AN ANALYSIS OF THE LEGAL AND INSTITUTIONAL FRAMEWORK FOR THE REALIZATION OF THE RIGH TO HEALTH IN NIGERIA

BY

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PhD/LAW/18805/2007-2008

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

APRIL, 2015

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BEING A THESIS SUBMITTED TO THE SCHOOL OF POSRGRADUATE STUDIES, AHMADU BELLO UNIVERSITY, ZARIA IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF DOCTOR OF PHILOSOPHY IN LAW- PhD

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APRIL, 2015

DECLARATION

I solemnly declare that this thesis entitled "An Analysis of the Legal and Institutional Framework for the Realization of the Right to Health in Nigeria" is the product of my personal endeavour under the supervision of Professor. J.A.M Audi, Professor Nuhu M. Jamo and Professor Ibrahim A. Aliyu. It has not been presented, to the best of my knowledge, anywhere before. All ideas from previous writers have been duly acknowledged. I remain solemnly responsible for all the views expressed and errors therein.

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CERTIFICATION

This dissertation titled An Analysis of the Legal and Institutional Framework on the Realization of the Right to Health in Nigeria meets the regulations governing the award of the degree of Doctor of Philosophy of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge and literary presentation.

Prof. J.A.M Audi Chairman, Supervisory Committee	_____ Signature	_____ Date
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DEDICATION

This thesis is dedicated to my daughters- Khadijah, Maryam, Fatimaand Aisha S. Yar'Adua for bearing with me during the course of writing this work.

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ABSTRACT

Health is an important element of an individual life and also to the individual's country. A country cannot develop with its citizens sick and dying. A healthy state is a wealthy state. As such, states must provide adequately for the health of its citizens. The research analysed international law and national legal framework that regulate the health system under international law and in Nigeria. It also examined health policies, institutions and other regulatory bodies established for the protection of the right to health in Nigeria. The research was informed by the dismal performance of Nigeria's health care system when the World Health Organization assessed its 191 member states in terms of responsiveness, fairness, overall goal attainment, level of health expenditure per capita, impact on health and overall performance. Nigeria was ranked 187 out of 191 despite its human and natural resources compared with many other African countries which is indeed a cause for concern. This is evidenced from the high level of maternal and childhood mortality, HIV/AIDS related deaths which continue to ravage families and communities, the slow pace of attaining international goals for health and survival and negative progress towards attaining the Millennium Development Goals (MDGs).The research adopted as methodology the doctrinal approach which entailed the use of relevant literature including international instruments, reports and general comments/recommendations. Nigeria is a party to the major regional and international human rights instruments recognizing and protecting the right to health and has assumed tripartite obligations- obligations to respect protect and fulfill the right to health of the Nigerians. Right to health under the Nigerian Constitution is non -justiciable. However, non justiciability of the right to health is a challenge but not a bar to the protection of the said right. It does not also absolve Nigeria from its obligation to protect health of its citizens. The research finds that according health the status of non-justiciable right is not infact related to any inability to deal with socio-economic rights including the right to health as was exemplified with the experience of South Africa which has justiciable socio-economic rights including the right to health. It also finds that the debate whether or not the right to health exist or is non-justiciable is irrelevant as the Indian experience revealed. The research therefore, recommends the court to adopt judicial activism in adjudicating socio-economic rights including the right to health as is done in India. The research finds that Nigeria had put in place and established laws, policies and institutions for the protection of health of her citizens. The research also finds that several factors impede the realization of the right to health in Nigeria including legal impediments, socio-economic impediment and lack of political will on the part of the government. It is also a finding of the research that Nigeria is moving at a slow pace towards attaining the MDGs with less than a year to the target date. Although the research finds that some progress had been achieved especially in reducing childhood mortality and halting HIV/AIDS, the progress is not sufficient to meet the MDGs target date of 2015. The research finds that several key challenges exist which exercabates the slow pace at which Nigeria is moving towards achieving the MDGs notably among them are lack of reproductive health care services, poverty, low socio-economic status of women, inequities in the distribution of human health resources which if addressed will come a long way in helping Nigeria to move faster towards achieving the MDGs and subsequently in fulfilling its obligations under the right to health.

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 Background of the Study

Health is important for every human being in the world. It is an important matter for individuals and states. It is a fundamental human right indispensable for the exercise of other human rights. This can be seen in the impact the denial or enjoyment of other rights can have on a person's ability to achieve the highest attainable standard of physical and mental health and, conversely, the role health plays in our enjoyment of other rights.[1]A person in bad health cannot live life to the fullest. Enjoying good health therefore, is a prerequisite to the enjoyment of other human rights. For instance, a sick person can work to earn a living, go to school and be educated therefore leading life to the fullest and ultimately contribute to the development of his country. Denying people good health care is to deny them the right to life as good health is an indispensable element of life.

Also, social and economic development is closely tied to good health. A country cannot achieve economic growth and development with sick and dying population. As such, for any country to achieve development, it must take care of its citizen's health. The World Health Organization (WHO) recognizes the international human right to health in its Constitution by stating that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[2]

This has led to global debate to focus on the human right to health which now occupies a prominent place on the agenda of the international community. Given the importance of

[1]Byrne, I. (2005). Making the Right to Health a Reality: Legal Strategies for Effective Implementation A Paper presented at the Common Wealth Law Conference, London, Sept 2005 Retrieved 13/08/13 from http:www.escr-net.org/docs/i/421042

[2] Preamble to the World Health Organization Constitution (WHO)1946, opened for signature 22 July 1046, 62 Stat. 6279, 14 UNTS 185 (WHO Constitution)

health as a vital feature of the human condition, health has been recognized as a human right in numerous international documents and every country in the world is a party to at least one human right treaty that protects health either directly or indirectly.

However, right to Health which is rooted under International Covenant on Economic, Social and Cultural Rights (ICESCR) has for long been objected to, and still suffers from marginalization. Although Civil and Political Rights and Economic, Social and Cultural Rights (ESCR) are said to be interdependent, interrelated and of equal importance,[3] there is the tendency on the part of the Western states (e.g. United States of America) to accord more significance to Civil and Political rights.[4] This is attributed to the language in which the ICESCR is couched which makes its contents to be regarded as non-justiciable, vague and regarded as 'general directives for states rather than rights.[5] In this regard, the right to health shares the same fate with Economic, Social and Cultural Rights (ESCR) which are also recognized in international treaties and whose meaning is only gradually being clarified.[6]

Countries whose legal systems are based on English Common Law generally do not provide constitutional guarantees regarding the right to health[7], though implicit references to public responsibilities for health can be found in the preambles to many constitutions, and in some of the content regarding social policy.[8] The United States, for example, does

[3] Art. 5 of the Vienna Declaration states: "All human rights are universal, indivisible, interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the states, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms"

[4] Art 2(1) International Covenant on Economic, Social and Cultural Rights (ICESCR)

[5] Toebes, B.(1999).Towards an Improved Understanding of International Human Right to Health. *Health and Human rights Vol. 23 No. 3 pp. 661-679*

[6] Leary V. A. (1994).The Right to Health under International Human Right Law in *Health and Human Rights Vol. 1 No. 1 p 27*

[7] With the exception of South Africa which has its own progressive constitution reflecting the values of the pluralist, egalitarian and democratic state that replaced apartheid in 1994.

[8] Nigeria, Ghana and Uganda.

not include any reference to health in its Constitution. However, countries with socialist constitutions incorporate the right to health as a fundamental right, along with all other economic, social and cultural rights.

Health in Nigeria is protected in the Constitution under the Fundamental Objectives as objective statement on certain socio-political, economic, and cultural issues meant to guide the government in the formulation of policies. The security and welfare of the Nigerian state being of paramount importance of the government,[9] the Constitution places a duty and responsibility on all "organs of government, and of all authorities and persons, exercising legislative, executive or judicial powers, to conform to, observe and apply the provisions"[10] of the fundamental objective. Health in Nigeria is also protected in other legally binding legislations and regional instruments which Nigeria has domesticated. Nigeria has also established institutions that seek to protect the health of its citizens. However, the health status of Nigerians is said to be in a deplorable state. It is against this background that this dissertation seeks to make an analysis of the legal and institutional framework on the realization of the right to health in Nigeria.

1.2 Statement of problem

Health is an important and beneficial asset for individual for them to lead a productive life. Until recently, health was considered as the private affair of individuals rather than the state as "issues related to the health of population and the availability of health care was not considered to be major social or governmental concern."[11]However, the health of the population is now considered important for the state for any progress and development to be achieved. This acknowledgement "reflects a broadened sense of

[9]S. 14 (2) (b) Constitution of the Federal Republic of Nigeria 1999 as amended (1999 Constitution FRN)
[10] S. 13 Ibid
[11]Ladan, M. T. (2006). Introduction to Jurisprudence: Classical and Islamic *Malthouse Press Ltd p.322*

governmental responsibility for the welfare of its citizens and a more inclusive understanding of human rights."[12]

The realization of the right to health can be achieved through many complimentary approaches such as formulation of policies, implementation of health programmes or the adoption of specific legal or international instruments.[13] The Nigerian Constitution[14] recognizes and protects health in a non-justiciable context under chapter II (Fundamental Objectives and Directive Principle of State Policy). The constitution establishes a state policy of ensuring the adequate provisions of medical and health facilities for all[15] and also ensuring that the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused.[16] The security and welfare of the citizens being of paramount importance, the Constitution places a responsibility on all organs of government to conform, observe and apply the provisions enshrined under chapter II.[17] Nigeria is also a party to major international and regional treaties protecting the right to health including the African Charter on Human and Peoples Rights.[18]

However, despite the legal framework put in place for the protection of health in Nigeria, the health system is said to be in a deplorable state. For example, in 2000, the World Health Organization (WHO) assessed the performance of its 191 member states in terms of their responsiveness, fairness, overall goal attainment, level of health expenditure per capita impact on health and overall performance, Nigeria was ranked 187 out of the 191

[12]Ibid
[13] Aniekwu, N. I. (2006). Health Sector Reform in Nigeria: A Perspective on Human Rights and Gender Issues, *Local Environment: The International Journal of Justice and Sustainability 11:1 p. 128*
[14]Constitution of the Federal Republic of Nigeria 1999 as amended (1999 Constitution)
[15] S. 17 (3) (c) 1999 Constitution
[16]S. 17 (3) (d) Ibid
[17]S. 13 Ibid
[18]African Charter on Human and People's Rights Adopted 26th June, 1981,O.A.U Doc.CAB/LEG/67/3 Rev. 5 Entered into force 21 Oct. 1986. Nigeria signed on 31 Aug. 1982 and ratified in 1983.

states.[19]The situation has not changed as in 2011, the United Nations Development Programme (UNDP) ranked Nigeria's health 156 out of 187 despite Nigeria's resources. In 2012-2013, the World Economic Forum (WEF) ranked Nigeria 142 out of 144 in terms of its health and primary education performance.[20]This is evidenced in the Nigerian health status for example, the Human Development Report 2013 showed that Nigeria's life expectancy at birth was 53.3 years.[21]This figure is said to have declined due to the rampant spread of HIV/AIDS in the country.[22]Women continue to die as result of child birth needlessly. The Millennium Development Goals 2013 Report showed that there is a decline in maternal mortality from 545 in the 2008 NDHS[23] Report to 350 deaths per 1000 live births.[24]Although there is a decrease in childhood mortality, Nigeria still has a long way to go to achieving the Millennium Development Goal 4 (MDG 4) of reducing the under 5 mortality to 64 deaths per 1000 live births.[25] HIV remains a threat to the population's health in Nigeria as it continues to strain the struggling health system and reverse many developmental gains of the recent past including maternal and Under 5 mortality.[26] Nigeria carries the second highest burden of HIV in Africa having an expanding population of people living with HIV (PLHIV).[27]Malaria continues to be a public health concern that Nigeria is battling with.[28] The dismal performance of Nigeria in spite of its natural resources in comparison with most African states must be a cause for concern. These high levels of morbidity and mortality and negative progress toward

[19] World Health Report 2000: Health Systems, Improving Performance, WHO, Geneva.
[20] Nigeria Global Competitive Index: Health and Primary Education 2006-2012 Retrieved on 05/11/14 from www.slideshare.net/statisense/nigeria-global-competitive-index-health-and-pry-education-2006-2012
[21] Human Development Report 2013 Retrieved on 15/11/14 from hdr.undp.org/sites/default/files/country-profiles/NGA.pdf
[22]Nigeria: Millennium Development Goals 2013 Report p. 33
[23]Nigeria Demographic and Health Survey 2013 Preliminary Report (NDHS Preliminary Report 2013) National Population Commission, Nigeria, MEASURE DHS, ICF International Calverton, Maryland, USA
[24]Millennium Development Goals 2013 Report p. 33
[25] NDHS Preliminary Report 2013 p. 19
[26]National Agency for the Control of AIDS (NACA), Federal Republic of Nigeria Global Aids Response: Country Progress Report GARPR 2012, Abuja Nigeria (NACA: Global Aids Response) p. 11
[27] Ibid p. 10
[28] Nigeria: Millennium Development Goals 2013 Report p. 46

the attainment of national and international goals for health and survival are living testimonies that the Nigerian health system has failed to contribute to national development goals.[29]

Significant questions therefore, arising from these issues which must be addressed are:

1. What is meant by the right to health under international law and what are Nigeria's obligations in protecting the health of its population under international law?

2. What are the linkages between health and human right?

3. Does the absence of direct recognition of the right to health in the Constitution mean that the right is totally unprotected? / Is non justiciability necessarily a bar to the applicability and enforcement of the right to health in Nigeria?

4. What are the legal, institutional and policy frameworks put in place for the protection of health in Nigeria?

5. What are the challenges for the realization of the right to health in Nigeria?

1.3 Aim and Objectives of the Research

The aim of this research is to underscore the role of law in promoting and protecting the right to health in Nigeria drawing from global and regional experiences. This is with the view of realizing the following objectives:

i. to examine the international provisions and national legal framework on health and the institutional framework regulating the health system in Nigeria and also to

[29]Aniekwu, N. I. (2006) op.cit fn 13 p. 137

examine Nigeria's obligation under international law with respect to the right to health;

ii. to examine the application and enforcement of the right to health in Nigeria drawing from other jurisdictions with justiciable and non-justiciable right to health;

iii. to examine the role of law in the protection of the right to health in Nigeria; and,

iv. to establish findings upon which recommendation would be made.

1.4 Scope of the Research

The concept of right to health is broad and wide and embraces entitlements which can be broadly categorized into health care and the underlying determinant of health. Health care consist of functioning facilities and services necessary for health e.g. health services provided at clinics, availability of hospital, doctors, nurses drugs etc. while the underlying determinant of health includes adequate food, safe portable drinking water, housing, education, adequate sanitation facilities e.tc.[30] Health care and the underlying determinant of health are interlinked and of equal importance. However, this research will only examine and analyze the legal and institutional regime on the right to Health Care in an attempt to answer the research questions posed above.

1.5 Research Methodology

The research adopted the doctrinal methodology. The source of data will be both primary and the secondary sources. The primary sources consist of the International and Regional Instruments and consensus agreements, the Constitution of the Federal Republic of Nigeria 1999 as amended, legislations and policies for the protection of health in Nigeria,

[30] United Nation CESCR General Comment 14 " *The right to the Highest Attainable Standard of Health"* (herein General Comment 14) (Twenty-Second session, 2000), U.N.DOC.E/C.12/2000/4 Para 11

case law that have bearing on right to health. The secondary sources on the other hand was used to lay down the theoretical and philosophical background and consists of the use of textbooks, scholarly articles in Journals, seminar and conference papers and literature sourced from the internet. The research also utilized secondary sources such as Nigeria Demographic Health Survey 2013 Preliminary Report (NDHS 2013), Multiple Indicator Cluster Survey 4 Report 2011, Nigeria MDG Country Report 2013, and National Agency for the Control of AIDS Country Progress Report 2012, Publications from the Federal Ministry of Health, Federal Ministry of Women Affairs and Social Development.

1.6 Justification of the Research

Health provides both the foundation for a just and productive society and the cornerstone of an individual's chance to develop his or her full potential. A population that is not healthy cannot learn, cannot work and cannot develop. The concept of "right to health" implies that fundamental principle of human rights i.e. dignity, nondiscrimination, participation and justice are relevant issues of health care and health status. This research is relevant because for any state striving to attain economic growth and development cannot do so with sick and poorly nourished dying population and therefore has to make adequate legal provision for the health of its people. No state can maintain a steady economic growth in the absence of an adequate health care system as in the words of Amartya Sen "among the different forms of intervention that can contribute to the provision of social security the role of health care deserves forceful emphasis ... a well-developed system of public health is an essential contribution to the fulfillment of social security objectives.''[31] These therefore, are the justification.

This research will be of great benefit to the academic circle, policy makers of the right to health, NGOs working on the right to health and the Nigerian populace at large.

[31]Asher, J. (2004). The Right to Health: A Resource Manual For NGOs *Common Wealth Medical Trust*

1.7 Literature Review

Literature review assists the researcher to focus on works already done related to the area of research on specific issues and to identify the gaps in knowledge which the researcher seeks to fill. Therefore, the aim of this research is to examine the normative framework of the right to health as it developed under international law and its relevance to Nigeria. The research is also aimed at examining the legal and institutional protection of the right to health in Nigeria and also the effectiveness of the institutions applying the legal framework. The research also aimed at examining the implementation of the right to health in Nigeria taking the MDGs 1(eradicating extreme poverty and hunger), 2 (achieving universal primary education), 3 (improving gender equality and women's empowerment), 4,(reducing childhood mortality), 5 (improving maternal health)and 6 (combating HIV/AIDS and malaria and TB) as a case study.

There is a rich literature on the subject which the present research found useful and relevant. Of significant relevance is the work of Mann, J. in his article *Health and Human Rights*[32] Mann in this work examined the inextricable link between health and human rights and also analyzed the framework for the right to health. This work however, analyzed the right to health in international law and the linkages of health and human rights without contextualizing it to any state. This present research contextualizes the right to health to Nigeria.

Of equal significance is the article of Leary, V. titled *the right to health under international human right law*.[33]Leary examined in depth the legal framework for the right to health in international law and also delved in detailed on the normative

[32]Mann, J. (1994). Health and Human Right in *Health and Human Right An international Quarterly Law Journal Harvard School of Public Health*

[33]Leary, V. (1994).The Right to Health Under International Human Right Law *Health and Human Rights Vol. 1 No. 1*

framework of the right to heath under international law. This literature is important to the present research in building the theoretical framework of the right to health in international law. The present research however, examined the right to health in Nigeria with particular reference to Millennium Development goals 1-6 in Nigeria.

Alicia E.Y. article *The right to health under international human right law to health and its Relevance to the United States*[34] also examined the normative framework and definition of the right to health and its relevance to the United States. She concluded that the right paradigm links health with laws, policies, and practices that sustain a functional democracy and focuses on accountability. This literature examined the right to health in the United States and not Nigeria.

Another work which the researcher found of immense relevant is the edited work of Mann, Mann et al *Health and Human Rights: A Reader*.[35] Of particular relevance in this edited book are the articles of Annas, J. G. *The Impact of Health Policies on Human Rights: AIDS and TB Control*[36] This article examined the impact and relationship of health and human rights and how health policies either positively or negatively affect human rights, and Mann, J. *Human Rights and AIDS: The Future of the Pandemic*[37]which examined the AIDS pandemic in the context of human rights and argues that the respect of human rights is the key to fighting the scourge of AIDS. This research differs from the two articles in the sense that it examined the legal and institutional framework of the right to health in Nigeria.

[34] Alicia, Y. (2005).The Right to Health under International Law and its Relevance to the United States American Journal of Public Health Vol. 95 (7)
[35] Mann, J. et al (1999).Health and Human Rights: A Reader *Rutledge London*
[36]Ibid
[37]Ibid

Brigit Toebes in her article *Towards an Improved Understanding of International Human Right to Health*[38]is another useful material. In this article, Toebes examined in detailed the content of the right to health in international law and not in Nigeria.

Kinney E. D. is also a relevant material. In his work *The International Human Right to Health: What does it mean to our Nation and World?*[39] In this work, Kinney examined the relevance of human rights in the development of health policies in the United States (US). This literature offered ideas on how international human right to health established in a variety of sources in international human right law and general international law created a right to health services in the nations of the world. This work provided for the legal framework on the right to health in international law particularly in the United States and not in Nigeria. This research is also different from this work in the sense that it examined not just the legal framework but also the institutional framework for the realization of the right to health in Nigeria.

Tony, E. in his article titled *A Human Right to Health?*[40] examined the controversies over health as a human right by exploring deep into the genesis of the controversies. His work is therefore, useful to the present research that seeks to posit health as a human right. But however, differs from the present research in the sense that the present research dealt with such arguments in the Nigerian context.

Literature on human rights were of importance to the present research. Examples of such literature include Shelton, D. *An Introduction to Human Rights*[41]which examined the

[38] Toebes, B. (1999).Towards an Improved Understanding of International Human Right to Health in *Human Rights Quarterly* Vol. 21 No 3

[39]Kinney, E.D. International Human Right to Health: What does it Mean to our Nation and World Retrieved on 26/05/11 from mckinneylaw.iu.edu/instructors/kinney/articles/kinney_constitutions.pdf

[40]Evans, T. (2002).A Human Right to Health? *Third World Quaterly Vol. 23, No. 2. Global Health and Governance: HIV/AIDS p.205.* Retrieved 11/05/09, from www.jstor.org/stable/3993496

[41]Shelton, D. (2003).An Introduction to Human Rights *George Washington university Law School Public Law Research Paper No 346* Retrieved on 25/05/12 from ssrn.com/abstract=1010489

origin of human rights. The article concluded that the modern human rights as we have it today were established after the World War II (WWII). However, older religions like Buddhist, Judaism, and Islam played significant role in contextualizing what the modern human right is today. This article is relevant in building the philosophical foundation for the origin of human rights in the present research but however, this research only touched on origin of human rights as a bases of the right to health and dwelled specifically on the right to health in Nigeria and particularly on the legal and institutional framework for the realization of the right to health in Nigeria.

Jamar, S.D. in his article *International Human Right to Health*[42] examined the sources of human right to health and traced its contours. The article developed standard against which conducts of states can be measured. The article finally finds that the right to health imposed a duty on states to respect, protect and fulfill the right to health of individuals or the population. This article did not discuss the right to health in Nigeria and the right to health in the context of MDGs 1-6.

However, there is paucity of materials of the right to health in Nigeria. This is however, not surprising as the right to health is an emerging right whose content and meaning is just being clarified. Despite this fact however, some authors have provided useful literature that this present research finds relevant. For instance, Nnamuchi, O. in his article *Right to Health in Nigeria*[43] examined the key health indicators in Nigeria and finds that although Nigeria is a party to the major international and regional instruments protecting the right to health, the Nigerian government is in violation of its international obligation to protect, respect and fulfill the right to health of its citizens. Although this article is instructive, it did not examine the institutional framework for the realization of

[42]Jamar, S.D. (1994). International Human Right to Health *22 Southern University Law Review*
[43]Nnamuchi, O. (2007). The Right to Health in Nigeria *Retrieved on 12/06/12 from ssrn.com/abstract=1622874*

the right to health in Nigeria and also did not examine the right to health in the context of the MDGs.

In his article titled *Kleptocracy and its many Faces: The challenges of Justiciability of the Right to Health care in Nigeria*[44] Nnamuchi, O., examined the obstacles to the justiciability of the right to health care in Nigeria. He maintained that citing non justiciability of the right to health due to absence of legal foundation and or lack of resources are misplaced. Rather, the major obstacle to the justiciability of the right to health care in Nigeria is Kleptocracy. The article also examined alternative the problem of non-justiciability of the right to health in Nigeria through the African Charter which Nigeria had domesticated.

Ladan, M.T. in his book *Law and Policy on Health, HIV/AIDS, Maternal Mortality and Reproductive Rights in Nigeria*[45]also examined and analyzed the normative content of the right to health under international law and also examined the legal framework of the right to health in Nigeria. However, although the book examined MDGs 5 and 6 and the right to health, it did not examine the institutional framework for the realization of the right to health in Nigeria and also did not examine MDGs1, 2, 3 and 4 in the context of the right to health in Nigeria.

All these literature above are useful and relevant to the present research particularly in building the theoretical/normative framework of the right to health under the international law. The authors have contributed greatly to the field of health and human rights. However, none of the literature discussed the right to health in the context of MDGs 4,5 and 6. Again, none of the literature above discussed both legal and institutional

[44]Nnamuchi, O. (2008).Kleptocracy and its Many Faces: the Challenges of Justiciability of the Right to Health Care in Nigeria *Journal of African Law* Vol. 52 No. 1 p 1-42
[45]Ladan, M.T. (2007). Law and Policy on Health, HIV/AIDS, Maternal Mortality and Reproductive Rights *Ahmadu Bello University, Zaria Press*

framework for the protection of the health of the Nigerians. The present research intends to fill this gap by:

i. Analyzing the legal and institutional framework for the protection of the right to health in Nigeria.

ii. analyzing the right to health in the context of the MDGs particularly MDG4 (reduction of childhood mortality), 5 (improving maternal mortality) and 6 (halting and reversing HIV/AIDS, Malaria and Tuberculosis) in Nigeria.

1.8 Structure of the Research

This research is structured into seven chapters. Chapter one is the introduction to the research which examined introduction to the research, statement of the problem, methodology adopted, literature review, scope of the research, aims and objective of the research, justification for the research.

Chapter two provides for conceptual clarification of the relevant key terms used in the research work and their historical development such as human rights, right to health, right to health care, maternal health and childhood health. The chapter concluded by linking health and human rights.

Chapter three examines the legal framework on the right to health in Nigeria and goes ahead to examine the justiciability of the right to health drawing from global and regional experiences to see what lesson Nigeria can draw from such jurisdictions (if any). The chapter also examines the application of international human right to health in Nigeria and the obligation of Nigeria under international law to respect, protect and fulfill the right to health and also the mechanism for monitoring and enforcement of the right to health under international Law.

Chapter four deals with the existing right to health schemes e.g. primary, secondary and tertiary schemes; it also analyzes and evaluate the existing legal, policy and institutional framework for the protection of the right to health in Nigeria.

Chapter five examines the relationship between the right to health and the Millennium Development Goals (MDGs). The chapter specifically examines the progressive realization of MDGs 4 (Childhood mortality), 5 (Maternal Mortality) and 6 (HIV/AIDS, Malaria and Tuberculosis) in the context of the right to health in Nigeria- issues, challenges and prospects.

Chapter six analyzes the factors-legal, political, economic, social and cultural which serves as clogs to an effective system for the realization of the international legal regime on the right to health in Nigeria. Chapter seven which is the concluding chapter comprises of summary of the work, conclusion and recommendations.

CHAPTER TWO

CONCEPTUAL CLARIFICATION OF RELEVANT KEY TERMS AND THEIR HISTORICAL DEVELOPMENT

2.1 Introduction

This chapter sets to examine relevant key terms such as Human Rights, health, the right to health, maternal mortality, maternal mortality ratio, childhood mortality and their historical development. The chapter also examines the linkages between health and human rights.

2.2 Human Rights

The link between health and human rights is relatively a new and dynamic field which has generated controversies in the academic circle as well as international politics. These controversies stem from the fact that the right to health falls within the rubrics of Economic, Social and Cultural Rights which are termed as aspiration and not rights. However, as the link between the two concepts i.e. human rights and health is gradually growing, the focus has now shifted from why health and human rights to how to apply health to human rights.

Human rights are regarded as fundamental to health work and have become an important concept in promoting health rights. For instance, those actors with responsibilities in health import the language of human rights into their work either in health advocacy or defining health policies and implementing programmes in different ways[1] which reflects the current United Nations policy of mainstreaming human rights which is the process "of assessing the human rights implication of any planned action, including legislation, policies or programs in all areas and at all times. It is a strategy for making human rights

[1]Mann , J. *et al* (1994).Health and Human Rights *An International Quarterly Journal Vol.1 No. 1 Harvard School of Public Health* pg. 15

an integral dimension of the design, implementation, monitoring and evaluation of policies and programs in political, economic and social spheres."[2]

Human right connotes something that is universal, fundamental and vital to human beings. This is therefore, a good foundation to rest the right to health.

2.2.1 Historical and Philosophical Evolution of Human Rights

There are divergent of opinions as to the origin of human rights.[3] Many observers regard the formation of the United Nations (UN) in 1945 and the promulgation of the Universal Declaration of Human Rights (UDHR) as the beginning of the modern struggle to protect human rights.[4] However, it is believed human rights has its roots in the earlier traditions and documents of many cultures which do not generally speak of rights but address moral duties and responsibilities towards others which provide foundation for the concept of human right e.g. the Hindus Vedas, Babylonian code of Hammurabi, the Koran.[5]

Right concept later began to appear in national documents as the Magna Cater of 1215.The Magna Cater was an agreement drawn between King John and his subjects which required the king to renounce certain rights, respect certain legal procedure and accept that the will of the king could be bound by law. This great document influenced the 17th and 18 century European English philosophers notably John Locke (1632-1704) to develop the concept of natural rights.

At the centre of Locke's argument was that individual possess natural rights independently of political recognition granted them by the state which are possessed

[2]United Nations (U.N): Reviewing the United Nations: A Program for Reform. Report by the Secretary General, July 14,1997. New York (NY): United Nations; 1997
[3]Shelton, D. (2003), An Introduction to the History of International Human Right Law *Retrieved on 03/03/11 from http://ssrn.com/abstract=1010489*
[4]Buergenthal, T. (1997).The Normative and Institutional Evolution of International Human Rights *19 Hum. Rts. Q 703*
[5] Sheldon, D. (2003) op.cit fn 3

independently of and prior to the formation of any political community.[6] He argued that natural rights flowed from natural law which originated from God and that the protection and promotion of individual's natural rights was the sole justification for the creation of the state.[7] The natural right to life, liberty and property set clear limit to the authority and justification of the state were presented as existing to serve the interest of natural rights of the people and not the monarch or the ruling cadre.[8] Locke formulated precedent of establishing legitimate political authority upon rights foundation which is undeniably an essential component of human rights. The idea of the right of the individual being natural, inherent and inalienable brought a paradigm shift in the overall understanding of the state and its functions.[9]

By the 17th century, Grotius who was a prominent figure by that time expounded the doctrine of natural rights without divine origin but rather upon the requirement of rationality.[10] The state no longer drew justification from mandates of divine but simply and solely from the need to protect the natural right of the individual i.e. right inherent in the nature of human being such as the right to life, liberty, property, security, happiness etc.[11]

This theory which has its roots in the teachings of John Locke (Second Treatise of Government, 1690), Thomas Paine (The Right of Man,(1791),Jean-Jacques Roussea (The Social Contract and Discourses, 1762) and other philosophers of the 17th century[12] was the driving force behind the French and the American revolutions[13] which produced the

[6]Locke's Political Philosophy Retrieved on 15/10/11 from plato.standford.edu/entries/locke-political/
[7]Ibid
[8] Ibid
[9]Ibid
[10]Ibid
[11]Ibid
[12]E.g. Hugo Grutious in his work " Of the Law of War and Peace in 1625.
[13]Nowak, M. (2003).Introduction to the International Human Rights Regime *Maritinus Nijho of Boston Publication p. 1.*

French Declaration of Right of Man and of the Citizen of 1789 and led federated states to insist on adding the Bills of Rights in the U.S Constitution between 1789-1791.[14] Both the French Declaration of the Right of Man and the American Bill of Rights established certain legal Rights e.g. the U.S Bill of Rights states "*we hold these truth to be self evident that all men are created equal, that they are endowed by their creator with certain rights that among these are life, liberty and the pursuit of happiness*." The two Declarations however, did not extend all natural rights to all people. For example, slavery was still being practiced in the U.S and minorities and women were not accorded full rights.[15]

In many respects, human rights have been a major issue in international politics since World War II. From the emergence of modern states in the 17th century, human rights have essentially been a matter between the state and its people with the behavior of states protected from outside interference by the doctrine of sovereignty.[16] Sovereignty has been a bed rock of the international system. Peace and stability among states were based on the premise that states recognized each other's sovereignty and agreed not to intervene into each other domestic affairs. Nevertheless, sovereignty beyond its legal dimension has never been uniform or absolute.

While the concept of internationally protected human rights did not appear until the 20th century, specific human rights issues emerged and were matters of international concern as early as the 17th century. For example, the International Community attempted through Treaties to protect Minorities from being oppressed by States. The Treaties that made up the Peace of Westphalia (1648) at the end of the religious wars prevailed on States to

[14]Weissbrosdt, D.S. and De La Vega, C. (2010).International human rights law: An Introduction *University of Pennsylvania Press, Philadelphia p.17*
[15]Lerner, K.L and Lerner, B.W. et al. (2006).Human Rights and Civil Rights *Thompson Gale Publication p.3*
[16]Salman, M. A. and Mclnerny- Langford, S. (2004). Human Right to Water: Legal and Policy Dimensions *The World Bank Washington DC*

ensure the rights of all groups to follow the religion which they belong. The imposition on states policy to minority rights extended into the 19th century when the major European powers pressurized the Ottoman Empire to protect Christian Minorities. During the 19th century, the international community via the Concert of Europe also made in road on the principle of sovereignty in abolishing the Slave Trade in 1863 and providing for the protection of the wounded and sick in war in the first Geneva Convention of 1864.

Though one could argue that the conceptual prerequisite for the defense of human rights had long been in place, a full declaration of human rights only finally occurred during the 20th century in response to the atrocious violation of human rights exemplified by the holocaust. Although a number of precursors existed, the modern history of contemporary international human rights[17]-[18] could be traced to the United Nation Charter.[19] The United Nations was established with the primary goal of protecting International peace and preventing conflicts.[20] This was expressly motivated to prevent the future occurrence of any similar atrocity.[21] Member states of the United Nations pledged to promote respect for human rights of all.[22]

One of the main purposes of the United Nations contained in Art.1 (3) is the promotion and encouragement of Human Rights and Fundamental Freedoms for all without distinction as to race, sex, language, or religion. To achieve this purpose, both the United Nation[23] and its members[24] commit themselves to promote higher living solutions of international economic, social, and health problems and universal respect for and

[17]Buergenthal, I.T. (2007*).* International Human Rights in a Nutshell*2nd ed. Nut Shell Series*
[18]Henkin, Louis. (1981). Introduction to International Bill of Rights *Columbia University Press*
[19] Ibid
[20] Preamble United Nations Charter (UN Charter) adopted June 26, 1945
[21] Ibid
[22] Ibid
[23] Art 55 UN Charter
[24] Art 56 Ibid

observance of human rights.[25] Thus, from 1945 it was clear that human rights could no longer be characterized as domestic issue hidden by the veil of sovereignty. This was the first use of the term human rights in a major international treaty the most important treaty of the century.

The United Nations Human Rights Commission (UNHRC)[26] was tasked with interpreting and developing the rights expressed in the UN Charter. In 1948, the UNHRC came up with the Universal Declaration of Human Rights (UDHR)[27] which contains Civil and Political Rights (CPR) and Economic, Social and Cultural Rights (ESCR)including the right to health. The UDHR was adopted by the United Nations General Assembly on Dec. 10 1948. On the importance and relevance of the UDHR Steiner explained:[28]

> No other document has caught the historical moment, achieved the same moral and rhetorical force or exerted so much influence on the human right movement as a whole… bore a more radical message recognized or exerted than as its framers recognized… its subversive path through many doctrines of international law forever changing the discourse of international relations on issues vital to human decency and peace.

The Declaration goes beyond any attempt to restate all individual possession of the right to life as a fundamental and inalienable human right. UDHR commonly referred to as the International Magna Cater, extended the revolution in international law ushered in by the United Nations Charter namely how a government treats its citizen is now a matter of

[25]Hestermayer, P. H. (2002). Access to Medication as a Human Right. in Gina A.D., (2009).The Case for a Human Right to Health in a Globalising World. *Retrieved 12/05/11, from http://cadair.aber.ac.uk/dspace/handle/2160/.../-*

[26] The United Nations Human Rights Commission (UNHRC) is an independent commission with the primary function of monitoring human rights abuses, policies and laws in member countries. It was set up by the Economic and Social Council (ECOSOC) Resolution 5 (1) of Feb. 1946. Art. 68 of the UN Charter provides: The Economic and Social Council shall set up commissions as may be required for the performance of its function.

[27] Universal Declaration of Human Rights (UDHR) adopted 10 December 1948, G.A.Res 217A(III),U.N.GAOR, (Resolution, part I).

[28]Steiner, H. J. and Alston, P. (2000*).*International Human Rights in Context- Law, Politics and Morals*2nd Edition, Oxford University Press 139.*

legitimate international concern and not simply domestic issue.[29] It maintained that all rights are interdependent and indivisible. Its preamble eloquently maintained that "recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom justice and peace in the world." Article 2 provides that "everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind such as race, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

The Declaration was followed by 29 Articles covering core CPR and ESCR. The UDHR is an authoritative guide to the interpretation of the United Nations Charter. The architects of the Declaration reaffirmed the language of the Charter in the preamble:

> Whereas as the peoples of the United Nations have in the charter reaffirmed their faith in fundamental human rights in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standard of life in larger freedom.

The reference to "social progress" was used together with the stated goal of Article 55 of the Charter which was to promote "higher standards of living, full employment, and conditions of economic and social progress and development" to make the case for the inclusion of social, economic and cultural rights in the Declaration. Social, Economic and Cultural Rights encompass human rights associated with the indispensable conditions needed to meet basic human needs such as food, education, water, shelter, clothing and **health care.** For example, the right to the enjoyment of the highest attainable standard of physical and mental health falls into the category of social economic and cultural rights.[30]

[29]Henkin, L. (1981). International Law, Politics, Values and Functions in Salman, M.A. and Mclnerny-Langford, S. (2004). op.cit fn 16 p 18

[30]Johannes, M. (1999).The Universal Declaration of Human Rights: Origins, Drafting and Intent. *Philidelphia University Press p.2.*

Following the adoption of the UDHR, the United Nations Commission on Human Rights drafted the reminder of the International Bill of Human Rights which contained the two Covenants- International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic Social and Cultural Rights (ICESCR) which were adopted by the United Nations General Assembly in 1966 and entered into force in 1976.

Building upon this central documents, a large number of additional Declarations and Conventions have been adopted at the International level and Regional levels focusing against their specific and which also protect the right to health e.g. Convention on the Elimination of Discrimination Against Women (CEDAW), Convention Against Torture (CAT), Convention on the Right of the Child (CRC) etc. Since 1948 the promotion and protection of human rights including the right to health have received increased attention from communities and nations around the world. While there are few legal provisions to compel states to meet their obligations, states are increasingly being monitored for their compliance with human rights norms by other states, NGOs, Media and Private Individuals.[31]

2.2.2 Definition and Characteristics of human rights

Prominent human rights documents proclaim that all human beings have rights. For instance, the UDHR which is part of the international Bill of Human Right states that all members of the human family possesses human rights, all peoples, all human beings, every individual, everyone have human rights.[32]

[31]Gina, A. D. (2009). The Case for a Human Right to Health in a Globalizing World. *An unpublished Mphil Thesis University of Aberystwyth. Retrieved 12/05/11 from www.cadair.aber.ac.uk/dspace/handle/2160/.../-Acessed 12/05/11*

[32]Article 2 UDHR

Louis Henkin said that while it is true that "human rights are the idea of our time"[33] defining human rights remains notoriously difficult. However, the very term human rights indicate both their nature and their source. They are the rights that one has by simply being human irrespective of race, sex, religion etc.[34] While it is true that the most striking feature of the concept of human rights is that it lacks universal definition, it is at the same time difficult to ignore. Basic definitions asserts that "every human being in every society is entitled to have basic autonomy and freedoms respected and basic needs satisfied"[35] Maurice Cranston defined human rights as " a universal moral right something which all men everywhere at all times ought to have something of which is owing to every human being simply because he is human"[36].

According to Nickel[37] human rights are those:

> basic moral guarantees that people in all countries allegedly have simply because they are people. Calling these guarantees "rights" suggests that they attach to particular individuals who can invoke them, that they are of high priority and that compliance with them is mandatory rather than discretionary. Human rights are frequently held to be universal in the sense that all people have and should enjoy them and to be independent in the sense that they exist and are available as standard of justification and critisms whether or not they are recognized and implemented by the legal system or officials of a country.

According Donnelly, human rights are:

> Human rights are the rights that one has simply because one is human…they are held by all human beings irrespective of any right or duties ne may (or may not) have as citizen, members of families, workers or part of any public or private organization or association…they are universal rights… are inalienable because being human cannot be renounced, lost or forfeited.[38]

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[33]Louis, Henkin.(1981) Op.cit fn 18
[34]Donnelly, J. (2003). Universal Human Rights in Theory and Practice *Cornell University Press*
[35]Louis, Henkin. (1981) op. cit fn 18
[36]Cranston, M. (1973).What are Human Rights? *The bodley Head, London* in Thurley, P. (2008).Health care as a Human Right A Rawlsian Approach. *An Mphil Thesis submitted to the University of Waterloo. Retrieved 04/05/11 from* http://www.gradworks.umi.com/MR/43/MR43840.html.
[37]Nickel, J. (1987).Making Sense of Human Rights: Philosophical Reflection on the Universal Declaration of Human Rights. *Berkley University of California Press* in Thurley, P. (2008). fn 27
[38]Donnelly, J. op. cit fn 34

Jacques Maritain[39] explained that:

> The human person possess rights because of the very fact that it is person, a whole, master of itself and of its acts, and which consequently is not merely a means , but an end , an end which must be treated as such. The expression means nothing if it does not signify that by virtue of natural law, the human person has the right to be respected, is the subject of rights, possesses rights. These are things which are owed to man because of the very fact that he is man.

The classical definition of human rights however, is regarded as "a universal moral right something which all men everywhere at all times ought to have, something of which no one may be deprived without grave affront to justice something which is owing to every human being simply because he is human.[40]

From the above definition, it can be safely concluded that Human rights are universal rights in the sense that they are held by people because they are human and they are of fundamental interest and something that human beings vitally need. Health therefore, will qualify as a human right because it is of fundamental interest and vital to human beings without which life itself will be meaningless.

2.2.3 Origin of Health as an International Human Right

The history of man cannot be separated from that of diseases. In the primitive period, people believed that disease were as a result of evil spirit, supernatural being or angry gods hence, they offered sacrifices to the gods to relive themselves of pain and suffering associated with disease.[41] Protecting public health can be traced to early religions and civilizations, even though the relationship between nature of disease and good health was not understood. Going through the early religions and civilization like the Roman, Greek and Egypt one finds evidences of the protection of public health for example, early religion attempted to protect behavior that specifically related to health from the type of

[39]Howard, R.E. (1989) op.cit
[40]Cranston, M. op.cit fn 36
[41]Kumar, S. (2002).History of Public Health. Retrieved on 20/06/11
From http://www.sciencemuseum.org.uk/broughttolife/themes/belief.aspx.

food eaten to regulating certain indulgent behaviors like drinking alcohol and sexual relations.[42] Again, there was the believe that in order to protect public health, there should be proper disposal of waste, good drinking water etc.[43] By this time, the commonest disease in Europe was leprosy. Lepers were excluded from public communities and isolated to prevent further spread of the disease and laws forcing their isolation were passed.[44]

The period between 1000 C.E, Europe was characterized by diseases such as the Black Death and English sweat Plague and other epidemic diseases that continued to strike Europe at that time. Small pox was transported to America where it had a great impact on the natives. As a result, the need was felt to take a closer interest in protecting the health of the population. These catastrophic events precipitated the three most important contributions of public health which include the organization of board of health, promulgation of the theory of contagion and the introduction of health statistics.

The spread of disease was further aggravated by the migration of people from farms and villages by 1750s during the industrial revolution in Europe. This period marked a major contribution in the field of public health. For instance, Johann Peter Frank, a German, published a six volume treatise system of complete medical policy in which he proposed a sweeping scheme of governmental regulation and program to protect the population against disease. The action that he advocated ranged from measures of personal hygiene and medical care to environmental regulation and social engineering.[45]In England, Jeremy Bentham in his Constitutional Code (1830) proposed radical new legislation

[42]Ibid
[43]Encyclopedia of Public Health: History of Public Health. *Retrieved 20/06/11,from* *http://www.enotes.com/science*
[44]Siddiqi, J. (1995).World Health and World Politics: The World Health Organization and the UN Systems. *Columbia: University of South Carolina Press*
[45]Wilkenstein, W.J. History of Public Health in *Encyclopedia of Public Health*. *Retrieved on 22/06/11, from*http://www.enote.com/public-health-encyclopedia

dealing with such issues as prison reform, the establishment of ministry of health, birth control and a variety of sanitary measures.[46]

Disease however, continued to strive in Europe due to unsanitary conditions. Chadwick Edwin, the then Secretary of England's Poor Law Commission, revealed the extent of public health crisis in Europe which pressured the government to pass its first Public Health Act in 1848.

The development of International Trade Route also created another avenue for the spread of disease in Europe and Americas. This development was as result of "availability of surplus grains, animals and manufactured goods"[47] in Europe and Americas. This trade route though fostered prosperity and connected people, it brought with it disease into Europe and Americas. The slave trade also propelled the spread of disease via ships. The colonialist on the other side were also threatened and killed by diseases like malaria and yellow fever in the states they colonized.[48] According to Gina "the disease exchange propelled the Tran nationalization of disease between the old and the new worlds, reshaped the contours of colonization and made disease a visible component of the entire colonial architecture."[49] Due to the high rate of the spread of disease across Europe and America, the need was felt to introduce a measure to contain its rapid spread. Thus, quarantine was introduced as a measure to tame the spread of disease. This measure was initially successful, but by the mid-19th century, it became difficult to contain the speed of the spread of diseases and also there was the outbreak of cholera in Europe which could not be contained by quarantine. Cholera in the 19th century spread in waves from

[46]Ibid
[47]Gina, A.D. (2009), op.cit fn 31 .
[48]Ibid
[49]Ibid

South Asia to the Middle East then to Europe and the United States did the most to stimulate the formal internalization of public health.[50]

By this time there was growing pressure to establish an international organization that would protect the population against disease and promote health. The first international sanitary conference was held in 1851 following the outbreak of cholera in Europe that killed tens of thousands people. Little was accomplished at the conference but it set the stage at establishing a mechanism for international cooperation for disease prevention and control. In between 1851 to the late century, about ten sanitary conferences which met in various states were held. These conferences deliberated upon quarantine regulations which were to deal with plague, cholera, yellow fever and other diseases reputed to be transportable.[51] However, they yielded not much result. In 1892 the International Sanitary Convention for the control of cholera was adopted.[52]

The permanent International Health Office known as the Office International d' Hygiene Publique (OIHP) was established in 1903 to "consolidate epidemiological information and oversee international quarantine arrangement."[53] This was an important period in the history of disease and the protection and promotion of public health because not only were etiological cause and means of transmission of most infectious disease known, success was also made in the discovery of vaccines. This paved way for the establishment of public health administration based on scientific understanding of the elements involved in the spread of communicable diseases. In 1920, the League of Nations

[50]Siddiqi, J. (1995). op.cit fn 44.
[51]Charles, J. (1968). Origins, History, and Achievements of the World Health Organization *British Medical Journal Vol. 2 p. 293-296.*
[52]Mccarthy, M. (2002).A Brief History of the World Health Organization (WHO).*The Lancet Vol. 360, Issue 9340 p 1111-1112*. In between 1851-1892 ten sanitary conferences were held but few yielded notable accomplishment. See Siddiqi, J. (1995).World Health and World Politics: The World Health Organization and the UN System. *Columbia: University of South Carolina Press* in Gina, A.D.,(2009), op.cit fn 31.
[53] Ibid

established a health organization. However, the establishment of the United Nations marked a "period of aggressive internalization and international organization building."[54]

At the time of establishing the United Nations, the need was seriously felt for the establishment of a body for the protection of world health. A proposal was therefore made to convene an international conference for the establishment of a new world health organization. The conference recognizing the importance of health as a factor in the promotion of "conditions of stability and wellbeing for the nation of the world included health among the field of corporative endeavour with which the United Nations should concern itself."[55] The outcome of the conference was the creation of a specialized agency of the United Nations having a wide international responsibility in all matters relating to health.[56] The World Health Organisation was established on the 22nd July 1946 with sixty one states signing its constitution.[57]

In order to avoid duplication of function, the WHO took over both the OIHP and the health organization established by the League of Nations. The WHO provided the definition of health which inspired the definition of right to health in numerous international human rights treaties and documents. It defined health not just from the negative side of "absence of disease and infirmity" but also from the positive side as "the state of physical, mental and social well-being." It went further to provide that health is a fundamental human right of every human being without distinction as to race, religion,

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[54]History of World Health Organization (WHO).Retrieved 16/06/11, from http://static.howstuffworks.com.
[55]Proceedings and Final Acts of the International Health Conference held in New York from 19th June to 22 July , 1946 United Nations, WHO Interim Commission. Retrieved 12/06/11 http://whqlibdoc.who.int/hist/official_records/2e.pdf. Accessed 12/06/11. The importance of health has been emphasized by President Roosevelt in 1939 when he said that
"the health of the people is a public concern; ill health is a major cause of suffering, economic loss and dependency; good health is essential to security and progress."
[56]Ibid
[57] For details of countries that have signed the WHO Constitution see WHO: Countries. Retrieved 20/06/11, from www.who.int/countries/en/.

and political belief, economic or social condition. The objective of the WHO shall be "the attainment by all people of the highest possible level of health."[58]

2.3 Concept and Definition of the Right to Health

The phrase "right to health" has been subject to critisms with respect to the terminology used (the right to health). For many, the phrase "right to health" is awkward and absurd.[59] This is because it is seen as guaranteeing something that even the state cannot give i.e. perfect/good health and the most appropriate phrase is the “right to health care” because it is more specific than the phrase “right to health”. To say A has a right to health will necessarily suggest that A has the right to be healthy. Hence, for this reason, many prefer to use the phrase "right to health care" or "right to health protection.

Among those who endorse the phrase "right to health care" is Prof. Ruth Roemer but in her definition of right to health care, she included "protective environmental services, prevention and health promotion and therapeutic services as well as related actions in sanitation, environmental engineering, housing and social welfare."[60]

However, the phrase the "right to health" is standard in the field of human rights and used internationally by international organizations, human rights organs and legal scholars. The right to health is wider in scope and includes the right to health care and the underlying determinant of health such as nutrition, portable water, sanitation, proper living conditions and other environmental and occupational conditions interconnected to improve peoples' health and lives. The phrase "right to health care" is more appropriately

[58]Preamble to the WHO Constitution (22nd July 1946),Reprinted in Basic Documents 1 (40th ed. 1994).
[59]Leary, V. (1994).The Right of Health in International Human Right Law in *Health and Human Right International Quarterly Journal A publication of Harvard Law School of Public Health*, See also Ladan, M.T. (2008), The Role of Law in the HIV/AIDS Policy: Trends of Case Law in Nigeria and other Jurisdictions *Ahmadu Bello University, Zaria Press*
[60]Toebes, B.(1999). Towards an Improved Understanding of the International Human Right to Health *Human Rights Quarterly Vol. 221 No. 3*

used in the context where the discussion is "about national health care priority setting or health care budget or expenditure."[61]

The right to health has been defined as the right to enjoyment of facilities, goods and services and conditions necessary for the realization of the highest attainable standard of health.[62] The right to health is inclusive and extends not only to timely and appropriate healthcare but also to the underlying determinants of health such as access to safe and portable water and adequate sanitation, an adequate supply of safe food nutrition and housing, healthy occupational and environmental conditions and to health related education and information including sexual and reproductive health.

The right to health is a fundamental human right which is enshrined in the Universal Declaration of Human Rights (herein UDHR)[63] and the ICESCR and numerous other international and regional human rights instruments as well as in domestic legislation in many countries. It entails specific government obligation regarding health care and the underlying determinants of health as well as obligation to ensure non- discrimination and people's right to participate in relevant decision making process.

The right to health should not be seen as the right to be healthy[64] because the state cannot be expected to provide people with protection against every possible cause of illness or disability such as the adverse consequences of genetic diseases, individual susceptibility and the exercise of free will by individuals who voluntarily take unnecessary risk including the adoption of unhealthy life style. Nor should the right to health be seen as a limitless right to receive medical care for any and every illness or disability that may be

[61] Ibid.
[62] Asher, J. (2004). The Right to Health: A Resource Manual for NGOs *Common wealth Medical Trust* p. 53
[63]Universal Declaration of Human Rights (herein UDHR) G.A.Res.217A (III), U.N.DOC. A/810 (1948)
[64]United Nation CESCR General Comment 14 " *The right to the Highest Attainable Standard of Health"* (herein General Comment 14) (Twenty-Second session, 2000), U.N.DOC.E/C.12/2000/4 (2000) Para 8

contracted. Instead, right to health should be understood as the right to the enjoyment of a variety of facilities and conditions which the state is responsible for providing as being necessary for the attainment and maintenance of good health.[65]

2.3.1 Nature of the right to health

The right to health having been grouped together with other Economic, Social and Cultural Rights (ESCR) suffers from definitional imprecision, vagueness and non justiciability. As has been noted by Hendricks that "it is widely believed that the absence of universal definition together with the lack of clarity about the nature and scope of the corresponding states obligation impede the state from realizing the aspirations enshrined in the right."[66]

Art 2 (1) of the ICESCR is said to provide the basis for the arguments against the right to health as a right but an aspiration which a state should strive to achieve. It provides:

> Each state party to the covenant undertakes to take steps individually and through international assistance and cooperation especially economic and technical to the maximum of its available resources with a view to achieving progressively the full realization of the rights recognized in the covenant by all appropriate means including particularly the adoption of legislative measures.

The ICESCR obligates states to take steps to "progressively realize" the right to health based on the “states available resources The phrases 'progressively realize', based on "available resources" and "appropriate measures" have been held to be the weak point of the ICESC thereby weakening the implementation of the rights contained in the covenant. It has the effect of making state parties to the covenant to post pone implementation of the rights therein or make excuses for non -implementation of the rights therein.

[65]Ibid

[66]Hendriks, A. and Toebes, B.(1998).Towards a Universal Definition of the Right to Health *Med. Law Vol.17, No. 3 pp 319-32.*

However, the provision of art 2(1) of the ICESCR has been described as the lynchpin of the covenant as it describes the nature of states parties' legal obligation under the covenant. Thus, the Committee on Economic, Social and Cultural Rights (CESCR) in its General Comment 3 explained that art 2(1) "is of particular importance to a full understanding of the covenant and must be taken as having a dynamic relationship with all of the other provisions. It describes the nature of the general obligations undertaken by state parties to the covenant."

The CESCR explained that the phrase *undertake to take steps* is not to be understood as postponing the obligation of state towards the right to health. The CESCR specifically mandates states to take "immediate action which are deliberate, concrete and targeted as clearly as possible towards meeting the obligation with respect to the right to health".[67]

The obligation to take steps has been described by the Limburg Principles[68] to be of immediate effect after the ratification of the ICESCR.[69] For example by constitutionalizing the right to health and making it justiciable, adopting a national health policy and or plan of action. A violation of the undertaking to take steps occurs where a state fails to take deliberate, concrete and targeted steps towards realizing the right to health[70] for instance not taking any of the appropriate measure provided under General Comment 3 (either legislative, administrative or judicial measures) to fulfill the right to health. Though the CESCR has mandated state parties to take immediate steps towards realizing the right to health, the full realization cannot be achieved overnight, but is subject to progressive realization.

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[67] UN General Comment 3 " *Nature of States' Parties' Obligations"*(Fifth session, 1990) U.N.DOC.E/199/23,annex III, 86 (1990) (herein General Comment 3), Para 2

[68] Limburg Principles (herein Limburg Principles) Adopted 8 Jan 1987, UN ESCR, Comm Hum Rts, 43rd Sess. Agenda Item 8, UN.DOC E/CN.4/19987/17/Annex (1987). Reprinted in 9 Human Rights Quarterly 122 (1987) Para 4

[69] Ibid Para 16

[70] Ibid Para 15 (a)

The ICESCR states that the right to health could be achieved by state taking all appropriate measures and especially the adoption of legislative measures. States are therefore, given the margin of discretion with respect to the measures that could be adopted to realize the right to health. The ICESCR in anyway, emphasize the adoption of legislative measure to protect the right to health. The phrase "by all appropriate measures" indicates that there are other measures which a state could adopt to realize the right to health apart from legislative measures. Other measures include administrative measures, judicial measures, policies, programs etc.

The phrase *"progressive realization* " of the right to health obligates states irrespective of the level of their economic development to move as quickly as possible towards the full realization of the right to health. The phrase is thus, inextricably linked to available resources and the full realization of the right to health. The right to health for example, cannot be achieved over night and hence states are to take steps in good faith based on its available resources after ratification of the covenant towards fully realizing the right to health. Any contrary indication would be inconsistent with the intent of the drafters of the covenant.

The insertion of the phrase takes into cognizance the fact that there are states that cannot implement the right to health immediately and can only do so progressively for example the under developed states. The use of the phrase should not therefore, in any way be taken as a weakness on the part of the covenant and as an escape hatch for states not to fulfill their obligations under the covenant. Rather, the article introduces a flexible device in terms of the obligation of states. The CESCR provides:

> Reflecting the realities of the real world and the difficulties involved for any country for ensuring the full realization of economic, social and cultural rights. On the one hand, the phrase must be read in light of the overall objective,

> indeed the *raison d'etre* of the covenant which is to establish clear obligation for states parties in respect of the full realization of the right in question.[71]

The Limburg Principles also reiterates the provisions of the General Comment 3 explaining that progressive realization cannot be interpreted under any circumstances to imply for states the right to defer indefinitely efforts to ensure fulfillment of the right to health.[72] State parties to the covenant are to take deliberate, targeted and concrete steps immediately towards realizing the right to health.

A violation occurs where state party takes unjustified retrogressive steps in the realization of the right to health. For instance, the CESCR explains that states action such as cuts in budget, repealing existing laws, policies or programmes on the right to health constitute acts of violation and if any retrogressive measures are taken, the state party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the covenant in the context of the full use of the state party's maximum available resources.[73]

Discrimination is said to be the key principle in international human right law and central to human right approach to health. Article 2(2) of the ICESCR obligates states to respect and ensure that all persons within its territory and subject to its jurisdiction, the rights recognized in the covenant without distinction of any kind such as race, color, language, religion or other political opinion, national or social origin, property, birth or other status.

[71] Ibid
[72] Ibid Para 15
[73] General Comment 14 Para 32

Discrimination should not be interpreted in a narrow sense but should be given a broader context to protect socio-economic rights in this instance the right to health.[74] For example the Canadian court in the case of *Eldridge* rejected the states idea that the right to nondiscrimination did not require the state to allocate resources in health care in order to address preexisting disadvantage of a particular group such as the deaf as "thin and impoverished vision of equality" and held that the government's failure to fund or provide sign language services in the provision of health care to the deaf was discriminatory more especially as doing so would not constitute any unreasonable burden for the government.[75]

General Comment 14 prohibits discrimination in access to health care and underlying determinant of health. ie. access to portable water, adequate housing and sanitation, access to food etc. as well as to the means and entitlement for their procurement, on the internationally accepted grounds which has the intention or effect of nullifying or impairing the equal enjoyment of the right to health.[76]

In ensuring nondiscrimination, states are obligated to take into consideration the vulnerable and the most disadvantaged in the state by recognizing differences and basic needs for instance women, children, minorities, disabled etc. States must also ensure equitable allocation and distribution of health care goods and services taking into account the needs of the vulnerable and disadvantaged in the state. For instance the CESCR explains:

> With respect to the right to health, equality of access to health care and health services has to be emphasized. States have special obligations to provide those

[74]General Comment 9 *"Domestic Application of the ICESCR"* 1998 U.N.CESCR, comm. On economic, social and cultural rights, 19th session, agenda item 3, U.N. DOC. E/C 12/2000/4 (1) (herein General Comment 9) Para 12

[75]Nolan, E. & Porter, B. (2007).Justiciability of Social and Economic Rights: An Updated Appraisal *Retrieved 13/08/11, from http://ssrn.com/abstract=1434944* .

[76] General Comment 14 Para 18

> who do not have sufficient means with the necessary health insurance and health care facilities, and to prevent any discrimination on internationally prohibited grounds in the provisions of health care and health services especially with respect to the core obligations of the right to health. Inappropriate health allocation can lead to discrimination that may not be overt. For example, investment should not disproportionately favor expensive curative health services which are often accessible only to a small, privilege fraction of the population, rather than primary and preventive health care benefiting a larger part of the population.[77]

Thus, while the full realization of the right to health may be achieved progressively, steps towards that goal must be taken within a reasonably short time after ratification of the covenant. Such steps must be targeted, concrete and deliberate as clearly as possible towards meeting the obligation of the right to health.

The phrase *maximum available resources* has been described to be very "controversial as states usually capitalize on lack of resources to shun away from the legal obligations "[78] in realizing the right to health. Resources are critical for the implementation of the right to health and hence, critics argue that the right to health cannot be a right as its implementation is dependent on the states available resources and will thus vary states obligation under the covenant. States obligation to implement the right to health is tied to the availability of the resources of the state. Resources have been described to mean "both resources within the state and those available from the international community through international cooperation and assistance"[79] that can be utilized in the progressive realization of the right to health. The fact that some states are wealthier than others means that the obligation of states under the covenant with respect to the right to health varies. That is to say, that a state that is wealthy will have a higher level of the realization of the right to health than a poor state. The obligation is thus, flexible depending on the level of

[77] Ibid Para 19
[78] Nolan, E. and Dutschke, M. op.cit fn 75
[79] Limburg Principles Para 26

the financial strength of the state. The obligation may also differ in the same state with respect to different rights as some rights may be more costly to realize than others.[80]

The fact that the realization of the right to health is dependent on the available resources of a state, does not however, mean that a state can shy away from its obligation under the covenant on the pretext of non-availability of resources. In other words, a state cannot employ non availability of resources as an excuse not to discharge its obligation under the covenant. For a state to attribute non availability of resources for non-compliance with the covenant obligation, it must show that it has made every effort to use all resources that are at its disposition in an effort to satisfy as a matter of priority those minimum obligations.[81]

A state must use it available resources equitably and judiciously in the satisfaction of at least minimum of the right to health and particularly to strive to achieve the enjoyment of the right to health even in times of resources constraints for the vulnerable and the marginalized by adopting relatively low cost programmes[82] for example realizing primary health care would not cost much. Thus, this has the effect of protecting the vulnerable and the marginalized from " pervasive corruption and theft of national resources by state officials that continue to hinder the capacity of many states to implement" the right to health.[83]

2.4 Maternal Mortality

The World Health Organization defined maternal mortality as the death of a woman while pregnant, or within 42 days of termination of pregnancy, from any cause related to or

[80] Hunt, P. (1998).States Obligations, Indicators, Benchmarks and the Right to Education. *Background Paper*
submitted to CESC.UN DOC. E/C.12/1998/11/ at 3 in Felner, E. Closing the ' Escape Hatch': A Toolkit for Monitoring the Progressive Realization of Economic, Social and Cultural Rights p. 406 *Journal of Human Rights Practice* Vol. 9 No. 3 pp 401-35.
[81] General Comment 3 Para 2 Para 10
[82] Ibid Para 12
[83] Nolan, E., and Dutschke, M., op.cit fn 75

aggravated by the pregnancy or its management but not from accidental or incidental causes. It is the death of a woman while still pregnant or 42 days after she ceases to be pregnant for the reason of her pregnant state and inefficient handling of her condition. The WHO definition of maternal mortality precludes maternal mortality as death resulting from accident or incidental causes in relation pregnancy.

2.5 Maternal Mortality Ratio (MMR)

This is defined as the total number of maternal death per 100,000 live births while maternal mortality rate is maternal death per 100,000 reproductive aged women. MMR is the annual total number of women who die from pregnancy during term and the process of childbirth, or 42 days post-delivery divided by 1000,000 live births. Challenges exist in measuring maternal mortality such as difficulty in collating and recording data, especially in sub-Saharan Africa where maternal mortality is highest. Precise registration of death and cause of death is inaccurately kept because they usually occur at home.

2.6 Childhood Mortality

Childhood mortality is also known as under five mortality rate.[84] It is the annual number of deaths of children aged less than five per 1000 live births. It is the best single indicator of social development and wellbeing of a child.[85] Childhood mortality is calculated as number of death of children less than five years of age in a given year/total live birth in the same year times 1000.[86]

2.7 Linkages between Health and Human Right

The development of the connection between health and human rights had been growing gradually from the Nuremburg trial to the creation of the United Nations over fifty years

[84]Onwasigwe, C. (2010).Principles and Methods of Epidemiology *El Demak Publishers Enugu p 118*
[85] Ibid p118
[86] Ibid

ago.[87] Though, until recent times, both concepts of health and human rights were approached separately and the health of individual was considered "a basic to be delivered by government and physicians rather than a basic right of individuals and communities."[88] Medical practitioners often wandered on the *nexus* and the applicability of human rights into their work so also human rights advocates wandered on the added value of incorporating health into their work[89]oblivious of the far reaching goal to be achieved (added value) by their complementarity.

The end of the cold war and the emergence of HIV/AIDS pandemic in the early 1980's and the issues of reproductive rights acted as a catalyst in bridging the gap and bringing together health practitioners and human rights advocates which brought about a shift in the traditional approach of an isolated approach to health or human rights. From the late 1980's, there has been awareness[90] within the public health community of the importance of human rights as "an integral component of an effective and sustainable HIV/AIDS programme or policy."[91]This is an important shift because the goal to be achieved will enhance human well-being than using the isolated approach to just health or human rights.

[87]Gruskin, S. Mills, E.J. et. al (2007).History, Principles and Practice of Health and Human Rights

[88]Toubia, F.N. (1994).From Health to Human Right to Health: Where Do We Go From Here? A paper presented At the First International Conference on Health and Human Rights at Harvard University, Cambridge, Massachusetts, USA Sept. 1994. Although, the stage had been set for the connection between health and human rights by the declaration of the Alma Ata which reaffirmed that health is fundamental human rights, the health and human rights concepts, practice and principles owe much to the response to HIV/AIDS. See also Gruskin, S. Mills, E.J. et.al (2007). op.cit fn 87

[89] Mann, J., et al op.cit fn 1

[90] This was achieved through series of United Nations conferences beginning from the early 1990s and also the United Nations 1997 program for Reform which mainstreamed human right into UN core activities and helped "moved issues of health and human rights from rhetoric to implementation, action and accountability." See generally Gruskin, S. et al op cit fn 87.

[91]See, Gruskin, S. and Mills, E.J. et al. (2007). op.cit fn 87

Health and human rights influence one another.[92]According to Mann, J.,[93] public health policies, programs and practices have an impact (negative or positive) on human rights. For instance states policy on mandatory HIV testing could violate the human right to privacy, and security of the person. Also, states may violate human rights by compulsorily isolating individuals for the protection of the larger community due to communicable disease without necessarily taking the human rights perspective of it thereby, violating their freedom of movement.[94] The state could also violate human rights in developing and implementing health policies by neglecting or refusing to acknowledge the health needs and priorities of marginalized or vulnerable groups thereby violating their right to non-discrimination and their right to security in the event of sickness.[95]

Again, violation of human rights, especially when severe, widespread and sustained, endangers important health affect and that the promotion and protection of human rights is fundamentally linked to the promotion and protection of health.[96] This is evident from human rights violation such as rape, torture, imprisonment under inhumane conditions which has brought both health practitioners and human rights advocates together.[97]

Yet, another important connection between health and human rights is that health is so fundamental that without it, one cannot fully realize other human rights e.g. right to work, right to education and accordingly, "people who are healthy may be best equipped to

[92]Haigh, F. (2002). Human Rights Approach to Health *Croat Med J Vol. 42 p. 167*
[93] Mann, J. (1994). op.cit fn1 p. 13
[94]Though this is explicitly provided for in the international bill of human rights e.g. Art 4 of the ICESCR provides "the state party to the present covenant recognize that in the enjoyment of those rights provided by the state in conformity with the present covenant, the state may subject such rights only to such limitations as are ***determined by lawonly in so far as this may be compatible with the nature of those rights and solely for the purpose of promoting the general welfare in a democratic society."*** See also Art. 29 UDHR, General Comment 14 Para 28, Siracusa Principles on the Limitation and Derogation in the ICCPR, 7 Hum Rts Q,3,5 (1985) (Siracusa Principles), Limburg Principles on the Implementation of ICESCR adopted 8 Jan 1987, U.N.ESCR, Comm. Hum. Rts, 43 Sess. Agenda Item 8, U.N.DOC.E/CN.4/1987/17/Annex (1987), Reprinted in 9 Hum Rts Quarterly 122 (19870 Para 48-51.

[95]Art. 25 UDHR. See also Mann, J. (1994). op cit fn 1,Haigh, F. (2002). op cit fn 92 p. 92
[96]Gruskin, S. et al op.cit fn 87
[97]Mann, J. et.al (1994). Op cit fn 1 p. 17

participate fully and benefit optimally from the protections and opportunities inherent in the International Bill of Human Rights."[98]

The connection between health and human rights is steadily growing and as such there are still development to be achieved between health and human rights.[99] The field is still young, and vibrant. As Toubia, F.N.[100] asserts the use of "health and human right will in many cases examine long standing and recognized health issues from a new angle. In other cases, it will look at new and unrecognized issues of concern to health professional."

[98] Ibid p.22
[99] Ibid p. 21
[100] Toubia, F.N. (1994). op.cit fn 88

CHAPTER THREE

RIGHT TO HEALTH IN NIGERIA

3.1 Legal framework on the right to health in Nigeria

According to Ladan[1], the "earliest conceptualization of the right to health did not so much emanate from a human right organ, but from an international health authority – the World Health Organization (WHO)" which proclaim the enjoyment of the highest attainable standard of health to be "one of the fundamental human right of every human being without distinction as to race, religion political belief, economic or social condition."[2]

Accordingly, the right to health had since become an integral part of human rights instruments at both national and regional levels[3] and to which Nigeria is signatory to. Notably among them include the Universal Declaration of Human rights (UDHR)[4] which was a declaration at the initial stage which was not meant to be binding but most of its provisions are now considered as constituting customary international law because of its wide acceptance by states.[5] The UDHR protects the right to a certain standard of living that basic needs can be met (health and wellbeing), the right to safety net of social services in the event of sickness, unemployment, old age and also maternal and child health.[6]

Apart from the UDHR, there are various international treaties, recognizing the right to health and binding on Nigeria. The International Covenant on Economic, Social and

[1] Ladan, M.T. (2008). The Role of Law in the HIV/AIDS Policy: Trend of Case Law in Nigeria and Other Jurisdiction *Ahmadu Bello University Press, Zaria*.
[2] Ibid p.22
[3] Ibid
[4] Universal Declaration of Human Right (herein UDHR adopted 10 Dec. 1948, G.A.Res.217A(III), U.N.GAOR,(Resolution, Part I) Art 25.
[5]Hannum, H. (1995). The Status of Universal Declaration of Human Rights in National and International Law*25 Ga J Int'l and Comp. Law* 287, 317-352
[6] See art 25 UDHR

Cultural Right (ESCR)[7]is arguably said to be the most important international provision on the right to health and is explicit about the recognition of the right to health and the attendant obligation on the part of the state.[8]Particularly Art 12 recognized "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health conducive for living a life of dignity."[9] It further provided for the means of achieving good health by mandating states to undertake the following steps to achieve its full realization:

(a) The provision for the reduction of the still birth rate and of infant mortality and for the healthy development of the child;

(b) The prevention, treatment and control epidemic, endemic, occupational and other diseases;

(c) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Another international instrument for which recognizes the right to health is the International Covenant on Civil and Political Rights (ICCPR).This covenant does not specifically protect the right to health directly like the ICESCR. However, certain provision in the covenant impliedly protects the right to health. Of particular significance are Art 6 and 7. Art. 6 provide "every human being has the inherent right to life…" The right to life is said to be the fulcrum of the right to health for without good health, of what essence would be the right to life. The United Nation Human Right Committee expatiated in its General Comment 6 on the expansive meaning of the right to life where it stated:

> The right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that states adopt positive measures. In this connection, the committee considers that it would be desirable for state parties to take all possible measures to reduce infant

[7]International Covenant on Economic Social and Cultural Rights (ICESCR) adopted 16 Dec. 1966, GA .Res 2200 (XXI), UN GAOR, 21ST Sess., Supp. No. 16 (herein ESCR). Accession date 29 July 1993
[8]Ladan, M.T op.cit fn 1
[9] Art 12 (1) ICESCR

> mortality and increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.[10]

While Art 7 provides that "no one can be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[11] is another treaty dealing specifically with the rights to health of women which Nigeria has ratified.[12] The treaty mandates states to take measures to eliminate discrimination against women in the field of health care so as to "... access to health care services, including those related to family planning."[13] The treaty specifically paid attention to the health of women in the rural areas.[14]The Convention on the Right of the Child[15]on the other hand reaffirms the universal protection of the right to adequate health and proclaims that children are the citizens of the state and as such are human beings guaranteed the right specified in the Universal Declaration of Human Rights (UDHR).[16]

In the year 2000 the United Nation Committee further expanded upon the right to health with General Comment 14,[17] Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights[18]and the Maastricht Guidelines on Violation of ESCR[19] which built upon the original ideas from 1966 by

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[10] General Comment 6 Para 5

[11] Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) adopted 18 Dec. 1979, G.A Res. 34/180, UN. GAOR 34TH Sess., Supp. No. 46 , U.N.Doc. A/34/46 (1980) (entered into force 3 Sept.)

[12]Nigeria signed on the 23 April 1984 and ratified on 13 June 1985.

[13] Art 12 CEDAW

[14] Art 14 Ibid

[15] Convention on the Right of the Child adopted 20 Nov. 1989, G.A Res, 44/25, U.N GAOR, 44TH Sess., Supp. No. 49, U.N.Doc. A 44/49 (1989) (entered into force 2 Sept. 1990). Nigeria signed on the 26 June 1990 and ratified 19 April 1991.

[16] See S. 6,19, 20,23, &24 of the Convention on the Right of the Child

[17] U.N Committee on Economic, Social and Cultural Rights General Comment 14 The Right to the Highest Attainable Standard of Health, CESCR,22 Sess. U.N.DOC E/CN.12/2000/4 (2000)

[18]Limburg Principles (herein Limburg Principles) Adopted 8 Jan 1987, UN ESCR, Comm Hum Rts, 43rd Sess. Agenda Item 8, UN.DOC E/CN.4/19987/17/Annex (1987). Reprinted in 9 Human Rights Quarterly 122 (1987)

[19] Maastricht Guidelines on Violation of Economic, Social and Cultural Rights as printed in Human Right Quarterly 1998: (20) 69(herein Maastricht Guidelines)

exploring the historical context of this right, further defining the meaning of an adequate health care system, detailing obligation of state, defining violation and discussing the basic of implementation.[20]

At the regional level, the Right to health is protected by the African Charter on Human and People's Rights[21] which Nigeria had not only ratified but domesticated and thus, forms part of its domestic laws.[22] The Charter is the basic human rights document of the African Union and establishes the right to adequate health for all Africans from conditions and treatment deleterious to their health. Art 4 protects the right to life and the dignity of the person which is an integral part of the right to health. Particularly, Art 16 provides that every individual shall have the right to enjoy the right to the best attainable state of physical and mental health and mandates state parties to the charter shall take the necessary measures to protect health. Art 18 prohibits discrimination against women and also mandates states to ensure the protection of the right of the women and the child as stipulated in international declarations and conventions. The rights of the aged and the disabled are also protected.

The African Charter on the right of the Child[23] outlines the basic right of the African child including provisions describing the health care and health care protection needed by children. Specifically, Art 14 deals with the health of the child and provides that "every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health." S.14(2) provides for the measures to achieve the right to health which shall include:

(a) to reduce infant and child mortality rate;

[20]Right to health. Available at www.unhchr.ch/tbs/doc.nsf/(symbol)C.E.12.2000.4.En?openDocument
[21] The African Charter on Human and People's Right adopted 26th June 1981, O.A.U Doc.CAB/LEG/67/3 Rev.5 entered into force 21 Oct. 1986. Nigeria signed on 31 August 1982 and ratified in 1983.
[22]*Gani vs Abacha* (2006) NWLR
[23]Nigeria signed on 13 June 1999 and ratified 23 June 2001

(b) to ensure the provisions of necessary medical assistance and health care to all children with emphasis on the development of primary health care;

(c) to ensure the provision of adequate nutrition and safe drinking water;

(d) to combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;

(e) to ensure appropriate healthcare for expectant and nursing mothers;

(f) to develop preventive health care and family life education and provision of service

Protocol to the African Charter on the Rights of Women[24] is the regional charter which specifically and efficiently deals with the right of women in Africa. Art. 14 protect the right to health and reproductive rights of women in Africa.

The right to health has also been addressed in International debates some of which have culminated in documented consensus statements that have come to be recognized as authoritative.[25] Notably among them include the Vienna Declaration, the Programme of Action of the Cairo Conference 1994, and the Beijing Declaration and Programme of Action 1995, have also elaborated on the meaning and scope of the International human right to health, and of international health issues generally and the United Nation Millennium Declaration adopted by the147 heads of states who attended the Millennium Summit. The Declaration addressed eight Millennium Development Goals (MDGs) to be achieved by the year 2015. One of the striking features of the Declaration is the prominence of health in the eight goals. Three of the MDGs are directly health related (MDGs 4 (reducing childhood mortality), 5 (improving maternal health) and 6 (combating HIV/AIDS, Malaria and other diseases). While the remaining five particularly MDG 1 (eradicating extreme poverty and hunger), 2 (education) and 3 (gender equality and women's empowerment) are indirectly related to health. Finally, a great number of

[24] Nigeria ratified on 16 December 2003
[25] Ladan, M.T. (2008). Op.cit fn 1 p. 23

National Constitutions include a right to health care or stipulate states' duties with regard to the health of their people[26] including the Nigerian constitution.[27]

3.2 Health as Justiciable Right

Millions of people are living in abject poverty with no basic health care. Health as part of social rights is a right that benefits those that lack political power. It is those that are voiceless that suffer most of the violation of the right to health. Without a voice, they become marginalize in the society and suffer an undignified life. In most situations, attaining a right to health becomes a dream, an illusion that can never be realized for majority of people.[28] ESCR therefore, spell out the minimum conditions needed to live a life in dignity and integrity.[29] Human rights cannot be left to the whims of the political organs otherwise there would be little need for right discourse in the first place.

The debates over the justiciability of the right to health must be viewed from a human right perspective and the effects it has on the right holders who are usually voiceless and have no other alternative but the courts to enforce their rights and to hold the government accountable for their promises to the people of their states. The court therefore becomes the only avenue for the voiceless in terms of enforcing ESCR in order to live a life in dignity. Thus, King argued that "judicial recourse provides an effective means of protecting social rights."[30] Courts therefore, acts as check on the exercise of public power ensuring that it is exercised in a manner consistent with the constitution which is

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[26] Yamin, A.E. (2005). The right to health under international law and its relevance to the United State *American Journal of Public Health* Vol. 95 No. 7 P 1156-1161.

[27] S. 17 (3)(d) of the Constitution of the Federal Republic of Nigeria 1999 as amended 2011 (1999 Constitution)

[28] This was stated by Justice Yacoob in the case of *Grootboom* 2001 (1) SA 46 (CC) Para 2 who described the plight of Irene Grootboom and her family living under plastic in Wallacedence Sports Field with the winter rain arriving that "the case brings home the harsh reality that the constitution's promise of dignity and equality for all remains for many a distant dream."

[29] Lehmann, K. (2006). In Defense of the Constitutional Court: Litigating Socio-Economic Rights and the Myth of the Minimum Core *American University International Law Review* Vol. 22, Issue 1 Article 8

[30] King, J. (2003). An Activist Manual on the International Covenant on ESCR *Law and Society Trust and Center for Economic, Social and Cultural Rights p. 139*

grounded on the rule of law. This has been reiterated by the CESCR that there must be somewhere to go to be heard and that there must be effective remedy provided if a right has been violated which the CESCR explained to be important to the relationship between human rights and the rule of law.[31] The CESCR particularly pointed out that:

> The adoption of a rigid classification of economic, social and cultural rights which puts them by definition beyond the reach of the court would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.[32]

Nolan further explained that priotizing CPR over ESCR has the effect of "propagating injustice and inequality from judicial review and thereby entrench systematic pattern of violation"[33] and would ultimately " effectively deny remedies to the most disadvantaged groups in society."[34]

However, in most recent times, there has been a shift from this traditional thinking to a thinking that embrace both rights as interdependent and interrelated and are treated on the same footing as proclaimed by the Vienna Declaration.[35] The world has witnessed the entrenchment of the right to health in national constitutions and its adjudication in different parts of the globe as justiciable rights. And accordingly, Friedman, E. *et al* stated:

> we believe that the right to the highest attainable physical and mental health can be a force to enable even the world's most poorest people to benefit from the immense health improvement that we know to be possible intervention that are proven and affordable. Increasingly, civil societies and communities, courts

[31]General Comment 9*"Domestic Application of the ICESCR"* 1998 U.N.CESCR, comm. On economic, social and cultural rights, 19th session, agenda item 3, U.N. DOC. E/C 12/2000/4 (1) (herein General Comment 9) Para 4
[32] Ibid
[33]Nolan, A. and Porter, B. (2007).Justiciability of Social and Economic Rights: An Update Appraisal *Retrieved 13/08/11, from* http://ssrn.com/abstract=1434944 .
[34] Ibid
[35] Art. 5 Vienna Declaration and Programme of Action (UNGA) (A/CONF.157/23),issued on July 12, 1993, by the United Nation World Conference on Human Rights, Vienna, Austria, June 14-25, 1993

> and constitutional assemblies, are turning to the right to health as a tool for developing a more just society… the days when a government could argue that the right to health was simply aspirational and unenforceable seem distant.[36]

3.3 Judicial Application of the Right to Health in Selected National Jurisdictions: South African and India

South Africa: South Africa has been heralded for the inclusion of some socio-economic rights[37] as justiciable rights in its Constitution and thus its constitution has been described as "heroic and revolutionary."[38] Adopting the principle of the UDHR, the South African constitution did not differentiate between CPR and ESCR. Article 7 (2) of the South African constitution emphasized that that the state must respect, protect and fulfill the rights contained in the constitution. The inclusion of ESR in its constitution has made South Africa to have a vibrant and well developed jurisprudence on ESCR including the right to health. It has also made South Africa to overcome the controversies relating to the justiciability of ESCR.[39] It is interesting however, to note that with a vibrant jurisprudence and justiciable ESCR, South Africa has not yet ratified the ICESCR.

India: The choice of India is also well informed. India shares with South Africa similar legal system (common law). Its ESCR termed as Directive Principles are not justiciable unlike South Africa. However, the courts in India are active and have developed an approach that enables them to adjudicate on ESCR giving meaning and life to them even in the absence of justiciable right. It is this approach that has made India to have a vibrant

[36]Friedman, E. and Gostin, L. (2012). Pillars for Progress on the Right to Health: Harnessing the Potentials of Human Rights through a Framework Convention on Global Health 14(1) *Health and Human Rights An International Journal* Retrieved 12/10/14 from wwwhhrjournal.org/index.php/hhr/article/view/483/751

[37] Socio-economic rights included as justiciable rights in the south African constitution are: Right to Work s.23, Right to Healthy Environment s.24, Right to Property s.25, Right to Housing s.26,Right to Health s.27, Right to Food s.27, Right to Water s.27, Right to Social Security s.27, and Right to Education s.29.

[38] Christiansen, E.C.(2007). Exporting South African Social Rights Jurisprudence. Retrieved on 17/12/11, from http://ssrn.com/abstract=1132342.

[39]Exparte Chairperson of the constitutional Assembly: In *Re Certification of the Constitution of the Republic of South Africa*, 1996, 1996 (4) SA 744 (CC) (herein the *First Certification Judgement*).

jurisprudence on socio-economic rights including the right to health despite all critisms against it.

The two jurisdictions are therefore at parallel ends with respect to the right to health yet, they have achieved a great deal with respect to the same right to which Nigeria can draw lessons.

3.3.1 South Africa

The South African constitutional court[40] adopts a purposeful approach in interpreting the constitution, taking into account the historical context of the apartheid.[41] The recent South African constitution is described as transformative because the earlier constitutions which promoted apartheid did not contain any mention of human rights at all. Therefore, the recent South African constitution itself was drafted to redress "social and economic injustice, eradicate poverty and promote greater control by communities and individuals over all aspects of their lives."[42] This is evident from the preamble to the constitution and the constitutional courts judgement which explained that the constitution introduces democracy and equality for the first time in South Africa. It acknowledges a past of intense suffering and injustices and promises a future of reconciliation and reconstruction.[43]

The constitution entrenched both the traditional CPR and ESCR including the right to health. The relevant provision with respect to the right to health is contained in s.27 (1) of the South African Constitution which provides:

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[40]Prof. De Devenish commented on the south African constitutional court thus:
The constitutional court is manifestly intended to be the most esteemed court in the land because it is the ultimate guardian of the constitution which is the supreme law of the republic, which is the product of the constitutional Assembly on elected body representative of the whole nation….
Prof. De Devenish, A Commentary on the South African Constitution (Butterworth, Durban) at 2334 in Deierto, D.A. Justiciability of Socio-Economic Rights: Comparative Powers, Roles and Practices in the Philippines and South Africa. *Retrieved 09/10/11,from*http://ssrn.com/abstract=1485555.
[41]*Soobramoneyv Minister of Health KwaZulu Natal* 1998 (1) SA 765 (C), (herein *Soobramoney*)Para 17.
[42] Health care in a Democratic South Africa
[43]*First certification Judgement*op.cit fn 39

a) Everyone has a right to health care including reproductive care.

(2) The state must take reasonable measures to achieve the progressive realization of these rights.

Recalling that the history of South Africa under the apartheid regime excluded the majority of South Africans from the enjoyment of human rights, the inclusion of ESCR in its constitution meant a life of dignity and integrity for them which had been a distant goal for the majority of South Africans under the apartheid.

The inclusion of the ESCR in the South African Constitution was however, subjected to numerous judicial and political controversies which centered on their justiciability, constitutional legitimacy and competency of the courts and separation of power. Infact it was contended that socio-economic rights had no place in the constitution as they were not justiciable. The controversies were however put to rest by the *First Certification Case* which held that:

> It is true that the inclusion of socio-economic rights may result in courts making orders which have direct implication for budgetary matters. However, even when a court enforces civil and political rights such as equality, freedom of speech and right fair trial, the order it makes often have such implications. A court may require the provision of legal aid, or the extension of state benefits to a class of people who formally were not beneficiaries to such benefit. In our view it may not be said that by including socio-economic rights within a Bill of rights, a task is conferred upon the courts so different from that ordinarily conferred upon them by a bill of right that it results in breach of separation of power.[44]

The court went on to stressed that "the question is therefore, not whether socio-economic rights are justiciable under our constitution, but how to enforce them in a given case."[45]

[44] *First Certification Judgement* Para 77
[45] *Grootboom* op.cit fn 28 Para 20

To the South Africans, the inclusion of ESCR in the constitution is important because it creates an avenue for the poor and the marginalized that are in the majority to hold the government accountable to their constitutional duty to protect, promote and fulfill as required under s. 7 (2) of the constitution.

The justiciability of ESCR in the constitution has made the South African constitutional court to move progressively in developing a body of jurisprudence on ESCR including the right to health and also develop a consistent methodology that put to rest the controversies over resource constraints and separation of power. Thus, the methodology adopted by the constitutional court becomes of immense value and importance to the countries around the world adjudicating on the right to health.

By putting the debates over the justiciability of the ESCR including the right to health to the background, the South African constitutional court has forged ahead and adjudicated on ESCR including the right to health. The methodology adopted by the constitutional court is the " reasonableness review approach". This approach is employed to evaluate governmental action or lack of it with respect to ESCR in the state. The central questions before the court in applying the reasonableness review approach is whether the program/policy adopted by the government of South Africa would facilitate the delivery of the particular right in question and in this instance the right to health? If it will, then the program/policy passes the test. The government however, retains the power to make its policies without any intrusion from the courts.

Justice Yacoob described the concept of reasonableness as having a direct link with human dignity, equality and freedom. He explained that:

> Reasonableness must also be understood in the context of the Bill of Rights as a whole. The right to access to adequate housing is entrenched because we value human beings and want to ensure

> that they are afforded their basic needs. A society must seek to ensure that the bare necessities of life are provided to all if it is to be a society based on human dignity, freedom and equality. To be reasonable, measures cannot leave out of account the degree and extent of the denial of the rights they endeavor to realize. Those whose needs are the most urgent and whose ability to enjoy all rights therefore, is most in peril, must not be ignored by the measures aimed at achieving realization of the rights. It may not be sufficient to meet the test of reasonableness to show that the measures are capable of achieving a statistical advance in the realization of the rights. Furthermore, the constitution requires that everyone must be treated with care and concern. If the measures though, statistically successful, fails to respond to the needs of those most desperate, they may not pass the test.[46]

The court in the in the case of *Grootboom*[47]held that:

> A court considering reasonableness will not enquire whether other more desirable or favorable measures could have been adopted, or whether public money could have been better spent. The question would be whether the measures that have been adopted are reasonable. It is necessary to recognize that a wide range of possible measures could be adopted by the state to meet its obligation. Many of these would meet the requirement of reasonableness. Once it is shown that the measures do so, this requirement is met.

The application of the reasonable approach is however constitutionally limited by the concept of available resources[48] and that of progressive realization and that the full realization of the right to health cannot be achieved overnight.[49]

This approach was first adopted by the constitutional court in overcoming critisms such as availability of resource, progressive realization and separation of power in the case of *Thiagraj Soobramoney v Minister of Health KwaZulu Natal* (herein *Soobramoney*).[50] The case involved the appellant Soobramoney who was suffering chronic renal failure, cerebra-vascular disease and ischemic heart disease. He needed regular dialysis at least three to four times a week which could prolong his life but would not cure his condition.

[46]*Grootboom* Para 44
[47]Ibid
[48]*Ibid*Para 46
[49] S. 27 (2) (b) Constitution of Republic of South Africa.
[50]*Soobramoney* op.cit fn 41

He was initially receiving treatment in a private hospital but after exhausting his resources in the private hospital; he applied to the public hospital for renal dialysis. Due to limited number of dialysis machines in the hospital and the burden on the machines, the hospital authority developed guidelines which provide that patients suffering from chronic renal failure are eligible for dialysis only if they are eligible for kidney transplant. Again, those eligible for kidney transplant must not suffer from other disorders as the appellant. This necessarily put the appellant as not eligible for renal dialysis.

He sued the government of South Africa and based his claim on s. 27(3) of the constitution. S. 27 (3) provides that "no one may be refused emergency medical treatment." The constitutional court did not dispute the justiciability of the right to health but applied a "reasonable approach" in evaluating government action. The court held that the right to emergency medical treatment as provided under Art. 27 (3) of the south African constitution was not violated as " to be kept alive, he would require such treatment two to three times a week"[51] which the court described as not an "emergency that calls for immediate remedial treatment "[52] as provided under Art 27 (3) because it is going to be an " on going state of affairs resulting from the deteriorating of the applicant's renal failure which is incurable."[53] Rather, the court held that the case fall under Art 27(1) and (2) which entitles everyone to have access to health care services by the state within its available resources.

The court further held that the appellant could not succeed under Art 27(1) because the eligibility criteria adopted by the hospital were reasonable given the resource constraints it faced and given the "agonizing choices" inherent in budgeting limited resources.[54] The

[51]Para 21
[52] Ibid
[53]Desierto, D.A. op.cit fn 40
[54] Lehmann, K. op.cit fn 29

court took into consideration the cost of offering dialysis to the appellant twice or three times a week to prolong his life which will cost 60,000 rand a year for doing it once a week and that would mean 60,000 times three for having the dialysis three times a week to keep him alive and also the limited and over utilized dialysis machines as compared to the number of those who need dialysis and could be save by same. It was held that:

> By using the available machines in accordance with the guidelines more patients are benefited than would be the case if they were used to keep alive persons with chronic renal failure and the outcome of the treatment is also likely to be more beneficial because it is directed to curbing patients and not simply to maintaining them in a chronically ill condition.[55]

The dialysis budget of the hospital still remains over stretched and unchanged and the court stated that "the state resources are limited." The implication was that offering dialysis to the appellant would mean someone who has a chance of surviving would not receive the treatment and extending the budget for dialysis would be at "the cost of other health services." [56] The court held that this was a decision better left to the political organs of the state and further held that " a court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility is to deal with such matters."[57] The court went on to explain that it was a dilemma which the hospital not just in South Africa but around the world has to face.[58]

The reasonable approach was also adopted in the case of *Treatment Action Campaign (TAC) v Minister of Health* (herein *TAC*).[59] The case involved the distribution of

[55] *Soobramoney* Para 25
[56]Ibid p.168.
[57]*Soobramoney* Para 29
[58]*R v Cambridge Health Authority* 13 (1995) EWCA(iv) 49; (1995)2 All ER 129 (CA) at 137
[59]*Treatment Action Campaign v Minister of Health* (2002) (5) SA 703, 721 (herein *TAC Case*)

Naviraphine drug.[60] The government of South Africa had developed a policy for the testing of Naviraphine drug in pilot cites which consisted of three provinces in South Africa. This policy limited the distribution of the drug to the designated pilot sites thereby neglecting the majority of HIV positive pregnant women from having access to the drug which also affected the unborn who may likely be born infected with the virus. The government policy was challenged as violating s. 27(1) of the South African constitution.

The question addressed by the court was "whether the applicants have shown that the measures adopted by the government to provide access to health care services for HIV positive mothers and their newborn babies fall short of its obligations under the constitution."[61] The court evaluated the action of the government by adopting the reasonable approach and held that the government policy of limiting Naviraphine to the designated pilot sites was unreasonable and unconstitutional and that it breached S. 27 (1) (a) and S. 27 (2) of the constitution of South Africa by excluding "those who cannot afford to pay for medical services"[62] and also addressed the issue in the context of children's rights as follows:

> Their needs are 'most urgent' and their ability to Naviraphine affects their ability to enjoy all rights to which they are entitled. Their rights are most 'in peril' as a result of the policy that has been adopted and are most affected by a rigid and inflexible policy that excludes them from having access to Naviraphine.[63]

In determining the question of availability of resources, the court explained the fact that the drug Naviraphine was offered free of charge and therefore was not a strain on the states health budget and the court found that the drug had been tested and approved by the W.H.O and therefore its efficacy was not in question. The court specifically held that "a

[60] Naviraphine is a drug that is administered to pregnant women to prevent mother-to-child transmission of HIV/AIDS. The efficacy of the drug has been tested by the WHO.
[61] *TAC Case* op.cit fn 59, Para 25.
[62] Ibid Para 70
[63] Ibid Para 78

potential lifesaving drug was on offer and where testing and counseling facilities were available it could have been administered within the available resources of the state without any known harm to the mother or child."[64]

The court ordered the government to remove the restriction of limiting the Naviraphine drug to pilot sites as it excluded those that could reasonably be included in the program and also ordered the government to come up with comprehensive program to prevent or reduce mother-to-child-Transmission (MTCT) of HIV/AIDS and to submit reports to the court outlining that program. The court came to this conclusion based on the fact that Naviraphine drug is inexpensive and therefore, could be provided without straining the government budget.

3.3.2 India

The Indian constitution just like the South African constitution was drafted to be transformative bringing social change to the people of India by the adoption of fundamental human rights and Directive Principles which was described as the "conscience of the constitution."[65] However, unlike the justiciable socio-economic rights in South African, the Indian constitution placed ESCR under chapter IV (Directive Principles) as non-justiciable. This is categorically spelt out in S. 37 of the Indian constitution which provides " the provision contained in this part of the constitution shall not be enforceable by any court...."

The fundamental rights and the Directive Principles are drafted as tool for good governance and thus, despite the non justiciability of the Directive Principle "the

[64]Ibid Para 80

[65] Austin, G. (1966).The Indian Constitution: Cornerstone of a Nation *Oxford, Clarendon Press* in Deva, S. (2009).Public Interest Litigation in India: A Critical Review *Civil Justice Quarterly Review Vol. 28, issue 1. Retrieved 12/17/11, from* http://ssrn.com/abstract=1424236.

principles laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws."[66]

There were initial controversies during the drafting of the Indian constitution with respect to Directives Principles and their place in the constitution i.e. whether to make them justiciable or not. The initial intention of the drafters of the constitution was to make them justiciable but it was finally settled that they should be non-justiciable. However, the intention of the drafters was not to leave them in the constitution as dead letters and of no importance for life. This was expressively stated by the chairman of the constitutional drafting committee that:

> The intention of the assembly is that in future both the legislative and the executive should not merely pay lip service to these principles enacted in this part but that they should be made the basis of all executive and legislative action that may be taken thereafter in the matter of governance of the country.[67]

Again, in order to give meaning to the directive principles in the constitution, S. 38 of the constitution imposed an obligation to "strive" to fulfill them despite all odds. The aim of the inclusion of the word "strive" was explained that:

> …even when there are circumstances which prevent the government, or which stands in the way of the way of the government giving effects to these directives principles they shall even under hard and unpropitious circumstances, always strive in the fulfillment of these directives…otherwise it would be open for any government to say that the circumstances are so bad that the finances are so inadequate that we cannot even make an effort in the direction in which the constitution asks us to go.[68]

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[66]Shankar, S.& Mehta, P.B., (1999).Courts and Socio-Economic Rights in India. *Retrieved 09/07/11, from* *http://www.ser.bd.com/doc/138569272/courts_and_socioeconomic_rights_in_india*.

[67]Ibid p. 9.

[68] Kothari, J. (2004). Social Rights and the Indian Constitution. *Law, Social Justice and Global Development (LGD). Retrieved 15/12/11, from*http://www.go.warwick.ac.uk/elj/lgd/2004_2/kothari.

In order to achieve social, economic and political change as envisaged by the Indian constitution, the judiciary was made to be independent and equipped with the power of judicial review. The Supreme Court, the apex court in India, is described as the most powerful court in the world due to its activities.[69] Initially, courts in India have interpreted the Directive Principles as non- justiciable rights as they appeared in the constitution and had thus, favored the traditional CPR over the Directive Principles.

There was however a paradigm shift in judicial attitude towards the judicial interpretation of the Directive Principles in the middle 70s after the emergency that was in force which was characterized by massive human rights violation.[70] The tide shifted from favoring the CPR over the Directive Principles to interpreting the CPR and the Directive Principles as "harmoniously" and that both set of rights are "supplementary, interdependent and indivisible."[71] It was explained in the case of *Unikrishnan J.P vs State of A.P*[72] that "the provisions of Part III and IV are supplementary and complementary to each other and not exclusionary of each other and that the fundamental rights are but means to achieve the goals indicated in part IV."

The Indian courts adopted an expansive definition of fundamental rights that are justiciable to give life and meaning to the Directive Principles which are non-justiciable and also to create new rights like the right to health[73] and new remedies for giving relief.[74] By interpreting S. 21 of its constitution which provides for the right to life and states "no one shall be deprived of his life or liberty except to according to the procedure

[69] Deva, S. (2009).Public Interest Litigation in India: A Critical Review *Civil Justice Quarterly Review Vol. 28, issue 1. Retrieved 12/17/11, from* http://ssrn.com/abstract=1424236 *p. 30.*
[70]Kathori, J.(2004). Social Rights and the Indian Constitution. Law, Social Justice and Global Development (LGD).*Retrieved 15/12/11, from* http://www.go.warwick.ac.uk/elj/lgd/2004_2/kothari
[71]Ibid p. 6.
[72]AIR (1993) SC 218 in Kathori, J., ibid.
[73] The constitution of India does not contain an explicit right to health. S. 47 merely talks of improving public health.
[74]Kathori, J. op.cit fn 68.

established by law", the court evolved new fundamental rights. "Life" in this context is interpreted to mean more than just mere physical existence and to include right to live with human dignity and all that goes along with it.[75] The courts have imposed positive duties from right to life which traditionally imposes a negative duty i.e. negative in the sense that states are mandated not to deprive any individual of his right to life or personal liberty except in circumstances permitted by law, to a positive duty i.e. "to take steps to ensure the individual a better enjoyment of his life and dignity."[76]The Indian constitution does not contain explicit right to health. However, implicit provisions can be found in S. 47 relating to public health which provides "the state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties."

When the court found right to health in the case of *CESC vs Subhash Chandra Bose and Ors*, the majority of the judges rejected it in the absence of codified right to health.[77]Adopting an expansive definition of S.21, the right to life, the courts created new set of rights like the right to health and food and has consistently held that the right to health is an integral part of a meaningful right to life[78] and that the state had a constitutional obligation to provide health facilities to its workmen which was later expanded to include the population at large.

Art. 21 thus, cast an obligation on states to protect the right to life. The court in the case of *Paschim Banga Khet Muzdoor Samity vs State of West Bengal*(herein *Paschim*

[75]*Francis Coralie v Union Territory of Delhi AIR 1981 SC, 753*
[76] Ibid
[77] The court in the case found that: The term health implies more than an absence of sickness. Medical care and health facilities not only protect against sickness, but also ensure stable man power for economic development. Facilities of health and medical care generate devotion and dedication to give the workers best physically as well as mentally in productivity … in the light of article 22-25 of the UDHR and the ICESCR and in the light of socio-economic justice assured in our constitution right to health is a fundamental human right to workmen.
[78]*Consumer Education and Research Center v Union of India* (1995) 3 SCC 42

Banga)[79] held that "Art. 21 impose an obligation on the state to safeguard the right to life of every person. Preservation of human life is thus of paramount importance." The case of *Paschim Banga* concerned a man who fell off a train and sustained multiples injuries including brain hemorrhage and was denied hospital bed in several public hospitals. Aggrieved by this situation, he filed a petition in the Supreme Court and the question that was before the Supreme Court was whether the lack of adequate medical facilities for emergency treatment constitutes a violation of his fundamental right under Art 21 of the Indian constitution. The court held that:

> The constitution envisages the establishment of a welfare state at the federal level as well as the state level. In a welfare state the primary duty of the government is to secure the welfare of the people. Providing adequate medical facilities for the people is an essential part of the obligation undertaken by a welfare state. The government discharges this obligation by running hospitals and health centers which provide medical care to the persons seeking to avail these facilities…The government hospital run by the state and the medical officers employed therein are duty bound to extend medical assistance for preserving human life. Failure on the part of the government hospital to provide timely medical treatment results in violation of his right to life guaranteed under Art. 21.[80]

In adjudicating Directive Principles, the courts acknowledges the problem of resource constraints, but however, has consistently refused to allow that to be a bar to the justiciability of Directive Principles. In the case of *Paschim Banga* the court acknowledged that resource was needed to provide medical facilities but however, it held that "a state could not avoid this constitutional obligation on account of financial constraints. Whatever is necessary for this purpose has to be done."[81] The court went ahead to explain that the issue of resource constraint is also visible in the traditional CPR

[79]1996 (4) SCC 37.
[80]Ibid
[81]Ibid

and is never used as a bar to the justiciability of CPR and as such issues relating to resource constraints cannot be a bar to the right to health. The court stated:

> In the context of the constitutional obligation to provide free legal aid to a poor accused, this court has held that the state cannot avoid its constitutional obligation in that regard on account of financial constraints. The said observation would apply with equal, if not with greater force in the matter of discharge of constitutional obligation of the state to provide medical aid to preserve human life.[82]

Using the expansive approach and interpreting the right to life under Art 21, court in India have adjudicated on different aspects of health care and services e.g. health of prisoners[83] and mentally ill[84], HIV/AIDS particularly discrimination,[85] smoking in public places,[86] safe drinking water,[87] environmental health[88] etc.

Unlike the South African experience which provides for the progressive realization of the right to health based on the availability of resources, the Indian experience is aggressive in the sense that the state is obligated to "strive" at all cost to enforce the right to health irrespective of the state' s resources and the principle of separation of power. The South African courts are cautious not to step into the shoes of the other arms of government e.g. the executive and the legislature.[89]

Though both methodologies adopted by both South Africa and India have been criticized- south Africa for not adopting the minimum core of the right to health and the Indian courts for stepping into the realm of the executive and legislature, they have nevertheless demonstrated that the right to health is a fundamental right that is capable of being

[82]Ibid
[83]*Paramahand Katara v Union of India and ors AIR 13, (1989) SC 2039*
[84] *T.N v Union of India 3 SC (3) 2002*
[85]*Mr. X v Hospital Z (1998) 6 SCALE 230, (1998) 6 SCC, 296*
[86]*Murli S Deora v Union of India (2001) 8 SCC, 765*
[87]*Puttapa Honappa Tlawar v Deputy Commissioner, Dharwad, AIR (1998) Kar 10 (1998)*
[88]*Mehta v Union of India (1987) 4 SCC 463*
[89] See *Soobramoney* op.cit fn 41

adjudicated at the national level despite all the criticisms against the right to health as part of ESCR with respect to separation of power, availability of resources, polycentric issues etc. Both experiences have shown that the court plays an important role in alleviating the hardship of millions of people by adjudicating on the right to health.

The South African experience has demonstrated that despite all the critisms with respect to the right to health, the right to health can be constitutionalized and litigated upon. By adopting the reasonable test approach, the courts have been careful not to encroach on the functions of other arms of government by adopting a standard of deference to the executive and the legislature. The constitutional court have persistently held that availability of resources does not constitute a bar to the justiciability of the right to health but rather it is "interpreted as a legal standard forming part of ESCR which aids the court in assessing governmental action of reasonableness under a balancing test."[90]

Nigeria stands to benefit from the South African experience by making health justiciable in the constitution and adopting the reasonable approach in assessing the government policies with respect to the right to health. In the absence of a constitutionally justiciable right to health in Nigeria, it can still review the actions or inaction of the state with respect to the right to health by adopting the reasonable approach.

The Indian courts on the other hand, have demonstrated that lack of constitutional protection of the right to health does not constitute an insurmountable difficulty with respect to adjudicating the right to health. The Indian supreme court having the final say on issues relating to the interpretation of the constitution, has proved to be proactive and has opened a new horizon to the interpretation of fundamental rights and Directive Principles by interpreting the two sets of rights harmoniously and complementary of each

[90] *Grootboom o*p.cit fn 28 Para 46

other particularly by giving an expansive definition of S. 21 protecting the right to life thereby creating new rights like the right to health and remedies to enforce them.

Alternatively and preferably, Nigeria can adopt the expansive and liberal definition of the right to life to include the right to health as an integral part of the right to life as demonstrated by the Indian Supreme Court. Health in Nigeria shares the same fate with India. Both are termed as directive principle of state policy and are non-justiciable under the constitutions. However, Indian Supreme Court have given the right to life a liberal interpretation as envisage by the United Nation General Comment 6 Para 5.

3.4 Application of International Human Right Approach to Health in Nigeria

Nigeria was ranked 156 out of 187 by the 2011 United Nations Development Programme (UNDP) despite Nigeria's abundant resources. This situation is worrisome and the question is how can international human right framework offer anything new to the health crises in Nigeria? Acknowledging a right to health can mainstream human rights into policy and programmes that affects the well- being of the population. International human rights can assist as it provides standard by which to evaluate Nigeria's conduct and can also be used to hold states accountable for its human rights violation.

Being a party to the major international treaties protecting the right to health, Nigeria is bound to realize the minimum core obligations as set out by the committee on Economic, Social and Cultural Rights in General Comment 3[91] and 14.[92]General Comment 3 specifically provides:

> The committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every state party.

[91]UN General Comment 3 " *Nature of States' Parties' Obligations"*(Fifth session, 1990), U.N.DOC.E/199/23,annex III, 86 (1990) (herein General Comment 3)
[92] United Nation CESCR General Comment 14 " *The right to the Highest Attainable Standard of Health"* (herein General Comment 14) (Twenty-Second session, 2000), U.N.DOC.E/C.12/2000/4 (2000)

> Thus, for example, a state party in which any significant number of individuals is deprived of … essential primary health care … is *prima facie*, failing to discharge its obligation under the covenant. … in order for a state to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources, it must demonstrate that every effort has been made to use all available resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.[93]

This has been reiterated by the Limburg Principles that "state parties are obligated regardless of the level of economic development, to ensure respect for minimum subsistence rights for all."[94] In the context of violation, the Maastricht Guidelines also provides that violation occurs where the state party to the covenant fails to satisfy the minimum core of the right to health to ensure satisfaction of, at the very least, minimum essential levels of the right to health.[95] The minimum cores are of immediate application and are therefore not subject to progressive realization and availability of resources. A state must take steps immediately to realize these core obligations by the adoption of legislation, policies, regulations etc. The ICESCR though, gives states flexibility on the measures that a state takes in realizing the right to health.[96]

Although there have not been reported cases on the minimum core in Nigeria, it can draw lessons from other jurisdictions. For example, the Indian Supreme Court has adopted the minimum core by the use of the phrases such as "what is minimally required" or the "essential minimum of a right" in many of its jurisprudence.[97] Columbia have also adopted the minimum core which is to be implemented immediately for some category of

[93] General Comment 3 Para 10

[94]Limburg Principles (herein Limburg Principles) Adopted 8 Jan 1987, UN ESCR, Comm Hum Rts, 43rd Sess. Agenda Item 8, UN.DOC E/CN.4/19987/17/Annex (1987). Reprinted in 9 Human Rights Quarterly 122 (1987) Para 25

[95]Maastricht Guidelines on Violation of Economic, Social and Cultural Rights as printed in Human Right Quarterly 1998: (20) 69(herein Maastricht Guidelines) Para 9

[96] Art 2 (1) ICESCR

[97]Chowdhury, J. (2009). Judicial Adherence to the Minimum Core Approach to Socio-economic Rights: A Comparative Perspective. *Cornell Law School Inter University Student Conference Paper .Retrieved 12/12/11, from* http://schorlarshiplaw.cornell/edu/ips_clacp/27

rights while other elements are to be progressively realized taking into consideration resource constraints.[98]

Therefore, the international legal framework imposes obligation on state parties interpreted and provided by general comment 14 which are non derogable.[99] The minimum cores are not expensive elements of a right or unreasonable demand that cannot be immediately implemented. General Comment 14 provides for the minimum core of the right to health and includes access:[100]

(a) immunization against major infectious diseases;

(b) measures to prevent; treat and control epidemic and endemic.

(c) essentials medicines as defined by WHO's Action Programme on Essential Drugs.

(d) reproductive, maternal (pre-natal and post-natal) and child health care.

(e) essential Primary Health Care.

(f) right of access to health care without discrimination especially for the poor and other vulnerable and disadvantaged groups.

(g) equitable distribution of health care facilities; goods and services.

The minimum core thus, addresses the basic needs of the poor to live a life in dignity. Many states shy away from their obligation to provide even the minimum core of the right to health on the pretext of non- availability of resources. There is a difference between 'unwillingness' and 'unable' to realize obligations under international law. A state

[98]Ibid. See also Yamin, A. and Oscar Parra Vera, The Role of Courts in Defining Health Policy: The Case of the Columbian Constitutional Courts. *Retrieved 12/12/11,from* *http://www.law-harvard.edu/programs/hrp/documents/ yamin_parra_working_paper.pdf*.

[99] Ladan, M.T. (2008).The Role of Law in the HIV/AIDS Policy: Trends of Case Law in Nigeria and Other Jurisdictions *Ahmadu Bello University, Zaria Press*

[100]General Comment 14 Para 43.

is unable to satisfy its obligations under a treaty where it has done all it can based on its available resources to provide basic health care and a state is unwilling to fulfill its obligations under a treaty where it has the resource but does nothing in attempt to provide basic health care. Such deprivation of the least core should be taken as a violation of the right to health. Thus, Forman explained that "the core is intended to indicate that denying basic health needs where there is no scarcity but rather uncaring, corrupt or neglectful governance is a human rights violation of the highest order."[101]

3.5 Nigeria's obligations under the international and regional instruments protecting the right to health

States obligation with respect to the right to health goes with the states ratification of international treaty to create a tripartite obligation to wit: obligation to respect, protect and fulfill the right to health. Having ratified the major international and regional instruments recognizing and protecting the right to health, Nigeria thus, has the legal obligation to respect, protect and fulfill the health of its citizens.

3.5.1 Obligation to respect

The obligation to respect with respect to the right health under international law implies that Nigeria to "refrain from interfering directly or indirectly with the enjoyment of the right to health to its people."[102] This imposes a negative duty on the part of Nigeria not to interfere with the enjoyment of the right to health of people within its territory. This obligation is further elaborated by the Committee on Economic, Social and Cultural Rights (CESCR) in the context of the right to health that states should not interfere by "denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and all illegal immigrants to preventive, curative and palliative

[101] Forman, L. What future for the minimum core? Contextualizing the implications of the South African socio-economic rights jurisprudence for the International Human Right to Health Global Health and Human Rights: Legal and Philosophical Perspectives J., Harrington & M, Stuttaford eds. Routledgep. 68. Retrieved 18/12/11, from ssrn: http://ssrn.com/abstract=1758848.
[102] General Comment 14 Para 33

services; and abstaining from imposing discriminatory practices relating to women's health status and needs."[103]

Nigeria's obligation to respect the right to health should be non-discriminatory on the basis of race, color, sex, language, religion political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil political, social or other status."[104]

In fulfilling its obligation to respect, Nigeria must ensure that its actions, laws and policies do not inhibit the enjoyment of the right to health. A state violate its obligation to respect the right to health where it adopts laws, policies that contravene or limit the enjoyment of the right to health e.g. laws that inhibit women from access to reproductive health services and information violates a state's obligation to respect.

Further, a state is in violation of its obligation to respect where it repeals or suspend laws, policies or programs that are in existence that protects the right to health, or denies its people within its territory access to health facilities, goods and services, or provide such services on discriminatory basis. E.g. the African Commission in the case of *SERAC vs Nigeria*[105] found that Nigerian government had violated its obligation to respect. It held that government are prohibited from directly threatening the health and environment of their citizens and found that the duty to respect these rights largely entails non-interventionist conduct from the state such as refraining from carrying out, sponsoring or tolerating any practice, policy or legal measures that violate the integrity of the individual.

[103]Ibid Para 34
[104] Ibid Para 18
[105] Suit No ECW/CCJ/APP/08/09 and RUL NO ECW/CCJ/APP/07/10 (ECOWAS,Dec.10, 2010

A state must not take retrogressive measures in its health related policies, programmes or practices e.g. cut back in resources allocated to health is a violation of states obligation to respect the right to health. Nigeria's allocation to health had experienced cuts back. For example, in 2007 -2010 the percentage allocated to health in the budget was 5.4%, 5.9%, 5.1% and 4.0% respectively. [106]This is far below the pledged 15% agreed at the Abuja Declaration[107] which was reinforced in the Maputu Declaration[108]and shows a clear violation of obligation to respect.

A state should desist from entering into multilateral or bilateral agreement with states or international organization that have adverse effect on the enjoyment of the right to health e.g. agreement with International Monetary Fund (IMF), World Bank [109] usually results in a state adjusting its laws, policies or programmes and replacing in its place laws, policies or programmes that have adverse effect on the enjoyment of the right to health. For example the adoption of austerity measures by the Nigerian government in the early 1980s further exercabated the level of poverty in the country which consequently affected the accessibility and affordability of health care. The introduction of user fees as a result of the austerity measures led to direct competition between the cost of medical treatment and other personal and family cost.

CESCR explained further that in respecting the right to health, states should not pollute the air, water and soil, urges states to protect the environment from harmful practices in mining and oil production and also desist from testing nuclear weapons whose substance has negative or adverse impact on the enjoyment of the right to health.[110] The case of

[106] Federal Ministry of Finance, Abuja
[107] Organization of African Unity: Abuja Declaration on HIV/AIDS, Tuberculosis and other Relate Infectious Diseases. Addis Ababa: OAU 2001, Abuja (Abuja Declaration).
[108] African Union: Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and other Related Infectious Diseases: Addis Ababa: A.U, 2003 (Maputo Declaration).
[109] Asher, J. (2004). The Right to Health: A Resource Manual for NGOs *Common wealth Medical Trust*
[110]General Comment 14 Para 34

SERAC vs Nigeria represents a typical example of violation of the obligation to respect with respect to clean environment.

3.5.2 Obligation to protect

Nigeria's obligation to protect the right to health entails states protecting the right against violation by third parties. A state is therefore, in violation of its obligation to protect where it does not take the necessary steps to protect its citizens against acts of third parties (individuals, groups or corporation) that inhibit their enjoyment of the right to health. Thus, state responsibility to protect with respect to the right to health includes adopting or taking:

> measures ensuring equal access to health care and health related services provided by third parties to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services, to control the marketing of medical equipment and medicines by third parties and to ensure that medical practitioners and other health professionals meet appropriate standard of education, skills, and ethical codes of conduct.

Privatization of health care can impact negatively on the right to health[111] particularly on the availability, acceptability, accessibility and quality (AAAQ) of healthcare, goods and services. States that opt to privatize their health care will have their obligation shifting from obligation to fulfill to obligation to protect in the sense that states must ensure that the providers of healthcare respect human rights standard and failure to do so would mean violating the obligation to protect the right to health. The consequence would imply neglecting the vulnerable and marginalized members of the society who generally go with-out health insurance as they cannot afford it. When a state privatizes its health care, it is no longer in direct control of health care. The private sector is in direct control and

[111] Toebes, B. Taking a Human Right Approach to Healthcare Commercializationp. 444. *Retrieved 18/06/11, fromhttp://www2.warwick.ac.uk/fac/cross_fac/healthatwarwick/research/currentfundedres/healthandhumanrights/liverpool/brigit.doc.*

generally private sector is out to make profit rather than taking the interest of people at heart.[112]

The obligation of states to protect the right to health in situation where the state privatizes is to ensure that " health care services …are available, accessible and of good quality"[113] and to "enact legislation that ensures that private health care providers provide health care services that meet the quality and accessibility standard" and make sure that " mechanism are in place for patients to seek legal redress if they have received inadequate or untimely care."[114]

State should take measures to control the marketing of medical equipment and medicines by third parties and also ensure that "medical practitioners and other health professionals meet appropriate standard of education, skill, and ethical code of conduct."[115]

States are also obliged to ensure that harmful social and traditional practices do not interfere with access to pre- natal and post natal care and family planning; to prevent third parties from coercing women to undergo traditional practices e.g. female genital mutilation (FGM), early marriage widowhood practices e.t.c. There is today in Nigeria the National policy on FGM and the Child Rights Act has prohibited the practice of FGM.[116]Also some states in Nigeria have enacted Laws prohibiting certain traditional practices e.g Edo,[117]Cross Rivers,[118] Anambra,[119]Rivers[120] States. Obligation to protect also include taking measures to protect all vulnerable or marginalized groups of society,

[112] Ibid p. 446
[113] Ibid
[114] Ibid
[115] General Comment 14 Para 35
[116]See Ladan, M. T. (2013). Women's Rights are Human Rights A paper presented at the Nigerian Institute for Advanced Legal Studies (NIALS) Law Summit 3-6 June, 2013, Transcorp Hilton Hotel, Abuja p. 17
[117]Edo State Prohibition of Harmful Traditional Practices Law, Laws of Edo State of Nigeria, 1999, Inhuman Treatment of Widows (Prohibition) Law 2004, Edo State.
[118] Cross Rivers State Prohibition of Harmful Traditional Practices Law, Laws of Cross Rivers State, 2000
[119]Malpractices Against Widows and Widowers (Prohibition) Law, 2005, Anambra State.
[120]Dehumanizing and Harmful Traditional Practices Law of 2003, Rivers State, Abolition of Female Circumcision Law, No.2 of 2001, Rivers State.

in particular women, children, adolescent and older persons, in the light of gender based expression of violence e.g. rape, domestic violence etc.[121]

The right to information is an important element of the right to health particularly as it relates to women's reproductive health. States obligation to protect the right to health imply that state should ensure that health related information is disseminated adequately and that no third party should "limit access to health related information and services."[122]

States should ensure that third parties do not engage in activities that would pollute the air, environment and the soil which will have negative impact on the enjoyment of the right to health of the population. For instance, the African Commission on human rights in *SERAC v Nigeria*[123] found that Nigeria had violated its duty to protect by failing to prevent a private multinational oil company from polluting the environment. In the case of *Jonah Ghambre vs Shell BP*[124] the applicants instituted an action against the respondents over the effects of gas flaring in their environment and on their health which violated S 33 (1), and S 34 (1) of the Constitution and also Articles 4, 16 and 24 of the African Charter on Human and People's Rights. The court ordered the respondents to restrain from further gas flaring in the applicant's community and also ordered the respondents to put in motion a process for the enactment of a bill for an Act of the National Assembly for speedy amendment of the Associated Gas Re- injection Act and the Regulations made there under.

3.5.3 Obligation to fulfill

States obligation to fulfill requires states to adopt "appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the

[121] General Comment 14 Para 35
[122] Ibid
[123] Communication 155/96 Para 63
[124] (2005) Unreported Suit No. FHC/B/CS/53/05 per Justice C.V. Nwokorie

right to health."[125] A violation of the obligation to fulfill occurs where the state concerned fails to take "concrete steps" that are "deliberate and targeted" for the enjoyment of the right to health. One of the measures required as taking concrete and targeted steps is the adoption of measures particularly legislative and judicial measures which facilitate holding government accountable to violation of the right to health and also adopting a national health policy which will specify in details, plan for progressively realizing the right to health.[126]

It also entails the budget of the state to be health responsive. The budget being an important mechanism for the protection of the right to health, an appropriate allocation of resources to the health sector could improve the lives of millions in need of health care particularly the vulnerable and marginalized members of the society. Thus, it would amount to states violation of the obligation to fulfill the right to health where there is a cut in the budget on health, or where the allocation is insignificant as compared to e.g. defense or where the allocated resource ends up in private pockets. Any misallocation of funds which impairs in the enjoyment of the right to health necessarily implies a violation of states obligation to fulfill the right to health.

A state is also under an obligation to protect public health by ensuring that "provisions of health care, including immunization programmes against major infectious diseases are put in place."[127] As part of its obligation to fulfill the right to health in relation to public health, the state is to ensure the provision of "underlying determinant of health which include nutritiously safe food, and portable drinking water basic sanitation, and adequate housing and living condition."[128] The CESCR notes that a state is in violation of its

[125]General Comment 14 Para 36
[126] Ibid Para 36
[127]General Comment 14 Para 36
[128] Ibid

obligation to fulfill where it fails to provide the most basic underlying determinant of health.[129] E.g. a state is in violation of its obligation to fulfill where it has foodstuff in its store houses but leaves a segment of the population to die of hunger,[130] or where the state maintains laws that denies its population access to water.[131] For a state to absolve itself from this obligation based on non-availability of resources, it must "demonstrate that every effort has been made to use all available resources that are it disposal in an effort to satisfy as a matter of priority those obligations."[132]

To fulfill its obligation to fulfill in the context of women's rights to reproductive services, a state must provide "reproductive health services including safe motherhood particularly in the rural areas."[133] Thus, it will amount to violation where a state limits its reproductive health services to the urban area thereby excluding women in the rural area who are most in need of the services. That is to say that such service should be provided in a nondiscriminatory manner between urban and rural areas. This is in accordance to international instruments prohibiting discrimination on any ground.

3.6 Effective Remedies for the Violation of the Right to Health

The CESCR has mandated states to provide for an effective remedy for the violation of the right to health in order to give domestic legal effect to the right to health. The relevant provision provides " everyone has a right to an effective remedy by the competent national tribunal for acts violating the fundamental rights granted him by the constitution or by law."[134] This is in consonance with the provision of article 8 of the UDHR which

[129] Ibid
[130] *Peoples Union of Civil Liberties (PUCL) v Union of India and ors W.P.* (Civil) No. 196/2001
[131] Maastrich Guidelines Para 14. See also the case of *Mazibuko & ors v City of Johannesburg & ors (herein Mazibuko)*(2009) Z A CC 28, 2010 (3) BCLR 239 (CC); 2010 (4) SA 1 (CC).
[132] General Comment 14 Para 93
[133] Ibid. See also Art 14 (2) (b) CEDAW op.cit fn 38
[134] General Comment 9 Para 3

provides "everyone has the right to an effective remedy by the competent national tribunal for acts violating the fundamental rights granted him by the constitution or by law."

The requirement of effective remedy is further emphasized by the Optional Protocol to the Economic, Social and Cultural Rights (OP-ESCR)[135] which required that for the CESCR to consider any communication from individual or groups, domestic legal remedies must have been exhausted. This provision presupposes the fact that a state must have justiciable right to health which is capable of effective judicial remedies in cases of violation.

Although, the CESCR does not provide for the exact way or manner in which a state could give legal effect to the right to health, whatever measures adopted by a state must be appropriate and fulfilling the states obligations under the covenant. The CESCR provides:

> The covenant does not stipulate the specific means by which it is to be implemented in the national legal order. And there is no provisions obligating its comprehensive incorporation or requiring it to be accorded any specific type of status in national law. Although the precise methods by which the covenants rights are given effect in national law is a matter for each state party to decide, the means used should be appropriate in the sense of producing results which are consistent with the full discharge of its obligations by the states parties.[136]

Though, the CESCR had highly recommended justiciability of the right to health as an effective means of giving it domestic legal effect, it had however indicated that effective remedy need not be interpreted as always requiring a judicial remedy and as such, other range of remedies could be utilized for the violation of the right to health such as administrative, legislative, budgetary, educational, social etc. in giving effect to the right

[135] See Art 3 (1) Optional Protocol to the –Economic Social and Cultural Rights (OP-ESCR).
[136] General Comment 9 Para 5

to health.[137] Whatever type of remedy adopted by a state would be subject to scrutiny by the CESCR when the state submits its periodic report. In the report, states must indicate their preference to whatever type of remedy they adopt. That is to say, why a state believes it is more "appropriate" and "necessary" over others, particularly judicial remedies.[138]

Denying remedies for ESCR including the right to health, would amount to a violation of the right to health and also is inconsistent with the principle of the rule of law one of which elements is the protection of fundamental human rights and an effective remedy for the violation of fundamental human rights. Courts must therefore, as part of the function of judicial review and respect for the rule of law, fashion remedies for the violation of the right to health as indicated by CESCR which provides:

> Within the meaning of the appropriate exercise of their functions of judicial review, courts should take account of covenant rights where this is necessary to ensure that the state's conduct is consistent with its obligations under the covenant. Neglect by the court of this responsibility is incompatible with the principle of the rule of law which must always be taken in to include respect for international human rights obligations.[139]

Effective remedies for the violation of socio- economic rights, including the right to health is something that Nigeria has to grapple with being a new right that is being clarified. Some of the available judicial remedies for the violation of the right to health granted by states with developed jurisprudence on socio economic rights including the right to health that Nigeria could borrow from include:

[137] General Comment 3 Para 7
[138] Ibid Para 3, Limburg Principles Para 19
[139] General comment 9 Para 14

3.6.1 Declaratory order

This is an order of the court which spells out that a particular violation has occurred without indicating how the violator will remedy such violation. Several cases are illustrative e.g. the South African case of *Grootboom* where the court only set out the requirement of S. 26 (2) of the South African constitution as being inconsistent with the reasonable test and that the state housing program was unconstitutional as it left out a significant section of the society who were in most dire need of housing. The court did not however, indicate how the government should go about remedying the inconsistency. The Indian case of *Unikrishnan J.P vs State of Andhra Pradesh* (*Unikrishnan)* is also illustrative of a declaratory order where the court only stated in the order that the right to education is implicit in and flows from the right to life guaranteed under art 21 of the Indian constitution and stopped there.

The issuance of declaratory order by the courts is based on the assumption that the state will comply in good faith with the courts order. The problem with declaratory order is that it is only successful where the state is sensitive to the plight of the people, respects the rule of law. It was equally held in the Canadian case of the *Little Sisters vs Canada*[140] that declaration "suffer from vagueness, insufficient remedial specifity, an inability to monitor compliance and an ensuing need for subsequent litigation to ensure compliance." In the Indian case of *Unikrishnan* for example, it took the state of India nine (9) years to respond to the court order and in the case of *Grootboom* the petitioner Irene Grootboom was said to have died living in shacks with no alternative housing. Infact, years after Grootboom, it has been said that the decision in *Grootboom* had little impact on the

[140] (2000), 2 SCR 1120 at 258-61

housing programmes in South Africa as it did little to help those in the same condition as Irene Grootboom.[141]

3.6.2 Mandatory Order

Mandatory orders are defined as " an order expressed in positive terms requiring the person to whom it is directed to undertake positive steps to remedy a wrong which he/she is responsible."[142] That is to say that the courts do not stop at stating that the law has been violated, but goes further to prescribe measures which the state should take in remedying the violation. This is particularly so in cases where the court has evidence of non-compliance of the court order as was indicated in the *TAC* case where the minister of health was televised indicating that the state would not comply with the order of the court. Some scholars have described this remedy as the most effective in terms of enforcing socio- economic rights including the right to health.[143]

The application of this order is illustrated in the case of TAC where the court directed the state to remove all restrictions preventing doctors at public hospital from dispensing Naviraphine and to provide for dispensing at public hospitals and clinics and to provide testing and counseling at such facilities.[144] Also in the Indian case of *Paschim Banga*[145]the court required the state to "ensure that primary health centers are equipped to provide immediate stabilizing treatment for serious injuries and emergencies." The court also ordered the state to " increase regional clinics around the country available to treat

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[141]Pillay, L. (2002).Implementing Grootboom: Implication for the enforcement of Socio- Economic Rights.Law, Democracy and Development Vol. 6, No. 2.Retrieved 25/12/11, from*www.idd.org.za/index.php?...189%3Aimplementation_of_grootboom*.
See also Pillay, L. (2000). Implementing Grootboom: Supervision Needed*ESCR Law Review vol. 3 no. 1. Retrieved 25/12/11 from www.escr-net.org/.../kameshni_pillay_ implementing _Grootboom*

[142]Mbazira, C.(2008). You are the Weakest Link in Realizing Socio-Economic Rights: Goodbye Strategies for Effective Implementation of Court Orders in South Africa *Socio-Economic Rights Project, Community Law Center University of Western Cape. Pp.210 P 24*

[143]Ibid. See however, Edobalahi, M *.op.cit* p. 1565 who argued that mandatory orders are ineffective in delivering transformation for Socio-economic rights and hence not an effective remedy for the violation of same.

[144]*Treatment Action Campaign v Minister of Health* (2002) (5) SA 703, 721 (herein *TAC Case*)at 765

[145]1996 (4) SCC 37.

serious injuries and also to create a centralized communication system among state hospital so that patients could be transported immediately to the facilities where space is available." [146]

3.6.3 Structural Interdicts

Where the government is insensitive to courts findings and the behavior of non-compliance and flaunting court orders is chronic and endemic, structural interdicts becomes the most effective remedy for the violation.[147] Structural interdict mean where the court finds that the state is in violation of the right, it gives the state a margin of discretion to choose the manner in which it would remedy such violation but under the active supervision of the court.

Structural interdict is usually the last remedy resorted to due to the fact that after the closure of the case, the court becomes actively involved in the implementation of its orders and its expenses. Though, circumstances usually dictate when to grant such an order. There are circumstances that the granting of a declaratory order is sufficient to compel compliance from the state where the state respects the rule of law and courts directives. However, where the state is intransigent, structural interdict will be more appropriate and effective.

What the court does is that it makes a declaratory order and directs the state to make a report usually under oath on how to remedy the violation including a timeline within which the state would act to remedy the violation. The state is then expected to report back to the court the court with the report for evaluation. The court then evaluates the

[146]Kathori, J. (2004).Social Rights and the Indian Constitution. Law, Social Justice and Global Development (LGD*). Retrieved 15/12/11, p. 26*

[147]Structural interdicts has however, been criticized that judges have gone too far in encroaching into the realm of the executive. See Hopkins, K., op.cit fn 115.See also the case of *Daucet-Boudreau v Nova Scotia(Min. of Education)* (2003) 3 SCR where in a dissenting judgement the judge argued against the granting of structural interdicts and went to the extent of referring to it as a political remedy that was inappropriate for a judge to make.

report and makes amendments if there is any need before it endorses same. The court then issues a final order mainstreaming the state plan and any amendment made by the court. Refusal of the state to honor the final order amounts to contempt of court and contempt proceedings begins against the state.[148] Structural interdict has the advantage of bringing together the judiciary and the executive or legislature together in a dialogue, more especially where the state needs further clarification on its constitutional duties with respect to the case at hand.

The South African constitutional court are always cautious in granting structural interdict perhaps because of its effect on the traditional principles of separation of power as it involves the court actually being involved in the execution of the law which is in truth the domain of the executive. The courts however, have consistently held that it has the power to grant such remedy as it held in the case of *TAC* that " the power to grant mandatory relief includes the power where it is appropriate to execute some form of supervisory jurisdiction to ensure that the order is implemented."[149]

Despite the effectiveness of structural interdicts, it has its own short comings. It is expensive and that is why it is usually the last to be resorted to. Secondly, there is the possibility that the state may refuse to honor the final order which would lead to contempt proceedings. Contempt proceeding takes the litigants back to square one which can be frustrating especially for the victim of violation which has the effect of making the victim lose hope as the judiciary is their last resort for the enforcement of their rights and if it cannot make the state to enforce their rights then who can?

[148]Edobalahi, M. Using Structural Interdicts and the South African Human Rights Commission to Achieve Judicial Enforcement of Socio- Economic Rights in South Africa. *N.Y.U L .Rev. p. 1565 at 1582.*
[149]*TAC Case* Para 104. The Indian courts on the other hand are more liberal in granting and retaining supervisory jurisdiction may be because of lack of trust on the state to implement court orders and therefore the courts take it upon themselves to be aggressive enough to retain such supervisory jurisdiction.

There is the general problem of non-enforcement of court orders by the state which is not peculiar to a particular jurisdiction but a problem that is faced in almost all jurisdictions. For instance, in the case of *Grootboom* the court issued a declaratory order believing in the state to act in good faith and honor the order, but unfortunately, the state did not comply. This brings to light the fact that even where parties obtain positive judgment, it is not always that it will bring any change. Infact, in some cases, another Pandora's Box is opened and a new beginning for another challenge for the judgment creditor.

The failure of the state to comply with court orders could be attributed to many factors and according to Mbazira include lack of political will, lack of understanding between the arms of government, respect for the rule of law and lack of transparency in the implementation of court orders.[150] In most circumstances, it takes more than court orders to achieve the desired compliance of the state. Resort is usually made to advocacy and social mobilization and even threat of contempt or contempt proceedings to compel the state to comply with court orders. For instance, in the case of *TAC*, the court resisted the pressure from the amicus curie to order for structural interdict holding that " there were no grounds for believing that the Government would not respect and execute the orders of the court."[151] However, the state did not comply with mandatory order of the court and after all pressure from the TAC, it finally had to resort to contempt proceedings against the state.

Conclusively, courts play an important and significant role in remedying violation of SER including the right to health. Despite the problem of enforcement of court orders by the state, the role of the court in the promotion and protection of the right to health cannot be undermined.

[150]Mbazira, C. op cit fn 142 p. 39
[151] *TAC* Case Para 129

3.7International Monitoring Mechanisms for the protection of the Right to Health

Prior to Dec. 2008, the only international mechanism for monitoring state's obligation with respect to the right to health was the system of state reporting established by the ICESCR. However, by December 10, 2008, the United Nation General Assembly adopted the Optional Protocol to the ICESCR (OP-ICESCR) which allowed individual complaint for the violation of rights contained in the covenant.

3.7.1 Reporting System under Art 16 and 17 ICESCR

The system of state report to the CESCR is established under Art 16 and 17 of the ICESCR. Art. 16 provide "the state parties to the present covenant undertake to submit in conformity with this part of the covenant reports on the measures which they have adopted and the progress made in achieving the observance of the right recognized therein".

The objective of the report system as envisage by Art.16 is to assist states parties to the covenant to fulfill their obligation under the covenant[152] and to help the CESCR and state parties to monitor the progressive realization of the right to health.[153] State parties report must contain certain information such as the available national legislation, administrative and practices in an effort to ensure the fullest possible conformity with the covenant.[154]

State parties must also furnish information with respect to any difficulty (ies) if any encountered in realizing the rights contained in the covenant.[155] This is important because it assist states understand the problems and short comings and to overcome such difficulties by providing framework within which more appropriate policies can be

[152]General Comment 1*"Reporting by States Parties"* (herein General Comment 1) Para 2
[153]Ibid Para 3
[154]Ibid Para 2
[155]ICESCR Art.17 (3)

devised.[156] It will also help the CESCR in making comparism with other states and make a basis for making the international community to assist member states of the covenant as provided under art.22 and 23 of the ICESCR and also compare notes with other state on how to effectively fulfill the right under the covenant.[157]

The CESCR has developed detailed guidelines which specify the kind of information needed and thus will assist states in the preparation of their report thereby enhancing state party's compliance with the provision of the covenant. With respect to the right to health, the guideline provides that state must furnish the CESCR with the following information relating to the general health status of the population (physical and mental health) accessibility, availability, acceptable and quality of health services, the situation of vulnerable sectors of the state e.g. women, children, persons with disability, migrants, minorities etc., the progressive nature of the measures undertaken by the state, the situation of HIV/AIDS in the state and the preventive measures taken by the state, the health status of prisoners, budgetary information with respect to the right to health.[158]

State parties to the covenant must submit report within two years of the entry into force of the covenant and subsequently every five years. After examining the report and oral presentation of the state party, the CESCR makes its concluding observation which constitutes the decision of the CESCR on the status of ESCR of the particular state. The concluding observation contains positive aspects of implementation, principal subjects of concern, suggestions and recommendation. It also indicates whether the state has failed in its obligations under the covenant. The concluding observation is however, not legally binding on state parties and thus lacks an enforcement mechanism.

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[156]General Comment 1 Para 8. See also the Limburg Principle Para 76
[157]Ibid Para 9
[158]Office of the High Commissioner of Human Rights, Fact Sheet No. 16 (Rev.1).The Committee on ESCR. Retrieved 12/09/11, fromhttp://www.unhchr.ch/htm//menu6/2/fs16.htm *16 (herein Fact Sheet No. 16)

The nonbinding nature of the CESCR observation weakens the monitoring mechanism as some scholars argued that the system is like a toothless bulldog that barks and does not bite.[159] The Limburg Principles provides that the effectiveness of the supervisory mechanism depends on submitting of reports on time by states parties to the covenant.[160] Though, one of the problems encountered by the nonbinding nature of the observations of the CESCR is that state parties are reluctant to submit report as at when due and or submit report very late which creates backlog for the CESCR. Though the CESCR goes ahead to consider the ESCR of a state even if the state party does not submit report or is not ready for constructive dialogue with the CESCR based on the available information, this however goes contrary to " the idea that the reporting system was set up to safeguard upon infringement of state parties' obligation under the ICESCR"[161]

Despite its weakness, the state report system has many advantages which make its presence important and necessary. First it boosts the image of the ratifying state at the international stage to be complying with human rights standards. That is to say that states would be seen to be serious and dedicated to human rights in their state and thus, has the effect of influencing state parties to respect their obligation under international human rights to health. Secondly, by ratifying the covenant, state parties should be seen to have done so in good faith as provided by art 26 of the Vienna convention on the law of treaties.

Also, state parties are able to monitor their own progress with respect to their obligation under the covenant. By this, they are able to address their shortcoming and difficulties faced in terms of implementation of the covenant and also plan and develop policies to

[159] Ding, G. (2009). The case for a Right to Health in a Globalizing World. *An MPhil Thesis submitted to the University of Aberystwyth. Retrieved on 12/05/11 from www.cadair.aber.ac.uk/dspace/handle/2160/.../-*
[160]*Para 74, Limburg Principles.*
[161]Office of the High Commissioner of Human Rights, Fact Sheet No. 16 (Rev.1).The Committee on ESCR. Retrieved 12/09/11, fromhttp://www.unhchr.ch/htm//menu6/2/fs16.htm *16 (herein Fact Sheet No. 16)

address their problems .This has been reiterated by the Limburg Principle that that " states should view their reporting obligations as an opportunity for broad public discussion on goals and policies designed to realize the right to health."[162] Reporting also assist states in engaging in constructive dialogue with the CESCR thus, facilitating the sharing and exchanging of ideas and information with the committee and other states. It also facilitates the harmonization of national laws and policies with the states international obligations.

Having ratified the ICESCR in 1993, Nigeria is bound to submit its periodic report to the Committee on Economic, Social and Cultural Rights in accordance with Art 16 of the ICESCR. In 1998, Nigeria submitted its initial report to the Committee. The Committee noted that the report did not conform with the guidelines the committee had established and that the additional information was received too late to enable its translation. The Committee further noted that the Nigerian delegation acknowledged that it was not equipped with detail and up to date facts and statistics required to satisfactorily answer the list of issues submitted by the Committee to the Nigerian Government eleven months earlier.[163]

The Committee also noted with concern that gross under funding and inadequate management of health services led to the rapid deterioration of health infrastructure in hospitals. The committee further noted the low budgetary allocation to health and also the fact that patients have to buy their drugs, hospital supplies and even bed space in the hospital. Nigeria's second report was due to be submitted since 30 June 2000.[164]

[162] Limburg Principles Para 76
[163]Para 1 Committee on Economic, Social and Cultural Rights Concluding Observation: Nigeria Retrieved on 15/08/12 from sim.law.uu.nl/SIM/caselaw/uncom.nsf/084bb175b68baaf7c125667f004cb333/7a01783ad7beff80cl2566970037cbb?OpenDocument
[164] Para 28 Ibid

3.7.2 Optional Protocol to the ICESCR

The optional protocol to the ICESCR was adopted amidst controversies on the 10th Dec. 2008.[165] The adoption of the OP-ICESRC was described as "closing a historic gap in human right protection under the international system"[166] and hence finally affirmed to the international community the interrelatedness, interdependence and indivisibility of human rights.[167] The OP-ICESCR is a complaint mechanisms which allows individuals to submit written complaint (communication) to the CESCR with respect to the violation of any of the rights contained in the ICESCR like the right to health. Its adoption therefore empowered the CESCR to exercise a quasi-judicial function with respect to the right to health as part of ESCR and thus develop a better understanding of the scope and nature of the right to health and helps in developing jurisprudence on the right to health. The adoption of the OP-ICESCR raises the standard of the right to health to be treated not just as an aspiration or Programme of state. This was well captured by Mellish when she said that the OP-ICESCR is necessary

> …not only to increase the stature and seriousness accorded to the ICESCR, but, by allowing the committee to speak directly to concrete instances of abusive conduct, to provide more effective protection to individuals victims and clearer normative protection, guidance on the nature of the rights and the scope of legitimate restrictions on them in distinct context. By engaging states in discussion of appropriate responsive measures to particularized abuses, it could moreover, better encourage the development of effective remedies and increase public attention to economic, social and cultural rights.

[165]There still remain controversies over the adoption of the OP-ICESCR. Some view it as not necessary due to the nature of the rights in the ICESCR see for example Dennis J. N. and Steward, P.D. (2004).Justiciability of Economic, Social and Cultural Rights: Should there be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing and Health? *American Journal of International Law Vol. 98 p. 462*

[166] Statement by the commissioner for Human Rights Ms Navenathan Pillay official records 65th plenary meeting, U.N.DOC.A/63/PV.66,Wednesday 10 December 2008 cited in Langford, M. Closing the Gap; An Introduction to the OP-ICESCR .*Retrieved on 12/12/12 from www.escr-net.org/usr_doc/closing_the_gap.pdf.*

[167]Vienna Declaration. Adopted 25 June 1993, reprinted in (1993) 14 Human Rights Law Journal 352 (5).

The CESCR receives complaints from individual (s) and also inter-state complaints, examines them, transmit its views and recommendation(s) to the state party concerned. Its views and recommendations are however not legally binding on states.

The much awaited OP-ICESCR came into force 5 May 2013. Whether the OP-ICESCR will protect the rights of the individual with respect to the rights contained in the ICESCR is yet to be seen. But its adoption is no doubt an important step in assisting the CESCR in developing a body of jurisprudence and "dealing with concrete harms to individuals caused by identifiable state conduct."[168] Nigeria has neither signed nor ratified the OP-ICESCR.

[168]Mellish, T. (2009).Introductory Notes on the OP-ICESCR*ILM XXX* (2009) p. 10.

CHAPTER FOUR

DOMESTIC IMPLEMENTATION OF THE RIGHT TO HEALHT IN NIGERIA: ISSUES, CHALLENGES AND PROSPECTS

4.1 Introduction

Health is one of the most important services provided in every country of the world. Providing access to good and quality health care services is therefore, a productive investment any government can make, as a healthy population is potentially a more productive population. Good health provides foundation for the enjoyment of other fundamental rights as a population that is not healthy cannot learn, cannot work and cannot develop. No nation can maintain a steady development and growth in the absence of an adequate health care system.

The issue or matter of health or access to it by citizens in Nigeria has been one of the longest challenges government over the years had been grappling with. The ever increasing populations in the country continue to put a lot of pressure on the existing facilities which were infact, inadequate in the first place. The main focus of the discussion in this chapter of the research is to consider the major legislations establishing the various institutions in the country whose primary objective is the delivery of health services to the citizens. These include Federal Ministry of Health (FMOH) and other agencies designed to protect the health of citizens. It is equally intended to consider all issues including policies and laws on the production, distribution and dispensation of drugs. The epilogue of the discussion accesses the penal process over erring medical practitioners and equally try to determine whether totaling all the issues above had infact led the country to the promised land of advancing or promoting the right to health.

While it is however, conceded that health under the 1999 constitution is technically non justiciable, the government in the discharge of the duties imposed[1] upon it to realize the objectives in chapter II, had passed a number of legislation, policies and has established institutions and taken far reaching executive actions designed to give effects to this obligation. These measures can broadly be classified into four categories for easy reference. They include:

a. Legal protection:

   i. Constitutional protection of the right to health in Nigeria

   ii. Child Right Act 2003

   iii. African Charter on Human and Peoples' Rights

b. Review of the implementation of the right to Health through Health policies in Nigeria

c. Health institutions and their regulatory bodies; and,

d. Legislation dealing with access to essential medicines and qualitative drugs.

4.2 Legal protection of the Right to Health in Nigeria

4.2.1 Constitutional Protection

The Nigerian government like any other nation of the world had made several pronouncements in the constitution for the general welfare of its citizens including the provisions of health care. The constitution is the ground norm of the country. Its provisions are supreme and have a binding force and any law that is inconsistent with its provisions is declared null and void to the extent of its inconsistency.[2] It spells out the underlying and unifying values of society and spells out the basic rights of individual citizens. The constitution protects human rights in its chapters II and IV. The provisions of chapter IV are entrenched as Fundamental Right and include the right to life, dignity of

[1] S13Constitution of the Federal Republic of Nigeria 1999 as amended 1999 (1999 Constitution FRN)
[2]S.1 (3) 1999 Constitution FRN.

the human person, personal liberty, fair hearing, private and family life, freedom of thought, conscience and religion, freedom of expression and the press, peaceful assembly and association, freedom of movement, discrimination and right to acquire and own immovable property.[3] Chapter II on the other hand, are the Fundamental Objectives and Directive Principles of State Policy (DPSP) and include political objectives, economic objectives, social objectives, educational objectives, foreign policy objectives, environmental objectives, directives on Nigerian Culture, obligations of the mass media, National ethics and duties of the citizen.[4] The fundamental difference between the two sets is that while Fundamental Rights are enforceable, the DPSP are not and cannot therefore be entertained by any court of law in the country. However, S 13 of the constitution placed a responsibility on the three arms of government to observe and promote the observance of the provisions of chapter II of the constitution. Thus, the three arms of government have a responsibility to observe and promote the provisions of DPSP including right to medical treatment in the event of sickness.

Apart from the provision of S 13 of the constitution, other provisions of the constitution protect the welfare of the Nigerian citizens. For example, the Constitution declared that "Nigeria shall be a state based on the principles of democracy and social justice"[5] and went further to assert that the "security and welfare of the people shall be the primary purpose of government."[6] This indicates that the government would cater to some extent (base on available resources) to the welfare of its citizens including the provision of medical services and facilities in the event of sickness. To this end, the constitution avers that the "state shall within the context of the ideals and objectives for which provisions are made in this constitution control the national economy in such manner as to secure

[3] Ss 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, & 43, 1999 Constitution FRN respectively.
[4] Ss 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23 & 24 1999 Constitution FRN respectively.
[5] S. 14, 1999 Constitution FRN.
[6] S. 14 (b) Ibid.

the maximum welfare, freedom and happiness of every citizen on the basis of social justice and equality of status and opportunity"[7] and also state that "the material resources of the nation are harnessed and distributed as best as possible to serve the common good"[8] of the state which include the medical facilities and services. To achieve this purpose the constitution enshrined the provisions of chapter II termed as Fundamental Objectives and Directive Principles of State Policy (herein Fundamental Objectives). The chapter contains ideals that are pursued by the government towards building a welfare state.[9]

The Constitutional Drafting Committee (CDC)[10]defined Fundamental Objectives as "ideals towards which the nation is expected to strive while the directive principles lay down the policies which are expected to be pursued in the efforts of the nation to realize the national ideals."[11]

The relevant provision of the constitution which refers to health are S. 17 (3) (c) and (d) which specifically mandated the government of Nigeria to "direct its policy towards ensuring the health, safety and welfare of all person in employment are safeguarded and not engendered or abused" and that "there are adequate medical and health facilities for all persons." Other provisions of the constitution which impliedly protect the right to health are found in chapter IV of the 1999 constitution which includes S. 33, S. 34 and S 42 of the constitution. S 33 provides "every person has a right to life, and no one shall be deprive intentionally of his life, save in execution of the sentence of a court in respect of a criminal offence of which he has been found guilty in Nigeria. The right to life is

[7]S. 16 (1) (b) ibid.
[8]S 16 (2) (b) ibid
[9] See Preamble to the 1999 Constitution FRN.
[10] 1979 CDC cited in Etudaiye, M.E. The *Municipalization of Economic, Social and Cultural Rights: To Be Or Not To Be?* University of Ilorin Law Journal Vol 2 P198-217
[11]Ibid

interpreted broadly to include the protection of health[12] which is an integral part of the right to life.[13] S.34 also provides "every individual is entitled to respect for the dignity of his person and accordingly- no person shall be subjected to torture or to inhuman or degrading treatment." The effect of these provisions can be construed as guaranteeing the right to health under the Nigerian constitution.

4.2.2 The Child Right Act 2003[14]

The Child Right Act 2003 (CRA 2003) was passed into law by the National Assembly against the background of Nigeria's obligation under the Convention of the Right of the Child (CRC)[15] which enjoined states parties to "undertake to disseminate the convention's principles and take all appropriate legislative, administrative and other measures for the implementation of the rights recognized in the present convention.[16]The Act consolidates all laws relating to children into one single piece of legislation as well as specify the duties and obligations of government, parents and other authorities, organizations and bodies in relation to children in Nigeria.[17]

The CRA protect the fundamental rights of children as recognized under Chapter IV of the 1999 Constitution including the right to life of children and the dignity of the human person, freedom from torture, inhuman and degrading treatment.[18] S 4 of the Act protects the right to survival and development of the Nigerian children while S 10 provides for freedom from discrimination.

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[12]General Comment 6 Para 5 on the right to life
[13]See the case of *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37
[14]Child Right Act LFN 2004
[15] Convention on the Right of the Child (CRC) adopted 20 Nov 1989, G.A.Res,44/25, UN GAOR, 44[TH]Sesss., Supp. No.49, U.N Doc a 44/49 (1989) (entered into force 2 Sept 1990) Nigeria signed on the 26 June 1990 and ratified 19 April, 1991.
[16]S. 4 CRC
[17]Ladan, M. T. (2007). The Child Rights Act, 2003 and the Challenges of its Adoption by the 19 Northern States A Paper presented at a one day interactive forum for the Sokoto State House of Assembly Legislators organized by the Sokoto State Ministry of Women's Affairs and UNICEF 23, July 2007 at the Sokoto State House of Assembly, Sokoto State
[18]S. 3 (1) CRA 2003

The right to health is specifically protected under S 13 which provides:

1) Every child is entitled to enjoy the best attainable state of physical, mental and spiritual health;

2) Every government, parent, guardian, institution service, agency organization or body responsible for the care of a child shall endeavor to provide for the child the best attainable state of health,

3) Every government in Nigeria shall-

    a. Endeavor to reduce infant mortality rate;

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

    c. Ensure the provision of adequate nutrition and safe drinking water;

    d. Ensure the provision of good hygiene and environmental sanitation;

    e. Combat disease and malnutrition within the framework of primary health care through the application of appropriate technology;

    f. Ensure appropriate health care for expectant and nursing mothers;

    g. Support through technical and financial means, the mobilization of national and local community resources in the development of primary health care for children;

The Act also made it compulsory for parents, and guardians to ensure that their children under the age of two are immunized[19] and made it an offence liable in a first offence to a fine not exceeding the sum of N 5,000 and in a second or any subsequent offence to imprisonment for a term not exceeding one (1) month.[20]

However, the Child Right Act has suffered and continues to suffer opposition form religious and traditional groups in Nigeria.[21] Their bone of contention relates to the fact that the provisions of the Act contradicts their religious and traditional norms and

[19] S 13 (4) CRA 2003
[20] S 13 (5) (a and b) CRA 2003
[21] Akinwumi, O.S. (2009). Legal Impediments on the Practical Implementation of the Child Right Act 2003 *International Journal of Legal Information* Vol. 37: Iss 3, Art 10 Retrieved 23/11/14 from http://scholarship.law.cornell.edu/ijli/vol37/iss3/10

beliefs.[22] Principally, the contention is with respect to the age of marriage. The relevant section provides that "no person under the age of 18 is capable of contracting a valid marriage and accordingly a marriage contracted is null and void and of no effect whatsoever."[23]

Due to the oppositions from traditional and religious groups, practical implementation of the Act becomes difficult as issues relating to child protection is in the residual list in the constitution which is exclusive to states. States are therefore, to adopt the Act for domestication as state laws. However, only fifteen states out of thirty six states in Nigeria have domesticated the Act as state Law.[24]

4.2.3 The African Charter on Human and People's Rights

Another legislation protecting the right to health domestically in Nigeria is the African Charter on Human and Peoples Rights which Nigeria had domesticated by way of the African Charter (Enforcement and Ratification) Act and which now is now part and parcel of Nigerian law and "courts must give effect to them like all other laws falling within the judicial powers of the courts."[25] Thus, the case of *Gani v Abacha* [26] is very illustrative on this issue where the Supreme Court held that "by virtue of the African charter on Human and Peoples Rights (Ratification and Enforcement) Act, Cap 10 Laws of the Federation of Nigeria 1990, the African charter is now part of the laws of Nigeria

[22]Ibid
[23]S21 CRA 2003
[24] Such states include Abia, Anambra, Bayelsa, Ebonyi, Ekiti, Imo, Jigawa, Kwara, Lagos, Nassarawa, Ogun, Ondo, Plateau,Rivers and Taraba.
[25]*Gani v Abacha* (2000) 6 NWLR (PT 660) 228. See also the cases of *Ogugu v the State* (1994) 9 NWLR Pt 366 p. 1, *Registered Trustees of the Constitutional Rights Projects v President of Nigeria* Unreported Civil Suit M/102/92, Judgment of 5 May, 1992.
[26]*Gani v Abacha* (supra)

and like all other laws, courts must uphold it."All rights under the African charter are justiciable.[27]

The relevant provision on health is Art 16 of the Charter which provides " every individual shall have the right to enjoy the best attainable state of physical and mental health" and that "state parties to the present charter shall take necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick."[28]Other relevant provisions relating to the right to health include Art 4 and 5. Art 4 provides "human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right." And Art 5 provides "every individual shall have the right of the dignity inherent in a human being and to the recognition of his legal status."

The African Charter therefore, is a regional as well as an international instrument that is legally binding on states that have voluntarily ratified it and cannot therefore legislate out of their international obligation. By ratifying and domesticating the African Charter, the National Assembly can be said to "bestow legislative imprimatur of justiciability and enforceability to the Directive Principles of the constitution that are enshrined in the charter. Although, the Directive Principles are not justiciable per se under the constitution, the government has bound itself to them being enforced through domestic adoption of the Charter."[29]

[27] See the case of *Socio-Economic Rights and Accountability Project (SERAP) v Nigeria and Universal Basic Education (UBE*) Commission No. ECW/CCJ/APP/0808 where the court held that "it is well established that the rights guaranteed by the African Charter are Justiciable."
[28] Art 16 (1) and (2) African Charter on Human and People's Rights
[29] Nnamuchi, O. (2006). Kleptocracy and its Many Faces: Challenges to the Justiciability of the Right to Health in Nigeria *African Journal of Law Vol.52 No. 1*

4.3 Review of the implementation of the Right to Health through Health Policies in Nigeria

4.3.1 National Health Policy

The National Health Policy (NHP) was first promulgated to achieve health for all Nigerians in the year 1988 and revised in 2004[30] to further meet the needs and aspirations of Nigerians with respect to achieving health for all Nigerians. The NHP describes the "goals, structure, and strategy and policy direction of the health care delivery system in Nigeria."[31] The overall objective of the policy was stated to be "to strengthen the National Health System such that it would be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health related Millennium Development Goals (MDGs)."[32]

The targets of the NHP as provided in paragraph 3.4 of the policy included:

i. Reduce by two-thirds, between 1990 and 2015, the under 5 mortality rate;
ii. Reduce by three-quarters, between 1990 and 2015, the maternal mortality rate;
iii. To have halted by 2015, and began to reverse the spread of HIV/AIDS rate;
iv. To have halted by 2015, and began to reverse the incidence of malaria and other diseases.

The NHP is segmented into the followings:[33]

i. The National Health System and Management
ii. The National Health Care Resources
iii. The National Health Interventions,
iv. The National Health Information System,
v. Partnership for Health Development,

[30] Federal Ministry of Health (FMH)National Health Policy and Strategy to Achieve Health for All (NHP) (Lagos, Nigeria: FMH,1988; Revised National Health Policy (Abuja, Nigeria, FMH,2004)
[31] NHP 2004 Nigeria FMOH Forward by the Minister of Health P. IV
[32] NHP 2004 Para 3.3
[33]NPH 2004 Para 3.6.

vi. Health and Research; and ,

vii. National Health Care Laws.

The national health policy in Nigeria is based on Primary Health Care (PHC) that is "promotive, protective, preventive, restorative and rehabilitative to every citizen of the country within the available resources." This is in line with the Declaration of the Alma-Ata of 1978[34] to which Nigeria has shown firm political and social commitment to and to which Nigeria is a signatory.

PHC is the first contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and constitute the first element of a continuing health care process.[35] The Nigeria national health care system pays greater care to the PHC. According to the FMOH there were 18,250 registered PHC in Nigeria, 3,275 secondary and 29 tertiary health facilities in Nigeria.

In a bid to fulfill its obligations of achieving "health for all", the NHP revised in 2004, developed appropriate health interventions in order to attain the national goal of achieving health for all Nigerians. These include the National Policy on Reproductive Health (NHPRH) to deal with health rights of specific groups, the National Policy on HIV/AIDS which goal is to control the spread of HIV/AIDS and to mitigate its impact, the National Health Policy on Roll Back Malaria (RBM) which goal is to significantly reduce the rates of mortality and morbidity due to malaria, National Policy on Female Genital Mutilation (FGM) which goal is to eradicate the practice of FGM and other harmful practices affecting the health of girls and women, the National Policy on Adolescent Health which specifically deals with the health of adolescent particularly as it relates to their reproductive health and information, the National Drug Policy which goal

[34] Declaration of Alma Ata, adopted by the International Conference on Primary Health Care (PHC),jointly sponsored by WHO and UNICEF in 1978, Principle VII, Retrieved on15/05/14 from www.rightothealthcare.org/Docs/DocumentsC.html

[35] Ibid

is stated to be "to make available at all times to the Nigerian populace, adequate supply of drugs which are effective, affordable, safe and of good quality, and to ensure the rational use of such drugs"[36], National Policy on Child Health which aims to reduce the burden of infant mortality and morbidity, National Policy on Food and Nutrition and National Policy on Food Hygiene.

The NPH provided for a health system which is delivered through three tiered system. The Federal Government through the FMOH is responsible for coordinating tertiary health facilities which includes the university teaching hospitals, Federal Medical Centers. These facilities provide highly specialized services for specific disease condition or specific group of persons and serve as referral centers for patients from secondary and primary health centers.

The second tier is the state and the FCT under the State Ministries of Health (SMOH). The SMOH is responsible for coordinating health care delivery and share the responsibility of planning for the organization of health in the state and support of local health system. Nonetheless, due to their weak capacities there are notable gaps.

The third layer is the local government. Health care at this stage is the responsibility of the Local Government Authority (LGA) with the support of the SMOH within the overall National Health Policy. The health system at local level is based on ward health system approach to enhance maximum benefit of the principle of decentralization of health sector and community participation. It emphasizes the principles of Primary Health Care (PHC) which is based on essential health care, equity, use of appropriate technology, community participation, intersectoral coordination and integration of services.[37] PHC is

[36]NHP Para 6.13

[37]Abdulraheem, I.S, Olapipo, A.R. et al (2012), Primary Health Care Services in Nigeria: Critical Issues and Strategies for Enhancing the Use by Rural Communities *Journal of Public Health and Epidemiology* Vol. 4 (1) pp5-13 available at http://wwwacademicjournals.org/JPHE Last accessed 12/12/12

supposed to be the bedrock of the country's health care policy[38] which was supposed to provide accessible health for all by the year 2000 and beyond. Health care at this level is delivered through health centers and health post which are staffed by nurses, midwives, community health extension workers (CHEW), Community Health Officers (CHO), Health technicians and doctors.

Services rendered by the PHC include prevention and treatment of communicable diseases, immunization, maternal and child health services, family planning, public health education, environmental health and the collection of statistical data on health and health related events.[39]

It is important to state here that health is under the concurrent legislative list. This had thus created problems for the three tier system with respect to the role each one plays in the health system. The resultant implications being weakness in coordination between the three tiers of government which make it difficult for the FMOH to be accountable for the health of the nation as legislated by the National Health Policy.

4.4 Health Institutions and their Regulatory Bodies protecting health in Nigeria

4.4.1 Federal Ministry of Health (FMOH)

The Federal Ministry of Health is the apex federal government institution vested with the responsibility to develop and implement health policies and programs and also undertake the action to deliver effective efficient quality and affordable health services in Nigeria.

The FMOH has five departments[40] and is the main layer for policy making,[41] strategic planning, regulating international relations and central source for technical support and guidance for states. The FMOH is linked to thirty six states and the Federal Capital

[38] Revised National Health Care Policy 2004Federal Ministry of Health, Abuja
[39]Abdulraheem, I.S, Olapipo, A.R. et al (2012), op.cit
[40] Department of family health, public health, planning, research and statistics, hospital services
[41]The FMOH had established the National Health Policy which was revised in 2004.

Territory (FCT) and the 774 local government of Nigeria by providing them with technical support and guidance.

4.4.2 Courts

"Where constitutional obligations do not explicitly protect the right to health, case law or court decisions have the potentials of implementing and enforcing commitment made at international tribunals, regional and international conventions."[42]The Constitution[43] established courts under Chapter VII and made them custodian of fundamental rights.[44] Being protectors of fundamental rights, the court has a constitutional responsibility under S 13 to see to the observance of the fundamental objectives in the constitution[45] and also the rights contained in the African Charter on Human and People's Rights.[46]

To this end, "the courts have occasionally drawn from the constitutional recognition of health care entitlement in translating and applying constitutionally enforceable right or apply the provisions of the African Charter.[47] In the case of *Jonah Ghambre v Shell BP*[48] the applicants instituted an action against the respondents over the effects of gas flaring in their environment and on their health which violated S 33 (1), and S 34 (1) of the Constitution and also Articles 4, 16 and 24 of the African Charter on Human and People's Rights. This is a land mark case in the country where there is no constitutionally entrenched right to healthy environment which is a determinant of the right to health. The court ruled that s 3(2) and (b) of the Associated Gas Injection Act and s 1 of the

[42]Ijeoma, N.A. (2012).Gender and Reproductive Health: Towards Advancing Judial Reforms in Nigerian Law Retrieved on 17/06/12 from www.panafrican-med-journal.com/content/article/16/10/full/
[43]1999 Constitution of the FRN as amended 2011
[44] See s 46(1) Ibid
[45] Apart from the Judiciary, other organs of the government i.e. the legislative and the executive have the responsibility under S 13 to pursue health objectives.
[46]Gani v Abacha (2006) supra. See section 16 of the African Charter
[47] See the case of *Festus Odafe and 3 Ors v A.G. Federation and 3 Ors* Unreported, Suit No. FHC/PH/CS/680/2003,Judgement of Honorable Justice R.O. Nwodo of February 23,2004 particularly p. 11 See also the case of *Ishmael Azubuike and 3 Ors v A.G. of the Federation* Unreported Suit No. FHC/PH/CS/679 Per Justice R.O. Nwodo p 19
[48] (2005) Unreported Suit No. FHC/B/CS/53/05 per Justice C.V. Nwokorie

Associated Gas Re Injection (Continued Flaring of Gas) Regulations of 1984 under which gas flaring may be allowed are unconstitutional and violated the Applicants right to life and dignity of human person under the constitution and also Articles 14, 16 and 24 of the African Charter. The court ordered the respondents to restrain from further gas flaring in the applicant's community and also ordered the respondents to put in motion a process for the enactment of a bill for an Act of the National Assembly for speedy amendment of the Associated Gas Re- injection Act and the Regulations made there under.

4.4.3 National Human Rights Commission[49]

The National Human Commission was established by the National Human Rights Commission Act 1995 (NHR Act)[50] in line with the United Nations resolution[51] which enjoined all member states to establish human rights institutions for the promotion and protection of human rights. S. 1 of the NHR Act established the Human Right Commission (the Commission) with the following functions:[52]

(a) Deal with all matters relating to the protection of human rights as guaranteed by the Constitution of the Federal Republic of Nigeria, African Charter, the United Nation Charter and the Universal Declaration on Human Rights and other international treaties on human rights to which Nigeria is a party;

[49] The National Human Rights Commission was originally enacted as the National Human Rights Decree No 22 of 1995. However, by virtue of S 315 of the 1999 Constitution FRN it became an Act of the National Assembly. It came into force on 27th September 1995. This Act was amended by the provision of the National Human Rights Commission (Amendment) Act 2010. The amendment principally seeks to provide among other things independence in the affairs of the commission, funding of the commission which will be direct from the Consolidated Revenue Fund of the Federation, establishment of the Human Right Fund (the Fund) and recognition of and enforcement of Awards and recommendation of the Commission as decisions of the High Court.

[51] See Resolution 1992/54 of 1992 and General Assembly Resolution 48/134 of 1993.

[52] S 5 NHR Act. This Section had been amended by the Amendment Act 2010 by the insertion of new paragraphs (a), (d), (e), (g), and (h).

(b) Monitor and investigate all alleged cases of human rights violation in Nigeria and make recommendation to the Federal Government for the prosecution and such other actions as it may deem expedient in each circumstance;

(c) Assist victims of human rights violation and seek appropriate redress and remedies on their behalf;

(d) Undertake studies on all matters relating to human rights and assist the Federal Government in the formulation of appropriate policies on the guarantee of human rights;

(e) Publish regularly on the state of human rights in Nigeria;

(f) Organize local and international seminars, workshops and conferences on human rights issues for public enlightenment;

(g) Liaise and corporate with local and international organization on human rights for the purpose of advancing the promotion and protection of human rights;

(h) Participate in all international activities relating to the promotion and protection of human rights;

(i) Maintain a library, collect data and disseminate information and materials on human rights generally; and,

(j) Carry out all other such functions as are necessary or expedient for the performance of these functions under the act.

For the purpose of carrying out the above mandate, the NHR Act established a Governing Council which "shall be responsible for the discharge of the functions of the Commission."[53] The Governing Council is composed of sixteen members to be headed by

[53] S.2 NHR Act

a retired chief justice of the supreme court of Nigeria, or court of appeal or a state high court[54] and 15 other members made up of:

(a) representative of the ministries of justice, foreign affairs, internal affairs,;

(b) three representatives of registered Human Rights Organizations in Nigeria;

(c) two legal Practitioners who shall have not less than 10 years post qualification experience;

(d) three representatives of the media at least two of who shall be from the private sector;

(e) three other persons to represent a variety of interests; and,

(f) the executive Secretary of the Commission,[55] who is the chief executive of the Commission, implements the decisions of the council and oversee the day to day administration of the Commission.

The effectiveness of the Commission lies in its independence which is guaranteed under S 6 (3) of the amended Act which states that the "commission shall not be subject to the direction or control of any other authority or person."

A Strategic Work Plan was drawn up by commission which identified twelve (12) thematic areas of focus in order to attain its mandate. The thematic areas were reviewed and expanded to fifteen (15) by the Strategic Work Plan in 2005 and health is inclusive.[56] However, most of the complaints received by the Commission are in the nature of civil and political rights, there is now awareness due to public enlightenment of the

[54]S 2 (2) of the NHR Act. To maintain independence of the council, the appointment of the Chairman is done by the President subject to the confirmation of the senate. See the new Section 2 (3) of the Amendment Act.

[55] The Executive Secretary is appointed by the President subject to confirmation by the Senate S.7 (1) (e) of the Amended Act 2010.

[56] Others include women and other gender related matters, children corruption and good governance, police, prison and other detention centers, environment and the Niger Delta, education freedom of religion and belief, torture, execution, extrajudicial, summary and arbitrary execution, law reform and law review, independence of the judiciary and access to justice, labor, food and shelter, communal conflict and other related violence, health and freedom of expression and the media.

Commissions activities that the commission also handle socio economic rights including the right to health. The number of cases involving health had been steadily growing over the years.[57]

The NHR Act established under S 5 a complaint mechanism wherein any person alleging violation of human rights may complain either orally or in writing to the Executive Secretary of the Commission. The Commission has the mandate to receive and investigate complaints concerning human rights violations including health and to make appropriate determination as may be deemed necessary in each circumstance.[58] The Commission employed different methods in handling its cases depending on the nature of the complaint. Such methods include litigation, mediation/conciliation, public hearing and advisory services. In most cases involving socio economic rights including the right to health, the Commission employed mediation or conciliation methods in resolving such cases.[59]

With the Amendment Act 2010, all recommendations or award of the commission are binding on parties upon application in writing to the court to be enforced by the court.[60]

Zonal offices were opened in order to reach out to people in the six (6) geo-political zones**.**

[57] See Odinkalu, C.A. (2008).The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights in: Gauri, V. and Brinks, D.M. (eds), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World *Cambridge University Press*.
[58]S 5 (j) Amendment Act 2010.
[59]Odinkalu, C.A. (2008).op.cit fn 57
[60] S. 22 (2) Amendment Act 2010. The Amendment Act 2010 defined Court to mean Federal High Court, or High Court of Federal Capital Territory (FCT) or High Court of a state see S 22 of the Amendment Act 2010.

4.4.4 National Agency for Food and Drug Administration and Control (NAFDAC)[61]

For drug to perform its function, it must be of good quality. According to Osunkwo, the term quality refers to "an acceptable standard of form and function and for a product to possess pharmaceutical quality. It has to be safe, effective, presented in an acceptable delivery form and possess a degree of chemical, physical and biological stability and properties".[62] Established in 1993 by Decree no. 15 of 1993 (as amended in 1999), NAFDAC is an agency in the Ministry of Health (FMOH) which replaced the Food and Drugs Administration Unit under the FMOH.[63] Its functions are stated in section 5 of the Decree. Section 1 of Act established the Governing Council which consists of experienced professional from health care system in the country. For it to function effectively and efficiently, the agency is divided into different directorates[64] as follows:

(a) administration and Human Resources Directorate;

(b) planning, Research and Statistics Directorate (PR&S);

(c) narcotics and Controlled Substances Directorate;

(d) registration and Regulatory Affairs Directorate (R&R);

(e) port Inspectorate Directorate and

(f) establishment Inspectorate Directorate (EID);

(g) laboratory service Directorate;

(h) enforcement Directorate;

(i) finance and Account Directorate;

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[61] Cap N 30 LFN 2004

[62] Osunkwo, U.A. (1991). Pharmaceutical Quality Policies in Mdi consult Vol. X, No. 62 p. 5-9 cited in Igbuzor, O. (2012).Access to Safe Medicines as a Human Right a paper delivered at the National Dialogue on Access to Safe Medicines as a Human Right in Nigeria organized by the Pharmaceutical Society of Nigeria (PSN) in collaboration with the National Human Right Commission (NHRC) held on the 25th September 2012.

[63] S 29 (1) and (2)

[64] NAFDAC had just recently undergone internal reconstruction to position it better to carry out its function in fighting fake and counterfeit drugs in the country. The directorates had been increased from nine to thirteen with six zonal offices and three additional laboratories.

(j) pharmacovigilance Directorate

The laboratories of NAFDAC are up to date with the state of the art equipment. Most of the laboratories are internationally recognized for instance, the seafood laboratory for fish and shrimp export has European Union (EU) accreditation, and the WHO has recognized the Central Vaccine Laboratories as the best in the West African Sub region. In the recent internal restructuring, three additional laboratories were established for the smooth running of the Agency.

Officers of the Agency have the powers to enter into any premises (by force if need be)upon reasonable suspicion that any Article to which the Act or Regulations apply is manufactured, prepared, preserved, packaged, stored or sold therein and to examine, take sample or specimen, seize and detain such an Article. Any person who obstructs an officer of the Agency in the performance of his duties under the section shall be liable on conviction to a fine of N 5,000.00 (five thousand naira) or to imprisonment to a term not exceeding two years or to both fine and imprisonment.[65] The punishment for violating the provisions of the Act is not stringent enough to deter violators.[66] Also there is lack of coordinated legislations that can adequately address and arrest the incidence of fake drugs in the country. The penalties under NAFDAC Act are insufficient for effective control and the general provisions under the Criminal[67] and Penal Codes[68] are also insufficient for effective control.

The Agency works in collaboration with other agencies like the Nigerian Police Force (NPF), National Drug and Law Enforcement Agency (NDLEA) and the Custom and Immigration in discharging its functions. However, there is lack of cooperation among these agencies with NAFDAC which hampers the smooth and effective control of fake

[65]S 25 (1)and (2) NAFDAC Act

[66] There is a bill before the House of Assembly to amend the NAFDAC Act which provides for life imprisonment for violators of the provisions of the Act.

[67] Ss 243 (2), 244 Criminal Code Cap C 38 LFN 2004

[68]Ss 184,185,188 and 189 Penal Code Cap P3 LFN 2004

and counterfeit drugs in the country. There is no law that safeguards and guides the teamwork for effective enforcement of the rule and regulation governing the control and regulations of counterfeit drugs at every level of production, manufacture, importation, distribution, sale, and use of the control products.[69]

From its initial inception, NAFDAC had recorded considerable success in fighting against fake and counterfeit drugs. A survey across the country showed that 70% of drugs circulating in Nigeria as of 2001 were counterfeit.[70] Nigeria had experienced several tragedies as a result of fake and counterfeit drugs.[71] However, in 2006 NAFDAC published a survey showing a 90% decrease in the incidence of counterfeit drugs in circulation and a take of US dollar 100 million in counterfeit drugs seized and destroyed over a period of 5 years.[72]

However, despite the recorded success of NAFDAC, fake and counterfeit drugs are still widely available and sold openly in the markets, patents and proprietary medicine vendors. License vendors continue to sell drugs outside the scope of their license with reckless abandon and on radio and T.V; there are advertisement for the treatment of all kinds of disease by traditional medicine practitioners in stark disregard for the laws governing the advertisement of certain disease.[73]

4.4.5 National Health Insurance Scheme (NHIS)[74]

Access to health care is no doubt an important element of the right to health care. Health care goods and services must be within safe physical reach and affordable to all Nigerian. One of the major problems with access to health care in Nigeria is finance. The Out of

[69]Alamika, E.I. (2009).Legal Framework for Food and Drug Security in Nigeria Retrieved on 10/12/12 from dspace.unijos.edu.ng>law>public law p 44
[70]Ibid
[71] It was reported that more than 80 children died after taking "My Pikin Teething Mixture" in 2008.
[72] How safe is diabetic drug
[73] See Food and Drugs Act S 2 (a) which prohibited the advertisement of certain drugs listed in the First Schedule to the Act.
[74]National Health Insurance Scheme (NHIS) Chapter N42 Laws of the Federation of Nigeria (LFN) 2004

pocket (OOP) expenditure as a percentage of private expenditure on health was 95.5 in 2007, 95.4 in 2008, 95.6 in 2009 and 95.3 in 2010.[75] The OOP expenditure indicates that people use their resources more in paying for health services despite the level of poverty in the country.[76] This exacerbates the burden of poverty on people or in many instances leads to failure to visit hospital when the need arise.

In order to lessen the burden of household health expenditure, the Federal Government launched the National Health Insurance Scheme (NHIS)[77] which aimed at providing health insurance which entitled Nigerians the benefit of prescribed good quality and cost effective health services and ensuring adequate distribution of health facilities within the federation and also ensuring availability of funds to the health sector for improved services.[78]

The management of the NHIS is vested in a Governing Council (the Council) established under S 2 of the Act. The Act sets out the broad governance framework while the Council is responsible for the promulgation of guidelines for implementing its various programs.[79] In line with this, the Council issued its operational Guidelines for the implementation of its programs in 2005.[80] However, the insurance is only compulsory for the public sector and the organized private sector.

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[75]WHO. Retrieved on 10/07/12 from www.tradingeconomics.com/.../health_expenditure_total_percent_of_totoal health_expenditure-wb-data.html.

[76]Nigerian National Bureau of Statistic Nigeria Poverty Profile See also Oshewolo, S. (2010).Galloping Poverty in Nigeria: An Appraisal of the Government Interventionist Policies *Journal of Sustainable Development in Africa* Vol. 12 No. 6

[77] The idea of Social Health Insurance (SHI) was natured since around 1962 but was discarded because at that time people had access to health care in public hospitals and clinics at no cost except for certain limited services. However things took a drastic turn as a result of economic recession which ultimately led to the introduction t user fees. See Nnamuchi, O.(2009). The Nigerian Social Health Insurance System and the Challenges of Access to Health Care: An Antidote or a White Elephant? Available at http://ssrn.com/abstract=1382761 2/12/12visited last

[78] S1 NHIS

[79] S 6(b) NHIS

[80] NHIS Operational Guidelines 2005 Retrieved on17/08/14 fromwww.scrid.com/doc/66143395/2008-Nhis-Operational-Guidelines-210705-1

The NHIS consist of a shared responsibility between the government and public sector and organized private sector through the Health Maintenance Organizations (HMOs).[81] It is the responsibility of the Council to issue license and to register Health Maintenance Organizations (HMOs). Participants on the scheme are registered with the HMOs who in turn links them up with health care providers. The HMOs are responsible for the collection of the contribution from eligible employers, employees and voluntary employees as well as rendering returns on their activities as required by the Council. Contributions come from government, 5% of the employee's basic salary, while the employer pays 10% of the employee's basic salary.[82]

The goals of the NHIS were stated in S 5 of the Act:

(a) ensure that *every* Nigerian has access to good health care services;

(b) protect families from financial hardship of huge medical bills;

(c) Limit the rise in the cost of health care services,

(d) Ensure equitable distribution of health care cost among different income groups;

(e) Maintain high standard of health care delivery services within the scheme;

(f) Improve and harness private sector participation in the provision of health care services;

(g) Ensure equitable distribution of health services within the federation;

(h) Ensure patronage of all levels of health care, and

(i) Ensure the availability of funds to health sector for improve services.

These goals are lofty goals which if implemented would go along away in solving Nigeria's health care problems. However, the goals had been described as portraying the

[81] The NHIS Operational Guidelines HMOs are defined as private or public incorporated companies registered by the scheme for the purpose of maintaining health care as specified by the scheme.
[82] The employer could however, put in more than the stipulated 10%.

image of a "white elephant"[83] as on the surface, they seemed to be realistic addressing most of the health problems in the country, but on a closer scrutiny, it is "fraught with weakness so debilitating as to render naught many of its salient goals."[84]

Like the National Health Service (NHS) in the UK,[85] the state covered certain health benefits while leaving others to be paid by individuals or private health insurance. Specifically, the Act has the following basket of benefits:[86]

(a) outpatient care (including consumables);

(b) prescription on drugs as contained in the Essential Drugs List;

(c) diagnostic tests as contained in the NHIS diagnostic test list;

(d) maternal care (including ante-natal and post natal) limited to four (4) live births per insured contributor or couple;

(e) immunization services as contained in the national program on immunization;

(f) family planning; consultation with specialist such as physicians, pediatricians surgeons, et al;

(g) hospital care in a standard word for a stated length of time, for physical and mental disorder; eye examination and care, excluding prescription glasses and contact lenses;

(h) prosthesis (limited to locally produced artificial limb); and,

(i) Dental care.

This means that there are certain health care services that are totally or partially not covered by the NHIS.

[83] Nnamuchi, O., (2009) op.cit fn 77
[84] Ibid
[85] Due to economic crisis, the UK had to introduce user fees in the health care delivery for or prescription, dental and eye services.
[86] S 18 NHIS Act

The NHIS is shrouded with problems such as funding from the government as the government allocation to health is below US$34 as required by WHO and falls below the 15% of the National Budget to health sector in the Abuja and the Maputo Declarations.[87] Secondly, the scheme is only compulsory to public sector and coverage has become an illusion for the NHIS. As in other developed nations, health insurance programmes are implemented in stages.[88] So also the NHIS had chosen to implement its scheme starting with the formal sector and organized private sector, members of the armed forces, police, and allied services, students of tertiary institutions, voluntary contributions, rural community, permanently disabled and prison inmates. The target for full coverage was set for 2015. However, till date only the formal sector employees are enrolled in the scheme leaving behind the informal sector and the rural community thereby limiting access to health care to those who need it the most.[89]

The Act established for each state of Federation and the Federal Capital Territory (FCT) a state health insurance Arbitration Board charged with the following responsibilities:[90]

(a) hearing complaints made by aggrieved party of violation of the provisions of the decree; or id

(b) against any of the agents of the scheme; or,

(c) against an organization or a health care provider.

[87]Organization of African Unity: Abuja Declaration on HIV/AIDS, Tuberculosis and other Relate Infectious Diseases. Addis Ababa: OAU 2001, Abuja (Abuja Declaration), African Union: Maputo Declaration on Malaria, HIV/AIDS, Tuberculosis and other Related Infectious Diseases: Addis Ababa: A.U, 2003 (Maputo Declaration).

[88] This is the practice in many countries but with good leadership, they attain universal coverage e.g. the NHS in the UK, the NHI in Korea which achieved universal coverage in 12 years. The US is the only developed country which has not achieved universal coverage. See generally Lee, J.C. (2003).*Health Care Reform in South Korea: Success or Failure* Am J Public Health 93 (1)

[89] Nnamuchi, O., fn 75 p 26. See also Labiran, A., Margaret, M. et al.(2008). Human Resources for Health Country Profile: Nigeria; *A publication of Global Workforce Alliance and WHO.*

[90] S 26 NHIS Act.

The complaints must however, be made in writing and within sixty days from the date of the action giving rise to the complaint. This creates a problem considering the nature of the society with half of the population is illiterates. Again, considering the attitude of Nigerians, there is the need to bring the existence of the Arbitration Board to the public by means of public enlightenment.

4.4.6 Nigerian Medical and Dental Practitioners Act[91]

The Nigerian Medical and Dental Practitioners Act (MDPA) was established in 1963 to regulate the practice of Medical and Dental practitioners in Nigeria. S 1 of the Act established the Medical and Dental Practitioners Council (the Council). S 2 of the Act gave the Council responsibilities including determining the standard of knowledge and skill to be attained by persons seeking to become members of the profession, preparing from time to time a statement as to the code of conduct which it considers desirable for the practice of the profession in Nigeria etc. and other such functions conferred on the Council by the Act. It is in line with this that the Council had established the Medical and Dental Practitioners Code of Medical Ethics (Code of Medical Ethics).[92] The Code of Medical Ethics among other things "requires medical doctors to preserve life whenever possible, to hold in confidence communications with patients, to be honest with patients, to put professionalism above profit making."[93] However, the Code of Medical Ethics deals specifically with professional misconduct and not rights of the citizens to health care. It addresses issues more from the perspective of those professions which it regulates rather than from a citizens rights perspective. For example, a person found guilty of professional medical negligence which resulted in permanent disability or even death

[91]Nigerian Medical and Dental Practitioners Act Cap M8 LFN 2004

[92] See the Code of Medical Ethics in Nigeria (Code of Medical Ethics) Retrieved on 02/05/13 from elearning.trree.org/pluginfile.php/623/mod_folder/content/0/3_2-CodeOnMedicalEthics.pdf?forcedownload=1 last accessed 02/02/13

[93]Onuabia, C.E. (2012).*The Rights of Patients in Nigeria Retrieved on 12/10/12*Available at www.dailytimes.com.ng/opinions/rights-patients-nigeria

would only face the Medical Tribunal for medical negligence and if found guilty would either have his name struck off the register or suspended for a period not exceeding six months.[94] The victim is not covered by the Act and would have to fall back to civil action under torts of negligence.

The council is charged with the responsibility of disciplining erring members of the profession for professional misconduct through the Medical Disciplinary Tribunal (Medical Tribunal) established under S 15 of the MDPA. The Medical Tribunal has the status of a high court of the federal republic of Nigeria.[95] The Medical Tribunal shall consist of the chairman of the Council and ten other members of the Council appointed by the Council two of whom must be fully registered Dental Surgeons.[96]

The Council also appoints members of the investigation panel established under S 15 of the Act. The Investigation panel is charged with the responsibility of conducting a preliminary investigation into any case where it is alleged that a registered person had misbehaved in his capacity as a medical practitioner or a dental surgeon or should for any other reason be the subject of proceeding before the disciplinary tribunal.[97]

S 16 (1-2) provides:[98]

> Where a registered person is adjudged to be guilty of infamous conduct in any professional respect; or a registered person is convicted, by any court of law or tribunal in Nigeria or elsewhere having power to impose imprisonment, for an offence whether or not an offence punishable with imprisonment which in the opinion of the disciplinary tribunal is incompatible with the status of a medical practitioner or dental surgeon, as the case may be… the Disciplinary committee may give a direction…

[94]Para 30 Code of Medical Ethics
[95] See Para 2 (b) of the Medical Code of Conduct
[96]S 15 (2) MDPA
[97]S 15 (3) Ibid
[98] S 16 Ibid

a. Ordering the registra to strike out the persons name off the relevant register or register's; or
b. Suspending the person from practice by ordering him not to engage in practice as medical practitioner or dental surgeon as the case may be for such period not exceeding six months as may be specified in the directives; or
c. Admonishing that person.

The Act had not defined "infamous conduct" and had thus given the Council discretion as to what constitute misconduct and the nature of the penalty to an erring professional. A medical or dental practitioner could commit a serious offence and the council may decide to just admonish him or to even let him go Scot free. Again, a person found guilty of infamous conduct has a right by the Medical Tribunal to appeal to the court of appeal. Such an appeal would act as a stay to any directives of the Medical Tribunal. In such instances the said person would go on practicing medicine until after the determination of the appeal.

Also, despite the responsibility of the Council to review and prepare a statement as to the code of conduct which the Council considers desirable for the practice of the profession in Nigeria,[99] it has failed to widen the scope of infamous conduct used in the Act to cover other emerging misconduct or misbehaviors by the medical professional it seeks to protect. For example delay in diagnosis, emergency treatment, prompt referral and other sharp practices employed by medical professional.[100]

[99] S 1 (2) (c) MDPA
[100] Jamo, N. (2003).Penal Sanction as A Stimuli for Health Care Delivery System in Nigeria *ABUJELMAS Vol. 5 No. 1 p 176*

4.5 Legislation dealing with Access to qualitative drugs

Health becomes an illusion without access to medicine that is of good quality, affordable and effective. Drugs "cure disease, relief symptoms and alleviate suffering and as such occupy a unique position in any health care system."[101] Because of the importance of drugs in the health care delivery system, the administration of drugs had been brought under government control by the establishment of laws regulating the production, procurement, distribution and sale since before independence.[102] Some of such laws include *inter alia Essential Drugs Act,* Dangerous Drugs Act, No 12 of 1935, Counterfeit and Fake Drugs Act Cap 73 of 1990, Drugs and Related Products (Registration) Decree No 19 of 1993 now Cap 33 Laws of the Federation of Nigeria 2004.

4.5.1 National Drugs Formulatory and Essential Drugs List Act[103]

For any health care system to function, drugs must be available and affordable. In an attempt to monitor the availability and affordability of drugs, and in line with the World Health Organization (WHO) mandate, Nigeria adopted the Essential Drugs Act (EDA) which aimed at making drugs available and accessible to Nigerians by encouraging local production and reducing importation not on the list.[104] The adoption of the EDA is also a key strategy for achieving one of the goals of the National Drug Policy.[105] Essential Drugs have been defined by the WHO as:

> ..those drugs that satisfy the priority health care needs of the population. They are selected with due regards to disease prevalence, evidence of efficacy and safety and comparative cost effectiveness. Essential medicines are intended to be available

[101]Ibid
[102]Alemika, E.I. (2009). op.cit fn 69
[103]National Drugs Formulatory and Essential Drug List Cap N 29 Laws of the Federation of Nigeria (ELD Act) 2004
[104]S 3 EDL Act
[105]National Drug Policy Published by the Federal Republic of Nigeria in collaboration with the World Health Organization (WHO) 2003.

> within the context of functioning health systems at all times, in adequate amounts, in the appropriate dosage forms, with assured quality and at a price the individual and community can afford. The implementation of the concept of essential medicines is intended to be flexible and adoptable to many different situations; exactly which medicines are essential remains a national responsibility.[106]

S 1 of the EDA established the National Drugs Formulatory and Essential Drugs List (NDFEDL) which contains the Essential Medicines in Nigeria and which shall be reviewed from time to time by the National Drugs Formulatory & Essential Drug List Review Committee (Review committee)[107] advise the Minister of Health on any addition to or deletion from the list as may be necessary to meet any change in health needs.[108] The Act established a monitoring secretariat in the department of Food and Drugs Administration in the Ministry of health which was responsible for monitoring and implementing the EDL.[109]

The problem with the EDL is that it is not widely circulated as it should be particularly at primary health care level.[110] Secondly, despite this law, only 30% of drugs are manufactured locally while the remaining 70% are imported from China and India thereby increasing cost of drugs and the potential consequences of this is that drugs becomes unaffordable to majority of Nigerian thereby eroding the essence of the law. Despite the EDL, lack of access to essential drugs had become pervasive in the health system in Nigeria.

The Act made it an offence punishable with a fine of N100,000 (One hundred thousand naira)or imprisonment for a term not exceeding 5 years (five years) for any person who

[106] World Health Organization: The Selection and use of Essential Medicines Report of the WHO Experts Committee, 2002 (including 12 model list of essential medicines). Technical Report Series No. 914.Geneva: WHO
[107] S 4 (1) EDL Act
[108]S 5 Ibid. The EDL was last revised in 2010
[109] S 9 EDL Act
[110] The EDL Act Forward by the Minister of Health pg. ii

contravenes its provisions.[111] Considering the importance of drugs in any health care delivery, the above punishment is inadequate to deter violators from violating the provision of the Act.

4.5.2 Dangerous Drug Act (DDA)[112]

The Dangerous Drug Act (DDA) regulated the selling, manufacturing, distributing, or consuming specified drugs such as raw or prepared opium, cocoa leaves, Indian hemp and other related dangerous drugs without permission or prescribed by authorized body.[113] The Act made it an offence liable to a fine of two thousand naira (N2, 000.00) or with an imprisonment for a period of ten years or both for anyone who contravened the provisions of the Act and such person shall forfeit such article in respect of which the offence was committed which may be destroyed or disposed of as the court may deem fit.[114]

4.5.3 Food and Drugs Act[115]

This is an off shoot and an improvement of the Dangerous Drugs Act.[116] The Act prohibits the sale of certain foods, drugs, cosmetics and devices[117] and also the sale or advertisement of food, drugs etc. as treatment for certain diseases.[118] The Act prohibits the importation, exportation, distribution and sale of specified drugs. It also prohibits practices such as misleading packaging, labeling and advertising as well as manufacturing food and drugs in unsanitary conditions.

The Act gave the minister of health the power to appoint inspecting officers and food and drugs analysts on the advice of the food and drugs advisory council (the Council) which

[111] S 8 EDL Act
[112] Dangerous Drugs Act Cap D 1 Vol. 5 LFN 2004
[113] S 4 Ibid
[114] S19 Ibid
[115] Food and Drugs Act Cap F32 LFN 2004
[116] Alamika, E.I., op.cit fn 69
[117] S 1 Food and Drugs Act
[118] S 2Ibid

was established under S 15 of the Act. The Minister is also empowered to appoint members of the council. Such appointment will however be politically motivated rather than merit. The implication being that "priority is usually given to mediocre who could not perform the professional functions required for control of drugs…"[119]

In a bid to check the safety of drugs in the country, the inspecting officers were saddled with enormous responsibilities which included:

(a) enter (if need by force)any premises in which he reasonably believes that any article to which this act or the regulation apply is manufactured, prepared, packaged, stored or sold;

(b) examine any article in the premises which appears to him to be an article to which this act or the regulations apply or anything in the premises which he reasonably believes is used for is capable of being used for the manufacturing, preparation, preservation, packaging, storage or sale of any such article;

(c) take sample or specimen of any article to which this act or the regulations apply or which he has power to examine under Para (b) of this subsection;

(d) open and examine, while on the premises, any container or package which he reasonably believes may contain anything to which this act or the regulations apply or which may help him in his investigation;

(e) examine any books, documents or other records found on the premises which he reasonably believes may contain relevant to the enforcement of this act or the regulations and make copies thereof or extracts there from, and

(f) Seize and detain for such time as may be necessary for the purpose of this act any article by any means of or in relation to which he reasonably believes any provisions of this act or the regulation has been contravened.

[119]Alamika E,I. op cit fn 69

The Act made it an offence liable on conviction to a fine of not less than fifty thousand naira(N50,000.00)or to imprisonment for a term not exceeding two years (2 years)for any person to obstruct an inspecting officer in the performance of the above mentioned duties. With all these legislations on ground to ensure the safety of drugs administration in the country, the lucrative business of fake and counterfeit drugs is still persistent and fake and counterfeit drugs continue to circulate openly in the markets which make the effectiveness and efficiency of these legislations to be very much in doubt. This is likely because the laws regulating drugs administration have been approached in a rather confused manner.[120] That is to say that that all these laws serve the same purpose and are duplicating each other in function. Secondly, taking into consideration the grave consequences which involves loss of human lives,[121] the penalty provided in the laws ranging from N 2000 to N50,000 or to a prison term ranging from 2 to 10 years will not act as deterrent to anyone let alone the wealthy barons who are massively benefiting from the trade. There is the need therefore, to review these penalties to give the law the strength that it requires and bring it in tune with the modern realities.[122]

4.6 Proposed Law

4.6.1 The National Health Bill[123]

There have been moves to provide for a legal framework that will operationalize health care delivery in Nigeria and give a legal backing to the National Health Policy. The National health Bill (NHB) was finally passed by the National Assembly in 2008 but has not been blessed with the president's assent. But this research will not be complete without discussing its salient features and what it seeks to provide.

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[120] Jamo, N. (2003). op.cit fn *100*

[121] For example in 2008, about 800 children died as a result of taking "My Pikin" teething powder.

[122] For example, in China indulging in such activities as fake or counterfeit drugs is a capital offence and the penalty is death while in India the penalty is life imprisonment. However, there is now pending before the National Assembly a Bill to amend NAFDAC Act to and part of the amendment is the inclusion of stiffer punishment (life imprisonment) for violating the provisions of the Act.

[123]National Health Bill 2008

The NHB seeks to provide a framework for the regulation, development and management of a national health system which will set standard for rendering health services in Nigeria.[124] The Bill gives backing to the National Health Policy and other health related policies in Nigeria as policies without any backing legislation seems futile.[125]

The NHB is the body responsible for setting standard for health care delivery system in Nigeria. The Bill includes both public and private health care providers. The aim of the Bill was stated as thus:

> to provide for persons living in Nigeria, the best possible health services within the limit of available resources, to set out the rights and duties of health care providers, health workers, health establishments and users, and to protect, promote and fulfill the rights of the people of Nigeria to have access to health care services.[126]

This is the first legislation on health in Nigeria that specifically spelled out that access to health care as the right which the government has responsibility to protect, promote and respect based on available resources. The Bill further elaborated on the rights and duties of health care providers, health workers, health establishments and health users and defined the relationship between the public and private health care providers.[127]

The Bill defined the role and responsibilities of the three tier of government with respect to health care delivery in the country.[128] This had been a problem in the health system as the three tier of government were confused with respect to the role they play with respect to health care delivery as the constitution did not mention health in either the exclusive nor concurrent legislative list.

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[124]S. 1 NHB
[125]Jamo, N. op.cit fn 100
[126]S 1 (1) NHB
[127] Ss 20-30 NHB
[128] S 2 NHB

S 3 (3) protects the rights of Nigerians to get basic minimum package of health care. The Section states " …all Nigerians ***shall*** be entitled minimum package of services". The Bill however, has not defined "minimum package". But from the aim of the Bill, minimum package is limited to "available resources" of Nigeria.

The Bill had made a significant innovation by providing for the right to emergency under S 20 (1). The Section reads thus" A health provider, health worker, or health establishment shall not refuse a person emergency medical treatment." This is a significant because doctors in Nigeria are in the habit of refusing medical care to victims of accident, gunshot without police report or where the patients cannot pay. This had led to unnecessary loss of lives. Any person who contravenes this provision will be guilty of an offence and shall be liable on conviction to a fine of N10, 000 naira (Ten Thousand Naira) or imprisonment for a period not exceeding three months. However, the fine of N 10,000 or imprisonment of a period of not more than three months seems to be negligible compared to the consequences involved.

In view of the high incidence of maternal and infant deaths in the country,[129] the Bill has exempted women and children from payment for health services in public health establishments.[130] The exemption also includes older persons and persons with disabilities.

A fund known as the Primary Health Care Fund (PHCF) was established by the Bill.[131] 50% of the fund will go on the provision for basic minimum package of health care services to all citizens in Primary Health Care facilities through the National Health Insurance Scheme (NHIS).25% to provide drugs to PHC; 15% to provision and

[129] See Nigeria Demographic Health Survey (NDHS) 2008 Nigerian Population Commission Federal Republic of Nigeria, Abuja, Nigeria, ICF Macro Calverton, Maryland, USA 2009
[130] S 3NHB
[131] S10NHB

maintenance of facilities of equipment and transport for PHC; and 10% for development of PHC. This has also emphasized the importance of PHC being the first contact of health care facility at grass root level. It is also from this fund that health care is subsidized and in some cases used in providing free health care for certain persons.

The Bill also and importantly provides for the rights of health users which includes right to have full knowledge of one's health status and nature of treatment,[132] right to receive emergency health care,[133] right to basic minimum health care,[134] right to confidentiality,[135]access to health records.[136] The Bill does not however provide for any penalty for the breach of any of the rights mentioned above.

A complaint mechanism is provided under S 30 wherein any person aggrieved with the treatment in any health establishment could lay complaint and have that complaint investigated. The Bill stipulates the minister or commissioner as the case may be to establish the procedure for laying complaint. This is innovation as there is no law that addresses issues such as basic courtesy and respect which are "matters that prevent uptake of essential health services and undermine trust in health professionals which in turn affect the efficacy of health services"[137] citizen of Nigeria are badly treated by health care providers particularly women going through ante natal and post natal care. This has made some not to patronize health care facilities there by increasing the rates of unattended birth and maternal mortality in the country.[138] The Bill does not however stipulate any penalty for failure to investigate such complaint or the steps the complainant should take in such circumstances.

[132]S 23 Ibid
[133]S 20 Ibid
[134] S 3 (3)Ibid
[135] S26 Ibid
[136]S 28 Ibid
[137]Onuabia, C.E., (2012) op.cit fn 93
[138] See the National Population Commission (NPC) & ICF Macro 2009. National Demographic Health Survey 2008: Key Findings. Cleveland, Maryland, USA : NPC & Macro

The Bill is yet to be law and as such it is still in the pipeline. But it is hoped that when it comes into operation, it will change the face of health care delivery in the country

4.7 Substantive Elements of the Right to Health in Nigeria

4.7.1 Availability: This entails that functioning health and health care facilities, goods and services as well as programmes are available in sufficient quantity within the state e.g., the provisions of functioning hospitals/clinics, trained staff and medical personnel with good salaries, essential drugs as defined by W.H.O[139] etc. It also includes the availability of health related programs. Most public health facilities in Nigeria are poorly equipped[140] with decaying physical structures and obsolete equipments.[141]

The main categories of human resources in the Nigerian health care system are doctors, nurses, midwives, laboratory staffs, community health officers (CHO), community health extension workers (CHEW). Although Nigeria is home to the highest number of human resources in health only comparable to Egypt and South Africa in the African region, it is still inadequate to meet the country's needs. There are about 39,210 doctors, 124,629 nurses and 88,796 registered in Nigeria.[142] According to the WHO, countries with fewer than 23 physicians, nurses and midwives per 10,000 populations generally fail to meet the adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals framework.[143]

The above problem is further confounded by brain drain as Nigeria it continues to loose medical personnel due to brain drain. Common factors fueling brain drain of medical

[139]Essential Medicines are medicines that satisfy the priority health care needs of the population and are selected with regard to disease prevalence, evidence on efficacy and safety and comparative cost effectiveness. See WHO Model List of Essential Medicines revised March 2010 16 edition (Updated) Retrieved on 10/09/12 from http;//www.who.int/medicines/publications/essentialmedicines/en/index.html
[140] National Strategic Health Development Plan (NSHDP) 2010-2015 Federal Ministry of Health November 2010
[141] Ibid
[142] Ibid
[143] Ibid

personnel in the country include poor remuneration as they are paid less than their counterparts in developed nations and better living conditions, inadequate equipment which frustrate them as they cannot work adequately without the necessary equipment.

Essential medicines should also be available and of good quality. Research in Nigeria has shown that 54% of key medicines were not available at public health facilities of Nigerians and that the prizes of medicines are unaffordable to majority of Nigerians.[144]

There is inequitable distribution of health facilities and human resources in Nigeria. Because the urban area is more developed than the rural area, health care facilities are concentrated in the urban areas leaving the rural area where the majority of Nigerians reside to suffer severe medical service shortage.

Availability also includes the underlying determinant of health such as portable water, nutritious food, basic shelter, adequate sanitation.[145] Water and sanitation coverage in Nigeria is among the lowest in the world. According to a report only 59% of household have access to improved sources of drinking water[146] (73% urban and 31% rural).[147] About two fifth of household draw their water from unimproved sources[148] and reports that more than half (51%) of the population of Nigeria are using improved toilet sanitation (79% in urban and 37% in rural)[149]

4.7.2 Accessibility: Health facilities goods and services must be accessible to everyone without discrimination within the jurisdiction of the state party and in a non-

[144] Labiran, A. Margaret, M. et al (2008*).* Human Resources for Health Country Profile: Nigeria *A publication of Global Workforce Alliance and WHO*
[145]General Comment 14 Para 12 (a)
[146]Improved sources of drinking water include pipe water (into dwelling compound, yard or plot, to neighbor public tap/standpipe), tube well/borehole, protected well, protected spring and rain water collection. Bottled water is considered as an improved water source only if the household is using an improved water sources for hand washing and cooking.
[147] Multiple Indicator Cluster 4, 2011 p. 94
[148] Ibid
[149] Ibid p. 102

discriminatory manner taking into consideration the vulnerable and disadvantaged groups in the state.[150] Poverty is endemic in Nigeria despite the abundant resources in the country. According to the National Bureau of Statistics, seventy percent of Nigerians live below the poverty line of less than 1 USD per day.[151] Poverty is a major barrier to access to health care even where health care is available.

According to the World Health Organization report, 95.3% of Nigerians use their resources in paying for health services despite the level of poverty in the country.[152] Insurance companies financing on health is gradually growing in Nigeria and therefore has not recorded much significance more particularly as the coverage is limited to the public and private formal sectors leaving behind the poor, unemployed rural dwellers that bear the highest brunt disease burden in Nigeria.[153]Accessibility is further compounded by lack of access to information concerning health services and issues.

Health facilities goods and services should be provided in a non- discriminatory manner. This implies that health related goods and services should be accessible to all in a non - discriminatory manner either *de jure* or *de facto*.[154] Although the Nigerian constitution prohibits discrimination certain classes of persons are discriminated on grounds of their health status. For instance, a research in Nigeria revealed that people living with HIV/AIDS (PLWH) are discriminated against by health care providers which affect their accessibility to health.[155] Although some states like Lagos and Enugu states have passed Laws prohibiting discrimination against people living with HIV/AIDS (PLWHA), these

[150] General Comment 14 Para 12 (b)
[151] National Bureau of Statistic: Nigerian Poverty Profile 2010
[152]Retrieved on 10/07/12 from www.tradingeconomics.com/.../health_expenditure_total_percent_of_totoal Health_expenditure-wb-data.html
[153]Labiran, A. Margaret, M. et al. (2008). Op.cit fn 80 See also Nnamuchi, O. (2004).The Nigerian Social Health Insurance System And the Challenges of Access to Health Care: An Antidote or a White Elephant. *Retrieved on 25/05/12fromhttp://ssrn.com/abstract=1138276* .
[154]Art.12 ICESCR
[155]Reis, C. Heisler, M. (2005).Discriminatory Attitudes and Practices by Health Workers towards Patients with HIV/AIDS*PLoS Med. Vol. 2(2)*

Laws operate only within their jurisdictions. The National Assembly is yet to pass into law the anti-discriminatory Bill into law a bill when passed will prohibit discrimination against PLWHA.

4.7.3 Acceptability: All health facilities goods and services must be respectful of medical ethics and culturally appropriate i.e. respectful of the culture of individuals, minorities, people and communities, sensitive to gender and life circle requirement as well as designed to respect confidentiality and improve the health status of those concerned.[156] The Nigerian Medical and Dental Practitioner Council (the Council) is charged with the responsibility of determining the standard of knowledge and skill to be attained by persons seeking to become members of the profession[157] and preparing from time to time, a statement as to the code of conduct which it considers desirable for the practice of the profession.[158] It was in line with this the Council established the Medical and dental Practitioners Code of Medical Ethics (Code of Ethics). Despite the code of Ethics, professional negligence, malpractice, misconduct and improper conduct continue to occur in the practice of medicine in Nigeria.[159]

4.7.4 Quality: Health facilities goods and services must be scientifically and medically appropriate and of good quality. This requires in particular trained health professionals, scientifically approved and unexpired drugs and hospital equipments.[160] Nigeria's health care system is characterized with decaying health facilities and obsolete equipments.

[156] Ibid Para 12 (c)
[157] S 1 Nigerian Medical and Dental Practitioners Act Cap M8 LFN 2004
[158] S 2 Ibid
[159] Akpabio, E.A. The Nature and Forms of Professional Misconduct in Medical Practice in: Aderinwale, A., (ed), Ethics and Professionalism in the Practice of Medicine *Retrieved on 12/05/13 from* *www.africaleadership.org/rc/ethicsmedical.pdf*
[160] General Comment 14 Para 12 (d)

Fake and counterfeit drugs continue flourish in the markets despite the recorded success of the National Agency for Food and Drug Administration and Control (NAFDAC).[161]

[161] Cap N30 Laws of the Federation of Nigeria (LFN) 2004

CHAPTER FIVE

AN ASSESSMENT OF PROGRESSIVE REALIZATION OFTHE MILLENNIUM DEVELOPMENT GOALS 1, 2, 3, 4, 5 AND 6 IN NIGERIA

5.1 Introduction

The return to democracy in Nigeria in 1999 brought hope to the millions of Nigerians as it provides the natural environment for the protection of human rights including the right to health. Under democratic political system, the government is under pressure to be accountable to its constituents. Providing for the health of the citizens of Nigeria is the responsibility of the government in a democratic state. The right to health is a fundamental human right[1] protected in the Universal Declaration of Human Rights (UDHR)[2] and other major international and regional human rights instruments to which Nigeria is signatory to.[3]

The Millennium Declaration[4] was adopted by 147 heads of states and government in 2000. The Declaration set targets and benchmarks for ending some of the vexing problems in the developing countries[5] as a global response to reduce poverty. The Millennium Development Goals (MDGs) are associated with targets and goals to be achieved by 2015. The MDGs include: Eradicating extreme Poverty and Hunger (MDG 1), achieving universal primary Education (MDG 2), Promoting Gender Equality and Empowering Women (MDG 3), Reducing Childhood Mortality (MDG 4), Improving Maternal Health (MDG 5), Combating HIV/AIDS, Malaria and other Diseases (MDG 6),

[1] The Constitution of the World Health Organization (WHO) 1946 opened for signature 22 July 1946, 62 Stat. 6279 , 14 UNTS 185 (WHO Constitution)
[2]Universal Declaration of Human Rights (UDHR) adopted 10 December 1948, G.A.Res 217A(III),U.N.GAOR, (Resolution, part 1)
[3]See Ladan, M.T. (2008). The Role of Law in the HIV/AIDS Policy: Trend of Case Law in Nigeria and other Jurisdictions *Ahmadu Bello University Press, Zaria* p. 26
[4] United Nation Millennium Declaration, GA res55/2, UNDOC.A/Res/55/2 (18 September 2000) (Millennium Declaration)
[5] Udombana, N.J. (2007). Right to Health and the MDGs: Confronting HIV/AIDS in Africa Retrieved on 15/05/12 from http//: ssrn.com/abstract=1810113 P. 359

Ensuring Environmental Sustainability (MDG 7) and Developing a Global Partnership for Development (MDG 8).

One of the striking features of the MDGs is the prominence of the right to health within the eight goals as "good health is not just an outcome of poverty reduction and development. It is a way of achieving them."[6] Three of the goals are directly health related (goals 4 reduce child mortality, 5 improve maternal health and 6 combat HIV/AIDS, Malaria and other diseases) while the remaining goals with the exception of goal 8 are indirectly health related. The directly health related MDGs are MDGs 4 (Reducing Childhood Mortality), 5 (Improving Maternal Health) and 6 (Combating HIV/AIDS, Malaria, and other diseases). Nigeria is signatory to the Millennium Declaration while the rest particularly MDG 1 (eradicating extreme poverty and hunger), 2 (attaining universal primary education) and 3 (promoting gender equality and women's empowerment) are indirectly related to health. The attainment of the MDGs is an obvious policy thrust of the Federal Government of Nigeria.[7]

Major challenges remain in attaining adequate health for Nigerians which makes Nigeria far from achieving the MDGs by the year 2015. For example over 70% of Nigerians still live below poverty line[8], though there are improvement in school enrolment, the quality of education is still poor and disadvantage groups are still excluded and a lot need to be done in terms of infrastructure, Nigeria has the second highest incidence of maternal mortality in the world after India, under five mortality though declining is still high, HIV/AIDS, malaria and tuberculosis are still high and continue to ravage families and communities. Though Nigeria had identified the magnitude of these problems and had

[6] Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Note by the Secretary General at A, U.N.DOC. No A/59/422 (2004) Retrieved on 06/07/13 from http://files.institut-fuer-menschenrechte.de/576/childSurvival.pdf
[7] See the Revised National Health Policy 2004 Federal Ministry of Health. Abuja
[8] Nigerian National Bureau of Statistics (2011).Harmonized Living Standard Survey 2010. Abuja

developed laws and policies in response, these actions have not translated into a significant improvement in achieving the MDGs in the country. In fact, several reports show that it is unlikely to meet the MDGs 4, 5 and 6 by 2015.[9] However, Nigeria has the potential to attain the MDGs ahead of 2015.[10]This chapter examines the relationship between the right to health and the MGDs, and assesses the progressive realization of the MDGs 1, 2, 3, 4, 5 and 6 in Nigeria. Equally, the chapter examines the key challenges and prospects to attaining the MDGs in Nigeria.

5.2 Millennium Development Goals and the right to health in Nigeria

The MDGs are a set of goals that needs to be reached by governments who have signed the Millennium Declaration and are required as a result to address some issues concerning ill health and poverty within their various countries. "The obligation upon states to provide its citizens with effective health care is one that rests both in international law in various human rights treaties and domestic law in relation to the provision of health care services whether by constitutional directive or otherwise."[11]

The focus of the MDGs is whether or not a particular state is providing its citizens with the internationally recognized obligations. It puts pressure on government to ensure that health care delivery comply with international obligations imposed upon those government and are consistent with human rights entitlement enjoyed by citizens of various states. The MDGs are therefore, useful criteria against which to measure a particular government compliance with providing adequate health care in particular and human rights in general.[12]

[9]Nigeria Millennium Development Goals (MDGs): Countdown Strategy 2010-2015 Achieving the MDGs (Nigeria) MDGs +10 Nigeria (Countdown Strategy)
[10] Ibid
[11] Kirby, N. (2012). South Africa: Millennium Development Goals: The What, the Who and the How
[12] Ibid

The human right to health provides the framework for the achievement of the MDGs as explained by Paul Hunt that:

> The right to health involves an explicit normative framework that reinforces the health related MDGs. This framework is provided by international human rights underpinned by universally recognized moral values and backed up by legal obligations, international human rights provides a compelling normative framework for national and international policies designed to achieve the goals.[13]

While the right to health is deeply rooted in human rights the MDGs are political commitments that calls for the end of poverty, gender inequality, improvement of maternal and child health, reversing the spread of HIV/AIDS and other diseases etc. These goals are however in line with government obligations under international human rights law and provide a bench mark for measuring government progress with respect to its international obligations.

5.3 Millennium Development Goals in Nigeria

Nigeria is located in West Africa. The country is made up of an area of 923,769 square kilometers. Nigeria's neighbors are Benin Republic by the west, Cameroun by the east, Niger and Chad by the south. Nigeria is said to be the most populous country in Africa in which an estimated population of 150 million and a projected population of 200 million by the year 2015.[14] The population of Nigeria is unevenly distributed with the rural area housing 51.7% of the population and 48.3 living in the urban area.[15]

[13] Hunt, P. (2004). The Right of everyone to the enjoyment of the Highest Attainable Standard of Health Report of the Secretary General, UN Doc A/49/422 Retrieved on 12/08/13 from >http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N04/543/38/PDF/N0504338.pdf?openElement>
[14] Nigeria Retrieved on 07/04/14 from www.en.wiki.org/wiki/Nigeria
[15] Ibid

Nigeria's economy in the early years of independence was dominated by agriculture which provided about 75% of the work force in the country.[16] With the discovery of oil, Nigeria abandoned the agricultural sector. Petroleum now plays a major role in the economy and account for 38% of Nigeria's Gross Domestic Product (GDP) and 80% of government earnings.[17] Nigeria is the 21st largest producer of petroleum in the world and the 8th petroleum exporter in the world.[18] Nigeria is also rich in other mineral resources which include natural gas, iron ore, limestone, coal bauxite, zinc, lead etc.[19]

However, with the above abundant resources, Nigeria is listed among the 20 poor nations in the world.[20] About 61.2% of Nigerians live below the poverty line of less than US 1 dollar per day.[21] Poverty in Nigeria is a paradox- poverty amidst plenty. With the level of poverty in the country, it is not surprising that the state of health in the country is deplorable.

In 2000, world leaders met in 2000 and signed the Millennium Declaration to address the problem of poverty, illness and development in the world. The Declaration led to the establishment of the Millennium Development Goals (MDGs) which were described as the:

> world's time bound and quantified targets for addressing extreme poverty in its many dimensions- income poverty, hunger, disease, lack of adequate shelter, and exclusion- while promoting gender equality, education and environmental sustainability. They are also basic human rights: the right of each person on the planet to **health**, education, shelter and security.[22]

[16] Ibid
[17] Ibid
[18] Ibid
[19] Ibid
[20] Obadan, I.M. (2002). Poverty Reduction in Nigeria: A Way Forward Retrieved on 15/06/13 from www.cenbank.org/OUT/PUBLICATIONS/EFR/RD/2002/EFRVOL39-4-4PDF
[21] Nigerian National Bureau of Statistics (NBS). (2011) Harmonized Living Standard Survey 2010. Abuja
[22] United Nations Millennium Project, 2006, Retrieved on 12/07/13 from http://www.unmillenniumproject.org/goals/index.htm

Nigeria is signatory to the Millennium Declaration. The MDGs share the common notion with Nigeria's own development vision as enshrined in the 1999 Constitution[23]under the Chapter Fundamental Objectives and Directive Principle of State Policy.[24]Nigeria had also established policies, institutions, programmes, and strategies for the implementation of the MDGs in the country and consequently its obligation under the right to health. For example, in 2004 Nigeria mainstreamed the MDGs into its National and sub-national economic Development Framework- National Economic Empowerment Development Strategy (NEEDS) with the following goals- poverty reduction, employment generation, wealth creation and value orientation, Vision 20:2020, the 7 Point Agenda with the main objective and principle of improving the general well-being of Nigerians and making the country become one of the biggest economies in the world by the year 2020.[25] The Transformation Agenda which is a medium term development strategy to speed up Nigeria's march towards becoming one of the 21st largest economies by the year 2020. It serves as a framework for the actualization of the Federal Government economic growth agenda from 2011-2015. It is anchored on the pillars and specific targets of Nigeria's Vision 20: 2020.[26]

In 2005 when Nigeria gain debt relief from the Paris Club, it applied the gains to pro-poor programmes.[27] This was described as a turning point for the implementation of the MDGs in the country. Nigeria utilized the debt relief in achieving interventions such as the Midwives Service Scheme (MSS) distribution of antiretroviral drugs and Insecticide Treated Nets (ITN).[28] A Virtual Poverty Fund (VPF) was established to track debt relief

[23] Constitution of the Federal Republic of Nigeria 1999 as amended (1999 Constitution FRN)
[24] See particularly sections 16, 17 and 18 of the 1999 Constitution FRN
[25]Countdown Strategy op.cit fn 9
[26]Mid Term Report of the Transformation Agenda (May 2011-2015): Taking Stock, Moving Forward
[27] Countdown Strategy op.cit fn 9
[28]Ibid

fund meant for poverty reduction.[29] The Office of the Special Adviser to the President on MDGs which was meant to overlook the disbursement of fund for implementing the MDGs was established. Also, Senate and House committees on MDGs were established with oversight function for the implementation of MDGs in the country.

With all the laudable visions, plans and institutions put in place for the implementation of the MDGs, Nigeria is still yet to achieve the MDGs with barely a year to 2015 there still remains problems and challenges in attaining the health related MDGs 4 (reducing childhood mortality), 5 (improving maternal health) and 6 (combating HIV/AIDS, Malaria and Tuberculosis).

5.4 An overview of MDGs 4 (Reducing childhood mortality), 5 (Improving maternal mortality) and 6 (Combating HIV/AIDS, Malaria and Tuberculosis) in Nigeria

5.4.1 Eradicating Extreme Poverty and Hunger

This goal was included as part of the strategy for the improvement of some of the vexing problems in the developing countries. Poverty and health are intertwined and form a vicious circle because poverty begets bad health while bad health begets poverty. People with bad health cannot go to school and be educated thereby earn a living and be productive in life. The more a person is poor, the sicker he is as he cannot afford medical bill due to poverty.

There is little progress made in eradicating extreme poverty in Nigeria with respect to the target of halving the USD 1 day poverty prevalence. With poverty at 62.60%, it is not likely that the 2015 target of 21.40% will be met. However, there is much better outlook for hunger reduction. The MDG target with respect to eradicating extreme hunger is halving between 1990 and 2015, the proportion of people who suffer from hunger. Hunger is measured by the proportion of under five children who are underweight, that is

[29]Ibid

have a low birth weight for their age, reflecting wasting or stunted growth or both. With the consistent progress in the past decade and the current efforts through the Agricultural Transformation Agenda, it is possible that the proportion of under five children that are underweight (24%) can be brought down to 17.85% by 2015.[30]

There are disparities in hunger rates across states and between rural and urban areas.[31]Hunger is higher in the Northern states and lowest in the South East for example, hunger rate is highest in Yobe state (48.0%) and lowest in Anambra state (4.5%).[32] The hunger rate is higher in rural area (27.5%) compared to urban area (16.8%).[33]It is important to note that some states have reached the national targets for the reduction of extreme hunger[34] while others are still lagging behind.[35]

Nigeria is ranked 40 out of 79 countries on the Global Hunger Index by the International Food Policy Research Institute and had a global hunger index of 15.7 in 2012, thereby, positioning Nigeria as a country "seriously" suffering from hunger.[36]

5.4.2 Achieving Universal Primary Education

Education is the key to national development and therefore, any nation striving to achieve development must pay great attention to the education of its people. An educated nation is a healthy nation as studies have shown the relationship between health and education.[37]

[30]Nigeria MDG 2013 Report Executive Summary
[31] Ibid p. 15
[32]Ibid p. 16
[33]Ibid
[34]Nasarawa (16.9%), Ebonyi (16.6%), Delta (15.7%), Kogi (14.7%), Ogun (13.8%), Akwa Ibom (13.6%), Cross River (13.0%), Abia (12.9%), Bayelsa (12.9%), Benue (12.4%), Ondo (12.2%), Imo (11.6%), Lagos (11.5%), Osun (11.0%), Abuja FCT (11.0%), Enugu (9.5%), Rivers (9.4%), Ekiti(8.7%), Edo (7.9%), Anambra (4.5%).
[35] Nigeria MDG 2013 Report p. 16
[36]Ibid p. 17
[37]Nigeria Demographic and Health Survey 2013 Preliminary Report (NDHS Preliminary Report 2013) National Population Commission, Nigeria, MEASURE DHS, ICF International Calverton, Maryland, USA p. 22

The target under this goal is to ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary education.

Nigeria is said to be on track on this goal with net enrolment in primary school at 68% in the base year 1990 and increased to 95.0% in 2000. The achievement is said to be associated with the favorable National policy environment such as the Education for All and the Universal Basic Education (UBE) launched in 1999.[38] However, there was a decline from 95% in 2000 to 80% in 2004 and gradually increased in 2008 to 88%.[39] However, the enrolment has remained steady at 80% from 2009-2013.[40]

This target is measured using two indicators:

a. Primary School completion Rate: this is the ratio of the total number students successfully completing (or graduating from) the last year of primary school to the total number of children of official graduation age in the population.[41] There has been a steady growth in this indicator and from 58% in 1990 to 82% in2004, 67% in 2006 and has remained stable at 87.70% in 2012.[42]

b. Literacy Rate of 15-24 Years Old: this indicator measures the proportion of youth aged 15-24 who can both read and write with understanding in any language.[43]The growth of this indicator has been sluggish indicating the likelihood of not able to attain the goal.

There is significant improvement in female primary school enrolment but however, there are disparities with their male counterpart with respect to completion rate. Male have a

[38]Nigeria MDG 2013 Report p. 19
[39] Ibid
[40]Ibid
[41]Ibid
[42]Ibid
[43] Ibid

higher primary school completion rate (91.60%) compared to female (83.20%).[44]This disparity indicates challenges in retaining females in school.[45]Other disparities include urban/rural and states disparities. While primary school completion rate is 90.50% in rural area it is lower in urban area with 81.50%. Literacy rate is higher in urban area with 87.0% compared to56.60% in rural areas.[46]The disparity in states may be associated with socio cultural factors as well as insecurity in the northern states where the primary school completion rates is lowest. For example while the completion rate is highest in Ekiti state with172.10%, it is lowest in Yobe state with 10.1%.[47]

5.4.3 Achieving Gender Equality and Women's Empowerment

This goal sets to eliminate gender disparity in primary and secondary education preferably by 2005, and in all levels of education not later than 2015. Indicators used to measure progress in this area are ratio of girls to boys in primary, secondary and tertiary education and the proportion of women in paid employment within the non-agricultural sector.[48] Ratio of girls to boys in primary, secondary and tertiary education is the ratio of the number of female students enrolled at primary, secondary and tertiary levels in public and private schools to the number of male students.[49] There has been a steady but gradual increase in the ratio of girls to boys in primary education (76.0% in 1990 to 90.0% in 2012). So also in secondary education the ratio of girls to boys rose steadily from 75.0% in the baseline year 1990 to 88.0% in 2012. The ratio of girls to boys in tertiary education has been fluctuating from 46 in 1990 up to 87 in 2002 and then declined in 2003 to 70% in 2005, 69% in 2006, 66.4% in 2007 to 66.82 in 2012.

[44]Ibid p. 20
[45]Ibid p. 20
[46]National Bureau of Statistic (NBS) (2013). Millennium Development Goals Survey, Abuja, NBS
[47] Ibid
[48] Millennium Development Goals Performance Tacking Survey Report 2012 p. 25
[49] Ibid

Table 1 - Trends and status of gender equality indicators

Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010	2012	2015
3.1a Ratio of Girls to boys in Primary education (girls per 100 boys)	76	78	78	79	79	81	81	83	85.1	85.41		90.0	100
3.1b Ratio of Girls to boys in Secondary Education(girls Per 100 boys	75	81	81	80	78	77.4	80.6	79.4	75.4	79.91		88.0	100
3.1c Ratio of Girls to boys in Tertiary education (girls per100 boys)	46	66	68	87	72	75.5	7.1	69.0	66.4	66.82			100

Indicator	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2010	2012	2015
3.2Share of Women in wage Employment In the non Agricultural Sector (%)	6.60					7.90	7.90				7.70	14.0	
3.3 Proportion Of seats in the Parliament (%)	1.0	3.10	3.10	3.10	3.10	3.10	3.10	3.10	7.70	7.50	7.50	7.00	35.0

Source: NBS (2013),[50] FME (2010)[51]

The percentage of women in wage employment other than the agricultural sector and the number of women in parliament has not been impressive though there has been increase in the proportion of women in the parliament from 3.10% in 2000 to 7.70% in 2007.[52] The non-impressive figure is attributable to the low status of women in the society and lack of understanding of gender issues and lack of access to land and other credit facilities. However, the overall policy environment for promoting gender equality and equity has improved over the years.[53]An innovative approach to mainstreaming gender issues has started with five pilots Federal Government Ministries-Agriculture, Health, Communication and Technology, Water Resources and Works.[54]

[50] National Bureau of Statistics (NBS) 2013) Millennium Development Goals Survey 2012 Abuja NBS
[51]Federal Ministry of Education (2010) Nigeria's Country Report: Eight E-9 Ministerial Review Meeting Abuja, June 21-24
[52]NigeriaMDG 2013 Report p. 27
[53] Ibid p. 29
[54] Ibid

5.4.4 Childhood Mortality

Nigeria has an under five (U5) mortality rate of 128 per 1,000 live births which means that one in every eight children born in Nigeria die before their fifth birthdays.[55] Child mortality stands at 64 per 1,000 live births while infant mortality, neonatal and postnatal mortalities are 69, 35 and 31 deaths per 1,000 live births respectively.[56]

Table 2-Childhood Mortality Trend1998-2013

Years	Neo natal mortality	Post neonatal mortality	Infant Mortality	Childhood mortality	U 5 Mortality
1998-2003	40	52	100	112	201
2003-2008	40	35	75	88	157
2009-2013	37	31	69	64	128

Source: NDHS 2013 p. 19

North-West has the second highest burden of infant mortality and under 5 mortality rates in the country- 123 and 208 per 1000 live births respectively[57] as compared to the South-West which has the lowest burden of infant mortality, child mortality and Under 5 mortality rates- 55 and 83 per 1000 live births respectively.[58]The high burden of mortality in the North-West can be attributed to the high level of poverty (which is a cause of malnutrition and low birth weight in children) low level of education of the mother and place of residence[59] and deficits in access to basic health care with 80% of the population lacking access to the eight lifesaving intervention tracked by the Countdown to 2015 Initiative.[60]

[55] NDHS op. cit fn 37 p. 21
[56] Ibid p. 19
[57] Nigeria: Monitoring the Situation of Women and Children Multiple Indicator Cluster Survey 2011 (MIC4 2011) Federal Republic of Nigeria, National Bureau of Statistic, UKaid, UNFPA, UNICEF p.18. See also Nigeria Millennium Development Goals 2013 Report p. 31
[58] Ibid
[59]Ibid.
[60]Nigeria Millennium Development Goals 2013 Report p.31

Table 3- Child Mortality 2011

Geo-political Zone	Infant mortality	Under 5 Mortality
North Central	91	147
North East	114	190
North West	123	208
South East	83	132
South-South	75	118
South-West	55	83

Source: MIC 4, 2011

Efforts made for the reduction of childhood mortality in the country include the expanded Program on Immunization (EPI) which is meant to increase the proportion of children covered by immunization. Despite this program, the level of children immunized is low.[61] Among reasons given by parents for the low level of immunization include lack of information which account for 27%, fear of side effect accounting for 26% and the immunization location being located far away accounting for 13%.[62]Although the percentage of children receiving no immunization has decreased by 28% from 27% in 2003 to 29% in 2008 and 21% in 2013,[63] only 25.4% received all immunization.[64]Other programs for childhood reduction include the Integrated Maternal Newborn and Child Health Strategy, the Roll Back Malaria (RBM) Initiative; strategies for controlling diarrhoea which are cost effective (e.g. breast feeding), cholera immunization, programmes of prevention of Mother to Child Transmission of Human Immune Virus/Acquired Immune Deficiency Syndrome.

[61]NDHS Preliminary Report 2013 p. 25. See also MIC4, 2011 p. 51
[62] Ibid p149
[63]Ibid p. 25
[64]Ibid. See also MIC 4, 2011 p. 51

The goal relating to childhood is goal 4 which aims at reducing childhood mortality by two thirds by 2015.[65] Childhood mortality in Nigeria has declined from 201 in 2003 to 157 in 2008 and 128 in 2013.[66] However, the decline is not significant to achieve the target of the goal of reducing childhood mortality by two thirds with less than a year to the target date as children continue to die of preventable diseases like malnutrition, diarrhea, pneumonia, malaria and HIV/AIDS.

5.4.5 Maternal Mortality

The MDG target for maternal mortality is improving maternal health by three quarter by 2015.[67] Nigeria has the second highest incidence of maternal mortality in the world after India.[68]Slow progress has been achieved as maternal mortality was 1,100 per 100,000 live births in 1990 the base year for the indicator[69] and the target is to bring it down to 275 per 100, 0000 live births. The maternal mortality ratio in Nigeria currently is recorded as 350 deaths per 100,000 live births[70] which is "nearly double the current global average of 290 per 100, 000 live births."[71]There are however, zonal disparities with the North East and North West having the highest maternal mortality ratio.[72] This has been attributed to a range of factors such as wealth indices of the mother, educational level of the mother, cultural practices and health care coverage and utilization.[73]

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[65] Millennium Declaration op.cit fn 4
[66]NDHS Preliminary Report 2013 p. 19
[67] World Health Organization: ICD-10: International Statistical Classification of Diseases and Health Related Problems: Tenth Revision Volume 2, Geneva: World Health Organization: 1993
[68]Ajeagbu, O.O. (2013). Perceived Challenges of Using Maternal Health Care Services in Nigeria *Arts and Social Sciences Journal, Vol*. 1 ASSJ-65
[69] Federal Ministry of Health 2011
[70]NDHS Preliminary Report 2013
[71] Gender in Nigeria Report 2012: Improving the Lives of Girls and Women in Nigeria: Issues, Policies Action British Council Nigeria (Gender in Nigeria Report)
[72]NDHS 2013 Preliminary Report p. 22
[73] NDHS 2013 Preliminary Report p. 22. See also Nwosu, J. Odubanjo, M.O. et al (eds) (undated). Reducing Maternal Mortality and Infant Mortality in Nigeria *Nigerian Academy of Science West Africa Book Publishers, Lagos* p. 1

The primary causes of maternal mortality in Nigeria include hemorrhage which accounts for 23% of maternal deaths, infection accounting for 17% of maternal deaths, toxemia/eclampsia accounting for 11%, malaria accounts for 11%, anaemia accounts for 11%, unsafe abortions accounts for11% and prolonged or obstructed labor accounting for11% maternal deaths.[74] Most of these deaths are preventable with appropriate and timely interventions. Other causes include underlying gender issues that undermine the status of women in Nigeria for example mother's low educational level, a woman's decision making status in the family and economic/financial status of a woman.[75]

Nigeria had developed policies and strategies aimed at reducing the high incidence of maternal and child mortality in the country. Notably National Health Policy 1988 revised in 2004 which adopted the Primary Health Care approach; National Reproductive Health Policy and strategy 2001 which aims to reduce peri- and neo- natal morbidity by 30%;National HIV/AIDS and Prevention of Mother To Child Transmission (PMTCT) Policy and Strategic Plan 2003;National guidelines for Women's Health developed in 2002;National Strategic Framework and Plan for Vesico-Vaginal Fistula 2005; the road map for accelerating achievement of the MDGs that cover maternal and new-born health, 2006 which sets priorities and strategies for reducing maternal and infant death; an integrated maternal and New-Born and Child Health Strategy 2007which sought to build synergy among the many programmes designed to reduce maternal, neonatal and child mortality in Nigeria, and the Midwives Service Scheme implemented by the Primary Health Care Development Agency (PHCDA).

[74] Onwasigwe, C. (2010). Principles and Methods of Epidemiology *El Demak Publishers, Enugu* p.19
[75] Gender in Nigeria Report 2012 op.cit p. 30

5.4.6 HIV/AIDS, Tuberculosis (TB), Malaria

MDG target 6a and 6b cover HIV/AIDS with the target to halt by 2015 and reverse the spread of HIV/AIDS and to achieve universal access to HIV/AIDS treatment by 2010 for all those who need it. The most recent HIV seroprevalence figure represents about 3.5 million people infected with HIV, ranking Nigeria second to South Africa with the highest burden of HIV/AIDS in the world.[76]

Table 4 Epidemiology of HIV in Nigeria: Key Facts

	2008	**2012**
National Median HIV Prevalence	4.6%	4.1%
Estimated number of people living with HIV/AIDS	2,980,000	3,459,363
Annual AIDS Death	192,000	217,148
Number requiring ART	857,455	1,449,166
New HIV Infections	336,379	388,864
Total Number of AIDS Orphans	2175,760	2,193,745

Source: NACA 2012

There has been a steady decline in HIV/AIDS rates from 4.6% in 2008 to 4.1% in 2012. Although the HIV/AIDS prevalence has declined, the number of people living with HIV (PLWHIV) has increased from 2,980,000 in 2008 to 3,459,363 in 2012.[77] Also, the annual death toll related to HIV/AIDS has increased from 192,000 in 2008 to 217,148 in

[76] National Agency for the Control of AIDS (NACA), Federal Republic of Nigeria Global Aids Response: Country Progress Report GARPR 2012, Abuja Nigeria (NACA: Global Aids Response)
[77] Ibid

2012.[78] There are zonal disparities with the North Central having the highest prevalence of HIV/AIDS (7.5%) and lowest in the North Eastern Zones (2.1%).[79]

There is also, gender inequality with male accounting for 1.23 million while female accounting for 1.72 million living with HIV/AIDS in Nigeria in 2008.[80] The total number of orphans as a result of HIV/AIDS was estimated as 2175,760 million in 2008 and 2193,745 million in 2012. Age specific prevalence is highest in the age group 25-29 accounting for 5.6% and lowest in the age group 40-44 accounting for 2.9%.HIV/AIDS has a strong impact on mortality rates thus bringing down life expectancy. In 1991, the average life expectancy was 53.8 for women and 52.64 for men. In 2007, the life expectancy had fallen to 50 for women and 48 for men. The MGD target 6b is to provide universal access to HIV/AIDS treatment to all by 2010. This has been rising steadily from 24.0% in 2010 to 33.0% in 2012.[81] That is to say that one out of every persons living with HIV/AIDS is receiving treatment against the target of 100.0% by 2015.[82] Only 15.9% of HIV positive women receive antiretroviral therapy (ART) to reduce the risks of Mother to Child Transmission (MTCT) of HIV.

In response to the scourge of HIV/AIDS in the country, Nigeria had established institution – National/State Agency for the Control of Aids (NACA/SACA) and developed programmes and policies in agreement with key national and international framework to guide in halting the spread of the infection. Notably among these policies is the National Policy on HIV/AIDS developed by the National Agency for the Control of Aids (NACA) which provide "regulation and guiding principles on topic ranging from prevention of new infection and behavior change, treatment, care and support for infected

[78] Ibid
[79] Ibid
[80] Ibid
[81] Nigeria Millennium Development Goals 2013 Report p.44
[82] Ibid

and affected persons, institutional architecture and resourcing advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by the various stakeholders in the national response"[83], the National Strategic Framework II 2010-2015 (NSF II) which has the target to halt and begin to reverse the spread of HIV infection as well as mitigate the impact of HIV/AIDS by 2015. It is linked to the universal and MDG targets, and vision 20:2020 and has an overriding emphasis on HIV prevention.[84] "The NSF II builds on the National HIV Policy and provides a broad structural framework for the implementation of the Policy."[85]

The World Health Organization (WHO) declared Tuberculosis a global emergency in 1993 and it remains one of the world's major causes of illness and death.[86] Globally, there has been progress though slowly in the prevention of tuberculosis (TB). There has been a 35% drop in the TB deaths rate since 1990 from a rate of 30 in 1990 to 20 per 100,000 populations in 2009. Nigeria ranks tenth among the twenty two high burden TB countries in the world.[87] This is further compounded by the prevalence of HIV/AIDS in the country.[88] Although TB death rates have declined from 11% in 2006 to 5% in 2010, the WHO estimated that 210,000 new cases of all forms of TB occurred in the country equivalent to 133 per 100,000 populations in 2010.[89] The TB prevalent cases were estimated as 320,000 in 2010 which is equivalent to 199 per 100,000 population.[90]However, the trend in the notification of TB has improved as a result of improvement in surveillance.[91] Progress with TB shows that the prevalence of death rates

[83]NACA: Global Aids Response op.cit fn 74
[84] Ibid p.15
[85] Ibid p.16
[86] Nigeria: Tuberculosis Fact Sheet 2012. Retrieved on 15/07/13 from http://photos.state.gov/libraries/nigeria/487468pdfs
[87]Ibid. See also Nigeria Millennium Development Goals 2013 Report op.cit p. 47
[88]Ibid
[89] Nigeria: Tuberculosis Fact Sheet 2012 op.cit
[90] Ibid
[91]Nigeria Millennium Development Goals 2013 Report p. 47

associated with TB has declined over time from 15.74 per 100,000 in 2000 to 5.0 per 100,000 in 2012.[92]

In 1993, Nigeria adopted the Directly Observed Treatment Short Course (DOTS) as a strategy for TB and implemented it in 36 states and the Federal Capital Territory (FCT). However, distance to DOTS centers and quality of DOTS services remained a huge challenge to the national target of TB case detection and treatment success rates.[93] Nigeria established the National Tuberculosis and Leprosy Control Program (NTLCP) an agency under the Federal Ministry of Health. The NTLCP coordinate TB and leprosy activities in Nigeria with the aim to reduce significantly the socio-economic impact and transmission of TB and leprosy in the country. The targets of the NTLCP have been set within the framework of the MDG. In 2006, the World Health Organization launched the Global Stop TB as an approach to reducing the burden of TB across all countries and in line with global target set for 2015. The main goal of Nigeria's TB program is to halve the TB prevalence and deaths rates by 2015. The states with high TB prevalence include Lagos, Kano and Oyo states. These states are worst affected due to overcrowding. TB affects the most productive age group of 25-34 which accounts for 33.6% of the smear positive cases registered in 2010.[94]Though progress has been achieved in controlling TB, challenges remain in meeting the set targets which include poverty as TB is more endemic in poor rural areas that are mostly overcrowded with inadequate ventilation coupled with malnutrition.[95]

[92]Ibid. See also the Mid Term Report of the Transformation Agenda: Taking Stock, Moving Forward p.205
[93] Nigeria Tuberculosis Fact Sheet Retrieved on 07/04/14 from photos.state.gov/libraries/Nigeria/487468/pdfs/JanuaryTuberculosisFactSheet/pdf
[94] Ibid
[95]Ibid

Malaria affects 3.3 billion or half of the world's population in 106 countries and territories.[96]Malaria continues to be a public health concern in Nigeria where it accounts for more cases and deaths than any other country in the world.[97] It is estimated that Nigeria records nearly 110 million clinically diagnosed cases of malaria every year with an estimated 300,000 children dying every year of malaria.[98] Only 3% of Nigerians live in the malaria free highland while 97% of Nigeria's population is at risk of malaria.[99] About 11% of maternal deaths, 25% of infant mortality and 30% of under-five mortality occur as a result of malaria in Nigeria.[100]

Nigeria had established policy and strategies for the prevention of malaria in the country. In line with the policy strategy, the National Malaria Control Strategic Plan (NMCSP) addressed national health and development priorities including the Roll Back Malaria (RBM) goal and the MDGs. Nigeria introduced the RBM Initiative in 1999 and had distributed millions of Long Lasting Insecticide Treated Nets (LLITN) procured under the debt relief gains to fill the gap and ensure comprehensive nation-wide coverage.

There is a drastic increase in the ownership of at least one Insecticide Treated Net(ITN) from 8% in 2008 to 50% recorded in 2013.[101]Poverty and place of residence affects ownership of ITNs.[102] For example there is rural and urban divide with the urban area more likely to own ITNs than those households in the rural areas.[103]

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[96] Nigeria: Malaria Fact Sheet 2011. Retrieved on 15/07/13 from http://photos.state.gov/libraries/nigeria/231771/publication
[97] Nigeria Millennium Development Goals 2013 Report p. 46
[98] Nigeria: Malaria Fact Sheet 2011 op. cit
[99] Ibid
[100] Nigeria Millennium Development Goals 2013 Report
[101]NDHS 2013 Preliminary Report p. 34
[102]Millennium Development Goals Performance Tracking Survey Report 2012 National Bureau of Statistic p. 35. See also MIC 4, 2011
[103] Ibid

5.5 Key challenges to attaining the MDGs in Nigeria

Addressing the MDGs needs to go beyond access to medical services to underlying human rights issues and socio-economic factors that exercabates the slow progress made in attaining the MDGs and consequently the right to health. The health related MDGs and targets therefore, needs to be considered in the context of the right to health taking into consideration a range of human rights commitments made by states.

5.5.1 Inequities in the distribution of human health resources and facilities

Equity is an ethical concept grounded in the principle of distributive justice and reflects "a concern to reduce unequal opportunities to be healthy associated with membership in less privilege social group, such as poor people, disenfranchised, racial, ethnic or religious groups, **women and rural residents**."[104] The right to health is based on the principle of equity in health care. Nigeria is home to one of the largest stock of human resources for health (HRH) in Africa only comparable to Egypt and South Africa.[105] However, in Nigeria, there are inequities in the distribution of health care infrastructures, facilities and human resources as most are located in favor of urban, southern and tertiary health care services delivery.[106] Most of the health facilities are located in the urban communities and people in the rural communities lack emergency services and care and suffer communication difficulties such as distance to health care, transportation problems and lack of information about health services that are available.

[104]Braveman, P. and Gruskin, S.(2003). Bulletin of the World Health Organization (WHO) 81(7)
[105]Human Resources for Health Strategic Plan 2008-2012 Federal Ministry of Health, Abuja (HRH Strategic Plan)
[106]Human Resources for Health Country Profile for Nigeria Africa Health Workforce Observatory Retrieved on 22/01/14 from www.unfpa.org/sowmy/resources/docs/library/R050_AHWO_2008_Nigeria_HRHProfile.pdf (HRH Country Profile)

On the average, an urban resident has access to nearly three times more doctors and two times more nurses/midwives compared to a rural resident.[107]As a consequence of this disparity, maternal and child mortality tend to be higher in the rural areas compared to the urban counterpart. For instance, child mortality in the rural area was 182 deaths per 1000 live births compared to 106 deaths per 1000 live births in the urban area while infant mortality was 110 in rural area compared to 68 in urban area.[108]73.9% of women in the urban area are more likely to be attended by skilled birth personnel than women in the rural areas (37.1%).[109] Women in urban areas (69%)are more than twice as likely to deliver in a health facility than their rural counterpart (34%).[110] Women in the urban area are more likely to get information and have knowledge of HIV/AIDS than those in the rural area.[111]Zones with high mortality have lower doctor density per 100,000.[112]

Table 5-Childhood Mortality by Area of Residence

Area of Residence	**Infant Mortality**	**Under 5 Mortality**
Urban	68	106
Rural	110	182

Source: MIC 4, 2011 p.17

Table-6 Maternal Care Indicators by Area of Residence

Area of Residence	Percentage delivered by skilled provider	Percentage delivered at health facility
Urban	73	69
Rural	37.1	34

Source: NDHS 2013, p.22

[107]Chankova, S., Nguyen, H. et al (2006*).A Situation Assessment of Human Resources in the Public Health Sector in Nigeria*. Bethesda, MD: The Partners for Health Reform *plus Project, Abt Associates Inc.*
[108]MIC 4, 2011 p.17. See also Millennium Development Goals Performance Tracking Survey Report 2012 p.27
[109] MIC 4, 2011 p145, NDHS Preliminary Report 2013 p 22, Millennium Development Goals Tracking Survey Report 2012 p30
[110]MIC 4 2011 p. 145, NDHS Preliminary Report 2013 p.22
[111] MIC 4, 2011 p. 33
[112] HRH Strategic Plan p.19 op.cit fn 103

Table 7- Knowledge about HIV/AIDS by area of Residence, 2013

Area of Residence	Male	Female
Urban	98.3	97.3
Rural	93.3	89.2

Source: NDHS 2013, p. 37

Meeting the MDGs has a lot of implication for HRH. Among the priorities for development assistance towards achieving the MDGs is increased accessibility and provisions of qualified health personnel.[113] In response to this, the government of Nigeria developed Policy document for Human Resources for Health and the Human Resources for Health Strategic Plan to "guide the implementation of the Human Resources for Health Policy at all levels. The Human Resources for Health Strategic Plan provides a framework for resource mobilization based on priority areas for intervention in health workforce, planning, management and development."[114]

5.5.2 Poverty and cost of health care

One of the elements of the right to health is that health care must be economically accessible which means that people should be able to afford health care. Poverty is a major barrier to accessibility to health care and towards achieving progress in the MDGs. Poverty and health have been described as a vicious circle as people who are poor cannot afford basic health care and people who are sick cannot work and earn a living thereby plunging them into further poverty. Poor households experience high burden of disease. 69% of Nigerians live below the poverty line.[115]Poverty is more endemic in the North-

[113]Chankova, S., Nguyen, H., et al (2006) op.cit p 19
[114] HRH Strategic Plan p. 7
[115]Nigerian National Bureau Statistics (NBS). 2011 Harmonized Living Standards Survey 2010. Abuja (NBS 2011

West with 77.7% of poor and North-East with 76.3%.[116] These regions have the highest maternal and child mortality in Nigeria.[117]

Poverty affects more women even though women account for more than half of the Nigerian population.[118]Accessing health care therefore, is illusive to most Nigerians particularly women due to poverty. For example in Nigeria, women in the highest wealth quintile are more likely to be attended by skilled birth personnel (89.7%) than women in the lowest wealth quintile (11.0%)[119] and children born into wealthy family are more likely to survive (76 deaths per 1000 live births) than those born into poor families (223 deaths per 1000 live births)[120] making women and children who are poor more at risk of maternal and child death.

Table 8- Assistance during delivery 2011

Wealth Index Quintile	**Delivery Assisted by any Skilled Attendant**
Poorest	11.0
Second	25.8
Middle	49.8
Fourth	72.7
Richest	89.7

Source: MIC 4, 2011 p. 145

[116] Ibid
[117] NDHS 2013 Preliminary Report, Nigeria: Millennium Development Goals 2013 Report
[118]Gender in Nigeria Report op.cit fn 69
[119] MIC 4, 2011 p 145, Millennium Development Goals Performance Tracking Survey Report, 2012 p.30
[120]MIC 4, 2011 p. 17

Table 9- Child Mortality by Wealth Index

Wealth Index Quintile	Infant Mortality Rate	Under 5 Mortality Rate
Poorest	132	223
Second	121	204
Middle	89	143
Fourth	73	115
Richest	51	76

Source: MIC 4, 2011 p. 17

Though maternal and child mortality affects all social strata, the fact that it is more prevalent among women and children from low socio economic groups makes it a poverty related issue. Getting money to attend antenatal care in Nigeria particularly among the rural women is the leading barrier to accessing health services in Nigeria.[121]

This had made some states in Nigeria to develop free user fee policies to reduce the burden of medical cost particularly for women and children. Kano state was one of the first states to introduce free maternal care in all the secondary health facilities in the state in 2001.[122]Services involved in the free maternity care program include free Antenatal care (ANC),including care and antennal drugs free vaginal and assisted vaginal delivery, free Caesarian Section (elective and emergency) free post abortion services, free management of ectopic and laporatory for obstetric complication, free child health care under 5, free Vesico-vaginal repair.[123]Since the introduction of the free maternal and child care, there had been an increase in ante natal attendance but however, the state faces the challenge of lack of corresponding increase in human resources for health (with a

[121] Baseline Study on Maternal Health Indicators in Nigeria, Federal Ministry of Women Affairs and Social Development Abuja, 2007 p. 77. See also Survey and Development of Social Framework on Reduction of Maternal Mortality in Nigeria Federal Ministry of Women Affairs and Social Development Sept 2009 p.26
[122] Galadanchi, H.S, Idris, S.A. et al (2010). *Programs and Policies for Reducing Maternal Mortality in Kano State: A Review* African Journal of Reproductive Health 14 (3) p33
[123] Ibid

ratio of one doctor to 42,847 persons and 6383 persons per nurse) and inadequate infrastructure and facilities.[124] An estimated 69% of Nigeria's population lives in poverty and poverty is a major factor in malaria prevention and treatment.[125] Other states that have introduced free maternal health services include Lagos, Gombe, Enugu, Jigawa, Rivers, Katsina, Kaduna.[126] However, with the exception of Enugu that has a policy on free maternal health services, in all the states mentioned there is no policy or legal framework to back the free maternal health services.

A research conducted in Nigeria,[127] revealed that the prevalence of fever was highest among children from the poorest households (17%) compared to the middle households (15%) and the wealthiest (13%). This is so because poverty prevents people from getting timely health care or affording preventive measures as Insecticide Treated Nets (ITN).

There are many policies and strategies aimed to reduce poverty in Nigeria. Notably National Economic Empowerment Development Strategy (NEEDS), Nigeria's Vision 20:20:20, 7 Points Agenda, Transformation Agenda and the MDGs. However, with all these strategies, poverty is endemic in Nigeria. Also, the National Health insurance Scheme (NHIS) was established to reduce the burden of household out of pocket expenses for health. However, the NHIS has failed to deliver in the sense that, it only covers the formal sector leaving the majority of Nigerians to bear the catastrophic household health cost.[128]

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[124] Ibid

[125] Nigeria: Malaria Fact Sheet op cit fn 71

[126]Report of the Assessment of Free Maternal Health Services in Nigeria Retrieved 12/11/14 fromwww.unilorin.edu.ng/publications/sakami/Technical%20Report%20%saka%20%MJ/Report%20of20%Free%20Maternal%20Health%20Services.pdf

[127] Adeoye, Y.O. (2010).Poverty and Fever Vulnerability in Nigeria: A Multilevel Analysis *Malaria Journal* Vol. 9 p.235

[128] Mid-Term Report of the Transformation Agenda (May 2011-May 2013): Taking Stock, Moving Forwardp.205

5.5.3 Availability of health care facility and poor utilization of reproductive health services

Availability of health care facilities is an element of the right to health and a means to attaining reduction in maternal mortality, childhood mortality and HIV/AIDS. It is recommended by the World Health Organization that there should be a minimum of 5 Emergency Obstetric Care (EMOC) facilities per 5000,000 populations with at least one providing comprehensive care.[129] However, the situation is the reverse in Nigeria as in a research conducted in the country only Lagos State met the standard of four Basic EMOC facilities per 500,000 populations. Overall, only seven states in the states surveyed met the standard basic EMOC per 500,000 populations putting both private and public health care facilities with a higher proportion of the private health care facilities meeting the EMOC standard.[130] Apart from nonavailability of standard EMOC, there is still the problem of poor coverage of services particularly in the Primary Health Care (PHC) which is the closest facility for children and pregnant women and most often with no qualified midwife and no adequate materials and infrastructure.[131]

Reducing childhood mortality, improving maternal health and combating HIV/AIDS, Malaria and Tuberculosis and consequently the right to health not only include access to medicines but also the right to health related information including reproductive health care and services. These rights are set out in a number of instruments including platform for action adopted at the Fourth World Conference on Women in Beijing in 1999,[132] the International Conference on Population and Development (ICPD) in 1994[133] and the

[129]National Study on Essential Obstetric Care Facilities in Nigeria Federal Ministry of Health and UNFPA 2003. See Baseline Study on Maternal Health Indicators in Nigeria Federal Ministry of Women Affairs and Social Development Abuja, 2007 p. 51
[130]Ibid
[131] Ibid
[132]Beijing Declaration and Plat Form for Action Fourth World Conference on Women 15th September 1995 A/CONF.177/20(1995)
[133]International Conference on Population and Development Program of Action (POA) Retrieved on 15/04/14 from wwwiisd.ca/cairo/program/p07000.html

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[134] the African Charter on Human and Peoples Rights,[135] Protocol to the African Charter on the Rights of Women[136]etc. One of the targets for MDG 5 is to achieve universal access to reproductive health by 2015 which is an element of the internationally recognized right to health.[137]

Maternal mortality reflects some of the most severe inequities in living conditions of women of reproductive age, their access to health services and the quality of the care they receive including access to reproductive health care services. The situation results in death and health problem that could be avoided. Quality reproductive health services as well as timely interventions are fundamental for achieving good maternal health. Yet, women in Nigeria continue to die needlessly as a result of lack of these services.[138] There is also inequity with respect to accessing reproductive health services particularly among women in the rural areas. Most of the health facilities are located in the urban area and women in the rural area lack emergency services and care and suffer communication difficulties such as distance to health care, transportation problem, and lack of information about health services that are available.[139]

One of the indicators for improving maternal health is the prevalence of contraceptive which can help women to space their children. The contraceptive prevalence remains low

[134] Convention on the Elimination of All Forms of Discrimination Against Women adopted 18 Dec. 1979, G.A Res. 34/180, UN. GAOR 34TH Sess., Supp. No. 46 , U.N.Doc. A/34/46 (1980) (entered into force 3 Sept.) Nigeria signed on the 23 April 1984 and ratified on 13 June 1985.
[135] The African Charter on Human and People's Right adopted 26th June 1981, O.A.U Doc.CAB/LEG/67/3 Rev.5 entered into force 21 Oct. 1986. Nigeria signed on 31 August 1982 and ratified in 1983.
[136]Protocol to the African Charter on the Rights of Women in Africa 2nd Ordinary Session; Assembly of the Union. Adopted July 2003Nigeria ratified on 16 December 2003
[137] CESCR General Comment 14: The Right to the Highest Attainable Standard of Physical and Mental Health (General Comment 14) Para 12.2. See also Art 12 and 14 CEDAW
[138] Baseline Study on Maternal Health Indicators in Nigeria Federal Ministry of Women Affairs and Social Development, Abuja, 2007
[139]Baseline Study on Maternal Health Indicators in Nigeria Federal Ministry of Women Affairs and Social Development Abuja, 2007 p. 51

in the country. This is despite the increase from 8.20% in 2004 to 17.30% in 2012.[140] Utilization of contraceptive is poorer in the North West (4%) and North East (7%)[141] with the highest incidence of maternal and childhood mortality[142] and high fertility rate of 7.2 and 6.7 respectively[143] which is higher than the national average of 5.7%.[144] For instance, use of contraceptive is lowest in Kano and Jigawa States (less than 1%).

Table 10- Differentials in Contraceptive use in Nigeria

Region	**Percentage**
North-Central	16
North-East	3
North-West	4
South-East	29
South-South	28
South-West	38

Source: NDHS 2013, p.17

Contraceptive has been an issue that has stirred controversies in Nigeria particularly among traditional and religious groups who value child bearing as pride for the woman and her family and or see it as a religious duty.[145] A finding of a research conducted by Pathfinder in six states in Northern Nigeria reported that utilization of contraceptive is low because of the belief that God has asked people to procreate and consequently the desire to have many children, lack of trust of those who promote child spacing as it is a

[140] Nigeria: Millennium Development Goals 2013 Report p. 36. See also Millennium Development Goals Performance Tracking Survey 2012, National Bureau of Statistics (NBS) p. 30
[141]MIC 4 Report, 2011 p. 131
[142]Nigeria: Millennium Development Goals 2013 Report p. 39
[143]MIC 4 Report, 2011 p.123
[144]Ibid p. 123
[145]www.pathfinder.org/publications-tools/pdfs/Reproductive -Health-Knowledge-and-Practices-in-Northern-Nigeria-Challenging-Misconceptions Retrieved 22/01/14 p11 . See also Baseline study on Maternal Health Indicators in Nigeria Federal Ministry of Women Affairs and Social Development Abuja, 2007 p. 27

western concept or for other cultural reasons e.g. to improve the social status of the woman in the family.[146]

Another indicator established to monitor progress towards improving maternal health is whether or not births are attended by skilled health provider.[147] The advantage of having a skilled health provider is to monitor the child birth in case of any complications and provide referrals to other services. In Nigeria 38% are delivered by skilled health provider and 36% take place in health facilities[148] thereby limiting the chances of being attended by skilled health provider. In Kano state, 83.3% of women give birth at home which is higher than the national figure of 62% of women delivering at home. Although the figure of births attended by skilled health provider in Kano rose from 18.3% in 2009 to 48.9% in 2011, there is still more to be done in order to improve reproductive health services in the state.[149]

The trend in ante natal attendance has drastically increased from 58 of women receiving ante-natal from skilled provider in 2003 to 61 in 2013.[150] Ante-natal detects pregnancy related problem early which will in turn lead to timely treatment and referral in case of any complications. The Ante-natal Policy in Nigeria recommends at least four ante-natal visits for women without complications.

Table 11- Maternal Health Indicators

Percentage delivered by a skilled provider	Percentage delivered in a health facility	Percentage with ante natal from a skilled provider
38.1	36.8	60.1

Source: NDHS 2013 p.22

[146]Ibid p11
[147]Skilled provider includes doctors, nurses, midwives and auxiliary nurses/midwives.
[148]NDHS Preliminary Report 2013 p. 21
[149]Report of the 2011Joint Annual Review of the Strategic Health Development Plan Kano State
[150]NDHS Preliminary Report 2013 p. 20. See also Nigeria: Millennium Development Goals 2013 Report p. 37, Millennium Development Goals Performance Tracking Survey 2012 p.30

5.5.4 Women's low socio-economic status and lack of empowerment

Improving the status of women and promoting their rights is a key to reducing maternal and child mortality and help to halt and reverse the spread of HIV/AIDS thereby making progress in attaining the MDG 4, 5 and 6. Women constitute more than 50% of the world's population and perform two thirds of the world's work, yet they receive one tenth of the world's income and own one of hundreds of the world's property and constitute 70% of the world's one billion poorest people.[151]When women are economically empowered, they are more likely to participate in major household decisions including those related to fertility. Women invest a higher proportion of the earnings in their families and communities. Child survival increases when the mother is economically empowered.[152]

Women constitute 49% of Nigeria's population representing 80.2 million girls and women.[153] Yet they lag behind in formal education, formal employment, ownership of land and resources. Without education, employment and resources, their ability to make decisions concerning their health and other major household decision is limited.[154] Men make most of the household decisions including those related to fertility.[155] The ability of women to make decisions that affect their personal circumstance is essential for their empowerment. A woman's desire and ability to control her fertility and her choice of contraceptive methods are affected by her status in the household and her own sense of

[151] Gender in Nigeria Report 2012: Improving the lives of Girls and Women in Nigeria 2nd ed. UK DFID
[152] Women Economic Empowerment The OECD DAC Network on Gender Equality (GENDERNET): In Poverty Reduction and Pro-Poor Growth: the Role of Empowerment 2012 Retrieved on12/04/14 from www.oecd.org/fr/cad/reductiondelapauvrete/povertyreductionandpro-poogrowththeroleofempowerment.htm
[153] Ibid
[154] Gender in Nigeria 2012 Report op.cit fn69
[155]Ibid. See also Baseline Study on Maternal Mortality: Appreciating the Impact of Socio-Cultural Factors in Nigeria Federal Min of Women Affairs and Social Dev. Abuja, 2010 (Baseline Study on Maternal Mortality 2010), Survey and Development of Social Strategic Framework on Reduction of Maternal Mortality in Nigeria Federal Ministry of Women Affairs and Social Development, 2009 p.23

empowerment.[156] As women become more empowered, they are more likely to participate in key decisions regarding their well-being and that of their children.[157]

Education is a powerful tool for the empowerment of women. Education of the mother plays a crucial role in determining maternal and child mortality. The higher a woman's education the more likely she will play a better role in decision making and exercise her reproductive rights. Educated mothers are more likely to use health services and have fewer and better nourished families.[158] Children of educated mothers are more likely to survive than children of uneducated mothers[159]. The NDHS 2013 reports that ante-natal care is highest among women with more than secondary education (97%) and lowest among women with no education (36%).[160] Educated women are more likely to be delivered by a skilled health provider (93.2%) than women with no education (11.7%) and are also more likely to deliver in a health facility (91.3%) than women with no education (11.2%).[161]

Table 12- Maternal care indicators and Mother's education

Mothers education	**Percentage delivered by a skilled provider**	**Percentage delivered in a health facility**	**Percentage with ante natal from a skilled provider**
No education	11.7	11.2	36.2
Primary	44.3	41.5	71.5
Secondary	71.7	65.9	87.6
More than secondary	93.2	91.3	97.3

Source: NDHS 2013 p. 22

[156] See Baseline Study on Maternal Mortality 2010
[157] Ibid
[158] Ibid p.45
[159] Gender in Nigeria Report op.cit fn 69
[160]NDHS 2013 Preliminary Report p.20
[161]NDHS 2013 Preliminary Report p.22. See also MIC 4, 2011 p. 145

Equally, infant and under five mortality is 66and 102 deaths per 1000 live births for children whose mothers have more than a secondary education, 83 and 134 for children whose mothers have primary education and 121and 203 for children with mothers with no education.[162]

Table 13- Childhood Mortality and the Mothers education

Mothers education	**Under 5 Mortality**
None	203
Primary	134
Secondary +	102

Source: MIC 4, 2011 p. 17

[162] MIC 4, 2011 p. 17

CHAPTER SIX

FACTORS IMPEDING THE REALIZATION OF THE RIGHT TO HEALTH IN NIGERIA

6.1 Introduction

Myriad factors combine to impede the realization of the right to health in Nigeria. Chiefly among these factors include legal impediment, socio- cultural and economic impediment and Lack of political will. This chapter examines these factors and how they affect the actualization of the right to health in Nigeria**.**

6.2 Constitutional Impediment

The bifurcation of the Civil Political Rights (CPR) and Economic, Social and Cultural Rights (ESCR) into two separate covenants has created a distinction between the two sets of rights which has create difference between the two set of rights and has contributed to the further marginalization of the ESCR in states. This much has been translated in the constitutions of different states in the world. In most parts of Africa with the exception of South Africa, ESCR are either non justiciable rights in the constitution (e.g. Nigeria, Ghana,[1] Uganda,[2] Malawi[3]) or are even absent in the constitution (e.g. Kenya and Botswana).

[1]Art. 34 (1) of the Ghanian Constitution provides "the Directive Principle of State Policy in this chapter shall guide all citizens, parliament, the president, the Judiciary, the council of state, the cabinet, political parties and other bodies and persons in applying or interpreting this constitution or any other law and in taking and implementing any policy decision for the establishment of a just and free society. (2) The President shall report to the parliament at least once a year all the steps taken to ensure that the realization of the policy objectives contained in this chapter and in particular the realization of basic human right, a healthy economy, the right to work, the right to good health care and the right to education.

[2] Art. 14 of the Ugandan Constitution provides General social and economic objectives the state shall endeavor to fulfill the fundamental rights of all Ugandans to social justice and economic development and shall, in particular, ensure that i) all developmental efforts are directed at ensuring the minimum social and cultural well-being of the people; and ii) all Ugandans enjoy rights and opportunities and access to education, health services, clean and safe water, work decent shelter, adequate clothing, food security and pension and retirement benefits.

[3] Art. 13 (2) of the Malawian Constitution provides: The state shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislations aimed at achieving the followings aims: to provide adequate health care, commensurate with the health needs of the Malawian society and international standard of health care.

Thus, in Nigeria, Economic, Social and Cultural rights found their way in the 1979 Constitution as Fundamental Objectives and Directive Principles of State Policy and as non-justiciable rights. This attitude can be seen from the cases of *Okogie v A.G Lagos State* [4]which decision had been re-echoed in several cases like *A.G Ondo State v A.G Federation.*[5] In *Uzuokwu v Izeonu*[6] the courts clearly made the distinction clear when it stated that:

> There is a clear distinction between 'Fundamental Human Rights' and Human Rights…Fundamental Rights"…are fundamental because they have been guaranteed by the fundamental law of the country that is the constitution. There are certain rights pertaining to a person, which are neither fundamental nor justiciable in the courts. These may include, for instance, rights given by the constitution under the Fundamental Objectives and Directive Principles of State Policy contained in Chapter II of the constitution of the Federal Republic of Nigeria, 1979.

The absence of an justiciable right to health increases the difficulty of holding the government accountable for its failure to provide lifesaving health care services to its populations and also to challenge government priorities for its expenditures as to "shut the jurisdiction of the court completely is to leave public officials to do as they fit, and to ravel in arbitrariness, impunity, corruption and irresponsibility and to leave the people in a state of perpetual hopelessness. What is the essence of government that you cannot hold accountable to the very objective of governance?"[7]

Apart from the non justiciability of the right to health under the Nigerian constitution, the constitution had not delineated the role and responsibility each of the three tiers of government should play with respect to the health system in the country. This had enabled the three tier of government to shirk away from its health responsibilities.

[4](1981) 1 NCLR 218
[5](2002) FWLR pt 111, 1972
[6](1991) 2 NWLR PT 200 p 708
[7]Francis, M *Reflections on Fundamental Objectives*

However, the Revised National Health Policy 2004 (NHP) had allocated the Primary Health Sector to the Local Government, the Secondary Health Sector to the State Government and the Tertiary Health Sector to the Federal Government. Each level of government is responsible for its health care leaving the Federal Government with little or no grip over the health system in the country. The NHP lacked legal force unlike the constitution or other legislations, it cannot enforce legal obligations.

This had resulted in "dysfunctional health care system in which all three tier of government have failed to priotized their health care duties and have faced no political or legal repercussions for doing so."[8]

6.3 The attitude of the court/judges

S. 6 of the 1999 constitution of Nigeria vests judicial powers on the courts. The section states that "[T]he judicial powers of the federation shall be vested in the courts to which this section relates being courts established for the federation." The constitution imposes a duty on the arms of government to see to the observance of the provisions of chapter II of the constitution.[9] The judiciary is tasked with upholding and assuming the role of watchdog so as to ensure that the other branches of the government act within their constitutionally imposed limitations. The court is therefore the last hope for the poor for the realization and enforcement of human rights as was explained that "court action plays a very important role in delivering social justice and realizing an egalitarian society where the political system has failed to respond to demand for socio-economic transformation court action might achieve significant result."[10]

[8] Broken Promises: Human Rights, Accountability and Maternal Death in Nigeria A Publication of Women Advocate Resource and Documentation and Center for Reproductive Rights
[9] S. 13 1999 Constitution of the FRN as amended
[10]Udonbana, N.J. (2007). Shifting Institutional Paradigm to Advance Socio-Economic Rights in Africa An unpublished PhD Thesis Submitted to the University of South Africa

The role courts play in delivering human rights in Nigeria is limited to civil and political rights by the ouster provision of section 6 (6) (c) of the constitution. As Udombana lamented, the attitude of Nigerian courts with respect to fundamental objectives has always been hinged on the decision in the case of *Archbishop Okogie v. A.G. Lagos State*.[11] Hence, the persistent attitude of the courts with respect to delivering socio-economic rights including the right to health is negative and not encouraging. This is because the attitude of the courts is always that fundamental objectives are non-justiciable and therefore the courts have no jurisdiction to entertain any case that falls under the provision of chapter II of the constitution.

Non justiciability of the right to health in the constitution is a challenge but not a bar to enforcement of the right to health. There are avenues within which such right could be litigated and enforced. Litigating the right to health however, all depends on how active and innovative our courts are. The constitution has guaranteed the independence of the judiciary[12] and has made the court the guardian of human rights.[13] This thus serves as enough impetus on the courts to be pro-active in dealing with socio economic rights as the Indian Supreme Court.

The courts play an important role in delivering social justice to Nigerians and hence they need to be progressive and expansive in their approach to socio economic rights like the right to health. The court has become the voice for the voiceless and should stand "firmly between individual citizens and the wielders of power" and become "the ultimate arbiter

[11](1981) 1 NCLR 218
[12] S 17 (2) (e) 1999 Constitution FRN
[13] S 46 Ibid

in the arena of constitutional rights necessitating a more active approach to adjudication."[14]

The time of treating socio - economic rights as non-justiciable is losing ground. And Nigerian judges should take cue and act progressively and liberally in protecting the right to health. The constitution has recognized the right to life[15] and human dignity[16] which should be interpreted liberally and generously to be part of the right to health. This has been stressed by the Committee on ICESCR in its General Comment 6 that:

> The right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner; and the protection requires that states adopt positive measures. In this connection the committee considers that it would be desirable for state parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.[17]

Life has been described as "the fulcrum of all other rights and as the fountain through which other rights flow with any violation of the right amounting to deprivation of the right to life."[18] Therefore, deprivation of the right to health will necessarily amount to deprivation of the right to life.

Law is said to be "alive" and therefore grows with the growth of the society and as such courts should interpret the constitution in a way to give it life and not to treat it as a "lifeless piece of museum."[19] As Aguda stated "…the primary duty of the judges is to make the constitution grow and develop in order to meet the just demands and aspiration of an ever developing society which is part of the wider and human society governed by

[14]Quinsah, E.K. and Fombad, C.M. Judicial Activism In Africa: Possible Defense and Authoritarian Resurgence. Retrieved on 25/05/12 from www.ancl--radc.za/.../judicial%20activism%20in%20Africa.pdf.
[15]S 33 1999 Constitution FRN
[16]S 34 Ibid
[17]UNICESCR General Comment 6 Para 5.
[18]*Forum of Conscience vs Sierra Leone* 2000 AHRLR 293 (ACHPR) Para 19.
[19]*Attorney General vs Daw* (1992) BLR 119 AT 166 per Aguda J.A.

some acceptable concepts of human dignity."[20]The constitution must then be "regarded as a living document designed to serve the present and the future generation as well as reflect and embody their fears, hopes and aspirations."[21]

Thus, Indian supreme court have overcome the debate of justiciability of directive principles by adopting an expansive and purposive approach through judicial activism. The Indian supreme court have demonstrated that non justiciability problem is not insurmountable and can be overcome by interpreting civil and political rights generously to accommodate directive principle and state policy. The Indian approach to expansive interpretation of the right to life has made a lot of impact in other jurisdictions. For instance, in Bangladesh, the court held in the case of *Dr. Mohiuddin Farooque v. Bangladesh and Ors*[22]that:

> The right to life is not limited to the protection of life and limb necessary for the full enjoyment of life but also includes, among other things, the protection of the health and normal longetivity of an ordinary human being and that if this was threatened by a man made hazard then the state could be compelled by the courts to remove the threat (unless justified by law) even where its primary DPSP obligation under art 18 to raise the level of nutrition and improve public health could not be enforced. [23]

Again, the enjoyment of the civil and political rights is dependent on the enjoyment of fundamental objectives as Justice Bhagwati explained in the case of *Minerva Ltd v. Union of India* that:

> There are millions of people in the country who are steeped in poverty and destitution, and for them these civil and political rights have no meaning. It was realized that to a larger majority of people who are living in almost sub human existence...and for whom life is one broken story of want and destitution, notion of individual freedom and liberty, though representing some of the most

[20]Ibid.
[21]Ibid.
[22]48 DLR (1996) HCD 438 in Byrne, I. (2005).Making the Right to Health a Reality: Legal Strategies for Effective Implementation. *Common Law Conference, London, September* Retrieved on 12/16/12 from http://www.escr-net.org/usr_doc/health_paper.doc p. 18.
[23]Ibid

> cherished values of a free society would sound as empty words bandied about in drawing rooms of the rich and well to do and the only solution for making these rights meaningful to them is to remake the material condition and usher in a new social order socio economic justice would inform all institution of public life so that the precondition of fundamental liberties for all may be secured. Fundamental rights are no doubt important and valuable in democracy, but there can be no real democracy without social and economic justice to every one which is the term of Directive Principles….[24]

This rightly suggests that even where the right to health is minimally protected under directive principles and therefore non justiciable in the case of Nigeria, it will not be a bar in making them subject to litigation and holding the government accountable. But courts must be bold enough to be expansive in their interpretation of rights. This explains why Benito insist more on the role of the courts rather than the constitution in the protection of socio – economic rights including the right to health. This is because even where the constitution entrenches rights as non-justiciable, the courts are active, such rights can be brought to life.

6.4 Socio-Cultural and Economic Impediments

Several socio-cultural and economic factors combine to impede the realization of the right to health in Nigeria. Nigeria is home to different ethnic groups and hence different cultures some of which impact negatively to the realization of the right to health in the country. Traditional beliefs, norms and values shape the attitude of a given community particularly as they relate to women and children. Such traditional norms include early marriage and childbearing, low status of women in the family as decision maker, food taboos, male preference to girl child etc.

Women are traditionally and generally subservient to their male counterpart in decision relating to fertility like when to have children, how many children to have, children's

[24]Ibid at 1843.

education etc. This limits their ability to influence major decisions in the family particularly as it relates to maternal health.[25] Some cultures have food taboos which influence negatively on maternal and child health where the eating of certain food which are nutritious and recommended for pregnant women is considered as taboo e.g. eating of snail, meat and fruits.[26]Other cultural practices include those related to bleeding during pregnancy which is attributed to the infidelity of a woman and it is believed that to have a successful delivery, she must confess her infidelity.[27] Also a survey conducted by the Federal Ministry of women Affairs shows that men do not like their wives being attended to by male doctors/skilled health providers during pregnancy and child birth thereby increasing the unattended birth and encouraging home delivery.[28]

Other factors include socio- economic factors like distance from of health facilities from the woman's home. Survey showed that women in the urban areas took less time to go to a health facility due to combination of factors including availability of better roads, more health facilities per unit population and better means of transport.[29] Another factor is the delay in seeing health provider at health facility and poor unfriendly attitude of health workers when eventually attended to by the health workers drives away women from attending the routine ante natal care and having their babies in a health facility.[30]

6.5 Corruption and mismanagement of states resources

Corruption is a global phenomenon that cuts across the globe though manifested in different manner and level. There is an inextricable link between acts of corruption and

[25]Survey and Development of Social Strategic Framework on Reduction of Maternal Mortality in Nigeria Survey and Development of Strategic Framework 2009), Federal Ministry of omen Affairs and Social Development, Abuja ,2009 p. 29
[26] Ibid p. 29
[27]Baseline Study on Maternal Mortality: Appreciating the Impact of Socio-Cultural Factors in Nigeria Federal Ministry of Women Affairs and Social Development, Abuja 2010 (Baseline Study 2010) p. 30. See also Survey and Development of Social Strategic Framework 2009, p. 36
[28]Baseline Study 2010 p.37
[29]Survey and Development of Strategic Framework 2009, p. 29
[30]Survey and Development of Social Strategic Framework 2009 p 30. See also Baseline Study 2010, p. 18

human rights including the right to health. Where the level of corruption is high, there is likely hood that the state will be disable to fulfill its duties to respect, protect and fulfill human rights of its citizens"[31] There is no universal definition of corruption. However, the Transparency International has defined Corruption as "the abuse of entrusted power for private gain."[32] Corruption has an adverse health consequence as put by Toebes that corruption "deprives people of access to health care and leads to poor health outcomes"[33] Corruption negatively affects the accessibility, acceptability, availability and quality of health services of a country. For instance, where corruption is endemic, money meant for health is siphoned and end up in private pockets. This means that drugs and other necessary medication meant to promote the health status of the citizens are not available. Also, citizens are denied physical and economic access to medication facilities, goods and services in cases where it is available but cannot be accessed due to poverty caused by corruption. Where hospital staffs divert drugs meant to be disbursed free for the promotion of health status of the citizens affects the availability of health care. Corruption equally affects the quality of life in the country. For instance, companies manufacturing fake or substandard drugs affects not just the right to health but equally, the right to life.

Nigeria is deeply imbedded in corruption. This fact is evidenced from the Transparency International (TI) Corruption Index that ranked Nigeria in 2010 as 143 out of the 183 states it assessed which the Nigerian government whole heatedly accepted when it said:

> President Obasanjo has no objection to the result shown in the (Transparent International) poll. The poll shows the magnitude of the challenge the present administration is facing and addressing energetically. It should also draw further attention to the need for

[31]Githii J. (2009). Defining the Relationship between Corruption and Human Rights *U. pa. J. Int'l L p 3*
[32] Transparency International (TI) (2011) *'Corruption Perception Index' Transparency Transparency International* Retrieved on 25/05/12 from www.transparency org/research/cpi/overview .
[33] Toebes, B. (2007).The Impact of Corruption on the Enjoyment of the Right to Health *Retrieve on 28/05/12.*

> Nigerians to support the federal government's efforts to stem corruption and redeem Nigeria's image within the international community.[34]

Corruption has thus become one of the major challenges for the realization of socio economic rights including the right to health in Nigeria as money allocated for the purposes of the welfare of the citizens are redirected and siphoned to fill private pockets and bank accounts. Thus, the lame excuse of scarce resources does not fit in Nigeria as Nigeria has adequate resources to provide for socio-economic rights including the right to health. It is more of Kleptocracy as argued by Nnamuchi that impedes the realization of the right to health in Nigeria.

In 2007, Nigerian government put in place measures to combat corruption by the establishment of Independent and Corrupt Practices Commission[35] and the Economic and Financial Crimes Commission[36] which all made it an offence to be involved in corruption. However, the commission has failed in cases where the corrupt act involve high standing official to which Nnamuchi stated rightly that:

> This is bound to bring the integrity of the commissions into question and attract serious negative consequences. Continued laxity on the part of the commission to bring high profile corrupt leaders to justice smirks of hypocrisy and lends credence to charges to politically motivated campaign against, and "scapegoating" of political adversaries of the present administration.[37]

This problem has thus undermined not just the commissions but also the rule of law which establishes the supremacy of the law above all citizens be it high ranking or low. It thus has become a problem as the commission established by the government to fight corruption has lost its impartial flavor in the eyes of the public and not only that, corruption continues to flourish and the general system remains "deeply compromised.

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[34]Ribado, N. (2006*).Corruption: The Trouble with Nigeria* Retrieved on 23/05/12 from 23/05/12 http://wwwgamji.com/artic/500/ NEWS5630HTML/.
[35] Laws of the Federation of Nigeria 2004
[36] Ibid
[37]Nnamuchi, O. (2008).*Kleptocracy and its Many Faces: Challenges to the Justiciability of the Right to Health in Nigeria* p 8.

Federal government contracts are routinely inflated to provide kickbacks for office holders and contractors frequently provide substandard or non-existent services. State and local level corruption has far more brazen."[38]

Nigeria lost its international image as a reputable country due to the corrupt practices and thus the country that was once heralded as the beacon of Africa,[39]

> has now fallen somewhat short of this potential. Years of kleptocratic repressive dictators and military rule, coupled with widespread corruption, have resulted in large scale neglect and deteriorating of public services. No where is this mere apparent than within the health sector. Government run health care services barely function [in] a country that is more than capable of providing effective services…"[40]

6.6 Poverty

It is really a paradox that Nigerians are living in poverty amidst wealth. With the abundant natural resources, about 62.8% of Nigerians are living below the poverty line of less than US$1 per day.[41] Poverty has a lot of negative impact on socio-economic right including the right to health. Nigeria thus, represents a classical example of how people in a resource rich country could wallow in abject poverty and have one of the world worst health indices. The recent statistics from National Bureau of Statistics reveal that 61.9% of Nigerians are living below the poverty line with 62.8% earning a dollar per day.[42] There is however, a geo regional disparity with the North - West having the highest percentage of poverty in the country (70%) as compared to North - East(69%), South East (58.7%), South - South (55.9%) and South - West (49.8%).[43] There is also a wide

[38] Kew, D. (2006). Sonja Tatic (ed), Countries at a Crossroad New York Freedom in Fagbadebo, O., (2007).Corruption, Governance and Political Instability in Nigeria *African Journal of Political Science and International Relations vol*. 1 (2) p 033
[39] Nnamuchi, O. (2007).op.cit fn 19, p 7.
[40]Ibid p 8
[41] National Bureau of Statistics: Nigeria Poverty Profile 2010
[42] Ibid Para 2.7.3
[43] Ibid.

difference of the incidence of poverty between rural and urban areas with a higher level of poverty incidence in the rural area (66.1%) as compared with the urban area (52.0%).[44]

As earlier established poverty and poor health are related Poverty is a major course of maternal and infant mortality and morbidity. This is evidenced from the fact that the north has the highest incidence of maternal and infant mortality and morbidity which can be attributed to high level of poverty in the northern region. Poor health and poverty run in vicious circle- while poor health plunges people into poverty (as once a person is poor, he cannot access any work, poverty further plunges people into poor health as they cannot access health care because they do not have the resources to do that. Again, the poor are more vulnerable to personal and environmental factors affecting their health and likely to be undernourished and unable to access health care.

6.7 Debts, Debt Servicing and Structural Adjustments Programmes in Nigeria

Nigeria like most African states is overburdened with debt. The impact of debt and debt servicing is devastating particularly as it relates to the class of rights to which the right to health belongs. In most instances, states that are in debt are made to adopt structural programs. Skogly notes that "the premise of structural adjustment conditions is that certain economic factors should be altered in a given country to ensure better economic performance with a view to repay debt and debt servicing, to achieve a better balance of payment situation and to achieve a healthier economy in general."[45]

However, the contrary is the consequence of structural adjustment programs as it has serious and damaging impact on the actualization of the right to health. As noted by Shadrack that:

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[44]Ibid

[45]Skogly, S. (1993).Structural Adjustment and Development: Human Rights- An Agenda For Change*1Hum. Rts. Q. 751, 752-753.* See also Chunakara, G.M. Globalization and its Impact on Human Rights in Chunakara, G. M., Ed. Globalization and and its Impact on Human Right. *Retrieved on 14/05/12from media.sabda.org/.../chanakara,%20George%20Mathews %20(ed)%...*

> [s]tructural adjustment policies of the World Bank and the IMF have adverse consequences as these policies means states have to reduce their imports, devalue their currencies, deregulate capital movement, dismantle social programs by cutting government expenditure on social services such as **health care**, education and removal of subsidies on market staples and provide "national treatment" to foreign investors.[46]

Adopting the SAP results in severe austere measures taken by the state which further plunges the citizens into poverty, under development and results in the states inability to uphold economic and social rights as guaranteed under the ICESCR. As part of the economic policies adopted, states are made to cut back spending on health which means less percentage of money will go on health. For instance, the percentage of the Nigerian budget allocation on health has been depreciating. This has negative consequences on health system of any given state as it means cut in the national health budget, introduction of user fees and the subsequent destruction of government hospitals, brain drain, lack of hospital equipments and staffs.

As part of the SAP, Nigeria spends more on debt servicing rather than focus on the general welfare of its citizens. For instance in 2008 budget Nigeria allocation on health was 144 billion Naira while that of debt servicing in the same year was 517 billion Naira.

The amount spent on debt servicing is alarming and the consequence of which is that it cripples state and incapacitates them from meeting their international obligation to respect, protect and fulfill socio-economic rights including the right to health. The United Nations Development Fund (UNDP) reports that "from 1983-89 rich creditors received a

[46]Agbokwa, S.C. (2002). Reclaiming Humanity: Economic, Social and Cultural Rights as a Cornerstone of African Human Rights*Yale Human Rights and Development Journal, Vol 5*

staggering $242 billion (dollars) in net transfers on long term lending from indebted developing countries."[47]

Nigeria's debt profile grew from $ 35.09 billion in December 2010 to $53.49billion as of 2014 ending and has spent a staggering amount in debt servicing which is more than the original loan. For instance, debt servicing increased from US$ 2.7 billion in 2010 to US$ 4.65 billion in 2014.[48] The real fact is that the creditors take more than they give. This amount could have been used to address basic necessities to alleviate the suffering of millions of Nigeria

6.8 Lack of Political Will to Address the Health Sector Crises

Apart from Kleptocracy, there is also lack of political will on the part of the politicians to actualize socio-economic right including the right to health. Public office is seen as the only road or ticket to self-enrichment and unfortunately, Nigerian leaders do not have national interest at their hearts but are eager to deep their hands and have a share of the national cake as rightly stated by Akande that government in the third world have "tended to be preoccupied with power and its material perquisites"[49] than the general welfare of the citizens.

Although the Nigerian government had recognized the deteriorating of the health system in the country and had developed policies to address the situation, lack of implementation of the laws and policies demonstrate insufficient political commitment to address the health crises in the country. For example, despite the high incidence of maternal and infant death in the country, it had been targeted that Nigeria cannot achieve the Millennium Development Goals by 2015 despite all the laudable policies developed by the government.

[47]UNDP, Human Development Report 1992 at 45 in Shadrack, A.C;(2002), Ibid.
[48] Nigeria's Debt Rises by $18bn in 4 Years *Daily Trust of May 11, 2015* Front Page
[49] Akande, J.O. (1982). An Inroduction to the Nigerian Constitution 1979 Sweet and Maxwell, London p 13

The cuts in the health budget also represent the lack of political will on the part of the Nigerian government to address the health crises in the country. Nigeria is one of the countries that spends the least on health care. Though Nigeria is a party to the Abuja Declaration and the Maputo Declaration and had pledged to allocate 15% of its total budget to health, this pledge had not be fulfilled. And infact, Nigeria had been experiencing cut in health allocation in the budget which demonstrates lack of political will on the part of the government officials to address the health of its population.

CHAPTER SEVEN

CONCLUSION

7.1 Summary

This chapter concludes the research work. The objective of this chapter is to provide summary, findings of the research work, proffer recommendations and give suggestions for further research. The chapter also draws a conclusion based on the finding of the research.

Any nation seeking to develop economically must pay critical attention to the health its citizens. Health therefore, becomes important as there cannot be a developed nation with sick and dying citizens. Health under international law and in Nigeria therefore, is the focus of this research. This research was necessitated by the poor performance of the Nigeria's health system and the subsequent ranking of Nigeria health system as 156 out of 186 by the UNDP. Subsequently this research aim and objective examined the nature and definition of the right to health under international law and also the legal and institutional framework of the right to health in Nigeria and Nigeria's obligations under international law with respect to the right to health.

Chapter one provided an introduction to the research by providing a background to the research which led to the research problem. The research raised a number of research questions in an attempt to achieve the aims and objective of the research. The chapter also contained the justification of the research, the research methodology and literature review.

The two examined conceptual clarification of relevant key terms used in the dissertation such as human rights, right to health and their historical development. Other concepts

examined in the chapter included health care, maternal mortality, maternal mortality ratio. Attempt was made to explain the linkages between health and human rights.

The discussion above was followed by an examination of the legal framework both international and regional and other soft laws to which Nigeria is a party to and thus assumes tripartite obligations in international law. This discussion led to the examinations of the questions relating to the types of obligation imposed by international law on state parties to such major international and regional treaties once a state ratifies same - such as the obligation to respect, protect and fulfill the right to health. The nature of the remedies available for the violation of the right to health was also discussed. It concluded by a discussion on the international monitoring mechanism for the right to health such as that provided under article 16 and 17 of the ICESCR which is the reporting system once a state is a party to the ICESCR which is applicable to Nigeria and the much debated and contested Optional Protocol to the ICESCR although Nigeria has not signed nor ratified it.

Other discussion include the constitutional framework of the right to health in Nigeria and the major legislation establishing the various institutions in the country whose primary objective is the delivery of health services to the citizens. These include the establishment of the Federal Ministry of Health (FMOH), and other agencies designed to protect the health of citizens. It also considered other issues including policies and laws on the production, distribution and dispensation of drugs by medical practitioners. The epilogue of the discussion assessed the penal process over erring medical practitioners.

Finally an examination into the implementation of the three health related Millennium Development Goals (MDG) was made which was followed by a discussion on the relationship of the right to health and the MDGs and key challenges to the realization of

the three health related MDGs in Nigeria. The three health related MDGs are - MDGs-Goals 4 (reducing child mortality), goal 5 (improving maternal health) and goal 6 (combating HIV/AIDS, Tuberculosis (TB) and malaria) in Nigeria.

Myriad factors that combine to impede the realization of the right to health in Nigeria were also examined. Chiefly among these factors include constitutional impediment with dealt with the issue of non-justiciability of the right to health, socio-economic impediment with dealt with corruption, poverty, debt servicing and Lack of political will. This chapter examined these factors and how they affect the actualization of the right to health in Nigeria**.** Finally, the dissertation concluded with a summary, findings and recommendations.

7.2 Findings

Based on the above discussions, the dissertation makes the following findings:

a. Despite being signatory to major international and regional treaties, the right to health falls under chapter II of the constitution which are non-justiciable. However, although the constitution places health under fundamental objectives, the right to health exist in the constitution as an ancillary right based on the provisions in Chapter IV particularly section 33 (right to life), section 34 (right to dignity of the human person) which are justiciable under chapter IV (Fundamental Rights). Also, Nigeria has domesticated the African Charter on Human and People's Rights and is now part of our laws. The right to health under the charter is a justiciable right and therefore a useful tool for the protection of the right to health in Nigeria.

b. It was also found that according health the status of a justiciable right is not, infact, related to any inability to deal with socio economic rights including the right to health. This is exemplified as in the case of South Africa with a justiciable right to

health without incurring any expenses on the state. While the Indian experience showed that the debate whether or not the rights exist or is non-justiciable is irrelevant.

c. The research finds that Nigeria has made provisions with respect to laws, policies, and has established regulatory bodies and institutions through which health is protected in the country. However, the research finds problems in the laws, institutions and regulatory bodies established for the protection of health of Nigerians. For instance, the research also finds that there is lack of coordinated legislations that can adequately address and arrest the incidence of fake and counterfeit drugs and unwholesome foods in Nigeria. The few laws under NAFDAC are insufficient for effective control and the general provisions under the penal and criminal codes are insufficient for effective control of unsafe drugs in the country for instance, the highest punishment for dealing in fake and counterfeit drugs range from three (3) months to five (5) years or fine which are not stringent enough to deter violators considering the grave consequences attached the offence. There is also inadequate cooperation among the agencies working with NAFDAC like the police, Nigeria Drug Law Enforcement Agency (NDLEA), custom etc. The Medical Dental Practitioners Council is given discretion as to what constitute misconduct and the nature of the penalty to an erring professional as the Medical and Dental Practitioners Act had not defined "infamous conduct." A medical or dental practitioner could commit a serious offence and the council may decide to just admonish him or to even let him go free. Again, a person found guilty of infamous conduct has a right to appeal to the court of appeal. Such an appeal would act as a stay to any directives of the Medical Tribunal. In such instances the said person would go on practicing medicine until after the determination of the appeal.

d. Funding had always been a major problem of health in Nigeria as the percentage of government allocation to health sector had always been about 2% to 3.5% of the national budget making the per capita public spending on health less than US $5 which is below US$34 as recommended by WHO for low income countries.

e. Poverty is taking its toll on majority of Nigerians as it is tightly related to the health of a nation. The poorer the people the more sick they are as they cannot afford to access hospital for treatment nor buy the necessary drugs to treat their ailment.

f. Corruption is pervasive in Nigeria and has terrible impact on the health of Nigerians as finances meant for health facilities and equipment are siphoned and filled in private bank accounts.

g. Finally, lack of political will on the part of the Nigerian leaders to improve the health system in Nigeria as whether the right to health is translated as a justiciable or non-justiciable in the Constitution, political will is needed to translate it into reality.

7.3 Recommendations

Based on the above findings, the research makes the following recommendations:

a. The Constitution of the Federal Republic of Nigeria should be amended and the objectives in Chapter II of the Constitution be transferred to chapter IV of the Constitution thereby making them justiciable. By doing such, the government can be held accountable directly for violation of the right to health just as is found in South Africa. In the absence of justiciable right to health under the constitution, the African Charter which Nigeria is a party and has domesticated provides a useful tool for the protection of the right to health in Nigeria. The Charter has not differentiated civil and political rights from socio-economic right. Both sets of rights are justiciable under the Charter. And the African Commission on Human

Rights has consistently held that socio-economic rights are justiciable under the African Charter. Nigeria must be seen to have ratified the African Charter in good faith and therefore, Nigeria cannot be seen to legislate out of its international obligations.

b. The framework for the right to health in Nigeria does exist which provides a foundation for action as such, the court should be proactive in protecting fundamental objective as is seen from other jurisdictions with similar constitutional provisions with minimal protection of the right to health such as is seen in India. The court play vital role in ensuring that liberal, purposive interpretation are given to those fundamental guarantee that are codified in order to offer the prospect of indirect protection for the right to health in Nigeria. The judiciary should take up the challenge and bridge the missing gap in the realization of the right to health.

c. Corruption and poverty are factors that impede the realization of the right to health in Nigeria despite the measures taken by the government to them. It is recommended that more efforts should be geared towards fighting corruption and poverty in the country particularly in the health sector which is very prone to corruption.

d. Laws relating to Food and drugs should be harmonized into NAFDAC because they are repetitive of function and purpose e.g. food and drugs act, dangerous drugs Act etc. Also, penalties for violating the legislations on food and drugs particularly those dealing with fake and counterfeit drugs should be amended and stiffer penalties put in place to meet with the realities of the consequences of the offence.

e. The health sector had suffered from lack of funding and cut back which exhibit the government lack of political commitment to health. Government should honor its Abuja and Maputo Declaration obligations of providing 15% of its annual budget to improve the health sector.

f. The National Health Bill (NHB) is the first health Bill in Nigeria that specifically makes access to health care as a right in Nigeria and also sets out the rights and duties of health care providers, health workers, health establishment and users and also protects, promotes and fulfill the right of the people of Nigeria to have access to health care services. It also defined the responsibility of the three tiers of government with respect to health care delivery in the country. The Bill is an important legislation which when passed will operationalize health care delivery in the country. It is therefore recommended that government should pass the Bill into Law.

g. The medical and Dental Council should revise the Medical code of ethics to include other emerging professional misconduct.

Health is a fundamental human right indispensible for the exercise and enjoyment of other human right and to enable people to live a life in dignity. The right to health has been defined as the right to enjoyment of facilities, goods and services and conditions necessary for the realization of the highest attainable standard of health. The realization of the right to health thus, can be achieved through numerous complimentary approaches such as adoption of legal or international instruments protecting the right to health, adopting health policies or the implementation of health programmes.

Nigeria is signatory to the major international and regional instruments and a party to consensus agreements protecting the right to health and therefore, has an obligation under international law to respect, protect and fulfill the right to health of the Nigerian.

7.4 Contribution to Knowledge

His research work has contributed to knowledge in the following ways:

a. analyzing the legal and institutional framework for the realization of the right to health in Nigeria.

b. Analyzing the right to health in the context of the MDGs particularly MDG1 (eradication of poverty), 2 (women's empowerment), 3 (education), 4 (reduction of childhood mortality), 5 (improving maternal mortality) and 6 (halting and reversing HIV/AIDS, Malaria and Tuberculosis) in Nigeria.

7.5 Suggestions for further Research

The right to health is a broad area of study and entails the right to health care and the underlying determinant of health. Health care consist of functioning facilities and services necessary for health e.g. health services provided at clinics, availability of hospital, doctors, nurses drugs etc. while the underlying determinant of health includes adequate food, safe portable drinking water, housing, education, adequate sanitation facilities e.tc.[1]Health care and the underlying determinant of health are interlinked and of equal importance.

This research is a doctrinal study on the legal and institutional framework for the realization of the right to health in Nigeria. As such further research could be conducted any of the underlying determinant of health. Also, an empirical research could be

[1] United Nation CESCR General Comment 14 " *The right to the Highest Attainable Standard of Health"* (herein General Comment 14) (Twenty-Second session, 2000), U.N.DOC.E/C.12/2000/4 Para 11

conducted to assess the level Nigeria's compliance with the international obligations under international law.

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