S Hickey and D Mitlin (eds) *Rights-Based Approaches to Development* (2009, Kumarian Press) 187, cited in Tobin *The Right to Health*, above at note 15 at 5.

90 Constitution of the Federal Republic of Nigeria 1999 (as amended), sec 17(3).

91 [2002] 9 NWLR (pt 772) 222.

92 Suit no FHC/PH/CS/680/2003, judgment delivered by the Federal High Court in Port Harcourt, Nigeria in 2004, available at: <https://www.globalhealthrights.org/odafe-and-ors-v-attorney-general-and-ors/> (last accessed 17 May 2022).

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Imperial Medical Centre and Another, it was held that denying the claimant medical care on grounds of her HIV-positive status constituted flagrant violation of the right to health guaranteed under article 16 of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act,[93] and article 12 of the ICESCR (ratified by Nigeria in 1993).[94] These judgements, even though they do not constitute a binding precedent, are plausible judicial aspirations in recognition of the rights-based approach to human rights.

The National Health Act set up the National Health System, with the mandate to "provide for persons living in Nigeria the best possible health services within the limits of available resources" and to "protect, promote and fulfil the rights of the people of Nigeria to have access to health care services".[95] This is in sync with the policy of the government as set out in section 17 of the 1999 Constitution. Achieving good healthcare and granting citizens access to good and affordable healthcare facilities as a matter of right is a serious issue of availability of resources. Where the resources are not available, attaining this feat becomes impracticable. The case of Nigeria is the more worrisome in that even the available resources are not properly allocated for the benefit of citizens due to large-scale corruption, healthcare policy inconsistency and an ineffective implementation system. Though it was in recognition of this reality that the African Charter refers to the "best *attainable* healthcare"[96] as a limit to the claim of such a right, as governments can only facilitate the realization of the right "within the limits of available resources", policymakers in Nigeria cannot be absolved of total responsibility for healthcare-system failure and most impediments to the realization of the right. Poor choices on resource allocation and corruption, among other things, are the products of such developments.

Though the boundary set by legislation which recognizes the limit of "availability of resources" was intended to impose a realizable obligation on government, it has turned out to be one of the impediments to the realization of this right. The implication is that the attainment of this right would always depend on the government's ability to provide the infrastructure and other supporting structures necessary for the fulfilment of the right. That notwithstanding, the fundamental premise that underscored the advocacy for and the subsequent legal recognition of socio-economic and cultural rights is that the "attainment of a certain level of social and economic living standard is a necessary condition for the enjoyment of negative [civic and political] rights. These rights therefore entail positive obligations on government to provide the living conditions without which the negative rights cannot be enjoyed."[97] It would amount to an abdication of responsibility for governments to evade the duty of providing the necessary environment for the realization of the right to health under the pretext of non-availability of resources. The right to life and the dignity of the human person provided for under sections 33 and 34 of the 1999 Constitution would have no meaning if citizens' right to health is not guaranteed. This is because any conception of human rights intended to protect the things most vital for a person's existence in the world and their ability to live a life of dignity and equality, free of degradation and imbued with the capacity to make the most meaningful choices in life, will accord health a prominent status.

The Act further establishes the National Health System as intended to have a national spread and is meant to provide healthcare services and facilities from primary to tertiary level. It also empowers the minister of health, in consultation with the National Council on Health, to prescribe conditions for eligibility to free medical services in public health centres in order to make sure that "all

93 Laws of the Federation of Nigeria, cap 10.

94 Suit no ID/1627/2000, judgment delivered by the Lagos State High Court on 27 September 2012, available at <https://www.escr-net.org/caselaw/2012/georgina-ahamefule-v-imperial-medical-centre-dr-alex-molokwu-suit-no-id16272000> (last accessed 17 May 2022).

95 National Health Act, Act no 8 of 2014, secs 1(1)(c) and 1(1)(e).

96 Art 16(1); emphasis mine.

97 ON Ogbu *Human Rights Law and Practice in Nigeria* (2nd ed, 2013, Snaap Press Ltd) at 26.

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Nigerians shall be entitled to basic minimum package of health services".[98] In an attempt to address the issue of the funding of medical services for citizens, the Act creates the Basic Health Care Provision Fund.[99] The sources of contributions to the fund are a minimum of 1 per cent of the Consolidated Revenue Fund and grants from international donor parties, among others.[100] Section 11(3) sets up the disbursement structure: 50 per cent of the fund is for primary and secondary healthcare facilities through the National Health Insurance Scheme, 20 per cent of the fund is meant for drugs and medical consumables, 15 per cent for the procurement and maintenance of healthcare facilities, 10 per cent for human resource development and 5 per cent for emergency medical treatment. The states and local governments are, however, required to access funding for project development from the fund subject to contributing at least 25 per cent of the funds needed for such a project.[101]

It is obvious that 95 per cent of the funds from the Basic Health Care Provision Fund are meant to be spent on medical facilities and 5 per cent on medical emergencies. The provisions of this Act are laudable on paper but do not have any reflection on the ground as far as the state of medical care in the country is concerned. The cost of access to good healthcare is still high and beyond the reach of the common Nigerian, who lives in abject poverty. Assuming the physical facilities are provided using the above funds, the target group, especially the vulnerable (children, women, the elderly and indigent rural dwellers), are unable to afford the out-of-pocket charges required for access to medical care, so of what relevance are those facilities and healthcare givers to this group, since they are not covered by the health insurance scheme that is supposed to take care of this category of persons? This lack of funding further jeopardizes their survival. It was in the light of this challenge that limits access to medical care that the idea of an insurance scheme was nurtured and birthed in the country.

Another attempt at addressing the funding gap was intended by the National Health Insurance Scheme Act, which was promulgated in 1999 and came into force in 2005.[102] Section 16(1) of the Act provides that an employer of a minimum of ten employees may contribute a negotiated part of employees' wages under the scheme. The purpose of the scheme is, among other things, to:

(a) ensure that every Nigerian has access to good health care services;
(b) improve and harness private sector participation in the provision of health care;
(c) ensure adequate distribution of health facilities within the Federation;
(d) ensure the availability of funds to the health sector for improved services.[103]

The above objectives are mere policy statements intended to drive institutional response, but they have not helped much in reality. The Act similarly provides for private-sector contributions without recognizing the place of rural peasants and the unemployed, who form most of the national demography. How, then, are they supposed to access medical care in the event of sickness? A system which requires the government to make a minimal contribution on behalf of all vulnerable persons who have no means of contributing themselves would have catered for them. This Act envisages a healthcare system that will cover all strata of society in all urban and rural communities; however, coverage has so far been limited to public and large private organizations – data shows that only 3 per cent of people aged 15 to 49 have health insurance.[104] This low level of coverage is an indication

98 National Health Act, sec 3.
99 Id, sec 11.
100 The Consolidated Revenue Fund is an account provided for by the Constitution of the Federal Republic of Nigeria 1999 (as amended) into which all moneys accruing to the federal government are paid, except where required by any other law to be paid into another account of the government.
101 Id, sec 11(5).
102 Laws of the Federation of Nigeria 2004, National Health Insurance Scheme Act, cap N42.
103 Id, sec 1.
104 National Population Commission "Nigeria demographic and health survey", above at note 3 at 48.

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that the goal of the scheme to attain universal coverage and access is still far off the finish line. How, then, has Nigeria fared in its healthcare facilities' development and access system using the rights-based approach?

Is the right to health a premise for accessing medical care?

Considering sections 17(3)(d) and 6(6)(c) of the 1999 Constitution (as amended), there is no doubting the fact that the Nigerian Constitution makes the right to health merely a policy issue and not a legal right. But in view of the decision in *Ondo State* and section 1(1)(e) of the National Health Act, it would be right to argue that the legislative backing required for the recognition of the right to health as an enforceable right in Nigeria has been furnished.[105] This has set up the threshold for transferring the constitutional provision in section 17 from being a policy to being a mandatory and enforceable legal right. In addition, section 3 of the National Health Act generally empowers the minister to determine the category of persons (vulnerable citizens) who are eligible for free treatment at government medical facilities. The most vulnerable groups in war times (the COVID-19 pandemic has been described using the war analogy)[106] are usually women and children. But how has this legal premise driven institutional response to healthcare in reality, in favour of women and children as a category of the vulnerable?

Furthermore, section 3(3) underscores the entitlement of "all Nigerians" to a "basic minimum package of health services". This right, in relation to the generality of the citizens, is only exercisable within the contours of the "limit of available resources" already cast in iron in section 1(1)(c). Section 64 of the Act further subjects the "basic minimum package of health services" to be what the minister of health prescribes as such, in consultation with the National Council on Health. At the moment, no such basic minimum healthcare services have been prescribed by the minister, six years since the enactment of the National Health Act. This legislation has only concretized the right on paper, without setting the infrastructure (whether soft or hard) for its realization; hence the policy-driven right to health recognized by the Constitution still holds sway. In any case, even if the minister operationalizes the said provision without the necessary health facilities, including access to affordable medicines, qualified personnel and the necessary equipment, the rights-based approach to healthcare provision would have failed. It is axiomatic that in the context of Nigeria, merely providing for the right to health is not a sufficient frame for the realization of the urgent need for access to medical care, especially by the vulnerable population, including the poor, aged, children and women.

Furthermore, the other premise for the realization of the right to health in Nigeria is the African Charter on Human and Peoples' Rights (Domestication and Enforcement) Act, especially article 16, which recognizes the right to health but falls short of framing a legal duty on the duty-bearers on access to medicines and healthcare infrastructure.[107] And as Baxi has observed, though regarding the international system's evasion of justice in healthcare discourse, "'scarcity' is a multiple function of misallocation of resources, the combined and uneven acts of a corrupt sovereign, and 'developmental' mal-governance".[108] This position holds true for Nigeria as it applies in the international realm. As it is, the right to health is an impotent claim without the corresponding duty on the government to provide the required environment for the enjoyment of this right. This is consistent with the obligation of the government in that regard, which formed the basis of the fight for and recognition of the right to health as a second-generation right.

105 *Ondo State*, above at note 91; National Health Act.

106 Spadaro "COVID-19", above at note 63.

107 Laws of the Federation of Nigeria 2004, African Charter on Human and Peoples' Rights (Domestication and Enforcement) Act, cap A9.

108 Baxi "The place", above at note 74 at 16.

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The third approach to recognizing the right to health in Nigeria can be built around the derivative interpretation of the right to life guaranteed by section 33 of the 1999 Constitution.[109] It is arguable that the right to life as guaranteed in the Constitution would have no meaning unless the right to good and accessible healthcare is realized. This derivative approach to constitutional interpretation was mainly developed in India and has gained currency and been deployed in several jurisdictions, including Nigeria, for the realization of second- and third-generation rights. In Nigeria, there has been an attempt to deploy this interpretative approach to delineating the province of the constitutionally guaranteed right to life in the case of *Gbemre v Shell*, where the Federal High Court tried to establish a link between the right to life on the one hand and a clean and healthy environment on the other.[110] The Court accepted the contention of the plaintiffs that there is a non-severable nexus between the right to life and the dignity of a person, and the right to a clean and healthy environment. The right to life and the dignity of a person, being fundamental rights, inevitably include the right to a clean, poison-free and healthy environment. This interpretative ingenuity is consistent with the expansive interpretation of the content and limit of the right to health of the Committee on Economic, Social and Cultural Rights' General Comment no 14. This lends credence to positivist activists' familiar affirmation of the state parties' obligations to "respect, protect and fulfil" the right to health, and by extension the obligation to "facilitate, provide and promote" the realization of the right to health in paragraph 30 of the General Comments; this would seem to be "the best 'weapon for the weak' and vulnerable".[111] Furthermore, though the derivative constitutional interpretation approach was employed in the case of environmental rights in India and even Nigeria, the principle applies to the claim to a right to health as well. Gross has contended that key necessary background conditions for the realization of the right to life include clean drinking water, sanitation, adequate nutritious food, environmental health and occupational health.[112]

Finally, access to medicines is another concern that should form part of the discourse on the right to health and access to healthcare. On a global scale, scarcity of medicines and semi-permeable access to healthcare is not a constraint created by scarcity, especially in the context of the North–South divide and the manipulative roles of the pharmaceutical industry. In relation to policymakers' duty to direct policy and action toward the realization of this right, the issue of healthcare justice is hampered by a "political production of scarcity".[113] In the Nigerian context, politically created scarcity reflects misplaced resource allocation and corruption. Until these challenges are addressed, the "conspiracy" against the poor will continue. As Baxi observes, it is this "violence" that creates conditions destructive of the culture of this right and the institutional availability of healthcare systems.[114] This intentionally thought-out policy and selfish "violence" against the vulnerable creates a system that shifts the burden of healthcare to the already vulnerable, and thereby creating with it the "living dead" who cannot meet the demands of existence as "preceding essence".[115]

Just like most low-income countries' residents, Nigerians are burdened by the challenge of out-of-pocket payment for healthcare access. Mills has posited that "a major problem in low- and middle-income countries is lack of financial support for those who need health care, deterring

109 Nwabueze "The legal protection", above at note 9 at 372.

110 Suit no FHC/B/C/53/05, above at note 88, quoted in RAO Mmadu and A Adeniyi "Oil exploration and environmental degradation in the Niger Delta: Benchmarking the human rights issues involved" (2014) 4 *Nigerian National Human Rights Commission Journal* 137.

111 Baxi "The place", above at note 74 at 16.

112 Gross "The right to health", above at note 50 at 295.

113 Baxi "The place", above at note 74 at 22.

114 Ibid.

115 Ibid.

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service use and burdening household budgets".[116] This perfectly reflects the position of most Nigerian households, where, like other low-income countries, about 50 per cent of payments are made out of pocket.[117] To offer equitable and universal healthcare to the residents of the country, the reality of a functional health insurance system for those in the formal sector cannot be sidestepped. This should be made compulsory. However, regarding the poor and vulnerable population, the government at all levels cannot avoid the responsibility of picking up the bills. This should be funded through budgetary provision on a per capita basis. Ghana practises the approach of making insurance compulsory for the formal sector, voluntary for the informal sector, and providing free coverage for the poor population not captured in either case, as payment for the last category is made from value-added tax.[118] But to assume that this would naturally work in Nigeria because it has functioned commendably in Ghana would be an overgeneralization. However, if public accountability and transparency in governance are pushed through, leaks in public revenue generation, public procurement and the expenditure system can be stopped, and more funds would be available to pursue this policy.

Conclusion

The development of the healthcare system in Nigeria cannot be divorced from the historical and colonial experience of the citizens, which maintained partial access due to limited resources. Since the end of the "glorious days" of funding and free access to healthcare in the 1970s and 80s, subsequent development has been based on out-of-pocket payment for most citizens, aside from the 3 per cent or so aged 15 to 49 who have been captured under the National Health Insurance Scheme. It is obvious at this point that the legally guaranteed right to health in the country has not contributed, at least not visibly, to ameliorating the problem of poor health infrastructure and access to good medical care services for Nigerian citizens, particularly the poor and vulnerable. The legal framework recognizing the place of scarce resources has accorded the governments a reliable alibi. As Baxi noted, the "staggeringly high rates of mortality and morbidity, often reproduced along class, caste, race and gender axes, constitute a 'global disease burden' which summon howsoever 'imperfect duties' for concerted social action in way [sic] that other related, but distinct, basic human needs type discourses do not".[119] Admittedly, the rights-based approach cannot guarantee access to healthcare in the country, but it has facilitated access to healthcare, as seen in *Odafe* and *Ahamefule*.[120] The talk about the human right to health would be deprived of meaning and value if both hard and soft infrastructure are not fortified with the necessary ingredients to effectively function and sustainably impact national populations, especially in Nigeria. As Hunt observed, an "effective health system" is a "core social institution no less than a court system or a political system".[121]

Finally, this situation calls for a review of the legal framework to address the problem of access to healthcare in relation to the poor and children below the age of 18. The health insurance scheme can be made free for the vulnerable, as envisaged under the National Health Act that has not yet been operationalized by the minister, and payment for their health be provided from tax revenue,

116 A Mills "Health care systems in low- and middle-income countries" (2014) 370/6 *The New England Journal of Medicine* 553, available at: <https://www.nejm.org/doi/pdf/10.1056/NEJMra1110897?articleTools=true> (last accessed 21 October 2021).

117 Ibid.

118 Id at 553–54.

119 Baxi "The place", above at note 74.

120 *Odafe*, above at note 92; *Ahamefule*, above at note 94.

121 "The right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (report of the United Nations Special Rapporteur Paul Hunt, 2006); UN ESCOR, Commission on Human Rights, 62nd session, agenda item 10, quoted in Baxi "The place", above at note 74 at 14.

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especially VAT, which has recently been increased from 5 to 7 per cent – just like the practice in Ghana. The working population and the rich should be made to contribute compulsorily towards sustaining the health insurance system as a gateway to accessing good healthcare, hence giving hope for universal healthcare coverage in the country by balancing the goals of the right to health with access to affordable and good healthcare facilities.

Conflicts of interest. None.

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