



The Right to Health as a Claim on Dignity: Implications for State Accountability in Nigeria

by

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DECLARATION

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ABSTRACT

This thesis argues that dignity is central to the realisation of the right to health in Nigeria and shapes the relationship of the Nigerian State with its people. The thesis posits that a contextual understanding of the nature of human dignity in Nigeria is predicated on a social compact where individuals and communities accede to the preservation of the Nigerian State and its union, on the condition that it will manage the power and economic resources of the Nigerian State for the fulfilment of the welfare of every Nigerian. A contextual framing of human dignity in shaping the management of Nigeria's affairs is shown to have been jettisoned over the years. Due to the lack of political will to act for the benefit of the populace, as well as corruption and mismanagement of scarce and limited resources, the Nigerian State has been limited in its ability to fulfil its obligations to the social compact. The result has been a steady decline of the nation's health system at all levels with dire consequences for the lives and wellbeing of the Nigerian people. While important legislative intervention has been made through the National Health Act (NHA) to remedy this dire state of the Nigerian health system, it is not the panacea to the multifaceted challenges facing healthcare in Nigeria. Drawing from other jurisdictions, the thesis shows that the realisation of the NHA will be largely dependent on its social, political, and legal framing. I argue that in the face of persistent State inaction, the courts must act to provide socio-economic justice and State accountability. In providing judicial clarity and enforcement, the courts must be mindful of various pitfalls in the framing of the key legal principles of the minimum core, the test of reasonableness and requirements for the progressive realisation of the right to health. I contend that due to a flawed understanding of the nature and intent of the right to health, there is a risk of undue deference to the State's framing of its obligations and ability to meet those obligations. I propose that the right to health must instead be understood and framed as a vital claim against the State and its power, rather than as simply a social good to be provided on the whims of the ruling class and their own political priorities. I argue that to hold the State accountable to its obligations to fulfil the right to health in a manner that is people centred, the right must be framed as being nested in the maximal respect and realisation of human dignity.

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Chapter 1

Providing a social, political, and legal context for right to health in Nigeria

Introduction

This thesis addresses the question of whether and how a dignity-based approach to health rights can provide a sound basis for the enforcement of the State's obligation to fulfil the right to health in Nigeria. The question is nested within the broader context of Nigeria's legal, economic and political limitations in respect of the recognition and subsequent realisation of the highest attainable standard of health, more colloquially known as the right to health; and especially with regard to the provision of healthcare. This limited recognition has for a long time been due to a lack of normative clarity on the nature and content of the right to health in Nigeria. The uncertainty around what the right to health entails and the obligations it places on the State has plagued the ability of scholars and activists to hold the Nigerian State accountable for the fulfilment of the right to health. It has also limited the nature and scope of judicial intervention possible for compelling State action. However, Nigeria's eventual passing of the National Health Act (NHA),¹ after several years of political contestation and social mobilisation, has caused a need to re-examine the issues confronting the realisation of health rights in that country. This is because passing specific right to health legislation has long been held out as the panacea to the plethora of problems arising from an often controversial and seemingly unsure claim to a right to health for all. Such an Act has been seen as necessary for providing the much-needed normative clarity on the existence and nature of the right to health, especially for the Nigerian context. Unfortunately, the hopes that the new-found legislative clarity would translate into State action and the necessary apparatus for compelling such action have remained unmet. The lack of State action to realise the mandate of the Act to deliver at least a minimum standard of care for the Nigerian populace, as well as the paucity of jurisprudence that holds the State to account regarding its responsibility, raises questions around what more is required to entrench a right to health in the legal consciousness of the Nigerian people, as well as in the actions of the Nigerian State.

As this thesis will show, the clamour for the right to health predates the passing of the NHA, as do the interventions of health-right scholars and activists to operationalise the right to health. These proposed interventions have been made despite the prevailing context of limited or uncertain legal

¹ National Health Act, 2014 (Act No. 8 of 2014).

backing on which to base health right claims against the State. Now, more than five years since the passing of the NHA, the questions about the true nature of the right to health persist. The Nigerian State is yet to operationalise the NHA and much of the reform the NHA requires has yet to commence. More damning is the perennial lack of judicial enforcement to compel State action. As such, the onus to realise the mandate of the NHA now appears to rest largely on the State's political willingness. However, as the history of the passing of the NHA and prior interventions for health rights have shown, depending solely on the State to fulfil its duties without a system of accountability, will result in further years of inaction. As such, the right kind of action that compels State compliance is necessary. Such a claim will have to be made on the State's resources as well as its administrative mechanisms, for it to deliver on the yearnings of the Nigerian people for good health and the right social determinants on which good health rests.

In this chapter I lay out the issues bedevilling the right to health in Nigeria in broad strokes. I provide the background for a contextual understanding of the legal, political, social and economic factors that have led to the steady decline of healthcare in Nigeria. I also describe some of the effects this decline of healthcare has had on the lives of Nigerians and the poor health outcomes that have resulted. I then discuss the background of the attempts at crafting a right to health, at the international level with the events that have shaped these interventions, as well as how these global health interventions have trickled down to local health law and policy. Having sketched the landscape upon which I frame my discussion of the right to health, I then outline the scope and structure of the thesis in order to answer the central research question I have laid out above.

The steady decline of health in Nigeria

The clamour for good health and the means to achieve and maintain it by the State is one that has merit in Nigeria. The steady decline of health indices in the country from independence in 1960 saw a particularly sharp decline from the 1970s, when social welfare programs, which included the provision of free health services in government-run health facilities, were stopped and the transition was made to the collection of user fees.² The economic downturn that beset many African countries at the time would see them turning to international loans as a means of running the State. A significant condition of these loans by the IMF and the World Bank would be that they ceased funding social welfare

² Asakitikpi, Alex E. "Healthcare coverage and affordability in Nigeria: an alternative model to equitable healthcare delivery." *Universal Health Coverage*. Ed. A.I. Tavares. London, UK: IntechOpen, 2019. 45.

programs, which included State-sponsored healthcare.³ In Nigeria, the defunding of the State's healthcare system, as well as reliance on user fees as the primary mechanism for funding healthcare, would see the decline of services, as well as increasing impoverishment of the Nigerian populace, who were beset by worsening economic odds without the previously available social buffers.⁴

Decades of authoritarian military rule resulted in the centralisation of legal and political power in the hands of a limited few at the highest levels of government. This was aided by majority State control of petroleum, which had also become the country's main source of revenue to the exclusion of other mineral resources and products.⁵ With more centralised State control over the main source of revenue came the increasing linkage of capital to political power and the converse decline of economic viability outside the tentacles of the State.⁶ The decline of the nation's once diverse economy and the increasing sole reliance on State-controlled crude oil would mean that the economy would become further linked to State patronage.⁷ Ultimately, access to the State, and its entrenchment as the site of enrichment, would create a political class vested in the status quo, whose interests had become inextricably tied to that of the State. In all this, the Nigerian State would lose its initial ideals of being a social welfare State — at least in practice. Several incidences of global downturn in the volatile international oil markets, as well as the entrenchment of graft, would also mean that the State would lose its ability to generate fiscal surpluses and the ability to provide quality social services.⁸ The socio-political and economic premise on which socio-economic rights were to be realised thus became faulty. The build-up of these factors would make it near impossible for the country to deliver the right to health. This inability was worsened by the fact that, over the years, the health system at all levels had been considerably weakened as a result of decades of underfunding. All of these factors over time have now led to a situation where, according to the 2019 Global Health Index, Nigeria's healthcare capacity is ranked 170th in the world out of 195 States.⁹

³ Sule, Segun Charles. "Social Protection in Nigeria; A Critical Assessment." Dipartimento di Cultura, Politica e Società." (2014/2015).

⁴ Ibid.

⁵ Ibid.

⁶ Ibid.

⁷ Ibid.

⁸ Ibid.

⁹ GHS Index, "2019 GHS Index Country Profile for Nigeria", October 2019, available at <https://www.ghsindex.org/country/nigeria/#overviewsect>, accessed on 5 October 2020.

The consequences of poor health in Nigeria

The weak health system in Nigeria has far reaching consequences for the standard of health of the population and ultimately on their life outcomes. The dire state of wellbeing in the country is vividly shown in the ever-retrogressing health data of the country. Health-related data is one of the best-known human development indicators,¹⁰ because the factors that come together to result in improved health would often also mean improved life in general. Indices such as life expectancy, infant mortality, access to safe water can therefore be a good pointer to health progress or decline and to general standards of living.¹¹ Unfortunately, the extent of the health concerns in Nigeria are compounded by the difficulty of ascertaining data. However, much of the available information points to a dire state of wellbeing in Nigeria. While Nigeria has one of the fastest growing populations globally, with 5.5 live births per woman and a population growth rate of 3.2% annually, estimated to reach 440 million people by 2050,¹² the health system is ill equipped to service this vast population. With its rapidly growing population and development challenges, the country drags down the socioeconomic indicators for the entire African continent.¹³ The infant mortality rate, for example, is still considerably poor despite progress made over the years.¹⁴ The figure in 1960 was 190 for every 1,000 children, moving to 187:1000 in 1978, and ranging from 104-110 in 1998.¹⁵ The situation has improved over the last 20 years. In 2003 infant mortality was 71.35; in 2004 it rose to 98.8, which was a 38.5% increase; it fell back to 95.72 in 2008; and 94.23 in 2009 and 2010.¹⁶ The most recent numbers point to a rate of 64.8 deaths per thousand live births;¹⁷ placing Nigeria as having the third highest

¹⁰ Alubo, Ogoh. "The promise and limits of private medicine: health policy dilemmas in Nigeria." *Health Policy and Planning* 16.3 (2001): 313-321.

¹¹ Ibid.

¹² USAID, "Global Health: Nigeria", September 22, 2020, available at <https://www.usaid.gov/nigeria/global-health>, accessed on 5 October 2020.

¹³ Ibid.

¹⁴ Nigeria was unable to meet the previously set of Millennium Development Goals (MDGs). The MDGs are eight goals set as a yardstick to measure international development efforts. They were agreed upon by all 191 United Nations member States and was signed in September 2000. These goals were to be met by 2015. See Karver, Jonathan, Charles Kenny, and Andy Sumner. "MDGs 2.0: What goals, targets, and timeframe?" *IDS Working Papers* 2012.398 (2012). 1-57

¹⁵ Imam, F.B., et al. An Assessment of the Emergence of Organised Healthcare Services in Nigeria. *IOSR Journal of Humanities and Social Science* 20.11 (2015): 40-46 at 44.

¹⁶ Ibid.

¹⁷ CIA, "The World FactBook", available at <https://www.cia.gov/library/publications/the-world-factbook/fields/2091.html>.

infant mortality rate in the world.¹⁸ The mortality of persons under five years of age is 104.3 deaths per thousand live births as at 2016.¹⁹

Maternal mortality, a key health indicator, has the country at 814 deaths per 100,000 live births as at 2015,²⁰ even worse than the rate of 800 in 1988.²¹ At the same time however, general life expectancy has improved, although current rates are still abysmal in comparison to other sub-Saharan countries. As at 2016, the life expectancy of a Nigerian male was 63.7 years, being an increase of 7 years over the past decade, while that of a Nigerian woman was slightly higher, at 66.4 years, an increase of 8.1 years from 2006.²²

As regards access to safe drinking water: only 46% of the Nigerian population is estimated to have access to safe drinking water.²³ When this is broken down into urban and rural Nigeria, it is estimated that, while 100% of urban dwellers have access to safe drinking water, only 20% of rural dwellers have access to safe drinking water.²⁴ However the assertion of 100% access for the urban population in Nigeria is misleading and inaccurate, because several years of infrastructural decay has meant that many urban areas have lost their access to water, with newly developed areas resorting to self-help interventions for their water supply.²⁵ As a result, even the figure of 46% access to safe drinking water may be exaggerated.²⁶

¹⁸ United Nations Inter-agency Group for Child Mortality Estimation, "Levels and trends in child mortality", available at https://childmortality.org/files_v21/download/IGME%20report%202017%20child%20mortality%20final.pdf, accessed on 5 October 2020.

See also, Ayodamola Owoseye, "Nigeria has third highest infant mortality rate in the world – WHO", *Premium Times*, 20 October 2017, available at <https://www.premiumtimesng.com/news/headlines/246720-nigeria-third-highest-infant-mortality-rate-world.html>, accessed on 15 October 2020.

¹⁹ World Data Atlas, "Nigeria-Under 5 mortality rate", available at <https://knoema.com/atlas/Nigeria/topics/Health/Health-Status/Under-5-mortality-rate>, accessed on 5 October 2020.

²⁰ World Health Organization. *Trends in maternal mortality: 1990-2015: estimates from WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division*. World Health Organization, 2015 at 74.

²¹ See n15.

²² Martins Ifijeh, "Nigeria's Life Expectancy Has Increased by 8 Years, Study Shows", *This Day Newspaper*, 21 September 2017, available at <https://www.thisdaylive.com/index.php/2017/09/21/nigerias-life-expectancy-has-increased-by-8-years-study-shows>, accessed on 15 October 2020.

²³ See n15.

²⁴ Ibid.

²⁵ Ibid.

²⁶ Ibid.

The healthcare system in Nigeria has also shown spatial variation in terms of availability and quality of facilities in relation to need, where rural areas more in need of health care services are underserved.²⁷

Despite various interventions, the disease burden is also worrisome. As at 2015, deaths resulting from HIV/AIDS stand at 128.7 per 100,000 people, while the deaths due to malaria are at 106.9 per 100,000 people.²⁸ Nigeria's malaria burden is still the highest globally and remains the top cause of child illness and death.²⁹ Malaria is Nigeria's most important public health challenge and is responsible for 60% of outpatient visits to health facilities in Nigeria, 30% of childhood deaths and 11% of maternal deaths. Over 90% of Nigerians are at risk of contracting malaria, with over 100 million cases per year and about 300,000 deaths.³⁰ In the face of these persistent challenges, the inadequate attention to healthcare over the years that largely led to these results are yet to be adequately and comprehensively addressed. The Nigerian State at various levels has sadly continued to show insufficient commitment to improving the health and social determinants of the Nigerian people in a manner that is systematic, sustainable and in line with its human right obligations.

Crafting a Right to Health in Nigeria

The Nigerian State's persistent hesitance or inability to provide social amenities for its people means that the right to health must first and foremost be crafted as such: a right. Right status for health means that it ceases to be merely a social good. As a right, the State is bound to deliver on it. Part of the State's obligations to deliver in this sense also includes moving from a stance of non-interference to one that proactively fulfils clearly outlined duties for the populace. The duties placed on the State for the realisation of this right are wide ranging. This is largely due to the nature of the subject matter itself. As defined by the World Health Organization (WHO) in its Constitution, health is "a state of complete physical, mental, and social wellbeing and not just the absence of disease."³¹ As Evans points out, this definition is very wide, and the possibility for the enjoyment of such an optimal state of being

²⁷ Eneji, Mathias Agri, Vonke Juliana Dickson, and Bisong John Onabe. "Health care expenditure, health status and national productivity in Nigeria (1999-2012)." *Journal of Economics and International Finance* 5.7 (2013):258-272.

²⁸ World Health Organization, "Nigeria: WHO statistical profile", January 2015, available at <https://www.who.int/gho/countries/nga.pdf>, at 1, accessed on 5 October 2020.

²⁹ USAID, "Global Health: Nigeria", available at <https://www.usaid.gov/nigeria/global-health>, accessed on 5 October, 2020.

³⁰ Pharm Access Foundation. *Nigerian Health Sector Market Study Report*. Pharm Access Foundation (2015) at 11.

³¹ Constitution of the World Health Organization, 1948 at 1.

for all, is herculean in nature.³² The fulfilment of such an all-encompassing mandate on the State can often be overwhelming. This is especially in the context of a low- and middle-income country, such as Nigeria, with limited resources. These economic realities have been used as the basis of sustained hesitance to recognise health as a right in Nigeria. The hesitance to fulfil the right to health on the basis of economic limitations has thus sparked both the global discussion around the modalities of a claim to a right to health, and, in turn, shaped the localised efforts in Nigeria to realise the right.

The controversial nature of the right to health

The right to health encompasses the right to access healthcare as well as the guarantee of the underlying determinants of health.³³ The right is wide in scope and not limited to the provision of healthcare. Rather, it covers all things that affect the ultimate health status of people.³⁴ Unfortunately, due to its all-encompassing nature, the right to health is a socio-economic right that has suffered criticism over the years; a major reason being that it is perceived as too wide and as such unduly nebulous.³⁵ While the definition of health by the WHO is comprehensive in its scope, it has lent further credence to the critics of the right, who view its ambit as unduly stretched.³⁶ For them, its sweeping definition is such that it is virtually impossible for any State to fulfil. This is not only because of the economic implications for such wide realisation but also that, in spite of the best efforts of the most willing of States, there is only so much the State can do to guarantee optimal health for all, with personal agency playing a large role.³⁷ In response to these criticisms, the right has over the years been broken down to identify its characteristics, and provide normative content and clear barometers for its fulfilment.³⁸ Despite these efforts at normative clarity, considerable disagreement continues to exist, as to whether "health" is a meaningful, identifiable, operational, and enforceable right, or

³² Evans, Tony. "A human right to health?" *Third World Quarterly* 23.2 (2002): 197-215.

³³ Bahar, J. "The Justiciability and Enforcement of the Right to Health under the African Human Rights System." *Haramaya Law Review* 2.1 (2013): 29-50.

³⁴ Ibid.

³⁵ Gostin, Lawrence O. "The human right to health: a right to the highest attainable standard of health." *The Hastings center report* 31.2 (2001): 29-29.

³⁶ Huber, Machteld, et al. "Health how should we define it?" *BMJ (Overseas and retired doctors ed.)* 343.7817 (2011): 235-237.

³⁷ Meserve, Harry C. "What is health?" *Journal of religion and health* 2.4 (1963): 263-266.

³⁸ Mann, Jonathan M. "Health and human rights." *British Medical Journal* 312.7036 (1996): 924-926.

See also, Mann, J. M., et al. "Health and human rights". *Health & Hum. Rts.* 1 (1994): 6-23. Gruskin, Sofia, Edward J. Mills, and Daniel Tarantola. "History, principles, and practice of health and human rights." *The Lancet* 370.9585 (2007): 449-455. Fidler, David P. "Globalization, international law, and emerging infectious diseases." *Emerging infectious diseases* 2.2 (1996): 77. Venkatapuram, Sridhar. "Jennifer Prah Ruger. Health and Social Justice." *Public health ethics* 3.2 (2010): 186-188. Sen, Amartya. "Why and how is health a human right?" *The Lancet* 372.9655 (2008): 2010.

whether it is merely aspirational or even rhetorical.³⁹ Ruger makes the point that, while various non-state actors like non-governmental organisations, activists and scholars have persistently made strides in the advancement of the right to health, the right still lacks a definite and concise philosophical basis.⁴⁰ The resultant quagmire, as Gostin aptly describes it, is that a right to health that is too broadly defined lacks clear content and is less likely to have a meaningful effect.⁴¹

Arguably the most seminal and authoritative exploration of the nagging questions around the nature of health and the right to health has been the General Comment made by the United Nations Committee on Economic, Social and Cultural Rights on the Right to the Highest Attainable Standard of Health as contained in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), more commonly referred to as General Comment 14.⁴² This authoritative recommendation was intended to provide much needed clarification on issues that have been the basis of decades of contestation on the central issues around the nature of the State's responsibility. It was written to provide a full exposition in response to the need for normative clarity on the nature and form of the right to health and the duties it placed on States. Shaping the international health governance regime, this General Comment sets out the 'signposts',⁴³ for framing progress in the realisation of the right to health.⁴⁴ Key among the issues that the General Comment addresses are questions around States' minimum core obligations that are non-derogable. Tied to this non-derogable minimum core is the Comment's recognition of a reality in which the key elements required for the right to health will have to be realised progressively and incrementally over time.⁴⁵ The crafting of each State's legal regime for the right to health is intended to be shaped by an understanding of their existing health system and the application of the principles of the General Comment to those realities.

Divergent interpretations and applications of the right to health

Despite claims of universality of the right to health and the attempts to enshrine a definitive minimum core in the General Comment, economic and political factors and domestic health priorities often

³⁹ See n35.

⁴⁰ Ruger, Jennifer Prah. "Toward a theory of a right to health: capability and incompletely theorized agreements." *Yale journal of law & the humanities* 18.2 (2006): 3.

⁴¹ See n35.

⁴² UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

⁴³ Toebes, Brigit. "International health law: an emerging field of public international law." *Indian Journal of International Law* 55.3 (2015): 299-328.

⁴⁴ Hunt, Paul. "Interpreting the International Right to Health in a Human Rights-Based Approach to Health." *Health and human rights* vol. 18,2 (2016): 109-130..

⁴⁵ Paragraph 31, General comment 14, 2000.

mean divergence of interpretation and application of the right. Emerging differences in the approach taken by States have led to fissions in understandings of the fundamental nature of the right to health and how it is to be achieved. As such, while, on the face of it, there is a standardised legal order on the right to health, its interpretation and ultimate fulfilment has taken different forms, raising questions about the foundational premise of the universality of the right. The divergence is also reflected in the scholarship that critiques the operationalisation of the right to health, as well as the recommendations made for more effective ways to realise the right to health. Debates around the enforcement of a minimum core vis á vis progressive realisation and a reasonableness test, for example, often lead to different opinions on how the right to health is to be realised. The questions of approach and priorities grapple with if, and how, States are bound to fulfil their duties, and whether their responsibilities are time bound.⁴⁶ In a similar light, concerns around whether the right to health is best fulfilled as a collective right with a focus on broad-based public health interventions, over and above delivery as an individual rights claim made against the State, have also been raised.⁴⁷

The challenges of the political economy underlying State obligations for the right to health.

In the various areas of conceptual disparity, the underlying premise in all the approaches to realising the right to health is that the State is seeking to provide the right while being constrained by scarce and limited resources. This is premised on the model of the neo-liberal capitalist State, which may or may not be run as a social welfare State. There is the understanding that the State is limited by its economic means, which itself presumes that the State needs to be economically viable in order to have enough resources to provide the right to health, considering that there are other interests competing for these scarce resources. This premise however runs contrary to the nature of rights being universal, inalienable, interdependent and interrelated.⁴⁸ In the midst of this conceptual quagmire, some scholars explore an understanding of rights that transcends the neo-liberal and often individualistic reading of rights, which they contend is an ineffective and costly way to deliver the right

⁴⁶ Odinkalu, Chidi Anselm. "Analysis of Paralysis or Paralysis by Analysis? Implementing Economic, Social, and Cultural Rights under the African Charter on Human and Peoples' Rights." *Human Rights Quarterly* 23.2 (2001): 327-369.

⁴⁷ London, Leslie. "What is a human-rights based approach to health and does it matter?" *Health and human rights* 10.1 (2008): 65-80.

⁴⁸ O'Manique, John. "Universal and Inalienable Rights: A Search for Foundations." *Human Rights Quarterly* 12.4 (1990): 465-485.

See also, Piechowiak, Marek. "What are Human Rights? The Concept of Human Rights and its Extra-Legal Justification." *An Introduction to the International Protection of Human Rights. A Textbook*. Eds. R. Hanski, and M. Suksi. Abo Akademi University: Institute for Human Rights, 1999. 10. Langlois, Anthony J. "Normative and theoretical foundations of human rights." *Human Rights: Politics and Practice*. Ed. M. E. Goodhart. Oxford: Oxford UP, 2016. 11-24.
practice (2009).

to health.⁴⁹ Those that make the alternative case for a communitarian ethic, argue that it holds the keys to the realisation of the right in a manner that is most beneficial to the larger society, while not neglecting the needs of the individuals within society. However, a concern with this alternative approach is that it also already operates within the confines of an ideological acceptance of an underlying state of lack and limitation of resources (whether factual or conceived). Within this rubric, the major concern of the collectivist approach is the allocation of resources in a manner it considers more equitable and with more reach for the largest number. Beyond the challenges of the collectivist's approach to resource allocation, there is the concern that a communitarian approach inadvertently leads to a form of responsibilisation that expects self-help-based interventions from the very people for whom the right is owed, thus absolving the State as the primary duty bearer for the rights.

The questions around the immediacy of the State's obligation to realise the right to health.

Apart from the contestations around the nature of the State's responsibilities, there have also been contrary views on the extent and time frames for States to realise the highest attainable standard of health.⁵⁰ This contestation has itself gone to the heart of the implications for making a right-based claim to health. If health is a right and the State is obligated to realise it, is the State duty bound to realise it immediately, on demand by the right holder? Are extenuating circumstances that preclude a State from meeting its obligations a sufficient exemption from its duties? How long can those extenuating circumstances be permissible to remain, after which point the State may be said to no longer have a tenable excuse for non-realisation? Does the obligation on the State change if the challenges to realisation are endemic, long running, and symptomatic of larger systemic challenges faced by the State? What if these systemic challenges consequently require long-term reform to be able to place the State in a position to begin to meet its obligations? What happens where the State chooses not to recognize its obligations for the right to health because it has estimated that it cannot fulfil such obligations? If the State adopts such a stance of avoidance, what recourse is available to the populace to enforce State recognition and compliance with health right obligations? Ultimately how can State compliance be enforced where no legal recourse has been made available due to non-recognition of health as a right? All these questions have been at the heart of the right to health discussion. The quest to provide satisfactory answers to them have shaped the landscape of both the jurisprudence and scholarship on the right to health, especially in the context of developing countries.

⁴⁹ London, Leslie, et al. "Social solidarity and the right to health: essential elements for people-centred health systems." *Health policy and planning* 30.7 (2015): 938-945.

⁵⁰ Bilchitz, David. "Towards a reasonable approach to the minimum core: laying the foundations for future socio-economic rights jurisprudence." *South African Journal on Human Rights* 19.1 (2003): 1-26.

The quest for answers to these questions have in turn shaped the unfolding history of the right to health and how it is framed.

The unfolding evolution of the realisation of the right to health

One important way the right to health has been shaped over time has been through practical interventions and the identification of policy gaps, which have in turn led to standardisation and legalisation. A key example of the efforts to drive health system reform through a normative framework has been the recognition of the centrality of a primary healthcare (PHC) approach to health service delivery. First given international recognition in the Alma Ata Declaration of 1978,⁵¹ the approach sought to remove health and healthcare delivery from a market-driven philosophy to one that addressed health through a broader societal context.⁵² This approach meant addressing both those who seek actual medical care as well as the broader societal population at risk.⁵³ In the years following the adoption of the PHC approach, it has been recognised that in order to have such a holistic approach to healthcare delivery, there has to be significant health funding. However, amid several competing interests for State resources, the need for sustainable funding mechanisms for healthcare that do not unduly burden the populace for whom it is intended has become more apparent.⁵⁴ This need for sustainable health funding mechanisms is also in tune with the understanding that, for the most part, those most in need of healthcare are often those least able to afford it.⁵⁵ The recognition of these funding realities has led to the emergence of the concept of Universal Health Coverage (UHC). Debates around UHC have also been helping to shape understandings of what the more effective

⁵¹ *International Conference on Primary Healthcare. Declaration of Alma-Ata*. WHO Chron. 1978 Nov;32(11):428-30. PMID: 11643481.

⁵² Hall John J., and Richard Taylor. "Health for all beyond 2000: the demise of the Alma-Ata Declaration and primary healthcare in developing countries." *The Medical Journal of Australia* 178.1 (2003): 17-20.

⁵³ Rasanathan, Kumanan, et al. "Primary healthcare and the social determinants of health: essential and complementary approaches for reducing inequities in health." *Journal of Epidemiology & Community Health* 65.8 (2011): 656-660.

⁵⁴ Ooms, Gorik, et al. "Is universal health coverage the practical expression of the right to healthcare?." *BMC International Health and Human Rights* 14.1 (2014): 1-7.

See also, Uzochukwu, B. S. C., et al. "Healthcare financing in Nigeria: Implications for achieving universal health coverage." *Nigerian journal of clinical practice* 18.4 (2015): 437-444.

⁵⁵ Dieleman, Joseph L., et al. "Trends in future health financing and coverage: future health spending and universal health coverage in 188 countries, 2016–40." *The Lancet* 391.10132 (2018): 1783-1798.

See also, Osoro, Alfred A., Edwine B. Atitwa, and John K. Moturi. "Universal Health Coverage." *World Journal of Social Science Research* 7.4 (2020.):14-28.

principles and patterns might be for funding healthcare, ensuring the distribution of health costs in an equitable manner and preventing undue financial strain for end users.⁵⁶

Another key site for the exploration of the nature of right to health and its legal and socio-cultural implications has been in the fight against HIV/AIDS. The disease has perhaps been the most important focal point around which the need for a human rights-based approach to health has been made in recent years.⁵⁷ The nature of the disease, its fatality, and the social context within which it spread exponentially in its early years, have provided a veritable base from which to further explore the nature of the right to health and its implications for right-bearers. The legal and social advocacy over the years in response to the disease importantly helped shape States' interventions in a manner cognizant of the human dignity of People Living with HIV/AIDS (PLWHA) and the society at large. Sustained global and local efforts especially at combating the virus have also shown that with a right-based approach and evidence-based interventions, more people with the disease the world over can now live healthy long lives.

More recently, the spate of global pandemics like SARS, Ebola and Covid-19 have once again highlighted the need for not just strong health systems and sustainable funding for those health systems, but also the need for public health interventions that save lives and uphold human dignity while making the difficult choices such outbreaks require.⁵⁸ As with HIV, they reiterate the need to create and increase easier and more equitable access for all to receive care and treatment, while encouraging more to voluntarily test and live responsibly as members of a larger interconnected world. Similarly, these outbreaks have exposed the systemic inequalities that make many disadvantaged portions of society, who themselves are already more prone to contracting the disease, unable to purchase the often-exorbitant healthcare they need.⁵⁹ The role of States to meet the needs of their people has thus been pushed to the front burner of global discussions. These events have also highlighted the global hierarchies of power among States and shed further light on the multiple layers

⁵⁶ Gruskin, Sofia, Jonathan Mann, and Daniel Tarantola. "Past, present, and future: AIDS and human rights." *Health and human rights* (1998): 1-3.

See also, Tarantola, Daniel. "The shifting HIV/AIDS paradigm: twenty years and counting." *Health and Human Rights* 5.1 (2000): 1-6. Gruskin, Sofia, Edward J. Mills, and Daniel Tarantola. "History, principles, and practice of health and human rights." *The Lancet* 370.9585 (2007): 449-455. London, Leslie. "What is a human-rights based approach to health and does it matter?" *Health and human rights* 10.1 (2008): 65-80.

⁵⁷ Stemple, Lara. "Health and human rights in today's fight against HIV/AIDS." *AIDS (London, England)* 22. Suppl 2 (2008): S113. See also Patterson, David, and Leslie London. "International law, human rights and HIV/AIDS." *Bulletin of the World Health Organization* 80 (2002): 964-969.

⁵⁸ Meier, Benjamin Mason, et al. "Rights-Based Approaches to Preventing, Detecting, and Responding to Infectious Disease." *Infectious Diseases in the New Millennium: Legal and Ethical Challenges*. Eds. M. Eccleston-Turner and I. Brassington. Basingstoke: Springer, 2020. 217-253.

⁵⁹ Gravlee, Clarence C. "Systemic racism, chronic health inequities, and COVID-19: A syndemic in the making?" *American Journal of Human Biology* e23482. (2020):1-8.

of disadvantage that many low- and middle-income States face.⁶⁰ Unfortunately, these events have once again underlined the stark realities of the lack of readiness, preparedness and resilience of health systems in many developing countries, and especially in much of Sub-Saharan Africa.⁶¹ Nigeria, which has suffered losses from HIV, Ebola and Covid-19, is still largely unable to effectively mitigate its health challenges and guarantee its populace quality healthcare. As such, there is an urgent need to examine the modalities for the realisation of the right to health in Nigeria. There is now, more than ever, an urgent need for the uptake and implementation of health as a human right by all relevant parties.

An argument for reimagining the fulfilment of the right to health in Nigeria through the lens of dignity

According to Labonté and Gagnon, “health is no longer a consequence of growth, but one of its engines”⁶² and, as such, it must be properly arranged on the scale of national concerns and this must be reflected in concrete action.⁶³ I address the question in this dissertation of how a dignity-based approach to the right to health might be theorised to provide a basis for the enforcement of the State’s obligation to fulfil the right to health in Nigeria in response to the systemic and entrenched failures to meet the health needs of the Nigerian populace. The question is premised on the acknowledgement of the country’s socio-political, economic, and legal context. At the same time, this theorisation is premised on acknowledging that, while Nigeria’s health status is especially bad and its attempts to address the challenge leaves much to be desired, this failing is symptomatic of a larger problem regarding the structure and ordering of the Nigerian State. The skewed power relations in favour of the Nigerian State in turn impacts its relationship with its populace, particularly its most vulnerable.

To approach the question of how to better realise the right to health in Nigeria in this broader context, I examine the nature of dignity and its definition in the context of human rights and unpack its implications for understanding the fundamental nature of rights as valid and enforceable claims against the State. While the assertion of dignity as the premise for understanding and interpreting rights is not a new one, the import of this assertion is scarcely interrogated and its implications often

⁶⁰ Shamasunder, Sriram, et al. "COVID-19 reveals weak health systems by design: why we must re-make global health in this historic moment." *Global Public Health* 15.7 (2020): 1083-1089.

⁶¹ Nkengasong, John N., and Wessam Mankoula. "Looming threat of COVID-19 infection in Africa: act collectively, and fast." *The Lancet* 395.10227 (2020): 841-842.

⁶² Labonté, Ronald, and Michelle L. Gagnon. "Framing health and foreign policy: lessons for global health diplomacy." *Globalization and health* 6.1 (2010): 1-19 at 5.

⁶³ Labonté, Ronald, and Michelle L. Gagnon. "Framing health and foreign policy: lessons for global health diplomacy." *Globalization and health* 6.1 (2010): 1-19.

left unexamined. This is perhaps due to the already contested nature of dignity in and of itself. As a right and as a philosophical concept it has been debated, dismissed and redefined in myriad ways. What this thesis does is to engage with dignity as the underlying ethic of the Constitutional social compact to which the State is bound, which in turn determine its obligations to fulfil the right to health. My recourse to dignity as an effective lens through which to understand what is required for the fulfilment of the right to health is posited on the belief that, while current understandings of the principles guiding the realisation of the right to health have advanced significantly, they have, in fact, been advanced inadvertently as administrative mechanisms for the State and not as robust expositions on the right to health. As such, principles like minimum core, progressive realisation and reasonableness have been developed as barometers for regulating what the State may be held accountable for, on the State's own terms, rather than as foundational principles for the realisation of its obligation, which was the original intent behind their formulation. I argue that the misrepresentation of the key concepts around the fulfilment of the State's obligations have decentred the original intent of the creation of the right to health and its formulation as primarily a State duty owed to its people. I contend that various interventions on how best to realise the right to health have thus invariably minimised the State's obligation, sometimes setting an artificial ceiling on what the State is obligated to do, with the principle of progressive realisation serving as a ready crutch for State inaction.

In the thesis, I examine the role of power as an important element of State ordering. In my analysis, I posit that the right to health, framed through the lens of dignity, is ultimately a claim on power and a push back against the State's framing of its duties and means to realise the right to health. As in the case of Nigeria, many scholars wrongly assume that the problem of the non-realisation of the right to health is the law or the seeming absence thereof. On this basis, they suggest that a full unequivocal recognition of the right to health in either the Constitution or in local legislation will prompt State action. I show that the greater challenge is that, even where the law recognises the right to health, it does not guarantee that the State will act to realise it. Understanding the Nigerian Constitution, and its guiding principles as being focused on the consolidation and division of political power is thus central to understanding the precarious nature of the right to health in this social and political context. Using this lens to view the Constitution, it is possible to better understand rights as bulwarks against State might, especially when bearing in mind Nigeria's history of brutal military dictatorships. Similarly, it is possible to understand the non-recognition of socio-economic rights as not being due to the 'impossible' demands they make on the State. Rather, the various limitations placed on the recognition and realisation of socio-economic rights can be understood as a weaponisation of law to place limitations on the power of the populace to make claims against the State and its resources,

which are at the centre of its power. I therefore argue that the right to health is fundamentally, at its heart, made up of claims by the populace against the State. While progressive realisation, minimum core and reasonableness have become tools for the entrenchment of State power and its consequent desire to deliver on its own terms at its own pace, a dignity-based right to health re-centres the right to health on what it truly is, which is a claim by a person(s) against the State for what they are due by virtue of their relationship to the State as laid out in the social compact.

Structure of the thesis

To fulfil the task of answering the query set out above, the subsequent chapters will be dedicated to that research agenda. As such, chapter two examines the literature that has shaped the understanding of the right to health in Nigeria, focusing on the problematisation of the lack of Constitutional provision for the right to health and some of the recommendations that have been made to address the concern. It highlights some of the reasons posited by scholars for the persistent lack of clarity of the right to health, focusing on claims around the role of institutionalised corruption in stalling the State from taking concrete steps to realise the right to health. I highlight the inability of these interventions to fully engage with the more far-reaching systemic constraints of the Nigerian State as it is presently set up, highlighting that any successful attempt to realise the right to health will have to take cognisance thereof.

Chapter three is dedicated to a discussion of Nigeria's social and political history, highlighting how the systemic problems the nation faces have been shaped, and the power dynamics that have played out in the actions of the ruling class. I discuss key events in the country's political and economic history that invariably changed the fundamental nature of the Nigerian State, the goals it sought to pursue, and how that translated into the types of laws and policies it passed, which were increasingly antithetical to the tenets necessary for realising the right to health. Through this historicisation of the trajectory of the Nigerian State, I show how it has become increasingly difficult to deliver socio-economic rights like the right to health. I make the case that the Nigerian State is more concerned with the consolidation of political and economic power than being the custodian of the people's hopes and aspirations, many of which can be achieved through the realisation of the right to health.

In chapter four, I show how the steady erosion of the ideals of being a welfare State and the consequent defunding of health has adversely impacted the Nigerian health system. By showing the shortfalls in management of the country's vast and complex health system, I highlight the far-reaching state of disrepair and disarray in the funding and management of the healthcare system and the implications on the State's lingering inability to adequately fulfil its functions.

Chapter five examines the current state of the law on the right to health in Nigeria, which I argue is a by-product of the political, economic, and social trajectory of Nigeria. To do this, I discuss the position of the international and regional covenants to which Nigeria is a signatory, as well as their implications on the Nigerian jurisprudence on the right to health. I discuss some of the hurdles that have been faced in the jurisprudence trying to make the case for the operationalisation of the right to health, highlighting the argument that the challenge of the right to health does not lie simply in an overly legalistic reading of rights, legal procedure, and the role of courts. I also discuss local laws that have a direct effect on the right to health. I pay close attention to the National Health Act, which is the full expression of the right to health in the Nigerian context and examine the ways in which this Act presents the role of the State vis á vis the right to health, as well as what the Act construes as the right to health. Through this analysis, I point out the challenges with this newest attempt to codify the right to health.

In chapter six I problematise the key principles that have come to shape our current understanding of the nature of the right to health and the obligations of States in this regard. I examine the role of arguments for a minimum core approach to the delivery of the right to health as against that of the progressive realisation of the right to health. I make the case that both concepts are a form of the law's meaning making, in this case of a normalised argument for State challenges of scarce and limited resources. I argue that even the test of reasonableness largely plays into the framing of State obligations in a manner that prioritises the convenience of the State. By exploring how the courts in similar jurisdictions have interpreted these principles, I show how judicial interpretation is often more willing to accept the State's framing of the issues and its conception of immediacy. I thereafter make the case that, for the right to health to begin to deliver on the aspirations of its formulation, the minimum core, test of reasonableness and the mandate of progressive realisation must be understood primarily as parameters for pacing the realisation of the people's rights and not as parameters for the convenience of the State. I argue that this kind of understanding of these principles is central to the realisation of health rights rooted in the respect for human dignity.

In chapter seven, I engage in a discussion of the concept of dignity and its role in providing normative clarity on the right to health. To do this, I examine definitions of dignity, the philosophical debates around human dignity and what it means vis á vis human rights in general and the right to health more specifically. I engage with the law's constant inability to adequately accommodate dignity and how this lingering limitation has served as a constant barrier to fully realising it. I particularly explore the notion of dignity as capability and examine the promise of such a reading of dignity along with its potential for framing the right to health. I follow this up with a critique of capabilities' premise and its

implications for right to health; showing how the viewpoint of dignity as capabilities may not be best suited to enforcing State fulfilment of the right to health, especially in the Nigerian context.

Chapter eight explores an alternative reading of human dignity that is rooted in the communitarian ethic. I discuss the philosophical roots of the communitarian reading of human dignity, especially in the context of African conceptions of personhood and explore the possible pitfalls of a communitarian ethic in the reading of human right obligations. I make the case that, regardless of appeals to collectivism, the intrinsic nature of rights demands that we respect human agency and autonomy, while encouraging its productive application. I argue that any philosophical framing of dignity must be grounded in people's lived realities and must not become a tool for the conscription of identity by a few gate keepers vested in systems that limit people's full enjoyment of their autonomy. I then juxtapose this normative framing of dignity with the understanding of human dignity in the Nigerian legal regime. I make the case that, while the communitarian ethic may influence social interactions in Nigerian society, those interactions are nested within a larger social ordering of the Nigerian State that brings together many divergent groups and cultures. As such, in the use of dignity as a claim to power, it is imperative to note the overarching social contract through which the people relate with the Nigerian State. I argue that this relationship is one that premises the unity of the Nigerian State on the equitable use of the centrally managed economic resources of the State. In this instance, the realisation of the right to health is not an altruistic service provided by the Nigerian State but is rather a central part of the larger socio-political construct of the State as provided for in the Constitution.

Chapter nine examines the implications of such a dignity-based approach to the right to health and what such an approach would mean for the judicial interventions for the fulfilment of the right in Nigeria. I discuss the implications for providing normative clarity, as well as how the courts may better contextualise the National Health Act. I examine the role of the judiciary in adjudicating the right to health and argue that, by virtue of the National Health Act, the ability to hold the State accountable to its duties is now possible. I argue that the judiciary has a duty to centre dignity in its considerations of the right to health of the populace, as this holds the key to the kind of duties for which it can hold the State accountable, as well as the consequent reliefs it grants as a result.

In Chapter ten, which is the concluding chapter, I show that the current nature of the Nigerian State is inherently antithetical to the recognition and fulfilment of the right to health and other socio-economic rights. Drawing on the preceding chapters, I show that the interests of the State through the ruling class and their consolidation of capital, does not lend itself to the delivery and fulfilment of such resource intensive rights as the right to health. I argue that, in the context of such a structural flaw, the most effective way to understand rights and to realise them ultimately is as claims against

State power. I show that a more in-depth understanding of human dignity holds the key to a better articulation of rights as such. I argue that the realisation of the right to health is dependent on a theoretical analysis that transcends the often-cited challenges of the right to health as being legality, corruption, and non-justiciability, as they are all, rather, symptomatic of a deeper power dynamic that must be understood, in order to be overturned for the good of the people, for whom the right to health is owed.

CHAPTER 2

Debates on the limitations to realising the right to health in Nigeria

Introduction

Scholars have grappled with two major questions regarding the right to health in the Nigerian context. The first question is whether there is, in fact, such a right in Nigerian law; the second is how that right (if it exists) should be realised in a developing country like Nigeria, with its limited resources. These enquiries have largely been targeted at finding effective ways to use the law, and especially human rights principles, to ensure essential health goods. In a quest for the answers, analysts have studied the international and regional human rights frameworks and sought to integrate them with existing domestic laws. These efforts have seen some push-back by those who assert that health is ill-suited to being recognised as a valid human right in Nigeria. The hesitance for them is based on the economic limitations of the Nigerian State to fulfil the obligations that recognition of such a right would place on it. Others who are opposed to a rights-based approach to health in Nigeria do so based on an ideological premise that healthcare and other factors that ensure good health are rather commodities that should be left to economic forces.

In this chapter, I canvas the ongoing debates about claims to the right to health in Nigeria and the most effective way to realise and operationalise the right. I discuss the approaches of various scholars grappling with the intractable issues around how best to make healthcare available, affordable, accessible and of good quality in Nigeria. Here I show a range of interventions made, along with the counterpoints to these interventions, as well as the debates that these contradictory positions have sparked. In doing this, I show the need for a more robust inquiry into the use of dignity to realise the right to health in Nigeria.

I first contextualise the Nigerian right to health as discussed in the broader global debates around the validity of a legal claim to the right to health. I then discuss interventions seeking to normalise the assertion that States, regardless of their economic capacity, are ultimately the primary duty bearers for the realisation of the right to health. This duty on States places obligations on them to respect, protect, and importantly, fulfil the right to health. Thereafter, I discuss the scholarly engagements with the specific challenges of developing the jurisprudence of the right to health in Nigeria. The key factors I review include the status of non-recognition of health as a human right in the Nigerian Constitution, justifications provided for this exclusion of the right to health as well as other socio-economic rights,

and the engagements with this situation in relation to the Constitution. This discussion is followed by an exposition of the various recommendations that have been made on how best to proceed with realising the right to health in the context of its limited Constitutional backing. I identify three major schools of thought in this regard and set out how they speak to each other. These three schools of thought are those minded to viewing Fundamental Objective Directive principles (FODP) as essential elements for the full realization of civil and political rights; those which seek to confront non-justiciability of the right to health by having an activist judiciary; and those that rather see FODP as a mandate on the State to provide legislative clarity — a step which they state is necessary for any subsequent judicial intervention (activist or not). I also engage with the scholarly interventions made to frame the domestication of the African Charter on Human and Peoples' Rights (African Charter)⁶⁴ as well as the passing of the National Health Act as fulfilments of the mandate of the legislature to provide normative clarity on the right to health. I then conclude with an examination of where the current legal dispensation has left contemporary discussions on the right in Nigeria.

Contextualising Nigerian right to health jurisprudence in larger global health governance discourses

Scholarship on the right to health in Nigeria is best understood in the context of an interconnected global health regime made up of individual States that are the primary duty bearers for the realisation of the right in their respective jurisdictions. Having this understanding as the starting point is important in the face of the increasing unsettling of the notion of the State as the seat of political and economic power. This emerging paradigm shift in turn raises questions around the capacity of States to be legitimate and effective duty bearers. The critique of the State as the primary duty bearer for the fulfilment of socio-economic rights and the right to health is one with considerable weight in the context of developing States with limited resources. This critique resonates when considering the ever-increasing influence of powerful non-state actors with an expanding role in agenda setting and policy implementation around the world.⁶⁵

The trend of incapacitated States increasingly overwhelmed by health crises that are either of a regional or global scale, queries the ability of States to be the primary duty bearers of the right to health. Global pandemics like the Ebola and Covid-19 outbreaks are lending credence to claims that alternative duty bearers (either in form or function) must increasingly be recognised, along with the

⁶⁴ *African Charter on Human and Peoples' Rights*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

⁶⁵ Marks, Susan. "State-centrism, international law, and the anxieties of influence." *LJIL* 19.2 (2006): 339-347.

duties and rights that accrue from that position.⁶⁶ However, in spite of concerns around the viability of primary State duty, this framing of responsibility is in many ways secured in place by a number of structural factors.⁶⁷ For one, the international human rights order is centred on States.⁶⁸ The seminal moments in world history leading up to the formulation of the United Nations and attendant human rights instruments, centre States as the primary actors and catalysts. While the regime of international law that would follow these events, requires international collaboration for optimal results, such collaboration is itself structured on the premise of having a comity of States.⁶⁹

This century has seen the rise of several powerful non-State actors which are, in some instances, richer and wield more power, and political, social and cultural capital, than several States combined.⁷⁰ While this state of affairs calls for interrogation on one hand, on the other hand, the emergent reality of powerful often supra-national non-State actors has created a clamour for a counterbalancing of their power by States.⁷¹ The need for legal and political structures to check the powers of non-state actors has served as a focal point for the call to further entrench States as the primary node of power.⁷² Proponents of this school of thought say that the fact that these powerful non-state actors are, in contrast to States, unaccountable to the people they serve, should serve as a key motivation for strengthening States to check their power.⁷³ The argument for strengthened States is that they can better act as equal partners, or, in the extreme, as bulwarks against the wanton exercise of power by non-state actors, especially in the context of health, where the effects are far-reaching.⁷⁴

An extension of the argument for strengthening the State as the primary duty bearer and custodian of the people's wellbeing is the notion of the social contract as intrinsic in democratic governance. In this framing, States are vested with their power through a social contract with their populace.⁷⁵ This social contract gives the State legitimacy, as the populace agree to respect its authority and that of its institutions in exchange for protection and provision of social goods via agreed upon terms,⁷⁶ often conveyed in a Constitution, which outlines the rights of the State's inhabitants and the duties of the

⁶⁶ Sirleaf, Matiangai. "Responsibility for Epidemics." *Tex. L. Rev.* 97 (2018): 285-354.

⁶⁷ Clapham, Andrew, and Mariano Garcia Rubio. "The obligations of states with regard to non-State actors in the context of the right to health." *Health and Human Rights Working Paper Series*, (2002).

⁶⁸ Ibid.

⁶⁹ Berman, Paul Schiff. "From international law to law and globalization." *Colum. J. Transnat'l L.* 43 (2004): 485.

⁷⁰ See n65.

⁷¹ Ibid.

⁷² Ibid.

⁷³ De Brabandere, Eric. "Non-state actors, state-centrism and human rights obligations." *LJIL* 22 (2009): 191.

⁷⁴ Carr, David M. "Pfizer's epidemic: a need for international regulation of human experimentation in developing countries." *Case W. Res. J. Int'l L.* 35 (2003): 15.

⁷⁵ Nussbaum, Martha C. "Beyond the social contract: capabilities and global justice. An Olaf Palme lecture, delivered in Oxford on 19 June 2003." *Oxford Development Studies* 32.1 (2004): 3-18.

⁷⁶ Ibid.

State.⁷⁷ It is this social contract that also makes a State accountable to its people, responsible for its wellbeing and, by extension, responsible for the fulfilment of its right to health. An effect of this power dynamic is that due to the amount of power the State wields over its people through its authority and the apparatus in place to enforce it, the State, and its mechanisms for social ordering and service delivery, often becomes a site of contestation for power and, subsequently, becomes the primary structure through which the power achieved is then manifested. Proponents of this view argue that the real issue is not so much whether the State is still relevant in the human right framework, but rather the extent of its power, considering the potential usurpation of that power by actors who would wrongly use said power.⁷⁸ Importantly also, recent global events concerning the management of the COVID 19 pandemic, have deepened the inquiry into States' power and how such power must be deployed in order to adequately meet the challenges posed by the health risks their inhabitants face. Where said responsibility is not properly used, the effects on the health outcomes of the people are far reaching.⁷⁹

Amid this debate, international law still recognises the role of the State as a key duty bearer for the realisation of the right to health. As such, in the Nigerian case, the question is not whether the State has a responsibility but rather what has caused it to not fully realise that responsibility.

The challenge of asserting the existence of the right to health in Nigeria

Much of the scholarly engagement with the challenges of the realisation of right to health in Nigeria are centred on its lack of Constitutional recognition. The question of Constitutional recognition of the right is often the starting point for scholars interrogating the seemingly nebulous nature of the right to health in Nigeria. The question of the Constitutional grounding of the right to health is rooted in an understanding of the Constitution as the *Grundnorm* of the State, so that what it includes and excludes has far reaching consequences.⁸⁰ The question then arises whether a right can be said to exist in a State if its Constitution does not provide for it? This central question is followed by various subsidiary questions which include asking: in the event the Constitution does not provide for the right, what legal instruments may suffice in the place of express Constitutional provision; and whether the Constitution

⁷⁷ Ibid.

⁷⁸ Ibid.

⁷⁹ See n65.

⁸⁰ Rachuonyo, J. O. "Kelsen's Grundnorm in modern Constitution-Making: The Kenya Case." *Verfassung und Recht in Übersee/Law and Politics in Africa, Asia and Latin America* 20.4 (1987): 416-430.

can, by its own provisions, render any subsequent attempt to make up for its omissions moot? These questions are the basis of much of the enquiry by scholars seeking to unpack the nature of the right to health in Nigeria. These scholars explore the dynamics of the Constitutional predicament of the right to health in Nigeria, which shows itself to be multi-layered and interwoven, as discussed below.

Non-recognition of health as a fundamental human right in the Nigerian Constitution

Like other health scholars, Oduwole and Akintayo identify the right to health as essential and intrinsic to the maximal enjoyment of all other rights.⁸¹ They point out that there is an important public health duty placed on the Nigerian State as a fundamental element of the right to health. However, they identify the provision for the right to health in Section 17(3)(d) of the Constitution as being one of the FODP, asserting that the provisions of the Constitution preclude matters delineated as FODP from being unenforceable.⁸² Onyebuchi identifies this limitation of the right to health to the status of FODP as a Constitutional challenge for the right to health.⁸³ Based on this observation, he describes the right to health as being merely an aspirational goal of the Nigerian State. Aregbeshola, in similar fashion, identifies the Constitutional omission of the right to health as the central concern for any meaningful attempt to enshrine the right to health and the consequent development of the jurisprudence on the right.⁸⁴

According to Nnamuchi, the right to health as contained in the Nigerian Constitution is a “toothless bulldog” incapable of any meaningful legal bite.⁸⁵ For him, the aspirational nature of the right to health means that the realisation of the right is a constantly moving target fuelled by incessant goal setting that is not time or duty bound on the State.⁸⁶ Atupare, however, has a contrary view on the implication of the right to health being a FODP. He asserts that, because Constitutions are the embodiment of a people’s ethos and fundamental law of reason, all of its content is equally important for charting the course of the State.⁸⁷ As such, according to him, if the Constitution provides the aspirational moral ideals for the common good of the people, the understanding of directive principles must transcend

⁸¹ Oduwole, Jumoke, and Akinola Akintayo. "The rights to life, health and development: The Ebola virus and Nigeria." *African Human Rights Law Journal* 17.1 (2017): 194-218.

⁸² Ibid.

⁸³ Arah, Onyebuchi A. "Time to do the right things right: Nigerian healthcare." *The Lancet* 360.9345 (2002): 1608-1609.

⁸⁴ Aregbeshola, Bolaji S. "Enhancing political will for universal health coverage in Nigeria." *MEDICC review* 19 (2017): 42-46.

⁸⁵ Nnamuchi, Obiajulu. "Kleptocracy and its many faces: the challenges of justiciability of the right to healthcare in Nigeria." *Journal of African Law* 52.1 (2008): 1-42.

⁸⁶ Ibid.

⁸⁷ Atupare, Atudiwe P. "Reconciling Socioeconomic Rights and Directive Principles with a Fundamental Law of Reason in Ghana and Nigeria." *Harv. Hum. Rts. J.* 27 (2014): 71-106.

a merely positivist reading to incorporate a moral understanding of law.⁸⁸ Such an understanding would mean a better appreciation of the value of socio-economic rights as the anticipated standard of living desired for the people, and not just the codification of meaningless words.⁸⁹ Despite this position, there is the lingering concern amongst these scholars of how to enforce State compliance of the FODP, considering the limitations the Constitution places on their justiciability. This constraint has been examined by scholars and is discussed below.

The analysis of non-justiciability of the right to health in the Nigerian Constitution

The lack of express Constitutional recognition of health as a right, but rather as an aspirational goal, is worsened by other Constitutional provisions, which render the right, in its aspirational state, non-justiciable.⁹⁰ As Ayanleye points out, all sections in Chapter 2 of the Nigerian Constitution are precluded from being considered by the Nigerian courts by virtue of Section 6(6)(c),⁹¹ which designates them as FODP.⁹² As Khaitan points out, FODP have been characterised as being, at best, provisions with mere moral appeal and having no practical implication or, at worst, as design flaws in the Constitution-making process.⁹³ Nonetheless, He argues that directive principles are, by their own nature, weighty.⁹⁴ For him, directive principles are orders on the State rather than merely representing a moral or political ideology. He posits that the Constitutional framers intended to place certain duties on different organs of the State,⁹⁵ and through directive principles, to provide direction as to what the State is obligated to do and how it is to do it. In the case of Nigeria, it has been suggested that the expectation of the Constitutional framers was that specific legislation on each of the directive

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Ayanleye, Oluwakemi. "Women and reproductive health rights in Nigeria." *OIDA International Journal of Sustainable Development* 6.05 (2013): 127-140.

⁹¹ Section 6(6)(c) when read together states: "The judicial powers of the Federation shall be vested in the courts to which this section relates, being courts established for the Federation. The judicial powers vested in accordance with the foregoing provisions of this section, shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act of omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution." See, Constitution of the Federal Republic of Nigeria, Act No. 24, 5 May 1999.

⁹² See n90.

⁹³ Khaitan, Tarunabh. "Directive principles and the expressive accommodation of ideological dissenters." *International journal of constitutional law* 16.2 (2018): 389-420.

⁹⁴ Ibid.

⁹⁵ Ibid.

principles would be passed by the National Assembly, until which time they could not be adjudicated upon.⁹⁶

The nature of non-justiciability

According to Nwabueze, a prominent Nigerian legal scholar, justiciability is “a combination of judicial power and duty bestowed Constitutionally on the courts to adjudicate violations of the law”.⁹⁷ This definition divides justiciability into two elements: the duly granted power of the court to hear a matter and the duty on the court to hear such a matter brought before it. By this definition, for a matter to be non-justiciable, it would not be enough that it be prescribed as such by law. It would also mean that the judiciary is stripped of its Constitutional duty and ability to serve as the final arbiter in legal disputes related to the matter. This line of thinking buttresses the school of thought that posits that the limitation of socio-economic rights in Nigeria is not just due to their inherently complex nature. Rather, it asserts that the lack of competence of the courts to entertain, examine and pronounce on claims affecting these rights are a conscious attempt to stifle any further interrogation of the implications of the right.⁹⁸

As a result of the legal hurdles non justiciability creates much of the grappling with the challenges of formulating the normative content of the right to health in Nigeria is largely concerned with addressing its constrained adjudicatory scope. Aregbesola, for example, states that, as a second step to expressly providing for the right to health in the Constitution, the ability to litigate that right is central to espousing and localising key global health principles. This includes the realisation of UHC, which has been identified as important for the optimal realisation of health goals.⁹⁹ For him, litigation provides an effective avenue to enforce the right to health in its most basic sense, which includes answering questions of access and equitable distribution of health resources.¹⁰⁰ In this sense, litigation can serve as an effective tool to hold up the State’s policies and implementation to scrutiny and review; and an important measure for ensuring compliance and accountability. An extension of this scrutiny and exposition of the State’s duty is the opportunity that litigation provides to develop the law to reflect emerging global health governance and health system reform best practices and

⁹⁶ Okeke, G. N., and C. Okeke. "The Justiciability of the Non-Justiciable Constitutional Policy of Governance in Nigeria." *IOSR Journal of Humanities and Social Science (IOSR-JHSS)* 7.6 (2013): 9-14.

⁹⁷ Nwabueze, Benjamin Obi. *Judicialism in Commonwealth Africa: The Role of Courts in Government*. St. Martin's Press, 1977 at 21.

⁹⁸ United Nations, Office of the High Commissioner for Human Rights. *Economic, Social and Cultural Rights Handbook for National Human Rights Institutions*. Geneva: UN, 2005.

⁹⁹ See n84

¹⁰⁰ Ibid.

standards.¹⁰¹ As such, the lack of provision for the right to health as a fundamental right, as well as its preclusion from litigation, makes it possible for the many inadequacies of Nigeria's weak health system to continue to fester in the absence of adequate measures to ensure accountability. This makes it increasingly more difficult to synchronise various disease-specific interventions and vertical intervention programs because there is no strong legal basis to compel much-needed reform as a matter of course.

The analysis of non-justiciability as a systemic impediment to State realisation of the right to health

Having recognised the significant limitations created by the non-justiciability of FODP, there is consensus in much of the scholarship that the challenge of the non-justiciability of Chapter 2 is insurmountable in its current form. Durojaye,¹⁰² Nnamuchi,¹⁰³ Ayanleye,¹⁰⁴ Ekhatior,¹⁰⁵ Duru,¹⁰⁶ and Ibe,¹⁰⁷ all emphasise that the right to health has been rendered a no-go area by the courts in their interpretation of the Constitution. FODP are thus largely treated in the scholarship as an opportunity for Constitutional framers to express adherence to lofty ideals without creating a system that binds them to realising those ideals.¹⁰⁸ These scholars also share the view that the effect of this sweeping preclusion has been, in essence, to stifle the jurisprudence on health rights. The effect is the silencing of any claim that health is a tangible right, which the State has a duty to fulfil. Ibe, for example, points out that this silencing of possible right to health claims has, over time, not only limited the advancement of socio-economic rights jurisprudence as a whole in Nigeria, but has insidiously entrenched the notion of civil and political rights as being the only real rights in Nigeria.¹⁰⁹ Duru reinforces this point by stating that the non-justiciability limitation creates a false dichotomy between socio-economic and civil and political rights, which are interdependent.¹¹⁰ In essence, the combination of both the initial demarcation of health as an aspirational right and its non-justiciability has created

¹⁰¹ Ibid.

¹⁰² Durojaye, Ebenezer. *Litigating the Right to Health in Africa: Challenges and Prospects*. Routledge, 2016.

¹⁰³ Nnamuchi, Obiajulu. "The right to health in Nigeria." *Available at SSRN 1622874* (2007)

¹⁰⁴ See n90.

¹⁰⁵ Ekhatior, Eghosa Osa. "The impact of the African Charter on Human and Peoples' Rights on domestic law: a case study of Nigeria." *Commonwealth Law Bulletin* 41.2 (2015): 253-270.

¹⁰⁶ Duru, Onyekachi. "The justiciability of the fundamental objectives and directive principles of state policy under Nigerian Law." *Available at SSRN 2140361* (2012).

¹⁰⁷ Ibe, Stanley. "Implementing economic, social and cultural rights in Nigeria: Challenges and opportunities." *African Human Rights Law Journal* 10.1 (2010): 197-211.

¹⁰⁸ See n85.

¹⁰⁹ See n107.

¹¹⁰ See n106.

a double-edged incapacitation of the right to health in Nigeria. Nnamuchi, like Aregbesola, points out that this incapacitation of right to health jurisprudence has real life consequences.¹¹¹ Because the issues raised in the directive principles are not amenable to judicial scrutiny, the realisation of the fruits of their provision are made impossible, with far-reaching effects on health systems and the ability to deliver health goods.¹¹² Both Nnamuchi and Aregbesola make the important point that civil and political rights are of little value without the socio-economic rights that ensure the conditions within which to enjoy them.¹¹³

Others, like Akande, defend the non-justiciable nature of the right to health, stating that it is the more practical approach to adopt in the context of an incapacitated State unable to meet the demands of being a welfare State.¹¹⁴ As a result, they argue that the demarcation of socio-economic rights as FODP pending the State's capacity to implement is the best approach. Scholars who take this more pragmatic approach to their understanding of the nature of fundamental objectives argue that, for the most part, Constitutions are a product of political compromise, reflecting the outcomes of these negotiations.¹¹⁵ Bearing this in mind, while the goals of the State may not be disputed, the means by which they are realised such as whether some entitlements should be treated as directive principles or rights may become too contentious and as such, are better left to a later time to be resolved.¹¹⁶ By this thinking, the argument is that the provision of socio-economic rights as FODP should be considered more as social goods that the State is still duty bound to realise, albeit not as pressingly as clearly stated rights. By this logic, the FODP's limitations of non-justiciability must be approached as a temporary hurdle that necessary legislative clarity and executive policy direction will get rid of, for the eventual realisation of the social good as a full-fledged right.

¹¹¹ See n85.

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Akande, Jadesola O. *The Constitution of the Federal Republic of Nigeria 1979: With Annotations*. London: Sweet & Maxwell, 1982.

¹¹⁵ Horowitz, Donald L. "Constitutional design: Proposals versus processes." *The architecture of democracy: Constitutional design, conflict management, and democracy* 15 (2002): 20-22.

¹¹⁶ The committee that drafted Nigeria's 1999 constitution considered, but rejected, the inclusion of socio-economic rights amongst the guaranteed fundamental rights and freedom, preferring to relegate them to the status of Directive Principles. Defending this view, Akande argues that, since Nigeria is not yet a welfare state in the same sense as western countries, "all the provisions for welfare assistance must remain unattainable goals or ideals. See, Nnamuchi, Obiajulu. "Kleptocracy and its many faces: the challenges of justiciability of the right to healthcare in Nigeria." *Journal of African Law* 52.1 (2008): 1-42, citing Akande, Jadesola O. *The Constitution of the Federal Republic of Nigeria 1979: With Annotations*. London: Street & Maxwell, 1982 at 13.

The recommendation to include the right to health in the human rights chapter of the Constitution

In the face of the two-tiered Constitutional challenge facing the right to health in Nigeria, some scholars recommend the incorporation of socio-economic rights into the bill of rights, with full and equal rights status to civil and political rights. They view this as the most effective solution to the challenges faced in giving the right to health normative clarity.¹¹⁷ For scholars with this orientation, the challenge of the right to health is not primarily its non-justiciable status but its non-recognition as a human right. Duru, for example, concludes one of his writings, on the state of the right to health and the non-justiciability conundrum, by recommending that Chapter 2 be incorporated with Chapter 4 of the Constitution.¹¹⁸ According to this point of view, moving the relevant contents of Chapter 2 into Chapter 4 would primarily solve the problem of the seemingly nebulous rights status of the socio-economic goods, currently outlined in Chapter 2. A ripple effect of transitioning FODP from Chapter 2 to Chapter 4 rights would be that they are not bound to the limitations placed on Chapter 2 issues, thus also resolving the justiciability problem.

The reasoning behind this proposed solution is that rights, by their nature, carry legal force that becomes imbued in them by their demarcation as such. By this logic, the moment we acknowledge something as a right, it enjoys stature accorded to human rights as well as the privileges and benefits that accrue to the right holders.¹¹⁹ This rights status means both that every right holder stands an equal chance to be aware of their right and to take steps to ensure they enjoy it, and that the State is put on notice that it has a duty it must meet and must begin to take concrete steps thereto.¹²⁰ In this sense, the ability to litigate the right is then mostly a by-product of its fundamental nature of being a right. It is a necessary component for holding the State accountable to fulfil its duty. The clamour for recognition of the right status of health, according to Ibe, is therefore not just an attempt to be fastidious on nomenclature.¹²¹ Rather, it is a tactical stance aimed at removing, once and for all, any legal barriers that exist or may be created to unduly limit the full enjoyment of the right to health. Furthermore, clarifying the rights status of health, using human rights language, allows for a more succinct expression of the substance of the right, in a manner that appropriately encapsulates what is central to the optimisation of the people's expected health outcomes.¹²² As Ake, a prominent scholar expresses it:

¹¹⁷ See n106.

¹¹⁸ Ibid.

¹¹⁹ See n107.

¹²⁰ Ibid.

¹²¹ Ibid.

¹²² Ibid.

if rights are to be meaningful in the context of a people struggling to stay afloat under very adverse economic and political conditions, they have to be concrete in the sense that their practical import is visible and relevant to the conditions of existence of the people to whom they apply and realized by them.¹²³

Ibe however states that the stated rights must be nested within a broader guiding principle and road map for the State.¹²⁴

The recommendation of incremental inclusion of socio-economic goods as human rights

The argument has been made that the better way to use FODP is to incrementally move relevant rights and social issues from FODP to human rights as the need arises.¹²⁵ And so, while some scholars, when addressing the challenge of non-justiciability, advocate for a repudiation of that section of the Constitution, others propose that these aspirational rights can be incrementally moved to human right status as either the need or capacity of the State to fulfil arises. For them, there will always be issues that would need to be demarcated as FODP and the real challenge is not the existence of such a section of the Constitution, but the inability of portions of it to make a transition to other actionable and justiciable portions of the Constitution.¹²⁶ And Duru points out, it is befitting if some of the principles in the FODP remain broad aspirational benchmarks against which the State and the people can periodically check their progress, provided that those FODP deal broadly with the intended ethos and direction of the State, and not with actual concrete rights that should ideally already have steps being taken to fulfil them.¹²⁷ Nnamuchi goes further to state that the actual spirit of the Constitution regarding FODP is that they remain in the consciousness of the polity.¹²⁸ This compels the State to elevate the FODP from being merely lofty aspirations to actionable rights. In his analysis, they are aspirational ideals not in the sense of being unattainable goals, but rather in that they are promises made by the State that it will prioritise the welfare of its citizens. On this basis, the desire to meet its obligations to the populace must be the underpinning motivation for all State action.¹²⁹

Apart from the prescriptive interventions, some scholarship has also grappled with the existing status quo, arguing for ways to give the right to health expression within the Constitution as it is. To them,

¹²³ Ake, Claude. "The African context of human rights." *Africa today* 34.1/2 (1987): 5-12 at 10.

¹²⁴ See n107.

¹²⁵ See n106.

¹²⁶ Ibid.

¹²⁷ Ibid.

¹²⁸ See n85.

¹²⁹ Ibid.

the chances of significant modification to the existing Constitutional makeup is slim.¹³⁰ This because, in their analysis, the political priorities of the ruling class that warrant Constitutional amendment are more concerned with the processes of allocating political power and have little to do with the interests of the populace.¹³¹ As such, many are of the view that the duty of ensuring accountability for the realisation of the right to health rests on the courts to step in to act for the right holders and live up to their moniker of being the last hope of the common man.¹³² With this understanding in mind, there has been a desire to find viable solutions within the existing constraints. To this end, scholars have engaged robustly with the role and place of the judiciary in realising socio-economic rights like the right to health. They have consequently considered various options which they posit would be best suited to the goals of realising socio-economic rights for right holders. In doing this, they have also considered some of the ideological and procedural challenges courts face, making recommendations to these identified challenges. This scholarship is outlined here.

The role of the judiciary in adjudicating socio-economic rights

Litigation provides a major platform through which the poor and marginalised are given the opportunity to voice their hardships.¹³³ The modalities for voicing displeasure and the remedies that accrue from the exercise, however, vary based on jurisdiction. However, in either situation, the focus is on the realisation of social justice. Litigation broadly and strategic litigation especially, is essential and ultimately beneficial in the long term for securing the affirmation of social benefits, which in turn will create a favourable environment for broader mobilisation around deeper and more sustainable long-term reforms.¹³⁴ In addition to the goals of reform, increased social justice litigation increases the participatory capabilities of otherwise marginalised portions of society who many times are not consulted when interventions that affect their lives are made. Through litigation, not only do they get to participate in governance, but they also get to shed light on their challenges. In this sense, litigation becomes an extension of agency in its exercise as well as through the consequent action that follows therefrom. It is thus through litigation that our individual and collective commitment to social justice is lived out. The outcomes of robust litigation are not limited to participation for the litigants or

¹³⁰ Ibid.

¹³¹ Oserheimen A. Osunbor, "Constitution amendment in Nigeria: concepts and misconceptions.", *Presentation to Students of the Faculty of Law, Ajayi Crowther University, Oyo* (2017).

¹³² Ajigboye, Oyeniya. "Realization of Health Right in Nigeria: A Case for Judicial Activism." *Global Journal of HUMAN-SOCIAL SCIENCE: F Political Science* 14.3 (2014): 23-34.

¹³³ Liebenberg, Sandra. "Needs, rights and transformation: adjudicating social rights." *Stellenbosch Law Review* 17.1 (2006): 5-36.

¹³⁴ Ibid.

accountability from the State, but also includes the enriching of the nation's jurisprudence and wider policies that come about as an offshoot which will benefit generations yet unborn.

With litigation being an important legal and political tool, the role of the judiciary thus becomes one of adjudicating the claims of right holders for their merits as well as considering any contradicting claims that may negate the assertion of the validity of those claims. With this task, the question is often raised about the effects of such intervention for the realisation of socio-economic rights. For while the intervention of the judiciary may be a net positive in more traditional civil and commercial disputes, the value of such intervention for the realisation of socio-economic rights and the right to health is contested. Some sociologists of law argue that litigation is not an appropriate strategy for advancing social rights.¹³⁵ Their argument is contextually nuanced, pointing out that, for the most part, many legal systems favour already vested interests, with members of the judiciary often being members of the social elite in any case.¹³⁶ The argument is thus that to resort to judicial intervention may in fact be counterproductive, if the political systems in place favour the entrenchment of judges that are more vested in ensuring the perpetuation of the unequal power relations that favour the State and the ruling class. This viewpoint also highlights the fact that, invariably, the laws that the courts are taxed with interpreting and adjudicating upon by and large reflect and reinforce the prevailing power-relations.¹³⁷ As a result, even if the judiciary were so minded, they are less likely to be able to make decisions that favour the disadvantaged, whose very social rights are at risk.¹³⁸ In view of this analysis, the recommendation is that the often time and resource-costly nature of litigation is better spent on political mobilisation, in which case the very premise of the unfair laws can be questioned without giving them legitimacy through formal legal processes.¹³⁹

And while this view is legitimate in its pessimism of legal systems as reproducing inequitable power structures, it is not an altogether bleak situation. As Gloppen shows, the judiciary can and has often given judgments that favour the common man.¹⁴⁰ Using South Africa as a case study, she shows that the ends of socio-economic rights can be advanced through litigation and a knowledgeable judiciary

¹³⁵ Gloppen provides a wider exposition of the arguments for and against the litigation of socio-economic rights. See Gloppen, Siri. "Social Rights Litigation as Transformation: South African Perspectives." *Democratising Development: The Politics of Socio-Economic Rights in South Africa*. Eds. P. Jones, and K. Stokke. Leiden: Martinus Nijhoff Publishers, 2005. 153- 176.

¹³⁶ Ibid.

¹³⁷ MacDowell, Elizabeth L. "Reimagining Access to justice in the Poor People's Courts." *Geo. J. on Poverty L. & Pol'y* 22.3 (2015): 473-544

See also, Galanter, Marc. "Access to justice in a world of expanding social capability." *Fordham Urb. LJ* 37 (2010): 115.

¹³⁸ See n135.

¹³⁹ Ibid.

¹⁴⁰ Ibid.

that is both awake to its duties as well as contextually grounded in the socio-political realities of the nation within which it is making its decisions.¹⁴¹ Furthermore, to concede the legal sphere to the State and the ruling class will ultimately be counterproductive. And so, while litigation may not solve every problem, it is a valid tool in a larger toolkit for driving social change and the realisation of the socio-economic rights. Anderson asks the important question: “If judicial institutions are ideally suited to the task of accountability, then why are the judicial (and legal) systems in poor countries not more effective at constraining the behaviour of political leaders and people who occupy positions of state authority?”¹⁴² The answer for him is based on three main factors, being: the nature of their Constitutions, uncertainty about the independence of the judiciary, and the consequent need for legal reform.¹⁴³ All of these points have been raised in the scholarship as root causes of the inability to have a robust expression of the right to health in Nigeria.

Tied to the argument that the right to health should be linked to civil and political rights is a critique of the hesitance of the Nigerian courts to adjudicate socio-economic rights. In this analysis, making this link in litigation has emerged as a pragmatic response to judicial reluctance to entertain health right claims on their own. Some have stated that a major constraint to entrenching the right to health is the judiciary and, as such, intervening in the judiciary is key for advancing health rights.¹⁴⁴ However, for interventions on the judiciary to be beneficial, it is necessary to understand the legal basis upon which the courts have thus far shown restraint as well as other issues that may preclude the courts from acting.

Reflecting on the judiciary’s motivations, some have stated that the problem with ensuring judicial enforcement of the right to health has been that the socio-economic rights have been litigated in their current form as FODP, thereby forcing the courts to uphold the provisions of the Constitution regarding non-justiciability. In Nnamuchi’s analysis of the seminal case of *Okogie v The Attorney-General of Lagos*,¹⁴⁵ he shows that the court gave many reasons for its hesitance to rule on the right to education, ultimately stating that it did not have authority, since it was bound by the provisions of the then Constitution,¹⁴⁶ which has been carried over to the current Constitution in that particular

¹⁴¹ Ibid.

¹⁴² Anderson, Michael. “Access to justice and legal process: making legal institutions responsive to poor people in LDCs.” *WDR 2000 Conference*. 1999.

¹⁴³ Ibid.

¹⁴⁴ Ibid.

¹⁴⁵ *Archbishop Anthony Olubunmi Okogie & Ors. v The Attorney-General of Lagos* [1981] 2 NCLR.

¹⁴⁶ The 1979 Constitution (an identical replication of the current 1999 Constitution).

regard.¹⁴⁷ The court did, however, provide clear directives as to when it would be able to consider such matters. In its judgment, the court placed the onus on the legislature to give legislative expression to the aspirational goals of Chapter 2, whereupon they would become enforceable law that could be adjudicated on.¹⁴⁸ The approach of the Court in *Okogie* is supported by Nwabueze, who posits that it is inappropriate to adjudicate on socio-economic claims as rights in the same manner as the bill of rights, since they do not have that status and as such are not justiciable.¹⁴⁹ In this regard, his view is that the hands of the courts are tied until such a time as legislation recognising and expounding on the right to health is passed.

Against this backdrop of restricted adjudicatory capacity, a few suggestions have been made by scholars on how the judiciary may approach matters concerning the relevant socio-economic rights not expressly provided for as rights in the Constitution.

Options of judicial approach to socio-economic right adjudication

Making a choice between conservative versus proactive jurisprudence

Nnamuchi argues that the choice for the judiciary boils down to whether it prefers to adopt an approach of proactive judgments or one that favours restraint.¹⁵⁰ He makes the case for the judiciary to adopt a proactive approach, stating that it is the judiciary's ethical responsibility to be so inclined.¹⁵¹ As such, there is a demand for judicial activism in jurisprudence on the right to health. Such activism would mean having judicial intervention, despite the designation of health rights as non-justiciable aspirational goals in the Constitution. Okeke and Okeke push for an extreme form of judicial activism in which the courts should outrightly find the non-justiciability clause itself unconstitutional, and not in line with the intent of providing for socio-economic rights.¹⁵² For them, such a decision would be in furtherance of a broader need to challenge the hitherto sacrosanct nature of non-justiciability of socio-economic rights in Nigeria.¹⁵³ Others, like Obilade have a more conservative approach to what

¹⁴⁷ The introduction of the non-justiciability clause was a novelty of the 1979 Constitution. It was provided for in Section 6(6)(c), which is the exact same provision carried over in Section 6(6)(c) of the new 1999 Constitution.

¹⁴⁸ See n145.

¹⁴⁹ Nwabueze, Benjamin Obi. *Constitutional law of the Nigerian Republic*. London: Butterworths, 1964.

¹⁵⁰ See n85.

¹⁵¹ Ibid.

¹⁵² Okeke, G. N., and C. Okeke. "The Justiciability of the Non-Justiciable Constitutional Policy of Governance in Nigeria." *IOSR Journal of Humanities and Social Science (IOSR-JHSS)* 7.6 (2013): 9-14

¹⁵³ Ibid.

the activist role of the judiciary should be in this regard.¹⁵⁴ They posit that there is room for innovation, without overstepping the Constitutional provision that precludes judicial scrutiny, until such a time that legislative measures are taken.¹⁵⁵ For them, the judiciary should not stop at recognising the limitations placed on it. Rather, it should compel the legislature to act on its duties and even to report back to it on its progress, as the situation may demand. Proponents of this approach argue that this strategy is more in line with the spirit of the Constitution and respectful of the principles of separation of powers and the provision of checks and balances.¹⁵⁶ An-Na'im, in similar fashion, makes the case for judicial activism as being central to the governance project, making the point that where the courts avoid all responsibility for discrimination in effect or in outcome by doing nothing, there is the risk of State complacency.¹⁵⁷

Applying lessons from similar jurisdictions

Some scholars prefer a form of judicial activism that is intended to be an improvement on the approach of Indian courts, linking the right to health with civil and political rights. In this sense, the Indian model is understood as contextually proactive.¹⁵⁸ This idea of contextual proactivity is juxtaposed with the approach of the South African courts, which is viewed as contextually conservative.¹⁵⁹ The starting point for this analysis is the nature of the laws in the two countries on the right to health. Indian courts are proactive since they, like Nigeria, do not have health clearly delineated as a human right.¹⁶⁰ As such, them giving judgement in a manner that gives expression to the right to health, despite the legal hurdles, is forward thinking. This is especially so in a case like *Paschim Banga Khet Mazdoor Samity v State of West Bengal*,¹⁶¹ where the Supreme Court rejected the argument that socio-economic rights are unenforceable because of limited resources, stating that a State could not avoid its Constitutional obligations because of financial constraints.¹⁶² In fact, the

¹⁵⁴ Obilade, A.O. "The Corrupt Practices and Other Related Offences Act and the right to privacy". *Contemporary issues in the administration of justice: Essays in honour of Justice Atinuke Ige*. Eds. A.O Obilade, et al. Lagos: Treasure Hall, 2001. 126.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid.

¹⁵⁷ An-Na'im, Abdullahi A. "To affirm the full human rights standing of economic, social and cultural rights." *Economic, Social & Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social & Cultural Rights*. Ed. Y. Ghai. London: Commonwealth Secretariat, 2004.

¹⁵⁸ See n85.

¹⁵⁹ Ibid.

¹⁶⁰ The right to health is provided for in the Indian Constitution under its Fundamental Objectives chapter, in Sections 39 and 47. See, *The Constitution of India*, 26 January 1950.

¹⁶¹ (1996) 4 SCC 37.

¹⁶² *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anor.* (1996) 4 SCC 37 at para 16.

court went on to direct the government to formulate a blueprint for primary healthcare with a specific emphasis on treatment of patients during emergencies.¹⁶³

In contrast to India, the South African Constitution provides for the right to health and the approach of South African courts' in adopting the principle of reasonableness, as applied in various cases, is seen as not expanding the law far enough, especially when considering the spirit of the Constitution and available legislative framework, from which the courts may launch.¹⁶⁴ In this analysis, the determination about whether a judiciary's stance is proactive or restrained is dependent on its judgments relative to the existing laws upon which it adjudicates, premised on a belief that a key role of the judiciary is to constantly advance the law and not to arbitrate between contesting parties on the substance of the law.

The argument of pragmatic expedience

Some scholars that favour the Indian approach, take a pragmatic approach. For them, the similarities in the Indian and Nigerian Constitutional heritage and legal set up make it easier to transpose the Indian approach to enforcing socio-economic rights in the context of limited legal wriggle room. This view is buttressed by the fact that the Indian approach, in terms of upholding the right to health as part of civil and political rights, is already gaining traction in the emerging jurisprudence on the right to health in Nigeria.¹⁶⁵ This approach can be seen in Durojaye's work, which shows that the nature of right to health claims has been adapted in a manner that ties such claims to fundamental rights as ancillary right claims.¹⁶⁶ He points out that the cases that have adopted this approach have received more favourable consideration by the Nigerian courts, which have generally found in favour of the litigants seeking to enforce their rights.¹⁶⁷ For proponents of this approach, the right to health is already being enforced by the Nigerian courts, albeit slowly. They argue that even these few cases are

¹⁶³ Ibid at para 10.

¹⁶⁴ This is observed from the findings in cases like *Government of the Republic of South Africa. & Ors v Grootboom & Ors* 2000 (11) BCLR 1169. (CC), and *Soobramoney v Ministry of Health, KwazuluNatal* 1997 (12) BCLR 1696. See, n85.

¹⁶⁵ Durojaye, Ebenezer. "Litigating the right to health in Nigeria: Challenges and prospects." *International Law and Domestic Human Rights Litigation in Africa*. Ed. M. Killander. Pretoria: PULP, 2010. 149-172.

¹⁶⁶ Odikpo, Josephine, and Ebenezer Durojaye. "Litigating Health Rights Issues: The Nigerian Experience." *Litigating the Right to Health in Africa: Challenges and Prospects*. Ed. E. Durojaye. London: Routledge, 2016. 141-156.

¹⁶⁷ Durojaye, Ebenezer. *Litigating the Right to Health in Africa: Challenges and Prospects*. Routledge, 2016.

revolutionary in that the rights of the litigants have been upheld in a social and political climate where little regard is paid to human rights.¹⁶⁸

Nnamuchi argues that this apparent success is short lived and is ultimately of little importance in the grander scheme of seeking the full recognition of the right to health and exposition of its normative content. He concedes, however, that litigation is cumbersome and expensive, and so the focus of litigants has rightly been to argue briefs that they feel give them the best chance of success.¹⁶⁹ With the existing jurisprudence being shaped within the confines of scant legislative clarity on the right to health, litigants are compelled to make a tenable case for their rights which they feel able to argue successfully.¹⁷⁰ An extension to this practical limitation is the one Durojaye makes, that the hands of the courts are tied from making pronouncements on issues that have not been pleaded before them.¹⁷¹ Nnamuchi concedes that, bearing in mind the various hurdles faced by the right to health, this kind of litigation is more contextually grounded and organic for the growth of the right to health.¹⁷² For him, judicial interpretation, grounded in the substantive reality of the state of the law at any given time, avails itself to being practical, with more easily obtainable remedies.¹⁷³ In this sense, applicants' right claims are not rendered vacuous. Rather, judgments reflect a diligent consideration of the totality of the State's position in terms of resources and its means and ability to meet the claims for the provision of health services. In the end, this approach by litigants, and by extension the judiciary, goes beyond 'advancing the law' on a jurisprudential level, to providing practical solutions that are of greater value to the applicants who ultimately are the ones for whom the law and justice are meant to serve.¹⁷⁴

Operationalising Fundamental Objective Directive Principles as essential elements to the full realisation of civil and political rights

Adopting the approach of the Indian courts, which share a similar Constitutional heritage and make up to Nigeria,¹⁷⁵ scholars have made a case for the amplification of the FODP by tying them to

¹⁶⁸ Durojaye, Ebenezer. "So sweet, so sour: A commentary on the Nigerian High Court's decision in Georgina Ahamfule v Imperial Hospital & Another relating to the rights of persons living with HIV." *African Human Rights Law Journal* 13.2 (2013): 464-480.

¹⁶⁹ See n85.

¹⁷⁰ Ibid.

¹⁷¹ See n168.

¹⁷² See n85.

¹⁷³ Ibid.

¹⁷⁴ Ibid.

¹⁷⁵ Nwabueze, Remigius Nnamdi. "The legal protection and enforcement of health rights in Nigeria." *The Right to Health at the Public/Private Divide: A Global Comparative Study*. Eds. C. M. Flood, and A. Gross. Cambridge: Cambridge UP, 2013.

Constitutionally recognised civil and political rights.¹⁷⁶ Based on an understanding of the indivisible and interdependent nature of rights, the case has been made that the right to health should be understood and realised as an integral part of the right to life and the right to dignity. Along this line of reasoning, good health is important for an optimal life. As such, access to healthcare that can guarantee good health should be one that ensures the protection of human dignity.¹⁷⁷ Oduwole and Akintayo, for example state:

A person who is critically ill with no access to appropriate and adequate healthcare is unlikely to appreciate, much less exercise, the rights to personal liberty, freedom of movement, religion, expression, shelter, privacy, among others. Such a person is also most likely to have their dignity and autonomy, values central to human rights norms, impacted in significant ways.¹⁷⁸

This view is synonymous with that of the Indian Supreme Court, which has held that the principles of the FODP are to be interpreted in harmony with the fundamental human rights, as they complement each other.¹⁷⁹ As Ibe points out, the understanding and legal practice in India is that FODP guide the State and so serve as the compass for determining appropriate State action.¹⁸⁰ Duru draws attention to the judgement in the case of *Minerva Mills v Union of India*¹⁸¹ as instructive for understanding the contemporaneous reading of FODP with human rights.¹⁸² In the words of Justice Bhagwati:

...to the large majority of people who are living in almost subhuman existence in conditions of abject poverty and for whom life is one long unbroken story of want and destitution, notions of individual freedom and liberty, though representing some of the cherished values of a free society would sound as empty words bandied about in the 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 conditions and usher in a new social order where socio-economic justice [will] inform all institutions of public life so that the preconditions of fundamental liberties for all may be secured.¹⁸³

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ Oduwole, Jumoke, and Akinola Akintayo. "The rights to life, health and development: The Ebola virus and Nigeria." *African Human Rights Law Journal* 17.1 (2017): 194-218 at 200.

¹⁷⁹ (1993) 1 SCC 645.

¹⁸⁰ See n107.

¹⁸¹ (1980) AIR SC, 1789.

¹⁸² See n106.

¹⁸³ *Minerva Mills v Union of India* (1980) AIR SC, 1789 at 97.

The application of linking the right to health to civil and political rights in Nigeria

The approach of making the right to health an ancillary or consequential claim tied to a civil and political right has been applied by the Nigerian courts with considerable success. Nnamuchi points out that prior to the decision in *Jonah Gbemre & Ors v Shell Petroleum Development Company of Nigeria LTD & Ors*,¹⁸⁴ the right to life and the right to dignity of the person had never been construed as incorporating the right to a healthy environment by the Nigerian courts.¹⁸⁵ He sees the connection made by the court in that case as important, especially when considering that the right to the environment itself had never been construed as a right in Nigeria's Constitution, much less a justiciable one. Thankfully, as Nnamuchi notes, the court found not only that it was justiciable, but that the right to life and dignity of the person includes the right to a clean, poison-free, pollution free, healthy environment, thus drawing the links between socio-economic rights and civil and political rights.¹⁸⁶

Citing the recent cases of *Georgina Ahamefule v Imperial Medical Center and Another*¹⁸⁷ and *Festus Odafe and others v AG fed and others*,¹⁸⁸ Durojaye says they are the right steps in the right direction, while noting the challenges the cases failed to address.¹⁸⁹ For example, in the *Ahamefule* case, the court's decision placed little focus on the infringements on the applicant's right to health, rather focusing on her right to dignity and freedom from discrimination.¹⁹⁰ By highlighting the reasoning of the courts in these cases, and the choice to frame the right to health claims as an assertion of human dignity, Durojaye opens the door to a deeper exploration of the possibilities that are inherent in a dignity-based approach to realising the right to health.

In his critique of the approach that folds the right to health into a different or more encompassing right claim, Durojaye points out that, as in the case of *Ahamefule*, the courts lost an important opportunity to better shape the jurisprudence on the right to health *per se* when they engaged with civil and political rights as the main claims to be considered.¹⁹¹ For him, it is not enough to slip in the right to health as an ancillary claim.¹⁹² Nnamuchi, in his own analysis of the *Gbemre* case,¹⁹³ states that the decision to not even make the claim for the right to a healthy environment based on the Nigerian

¹⁸⁴ (2005) AHRLR 151 (NgHC 2005).

¹⁸⁵ See n85.

¹⁸⁶ Ibid.

¹⁸⁷ (Suit No. ID/1627/2000).

¹⁸⁸ (2004) AHRLR 205 (NgHC 2004).

¹⁸⁹ See n165.

¹⁹⁰ Ibid.

¹⁹¹ See n168.

¹⁹² See n189.

¹⁹³ See n85.

Constitution, is telling.¹⁹⁴ This is because Section 20 of the Constitution provides that “the State shall protect and improve the environment and safeguard the water, air and land, forest and wildlife of Nigeria”. Nnamuchi suggests that, perhaps, counsel’s choice not to make a claim based on Section 20 was strategic and based on a belief that reliance on a FODP would be of little use in the best-case scenario, and counterproductive in the worst case. For him, this decision by counsel is further proof of the entrenchment of the notion that a case pleading FODP is unwinnable and is hence a waste of effort.¹⁹⁵ The ripple effect of such a perception, as he points out, is that it serves to further limit the possibilities of a robust engagement with FODP that can yield significant normative expansion of the right to health.¹⁹⁶ This outcome is untenable and ultimately unfavourable to the development of the right to health in its fullest form. The persistent lack of judicial exposition on the nature, scope and content of the right to health is counterproductive to the long-term project of normalising recognition of the existence of a right to health with attendant State duties at all levels of governance.

Challenging the judiciary to take a more activist stance for the realisation of the right to health

Attitudinal challenges for judicial activism

Scholars alternatively problematise the issue of judicial activism as being more indicative of a lacklustre attitude of the bench. They posit that that judges’ philosophical leanings, legal and judicial training, and their more practical bureaucratic considerations, make it almost impossible for the Nigerian courts to exercise any form of judicial activism that will result in a reinterpretation of the right to health in a manner that is able to circumvent the limitations placed on it.¹⁹⁷ The Nigerian courts have been accused of timidity in their interpretation of socio-economic rights, such as the right to health.¹⁹⁸ For these critics, as an institution, the Nigerian judiciary is set up in a manner that prevents it from being truly innovative. Ajigboye, for example, asserts that no judicial intervention will provide true justice without the zeal and fervour of an activist judiciary.¹⁹⁹ For him, the burden rests on the judiciary to rise to the challenge and fully execute its mandate. The onus is on the judiciary to both be proactive in its crafting of the jurisprudence around the duties of the State for the fulfilment of the right to health, as well as in the attendant remedies it is to provide to make this possible.²⁰⁰ An extension of this critique is that the judiciary has repeatedly failed to engage critically with the gamut

¹⁹⁴ Ibid.

¹⁹⁵ Ibid.

¹⁹⁶ Ibid.

¹⁹⁷ See n132

¹⁹⁸ Onyemelukwe, Cheluchi. "Access to anti-retroviral drugs as a component of the right to health in international law: examining the application of the right in Nigerian jurisprudence." *African Human Rights Law Journal* 7.2 (2007): 446-474.

¹⁹⁹ See n132.

²⁰⁰ Ibid.

of existing laws which would, in fact, be enough to make a claim for the right to health.²⁰¹ Instead they have sought refuge under the provisions of Section 16 of the Constitution on non-justiciability, claiming it as sacrosanct and not providing any room for variance.²⁰² Ibe believes that the courts' approach to justiciability depicts a lack of legal creativity and political will.²⁰³ He argues that administrative limitations, such as case-load management, which are given as reasons for non-justiciability, are predominantly institutional concerns that can be tackled by building more court rooms, appointing more judges and improving their conditions of service, and adopting automation in delivering timely justice.²⁰⁴ On this analysis, non-justiciability is not inherently grounded in an overarching legal principle, but is more of a procedural and administrative stop gap put in place by the executive and the legislature, which the judiciary wilfully helps to uphold.

Ajigboye takes a contrary position, making the case that judicial activism is actually not foreign to the Nigerian judiciary.²⁰⁵ He argues that past judgments, in various instances, have shown the capability of the judiciary to repel and correct the State when it has erred.²⁰⁶ So, for him, the hesitance to engage in meaningful exposition on the right to health is in stark contrast and antithetical to the Nigerian judiciary's historical ethos.²⁰⁷ Ajigboye goes further to show that, going on the principles upheld by many of Nigeria's jurists of great repute, there is no reason why the judiciary should shy away from its responsibilities.²⁰⁸ He cites, for example, the powerful words of Kayode Eso JSC, who buttressed his point by saying:

I believe it is the function of judges to keep the law alive, in motion, and to make it progressive for the purpose of arriving at the end of justice, without being inhibited by technicalities, to find every conceivable, but acceptable way of avoiding narrowness that spells injustice.²⁰⁹

The question of how and why the call for judicial activism is particularly strong in the Nigerian context is further explored by scholars, seeking to grapple with the role of the Nigerian judiciary over the years.

²⁰¹ le Roux-Kemp, Andra. "Realising the right to health in Nigeria: Incongruities between international obligations and domestic implementation." *Africa Nazarene Law Journal* 2.1 (2014): 119-138.

²⁰² Ibid.

²⁰³ Ibe, Stanley. "Beyond justiciability: Realising the promise of socio-economic rights in Nigeria." *African Human Rights Law Journal* 7.1 (2007): 225-248.

²⁰⁴ Ibid.

²⁰⁵ See n132.

²⁰⁶ Ibid.

²⁰⁷ Ibid.

²⁰⁸ Ibid.

²⁰⁹ Kayode Eso, JSC, in *Transbridge Trading Company Ltd v Survey International Ltd* (1986) 4 NWLR (pt. 37) 576 at 596-7.

The independence of the Nigerian judiciary over time and its role in providing impartial jurisprudence.

The approach of the Nigerian judiciary to socio-economic right litigation has been significantly shaped by its larger role in the shaping of the Nigerian State and its relationship to the existing laws at any given time. As Imam notes, the structure of governance and the Nigerian State has largely skewed the structure of power in such a manner as to negate the realisation of the tenets of good governance.²¹⁰ As he explains, in the pursuit of often personal interests, the ruling class, using the apparatus of State, have often co-opted other organs of State or curtailed them when co-opting appears impossible. This has often created a situation where there is a conflict of interest between personal interests and the interest of the populace. And while often the State has not been a good representative of the people and their interests, the role of the judiciary has been to weigh the conflicting interests and adjudicate fairly, while being aware of whatever vested power imbalances there are. As he points out, this overbearing imposition of the State on the judiciary is largely a product of the long years of military rule and the over centralisation of power in the federal executive at the centre.²¹¹

In response to this skewed power dynamic, the Nigerian judiciary has made valiant attempts at holding the State accountable but has unfortunately suffered the attendant wrath of the State as a consequence.²¹² Citing landmark cases like *Lakanmi v Attorney General (Western Nigeria)*,²¹³ *Government of Lagos State v Ojukwu*,²¹⁴ *Eleso v Government of Ogun State*,²¹⁵ *Fawehinmi v Abacha (1993)* and *Abaye v Ofili and Attorney-General of Rivers*.²¹⁶ as well as the military promulgations that followed the outcome of some of those cases,²¹⁷ Imam has shown how the Nigerian Supreme Court as the apex court has at times defied the government, albeit with serious consequences to members of the judiciary's persons and/or profession. And while much of the analysis is nested in the context of the country's undemocratic past, sadly this sort of heavy-handed response to the judiciary and its independent decision making has carried over into the country's democratic dispensation since 1999.

²¹⁰ Ibrahim Imam, "The Military Myth and Judicial Attitude in Nigeria: Judicial Activism or Passivity in Construing Military Decrees", available at https://www.academia.edu/12809212/The_Military_Myth_and_Judicial_Attitude_in_Nigeria_Judicial_Activism_or_Passivity_in_Construing_Military_Decrees, accessed on 10 October 2020.

²¹¹ Ibid.

²¹² Ibid.

²¹³ (1970) 1 NSCC 201.

²¹⁴ (1986) 1 N.W.L.R. (Pt.18) p.621.

²¹⁵ (1990) 2 N.W.L.R. (Pt.133) p.420.

²¹⁶ (1988) 1 N.W.L.R. (Pt.15) p.134.

²¹⁷ Various Military decrees ousted the jurisdiction of courts to challenge any act done or assumed to have been done under the Decrees.

Several reasons have been proffered for why there is still a continuation of this undemocratic tradition even in democracy. One argument is that, for the most part, it has still largely been the same ruling elite from the military era that have been in power in the democratic era, with two out of the country's four presidents since 1999 being former military rulers themselves before and a third having close family ties to past military rulers.²¹⁸ Another reason that has been given is that the new democratic dispensation as provided for in the current Constitution is still largely a vestige of the military era, having been midwifed by the last military government of the country. A third and even more insidious reason given is the nature of the administration of the judiciary. While on paper, it is intended to ensure a system of checks and balances between the various arms of government it can and is often abused to exert the will of the executive at various levels against the judiciary.²¹⁹ Appointment, promotion, and funding processes give considerable power to the other arms of government with the attendant effect being that, often, the judiciary is made to conform to the wishes of the other arms of government.²²⁰ All these factors threaten judicial autonomy, which is itself crucial to the kind of dispassionate judicial intervention that is required for social justice and correcting an overly skewed power dynamic that is in favour of the already powerful State.²²¹ However, despite these unfavourable circumstances, the Nigerian judiciary has a long institutional history of asserting its autonomy and impartiality through the provision of sound jurisprudence, often despite the legislative restraints placed upon it by the existing laws it is saddled with interpreting.²²²

Procedural challenges to judicial activism.

There are those who raise the concern that judicial activism, especially as it concerns socio-economic rights, is a breach of the principle of separation of powers.²²³ However, contrary to critics who hold this view, An-Na'im is confident that judicial enforcement is unlikely to slide into attempts at detailed

²¹⁸ Presidents Olusegun Obasanjo and Muhammadu Buhari were military Heads of State from 1976 to 1979 and 1983 to 1985 respectively. Late former President Umaru Musa Yar'Adua was a brother to Shehu Musa Yar'Adua, who was the de facto second in command to then General Obasanjo when he ruled as military Head of State.

²¹⁹ Sule, Ibrahim. "Judicial independence in Nigeria: Between global trend, domestic realities and Islamic law." *THE UUM INTERNATIONAL CONFERENCE ON GOVERNANCE 2014* (2014).

²²⁰ Enweremadu, David U. "The judiciary and the survival of democracy in Nigeria: analysis of the 2003 and 2007 elections: democratisation in Nigeria." *Journal of African Elections* 10.1 (2011): 114-142.

²²¹ Ibid.

²²² See n210.

²²³ Nolan considers the merits and demerits of the argument. See, Nolan, Aoife. "Ireland: The Separation of Powers Doctrine vs. Socio-Economic Rights." *Social Rights Jurisprudence: Emerging Trends in Comparative and International Law*. Ed. M. Langford. Cambridge: Cambridge UP, 2008. 295-320. See also, O'Connell, Paul. "The Death of Socio-Economic Rights." *The Modern Law Review* 74.4 (2011): 532-554. Kende, Mark S. "The South African Constitutional Court's embrace of socio-economic rights: A comparative perspective." *Chap. L. Rev.* 6 (2003): 137.

determination of policy and practice. This is because, according to him, judges are aware of the limitation of their office and the nature of the judicial process.²²⁴ He suggests that the risk of judicial overreach is minimal and argues that judicial pronouncements ought to begin, even when the issues are still couched as directive principles,²²⁵ which would also begin to help frame eventual legislation.

There is, however, an argument that the most effective path of judicial activism, that will not be tantamount to judicial recklessness, is one that follows the roadmap laid out in the Constitution for giving FODP legally binding and justiciable status, and that is through the passing of legislation on the relevant issue. Some scholars perceive any judicial intervention outside of this as a usurpation by the courts of the role of the political organs of State and question the legitimacy of such action.²²⁶ Their perspective is that courts lack the requisite institutional capacity that is essential in resource allocation matters, and ought to be wary of wading into and questioning decisions made by competent, politically accountable, bodies.

The justification for precluding the justiciability pre-legislation is framed by Ghai and Cottrell as being subject to debate by two varying sides.²²⁷ One side posits that courts are inherently incapable of adjudicating on socio-economic rights because they do not have the capacity to make well-informed decisions about methods of implementation and are ill-equipped to ensure or supervise the enforcement of their decisions. The other side contends that these rights are non-justiciable because Constitution makers have, for other policy reasons, chosen to exclude courts from these areas by casting these rights as Directive Principles of State Policy rather than as individual rights.²²⁸ By extension, this means that FODP allow the legislature to express the State's commitments in broader terms than would be possible through an individualistic reading synonymous with rights language. This latter argument justifies the limits of non-justiciability on FODP based on preventing the judiciary from falling into old habits of individualistic right interpretation, until a time when local legislation is made that will clearly state how the general, public good objectives of socio-economic rights are to be attained. An-Na'im disagrees with these positions. He thinks that the role of judicial enforcement should be assessed and developed in relation to each human right, instead of denying justiciability to

²²⁴ See n157.

²²⁵ Ibid.

²²⁶ See n97.

²²⁷ Ghai, Yash and Cottrell, Jill. "The Role of The Courts in the Protection of Economic, Social & Cultural Rights." *Economic, Social & Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social & Cultural Rights*. Ed. Y. Ghai. London: Commonwealth Secretariat, 2004.

²²⁸ Ibid.

a class of rights because they do not fit the existing model of judicial enforcement of civil and political rights.²²⁹

Implications of judicial intervention in right to health claims

Nwabueze contends that it will inevitably be futile to compel a State by judicial fiat to allocate resources, which it has shown itself to not possess by the act of legally providing for such allocation. Exercise of judicial restraint is therefore an act of self-preservation, necessary for preventing the judiciary from becoming, or being perceived to be, ineffective.²³⁰ Because socio-economic rights are programmatic and not just performative,²³¹ judicial pronouncements that are incapable of realisation are a threat to the credibility of the courts. Action would need to follow the pronouncement for the judgment to hold weight. Without the legislature passing specific legislation, stating how performance is to be carried out, there is no set of actions to which courts can anchor their pronouncements and so compel performance. Proponents of this view argue that, for reasons of democratic legitimacy, crucial resource allocation decisions are better left in the hands of the legislature and executive.²³² In essence, they advocate a restricted judicial supervisory role.²³³ Marius, buttressing this position, argues that, as seen in the case of South Africa, without a workable framework for implementation, judicial pronouncements may be of little effect, until there is little or no faith left in them to yield any meaningful change.²³⁴ He makes the point that, because of their transformative nature, for socio-economic rights to be meaningful to the right holders, their realisation will have to be staggered over the long term. The effect of judicial intervention, however, is that it can create a sense of immediacy, which, while optimistic, will ultimately be counterproductive to the redistributive nature of the right being contested, whose nature often means that it will take time to be fully realised.²³⁵

Based on this reasoning, the argument is that the courts should rather seek to compel the legislature to act to give fuller expression to the promise of the right to health as contained in the FODP. This legislative clarity is held up as the necessary impetus the judiciary needs to take swift action to uphold the right to health, knowing that its judgment is grounded in the legislation that has been passed.

²²⁹ See n157.

²³⁰ See n97.

²³¹ Pieterse, Marius. "Coming to terms with judicial enforcement of socio-economic rights." *South African Journal on Human Rights* 20.3 (2004): 383-417.

²³² Mbazira, Christopher. *Litigating Socio-economic Rights in South Africa: A Choice Between Corrective and Distributive Justice*. Pretoria: PULP, 2009.

²³³ Ibid.

²³⁴ See n231.

²³⁵ Ibid.

The prescription of Fundamental Objective Directive Principles as being a mandate to legislate

The understanding of FODP as a mandate to legislate is not advanced in the scholarship only as a basis upon which the judiciary can uphold the right to health. There are also various reasons put forward for why the preclusions placed on matters in Chapter 2 of the Constitution should be understood as a mandate to the legislature to pass laws giving full effect to the right to health. Ibe,²³⁶ Duru²³⁷ and Nnamuchi,²³⁸ for example, agree that the fundamental nature of FODP is to provide a road map for the State to legislate. They are aspirational only in the sense that they lay out the trajectory for the State and demarcate commitments and guiding principles for what it intends to do for its people. This view is also expressed in the proceedings of the committee responsible for drafting the 1979 Constitution, where the concept of FODP first appeared.²³⁹ That committee made a distinction between fundamental objectives and directive principles, highlighting how the two should interact. ‘Fundamental objectives’ consist of the ideals which the Nigerian State is expected to strive towards, which the committee saw as different from ‘directive principles’ that identify the policies expected to be pursued to realise the State’s national ideals.²⁴⁰ In this manner, the directive principles are the benchmarks used to gauge the realisation of the fundamental objectives. The problem, according to Nnamuchi, arises when they remain perpetually aspirational goals with no concrete action being taken to realise them, so that they are no more than nice words on paper.²⁴¹ The lofty goals of the FODP place weighty responsibilities on the State. As such, anything short of the State’s fulfilment of the established benchmarks are empty promises that the people can never quite enjoy. FODP then become an Eldorado of sorts whose promise is tempting, but reaching its destination, forever elusive. Nnamuchi goes on to argue that the true nature of FODP is that they place a definite burden on States to show the steps being taken to realise their aspirational goals.²⁴² It is this requirement that makes them transition into being tools for the transformation of society. As Ibe²⁴³ and Duru²⁴⁴ separately point out, this is the approach implemented in India, where there is the understanding that the intent of the lawmaker in including FODP in the Constitution, is to set out the road map for understanding and then realising the various complex socio-economic rights it provides for. As done in India, where

²³⁶ See n107.

²³⁷ See n106.

²³⁸ See n85.

²³⁹ See n114.

²⁴⁰ See n85.

²⁴¹ Ibid.

²⁴² Ibid.

²⁴³ See n107.

²⁴⁴ See n106.

necessary, certain rights in the FODP may be amended to be fundamental rights, if it is felt such a step would give more value to the right and/or that the affected right is more clearly defined normatively.²⁴⁵

For this task of activating the FODP in Nigeria, the often-cited first step is legislation, for two important reasons. First, it shows clear political will and commitment to deliver on the issues being legislated upon. Second, it gives the opportunity to provide necessary normative clarity. This clarity is especially important when considering that the right to health, for example, is quite broad and its essence is often not completely captured in the few lines establishing it as an aspirational goal. If it is to be recognised as a clear right, then recognition should be done in a manner that provides clarity about what the State intends to provide and, as such, what it may be held accountable for. This accountability is seen as a major reason why the right to health and other socio-economic rights were designated as non-justiciable, pending express legislative enunciation.²⁴⁶ Accordingly, it would be foolhardy to require the courts to hold the State accountable on an issue that is lacking legislative clarity.²⁴⁷ The lack of legal certainty, he argues, would lead to significant incoherence, which would further complicate the job of the judiciary and make it more difficult for the judiciary to fulfil its role of holding the State accountable to its duties.²⁴⁸

Interventions on the proper procedure for legislating on fundamental objective directive principles

The view that the intention of the Constitution is for legislation to give full expression to the aspirational goals contained in the FODP, as the first step to making FODP actionable, is supported by the Nigerian courts. Per Justice Niki Tobi in *Federal Republic of Nigeria v Alhaji Mika Anache & Others*:

it is clear therefore, that although section 15(5)²⁴⁹ of the Constitution is, in general not justiciable, as soon as the National Assembly exercises its power under section 4 the Constitution with respect to item 60 (a) of the Exclusive Legislative List, the provisions of section 15(5) of the Constitution becomes justiciable.²⁵⁰

²⁴⁵ Examples are the amendments to Articles 39, 43, and 48 at various times. See, General Knowledge Today, “Directive Principles of State Policy (DPSP)”, 10 March 2013, available at <https://www.gktoday.in/directive-principles-of-state-policy/>, accessed on 10 October 2019.

²⁴⁶ See n97.

²⁴⁷ Nwabueze, Benjamin Obi. *Constitutional law of the Nigerian Republic*. London: Butterworths, 1964.

²⁴⁸ Ibid.

²⁴⁹ Section 15(5) Constitution of the Federal Republic of Nigeria, Act No. 24, 5 May 1999.

²⁵⁰ Per Justice Niki Tobi in *Federal Republic of Nigeria v Alhaji Mika Anache & Others* (2004) LCN/3183(SC) citing Obilade in Obilade, A.O. “The Corrupt Practices and Other Related Offences Act and the right to privacy”.

Ogun has proposed that the wide-ranging possibilities for reforming society, which the FODP encapsulate, are obscured and have, over time, been rendered of no true effect as a result of noncompliance.²⁵¹ For him, the legislature holds the key to unlocking the potential of FODP and this is an avenue that the legislature must take to ensure the realisation of a better life for the Nigerian people.²⁵² On this reading of the relevant Constitutional provisions, scholars and jurists have placed the primary responsibility of giving full legal expression to the right to health as well as other socio-economic rights at the feet of the legislature.

Scholars' analysis of the legislature's attempt at providing legislative clarity on the right to health

The clamour for specific legislation to provide for the right to health is premised on the notion that the three arms of government each have critical roles to play in order to realise the right.²⁵³ The legislature is to pass laws that provide normative clarity on matters designated as FODP. The expectation is that, after normative clarification has been provided, courts will adjudicate on the substantive legislation that gives the FODP meaning, interpreted in light of the Constitutional intent as stated in the principles.²⁵⁴ The codification of law is seen by many scholars as essential for a valid claim to be made on a right to health. On this view, a right can only be said to truly exist and be worthy of legal recognition (especially by the courts) when it is clearly vested with right status by the passage of legislation. Outside of legal vesture, such a right claim can be dismissed as "simple nonsense: natural and imprescriptible rights, rhetorical nonsense, and nonsense upon stilts".²⁵⁵ Based on an understanding of the combined effect of Section 4(1)&(2) and item 60(a) on the Exclusive Legislative List, the case has been made that the National Assembly has the power to do either of the following: one, enact legislation declaring the provisions of Chapter 2 of the Constitution legally enforceable and therefore justiciable; and/or, two, repeal Section 6(6)(c), thus conferring jurisdiction on the courts.²⁵⁶ In fulfilment of this legislative obligation, the National Health Act²⁵⁷ has been passed, which sets out

Contemporary issues in the administration of justice: Essays in honour of Justice Atinuke Ige. Eds. A.O Obilade, et al. Lagos: Treasure Hall, 2001 at 127.

²⁵¹ Ogun, Festus. "Non-Justiciability of Chapter Two of the 1999 Constitution: A Hindrance to Nigeria's Development." Available at SSRN 3663868 (2020).

²⁵² Ibid.

²⁵³ Lester, Lord, and Colm O'Cinneide. "The effective protection of social-economic rights." *Economic, Social & Cultural Rights in Practice: The Role of Judges in Implementing Economic, Social & Cultural Rights*. Ed. Y. Ghai. London: Commonwealth Secretariat, 2004.

²⁵⁴ Ibid.

²⁵⁵ See n85.

²⁵⁶ Ibid.

²⁵⁷ Act No. 8 of 2014.

the scope and nature of the right to health in Nigeria. This Act is a fuller expression of the right to health than that provided for in the African Charter (Enforcement and Ratification) Act.²⁵⁸

In the face of these laws that have been touted as the solution to the quagmire of the right to health, scholars have begun to grapple with whether those laws are a sufficient fulfilment of the legislature's mandate and whether or not those laws sufficiently deliver.²⁵⁹ They query whether the aspirations for the right to health are met in the legislation and whether they provide an adequate platform for the State to fulfil its duties and for the populace to make valid claims against the State.²⁶⁰ Importantly, inquiries into this issue have sought to determine whether the legislative clarity provided addresses the major challenge of prior judicial incapacity.

Domestication of the African Charter and the challenges of applicability

Nnamuchi notes that, of all the international treaties that provide for the right to health and to which Nigeria is a signatory, it is only the African Charter that Nigeria has domesticated into local legislation and which is therefore legally binding.²⁶¹ As such, the domestication of the African regional human rights instrument has been the basis of claims by various scholars that there is an actionable right to health in Nigeria.²⁶² This claim is particularly significant bearing in mind that, in the Nigerian context, signing and ratification of international law alone is not sufficient to make it binding law within Nigeria. Because of Nigeria's dualist legal system, as provided for in Section 12(1) of the Constitution,²⁶³ domestication is the final and most important step for international law to have direct legally binding effect.²⁶⁴ The understanding behind this is that with the further step of domesticating international law, the legislature would have had the chance to fully consider the finer details of the law and to evaluate its merits and the State's willingness and capacity to carry out the provisions of said law. In this regard, legislation would be a conscious positive choice to be bound by the tenets of the international law it has ratified, having been fully convinced of the merits of its content. As such, the assertion that there is a right to health based on the provisions of Article 16 of the African Charter is

²⁵⁸ African Charter (Enforcement and Ratification) Act, Cap A 9 LFN 2004.

²⁵⁹ Adedoye, Davies, et al. "Health workforce and governance: the crisis in Nigeria." *Human resources for health* 15.1 (2017): 1-8.

²⁶⁰ Ibid.

See also, Enabulele, Osahon, and Joan Emien Enabulele. "Nigeria's National Health Act: An assessment of health professionals' knowledge and perception." *Nigerian medical journal: journal of the Nigeria Medical Association* 57.5 (2016): 260.

²⁶¹ See n103.

²⁶² See n46.

²⁶³ Constitution of the Federal Republic of Nigeria, Act No. 24, 5 May 1999.

²⁶⁴ See n103.

not one limited to its binding nature as international law but is also rooted in its nature as local legislation. In this manner, through the domestication of the Charter giving it legally binding force, there is the case made that there has been a fulfilment of the Constitutional requirement to pass necessary legislation to give full expression to the FODP. As a result, it is argued, the domestication of the African Charter in effect makes the right to health justiciable.²⁶⁵

Contestation on the extent of the applicability of the African charter

The position that ratification of the African Charter makes the right to health justiciable in Nigeria has been contested over the years in the courts and in the scholarship. For one, there is a debate about the level of immediacy the obligations in the Charter place on States. Some scholars claim that the African Charter does not provide for the progressive realisation of economic, social, and cultural rights.²⁶⁶ They argue that the economic, social, and cultural rights in the African Charter have to be realised immediately.²⁶⁷ This buttresses the claim that the Charter serves as a sufficient legal basis upon which to make claims for the immediate delivery of health goods in the furtherance of the right to health. It is an assertion meant to instigate speedy State action to begin to fulfil its obligations. This position has, however, been opposed by those who assert that, bearing in mind the continent's political, social and economic realities, it would be implausible for the Charter to have immediate full application.²⁶⁸ They make the case that the reality is that a great number of States lack the material resources to enable them to enforce economic, social and cultural rights immediately.²⁶⁹ Craven, for example, argues that the economic, social and cultural rights in the African Charter are generally considered to be incapable of immediate implementation, owing to the considerable expenses involved in their realisation.²⁷⁰ Bahar points out a further flaw in the argument for immediate realisation of the economic and socio-cultural rights in the African context, which is that such a demand is at odds with the dynamic nature of the standard of each of those rights.²⁷¹ The requirements for the full realisation of the various socio-economic rights are dynamic, as they are defined by changing socio-economic circumstances and establish shifting standards as the times dictate.²⁷² He states that the requirements for the full realisation of socio-economic rights will vary

²⁶⁵ See n85.

²⁶⁶ See n46.

²⁶⁷ Ibid.

²⁶⁸ See n33.

²⁶⁹ See n46.

²⁷⁰ Craven, Matthew. *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*. Oxford: Clarendon P, 1995.

²⁷¹ See n33.

²⁷² Ibid.

and would often necessitate that structures be put in place first for their optimal realisation.²⁷³ To demand, therefore, immediate realisation of those rights, would be to either ignore these realities or to expect that a rushed job be done of giving effect to rights that are ideally meant to be realised step by step over the long term. And so, according to Bahar, there is enough justification for the onus to be on progressive realisation of socio-economic rights where the State does what it can, while it can, with what it has, until it can do more.²⁷⁴

The question of hierarchy of the African Charter vis á vis the Constitution

Scholars point to a further conundrum around the status of the African Charter, in respect of which there has been long-running uncertainty around its hierarchy in relation to contradictory local legislation. Nnamuchi points to the case of *General Sani Abacha and Others v Gani Fawehinmi*,²⁷⁵ as instructive for understanding the position of the African Charter and its status as law. In that case, the Supreme Court held that, while the African Charter is that of a municipal law enforceable in Nigerian courts and is on a higher pedestal than other municipal law because of its international origins, it is, still inferior to, and cannot override the provisions of, the Constitution from which it derives its authority.²⁷⁶ Nnamuchi posits that the judgment in the case of *Gbemre* might change this dynamic.²⁷⁷ He argues that the case was largely grounded on the African Charter, which provides for the right to a healthy environment, which the Nigerian Constitution does not. The court stated clearly that, regardless of the lack of enforcement procedure at the time, the African Charter is applicable.²⁷⁸ Nnamuchi states that, while the position taken by the court advances the justification of the right to health, it also precludes any attempt to provide further legislative clarity on the provisions of Chapter 2 of the Constitution, which the legislature has been mandated to do.²⁷⁹ According to him, holding the position that socio-economic rights are forever and always non-justiciable except through the lens of the Charter, is counterproductive to the ends of the Constitution and renders any attempt to provide legislative clarity moot, which was not the intent of the Constitution. The real challenge of using the African Charter as the normative basis for the claim of a right to health in Nigeria is that contrary to the intent of the Constitution, the domesticated African Charter is not a legislative exposition of the

²⁷³ Ibid.

²⁷⁴ Ibid.

²⁷⁵ *General Sani Abacha & Others v Gani Fawehinmi* (2000) 6 NWLR (Supreme Court of Nigeria).

²⁷⁶ Ibid.

²⁷⁷ *Jonah Gbemre & Ors v Shell Petroleum Development Company of Nigeria LTD & Ors* (2005) AHRLR 151 (NgHC 2005).

²⁷⁸ See n85.

²⁷⁹ Ibid.

nature and content of the right to health.²⁸⁰ In its current domesticated form, it provides for the right without enumerating the steps to be taken to bring this right to life. As a result, Nnamuchi makes the case that the basis for an actionable right to health lies in local legislation made with the full and clear intention to give full expression to the right to health.

The passing of the National Health Act as a fuller expression of the right to healthcare: a brief introduction

The National Health Act is seen as the legislature's major attempt to codify the right to health. Passed in 2014, it represents not just the direct codification of the right to healthcare specifically in Nigeria, but also the rearrangement and consequent regulation of the health system as the conduit through which this right would be delivered.²⁸¹ It signifies what the country's legislators in consultation with the executive have posited as necessary for the fulfilment of its obligation to the Nigerian people. The Act mandates a minimum standard of healthcare for everyone.²⁸² It also provides extensive guidance on how the health system, which is to guarantee and deliver this minimum standard health service, is to be managed and regulated.²⁸³ The content and import of this Act is discussed in detail in Chapter 5 of this dissertation. For now, it is important to note that, despite the passing of the National Health Act, there has been little financial commitment by the State,²⁸⁴ with the problem of State inaction in fulfilling the provisions of the Act ascribed to a persistent lack of political will. Nnamuchi makes a strong case that this trend of State inaction is symptomatic of a deeper, more far-reaching malaise among key State actors, which is tied to corruption.²⁸⁵

Corruption as the obstacle for the fulfilment of the right to health by the Nigerian State

Nnamuchi asserts that claims that the right to health is denied justiciability solely on the basis of legality, are misplaced.²⁸⁶ He posits that a closer look at the legal hurdles that stand in the way of the full recognition of the right to health, show them to be deliberate diversions put in place by the ruling

²⁸⁰ Ibid.

²⁸¹ Cheluchi Onyemelukwe-Onuobia, "Nigeria's National Health Act and the promise of Universal Health Coverage", available at <https://cheld.org/nigerias-national-health-act-and-the-promise-of-universal-health-coverage/>, accessed on 9 October, 2019.

²⁸² Section 3(3) Act No. 8 of 2014.

²⁸³ Act No. 8 of 2014.

²⁸⁴ Tejuoso, Olanrewaju, Gafar Alawode, and Elaine Baruwa. "Health and the Legislature: The Case of Nigeria." *Health Systems & Reform* 4.2 (2018): 62-64.

²⁸⁵ See n85.

²⁸⁶ Ibid.

class.²⁸⁷ For Nnamuchi, it is the kleptocracy of the ruling class and ineptitude, rather than finite resources, that is the major challenge to justiciability and enforceability of the right to health.²⁸⁸ To move beyond health as an aspirational goal requires tackling corruption head-on. Agbokogba and Mammah support this view, dismissing the justification of unavailable resources for the non-realisation of FODP as excuses meant to obscure the fact that, in the context of a resource-rich nation like Nigeria, the unavailability of resources should not be an issue.²⁸⁹ The larger issue, they argue, is that corruption enabled by a skewed capitalist economy run on patronage and cronyism has allowed for the private amassing of wealth to the detriment of the common weal.²⁹⁰ They contend that in the absence of corruption, there would be more resources available with which to make necessary allocations for the fulfilment of the socio-economic rights in the FODP. They present corruption as not only being a practice synonymous with bad leadership, but one that ensures that bad leadership continues to perpetuate itself.²⁹¹ Corruption, in this sense, precludes the initiative to act for the betterment of the populace, as well as stealing from the paltry amounts that may be allocated.²⁹² As Obansa puts it, pervasive levels of corruption end up influencing the judicious and effective use of limited resources.²⁹³

This level of corruption has been shown by scholars to have repercussions for funding health systems that require capital intensive intervention. The effect of this effective defunding is that the Nigerian health system is ill equipped to guarantee and provide, at least, the minimum standard of care for the populace as mandated by the NHA.²⁹⁴ Ibe shows, in vivid terms, that corruption has a debilitating effect on the health system and the economy at large. Pointing to the estimate that Nigeria lost £225 billion to corruption in the early 2000s, he makes the argument that these lost resources have, over time, limited the country's ability to meet its obligations to the people.²⁹⁵ Ibe also makes the point that corruption not only stifles the State's ability to fund the health system, but significantly limits its

²⁸⁷ Ibid.

²⁸⁸ Ibid.

²⁸⁹ Agbakoba, O., and W. Mamah. "Towards a peoples' constitution in Nigeria: a civic education manual for the legal community." *Human Rights Law Service, Lagos* (2002).

²⁹⁰ Ibid.

²⁹¹ Ibid.

²⁹² Ibid.

²⁹³ Obansa, S. A. J., and Akinagbe Orimisan. "Healthcare financing in Nigeria: prospects and challenges." *Mediterranean Journal of social sciences* 4.1 (2013): 221-236.

²⁹⁴ Welcome, Menizibeya Osain. "The Nigerian healthcare system: Need for integrating adequate medical intelligence and surveillance systems." *Journal of pharmacy & bio allied sciences* 3.4 (2011): 470-478.

See also Fatusi, A. O. "Public health leadership, policy development and the Nigerian health system." *A Paper Presented at the Induction Program of the Institute for Government Research Leadership Technology* (2015).

²⁹⁵ See n293.

chances of attracting foreign aid for fear of mismanagement.²⁹⁶ The more corrupt a nation is, the less likely it is to receive foreign investment, as investors perceive corruption as a sign of instability and unpredictability in a system.²⁹⁷ Hargreaves also notes that the effects of the corruption-laden years of military rule have resulted in an inept, ill-equipped public service and health sector.²⁹⁸ Moreover, even the civilian governments that have since taken over are yet to show any solid commitment to the improvement of the country's healthcare.²⁹⁹ Hargreaves' cynicism is shared by Nnamuchi, who posits that gains from recent efforts by the Nigerian State to clamp down on corruption and to repatriate stolen funds are likely to be lost yet again to re-misappropriation, while the effect of this endemic corruption is that the motivation to realise the right to health is of little concern for the State and those who use it as a site for their personal enrichment.³⁰⁰

In a bid to proffer a solution to the seemingly unending cycle of graft, Nnamuchi postulates that an understanding of the history and nature of corruption in Nigeria is key to unpacking the tiered layers of challenges to realising the right to health, as well as the legalistic justifications put in place to justify the inability to realise this right.³⁰¹ He argues that understanding the political and legal systems that allow the entrenchment of a skewed power dynamic between the Nigerian State and its populace, is key to understanding and dismantling those systems. For him, the levels of corruption that became normalised under the successive military governments made the plundering of State resources an official State practice,³⁰² making it futile to address the corruption of the Nigerian State as a once-off anomaly. The alternative is to analyse and critique the political and legal systems that skew the mechanisms of the State in favour of enriching a few over the wellbeing of many. It is this kind of exercise that can provide lasting solutions to the challenges of the Nigerian State in realising the right to health for its people.

Conclusion

From the examination of the existing scholarship and the ongoing debates seeking to make interventions on how best to realise the right to health, key thematic concerns arise. The role of the

²⁹⁶See n203.

²⁹⁷ World Health Organization, "The Nigerian Health System" available at <https://www.who.int/pmnch/countries/nigeria-plan-chapter-3.pdf>, accessed on 19 October, 2019.

²⁹⁸ Hargreaves, Sally. "Time to right the wrongs: improving basic healthcare in Nigeria." *The Lancet* 359.9322 (2002): 2030-2035.

²⁹⁹ Ibid.

³⁰⁰ See n85.

³⁰¹ Ibid.

³⁰² Ibid.

Constitution and its limitations are a prominent concern, with three distinct approaches to overcoming the limitations of the non-justiciability of the right to health as presently outlined as a FODP. However, despite the legislature's decision to provide much-needed normative clarity on the form and nature of the right to health in Nigeria through the National Health Act, scholars have noted that very little has been done to fulfil the mandate laid out in that Act. While this failure has predominantly been laid at the feet of an unfeeling ruling class given to looting the commonwealth, others have blamed the lack of realisation on scarce and limited resources. In the face of this inaction, there is undoubtedly the need for an intervention that charts a path forward for the progressive realisation of the right to health, while taking into consideration existing legal, political and fiscal challenges. To chart this path, and provide fresh insights, Nnamuchi recommends an analysis of the challenges through a historical context, while Durojaye sets out the foundations on which to begin building a dignity-centred approach to the realisation of the right to health. It is this dual challenge that is taken up in subsequent chapters of this dissertation.

Chapter 3

Healthcare provision and the public health system in Nigeria

INTRODUCTION

In this chapter, I trace the historical trajectory of healthcare delivery in Nigeria, showing where and how things went wrong in the development of Nigeria's health system. I make the case that this understanding is key for charting a path towards the development of the country's now weak health system. By showing where and how the right to health has been misunderstood, it is possible to properly frame the compromises that have been made and the effect they have had in sabotaging the right to health. This exercise is key to making interventions that are circumspect and capable of addressing the systemic issues that have led to the weakened healthcare system and the resultantly poor health outcomes of the Nigerian populace.

The trajectory of Nigeria's health system has not been a smooth one. This is because, for the most part, its progress or decline has been strongly linked to the country's political and economic course. The events that have occurred in the history of the country have shaped its current form and performance. Tracing the path of the country's healthcare system and examining its history, I highlight the seminal events that shaped the country's economic and political fate, and how they affected both the perception of the State's duties to deliver on health, as well as how that perception affected the health system and its mismanagement and eventual decay. It is important to note that the current Nigerian healthcare system is framed after the western medical model, which is largely a result of the country's colonial heritage.³⁰³ Medical care in Nigeria, however, did not begin with the arrival of the European traders, missionaries and invaders.³⁰⁴ Traditional herbal practitioners, with specialised training that catered for the physical and spiritual needs of the people in the various tribes that would later make up Nigeria, had existed for centuries prior to the arrival of the first Europeans.³⁰⁵ Over the

³⁰³ Scott-Emuakpor, Ajovi. "The evolution of healthcare systems in Nigeria: Which way forward in the twenty-first century." *Nigerian Medical Journal* 51.2 (2010): 53.

See also, Anthony, Iroju Opeyemi. "Understanding the Nigerian Healthcare Delivery System: A Paradox of Preventive Medicine Since the Colonial Epoch." *International Journal of Tropical Disease & Health* 34.3 (2019): 1-9; Schram, Ralph. *History of the Nigerian Health Services*. Nigeria, Ibadan University Press, 1971; Welcome, Menizibeya Osain. "The Nigerian health care system: Need for integrating adequate medical intelligence and surveillance systems." *Journal of pharmacy & bioallied sciences* 3.4 (2011): 470-478; Ogaji, D., and S. F. Brisibe. "The Nigerian Health Care System: Evolution, contradictions and proposal for future debates." *Port Harcourt Medical Journal* 9 (2015): 79-88.

³⁰⁴ Isola, Omoleke Ishaq. "The "relevance" of the African traditional medicine (alternative medicine) to healthcare delivery system in Nigeria." *The Journal of Developing Areas* 47.1 (2013): 319-338.

³⁰⁵ Ibid.

years from the time of contact with the West, the use and impact of formal western healthcare services grew in the country and superseded traditional medical practices, which became relegated to the fringes. Even though it is no longer the predominant form of healthcare, traditional medicine is still used by many in Nigeria; especially by the poor and in rural areas.³⁰⁶ I provide a brief historical context to the current state of healthcare in Nigeria. After a quick introduction of the emergence of western medicine in Nigeria during the precolonial and colonial period, I discuss the formation of the Nigerian health system, highlighting key events that shaped the country as a whole and influenced the health system's ability to operate maximally. To do this, I discuss the early years of independence and nation building and the Nigerian civil war, which significantly disrupted the nation-building project. I go on to discuss the years of military rule, the country's return to democratic rule and the present situation in the current democratic dispensation. This historical analysis of Nigeria's healthcare over the decades provides a basis for contextualising the various laws put in place over time and why they have done so little to rectify the historical under-service of the right to health in the country.

The history of healthcare in Nigeria over time

The pre-colonial period

Prior to contact with European traders and eventual colonisers, the various tribes and kingdoms that made up the geographical area now known as Nigeria had medical practices, which are now collectively referred to as traditional medicine. This appellation is in contradistinction with western medical practices that are now the country's mainstream mode of healthcare delivery. Traditional medicine practitioners included herbalists, divine healers, soothsayers, midwives, spiritualists, bonesetters, mental health therapists and surgeons.³⁰⁷ Although this traditional mode of healthcare evolved separately in different cultures, there was and still is a great deal of philosophical and conceptual similarity among the various tribes.³⁰⁸ The central thinking over time around ailments and health in traditional medical practice has been that the physical is intrinsically linked to the spiritual, and that spiritual interventions, whether positive or malevolent, can have an impact on physical health.³⁰⁹ There was, and still is, a strong sense that physical health is the full expression of a well-balanced individual, worthy of being a productive and fully participating member of society.³¹⁰ III

³⁰⁶ Ibid.

³⁰⁷ See n303.

³⁰⁸ Ibid.

³⁰⁹ Ibid.

³¹⁰ Ibid.

health, thus, not only represented physical infirmity, but was also symptomatic of a deeper spiritual and social disconnect.³¹¹ Ailment was a manifestation of a lack of equilibrium between any of the key features that made the individual a 'whole' person. As such, many traditional healing practices then and now, have spiritual interventions that work with physical interventions. The conception of health and wellbeing has remained holistic: viewing the physical as being tied to the spiritual and the individual as being tied to the collective.³¹² Interestingly, a significant amount of traditional healing and medical practices remains a part of the complex healthcare system in Nigeria today, more than 150 years after the introduction of western style medicine to Nigeria.³¹³ This is attributable to factors that include the persistent cultural ties with medical practice in many parts of the country, an inadequate presence of formal medical practices in many rural areas, and a mistrust of western medicine in some communities based on their own bad experiences or those of others.³¹⁴

The colonial/pre-independence period

The first record of modern medical services in Nigeria was during the various European expeditions in the early-to mid-nineteenth century. The earlier explorations of Mungo Park and Richard Lander along the Niger river had been seriously hampered by disease with many personnel dying from fever.³¹⁵ In the expedition of 1854 into the Niger, Dr William Baikie, who was both the ship surgeon as well as in charge of the expedition, used quinine to great effect.³¹⁶ On that expedition, no life was lost and only a small number of illnesses were recorded. The use of quinine, both as a prophylaxis and as a therapy for malaria fever, then became more common.³¹⁷ This development made it easier for Europeans to survive the harsh conditions of the tropical rain forest and allowed them to expand their exploration and trade further inland.³¹⁸ The success of this intervention proved important in aiding the British Empire to secure the areas that would later become part of Nigeria in the scramble for Africa.³¹⁹

The earliest form of western-style healthcare in Nigeria was provided by doctors brought by explorers and traders to cater for their own wellbeing, and these services were not available to the indigenes

³¹¹ Ibid.

³¹² Ibid.

³¹³ Ibid.

³¹⁴ See n74.

³¹⁵ See n303.

³¹⁶ Carlson, Dennis G. "West African Environment." *Bulletin of the History of Medicine* 51.3 (1977): 386-396.

³¹⁷ Ibid.

³¹⁸ See n303.

³¹⁹ King, J. B. "JB Baikie—Doctor and Explorer." *Res Medica* 4.4 (1965):22-24.

with whom they interacted.³²⁰ Church missionaries were the first to establish healthcare services for the indigenous people.³²¹ They, like the existing traditional medicine practitioners sought to merge spiritual care through their evangelism of Christianity with physical care in the communities where they were involved.³²² The Roman Catholic mission, the Church Missionary Society (the Anglican Communion) and the American Baptist Mission were particularly at the forefront of this kind of missionary medical outreach.³²³ The first healthcare facility in the country was a dispensary opened in 1880 by the Church Missionary Society in Obosi, Anambra state, followed by others in Onitsha, Anambra state and Ibadan, Oyo state, in 1886.³²⁴ The first hospital in Nigeria was the Sacred Heart Hospital in Abeokuta, built by the Roman Catholic Mission in 1885.³²⁵ Due to persons with diseases, such as smallpox, dysentery, malaria, hookworm, yaws, jaundice, and others, quickly responding to the treatment provided by the missionary doctors, western medicine steadily gained popularity and acceptance amongst local people amongst whom the missionaries worked and ministered.³²⁶ The mission-owned health facilities gained so much traction over time that, by Nigeria's independence in 1960, mission-owned hospitals surpassed government-owned hospitals in number.³²⁷ They were also known to be of higher quality, with the prime examples being the Seventh Day Adventist Hospital in Ilesha, Osun state, as well as the Wesley Guild Hospital in Ile-Ife, Osun state, which would eventually become the nucleus of the teaching hospital complex of the University of Ife.³²⁸

By the time of World War I, present-day Nigeria was being formed from the amalgamation of the Northern and Southern protectorates.³²⁹ The war meant that European countries relied more heavily on their colonies for resources and as bases of operation.³³⁰ In the case of Nigeria, this meant an increased British military presence. With this increased presence, came the need for medical services to cater to the health needs of the British military.³³¹ Special medical services were thus established

³²⁰ Imam, F.B., et al. An Assessment of the Emergence of Organised Healthcare Services in Nigeria. *IOSR Journal of Humanities and Social Science* 20.11 (2015): 40-46.

³²¹ Ibid.

³²² Ibid.

³²³ Ibid.

³²⁴ See n303.

³²⁵ Ibid.

³²⁶ Agbiji, Emem, and Christina Landman. "Health and healthcare in a Nigerian historical context." *Studia Historiae Ecclesiasticae* 40.1 (2014): 233-249.

³²⁷ See n320.

³²⁸ Ibid.

³²⁹ Ubaku, Kelechi C., Chikezie A. Emeh, and Chinenye N. Anyikwa. "Impact of nationalist movement on the actualization of Nigerian independence, 1914-1960." *International journal of history and philosophical research* 2.1 (2014): 54-67.

³³⁰ See 320.

³³¹ Ibid.

for them in Lokoja, in now Kogi state.³³² Medical care, which the colonial government provided to its officials, became available to the local population only as an incidental service. This reinforced the recurring theme of healthcare being secondary to the political ends of the State, and an entitlement of the elite, which continue through the country's history till today. As time passed, services intended specifically for civilian use were also established by the colonial government.³³³ By the end of World War I in 1918, many of the military healthcare facilities that had been built to service the war effort were repurposed for civilian use as hospitals.³³⁴ The incursion of the Spanish flu into Lagos, which was then both the colonial capital as well as the commercial nerve centre, marked a key moment in the shaping of central government's role in public health intervention and management. While it first came into Lagos by ship (then the main form of international transportation), it soon spread to other parts of the country by trains, carried by those going inland for work or fleeing the impact of the pandemic in Lagos.³³⁵ The pandemic led to widespread public health interventions, which included the closing of schools and places of worship, and the enforcement of sanitary and social distancing measures.³³⁶ The central role of the colonial government to stop the spread of the disease and to coordinate the public health response served to solidify its role in organising healthcare policy and interventions in the country.³³⁷ With time, several government-owned healthcare facilities were merged and controlled by the colonial Office.³³⁸ This concentration of control was done across the various British colonies in West Africa, marking the first centralisation of control over health services in West Africa,³³⁹ and setting the tone for another recurring theme, of centralising healthcare service and policy, that continues till today. The colonial Office determined the type of services that were available and provided the manpower to deliver those services.³⁴⁰ Healthcare provision was considerably top down in policy formulation, funding and in the provision of health goods; yet another colonial vestige that has become a recurring theme in the administration of healthcare. As healthcare management became more complex, the central administration of healthcare services became regionalised. Between 1952 and 1954, the control of medical services was transferred to the regional governments, as was the control of other services.³⁴¹ However, the regions maintained some common

³³² See n303.

³³³ Ibid.

³³⁴ Ibid.

³³⁵ Ohadike, Don C. "Diffusion and physiological responses to the influenza pandemic of 1918–19 in Nigeria." *Social science & medicine* 32.12 (1991): 1393-1399.

³³⁶ Ibid.

³³⁷ Ibid.

³³⁸ See n303.

³³⁹ Ibid.

³⁴⁰ Ibid.

³⁴¹ Ibid.

West African facilities, such as the West African Council for Medical Research, which came into being in February 1954.³⁴²

In Nigeria, specifically, medical services developed and expanded with industrialisation.³⁴³ Most medical doctors were civil servants, except for those working for missionary hospitals, who still maintained the model of combining evangelical work with healing. As an administrative intervention in the civil service, a Chief Medical Officer (CMO) was appointed. The CMO was the principal executor of healthcare policies in Nigeria aided by several other junior colleagues (Senior Medical Officers and Medical Officers). Together they formed the nucleus of the Ministry of Health, then situated in Lagos.³⁴⁴ Control of medical services was further decentralised across the country over time. Consequently, each of the country's three regions at the time (Northern, Western and Eastern) set up their own Ministries of Health, in addition to the now Federal Ministry of Health, which was still in charge of goal setting and policy formulation.³⁴⁵ This period marked the implementation of the first colonial development plan, which began in 1945 and lasted till 1955.³⁴⁶ It was known as the decade of development, due to the expansion seen in the health sector, both in the increasingly formalised structure of the health system, as well as the proliferation of health facilities across the country.³⁴⁷ Although the federal government was responsible for most of the health budget of the regions, the regional governments were free to allocate the healthcare budget as they deemed fit. With the allocated funds, new facilities were established in the different regions, ranging from rural health centres to general hospitals.³⁴⁸ However, despite these efforts, the reach of these facilities was still very limited. It is estimated that by 1960, only 10-15% of the Nigerian population was covered by any form of modern healthcare services.³⁴⁹ Many of these modern health services were concentrated in the urban areas to the detriment of the rural areas. Consequently, whereas more than 50% of the urban population had access to healthcare, less than 5% of the rural population had comparable access, and 90% of the population was rural in 1960. This marked the beginnings of the urban/rural divide of healthcare access that has set the tone for a lingering disparity in health goods and health outcomes across the country. The second colonial development plan was subsequently formulated to run from 1956 to 1962, with a focus on creating sustainable healthcare systems across the country.³⁵⁰

³⁴² Ibid.

³⁴³ Ibid.

³⁴⁴ Ibid.

³⁴⁵ Ibid.

³⁴⁶ Ibid.

³⁴⁷ Ibid.

³⁴⁸ Ibid.

³⁴⁹ Ibid.

³⁵⁰ Ibid.

The ever-expanding health system was now also being redirected to focus on curative care rather than preventive care. The health system thus shifted its focus to providing palliative care instead of having a comprehensive approach to healthcare that focused on both health outcomes as well as their determinants.³⁵¹ This period of change in the health system coincided with the ramping up of the country's struggle for independence. It would thus be the plan that would usher in the country into independence and set the tone for how healthcare was approached and delivered on in the nascent nation.

The early years of Independence

The first National Development Plan, which replaced the colonial development plan, began in 1962 and lasted till 1968.³⁵² It marked a significant departure from the earlier colonial development plans. The objective of the plan was to maintain and, if possible, surpass the average rate of growth of the country's gross domestic product (GDP).³⁵³ The plan envisaged a spending of about \$1,900,000,000 on development and productivity enhancing projects. The intent of this plan was to have enough of a surplus to be able to spend considerable funds on social welfare programmes.³⁵⁴ Under this plan, expenditure on health was to increase from 2.9% under the earlier program, to 10.3%.³⁵⁵ Increased healthcare expenditure, along with an increase in various other sectors like education, referred to as social overhead, was intended to move the country closer to a well-functioning capitalist state with a strong welfare system.³⁵⁶

During this period, healthcare at public facilities was largely free, as the goal was to provide national health services for all as part of the social welfare system.³⁵⁷ Also, since urban services were well developed (by then prevailing standards), the government intended to expand rural services.³⁵⁸ These rural services would be in the form of rural hospitals of 20-24 beds, supervised by a medical officer, who would also supervise dispensaries, maternal and child welfare clinics and preventive work (such as sanitation workers). The intent was to have rural healthcare centres that met the basic health needs

³⁵¹ Ibid.

³⁵² Oyelaran-Oyeyinka, Banji. "The state and innovation policy in Africa." *African Journal of Science, Technology, Innovation and Development* 6.5 (2014): 481-496.

³⁵³ Forrest, Ona B. *Financing development plans in West Africa*. Cambridge, Mass.: Center for International Studies, Massachusetts Institute of Technology (1965).

³⁵⁴ Ibid.

³⁵⁵ Ibid.

³⁵⁶ Ibid.

³⁵⁷ See n303.

³⁵⁸ Ibid.

of their host communities.³⁵⁹ In furtherance of this goal, the local governments were required to contribute to the cost of developing and maintaining such rural services, with grants-in-aid from the regional government.³⁶⁰

Also, during this period, the United States Agency for International Development (USAID) and the World Health Organization (WHO) launched a successful program against smallpox, in 1967 and 1968, in collaboration with the Nigerian government.³⁶¹ Under this program, USAID financed the cost of technical concerns and immunisation costs, while the Nigerian Government and the WHO provided medical personnel and covered local costs. This program was so successful in Lagos that, in 1968, a 97% efficiency was estimated for it, with more than 90% of the target population being immunised.³⁶² However, its success was limited to the urban areas, especially in the western part of the country.³⁶³ This concentration of healthcare in the urban areas remained true for many other health interventions. For the most part, healthcare in the urban areas significantly improved, due to constant State intervention and policy implementation, backed by considerable funding sourced locally as well as from international donors, leaving behind the rural areas.

The Nigerian Civil War years

Progress in healthcare provision, albeit skewed in favour of the urban areas, was significantly halted by the start of the Nigerian civil war in 1967, which also further exacerbated the disparities in healthcare development across the various regions, as well as between urban and rural areas.³⁶⁴ While the war generally led to the diversion of important resources to the war effort, and limited progress made in the building of infrastructure, the areas where the war was fought were especially adversely affected. In the eastern part of the country, which had seceded as Biafra, the war saw severe human rights abuses which ushered in untold hardship, malnutrition, and suffering. This was largely due to the use of starvation as a tool of warfare by the national troops against Biafran troops and people.³⁶⁵ The devastation and toll on human life was so high that it necessitated what came to be known as the Biafran airlift, an international humanitarian relief effort that transported food and medicine to

³⁵⁹ Ibid.

³⁶⁰ Ibid.

³⁶¹ Ibid.

³⁶² See n320 at 43.

³⁶³ See n320.

³⁶⁴ Ibid.

³⁶⁵ Smock, Audrey. "The politics of relief." *Africa Report* 15.1 (1970): 24-26.

Biafra.³⁶⁶ It ultimately instigated the creation of Médecins sans Frontières (Doctors without Borders), an international volunteer effort by medical personnel across the world to intervene and provide medical aid to the suffering Biafrans.³⁶⁷

One unintended outcome of the war was that by its end, the Nigerian Army Medical Service (NAMS), which became the Nigerian Army Medical Corps (NAMC) in 1976, had become arguably the most advanced on the continent in the field of trauma surgery and psychiatry.³⁶⁸ The NAMC had learnt valuable technical lessons in acute and chronic care during the war and had become proficient at customising its medical services to meet the health needs of its target population in the operational areas around the country where it was stationed.³⁶⁹

The Military Years

The third National Development Plan was produced in 1975,³⁷⁰ and attempted to address some of the nagging issues the country had started to face by the end of the civil war in 1970. It sought to deal with issues such as health, and the provision of health facilities, through the Basic Health Services Scheme.³⁷¹ The goal was to establish healthcare infrastructure more broadly across the country, through the construction of comprehensive health centres (CHCs), which were intended to provide a wider range of health services. To do this, CHCs were to be increased from 250 to 1650, while Primary Health Centres (PHCs), which were to provide basic health services were to be increased from 1600 to 7200 in five years.³⁷² To meet this goal, as much as 29% of the budget was allocated to basic health and preventive services.³⁷³ Health workforce needs were to be addressed through a proliferation of federally managed teaching hospitals responsible for training different categories of health workers.³⁷⁴ There was an increased spread of medical schools across the nation, with 13 different medical schools functioning, and schools of health technology were established to produce intermediate-level staffing for community health.³⁷⁵ Many general hospitals and over 10,000 other

³⁶⁶ Desgrandchamps, Marie-Luce. "Organising the unpredictable: the Nigeria-Biafra war and its impact on the ICRC." *Int'l Rev. Red Cross* 94 (2012): 1409.

³⁶⁷ Redfield, Peter. "Doctors, Borders and life in Crisis." *Cultural Anthropology* 20.3 (2005): 328-361.

³⁶⁸ Akukwe, Chinua. *Health Services in Africa*. London: Adonis & Abbey Publishers Ltd, 2008

³⁶⁹ Ibid.

³⁷⁰ Lall, Somik V., et al. "Nigeria-National development plan 1962-1968."

³⁷¹ Osibogun, A. "Crises and challenges in the Nigerian health sector." *Journal of Community Medicine and Primary Healthcare* 16.2 (2004): 1-7.

³⁷² Ibid at 2

³⁷³ Ibid.

³⁷⁴ See n371.

³⁷⁵ Ibid.

health centres were introduced;³⁷⁶ and by 1980, the desirable doctor to population ratio recommended by the WHO for the African Region of 1:10,000 had been met.³⁷⁷ This was a stark contrast to the ratio of 1:40,000 in the 1950s when the first medical school was started in Ibadan.³⁷⁸ The focus on increasing the health work force was hinged on the hope that, with more skilled medical personnel spread across the country, healthcare would be more readily available to all.³⁷⁹ Invariably, because of better working conditions, these trained staff would mostly service the urban areas and later would be a major source of medical staff brain drain to the benefit of more developed countries.³⁸⁰ Unfortunately, while the increase in medical personnel improved access in many ways, it did not significantly improve the health and welfare of the general populace, and especially that of children.³⁸¹ This is perhaps because, while the health workforce was growing, several other determinants of health were depreciating. The economic policy of the 1970s was skewed towards heavy spending, which moved the fiscal balance from a small surplus to a deficit.³⁸² The State was increasingly engaged in costly and often unnecessary infrastructure projects, often funded by loans given at questionable interest rates with recurrent cost implications.³⁸³ This period also saw increasing dependence on oil exports, which grew from 3% of the nation's GDP in the 1960s to more than half of the GDP by this time.³⁸⁴ Despite the neglect of the agricultural sector and an uncompetitive manufacturing sector, the country's economy remained buoyant as it was propped up by favourable oil prices. This economic policy orientation left the country ill prepared for the eventual collapse of oil prices by the early 1980s.³⁸⁵

By the time of the Fourth National Development Plan, which ran from 1981 till 1985,³⁸⁶ the economic posture of the State was one of austerity.³⁸⁷ The focus was thus on the consolidation and implementation of the Basic Health Services Scheme. It clearly delineated the various levels of healthcare and their roles: CHCs were to serve communities of more than 20, 000 people; PHCs were to serve communities of 5000 to 20, 000 persons; and Health Clinics (HC) were to serve 2000 to 5000

³⁷⁶ See n371.

³⁷⁷ Ransome-Kuti, O. "Child health in Nigeria: past, present, and future." *Archives of disease in childhood* 61.2 (1986): 198-204 at 200.

³⁷⁸ Ibid at 199.

³⁷⁹ See n371.

³⁸⁰ Ibid.

³⁸¹ See n377.

³⁸² National Centre for Economic Management and Administration (NCEMA). "Structural adjustment programme in Nigeria: Causes, processes and outcomes." 2-18

³⁸³ Ibid.

³⁸⁴ Ibid.

³⁸⁵ Ibid.

³⁸⁶ Ibid.

³⁸⁷ Ibid.

persons.³⁸⁸ As a result, a CHC would have at least one, but ideally four, PHCs in its catchment area; and a PHC would have at least one, or ideally two, HCs in its catchment area. This policy created a clear hierarchy of healthcare provision and management.³⁸⁹ These institutions were to be built and operated by state and local governments with financial aid from the federal government.³⁹⁰ By this policy, the provision of health services would be the joint responsibility of the federal, state and local governments. However, the existing austerity measures meant an increase in taxes and consequent inflation.³⁹¹ This period also marked the fizzling out of free healthcare, as user fees were increasingly being introduced.³⁹² Reduced State subsidisation of health services coincided with an increase in unemployment and a high incidence of poverty.³⁹³ The convergence of these two situations led to less access to health facilities due to the increased inability of Nigerians to afford it.³⁹⁴

By the time of the 1985 coup of General Babangida, which toppled General Buhari's own military government, the state of the nation's healthcare was cited as one of the main reasons for the overthrow of the government.³⁹⁵ In a speech by General Abacha, providing justification for the December 1983 coup, he stated that:

"Health services are in shambles as our hospitals are reduced to mere consulting clinics, without drugs, water and equipment. Our educational system is deteriorating at an alarming rate. Unemployment figures, including the graduates have reached embarrassing and unacceptable proportion."³⁹⁶

In a similar vein, in his first speech as the new head of State, General Babangida stated:

The last twenty months have not witnessed any significant changes...contrary to expectations, we have so far been subjected to a steady deterioration in the general standard of living; and intolerable suffering of the ordinary Nigerians have risen higher...hospitals still remain mere consulting clinics. While educational institutions are on the brink of decay. Unemployment has stretched to critical dimensions.³⁹⁷

³⁸⁸ See n303.

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ Ibid.

³⁹² Ibid.

³⁹³ Ibid.

³⁹⁴ Ibid.

³⁹⁵ Ibid.

³⁹⁶ Ihonvbere, Julius O., and Eme N. Ekekwe. "Dependent Capitalism, Structural Adjustment and Democratic Possibilities in Nigeria's Third Republic." *Africa Spectrum* (1988): 273-291 at 280.

³⁹⁷ Ibid at 282.

This reference to the country's health facilities as mere clinics was symptomatic of the steady decay that had beset the health system and the lack of faith in its ability to deliver proper care. However, unfortunately, the economic wherewithal to positively alter the downward trajectory of healthcare delivery as well as other important social amenities was now also lacking. Global economic trends that affected the price of crude oil, the nation's main source of revenue, as well as widespread corruption and the ever-growing looting of already limited resources meant that there was an increasingly acute shortage of funds available to meet the needs of the populace. Nigeria, like many other developing countries in Africa and across the world, was confronted with a massive economic decline heightened by the global recession and an overbearing debt burden, which it was increasingly unable to service.³⁹⁸ This meant that many national programs, including those focused on healthcare, eventually ground to a halt and the few still in progress were unable to function optimally.

While Nigeria, for a while, resisted taking foreign loans to make up for the financial short fall, by June 1986 the Babangida-led Government had adopted a comprehensive Structural Adjustment Program (SAP) as a conditionality for receiving a loan from the World Bank and the International Monetary Fund (IMF).³⁹⁹ The acceptance of this loan, on the condition of adopting a SAP, happened despite sustained civil society protest against it.⁴⁰⁰ Nigeria's adjustment efforts were supported by three stand-by arrangements with the IMF, although the government decided not to use the fund's resources.⁴⁰¹ The World Bank also supported the adjustment program through a \$450 million trade policy and export diversification loan.⁴⁰² A significant condition of these loans by the IMF and the World Bank was that the Nigerian government ceased the funding of social welfare programs, which included State-sponsored healthcare.⁴⁰³ While the intent of the SAP was to have medium and long-term improvements in economic efficiency, its actual effect was to increase budgetary constraints, with a resultant diminished provision of social services.⁴⁰⁴ The cuts in public expenditure invariably affected the supply of basic needs such as education, health, and sanitation. It also had a knock-on effect in heightening rural and urban unemployment.⁴⁰⁵ Ultimately, there was a slump in

³⁹⁸ Nwagbara, Eucheria N. "The story of structural adjustment programme in Nigeria from the perspective of the organized labour." *Australian Journal of Business and Management Research* 1.7 (2011): 30-41.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

⁴⁰¹ Ibid.

⁴⁰² See n382.

⁴⁰³ Ibid.

⁴⁰⁴ Sahn, David, and Rene Bernier. "Have structural adjustments led to health sector reform in Africa?." *Health Policy* 32.1-3 (1995): 193-214.

⁴⁰⁵ Ukah, Michael. "Structural adjustment programme and its negative effect on education in Nigeria: A philosophical reconceptualization." *International Journal of Public Administration and Management Research* 2.2 (2014): 170-186.

government's ability to fund universal free health. This led to a period of rationalisation and commercialisation. Several services were either withdrawn or had user fees levied on them.⁴⁰⁶ The effects of this wide spread State defunding were seen in such things as the withdrawal of free meals for patients on admission as well as the institution of charges for services such as consultation, bed, laboratory, surgery.⁴⁰⁷ In a similar vein, public pharmacies came to be run as businesses under the Drug Revolving Fund (DRF), which focused on revenue generation by dedicating large sums of capital to pharmacy units in public hospitals to purchase drugs, with the drugs being sold to patients and the proceeds ploughed back into further purchases of drugs with no subsidisation for the purchaser.⁴⁰⁸

The comprehensive defunding of the State healthcare system, as well as the reliance on user fees as a primary healthcare funding mechanism, would see the steady decline of services and the increasing impoverishment of the Nigerian populace, who were now increasingly beset by worsening economic odds without the previously available social buffers. Ineffective corporate governance, the distortions of continued government interventions, and government's unwillingness to carry the various stakeholders along in the design, implementation and execution of programmes, all limited the level of success for the programmes and reforms⁴⁰⁹ and led to a further deterioration of health services.

The result of this reversal of fates for much of the Nigerian populace was a spike in adverse health outcomes. For example, the convergence of mass poverty and inequality, increased illiteracy and unattended emergencies led to the increase in maternal mortality, which rose to as high as 1,000 per 100,000 births.⁴¹⁰ The adoption of structural adjustment thus had far-reaching consequences for healthcare delivery and other social welfare amenities. It brought few tangible benefits to the people, rather leading to worse health and social outcomes for them. The diminished value of the Nigerian currency on the foreign exchange markets also further exacerbated the already dire health outcomes.⁴¹¹ The heightened cost and lack of access to foreign exchange meant that drugs and other imported medical supplies became increasingly scarce and expensive. This period also saw the mass migration of skilled health workers especially in the public health system.⁴¹² The resultant shortage of skilled health work force led to a further strain on the now weakened public health system.

⁴⁰⁶ Alubo, S. Ogor. "Health services and military messianism in Nigeria (1983-1990)." *Journal of SocUll De~ lop1Mnt in Africa* 7.1 (1992): 45-65.

⁴⁰⁷ Ibid.

⁴⁰⁸ Ibid.

⁴⁰⁹ See n382.

⁴¹⁰ Harrison, Kelsey A. "Maternal mortality in Nigeria: the real issues." *African Journal of Reproductive Health/La Revue Africaine de la Santé Reproductive* 1.1 (1997): 7-13 at 8.

⁴¹¹ See n406.

⁴¹² Brunelli, Bianca. "Structural adjustment programs and the delivery of health care in the third world." *Pell Scholars and Senior Theses* 16 (2007).

The waning quality of healthcare delivery at the public health facilities ushered in an increase in private medical practices to fill in the need for adequate healthcare across the country.⁴¹³ The inability by a vast majority of the now more impoverished, rural population to afford private care meant that the private health facilities mostly catered to the few in the urban centres who could afford to pay for the services. Many of the rural poor resorted to traditional healers who had been supplemented by a lot of quacks. The general disdain by the formal health sector for traditional health practices also meant that they went unregulated. The high rates of poverty also meant that more citizens resorted to self-care which can often be medically unsound and detrimental.

The inability of the SAP to remedy the challenges of the economy and health services was also because much of the funding received from the IMF and the World bank was frittered away on white elephant projects or worse still embezzled. While corruption had always been an issue of concern from independence and was often a reason cited for the military coups that saw the country's sustained period of dictatorship, by the 1980s it became fully entrenched as an intrinsic part of statecraft.

Despite these issues, the Babangida regime saw the creation of the Fifth National Development Plan, which shifted emphasis to primary healthcare.⁴¹⁴ Under the steady leadership of a new Minister of Health, Prof Olikoye Ransome-Kuti, the Alma Ata Declaration of 1978 was put on the front burner of the country's strategy to reform the health system.⁴¹⁵ While previous efforts had been made through the prior Basic Health Services Scheme, it could not achieve its goals due to implementation challenges,⁴¹⁶ many of which are noted above. The appointment of the new minister and his commitment to the PHC model as the foundation for wider health reform culminated in the explicit formulation of the National Health Policy of 1988.⁴¹⁷ This resulted in the increased adoption of the PHC model across the country.⁴¹⁸ While the model was first piloted in 52 local governments, from 1986 to 1990, PHC facilities were expanded to all local governments. The introduction of PHC facilities into every local government also saw a better implementation of universal child immunisation, which increased to 80%.⁴¹⁹ The return to preventive medicine and a focus on grassroot health-care services marked a positive turn in public healthcare.⁴²⁰ The health system now focused on ensuring exclusive breast-feeding practice, introducing free immunisation to children, encouraging the use of oral

⁴¹³ Ibid.

⁴¹⁴ See n303.

⁴¹⁵ Aregbeshola, Bolaji Samson, and Samina Mohsin Khan. "Primary healthcare in Nigeria: 24 years after Olikoye Ransome-Kuti's leadership." *Frontiers in public health* 5 (2017): 48.

⁴¹⁶ Ibid.

⁴¹⁷ Ibid.

⁴¹⁸ Ibid.

⁴¹⁹ See n415 at 1.

⁴²⁰ See n294.

rehydration therapy by nursing mothers, making the recording of maternal deaths compulsory, and encouraging continuous nationwide vaccination. In 1992, the National Primary Healthcare Development Agency (NPHCDA) was established to ensure that the PHC agenda continued and was sustained.⁴²¹ However, much of the progress that had been made in the upscaling of PHC across the country was sadly not replicated at the higher levels of healthcare service provision, due to the reality of limited resources.⁴²²

The period also saw the sparking of local drug content creation, as the federal government sought to improve the availability of pharmaceutical drugs.⁴²³ However, the problem that was intended to be solved remained largely unsolved. This was because the raw materials for local drug manufacture had to be imported. This dependency required continued availability of foreign exchange, which depleted foreign reserves, and so ultimately, costs were reduced only partially. This meant that it was still considerably expensive for the populace especially in the absence of prior government subsidisation.⁴²⁴ Increasingly, medical facilities had to depend solely on imported equipment and drugs as well as rely heavily on expatriate personnel who were mostly physicians.⁴²⁵ The dependence on importation of goods and skilled resources further depleted the reserves.

A combination of salary freezes, the removal of a minimum wage, and the devaluation of the naira, as well as the removal of all previous subsidies on food, petrol and fertiliser, meant that poverty was at a record high.⁴²⁶ The burden of structural adjustment was now clearly seen to be having a serious effect on the long-term survival of the country's poorest and weakest.⁴²⁷ Poverty had a gendered lens, as it placed an additional burden on women, who were already mostly confined to low-paying wage employment, or were teachers and nurses in state-owned facilities.⁴²⁸ When there were mass retrenchments, women were often the first to go in all sectors.⁴²⁹ This created a double burden on the country's women, who were also often relegated to the roles of reproduction and home maintenance. These responsibilities were not backed up by access to and control of resources, either within their households or in the larger society.⁴³⁰ Invariably, proper nutrition in the population and especially

⁴²¹ See n415.

⁴²² Ibid.

⁴²³ See n406.

⁴²⁴ Ibid.

⁴²⁵ Ibid.

⁴²⁶ Ibid.

⁴²⁷ Odulana, Justin A., and Joseph A. Olomajeye. "The impact of government's alleviation of poverty program on the urban poor in Nigeria." *Journal of Black Studies* 29.5 (1999): 695-705.

⁴²⁸ Owoh, Kenna. "Gender and Health in Nigerian Structural Adjustment: What Does it Mean for Women?" *Canadian Woman Studies* 13.3 (1993):71-74.

⁴²⁹ Ibid.

⁴³⁰ Ibid.

amongst children waned. Sanitation and living conditions also deteriorated considerably, further making the population more susceptible to illness and in dire need of mostly scarce medication.⁴³¹

In the absence of a steady supply of available and affordable medication, there was a massive influx of fake and expired drugs, which were often brought into the country to meet the shortfall of actual medication. At one time, there was an estimation that 70% of drugs in circulation in the country were either fake or expired.⁴³² This ultimately prompted the setting up of the National Food and Drug Control Agency (NAFDAC) in 1993 to monitor and regulate foods and drugs importation, manufacture, procurement, and consumption in the country.⁴³³

Unfortunately, yet another military coup, this time by General Abacha saw the stalling of much of the progress that had been made.⁴³⁴ In 1995, a National Health Summit was held to review the National Health Policy and develop a plan for its implementation. The revised National Health Policy continued to recognise primary healthcare as the cornerstone of the nation's healthcare delivery system,⁴³⁵ although progress in further implementation was abysmal.

Return to democratic governance

By 1999, there was a consensus that the Nigerian Health System had virtually collapsed.⁴³⁶ However, with the eventual return to democratic rule, there was a general sense of renewed hope in the country and belief in the government's ability to commence necessary healthcare reform, as well as to attend to other socio-economic welfare concerns. This political climate of renewed hope and a belief in the possibility of once again creating economic growth to jumpstart the nation's development, created a window of opportunity for public health technocrats eager to see change in the health system. They thus sought to create policy that would set a new direction for the country's public health system. The idea for the new health policy was mooted by Professor Eytayo Lambo,⁴³⁷ to the UK Department for International Development (DfID), a global health actor with a strong presence in Nigeria.⁴³⁸ The acceptance of the idea led to the creation of a think tank, called the Change Agents Programme (CAP),

⁴³¹ Ibid.

⁴³² See n371 at 4.

⁴³³ See n371.

⁴³⁴ Ibid.

⁴³⁵ Ibid.

⁴³⁶ Ibid.

⁴³⁷ Prof. Eytayo Lambo had only recently retired as the Senior Health Economist of WHO African Region.

⁴³⁸ Nigeria Health Watch, "The National Health Bill: After Ten Years in the Making is an End in Sight?", 4 November 2014, available at <https://nigeriahealthwatch.com/the-national-health-bill-after-ten-years-in-the-making-is-an-end-in-sight/>, accessed on 19 October 2020.

in 2001 made up of 30 reform-minded Nigerians, many of whom occupied key positions in the Ministry of Health.⁴³⁹ This building of strategic alliances with potential allies led to the push for the policy in the ministry gaining wide spread support. The appointment of Professor Lambo, the CAP director, as the Minister of Health led to an increase of power for CAP, which had a strong ally in Lambo.⁴⁴⁰ Lambo's new power as minister also granted him access to the President, who became keen on the policy. This interest by the President in turn led to the support of other key cabinet members. The National Economic Council and the Minister of Finance who were especially powerful in that administration and whose support was necessary due to the financial implications of the policy were also on board. However, subsequently, sustained politicking by both the executive and the legislature and jostles for power by various stakeholders led to the stalling of the policy that would eventually become the National Health Act. This resulted in the policy taking 10 years to be eventually passed into law in 2014. However, since the passing of the NHA in 2014, the lack of adequate funding has stalled progress in its full implementation.

In the meantime, the federal government made several other interventions meant to uplift the living conditions of Nigerians. In 2000, the federal government initiated the Poverty Alleviation Programme (PAP), which was meant to provide employment for about 200,000 people.⁴⁴¹ The next year, PAP was replaced with the National Poverty Eradication Programme (NAPEP), which was tasked with the responsibility of coordinating and monitoring the activities of the core poverty eradication ministries and agencies, which covered health, education, power and steel, water resources, work and housing, among others.⁴⁴² Additionally, the government created the National Health Insurance Scheme and the enabling Act for its establishment was passed into law.⁴⁴³ The scheme currently encompasses government employees, the organised private sector and the informal sector.⁴⁴⁴ In 2004, the scheme was given even more powers through amendments to the initial 1999 Act. Unfortunately, however, the number of Nigerians covered by the National Health Insurance Scheme (NHIS) since its establishment has remained low, at about 4% of the population.⁴⁴⁵ Uptake has been slow despite several interventions. The scheme has been largely unable to properly capture the informal sector,

⁴³⁹ Ibid.

⁴⁴⁰ Ibid.

⁴⁴¹ Ibid.

⁴⁴² Bello, R. A., et al. "Poverty Alleviation Programmes and Economic Development in Nigeria: A Comparative Assessment of Asa and Ilorin West Local Govt. Areas of Kwara State, Nigeria." *African Research Review* 3.4 (2009):283-297.

⁴⁴³ Onoka, Chima A., et al. "Promoting universal financial protection: constraints and enabling factors in scaling-up coverage with social health insurance in Nigeria." *Health research policy and systems* 11.1 (2013): 1-10.

⁴⁴⁴ Ibid.

⁴⁴⁵ Ibid at 1.

which makes up about 67% of the population.⁴⁴⁶ It has thus plateaued at covering the civil service and a limited section of the formal private sector. In 2017, the Minister of Health stated that even though the sum of N351 billion had been expended on health management organisations (HMOs) so far, there had not been commensurate results.⁴⁴⁷ The varied interventions of the democratic governments over time started to lead to an improvement in the life outcomes of the populace. In 2000, the life expectancy in Nigeria was 48 years for males and 49 years for females.⁴⁴⁸ At the time, the World Health Report ranked Nigeria as the 187th of the 191 member nations for its health systems performance.⁴⁴⁹ However, progress was steadily made and by 2010, life expectancy increased to 51 years and 53 years for males and females, respectively.⁴⁵⁰

Despite the impact of the broad interventions, the health system still suffered from underfunding and inadequate reform. The inability to properly fund and reform the country's healthcare system almost cost the country through severe health risks of pandemic proportions. In July 2014, after several months of the rapid spread of the Ebola Virus Disease (EVD) across neighbouring West African countries, like Liberia, Sierra Leone, and Guinea, Nigeria experienced its first case of the virus.⁴⁵¹ An acutely ill traveller from Liberia arrived at the international airport in Lagos, Nigeria, and was confirmed to have Ebola after being admitted at a private hospital.⁴⁵² This index patient potentially exposed at least 72 other people at the airport and at the hospital.⁴⁵³ The Federal Ministry of Health, with guidance from the Nigeria Centre for Disease Control (NCDC), declared an Ebola emergency upon the discovery of this fact.⁴⁵⁴ Rapid steps were immediately taken, aimed at contact tracing. This was especially important, considering that the index patient came into the country through Lagos, which is considered a regional hub of economic, industrial, and travel activities. Under these circumstances,

⁴⁴⁶ Tonuchi, E., et al. "How large is the size of Nigeria's informal economy? A MIMIC approach." *International Journal of Economics, Commerce, and management* 8.7 (2020): 204-227 at 204.

⁴⁴⁷ Emma Ovuakporie and Levinus Nwabughio, "Health insurance: FG calls for scrapping of HMOs", *Vanguard Newspaper*, 22 June 2017, available at <https://www.vanguardngr.com/2017/06/health-insurance-fg-calls-scrapping-hmos/>, accessed on 19 October 2020.

⁴⁴⁸ Odeyemi, Isaac A. O, and John Nixon. "Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis." *International journal for equity in health* 12.1 (2013): 1-18 at 4.

⁴⁴⁹ Asuzu, Michael C. "Commentary: The necessity for a health systems reform in Nigeria." *Journal of community medicine and primary healthcare* 16.1 (2004): 1-3 at 2.

⁴⁵⁰ Sede, Peter I., and Williams Ohemeng. "Socio-economic determinants of life expectancy in Nigeria (1980–2011)." *Health economics review* 5.1 (2015): 1-11 at 1.

⁴⁵¹ Althaus, Christian L., et al. "Ebola virus disease outbreak in Nigeria: transmission dynamics and rapid control." *Epidemics* 11 (2015): 80-84.

⁴⁵² Otu, Akaninyene, et al. "An account of the Ebola virus disease outbreak in Nigeria: implications and lessons learnt." *BMC Public Health* 18.1 (2018): 1-8.

⁴⁵³ Shuaib, Faisal, et al. "Ebola virus disease outbreak—Nigeria, July–September 2014." *MMWR. Morbidity and mortality weekly report* 63.39 (2014): 867-872.

⁴⁵⁴ Ibid.

the risk of the disease spreading at an exponential rate was considerable. An Emergency Operations Centre (EOC), was established and, using an Incident Management System (IMS) to coordinate the response and consolidate decision making, Nigeria was able to contain the outbreak early.⁴⁵⁵ The ability to quickly mobilise the EOC was due to the health system's earlier creation of the parastatals that were key to nipping the spread of the disease in the bud. The EOC and the IMS, for example, had been created in 2012, when Nigeria declared polio a public health emergency and restructured its national polio program.⁴⁵⁶ In addition, having the capacity to conduct Ebola laboratory diagnosis in-country at the Lagos University Teaching Hospital facilitated rapid identification of confirmed cases and quick discharge of persons with suspected Ebola who tested Ebola negative.⁴⁵⁷

The Ebola pandemic brought to the fore the importance of the Nigeria Centre for Disease Control (NCDC) as a frontline institution for the health system. This prompted considerable funding for it, as well as the passing of the Bill establishing it and enabling its powers to monitor and coordinate the national response to pandemics in the country, a task which it had already been performing for at least seven years before its signing into law in 2018. With the passage of the Bill into law, the agency was given the full legal mandate to implement the International Health Regulations (IHR) which provide the global blueprint for pandemic preparedness.⁴⁵⁸ The strengthening of the NCDC would prove especially important in 2020, when Nigeria would begin to tackle its own cases of the fast-spreading Covid-19 disease during the global pandemic that began in late 2019. However, despite this relative success in responding to the spread of the pandemic, issues around limitations of equipment and skilled personnel have once again highlighted the systemic issues afflicting the Nigerian health system. The insistence of health workers to go on strike in the middle of the health crisis because of poor conditions of work and compensation⁴⁵⁹ further highlight the effects of decades of underfunding of healthcare at the federal, state and local government levels.

While the country has been able to rise to the occasion in these instances, it still has a high burden of several communicable diseases, as well as an ever-increasing burden of non-communicable diseases that constantly put a strain on the country's already weakened health system.⁴⁶⁰ Nigeria is one of the

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid.

⁴⁵⁷ Ibid.

⁴⁵⁸ Nigeria Centre for Disease Control and Prevention (Establishment) Act 2018 (Act No. 18 of 2018)

⁴⁵⁹ Reuters, "Nigerian Health Workers End Strike Despite No Coronavirus Hazard Pay", *Reuters*, 21 September 2020, available at <https://www.usnews.com/news/world/articles/2020-09-21/nigerian-health-workers-end-strike-despite-no-coronavirus-hazard-pay>, accessed on 19 October 2020.

⁴⁶⁰ Oleribe, Obinna Ositadimma, and Simon David Taylor-Robinson. "Before sustainable development goals (SDG): why Nigeria failed to achieve the millennium development goals (MDGs)." *The Pan African medical journal* 24 (2016):156.

developing countries particularly faced with this 'double burden' of persisting high prevalence of communicable diseases and rising prevalence of non-communicable diseases. Key health indicators in the country are worse than the Sub-Saharan African average and Nigeria noticeably failed to achieve most of the health-related MDGs by 2015.⁴⁶¹ In the face of the steady decay of the local health system, Nigerians who can afford it have resorted to medical tourism especially for surgeries, cardiological concerns, neurological issues and the management of cancers. Nigerians spent an estimated \$260 million on medical bills in India alone in 2012 and 40% of all visas to India were for medical reasons.⁴⁶² The Nigerian Medical Association (NMA) estimates that Nigerians spend between \$500 million to USD1 billion on medical tourism per year. Nigerians who can afford the often-exorbitant prices also heavily patronise other countries like Turkey, South Africa, Saudi Arabia, USA, UK and Germany for their medical care.⁴⁶³

All the concerns raised thus far point to a poor state of healthcare in the country and together are a strong indication of the country's inability to meet the health and social needs of its people. From the historical analysis done above, a few key themes arise that help better explain the current state of healthcare and the health system that came about. An exposition of these factors is important for a better understanding the challenges of the Nigerian health system as systemic issues and not as a one-off issue that can be addressed with the wave of the hand.

Thematic issues underlying Nigeria's poor health system

As shown above, the events leading up to the present Nigerian health system are numerous and interwoven. While many of the interventions that shaped the evolution of the health system and the delivery of healthcare to the Nigerian people were specific and health focused, many others were consequences of broader political and policy interventions which had far reaching implications. In all these events, a centrally recurring theme has been the politicisation of healthcare. Healthcare has often been the victim of limited political will, while at the same time being used as a political tool to justify the need for regime change and claims to power. From pre-colonial times, those with the means to cater to the health of the populace have wielded immense power. This power has, in turn, been co-opted by formal State structures, beginning with the colonial State and later by subsequent governments from independence onwards. This use of healthcare as a political tool has largely been in a bid to earn legitimacy and the acquiescence of the populace. However, the resultant centralised

⁴⁶¹ Ibid.

⁴⁶² Pharm Access Foundation. *Nigerian Health Sector Market Study Report*. Pharm Access Foundation (2015).

⁴⁶³ Ibid.

and top-down approach to health policy formulation and implementation has, at times, led to shortfalls in both the relevance and implementation of the stated health goals. In many instances of non-realisation, it has been due to health goals being at loggerheads with other economic interests, especially if those are interests of the ruling class.

These issues are as much about de-prioritisation of healthcare as they are about the broader mismanagement of the Nigerian State. While no single issue is solely responsible for Nigeria's currently weak health system, several long standing issues can be identified. Some of the issues that have cumulated into the present state of decay include: the larger macroeconomic and political context of increased debt since the late 1970s due to the global oil crisis and the consequent focus on debt repayment to the detriment of other responsibilities by the state; a decreasing investment in social institutions; and the erroneous ideological belief in the need for a limited role of the State and over-reliance on the private sector.⁴⁶⁴ Corruption and lack of effective systems of accountability have also meant that even what is intended for the use of the health system does not get to the intended end user. Years of mismanagement of scarce resources tied in with the sustained underinvestment in the health system have resulted in poor infrastructure, inadequate modern equipment and technology and an inadequate number and mix of healthcare workers. These have resulted in the absence of key specialist services, poor quality of care, and loss of confidence in general health services. All these issues can be understood in the context of the political, legal and economic structure of the Nigerian State vis á vis its obligations to realise the right to health and to strengthen the health system, the Nigerian State being primarily responsible for this task.

The recurring lack of political will to deliver affordable, accessible, and quality healthcare.

In seeking to fulfil its mandate to deliver healthcare, the Nigerian State through various policies around quota systems has tried to take into consideration historical inequalities that have left some parts of the country less developed than others.⁴⁶⁵ The regional inequalities have been further exacerbated by the colonial legacy. Colonialism in Nigeria left behind a health system structure that was not primarily targeted at securing the health needs of all Nigerians. The location of services was to aid the economic

⁴⁶⁴ Bangdiwala, Shrikant I., et al. "Workforce resources for health in developing countries." *Public Health Reviews* 32.1 (2010): 296-318.

⁴⁶⁵ Asaju, Kayode, and Tony Egberi. "Federal character and national integration in Nigeria: The need for discretion and interface." *Review of History and Political Science* 3.1 (2015): 126-134.

interests of the British empire and its officials working in the colony.⁴⁶⁶ The relationship of the British government with the colony was extractive and so the needs of the local population were not the central focus of enacted policies. The agitation for independence was also largely political in nature and was focused on the division of power among the various ethnicities.⁴⁶⁷ At independence, through the provision of free or subsidised education, water and healthcare, the Nigerian State sought to make up for the regional disparity and urban rural divide in development.⁴⁶⁸ As stated in its First National Development Plan, the focus was on raising the country's gross domestic product (GDP) and using this increased revenue to better fund its various welfare programs.⁴⁶⁹ The aim was to provide additional social services in more parts of the country and to improve their quality while at it. The political choice to realise a fully functioning welfare system has however waned as the country's economic fortunes have waned. The implications of this decline were particularly sweeping for the health system.

By the return to democratic rule in 1999, the resources to realise the mandate of a social welfare State had been significantly impacted by its negative economic reality and the mismanagement of its limited resources and fragile institutions. While the country's return to democratic rule in 1999 brought with it renewed hope that the change in political structure of the State would also usher in a return to a social welfare model, the means to achieve it were severely lacking. The early 2000s was marked by mass privatisation efforts with varied levels of success. In the ensuing allocation of the scarce resources for which the State still maintained the primary responsibility, healthcare was persistently a secondary concern with health crises often being the major impetus for reform, which were often not sustained over time. Unfortunately, this persistent neglect of healthcare was largely enabled by a legal regime that made the Nigerian State unaccountable.

The erosion of the duties of the Nigerian State by the law

While the assertion of healthcare as a primary imperative of the State does not always have to be clearly stated in a specific law, such clear legal provision is often quite useful for plainly laying out the duties of the State and how it is to go about fulfilling them. Another benefit of clear policies and specific laws is that they point to the intent of the law maker, and they serve as a clear promise to the populace, guaranteeing them what they can legitimately expect from the State. In the case of Nigeria, there is a written Constitution with express provisions that set out the intended priorities for nation

⁴⁶⁶ Jarrett, Alfred A. "Problems and prospects of the social welfare systems of Sierra Leone and Nigeria." *International Social Work* 34.2 (1991): 143-157.

⁴⁶⁷ See n465.

⁴⁶⁸ See n353.

⁴⁶⁹ Ibid.

building. The preamble of the Nigerian Constitution provides that the Nigerian government has, as part of its purpose, a duty to promote good governance and the “welfare of all people.”⁴⁷⁰ This mandate is further provided for in Section 14(2)(b) of the Constitution, which states that the “security and welfare of the people shall be the primary purpose of the government.”⁴⁷¹ Section 16(1)(b) is even more explicit in its mandate of the State to “control the national economy in such manner as to secure the maximum welfare, freedom and happiness of every citizen on the basis of social justice and equality of status and opportunity;”⁴⁷²

In furtherance of this mandate, Section 16 (2)(c) goes on to provide that the Nigerian State has a duty to direct its policy to ensure “that the economic system is *not operated in such a manner as to permit the concentration of wealth*”⁴⁷³ or the means of production and exchange in the hands of few individuals or of a group;”⁴⁷⁴

Consequently, the State is to ensure that there is suitable and adequate housing, food, welfare benefits for the sick and disabled as well as a national minimum living wage and pension for the elderly.⁴⁷⁵ The provision of affordable and accessible healthcare as well as the social determinants of health are essential to the fulfilment of the State’s obligations. However, these provisions are legally unenforceable against the Nigerian State. This is due to the provisions of Section 6(c) of the Constitution, which states that all the above listed provisions, which form part of Chapter 2 of the Constitution, cannot be adjudicated upon by Nigerian courts. The ouster of jurisdiction means that while the obligations of the State are clearly laid out, the populace cannot compel the State to fulfil its duties by legal action. This limitation has, as described in Chapter Two of this dissertation, also been upheld by the Nigerian courts, which have declined to adjudicate on such matters.⁴⁷⁶ The inability to hold the Nigerian State accountable to its own stated duties is a major impediment that raises questions about the very premise of it being the welfare State it claims to be. This is because the fulfilment of its duties become solely dependent on the will of the ruling class to act in favour of the masses, outside of themselves. This, however, runs contrary to the premise of the social welfare State as a product of political and economic compromise. When delivery of a mandate to ensure that “wealth, capital and power is not concentrated in the hands of a few” is solely dependent on those few who currently own the wealth and have the power, there is a systemic imbalance of power. This

⁴⁷⁰ Preamble, Constitution of the Federal Republic of Nigeria, Act No. 24, 5 May 1999. Emphasis mine.

⁴⁷¹ Section 14(2)(b), Constitution of the Federal Republic of Nigeria, 1999.

⁴⁷² Section 16 (1)(b), Constitution of the Federal Republic of Nigeria, 1999.

⁴⁷³ Emphasis mine.

⁴⁷⁴ Section 16 (2) (c), Act No. 24, 5 May 1999.

⁴⁷⁵ Section 16 (2) (d), Act No. 24, 5 May 1999.

⁴⁷⁶ See n145.

imbalance of power that unduly favours the already powerful means that the realisation of the aspirations of a welfare State are at the whims and caprices of those who wield said power to be 'benevolent' or not. This often means that the working class and masses are confined to seeking other means of guaranteeing the protection of their welfare and wellbeing, which can sometimes be extrajudicial and, in the extreme, volatile.

The persistent economic de-prioritisation of health by the Nigerian State

Closely tied with the political and legal dispensation that has created an enabling environment for the decline of the health system has been the economic environment in which healthcare has been deprioritised. And so, even if the nature of the State's responsibilities is clearly outlined, its ability to deliver on them is largely dependent on its capacity. Capacity itself is dependent on both its revenue as well as the mechanisms for acquiring that revenue and the amount of discretion it has on how to dispense it. As earlier noted, in Nigeria the discovery of crude oil and its economic viability soon led the country to shift to a mono-mineral export economy.⁴⁷⁷ Due to State ownership of natural resources, economic capital also became inextricably linked to the State. The concentration of political and economic power in the hands of the few in the elite and political class soon meant that the fate of the nation, as well as that of the working class, was tied to the fortunes of oil revenue and its management by the State and its few private beneficiaries.⁴⁷⁸ This would prove dangerous, as the global economic collapse of the 1970s and 80s saw the country experience serious shortfalls in its revenue, causing it to embark on austerity measures. These measures were not enough, and the government eventually adopted SAP as a precondition for receiving loans from the World Bank and the International Monetary Fund (IMF). The decision to take on foreign loans, with conditionalities, grossly affected the nation's ability to meet its social welfare obligations. Even now, the persistently faltering crude oil prices and the inability to pay off its ever-increasing foreign loans have meant that the Nigerian State has been run at a deficit for years.⁴⁷⁹ Corruption and the frittering away of what little resources are available has also meant that the scarce resources have been mismanaged. This has left little to nothing available for social programs. Lack of political will is further reflected in the choices of the State when it comes to priority setting and budgetary allocation. Allocations to health and education, for example, have remained persistently below 10%, despite the Abuja Declaration

⁴⁷⁷ Joseph, Richard A. "Class, state, and prebendal politics in Nigeria." *Journal of Commonwealth & Comparative Politics* 21.3 (1983): 21-38.

⁴⁷⁸ Ibid.

⁴⁷⁹ Maji, Abu, and Joseph Oboba Achegbulu. "The impact of fiscal deficits on economic growth in Nigeria." *International Business and Management* 4.2 (2012): 127-132.

laying out the target of 15% as a concrete show of political will to deliver health goods.⁴⁸⁰ Nigeria's health expenditure is relatively low, even when compared with other African countries. The total health expenditure (THE), as percentage of the gross domestic product (GDP) from 1998 to 2000, was less than 5%, falling behind THE/GDP ratio in other developing countries like Kenya, Ethiopia, and Ghana, with THE of 5.4%, 4.5%, and 4.8% of GDP, respectively.⁴⁸¹ In the face of this persistent underfunding of healthcare, household out-of-pocket expenditure (OOP) has remained the major source of healthcare expenditure, constituting about 70.3% of THE.⁴⁸² The implication of this high out-of-pocket expenditure is that the average household spends between 25 to 40% of their income annually on health.⁴⁸³ As a result of this, a majority of Nigerians, especially the poor, have to pay for their healthcare, as they have no insurance coverage.⁴⁸⁴ The uptake of health insurance in the country however remains low, with just about 5% of the population having health insurance. This percentage is also largely drawn from the formal sector, with little to no coverage of those in the informal sector, many of whom have precarious work and whose exposure to adverse social determinants means that those that are most in need of affordable healthcare and coverage are the ones with the least ability to afford it.⁴⁸⁵ It remains difficult to sustain satisfactory levels of financing primary healthcare as out-of-pocket spending.⁴⁸⁶ Evidence reveals that the out-of-pocket payment method can be "catastrophic" in the sense of leading to or worsening poverty levels by crowding-out important goods such as clothes, diet and housing.⁴⁸⁷ A study using data from 153 nations found that a 10% increase in

⁴⁸⁰ Paragraph 26. Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. See also, Musango, Laurent, et al. "The state of health financing in the African Region." *Health Monitor* 16.9 (2013):9-14 at 12.

⁴⁸¹ Lawanson, Mr Akanni O. "National Health Accounts estimation: lessons from the Nigerian experience." *African journal of medicine and medical sciences* 41.4 (2012): 357-364 at 362. See also, Odeyemi, Isaac A. O, and John Nixon. "Assessing equity in health care through the national health insurance schemes of Nigeria and Ghana: a review-based comparative analysis." *International journal for equity in health* 12.1 (2013): 1-18.

Mills, Anne, et al. "Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage." *The Lancet* 380.9837 (2012): 126-133.

⁴⁸² Lawanson, Akanni Olayinka. "Health care financing in Nigeria: National health accounts perspective." *Asian Journal of Humanities and Social Studies* 2.2 (2014):237-252 at 248.

⁴⁸³ See n371 at 5.

⁴⁸⁴ Adeniji, Foluke O. "National Health Insurance Scheme in Nigeria; Progress towards Universal Coverage." *Asian Journal of Medicine and Health* (2017): 1-2.

⁴⁸⁵ Olakunde, Babayemi O. "Public healthcare financing in Nigeria: which way forward?" *Annals of Nigerian Medicine* 6.1 (2012): 4.

⁴⁸⁶ Ejughemre Ufuoma John, et al. "Healthcare financing in Nigeria: A systematic review assessing the evidence of the impact of health insurance on primary healthcare delivery." *Journal of Hospital Administration* 4.1 (2015):1-8.

⁴⁸⁷ Narayan, Deepa, et al. *Voices of the poor: can anyone hear us? (English)* Washington D.C: World Bank Group, 2000.

See also World Bank. *Poverty, Attacking. "World Development Report 2000/2001.": Attacking Poverty.* Ravi Kanbur and Nora Lustig, Eds. (2001) OUP (2001).

government spending on health led to an average reduction of under-5 mortality by 7.9 deaths per 1000 and adult mortality by 1.6 (women) and 1.3 (men) per 1000.⁴⁸⁸ The source of the funding (government expenditure versus out-of-pocket) was a significant factor, with a rise of 11.6 female deaths per 1000 on average in response to a 10% higher out-of-pocket share.⁴⁸⁹ The same study also demonstrated that “broader health coverage generally leads to better access to necessary care and improved population health, with the largest gains accruing to poorer people.”⁴⁹⁰

Although the Nigerian government generates revenue through taxation, the bulk of its revenue derives from the sale of oil and gas.⁴⁹¹ Revenue is raised at the federal, state, or local government levels. However, the federally generated revenue, which is shared according to a predetermined formula, constitutes most of the funds for the other tiers of government.⁴⁹² The states and local governments, being closer to PHC, are expected to provide adequate funding for PHC, but owing to their low internal revenue generation capacities, most of them still largely depend on the allocation from the federal government.⁴⁹³ The poor state of healthcare funding is compounded by increasingly low donor funding. This, as well as limited institutional capacity, corruption, and an unstable economic and political context, are key factors dooming the proper financing of healthcare.⁴⁹⁴ Thus, achieving the objectives of good health outcomes, equity, patients’ and providers’ satisfaction is very challenging. Given the backdrop of the weak institutional capacity, technical expertise, and high level of poverty, Nigeria will have to rely on a combination of mechanisms to achieve effective healthcare financing. To achieve universal coverage of healthcare services for the poor, Nigeria will have to move from out-of-pocket payments to other mechanisms of financing that allow the State to fulfil its role as the primary duty bearer for the fulfilment of the right to health and the institutions necessary to realise it.⁴⁹⁵

Schieber, George J. Ed. *Innovations in healthcare financing: proceedings of a World Bank conference, March 10-11, 1997*. World Bank discussion paper; no. WDP 365; Proceedings; Health, Nutrition and Population (HNP) discussion paper. Washington, D.C, World Bank Group (1997).

⁴⁸⁸ Network, Sustainable Development Solutions Network. “*Financing Universal Health Coverage in the Post-2015 Agenda*”. Sustainable Development Solutions Network, *Thematic Group on Health for All* (2015) at 2.

⁴⁸⁹ Ibid.

⁴⁹⁰ Ibid.

⁴⁹¹ See n485.

⁴⁹² Ibid.

⁴⁹³ Ibid.

⁴⁹⁴ Adinma, Echendu D., and Brian-D. JI Adinma. “Community based healthcare financing: An untapped option to a more effective healthcare funding in Nigeria.” *Nigerian Medical Journal* 51.3 (2010): 95.

⁴⁹⁵ See n485.

Conclusion

Political commitment to good health must be shown in financial commitment to see desired changes through. The very nature of health systems requires long-term sustained financial input, as well as policy intervention and regular review, to yield meaningful results. Unfortunately, the lack of political will of the Nigerian ruling class to see through the necessary reforms needed in the health sector is exacerbated by a legal structure that makes it difficult to hold the State accountable. Instead, healthcare continues to remain a bargaining chip for the consolidation of power. When and where interventions become necessary, the quest for a 'magic bullet' - a quick single intervention to solve all problems - becomes the central focus of the government of the day, looking to assert legitimacy and gain the acceptance of the populace. This short-sighted approach has both undermined the development of Nigeria's health system and allowed the sustained mediocre approach to solving the country's health challenges.⁴⁹⁶

The hitherto framing of healthcare delivery as a service and social good has allowed the gradual widening of various fissures that were excused, when they first started, as shortcomings in an imperfect system trying its best to function under the circumstance. However, the critical paradigm shift that can allow for the needed political engagement and necessary judicial intervention, lies in reframing of the duties of the health system as rights held by the populace. It is in the enforcement and delivery of the right to health that the current abysmal state of the Nigerian health system may be properly reformed to enable it to deliver on its duties. To ensure the delivery of a right to health that is not seen as a one-off intervention, especially in times of crises, there is a need for sustained legal and political pressure to ensure State accountability. The imperative to press for change is especially necessary in the face of a population where many are beset by intergenerational poverty⁴⁹⁷ and have limited economic options, limited viable healthcare alternatives and poor social determinants of health. This need for change is more obvious, when one considers the plethora of issues that affect the Nigerian health system; challenges will be discussed in the next chapter.

⁴⁹⁶ See n464.

⁴⁹⁷ World Bank, "Poverty & Equity Data Portal: Nigeria", 2018, available at <https://povertydata.worldbank.org/poverty/country/NGA>, accessed on 2 November 2019.

Chapter 4

Structural challenges of the Nigerian health system

Introduction

The WHO framework provides for six pillars of a health system, which are the building blocks upon which effective health systems are built.⁴⁹⁸ These are leadership and governance, health financing, medical technologies that include medical products and vaccines, a health information system, the health workforce, and good health services.⁴⁹⁹ The expectation is that all six pillars of the health system work in unison to deliver optimal healthcare.⁵⁰⁰ This cohesion is imperative, because each pillar plays a critical role in the proper functioning of the system as a whole, and setbacks in one of those pillars can have a ripple effect on the proper functioning of the others. This is especially the case in Nigeria where, as the previous chapters of this dissertation have shown, years of deprioritising healthcare and the health system responsible for delivering it have resulting in system-wide decline.

While every aspect of the six pillars of the Nigerian healthcare system have been adversely affected, certain key issues have been central to the presently dire state of the health system. These issues include: a skewed model of policy formulation and implementation and the resultant over politicisation of health interventions; mismanaged health resources; outdated or non-existent health infrastructure; an inadequate primary healthcare network; and the scarcity of a skilled workforce largely due to poor working conditions. By discussing some of these key challenges, I illustrate how persistently flawed health system management and half-baked interventions have created intersectional systemic issues that will need to be addressed if there is to be effective healthcare reform and the subsequent delivery of the right to health in Nigeria.

The absence of coordinated national health policy formulation and implementation.

The health system in Nigeria is structured along three levels of care being the primary, secondary and tertiary levels of care. The system is run concurrently, such that all the three levels of government -

⁴⁹⁸ World Health Organisation. *Everybody's Business: "Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action."* Geneva: World Health Organisation (2007).

⁴⁹⁹ World Health Organization. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva: World Health Organization, 2010.

⁵⁰⁰ Ibid.

local, regional/state and national/federal, play a role in the management of healthcare. However, each level of government holds primary responsibility for only one level of the system but can exceed it and provide services at any of the other two levels of care.⁵⁰¹ The federal government as the highest level of health governance is largely responsible for the provision of policy guidance, planning, and technical assistance; coordination of state-level implementation of the national health policy; and the establishment of health management information systems. It is also responsible for disease surveillance, vaccine management, drug regulation, and training of health professionals, as well as the management of teaching, psychiatric, and orthopaedic hospitals, including some medical centres.⁵⁰² On the other hand, at the state level, the responsibility for management of health facilities is shared by the state ministries of health, state hospital management boards, and the local governments.⁵⁰³ Though states are responsible for secondary hospitals and for the regulation and technical support of PHC services, PHCs are largely the responsibility of local governments, providing health services through the ward health system. The local government administrations (LGAs) provide oversight for the operations of PHC facilities within their geographic areas and the provision of basic health services, community health, hygiene, and sanitation.⁵⁰⁴ In line with these vast structural realities of the health system, a system of coordinated norm setting and subsequent adoption, as well as localisation of these norms to meet the specific needs of the specific areas, is required to ensure the necessary congruence, while affording communities the chance to exercise agency in their own healthcare.⁵⁰⁵ However, there is poor health governance at all levels of government. Implementation of national health policies as well as their domestication and application among various state governments is often varied, with disparate levels of application and compliance.

The challenge of effective data gathering and utilisation

A deficit of up-to-date reliable data and statistics as well as proper dissemination of the relevant data is one of Nigeria's major health system's constraints.⁵⁰⁶ This challenge of collating data is made difficult by weak communication links across the nation's health system. The ripple effect is that there is little reliable and effective data with which to generate and ultimately use medical intelligence. Research into the defects of the surveillance and communication pillar of the Nigerian health system has been

⁵⁰¹ Act No. 24, 5 May 1999.

⁵⁰² See n371.

⁵⁰³ Ibid.

⁵⁰⁴ Odutolu, Oluwole, et al. "Putting institutions at the centre of primary healthcare reforms: experience from implementation in three states in Nigeria." *Health Systems & Reform* 2.4 (2016): 290-301.

⁵⁰⁵ See n371.

⁵⁰⁶ See n294.

conducted and point to several factors, such as poor research funding, poor uptake of research output, and the lack of coordinated research output as being responsible for the shortcomings in health system research and surveillance.⁵⁰⁷ There are concerns that the healthcare system remains weak as evidenced by lack of coordination, fragmentation of services, dearth of resources, including drug and supplies, inadequate and decaying infrastructure, inequity in resource distribution, and access to care and deplorable quality of care due to the inability to properly gather relevant data.⁵⁰⁸ This is affected by the lack of clarity of roles and responsibilities among the different levels of government, which further compounds the situation.⁵⁰⁹ The need to dramatically improve the database for informed decision making in the health system has been identified as an important tool too for successful resource mobilisation and management.⁵¹⁰ Because necessary information has been unavailable of the existing resources and their location and usage, there has been an unnecessary duplication of efforts and a resultant wastage of resources.⁵¹¹ These data inadequacies have also led to ineffective matching of the scarce available resources to populations leading to maladministration and maldistribution of the various available resources.⁵¹² The generally abysmal state of information gathering in the Nigerian health system is made worse by the top-down approach of the health system in its policy formulation and implementation. Enabled by the concentration of power in the hands of a few at the top, not enough consideration is given to health recipients for whom the policies are made. These sections of the populace that are intrinsic for data gathering are often not involved in the research or policy formulation process. Due to this, probably the most important component of the feedback loop of the health system is missing.

And so, while the Federal Ministry of Health (FMOH) may lay out health sector reforms, without the buy in and implementation of the other key actors, who often are closer to the people, the necessary uptake needed to see sustained reform at all levels will be lacking. It is not enough for the Ministry of Health to embark on health sector reforms without other relevant players at the various tiers of healthcare provision. While this has often not being the case, all tiers of the health system need to be active collaborators working towards shared goals. This kind of multi-level coordination is necessary if the right to health as envisaged by the NHA is to be realised.⁵¹³

⁵⁰⁷ Ibid.

⁵⁰⁸ Ibid.

⁵⁰⁹ Ibid.

⁵¹⁰ See n371.

⁵¹¹ Ibid.

⁵¹² Ibid.

⁵¹³ Ibid.

The problem of over-politicising healthcare

A major ripple effect of the federal structure of healthcare in Nigeria is the over-politicisation of healthcare at the various levels of management and administration. An extension of the lack of a coordinated policy implementation is the subsequent lack of project and policy continuation.⁵¹⁴ Issues arise when policies are not properly communicated, implemented and monitored.⁵¹⁵ Health system policy implementation requires adequate feedback loops to ensure health system responsiveness.⁵¹⁶ Intended or already implemented policies thus need to be adapted to fit the actual needs of the health users, so as not to become obsolete.⁵¹⁷ While the proper proliferation of norms is already a herculean task because of the federal character of the Nigerian health system, it is further complicated by clashes in health leadership at the various levels, which may sometimes have little to do with the merits of policies.⁵¹⁸ These clashes are also compounded by the political motivation for 'quick wins' by political office holders at the various levels who want to be seen to be working. The changes that come as a result of wanting to be seen to innovate is that constant and often unnecessary change in policy direction usually stifles quantifiable progress.⁵¹⁹ The result of too many changes in policy direction is a lack of policy congruence and a tendency for trial and error, in the hopes that the new policies will work better even though they are often treated with the same negligence as the ones before.⁵²⁰ Health policies are better implemented when those charged with their fulfilment can identify the capacity challenges and the solutions required to address the identified challenges and are given the necessary time and tools required to implement them optimally.⁵²¹ However, recurrent flip-flops in policy direction result in moribund projects and constant restarts that cost time and money. The situation is made worse by the fact that, by and large, there is a gross mismatch between policy declarations and political will and commitment to such statements by the authorities in terms of budgetary provisions.⁵²² Government is often too concerned with gaining political legitimacy when it commits to unreasonable timelines backed by fallacies at the expense of the peoples' health.⁵²³ Policy formulation

⁵¹⁴ See n293.

⁵¹⁵ Ibid.

⁵¹⁶ Corrigan, and Molla S. Donaldson. Eds. *To Err is Human: Building a Safer Health System*. Washington (DC): National Academies P, 2000.

⁵¹⁷ See n371.

⁵¹⁸ Ibid.

⁵¹⁹ Ibid.

⁵²⁰ See n293.

⁵²¹ Uneke, Chigozie J., et al. "Development of health policy and systems research in Nigeria: lessons for developing countries' evidence-based health policy making process and practice." *Healthcare Policy* 6.1 (2010): e109.

⁵²² Ijadunola, K. T. "Free health services in Nigeria: how beneficial to the poor." *Department of Community Health. College of Health Sciences, Ile-Ife* (2016).

⁵²³ Ibid.

is not enough to yield quantifiable gains in health system growth. The actual work of application is required.

The problem of constant vacillation in policy implementation is further complicated by the overconcentration of power in the hands of a few political appointees.⁵²⁴ This power dynamic often means that the success of policies may rest solely on the political will of the appointee to act and fulfil their responsibilities as laid out in the relevant law or policy. As seen over time in Nigeria, the political will to act is often tied to the perception of authorship of an intervention.⁵²⁵ However, such a narrow-minded approach is often counterproductive. Policy implementation must transcend the political dispensation at any given time to be sustainable over time. This is especially so, since health systems, by their very nature, take a long time to change and for that change to become visible enough. By extension, the appointment of competent health managers ought not to be subject to undue political influence. The problem with a system that rewards political patronage over and above quality and efficiency is that it is more likely to continue to produce mediocre results as gratification and promotion is not linked to productivity.⁵²⁶ Leaving change up to political office holders discountenances the realities of the very system intended to be changed and makes it vulnerable to constant interference, which is itself counterproductive to the change envisioned by the act.

The challenge of mismanagement and misappropriation of already underfunded health resources

Health financing and resource management is a complex part of the proper running of an effective healthcare system. This is especially so when bearing in mind the context of the country's limited resources, with increasingly less of it going towards healthcare. In this sort of situation, every little amount counts and it must be strategically deployed to realise the most benefit for the greatest number of people. With a health budget of N427 billion, equivalent to just over \$1 billion in 2020 for example, Nigeria must find a way to equitably allocate its resources to adequately cater for its recurrent expenditure, while advancing the reform of healthcare through sizeable capital

⁵²⁴ See n371.

⁵²⁵ Ibid.

⁵²⁶ Savas, Emmanuel S., and Sigmund G. Ginsburg. "The Civil Service-a Meritless System?." *The Public Interest* 32 (1973): 70.

See also, Blunt, Peter, Mark Turner, and Henrik Lindroth. "Patronage, service delivery, and social justice in Indonesia." *International Journal of Public Administration* 35.3 (2012): 214-220.

expenditure.⁵²⁷ In doing this, the structure of PHC, which serves as the bedrock of the country's health system, must not be abandoned. As it currently stands, over 70% of this amount – N336 billion – is earmarked for recurrent expenditure, like medical staff salaries.⁵²⁸ Forty-six billion naira is earmarked for capital expenditure (medical infrastructure and equipment) while just 44 billion naira is set aside for the Basic Healthcare Fund (actual service delivery), which amounts to 220 naira per citizen for the year.⁵²⁹

Traditionally, to overcome the budgetary constraints to capital investments in the tertiary hospitals, the federal government has over the years, adopted a 'special projects' approach to fund major upgrades in the health system. Funds are earmarked for these projects outside the standard budget and sometimes funding is also sourced from partners. These special projects are usually determined by each government as part of their broad reform agenda when they come into power.⁵³⁰ Public-private partnerships (PPPs) have also been adopted in recent years. Some of the different models that are currently being used in Nigeria are: government solely finances infrastructure and contracts a private operator to operate the facility; government and private partner co-investing and co-owning the facility and contracting an independent private operator; having an operator co-investing with government to show commitment and share risks.⁵³¹ Unfortunately however, most of these new funding initiatives have focused on the big capital intensive projects and have left the PHC centres largely unfunded.⁵³² This skewed funding approach has led to grassroots care going unattended and as an extension, creating a preference for service from tertiary centres, ultimately overburdening them.

Sadly, the system of patronage combined with corruption, can mean that what little work is carried out is done arduously and with a great economic burden on the system. With a proclivity for diverting already limited resources meant for the realisation of health system goals, institutionalised graft means that actually very little gets done.⁵³³ There have been several well publicised corruption scandals in the health sector, with some being at the highest levels of leadership. A former minister of health was fired in 2008 for her complacency in the sharing of N300 million unallocated health sector funds.⁵³⁴ In all, such incidences not only deprive the nation and the health system of much

⁵²⁷ Paul Adepoju, "A breakdown of Nigeria's 2020 budget for health", *Healthnews.ng*, 2020, available at <https://www.healthnews.ng/a-breakdown-of-nigerias-2020-budget-for-health/>, accessed on 13 October 2020.

⁵²⁸ Ibid.

⁵²⁹ Ibid.

⁵³⁰ See n462.

⁵³¹ Ibid.

⁵³² See n293.

⁵³³ Ibid.

⁵³⁴ Ibid.

needed funds, but it also ultimately leads to a lack of faith in the system both at home and abroad, consequently stifling other opportunities for funding.

Problems of inadequate health infrastructure

Health infrastructure, from an all-inclusive lens, has to do with people, institutions, and legal framework, all interacting systematically to mobilise and allocate resources specifically for health management, prevention and care of diseases, illnesses and injuries.⁵³⁵ By and large, however, health infrastructure often refers to the equipment, tools and systems in place that make it possible for the health workforce to deliver on its mandate to provide health services. The current responsibility of providing health infrastructure is spread out across the various tiers of government, who often provide infrastructure to the facilities for which they are responsible. However, as noted above, scarce resources and their mismanagement often mean that not enough is available to properly provide the necessary health infrastructure.

In addition, the fluid system of management of health services within the health system often mean that infrastructure provision is targeted at sites that can provide the most political capital and not necessary where they are most needed. As such, the drive to improve the tertiary healthcare is paramount as it is a more politically attractive step. This kind of one-sided attention is however detrimental to the other levels of care. The neglect of the primary healthcare system, its maldistribution as well as the neglect of secondary healthcare, result in an inverted healthcare pyramid.⁵³⁶ While rural areas, which actually constitute the majority of Nigeria's geographical and population majority, are largely underserved due to neglect, what little attention is paid to healthcare provision is done by focusing efforts on urban areas in the country.⁵³⁷ For the most part, the federal government and the state governments often have more material and financial capacity necessary for the construction and maintenance of healthcare facilities. As such they play a key role in determining if, how, when, and where health facilities are built and deployed. This trend is also the case in the spread of private medical facilities, which are concentrated in urban areas due to their primary incentive of profit maximisation.

⁵³⁵ Ademiluyi, Isreal A., and Sunday O. Aluko-Arowolo. "Infrastructural distribution of healthcare services in Nigeria: An overview." *Journal of geography and regional planning* 2.5 (2009): 104-110.

⁵³⁶ Asuzu, Michael C. "Commentary: The necessity for a health systems reform in Nigeria." *Journal of community medicine and primary healthcare* 16.1 (2004): 1-3.

⁵³⁷ See n535.

Lack of drugs is also still an important resource constraint in Nigeria. Important medication for malaria, HIV/AIDS and tuberculosis is still severely lacking.⁵³⁸ This is despite substantial increases in funding, as in the case of the Global Fund to fight AIDS, Tuberculosis and Malaria. There are thus still deficiencies in the building of effective and accountable national procurement and drug management systems as a component of the health system.⁵³⁹ To make up for the shortfall and a way to take advantage of the ever-increasing demand, the drug system has been plagued with fake, substandard, adulterated, and unaffordable drugs.⁵⁴⁰ Erratic supplies, non-availability of some basic essential and specialised drugs and other health supplies as a result of the dependence on imported drugs are common. In addition to this, the drug distribution system is chaotic because of adherence to pharmaceutical regulations that need to be updated. Although very vital for the provision of quality service, provision of drugs and vaccines alone cannot build systems nor ensure quality of care, but without the appropriate facilities and materials to do their job, health workers cannot function. Sadly, whenever health systems cannot deliver, people turn elsewhere. This has contributed greatly to poor client satisfaction, which makes clients to turn to the private sector and unqualified health workers. This poor drug supply system has unfortunately also led to drug resistance, with the current problem of the resistance to anti-malaria drugs by the disease pathogens being a clear example.⁵⁴¹ The provision of health services relies on the availability of regular supplies of drugs and equipment, as well as appropriate infrastructure at the facility level. Sadly, many facilities in many states of the country still operate without safe water and electricity, with non-functioning equipment, and inadequate deliveries of drugs, diagnostic and other supplies.⁵⁴² There is an infrastructural concern around the dearth of quality higher-level facilities that provide auxiliary health services. Diagnostic laboratories that aid in making proper diagnoses in most primary and secondary healthcare facilities across the country require infrastructural upgrading to provide safe, secure and appropriate results.⁵⁴³ This is in addition to the fact that many of the workers in these laboratories are often undertrained and are not sufficiently qualified to carry out the work they do.⁵⁴⁴

⁵³⁸ See n293.

⁵³⁹ Ibid.

⁵⁴⁰ Ibid.

⁵⁴¹ Ibid.

⁵⁴² Ibid.

⁵⁴³ Ibid.

⁵⁴⁴ Ibid.

A skewed healthcare service model and inadequate primary healthcare approach

The PHC model has over the years been accepted as the Nigeria's main structure of delivering healthcare services to the people. All other tiers of healthcare are considered as being built on the foundation of PHC. While PHCs are meant to cover basic health services, which may sometimes only require the services of community health workers, comprehensive health centres provide both PHC-type health services as well as a limited number of secondary clinical services. As such, they are expected to have at least three doctors on their staff.⁵⁴⁵ There should be at least one comprehensive health centre per local government area. In addition to this, each ward (which is an electoral delineation comprising of clusters of neighbourhoods) should have at least one Basic Essential Obstetric and Neonatal Care Centre staffed by medical personnel, which may include doctors currently serving in the mandatory National Youth Service Corps (NYSC) for all fresh graduates (where available), two midwives, two community health officers with nursing/midwifery background; senior and junior community health extension workers, laboratory and pharmacy technicians, all offering basic preventive and curative services.⁵⁴⁶

The necessary action to back the requirements for a robust PHC model has been largely subpar.⁵⁴⁷ Due to limited funding and poor management, the current state of the PHC system in Nigeria is poor with only about 20% of the 30,000 PHC facilities across Nigeria working. Presently, most of the PHC facilities in Nigeria lack the capacity to provide essential healthcare services. This is due to poor staffing, inadequate equipment, poor distribution of health workers, poor quality of healthcare services, poor condition of infrastructure, and lack of essential drug supplies.⁵⁴⁸ In part, problems with the implementation of the PHC in Nigeria are related to the hand-over in the 1980s to the local government administration, which is the weakest level of government, both at the financial and administrative level.⁵⁴⁹ The impact of local government administration (LGA) on the people in Nigeria remains a subject of intense debate. The LGA level is the least funded and least organised level of

⁵⁴⁵ Uzochukwu, B. S. C, et al, "Primary healthcare systems (PRIMASYS): case study from Nigeria." *World Health Organization*, 2017, available at https://www.who.int/alliance-hpsr/projects/alliancehpsr_nigeriaprimasys.pdf, accessed on 13 October 2020.

⁵⁴⁶ Ibid.

⁵⁴⁷ See n536.

⁵⁴⁸ Chinawa, Josephat M. "Factors militating against effective implementation of primary healthcare (PHC) system in Nigeria." *Annals of Tropical Medicine and Public Health* 8.1 (2015) at 5.

⁵⁴⁹ Okafor, Jude. "Local government financial autonomy in Nigeria: the state joint local government account." *Commonwealth Journal of Local Governance* 6.1 (2010): 127-131.

government and therefore has not been able to properly finance and organise primary healthcare, thereby creating a very weak base for the healthcare system.⁵⁵⁰

There are also concerns around the urban/rural divide in spatial distribution of PHC facilities. Eighty percent of these facilities are in urban areas, while the rural areas that have more need of them do not have enough. This special disparity is also replicated in the distribution of private health facilities, which are driven by profit and hence more likely to be situated in urban areas, especially in the southern part of the country. Even at the higher levels of care, the north is at a disadvantage with fewer public secondary health facilities.⁵⁵¹

The poor state of PHC facilities is not helped by the constant propping up of tertiary-level care to the detriment of others, which in turn makes it the most effective level of healthcare. The effect of this is that tertiary care facilities become oversaturated. This skews the referral system, which is an integral part of the health service delivery structure of the health system. It is meant to create an interconnected network of health facilities at various tiers and levels, such that necessary services are available either directly or through the referral channel to end users of the health system. Apart from ensuring the availability of necessary services, it is also meant to help regulate treatment at various levels, ensuring that minor health concerns are given adequate attention at the lower levels of the healthcare delivery system, while more complex cases are treated by better equipped and trained specialists who have both the time and tools to address the complex health concerns. PHCs are therefore supposed to be the point of first contact of patients and are meant to address many of the health concerns of the populace without needing to go up to the higher levels of care.⁵⁵² However, studies have shown that 92.9% of patients at tertiary hospital reported directly to tertiary hospitals without necessarily being referred there.⁵⁵³ Most patients were either referred from private clinics, or outrightly bypassed primary and secondary levels of healthcare because of the perception that they would not get proper care there. Unfortunately, due to this propensity to bypass the lower levels of medical care and report directly to tertiary healthcare centres, there is an overcrowding of health facilities with problems that can and should be managed at the lower levels.⁵⁵⁴ The resultant effect is that highly skilled manpower and equipment are wasted on health problems requiring lesser resources to solve. Apart from the largely justified lack of faith in the lower cadres of health facilities, the lack of a well-designed referral system with defined procedures, management support and

⁵⁵⁰ See n462.

⁵⁵¹ Ibid.

⁵⁵² Akande, T.M. "Referral system in Nigeria: study of a tertiary health facility." *Annals of African Medicine* 3.3 (2004):130-133.

⁵⁵³ Ibid.

⁵⁵⁴ Ibid.

appropriate forms is another limitation to a proper and effective referral system that does not overburden tertiary facilities. Ultimately, lower tiers of care are underutilised, further reinforcing the underinvestment in them, while the tertiary facilities that are receiving limited funding can also not function optimally due to being overburdened. Long patient waiting times at tertiary facilities also further exacerbate the inefficiency.⁵⁵⁵ The resultant inefficiency even at the highest levels of care further creates the impression that further extension and development of these facilities is required when in fact the real need is for an increase in the number of effectively functioning primary and secondary healthcare centres.⁵⁵⁶

Another concern that arises from the underfunding and underutilisation of PHC facilities is the resort to self-help by many who cannot afford to go to the tertiary care facilities. The persistent lack of access to proper healthcare further worsens their ignorance on proper health practices and makes them susceptible to being taken advantage of by charlatans masquerading as traditional medicine practitioners. Another problem of a largely ignorant populace is the low levels of consumer/health user awareness of available services and as a result, low levels of usage and participation in the health system.⁵⁵⁷ Where there is inadequate understanding of what services ought to be available to the health user, the ability to make the claim for them is greatly diminished. All this only serves to further alienate the health system from the people for whom it is intended to serve, sowing seeds of mistrust, and enabling a vicious cycle of poor health and inadequate medical intervention.

The challenge of remunerating the health workforce

As powerful as well-driven leadership with the right norms and values is, its policies may be incapacitated by a poor, ill-motivated and even unskilled health workforce. The health workforce is meant to be a well performing cohesive unit that works in a manner that is responsive, fair and efficient. Unfortunately, the problems of limited facilities at all levels of healthcare converge with the challenge of a sufficiently skilled workforce. While Nigeria has a relatively large health workforce by numbers, there is spatial disparity in where they are concentrated. The concentration of these workers is in the urban commercial areas, and although efforts have been made by many states to provide incentives for health workers to volunteer to serve in rural areas, not much has been achieved in

⁵⁵⁵ Dunne, M. O., and A. J. Martin. "The appropriateness of A&E attendances: a prospective study." *Irish medical journal* 90.7 (1997): 268-269.

⁵⁵⁶ See n552.

⁵⁵⁷ See n293.

creating a significant shift.⁵⁵⁸ Professional medical personnel are disproportionately distributed to teaching hospitals, as urban-based hospitals are relatively better stocked with what health infrastructure is available.⁵⁵⁹ The inadequacy of personnel is both an offshoot of inadequate health facilities and on the converse is one of the reasons for the inadequacies of health facilities. Generally, professional healthcare workers like doctors and other highly skilled professionals would prefer to stay in the urban areas, especially where there is adequate infrastructure, to practise their profession. Apart from this, resources like water, energy (electricity), good roads, shelter, school for children, employment for spouses, which would otherwise likely attract these personnel to sub-urban and rural areas, shanties/ghettos in urban outskirts and blighted environments or slum areas in the urban areas, are not generally provided in these geographic locations.⁵⁶⁰

There is also a noticeable disparity in the numbers of healthcare workers in the south of the country, with the south having more doctors per capita for example.⁵⁶¹ Other skilled health workers like nurses and auxiliary staff are also disproportionately spread.⁵⁶² In addition to the spatial difference, there is the difference in staff uptake in the various tiers. Most doctors and nurses work either in secondary and tertiary level health facilities or in private practices. PHC facilities are thus largely understaffed.⁵⁶³ The drive to make up for this short fall with community health practitioners is also yet to yield much fruit since this tier of healthcare is still greatly underfunded.

This problem is compounded by the challenge of health worker retention. The problem of health worker retention is two-tiered. On one hand is the need to retain workers in more underdeveloped parts of the country. On the hand is the need to keep the workers within the country in general. While many health workers refuse to work in underdeveloped and rural areas due to a lack of appropriate compensation, resources and/or security concerns, especially in the northern part of the country, in many other instances, they outrightly emigrate to other countries in search of better working and living conditions.⁵⁶⁴ Out of the 72,000 doctors registered with Medical and Dental Council, only about 27,000 are practising in Nigeria, while others are practising outside the country.⁵⁶⁵ Up to 7,000

⁵⁵⁸ See n464.

⁵⁵⁹ Adebajo, A. A., and S. I. Oladeji. "Health Human Capital Condition: Analysis of the Determinants in Nigeria." *Traditional and modern health systems in Nigeria*. Eds. T. Falola, and M.M. Heaton. Trenton, NJ: Africa World P, 2006. 381-398.

⁵⁶⁰ See n535.

⁵⁶¹ Ibid.

⁵⁶² Ibid.

⁵⁶³ Ibid.

⁵⁶⁴ See n464.

⁵⁶⁵ Chioma Obinna, "Why Nigerian Doctors are rushing abroad- NMA, Others", *The Vanguard*, 27 April, 2019 available at <https://www.vanguardngr.com/2019/04/why-nigerian-doctors-are-rushing-abroad-nma-others/> accessed 20 April, 2020.

Nigerian doctors work in British and the American public health sectors, while some have left the medical profession all together due to poor working conditions.⁵⁶⁶ As of 2019, the NMA stated that there were only 40,000 doctors to care for 200million people in Nigeria, contrary to the assertion of a Federal Minister that the country had more than enough doctors and could afford to “export” them.⁵⁶⁷ However, despite these stark figures, a recent federal minister of health was known to have made disparaging remarks concerning the nation’s doctors, stating that those unable to practice medicine due to inadequate facilities, should consider alternative trades like farming.⁵⁶⁸ In a similar vein, a federal Minister of Labour, who is also a medical practitioner by training and had served in the public health system, said that the mass migration of doctors was not an issue of concern as Nigeria had more than enough doctors and could afford to ‘export’ to other countries.⁵⁶⁹ Amid all this, the country still suffers from perennial industrial action taken by doctors, nurses, and other axillary health workers at all the various levels of healthcare due to poor conditions of service, all of which have had an adverse effect on the health system and service delivery to end users. The abysmal care given to health workers has most recently been exemplified in the refusal to pay frontline health workers an adequate hazard allowance for serving in the nation’s Covid-19 response. This action has once again highlighted the persistent disdain for the welfare of health workers. However, due to the context of this most recent refusal by the State to treat health workers fairly, there has been a renewed public outcry against the government as well as a parliamentary hearing where an adamant Minister of Health was seen to be justifying the government’s incalcitrant position on the matter.⁵⁷⁰

Government, as the largest employer of health workers, needs to channel its resources in a manner that places a premium on the skillset of its health workforce as opposed to frittering its funds on even more unnecessary capital expenditures aimed at quick political gains. Ultimately, better working and living conditions as well better remuneration are what will draw skilled health personnel to work at levels of healthcare and especially in the PHC facilities in rural areas, since it is these considerations

⁵⁶⁶ Ibid.

⁵⁶⁷ Olufemi Atoyebi, “NMA, NARD tell Ngige: You’re wrong, as only 40,000 doctors care for 200m people in Nigeria”, *Punch Newspaper*, 24 April 2019, available at <https://punchng.com/nma-nard-tell-ngige-youre-wrong-as-only-40000-doctors-care-for-200m-people-in-nigeria/> accessed on 20 April 2020.

⁵⁶⁸ Paul Adepoju, “A breakdown of Nigeria’s 2020 budget for health”, *Healthnews.ng*, 2020, available at <https://www.healthnews.ng/a-breakdown-of-nigerias-2020-budget-for-health/>, accessed on 13 October 2020.

⁵⁶⁹ Muanya, Chukwuma and Daniel Eniola. “Doctors can leave, Nigeria has enough, says Ngige”, *The Guardian*, 25 April 2019, available at <https://guardian.ng/news/doctors-can-leave-nigeria-has-enough-says-ngige/> accessed 20 April, 2020.

⁵⁷⁰ Yusuf Akinpelu, “Nigeria’s health minister unaware medical workers battling coronavirus don’t get ‘hazard allowance’” *Premium Times*, April 10 2020, available at <https://www.premiumtimesng.com/news/headlines/387169-nigerias-health-minister-unaware-medical-workers-battling-coronavirus-dont-get-hazard-allowance.html>, accessed on 20 April 2020.

that often lead them to work in other places.⁵⁷¹ It is, however, not enough to have a well-trained and motivated workforce. The workforce must be equitably distributed across the nation based on an impartially established set of guidelines that ensure that the allocation of healthcare personnel is through an appropriate distribution system across the entire health system. Taking these steps in addition to the provision of better health infrastructure to assist health workers to hone their skills and deliver better care to their patients is necessary for health worker satisfaction and a stronger healthcare system.

Conclusion

The factors that affect the delivery of healthcare in Nigeria have been shown above to include: inadequate health facilities/structure; poor human resources management; poor remuneration and motivation; lack of equitable and sustainable healthcare financing; unequal bargaining power; corruption; illiteracy; persistently low government spending on health; persistent shortages of essential drugs and supplies; and an insufficient number of healthcare workers.⁵⁷²

While the NHA has laid out laws on what is the expected ideal for the Nigerian health system and in some instances laid out a way to address the ongoing concerns and fix the highlighted problems, there is still a lack of political will. Ultimately, the role of leadership and governance in highlighting the problems, mapping out solutions and implementing them is a primary factor that cannot be overlooked. Responsibility for the performance of a country's health system lies with government,⁵⁷³ who must begin to deliver on its responsibilities.

The poverty and despondence of the populace has long been permissive of the State's negligence in fulfilling its duties. Deliberate effort to educate and enable individuals and communities is thus important both for demanding better healthcare, as well as exercising better agency in the management of the factors within their control, in furtherance of more favourable health outcomes.

⁵⁷¹ See n535.

⁵⁷² See n293.

⁵⁷³ World Health Organization. *The world health report 2000: health systems: Improving performance*. Geneva: World Health Organization, 2000.

Chapter 5

The current legal framework for the right to health in Nigeria

Introduction

In the face of the various challenges faced by the Nigerian health system over the years, there has been a concerted effort to use the law as a tool for compelling State action to deliver better healthcare. However, until very recently, the existing legal framework on the right to health has been incapacitated by several hurdles embedded in the relevant laws and the procedures for their enforcement. More recent legislative interventions and judicial rules of interpretation have created a wider space within which the law can be effectively utilised to enforce the right to health. However, even this intervention, like their prior counterparts are subject to several constraints. And so, while the whole gamut of laws that provide for various aspects of the right to health are robust in their scope, there are several factors that limit the application of their scope and content. These laws, beginning from the international and regional instruments that Nigeria is a signatory to, are here discussed, highlighting both their relevance to the right to health as well as the extent of their applicability and the implications for the understanding of the law on the right to health in Nigeria. This task will similarly be carried out with the domestic laws that have significance to the right to health in Nigeria as well as the management of the health system, which is a major conduit for delivering on that right.

While the state of the law may sometimes appear contradictory when factoring the provisions of the various instruments that provide for health in Nigeria, through an analysis that takes into consideration both form and function of the various laws, it is possible to decipher the nature and scope of the right to health in Nigeria. From the analysis done in this chapter, I make the case that, while the aspirations considering the right to health are robust and encompassing, the actual scope of the State's duties have been narrowed down significantly and made subject to terms that, while desirous of progressive realisation, only demand a minimum core.

The right to health in International law

International law on the right to health is the foundation upon which the global health regime is based. It sets out the mandate of various State parties both as individual duty bearers as well as in

collaboration for a coordinated global health response.⁵⁷⁴ It importantly sets out the fundamental premise of State parties as the primary duty bearers responsible for respecting, protecting and ultimately, fulfilling the right to health. Because Nigeria is also a signatory to these international laws and principles, it is important to foreground them to arrive at an understanding of the nature and content of the right to health in Nigeria.

The Universal Declaration of Human Rights

The Universal Declaration of Human Rights (UDHR)⁵⁷⁵ is the first international instrument where all acceding State parties laid out what constitute universal human rights. While the Declaration is not a binding legal instrument,⁵⁷⁶ it still holds weight as both a defining moment in the history of human rights and as the guiding ethos of human rights. In a sense, it is the gold standard to which States must aspire.⁵⁷⁷ In this pivotal instrument, the right to health is provided for in Article 25(1) which states:

Everyone has the right to a standard of living adequate for the health and well-being⁵⁷⁸ of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.⁵⁷⁹

It is important to note that this initial conception of the right to health focuses on enabling the ability of the individual to achieve optimal health by having the necessary access to the various conditions and tools that will guarantee a life that can be healthy. This crafting of the right understands it as dependent on both healthcare as well as the social determinants of health. Based on the provisions of the UDHR, it is not enough for a man to pursue good health as an individual in charge of his fate. The state must also equip him with the ancillary social and economic wherewithal to make the realisation of optimal health practical and attainable.

Providing for the right to health as both the right to healthcare services, goods and facilities, as well as the right to the underlying determinants of health is also a recognition of the interdependent nature

⁵⁷⁴ Paragraph 40 UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant)*, 11 August 2000, E/C.12/2000/4.

⁵⁷⁵ UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

⁵⁷⁶ Glendon, Mary Ann. "The rule of law in the Universal Declaration of Human Rights." *Nw. UJ Int'l Hum. Rts.* 2 (2004): 1.

⁵⁷⁷ United Nations, "The foundation of International Human Rights law", available at <https://www.un.org/en/sections/universal-declaration/human-rights-law/>, accessed on 10 October, 2019.

⁵⁷⁸ Emphasis mine.

⁵⁷⁹ Article 25, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

of human rights.⁵⁸⁰ This framing of the right highlights that optimal health contributes to and is reliant on realisation of other human rights.⁵⁸¹ Such an exposition is further important when considering that the realisation of the right to health is a necessary precursor to the realisation of other socio-economic rights; a fact which causes it to be seen by some as central to the overarching project of fulfilling socio-economic rights as a whole for human development.⁵⁸²

While the UDHR is a declaration by participating State parties, the first international covenant with legal authority that provides for the right to health is the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁵⁸³

The International Covenant on Economic, Social and Cultural Rights

Unlike the International Covenant on Civil and Political Rights (ICCPR),⁵⁸⁴ which as its title suggests provides for the civil and political rights, the ICESCR protects socio-economic rights, including the right to health. Article 12 of the ICESCR provides that:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

⁵⁸⁰ Winston, Morton. "On the indivisibility and interdependence of human rights." *The Paideia Archive: Twentieth World Congress of Philosophy* 7 (1998): 54-61.

⁵⁸¹ World Health Organization. "Office of the United Nations High Commissioner for Human Rights." *The Right to Health. Fact Sheet No 31* (2008).

⁵⁸² See n35.

⁵⁸³ UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. GA res. 2200A (XXI), 21 UN GAOR Supp, (No. 16) at 49, UN Doc. A/6316 (1966); 993 UNTS 3; 6 ILM 368.

⁵⁸⁴ UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171. GA res. 2200A (XXI), 21 UN GAOR Supp (No 16) at 52, UN Doc.A/6316 (1966); 999 UNTS 171; 6 ILM 368 (1967).

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

The ICESCR is especially important because it provides the most comprehensive provision on the right to health in international human rights law.⁵⁸⁵ The exposition given by Article 12 of the ICESCR is important for understanding the right to health. The article is a broader extrapolation of the nature and content of the right to health. For one, it expressly provides that States have an obligation to acknowledge the right of people to enjoy the maximal health they can. This provision recognises that the concept of “the highest attainable standard of health” takes into consideration the fact that people have genetic, biological, and socio-economic preconditions that ultimately affect their health and life outcomes, which cannot be controlled by the State.⁵⁸⁶ Article 12.1 also precludes States from interfering with the enjoyment of the right by mandating State respect for its enjoyment. However, the obligations of the State in this regard transcend recognising the right to be healthy. The duty of the State transcends non-interference.⁵⁸⁷ Such a narrow interpretation of the right to health would severely limit the obligations of the State to only respecting the individual autonomy of the individual to pursue choices that can guarantee his health.

Subsection 2 of Article 12 goes on to provide that States have a further duty to take active steps to realise the right as provided for in the Covenant. It lists several necessary aspects of health that require a programmatised approach to achieving. By requiring States to not only respect and protect the right to health but to take steps to fulfil it, it moves the domain of the right to health from the mere recognition of the right of the individual to be healthy to one of the duty of the State to do all that is possible and necessary for the optimal health of its people.

Regarding the State’s duty to fulfil, paragraph 5 of General Comment 14 by the UN Committee on Economic, Social and Cultural Rights, states that it is imperative to distinguish the inability of a State from its unwillingness; acknowledging that there are in fact tangible burdens on the State even if it may currently not be able to meet them all.⁵⁸⁸ As such, while the General Comment makes an effort not to saddle States with an overly burdensome and unattainable goal, it also seeks to discourage disingenuous inaction.

The obligation to fulfil is by extension a validation of the people’s right to demand this fulfilment from the State. This is further buttressed by the provisions of paragraph 59 of General Comment 14 which

⁵⁸⁵ See n33.

⁵⁸⁶ Paragraph 9, General comment 14, 2000.

⁵⁸⁷ Ibid at Paragraph 8.

⁵⁸⁸ Ibid at Paragraph 5.

states: “Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.”⁵⁸⁹

This provision is a more robust exposition on Paragraph 33, which provides that an essential element of realising the State’s obligation to fulfil is in the provision of appropriate administrative, judicial and promotion measures, amongst others. The General Comment also importantly states that the full enjoyment of the right to health is in pursuit of the possibility of a dignified life.⁵⁹⁰ This allusion to dignity is important as it serves both as a threshold for determining a bare minimum expectation as well as illustrating how intrinsically linked the right to health and dignity are.

In essence, the right to health includes both freedoms and entitlements,⁵⁹¹ i.e., it is both a right in the negative and in the positive sense.⁵⁹² The freedoms include the right to control one’s health and body and to be free from interference especially when against the will of the person. The entitlements on the other hand include having the right to an effective health system that gives everyone the equal opportunity to enjoy the highest attainable level of health as well as being assured that the socio-economic conditions of their lives that surround their ability to enjoy the right to health optimally are constantly improved upon at an appreciable pace.⁵⁹³

The right to health at the regional level

Various regional institutions have interpreted the whole range of rights against the backdrop of their social, political, cultural, and economic histories and realities, and so while the list of rights protected by the various regional instruments bear similarities, their focuses differ, as do their underlying

⁵⁸⁹ Ibid at Paragraph 59.

⁵⁹⁰ Ibid at Paragraph 1.

⁵⁹¹ Ibid at Paragraph 8.

⁵⁹² Murphy, Thérèse. *Health and human rights*. London: Bloomsbury Publishing, 2013.

See also Mzikenge Chirwa, Danwood. "The right to health in international law: Its implications for the obligations of state and non-state actors in ensuring access to essential medicine." *South African Journal on Human Rights* 19.4 (2003): 541-566.

⁵⁹³ Leary, Virginia A. "The right to health in international human rights law." *Health and Human Rights* (1994): 24-56.

premises.⁵⁹⁴ The African Charter on Human and Peoples' Rights,⁵⁹⁵ (The African Charter) is Africa's regional human rights instrument. It, unlike the European instruments for example, does not provide separately for political and economic rights. In fact, the preamble of the African Charter provides that civil and political rights cannot be disassociated from economic, social and cultural rights in their conception as well as universality.⁵⁹⁶ This represents a stance that sees rights as truly interdependent, realising that political rights are of no merit without the rights to social, cultural and economic wellbeing to provide the context to enjoy those rights.⁵⁹⁷ It also recognises that while political rights are effective tools in realising the fulfilment of socio-economic rights, the institutions for which political rights are meant to uphold and protect can be destroyed when socio-economic rights are not met.⁵⁹⁸ This viewpoint is important to understand and explore, especially considering that Nigeria is a party to the African Charter and has gone on to further domesticate it as local law. The regional stance of the Charter thus not only influences Nigeria's interpretation and understanding of rights but determines how socio-economic rights are to be understood and implemented.

The African Charter

The African Charter represents the values agreed on by member African states and is unique in how it imbibes the African notion of corresponding rights and responsibilities.⁵⁹⁹ In the Charter, a person is entitled to rights, as well as having corresponding duties. According to this understanding of rights, people have fundamental rights whose enjoyment is dependent on the accession and cooperation of other people and the community as a whole.⁶⁰⁰ As such, due to the dependence of rights on the accession of others to their validity, the enjoyment of the rights then place corresponding duties on

⁵⁹⁴ The American Convention on Human Rights, 1969, and its Protocols of 1988 and 1990 apply to the member nations of the Organization of American States. It provides for the right to health in Article 11 and states that every person has the right to the preservation of his health through sanitary and social measures relating to food, clothing, housing, and medical care, to the extent permitted by public and community resources. See, Organization of American States (OAS), *American Convention on Human Rights, "Pact of San Jose", Costa Rica*, 22 November 1969. Asia on the other hand has no binding conventions but has the ASEAN Human Rights Declaration which provides copiously for the right to health in Articles 28 and 29. See, Association of Southeast Asian Nations (ASEAN), *ASEAN Human Rights Declaration*, 18 November 2012.

In Europe, there is the EU Charter of Fundamental Rights, which protects the right to health in Article 35. *Charter of Fundamental Rights of the European Union (2007/C 303/01)*, 14 December 2007, C 303/1.

⁵⁹⁵ *African Charter on Human and Peoples' Rights*, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

⁵⁹⁶ The Preamble, African Charter on Human and People's Rights, 1982.

⁵⁹⁷ The preamble states that against the background of colonial operation in the past against African States, there is need to coordinate efforts to ensure a better life for all people in Africa. African Charter on Human and People's Rights, 1982.

⁵⁹⁸ The Preamble, African Charter on Human and People's Rights, 1982.

⁵⁹⁹ Deng, Francis Mading, et al. *Identity, diversity, and constitutionalism in Africa*. Washington, D.C: US Institute of Peace P, 2008.

⁶⁰⁰ Kohler, Thomas C. "Individualism and Communitarianism at Work." *BYU L. Rev.* 2.13 (1993): 727.

the beneficiary of the rights to others and to the collective.⁶⁰¹ This is fundamentally a relational understanding of the nature of law and the transactional nature of human relations.⁶⁰² As a reflection of this viewpoint, the preamble of the Charter states that while the fundamental nature of human rights is non debatable, they stem from the basic nature of human beings and their attributes, meaning that respect for them should be guaranteed, in essence implying that to deny them is to deny the humanity and inherent dignity of people.⁶⁰³ The preamble goes on to state that the recognition of this humanity implies that since humans do not live or operate in isolation, the enjoyment of their rights requires the performance of certain duties by everyone.⁶⁰⁴ Importantly, the preamble of the Charter provides that the essential focus is on development, civil and political rights as well as economic, social and cultural rights, which must be guaranteed in a way that ensures collective, side-by-side growth.

In this Afrocentric iteration of rights, the right to health is protected in Article 16, which provides:

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.
2. State Parties to the present Charter shall take the *necessary measures*⁶⁰⁵ to protect the health of their people and to ensure that they receive medical attention when they are sick.

In a manner like the ICESCR, the African Charter seeks to both protect individual health rights from undue interference and places a burden on States to fulfil the right for their people. While, on the face of it, the obligation to fulfil in this provision may be narrow and limited to the guarantee and provision of medical care through effective health services, where it provides that States should ensure citizens receive medical attention when sick, the demand on States to take 'necessary measures' aimed at protecting the health of their people broadens the ambit and gives wide powers to do all that is needed to guarantee good health. This would mean a wide fiat on the types of action that may be taken, including legislative, administrative, and judicial action as well as more unconventional collaborative action with populace and civil society where necessary and possible. It also implies that the goal of States is to "protect the health of their people", and as such, other social determinants of health that can enable such good health must be addressed.

⁶⁰¹ Metz, Thaddeus. "Ubuntu as a moral theory and human rights in South Africa." *African Human Rights Law Journal* 11.2 (2011): 532-559.

⁶⁰² Ibid.

⁶⁰³ The Preamble, African Charter on Human and People's Rights, 1982.

⁶⁰⁴ Ibid.

⁶⁰⁵ Emphasis mine.

Some scholars make the claim that the African Charter does not provide for the qualification of progressive realisation and maximum available resources for the realisation of economic, social and cultural rights.⁶⁰⁶ As a result, they have argued that the economic, social and cultural rights in the African Charter have to be realised immediately.⁶⁰⁷ While on the face of it, it is a well-intentioned assertion meant to instigate immediate State action to begin to fulfil their obligations to their people, it does not seem in line with the provisions of the Charter, for its states in its first article:

The Member States of the Organization of African Unity parties to the present Charter shall recognize the rights, duties and freedoms enshrined in this Chapter and shall *undertake to adopt legislative or other measures to give effect to them*.⁶⁰⁸

This language is like other international instruments, which place a mandate of progressive realisation. Because the phrase adopts “legislative and other measures” more likely means that the Charter has factored in the realities of the politics and bureaucracy of law making, which is in itself is not often a speedy process as well as the fact that “other measures” would most likely be determined as the need arises, thus being tantamount to a progressive realisation. A further argument may be made for the implausibility of the argument that the rights in the African Charter are not subject to progressive realisation. This is the fact of the socio-economic and political reality of many African States.⁶⁰⁹ While a counter may be made that progressive realisation lends itself to making rights end up as merely being aspirational, the truth is that socio-economic rights cannot be realised outside of the economic and political realities of a State. It is difficult to expect such economies as those prevalent in Africa to immediately overcome their structural problems and to marshal the resources necessary to provide for all socio-economic needs immediately.⁶¹⁰ The reality is that a great number of States lack the capacity to realise economic, social and cultural rights immediately.⁶¹¹ It would thus be counterproductive to interpret the seeming omission of express language delineating socio-economic rights as subject to progressive realisation as an ‘African understanding’ of rights.⁶¹² Further proof of the error of such a reading lies in the fact that subsequent charters that provide for rights of specific

⁶⁰⁶ See n46.

⁶⁰⁷ See n46.

⁶⁰⁸ Article 1, African Charter on Human and People’s Rights, 1982. Emphasis mine.

⁶⁰⁹ See n33.

⁶¹⁰ Mbazira, Christopher. "Enforcing the economic, social and cultural rights in the African Charter on Human and Peoples' Rights: twenty years of redundancy, progression and significant strides." *African Human Rights Law Journal* 6.2 (2006): 333-357.

⁶¹¹ Ouguergouz, Fatsah. *The African Charter of Human and People’s Rights: A Comprehensive Agenda for Human Dignity and Sustainable Democracy in Africa*. The Hague: Kluwer Law International, 2003.

⁶¹² Bahar counters the view that the omission is justified as forming part of the African notion of human rights. See n33.

groups, like the African Women's Protocol and Children's Rights Charter provide for progressive realisation of economic, social and cultural rights.⁶¹³

International law and regional instruments are in line regarding providing for the right to health as well as determining its normative content and requirements for fulfilment. A major challenge however lies in giving life to these instruments in local understandings and application of the instruments. This challenge is even more apparent where they may be seeming disparities with local legislation and there is thus need for determining the hierarchy of the various laws in order to determine their authority. In Nigeria, there are divergent views on the legal efficacy of socio-economic rights such as the right to health. While the Constitution has remained largely unchanged in this regard, emerging jurisprudence may help provide a richer interpretation of the law, as well as new legislation which can provide even better clarity on the right to health in the country.

Domestic law on the right to health in Nigeria

In Nigerian jurisprudence, the Constitution is the supreme binding legal document that lays out the norms and principles that govern the nation. In this hierarchy, the Constitution supersedes all other local law, which must be read with an eye on their consistency with the Constitution, barring which they are null and void to the extent of their inconsistency. By extension, the Constitution lays out the procedure and motivations for any subsequent legislation that is intended to give its provisions further exposition for better realisation. This understanding of the nature of the legislative landscape is important for the subsequent analysis of the law regarding the right to health in Nigeria.

The Nigerian Constitution

The right to health is contained in Section 17 of the Nigerian Constitution.⁶¹⁴ It forms a part of the FODP as contained in Chapter 2 of the Constitution. Section 17(3) provides thus:

The State shall direct its policy towards ensuring that-

(a) all citizens, without discrimination on any group whatsoever, have the opportunity for securing adequate means of livelihood as well as adequate opportunity to secure suitable employment;

⁶¹³ See n33.

⁶¹⁴ Constitution of the Federal Republic of Nigeria, 1999.

(b) conditions of work are just and humane, and that there are adequate facilities for leisure and for social, religious and cultural life;

(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;

(d) there are *adequate medical and health facilities for all persons*.⁶¹⁵

This section mandates the State to act and lay out policies to provide adequate medical facilities for every inhabitant within its borders. Section 17(3)(d) is a health facilities-focused interpretation of the nature of the requirements for the realisation of the right to health. However, the preceding subsection of Section 17(3) almost mimics the provisions of the UDHR in that it lays the groundwork for the right of all persons to be able to pursue a meaningful livelihood that would enable them the physical safety and state of wellbeing that would allow for a meaningful existence.⁶¹⁶ Sub-sections (b) and (c) then further go on to provide that, within the ambit of this pursuit of livelihood, the work undertaken by citizens to provide a suitable life for themselves must not impinge on the citizens' dignity and humanity and must also provide favourable and safe working conditions that are conducive for productivity, while not jeopardising good health. These preceding sections thus address the second prong of requirements for fulfilling the right to health, which address the social determinants of health.

A joint reading of all the subsections of Section 17(3) may then be read thus: the State has a duty to ensure that its policies create and enable a conducive environment for all within it to thrive and seek means to live with dignity and be able to meet their needs. The state has a further duty to ensure that the nature of work carried out to meet these needs are favourable for their purpose and are not detrimental to health. As an extension of the State's duties to ensuring a life of dignity and good health for its people, the State is required to provide the necessary medical facilities to cater for all those within it. Such a reading of the Section 17 provides a more holistic understanding of the intent of the drafters of the Constitution regarding what the right to health should look like in Nigeria.

However, the attendant benefits of such a rich interpretation have for the most part been lost due to the fact that the right to health is not expressly crafted as a right, but as a State obligation; one whose enforcement has been further hampered by its non-justiciable status in the Constitution. The non-

⁶¹⁵ Emphasis mine.

Section 17(3), Constitution of the Federal Republic of Nigeria, 1999.

⁶¹⁶ Section 17(3)(a), Constitution of the Federal Republic of Nigeria, 1999.

justiciability of Section 17 and other rights/ State obligations contained in Chapter 2 of the Nigerian Constitution is clearly provided for in Section 6(6)(c) of the Constitution, which states:

6) The judicial powers vested in accordance with the foregoing provisions of this section

(c) shall not *except as otherwise provided by this Constitution*,⁶¹⁷ extend to any issue or question as to whether any act of omission by any authority or person or as to whether any law or any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution;⁶¹⁸

The provisions of Section 6(6)(c) on the face of it may appear absolute in its assertion on the non-justiciability of Chapter 2 of the Constitution. However, the section provides that “except as otherwise provided for in the Constitution”, any content of Chapter 2 is non-justiciable. The implication of this is that any subject matter covered in Chapter 2 may be justifiable if it is subsequently specifically provided for in some other part of the Constitution. The question then arises as to where else the subject of health is provided for in the Constitution.

Section 45(1) states that:

Nothing in sections 37, 38, 39, 40 and 41 of this Constitution shall invalidate any law that is reasonably justifiable in a democratic society

(a) in the interest of defence, public safety, public order, public morality or public health;
or....⁶¹⁹

While this provision is limited in that it only provides justification for the limitation of certain human rights provided for in Chapter 4 and not in Chapter 2, it is instructive in that it empowers the State to make laws necessary for the protection of public health and lays the foundations for the right approach to balancing between private rights and public health rights.

However, a more relevant provision for the exception found in Section 6(6)(c) is contained in number 17 of the Concurrent legislative list,⁶²⁰ which provides for the extent of the powers of the federal and state legislatures. It provides:

The National Assembly may make laws for the Federation or any part thereof with respect to -

⁶¹⁷ Emphasis mine.

⁶¹⁸ Section 6, Constitution of the Federal Republic of Nigeria, 1999.

⁶¹⁹ Constitution of the Federal Republic of Nigeria, 1999

⁶²⁰ The concurrent list of the Nigerian constitution contains matter which both the federal and state legislative houses have the authority to make laws on, while the exclusive list contains matters that are in the purview of only the National Assembly.

- (a) the health, safety and welfare of persons employed to work in factories, offices or other premises or in interstate.⁶²¹

This provision empowers the National Assembly to make laws on the healthcare of all workers all around the country. In addition to this provision, the exclusive list in Part 1 of the Second Schedule also grants exclusive legislative powers to the National Assembly to legislate on various health-related issues, which include: Drugs and poisons per Item no 21 of the list, quarantine, as provided in Item no 54, as well as *the creation of federal authorities saddled with the responsibility of promoting the enforcement and realisation of the FODP in the Constitution*⁶²² as provided for in Item no 60.⁶²³ All of these read together indicate an intent for the National Assembly to be able to legislate on the matters of health for the nation; thus making health a subject matter that is mentioned outside of the provisions of Chapter 2 and for which the legislature has been given the right and mandate to pass legislation that gives life to issues of health and healthcare of the entire populace. This position has been upheld in the case of *Archbishop Anthony Olubunmi Okogie & Ors. v The Attorney-General of Lagos*⁶²⁴ where the court stated that the arbiter for any breach of the Objectives and Directive Principles of State Policy is the legislature itself or the electorate and that Chapter 2 is subject to legislative powers conferred on the State.⁶²⁵ In the case of the *Attorney General Ondo v Attorney General Federation*⁶²⁶ the Supreme Court also held that courts cannot enforce any of the provisions of Chapter 2 of the Constitution until the National Assembly has enacted specific laws for their enforcement. The Court went further to state that the Directive Principles can be made justiciable by legislation. In the case of *Federal Republic of Nigeria v Alhaji Mika Anache & Others*, Niki Tobi (JSC), stated: “In my humble view section 6(6)(c) of the Constitution is neither total nor sacrosanct as the subsection provides a leeway by the use of the words ‘except as otherwise provides by this Constitution’. This mean that if the Constitution otherwise provides in another section, which makes a section or sections of Chapter 11 justiciable, it will be so interpreted by the courts.”⁶²⁷ This explanation by the eminent jurist is an important point in understanding the nature and purpose of FODP; especially as contained in the Nigerian Constitution.

⁶²¹ Constitution of the Federal Republic of Nigeria, 1999.

⁶²² Emphasis mine.

⁶²³ According to item 60, The establishment and regulation of authorities for the Federation or any part thereof

(a) To promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution. See, Constitution of the Federal Republic of Nigeria, 1999.

⁶²⁴[1981] 2 NCLR.

⁶²⁵ Ibid.

⁶²⁶ *Attorney General Ondo v Attorney General Federation* (2002) 9 NWLR (part 772)

⁶²⁷ *Federal Republic of Nigeria v Alhaji Mika Anache & Others* (2004) LCN/3183(SC).

As shown above, while the Constitution lays the groundwork for the recognition of the need for a right to health, it requires subsequent subsidiary legislation to give it full expression. And so, while seeking to understand the right to health through a reading of the Constitution may lead to an interpretation that its provisions on the right to health are moot, understanding the responsibilities it places on the legislature for its full realisation is central to the analysis of other health-related legislation.

The African Charter (Enforcement and Ratification) Act

While the African Human Rights Charter is a regional instrument and has been discussed above, Nigeria operates a dualist legal system as provided for in Section 12(1) of the Constitution. The provision states that all foreign treaties must be ratified and passed by the legislature to have legal authority. This resulted in the passing of the African Charter (Enforcement and Ratification) Act.⁶²⁸ This requirement has led to some previous uncertainty as to the hierarchy of the African Charter Act vis á vis the Nigerian Constitution and other domestic laws. The courts have held that it is not above the Constitution as that would create a legal irregularity and would negate the position of the Constitution as the *Grundnorm*. However, the courts have gone on to say that it is of a higher level of authority than other legislation. These points were made in the case of *General Sani Abacha and Others v Gani Fawehinmi*,⁶²⁹ where the Supreme Court held that while the African Charter is a municipal law enforceable in Nigerian courts and is on a higher pedestal than other municipal law because of its international origins, it is, however, inferior to and cannot override the provisions of the Constitution from which it takes its authority. By virtue of this, its provisions on socio-economic rights and the right to health on the face of it are binding on the State and make the right to health a tangible right, thus shifting it from the ambit of mere State obligation to a clear right that may be demanded. This is in line with the Fundamental Rights Enforcement Procedure Rules of 2009, which provide:

3. The overriding objectives of these Rules are as follows:

(a) The Constitution, especially Chapter IV, as well as the African Charter, shall be expansively and purposely interpreted and applied, with a view to advancing and realising the rights and freedoms contained in them and affording the protections intended by them.

(b) For the purpose of advancing but never for the purpose of restricting the applicant's rights and freedoms, the Court shall respect municipal, regional, and international bills of rights cited

⁶²⁸ African Charter (Enforcement and Ratification) Act, Cap A 9 LFN 2004.

⁶²⁹ (2000) 6 NWLR 228 (Supreme Court of Nigeria).

to it or brought to its attention or of which the Court is aware, whether these bills constitute instruments in themselves or form parts of larger documents like Constitutions. Such bills include;

- (i) The African Charter on Human and Peoples' Rights and other instruments (including protocols) in the African regional human rights system,
- (ii) The Universal Declaration of Human Rights and other instruments (including protocols) in the United Nations human rights system.⁶³⁰

However, interpreting the full range of the normative content of the right to health based on the sparse wordings of the Charter, which were ratified as is, provide some challenges for domestic application to the specific Nigerian context. This limitation has however been addressed in the new National Health Act, which was passed in December 2014.

The National Health Act, 2014

The preamble of the National Health Act⁶³¹ states that the Act is to provide a framework for the regulation, development and management of a National Health System and set standards for rendering health services in the federation, as well as other related matters. The Act sets its purpose as being to lay out a health system framework for the country as well as determining what is obtainable within that framework.⁶³²

From the broad divisions of the Act, it is possible to see the intent of the legislator to adopt the WHO framework for health systems. This is especially when considering that the Act was driven by policy actors who had worked for the WHO and were familiar with the emerging trends and discussions in health systems policy and governance.⁶³³ The Act is broadly divided into seven parts. Part one is central to framing the responsibilities of the Nigerian Health System as well as providing for those who are eligible for the health services to be provided by the new National Health System, as created in that section. Part three is especially dedicated to outlining the rights of all under the newly created health system. It delineates the duties that go along with the rights of both the beneficiaries, which are the users, and the health providers, who are the personnel that dispense the right. This provision is

⁶³⁰ Fundamental Rights Enforcement Procedure Rules of 2009.

⁶³¹ Act No. 8 of 2014.

⁶³² Ibid, at Preamble.

⁶³³ Prof. Lambo, the principal initiator of the reforms had only just retired from the WHO's African Regional Office as its leading health economist.

particularly important because not only does it state the rights that users have and the responsibilities owed them, it also provides for duties on the very people for whom the right is created and laid out.

Section 1 of the Act states:

1(1) There is established for the Federation the National Health System, which shall define and provide a framework for standards and regulation of health services, without prejudice to extant professional regulatory laws and which shall-

(d) set out the rights and obligations of healthcare providers, health workers, health establishments and users; and

(e) protect, promote and fulfil the rights of the people of Nigeria to have access to healthcare services.⁶³⁴

This section also mandates that the National Health System is made up of both the public as well as private health service providers.⁶³⁵ This inclusion of private health providers is especially positive in the face of the reality of the country's years of increased reliance on private healthcare due to the failing standards of public healthcare, all leading to the eventual reliance on user fees as the primary method of funding the health system, especially private care.

Regarding setting out the normative content of "the the rights of the people of Nigeria to have access to healthcare services", Section 3(3) states: "Without prejudice to the prescription by the Minister in Section 3(1) of this Act, all Nigerians shall be entitled to a *basic minimum package*⁶³⁶ of health services."⁶³⁷

The language of this section posits a minimum core package that is owed all citizens by the State. This provision takes into consideration the reality of the fact that a sizable portion of the populace have for years not been able to enjoy even a bare minimum standard of healthcare in the country. The provision thus seeks to guarantee the enjoyment of such access to all, regardless of cost and the ability to meet such cost. This minimum package is described in Section 64 as "the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health".⁶³⁸

⁶³⁴ Act No. 8 of 2014.

⁶³⁵ Ibid at Section 1(1)(a) and (b).

⁶³⁶ Emphasis mine.

⁶³⁷ Act No. 8 of 2014.

⁶³⁸ Ibid.

This definition of 'minimum' avoids being descriptive in listing out specific goods and services that must be provided by the State. This leaves the package subject to constant redefinition by the Minister on the advice of the National Council on Health, based on prevailing circumstances. It is thus expected that the minimum at any given time will take into consideration international standards and best practices, the stated goals of the Ministry of Health and the prevailing health challenges of the populace. It is thus expected that the minimum package will be stated in the National Health Policy and be constantly reviewed as circumstances dictate. Unfortunately, there is a risk that the lack of political will or a lack of resources may preclude the express declaration of the services to fall under this minimum standard of health. This has been the case in the six years since the passing of the Act. In addition, there is the concern that even when it is eventually defined, that minimum standard of care as defined by the Minister may be one that is so low, that it represents no meaningful action by the State to fulfil the right to health and guarantee a substantive health package for the populace. However, some of this risk is mitigated by sections of the NHA that state some services that must form part of that minimum package. The NHA for example guarantees the provision of immunisation and vaccination from infectious diseases for children between the ages of zero and five and pregnant women in Section 5(1)(i) thereof. This minimum standard of healthcare also includes guaranteeing that no citizen can be refused emergency medical treatment on any grounds, according to the provisions of Section 20 of the Act.

The Health Act importantly also recognises that there are health disparities in the country and seeks to begin to bridge the gaps by ensuring a minimum that the lawmakers feel can begin to guarantee an amount of dignity and fulfil the right to health for all. It moves the discussion for the first time from protecting and respecting the right to health, to fulfilling the right to health. It does this by constructing various aspects of the State's duties and responsibilities regarding various aspects of healthcare delivery. Together, these sections present a comprehensive package as to what the right to health means normatively with regards to what the State has an obligation to fulfil. This is a step in the right direction that guarantees citizens, in clear terms, claimable rights to access and use the Nigerian health system.

In line with the powers of the National Assembly in the Constitution, the legislature, by passing the law, has sought to give life to the provisions of Section 12 of the Constitution. Through a joint reading of the nature of its powers in the Constitution and its implementation in the domesticated African Charter as well as the National Health Act, the right to health is now a clearly provided for.

Unfortunately, the right to health and the provision of its minimum core in the Nigerian context is limited. This limitation lies in both the nature of the substantive content minimum core as well as the

description of the right to health. In the context of the NHA, it constructs health in terms of access to health and does not provide for a more robust reading of health as including the social determinants of health. As such, the obligations of the State are not only reduced in terms of the type of healthcare it must provide but also in terms of the scope of its health-related duties to the people. However, such limited reading of the right to health may be defended by the fact that the Act addresses the Nigerian health system specifically. By extension, the Act is premised on an acknowledgment of the fact that the health system is not equipped nor suitable to appropriately address the other socio-economic issues that determine health outcomes. Nevertheless, there is need for a more robust understanding of the scope of the right to health, which must then be normatively laid out for onward fulfilment by the State.

There are also various other relevant domestic laws with implications for the management of aspects of the health system, as well as the delivery of healthcare. They include; National Health Insurance Scheme Act,⁶³⁹ Nigerian Medical and Dental Practitioners Act,⁶⁴⁰ National Agency for Food and Drug Administration and Control Act,⁶⁴¹ National Drug Formulary and Essential Drugs List Act,⁶⁴² and the Dangerous Drugs Act.⁶⁴³ While these laws address particular concerns, they operate within the larger framework of the nature of the health system and its duties as defined by the NHA, the African Charter and the Constitution. In this sense, they have a more direct impact on how the aims of the health system are met.

Conclusion

The emphasis on the duties of the State towards its people in international law is important for grounding claims against the State. It is not enough to provide healthcare as a social good. Herein lies one important power of rights language. With the guarantee of the right to health in Nigeria, albeit through a currently limited lens, there is now an onus on the State to provide the processes and system through which its obligations to the people will be met. Overtime, the obligation will have to necessarily consider the other socio-economic factors that create inequity and subsequent ill health among large portions of the populace.

⁶³⁹ National Health Insurance Scheme Act, Cap N42 LFN 2004.

⁶⁴⁰ Nigerian Medical and Dental Practitioners Act, Cap M8 LFN 2004.

⁶⁴¹ National Agency for Food and Drug Administration and Control Act, Cap N 30 LFN 2004.

⁶⁴² National Drug Formulary and Essential Drugs List Act, Cap N 29 LFN 2004.

⁶⁴³ Dangerous Drugs Act, Cap D1 LFN 2004.

The underlying tenet of the right to health is not that an individual should or can be perfectly healthy; rather, it is that each person should have the best opportunity to get the best state of health possible in light of their circumstances.⁶⁴⁴ It is the right to enjoy the various goods, facilities, services and conditions necessary for the realisation of an optimal state of health and wellbeing.⁶⁴⁵ What this implies is an obligation on States to create the right conditions for individuals to achieve optimal health.⁶⁴⁶ This understanding of the right to health places a burden on the State to subsequently do all it can do, while it strives to do more as it has increased capacity.⁶⁴⁷ While it is acknowledged that the right to health in its most comprehensive sense indeed requires progressive realisation, the reality is that any country desirous of meeting its socio-economic right obligations, must start somewhere.⁶⁴⁸ While Nigeria at the moment may not be able to operate a robust universal healthcare package, it must, as it finally has, recognize the right to health of all by expressly guaranteeing it and taking the necessary steps to protect, respect and importantly, fulfil it — even if currently only through a basic package of healthcare.

⁶⁴⁴ Paragraph 8 and 9, General comment 14, 2000.

⁶⁴⁵ See n581.

⁶⁴⁶ Tarantola, Daniel, et al. "Human rights, health and development." *Australian Journal of Human Rights* 13.2 (2008): 1-32.

⁶⁴⁷ There must also be a continuous effort to increase State capacity itself which includes its infrastructural, policy and economic means and ability. See Paragraph 31, General comment 14, 2000.

⁶⁴⁸ See n85.

Chapter 6

Understanding the persisting non-realisation of the right to health in Nigeria

Introduction

As noted in the previous chapters of this thesis, there had been a persistent call for normative clarity to the right to health in Nigeria. The National Health Act as shown in Chapter 5 provides much of the clarity that had been sought on the nature of the right to healthcare in Nigeria, which is but a limited portion of the right to health in its entirety. While the right is considerably limited in scope to the right to healthcare — a limited one at that, it opens a world of possibilities that did not previously exist. However, despite the realisation of the mandate to legislate on the right to health, little has been done to implement the legislation by the Nigerian State. More than six years since its passing, the right to a minimum standard of healthcare has had life only in the law books with little impact in the life of the average Nigerian. The problems that have plagued the nation's health system as shown in Chapters 3 and 4 persist. In the face of one regional epidemic⁶⁴⁹ and a major global pandemic,⁶⁵⁰ instead of spurring significant reform and the upscaling of healthcare, the events have highlighted and exacerbated the challenges of the Nigerian health system and its far-reaching effects on the populace. While various local and international non-State actors have risen to the occasion to provide much-needed assistance to the government at the various levels, the inherent limitations of the health system that have been left to fester for long are making effective intervention considerably harder. As previous vertical programs in HIV, malaria, polio and tuberculosis have shown, the ability of vertical programs to function optimally is dependent on the context of the wider health system in which they are nested.⁶⁵¹ Even where considerable resources are diverted to these particular responses, their

⁶⁴⁹ Onyeonoro, Ugochukwu Uchenna, et al. "Ebola epidemic-the Nigerian experience." *The Pan African Medical Journal* 22. Suppl 1 (2015.):17.

See also, Bell, Beth P. "Overview, control strategies, and lessons learned in the CDC response to the 2014–2016 Ebola epidemic." *MMWR supplements* 65.3 (2016):4-11.

Tomori, Oyewale. "Will Africa's future epidemic ride on forgotten lessons from the Ebola epidemic?" *BMC medicine* 13.1 (2015): 1-4.

⁶⁵⁰ Ebenso, Bassey, and Akaninyene Otu. "Can Nigeria contain the COVID-19 outbreak using lessons from recent epidemics?" *The Lancet Global Health* 8.6 (2020): e770.

⁶⁵¹ Mills, Anne, Fawzia Rasheed, and Stephen Tollman. "Strengthening health systems." *Disease control priorities in developing countries* 2 (2006): 87-102.

See also, Atun, Rifat A., et al. "When do vertical (standalone) programmes have a place in health systems?." *Copenhagen: WHO Regional Office for Europe, No. EUR/07/5065810* (2008).

Msuya, Joyce. "Horizontal and vertical delivery of health services: what are the trade-offs." *Background paper for the World Development Report of the World Bank* (2004).

long-term efficacy is limited by the prevailing challenges around general healthcare needs, which do not cease in the midst of the specific response. If anything, because of the prevailing socio-economic conditions, the social determinants of health that affect people's health outcomes constantly put them at risk of recurring infection or other ancillary health issues, with the same eventual result of ill health and or death.⁶⁵²

The question then becomes, why does the realisation of the right to health in Nigeria continue to falter if the need for it is clear, the legal provision for its existence is available and the road map for its realisation has been laid out? In this chapter, I identify the principles, which enable State non-compliance, as being faulty premises for a minimum core of the right to health in the Nigerian context, an unclear roadmap for progressive realisation and an ineffective mechanism for ensuring State accountability. I also argue that an application of the test of reasonableness, which began in the South African courts and has gained international traction, considerably misunderstands the principle of the minimum core it was created to supplant, and as such is ill suited to the Nigerian context. These issues are here discussed to highlight the original intent of their formulation, how they were intended to be applied as well as their consequent bastardisations and the implications for the lag in realising the right to health in Nigeria. I show that ultimately, "minimum core", "progressive realisation" and the seeming alternative of the "test of reasonableness" have become, in the words of Baxi, "languages of constraint"⁶⁵³ to avoid or delay the obligations owed to the people. I argue that the now seemingly entrenched normative accession to State delay must be untangled and reframed to reflect the original ideals and aspirations of the right to health in a manner that is both practical and cognisant of the contextual resource limitations that exist in the current Nigerian State.

The concept of the minimum core

History of the formulation of the concept

The history of the conceptions of the idea of a "core" of rights can be traced to the writings of scholars like Shue, Andreassen et al and Özüdö. ⁶⁵⁴ Through the importation of German and Turkish legal

⁶⁵² Venkatapuram, Sridhar, and Michael Marmot. "Epidemiology and social justice in light of social determinants of health research." *Bioethics* 23.2 (2009): 79-89.

⁶⁵³ Baxi, Upendra. "The Place of the Human Right to Health and Contemporary Approaches to Global Justice: Some Impertinent Interrogations." *Global Health and Human Rights Legal and Philosophical Perspectives*. Eds. J. Harrington, and M. Stutterford. London: Routledge, 2010. 12 at 16.

See also, George, Erika. "John Harrington and Maria Stuttaford (eds). *Global Health and Human Rights: Legal and Philosophical Perspectives* John Tobin. *The Right to Health in International Law*." (2013): 1252-1256.

⁶⁵⁴ In "the morality of depths" Forman et al point to the works of Esin Özüdö, and Henry Shue as being seminal interventions that began to argue for the existence of a core of rights. See Özüdö, Esin. "The Core of Rights and

doctrines,⁶⁵⁵ these scholars began to make the case for understanding rights as having layers to them that comprised of a core, a circumference and an outer edge.⁶⁵⁶ These progenitors of the concept made the case that rights could best be understood and realised by identifying their essential nature, which needed to be protected at all costs, even when the rights in general were to be qualified.⁶⁵⁷ According to Andreassen et al, there was need for a practicable minimum floor of well-being that was necessary for a meaningful distributive analyses of socio-economic rights.⁶⁵⁸ Shue captured this sentiment as the “morality of depths”; being the line below which no human was allowed to sink.⁶⁵⁹ His framing, firmly put the enjoyment of rights as integral to human dignity and determined that for rights to be said to be of any tangible merit, they would have to be of such a nature as to guarantee a non-negotiable standard of life that preserved and protected human dignity. By showing how adequate food, clothing, shelter and minimal preventive public healthcare converged to guarantee a dignified life, he also emphasised the interconnectedness and interdependence of human rights.⁶⁶⁰

This scholarly and philosophical framing of the nature of rights would go on to be a major influence on the Committee on Economic, Social and Cultural Rights (CESCR) and its then rapporteur, Phillip Alston, who stated that the Committee would look to adopt and develop the concept of the minimum core and to provide normative clarity on the nature of State duties and how they became due.⁶⁶¹ He argued that this kind of core was necessary for State accountability. The moment the realisation of the rights fell below the minimum entitlement of the populace, the State would be liable to make amends.⁶⁶² All this accretion of thought and knowledge would subsequently go into the formulation of the concept of the minimum core by the Committee and would form the normative basis for our current framing of the concept.

Freedoms: The Limits of Limits.” *Human Rights: From Rhetoric to Reality*. Ed. T. Campbell. Oxford and New York: Basil Blackwell, 1986. 37-59. See also, Shue, Henry. *Basic Rights: Subsistence, Affluence, and US Foreign Policy*. Princeton: Princeton UP, 2020.

⁶⁵⁵ Forman, Lisa, et al. “Conceptualising Minimum Core Obligations under the Right to Health. How Should We Define and Implement the ‘Morality of the Depths?’” *Healthcare as a Human Rights Issue, Normative Profile, Conflict and Implementation*. Eds. S. Klotz, et al. Bielefeld: Transcript. 95-122.

⁶⁵⁶ Özücü, Esin. “The Core of Rights and Freedoms: The Limits of Limits.” *Human Rights: From Rhetoric to Reality*. Ed. T. Campbell. Oxford and New York: Basil Blackwell, 1986. 37-59.

⁶⁵⁷ See n655.

⁶⁵⁸ Andreassen, Bård-Anders, et al. “» Assessing Human Rights Performance in Developing Countries: The Case for a Minimal Threshold Approach to the Economic and Social Rights «.” *Human Rights in Developing Countries* 1988 (1987): 333-355.

⁶⁵⁹ Shue, Henry. *Basic Rights: Subsistence, Affluence, and US Foreign Policy*. Princeton: Princeton UP, 2020.

⁶⁶⁰ Ibid.

⁶⁶¹ See n655.

⁶⁶² Alston, Phillip. “Out of the abyss: the challenges confronting the new un committee on economic, social and cultural rights.” *Hum. Rts. Q.* 9 (1987): 332.

The nature of the minimum core

The Committee's 1990 General Comment 3 lays out its conception of the minimum core and its implications for State parties' obligations for the realisation of socio-economic rights. Paragraph 10 of the General Comment states that "...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."⁶⁶³

Here, the Committee lays out its conception of the minimum core as inherently necessary for the understanding of both the nature of socio-economic rights as well as the obligations they place on States for their fulfilment. In clarifying what it means by the minimum core, the Committee states in the same paragraph that "a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary healthcare, of basic shelter and housing, or of the most basic forms of education is, *prima facie*, failing to discharge its obligations."⁶⁶⁴

With this example, the Committee lays emphasis on two important elements. First is the "essential" nature of the aspects of the various rights and second is the fact that they would need to have wide coverage. As such, in a situation where a sizeable portion of the population of the country is unable to enjoy these "essential" elements of the right, the State cannot be said to have fulfilled its obligations regarding the affected socio-economic rights.

Importantly also, the same paragraph 10 goes on to state: "If the Covenant⁶⁶⁵ were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*."⁶⁶⁶

This section of the General Comment emphasises the necessity of having the minimum core. As Bilchitz notes, the notion of the minimum core is essentially to give priority to the most urgent needs of the people, which will in turn improve the lives of the worst off in society.⁶⁶⁷ Here, the essential function of minimum core obligations is the creation of a threshold of basic minimum resources that are necessary to allow people a guaranteed minimal level of wellbeing. One of the key shortfalls of socio-economic rights that the minimum core was formulated to address, was the lack of practical benchmarks against which State performance could be measured. As such, the concept of a minimum

⁶⁶³ UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 14 December 1990, E/1991/23.

⁶⁶⁴ Ibid.

⁶⁶⁵ Covenant here being the International Covenant on Economic, Social and Cultural Rights

⁶⁶⁶ General comment 14, 2000.

⁶⁶⁷ See n50.

core was formulated to give the obligation of progressive realisation, clearer direction.⁶⁶⁸ This determination of a non-negotiable minimum was put in place to prevent the realisation of rights from becoming meaningless aspirational goals. As such, action was to be set in motion, both to use that action to provide immediate pressing needs, but to use them to start the process of continuous realisation of the right. To do this, the minimum core set out the non-negotiable negative and positive elements of the right that needed to be in place for a State to take necessary further action in the continuous process of progressively realising the right to health.⁶⁶⁹ In this manner, the minimum core was formulated to address the seemingly inexact nature of State obligations that stemmed from progressive realisation.

The nature of the minimum core of the right to health

In General Comment 14, the Committee provides specifically for States' obligations for the right to health. It lays out the particulars of a non-negotiable essential list of State responsibilities. Laying the foundation for subsequent exposition, paragraph 9 of General Comment 14 is clear that "the right to health must be understood as a *right to the enjoyment*⁶⁷⁰ of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health".⁶⁷¹

According to the Committee, if the right to health were to be shaved down to its bare essentials for any number of reasons, major of which would be resource constraint, the right to health would still need be seen to be fulfilled by the State guaranteeing a range of duties. According to paragraph 30 of General Comment 14, while Article 12 of the the International Covenant on Economic, Social and Cultural Rights (ICESCR),⁶⁷² allows for the progressive realisation of the right to health due to limited available resources, there are also obligations of immediate effect. As stated in the General Comment, some are of such a nature as to require respect or protection of the right. Others however go on further to require proactive action on the part of the State. As stated in paragraph 43, key amongst the obligations to respect that form part of the minimum core is that of ensuring non-discrimination of any sort in the delivery of the right. Access to health facilities, goods and services is to be

⁶⁶⁸ Müller, Amrei. "The Minimum Core Approach to the Right to Health." *Healthcare as a Human Rights Issue, Normative Profile, Conflict and Implementation*. Eds. S. Klotz, et al. Bielefeld: Transcript. 55-94

⁶⁶⁹ Ibid.

⁶⁷⁰ Emphasis mine.

⁶⁷¹ Paragraph 9, General comment 14, 2000.

⁶⁷² UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 49, UN Doc. A/6316 (19660; 993 unts 3; 6 ILM 368.

unconditional, especially for vulnerable or marginalised groups.⁶⁷³ The list of core obligations goes on to include ensuring access to health facilities, minimum essential food that is nutritionally adequate and safe, basic shelter and sanitation.⁶⁷⁴ Regarding these three, while access is the operative qualifier, one can argue that access can only be possible for something that is available. In addition to this is the obligation to provide essential drugs, as defined by the WHO Action Programme on Essential Drugs,⁶⁷⁵ which is an unambiguous obligation to fulfil. Tied to these requirements are the obligation to adopt and implement a national public health strategy⁶⁷⁶ and plan of action as well as ensuring equitable distribution of the health facilities, goods and services.⁶⁷⁷

In addition to these provisions in paragraph 43, paragraph 44 provides another list of obligations that are of comparable priority for States, in the fulfilment of the right to health. They include ensuring reproductive, maternal and child healthcare, providing immunisation against major infectious diseases, preventing/treating, and controlling pandemics, providing access to information on major health problems in the community and providing adequate training of health personnel.⁶⁷⁸

However, this list of obligations has been critiqued as being unduly broad.⁶⁷⁹ The result of this broad scope is that it may create inertia by developing States in the face of the inability to provide all that is listed, which is in fact opposed to the very reason for which minimum core obligations were laid out in the first place. The cumulative effect of this is that, invariably, the minimum core becomes both a barometer overtly focused on the performance of developing countries, while also being incapable of ensuring said performance.⁶⁸⁰ In effect, the minimum core waters down the essence of the right, while not even benefiting from that trade off.

Despite this possible pitfall, any attempt at realising any socio-economic rights in a meaningful way, will require ascertaining and then protecting the core of that right.⁶⁸¹ If this is then the premise for approaching the right to health, the questions then become: What is at the core of the right to health? What range of goods and services are necessary for its observation? In response to these questions, more than anything, the right to health seeks to ensure optimal health of all, regardless of means. At its core is a belief that everyone needs to be granted an equal opportunity to access goods and services

⁶⁷³ Paragraph 43(a) General comment 14, 2000.

⁶⁷⁴ Ibid at Paragraph 43.

⁶⁷⁵ Ibid at Paragraphs 43 and 44.

⁶⁷⁶ Ibid at Paragraph 43 (d).

⁶⁷⁷ Ibid at Paragraph 43 (e).

⁶⁷⁸ Ibid at Paragraph 44 (e).

⁶⁷⁹ See n668.

⁶⁸⁰ Young, Katharine G. "The minimum core of economic and social rights: a concept in search of content." *Yale J. Int'l L.* 33 (2008): 113-175.

⁶⁸¹ See n50.

that will allow them be in good health in order to stand the chance at living a more robust life, during which their other rights and aspirations may be pursued and realised. If this then is the primary motivation for the formulation of the right it then stands to reason that at its core will be the guarantee of access of all, regardless of means to a range of services that ensure that they get both preventive care and curative care for at least the most common diseases to which they are susceptible in their communities. If this then is the case, there will be need for a contextual determination of the specific health challenges that are prevalent in that society; especially if it disproportionately affects a large portion of that society's poor and vulnerable population. In this manner, it will not be enough to transpose an international standard on the necessary range of services for the purpose of conformity. While access to contextually appropriate healthcare alone will not address the overarching social and economic factors that affect the ability to live a dignified life, access to quality healthcare is an important entry point into providing a more robust right to health as well as reinforcing the inherent value of members of society. The ability to have quality health care that is restorative of health and general wellbeing is particularly important in the context of Nigeria, where health outcomes are poor and there are limited social buffers, to guarantee the ability to live dignified lives.

As laid out in the Alma Atta Declaration and General Comment 14, it is possible to make the case that, in meeting the locally identified health needs of the people, the PHC model both as an approach to healthcare delivery⁶⁸² and as an administrative formulation will be best suited to ensure maximal availability and accessibility to the healthcare provided. Through this lens, it is possible to see the international and the local not as either or, but as a connected and contextual understanding of what is required to optimally deliver health goods, especially where they have been lacking for so long.

In framing the State obligations laid out in General Comment 14, it is important to understand their relevance and interconnectedness, for any meaningful enjoyment of the right to health, even in its most basic form. For one, the availability of health services will be of little consequence if there are restrictions placed on who may access them. Discrimination on any number of grounds limits the ability to benefit from the available resources as does an inability to afford the services rendered.⁶⁸³ In addition to the healthcare provided that addresses the needs of those communities is a recognition that the care provided will be of minimal effect if the people using those services have to return to the unsanitary living conditions that put their health at risk in the first place. As such, they need to be

⁶⁸² Muldoon, Laura K., William E. Hogg, and Miriam Levitt. "Primary care (PC) and primary healthcare (PHC)." *Canadian Journal of Public Health* 97.5 (2006): 409-411.

See also, Bitton, Asaf, et al. "Primary healthcare as a foundation for strengthening health systems in low-and middle-income countries." *Journal of general internal medicine* 32.5 (2017): 566-571.

⁶⁸³ Paragraph 12 (b) General Comment 14, 2000.

able to access clean water both for consumption and for sanitation, shelter to protect them from the elements and environmental issues that can either directly affect their health or provide a breeding ground for infections or biological attacks that compromise their system. If one were to understand all these requirements above as the crux of the minimum core for the enjoyment of health, the requirements laid out in the General Comment 14 make more sense. These goods and services are necessary for a good foundation upon which to build further health-seeking action. Bilchitz appears to share this sentiment when he states that the practical concerns the minimum core seeks to address, cannot happen in a vacuum.⁶⁸⁴ As he points out, the necessary practical add-ons will have to first be grounded in an approach based on the right principles and goals.

A ripple effect of recognising the need for a contextual application of the minimum core is a lingering perception that it is incapable of universality, which some scholars argue is integral to any claims of legitimacy the minimum core obligations are to have.⁶⁸⁵ In view of the stark disparities in State capacity to realise the mandate of paragraphs 43 and 44, there has been considerable interrogation of the possible merits of understanding the minimum core as absolute and universal.

The question of whether the minimum core is absolute or relative.

A case has been made that the nature of the minimum core is more suited to the international enforcement of socio-economic rights and less so for their domestic enforcement.⁶⁸⁶ The rationale for this is that in a domestic context, the minimum core would need to be more specific, concrete, contextual and flexible. In this formulation, the provisions of General Comment 14 provide broad guidelines for setting out the core entitlements of the populace.⁶⁸⁷ As such, the question of whether the obligation is absolute is largely dependent on the presence of resources necessary for fulfilling the core obligations. Where the core obligations as laid out by the committee are framed as non-derogable, they place an unrealistic financial obligation on especially poorer countries to meet their obligations.⁶⁸⁸ The minimum core is therefore seen as more of an attempt at creating a much-needed interpretive tool for guiding States in the fulfilment of their treaty obligations.⁶⁸⁹ As such, the minimum

⁶⁸⁴ See n50.

⁶⁸⁵ Young explores in depth, the arguments for and against a universal consensus on the nature and content of the minimum core. See n680.

⁶⁸⁶ Ibid.

⁶⁸⁷ Ibid.

⁶⁸⁸ Forman, Lisa, et al. "What could a strengthened right to health bring to the post-2015 health development agenda? interrogating the role of the minimum core concept in advancing essential global health needs." *BMC international health and human rights* 13.1 (2013): 1-11.

⁶⁸⁹ Tobin, John. *The Right to Health in International law*. Oxford: Oxford UP, 2012.

core should rather be understood as an international guide for State practice and not the other way around, where the international guidelines are an aggregation of varied State practices. This is because the varied kinds and levels of State practices do not have the requisite consensus for such an aggregation.⁶⁹⁰ Young shares a similar view on the question of whether the minimum core needs to be an absolute, immutable set of rules that may not be deviated from. She states that an insistence on consensus in determining the core of socio-economic rights will more likely lead to accession on only the lowest common denominator, which will more likely lead to a consensus around only the barest minimum, with deliberate vagueness. The effect of this would invariably be an inability to hold State's accountable on any actual substance.⁶⁹¹

Importantly, for the populace and communities, a contextual framing of the minimum core is important for aligning their expectations to reflect both their lived realities as well as meet their essential health needs. Such an approach can help them avoid selling themselves short to a government that both under-promises and then subsequently under-delivers. The real task of the minimum core goes beyond intellectual commentary on form to an entrenchment of a rights-based approach to systemic deprivation that would require a reorganisation of the public priorities.⁶⁹² In this sense, the minimum core first and foremost helps us understand the absence of basic needs as not just the misfortune of a few that may be more readily ignored but as systemic injustice.⁶⁹³ This is important for moving the needle past weaponising legal principles for the justification of State inaction.

The intervention of Bilchitz is particularly instructive in this regard. He explains that those making the rigidity criticism, underestimate the flexibility in the "minimum core". In his understanding, rigidity to the extent there is predictability and subsequent justiciability is permissible. What is thus most important is a level of determinacy that the minimum core provides.⁶⁹⁴ The question of the absolute nature of the minimum core is thus not as sacrosanct as critics would make it out to be.⁶⁹⁵ The key role of the General Comments is to provide broad guidelines that State parties are to adopt to reflect their own unique realities. Invariably, the ability to adequately enjoy the right to health would be dependent on States seriously addressing the issues laid out in the Comment's core. The question of extent of focus to be given to each of the core obligations is a granular issue that should be dependent

⁶⁹⁰ Ibid.

⁶⁹¹ See n680.

⁶⁹² See n50.

⁶⁹³ Ibid.

⁶⁹⁴ Ibid.

⁶⁹⁵ Ibid.

on addressing the public health realities of the State in question.⁶⁹⁶ The argument may thus be made that the minimum core as laid out in General Comment 14 is a guideline for States in their own domestic norm setting. This is especially when bearing in mind that, for the most part, international instruments will many a times have to be ratified and domesticated to be made compatible with the domestic laws and local realities. Importantly, as Müller points out, we need to recognise that international human rights do not operate in a vacuum. They are applied to a national context. And so, they must be read together with domestic realities. In some contexts, like Nigeria's, these international laws need to be ratified and domesticated, which essentially creates the window period to make them contextual. This approach is in line with the intent of the democratic process, where there is consensus and not just a top-down imposition, especially when it is from a supranational authority. Often, such imposition denies agency and is also unduly paternalistic. If anything, international law should be used to serve as a benchmark. As Müller puts it, democracy should work towards joint egalitarian goals.⁶⁹⁷ This also means that the process of determining the nature of claims should also ideally be arrived at through a democratic process. The people should be involved in crafting the laws that govern them; in that manner ensuring that they are more vested in ensuring their fulfilment.⁶⁹⁸ By extension, the right to health ought to provide protection against governmental claims of resource scarcity, even if those claims come from democratically elected governments.⁶⁹⁹

The critique of lack of clarity of the minimum core obligations of the right to health

The issue of relativity and contextual application lends credence to another critique of the minimum core as lacking enough clarity. The formulation of this challenge is that at the international level, the need to be wide in scope makes the minimum core unduly vague. Thus, in a bid to leave room for State modification and application, its wide scope can become an unwitting tool of inaction for an unwilling State looking to not be bound by clear, quantifiable requirements. As Forman points out, the Committee's interpretation of the minimum core provides little clarity on which specific range of health services and facilities would form part of that core. In addition to this, there is a lack of certainty on what kind of food, shelter, sanitation, and water would count as adequate fulfilment of the core obligations as envisioned in General Comment 14. There is also the critique of the nature of the obligations of "comparable priority" in paragraph 44. Are they in fact part of the minimum core? Are

⁶⁹⁶ Ibid.

⁶⁹⁷ Müller, Amrei. "The Minimum Core Approach to the Right to Health." *Healthcare as a Human Rights Issue, Normative Profile, Conflict and Implementation*. Eds. S. Klotz, et al. Bielefeld: Transcript. 55-94

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid.

they issues to be considered when realising the minimum core or upon completion of that first task? The lack of clarity on these questions presents a challenge for the judiciary in seeking to make determinations on the nature and extent of State liability for the realisation of the right to health.⁷⁰⁰ In a similar vein, Tobin argues that the substantive content of the minimum core is an impractical list that is as vague, as it is unduly sweeping.⁷⁰¹

This critique of vagueness is particularly poignant in the specific case of Nigeria where the State has adopted a minimum core approach to the framing of its duties to realise its narrow scope of the right to health. Arguments that lack of clarity eventually result in lack of provision become more apparent when considering the nature of the NHA. It is important to note that neither Section 3 nor Section 15 of the NHA expressly state the range of services that constitute the basic minimum package of health services. According to Section 64 — the definition section of the act — "basic minimum package" means the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health. This means that what constitutes the minimum standard of care is ever changing and dependent on the considerations of the National Council based on a varying number of factors which will be determined by the needs of the time. The fluidity of the minimum is an advantage in that it can always progressively be increased based on both the capacity of the health system as well as international best practices and global health goals. However, it is important that whatever the minimum is at any given time should be clearly stated by the Minister and the Council and adequately transmitted to health establishments, the health workforce and healthcare users. The value of the right is in knowing its content to be able to claim it. Unfortunately, since the passing of the Act, the basic minimum package is yet to be determined by the National Council and the new National Health Policy, which was made to flesh out the goals of the NHA also fails to clearly delineate the minimum core.⁷⁰² The implications of this is that it still leaves the right to healthcare indeterminable and unclear. The health system and health establishments within it cannot be held unaccountable for failure to provide a minimum basic standard, where that standard remains unclear.

⁷⁰⁰ Forman, Lisa. "Can core obligations under the right to health achieve their ambitions." *Zeitschrift für Menschenrechte (J Hum Rights)* 9.2 (2015): 36-48.

⁷⁰¹ See n689.

⁷⁰² While Paragraph 4.2.2 states that an objective of Health Service Delivery in the Nigerian Health System is to provide a minimum healthcare service package for all Nigerians at all levels, it also does not state what the minimum package entails. In the same vein, paragraph 4.2.3 states that part of the objectives of health financing is to guarantee financial access to a minimum package of health services, which is to be through mandatory health insurance for all Nigerians. The minimum package of health services is however not clearly enumerated in the policy, which is to be an exposition on the earlier passed NHA.

The question of immediacy in the framing of core obligations.

In a bid to prevent the right to health from becoming ineffectual and consisting only of empty promises, General Comment 14 lays out the blueprint for the fulfilment of the right to health; stating what is immediately required in the continuum of progressive realisation. Core obligations are meant to provide the necessary scope and heft essential to the right to health claims. As an expression of this, is the assertion that States have a non-derogable obligation to provide certain essential health services that are immediately demandable and not subject to progressive realisation.⁷⁰³ In essence, core obligations provide the baseline of legal protection for health needs by mandating a set of health services that must be immediately made available to the populace. This gamut of services may not be made subject to claims of scarcity, insufficient international assistance or competing private interests.⁷⁰⁴ General Comment 3 is quite adamant about this point.

Paragraph 1 of General Comment 3 states: “While the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various obligations which are of *immediate effect*.”⁷⁰⁵

Paragraph 10 of General Comment 3 states:

Article 2 (1) obligates each State party to take the necessary steps ‘to the maximum of its available resources’. In order for a State party 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 resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.⁷⁰⁶

This portion of paragraph 10 is quite instructive for providing guidance on the original understanding of minimum core obligations as placing a burden of duty on the State. This burden of duty is such that where the State cannot meet it, it is its responsibility to prove that inability. In this framing, the burden of proof is on the State to justify why it is unable to meet its obligations. This is markedly different from the emerging normative uptake of presumption in the favour of the State.⁷⁰⁷ Importantly also, this framing of State responsibility is not as inflexible as has been accused of being.⁷⁰⁸ It recognises the nuance of varying State economic power and capacity. It however responds to that challenge by

⁷⁰³ See n700.

⁷⁰⁴ Ibid.

⁷⁰⁵ General Comment No. 3. Emphasis mine.

⁷⁰⁶ Ibid.

⁷⁰⁷ See n50.

⁷⁰⁸ Ibid.

requiring proof of said inability by the State as opposed to presuming that the failure of the State to act is due to an inability to do so.

General Comment 14 is even less forgiving of the inability or incapacity of the State. Paragraph 47 of the Comment gives an indication as to why, when it states: “In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish the inability from the unwillingness of a State party to comply with its obligations under article 12.”⁷⁰⁹

It goes on to state that it is incumbent on the State to use the maximum available resources to realise the right to health and that when it fails to do so, it is in violation of its obligations to realise the right to health as contained in Article 12. It goes on to state:

If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above.⁷¹⁰

However, in its unforgiving nature, it goes on to state that this concession to excuse non-compliance with resource constraints cannot be applied to the obligations that concern the core obligations laid out in paragraph 43. Here, it is clear that “a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.”⁷¹¹

Young is, however, critical of this non-derogability and finds it out of step with economic reality and the range of judicial competence. According to her, the inability of the judiciary to mandate the State to fulfil an obligation it does not have the capacity for, is tantamount to drawing spurious lines in the sand.⁷¹² She alternatively proposes a value-based approach that will rather create benchmarks and indicators of assessment of progress as they are reached in the provision of the right to health. One may argue that these alternatives are in themselves doing the same things the minimum core does, which is to stagger the duties of the State in the realisation of the right to health. In the case of the minimum core, it outlines the “benchmarks” it considers as a sacrosanct foundation upon which subsequent State action is to be built on and then goes on further to create liability when these markers are not met. Whether one chooses to call them benchmarks or core obligations, what is central is the recognition that invariably, the reality of limited resources means that it is near

⁷⁰⁹ General Comment 14, 2000.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² See n680.

impossible to do everything all at once and as such, action will have to be staggered. This staggered action will have to start from somewhere, have a commencement time frame and barometers of accountability. In the absence of clear timelines and benchmarks/hierarchies of needs (which is inadvertently what a “minimum core” does), it will always be an ever-shifting goal post. In the 40 years since the formulation of the ICESCR, no State can say it has reached its ‘destination’ in the realisation of the right. It would then be disingenuous to scoff at the reality of needing incremental progress over time. What is required in the pursuit of this goal is a social protection baseline.

In the preference for immediacy of State duty, the issue is not solely about whether the State can or will fulfil its obligations. It is equally important to let it be on record that the State has been held to account for its inability to meet its core obligations.⁷¹³ The State ought to be made aware of its moral failings so that when the economic opportunity arises, it is in no doubt as to where it needs to channel those resources and the immediacy with which such action is to be made a priority.⁷¹⁴ As Bilchitz puts it “the minimum core approach does require us to take a rigid stance in one respect: it requires us to recognise that it is simply unacceptable for any human being to have to live without sufficient resources to maintain their survival”.⁷¹⁵ Bilchitz’s approach is more in step with the central focus of ensuring State accountability for meeting the needs of the peoples, as opposed to bureaucratic expedience that largely leans in favour of eventual State inaction.

However, despite these interventions, there has been a judicial rejection of the concept of the minimum core, particularly by the South African courts. Alternatively, there has been a formulation and international uptake of the principle of accessing the reasonableness of the State’s actions vis á vis the realisation of socio-economic rights. The reasonableness test as it is more commonly referred to will now be examined to consider its merits to the central goal of realising the right to health for the Nigerian people.

The test of reasonableness

The development and nature of the test

The test of reasonableness is credited to the South African Constitutional Court who curiously began the formulation of the legal principle in a health rights claim case. This was the case of *Soobramoney*

⁷¹³ See n50.

⁷¹⁴ General Comment 14, 2000.

⁷¹⁵ See n50.

*v Ministry of Health*⁷¹⁶ which was the first opportunity for the Court to consider the nature of socio-economic rights and their normative content since the adoption of the new South African Constitution. In that case, the Court had to make a determination on whether the claimant had a right to dialysis treatment for cancer from which he was suffering, and which was at a considerably advanced stage. The State-funded hospital where he sought treatment refused him treatment on the grounds that his poor physical condition did not qualify him for treatment, based on the criteria the hospital used to determine eligibility for treatment. The criteria had been put in place because the demand for the treatment protocol was considerably higher than the ability to supply as well as the fact that it was also very expensive. In that instance, the hospital denied him treatment, for which Mr Soobramoney brought an action to court, seeking an order for the hospital to give him the dialysis treatment. After having his claim dismissed at the lower court, he appealed to the Constitutional Court. In arriving at its decision, the Court held that the standards put in place by the hospital to determine eligibility were reasonable and were fairly applied to Mr Soobramoney. In dismissing his application, the Court stated that the decision of the hospital was not a breach of his right to health as provided for by the South African Constitution, as the treatment sought by Mr Soobramoney did not constitute “emergency care” as laid out in the Constitution. Importantly, in reaching its decision, the court held that in view of the limited resources available to the hospital, its procedure for selection was “reasonable” and taken in good faith and so it would not interfere with such a decision, especially when considering that such an interference would also have budgetary and bureaucratic implications on the State’s priorities. In the cases of *Government of the Republic of South Africa & Ors v Grootboom & Ors*⁷¹⁷ and the *Minister of Health v Treatment Action Campaign*,⁷¹⁸ the Court also rejected the adoption of a minimum core approach. Rather, in both instances the Court preferred to decide on the reasonableness of the State’s actions in each case. To do this, the courts considered the State’s resource limitations and the legislative and administrative processes that had been made to determine the State’s choices in each instance. While the Court found for the State in *Grootboom* it found against the State in *Treatment Action Campaign*, ordering that the supply of nevirapine, the anti-retroviral drug, whose distribution was the subject of contestation be made immediately available across the country.

In the case of *Lindiwe Mazibuko & Others v City of Johannesburg & Others*⁷¹⁹ where the facts of the case more readily presented the opportunity to consider the merits of a minimum core approach, the

⁷¹⁶ 1997 (12) BCLR 1696.

⁷¹⁷ 2000 (11) BCLR 1169. (CC).

⁷¹⁸ (2002) 5 SA 721 (CC).

⁷¹⁹ *Lindiwe Mazibuko & Others v City of Johannesburg & Others*, Case CCT 39/09, [2009] ZACC 28

South African Constitutional Court yet again deferred to an approach of considering the reasonableness of the State's action. In that case, the main question for consideration was the city's policy in relation to the supply of free basic water and its determination of what constituted enough water for that. The issue was thus whether 6 kilolitres was enough to constitute a fulfilment of the State's duties under Section 27 of the Constitution, and if so whether the installation of pre-paid water meters to charge past the determined basic minimum was lawful. While the High Court and Supreme Court of Appeal both reviewed the amount of water upwards to varying degrees,⁷²⁰ the Constitutional Court overturned their decisions, rather holding that the requirement of the right to access to sufficient water was one of progressive realisation. In view of this, the Court held that what was required of the State was that it take reasonable legislative and other measures progressively to realise the right. It held that in this instance, the State had done that per the Water Services Act and the subsequent administrative procedures it had put in place to determine what was sufficient at the time. Following in its own footsteps in the previous cases, the Court found that it did not have to make a quantified determination on what was enough content for the right to water. Here, it also rejected adopting a minimum core approach, stating that its duties were not to make such granular determinations but to consider the merits of the State's actions and decide whether they were reasonable. It found that in this instance, the City's free basic water policy was reasonable and not a contravention of the ideals of the Constitution vis á vis the right to water.

In the varied analyses of the courts' decisions in these cases that would follow, various scholars have either praised⁷²¹ the decisions or maligned them individually⁷²² or as a body of jurisprudence.⁷²³ While some that support some or all of the decisions do so based on outcomes they perceive as fair under the circumstances, their grouse with the court lies in the process of reaching its decision and the formulation of the legal principles in these cases, which would go on to be replicated in the other seminal socio-economic rights cases.⁷²⁴

⁷²⁰ The high court determined that 50 litres of free basic water daily was required as a sufficient disbursement of the State's duties while the Supreme Court of Appeal found that 42 litres was a more accurate amount.

⁷²¹ Lehmann, Karin. "In defense of the Constitutional Court: litigating socio-economic rights and the myth of the minimum core." *Am. U. Int'l L. Rev.* 22.1 (2006): 163-197.

⁷²² Chapman, Audrey. "Core obligations related to the right to health and their relevance for South Africa." *Exploring the core content of socio-economic rights: South African and international perspectives* (2002): 35-60.

⁷²³ Brand, Danie. "The proceduralisation of South African socio-economic rights jurisprudence or what are socioeconomic rights for." *Rights and Democracy in a Transformative Constitution*. Eds. H. Botha, et al. Stellenbosch: Sun P, 2003. 33-56.

⁷²⁴ Most accept that Mr. Soobramoney's interest in prolonging his life had to be sacrificed in the interest of the general welfare. The authors accept the outcome of the case but are critical of the court's reasoning. They argue that the court's interpretation of section 27(3) and its failure to articulate a minimum core could lead to a situation in which "[t]he individual is quickly sacrificed to an amorphous general good. See, Scott, Craig, and

The uptake of the test of reasonableness has gone beyond the shores of South Africa, on to international human rights discourses, where it has formed part of the most recent framing of State duties in the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights.⁷²⁵ Despite the wide-spread accession to the concept of reasonableness as a barometer for determining the rightness of State action, there are those who see the concept of reasonableness as either wrongheaded or based on a faulty premise. There are others who argue that while it may be well intentioned, it is not an adequate replacement for the minimum core and it is at best an add on, only to be used when a determination on the minimum core alone is impossible.

The analysis of the test of reasonableness

The argument has been made that the South African Constitutional Court squandered an important opportunity to provide adequate exposition on the normative content of the right to health and its implications for defining State duties.⁷²⁶ The critique is that the Court rather took the path of least resistance by examining the case through a narrow lens of administrative due process and in the process, set the South African jurisprudence at odds with the concept of the minimum core. The approach of the Court has also been critiqued as being unduly deferential to the State and its framing of the issues.⁷²⁷ Scholars like Yeshnaw on the other hand, find merit in the principle of reasonableness and proposes that it does not inherently need to be at odds with the minimum core. She is a proponent of combining the two in making a determination on the nature of the State's duties and whether or not it has sufficiently fulfilled them.⁷²⁸ She argues that per the Court's judgment in the case of *Grootboom*, its hesitation to adopt a minimum core was not a rejection in principle, but rather one based on inadequate information comparable to that of the Committee when informing its decision to formulate and apply the minimum core.⁷²⁹ She points to the case of *Mazibuko* as proof of the acquiescence of the Constitutional Court to the concept of the minimum core in theory. She argues that in that case, the Constitutional Court took cognisance of the "minimum" package as contained in the free basic water policy and then considered whether that was in fact reasonable under the political, social, and economic context of the country as well as that of the people for whom it was

Philip Alston. "Adjudicating constitutional priorities in a transnational context: A comment on Soobramoney's legacy and Grootboom's promise." *South African Journal on Human Rights* 16.2 (2000): 206-268.

⁷²⁵ UN General Assembly, *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights* resolution / adopted by the General Assembly, 5 March 2009, A/RES/63/117.

⁷²⁶ See n50.

⁷²⁷ Ibid.

⁷²⁸ Yeshanew, Sisay. "Combining the "minimum core" and "reasonableness" models of reviewing socio-economic rights: feature." *ESR Review: Economic and Social Rights in South Africa* 9.3 (2008): 8-13.

⁷²⁹ Ibid.

intended. For her, this was a case in point of a layering of the test of reasonableness over an acceptance of a minimum core. While this point appears reasonable on the face of it, it raises the question of what the Constitutional Court would have done if it believed that the amount mandated by the State was insufficient. Would it have gone ahead to amend the amount as done by the lower courts or would budgetary constraints have forced it to temporarily accede to the State, with an order to improve on the amount as the ability to do so arose? The latter seems unlikely, as the hesitance of the court was due to a reluctance to engage in such a determination in the first place as it felt ill-suited to decide such a benchmark.

In *Mazibuko*, as with all the other cases, there is a clear hesitation by the South African courts to make decisions that require granular and substantive rights content determinations. And while it has justified this position as a respect for the principle of separation of powers and incapacity or impropriety of making decisions with practical budgetary allocation implications, its position has been critiqued as lacking judicial courage.⁷³⁰ The implication of this hesitation is that its loud 'silence' on the question of the nature and content of the minimum core is in fact a judgment call on the intent and purpose of the minimum core.⁷³¹ I would go as far to say that, in fact, what the court has done in those cases is cede the determination of what is a dignified threshold of human enjoyment for the various socio-economic rights that have been brought to it for consideration. This is especially the case in the right to health, per the cases of *Soobramoney* and *Treatment Action Campaign*.

Alternatively, the argument has been made that the virtue of reasonableness is that it is a contextual determination that can be made on a case-by-case basis.⁷³² While this is true, it appears to be a contradiction of the whole point of having socio-economic rights and a minimum core to ensure basic compliance. It is important not to lose sight of what prompted the need for the minimum core in the first place. The need for certainty, non-derogability and immediacy regardless of State means were all put in place to ensure State compliance, which can only come from prioritisation. As seen in the cases of *Grootboom* and *Soobramoney* where there was no pre-existing minimum core to contrast State action against, the material effect was that no significant determination was made to shift the responsibility to deliver on the State past its pre-existing levels and pace. In the case of the *Treatment Action Campaign*, where a decision was made against the State, it was not on the basis of a determination that provision of ARVs should form part of the State's minimum core obligations to the populace, bearing in mind the nation's HIV/AIDS prevalence and its identification as a public health

⁷³⁰ See n322.

⁷³¹ See n50.

⁷³² Lehmann, Karin. "In defense of the Constitutional Court: litigating socio-economic rights and the myth of the minimum core." *Am. U. Int'l L. Rev.* 22.1 (2006): 163-197

crisis. In fact, Bilchitz notes that the State had already shown that it had the means to deliver ARVs more widely.⁷³³ The question that arises from this point then is, if the State had shown capacity and the case made by the *amicus* had shown that HIV was in fact a national health crisis, why was the decision then limited to a determination that more largely questioned the political choice of hesitation to scale? Why was need and State capacity not added together to arrive at a judgment call on the nature of the minimum core and its need to now incorporate ARV treatment?

In the case of *Soobramoney*, where the court found that the administrative procedure was fair, why wasn't there a consideration of State capacity at a systemic level and comparison with need? It is likely that at the time, an analysis of the prevalence of cancer would show that while it was concerning, it did not constitute such a threat as to require immediate sweeping systemic intervention. This determination, along with the State's inability to adequately provide treatment more broadly, would have led to a determination that at the time, access to cancer treatment did not form such a treatment as to be part of the country's minimum core health package. In such an event a determination would have had to be made around a consideration of whether what the State was doing up until that moment was a fair and ever-increasing progressive realisation of the right to health. In the 23 years since the case was heard, would an analysis of State capacity and disease prevalence point to a different determination? Would the steady increase of non-communicable disease (NCD) lead to a decision today that South Africa is ready for the inclusion of certain treatment protocols for cancer and other NCDs? Would the fact that in this time, the State has had enough time to build its capacity factor to include NCD care into the minimum core? Sadly, this kind of public health and systems-conscious determination is not possible because of the approach of the Courts.

As Bilchitz points out, the test of reasonableness is inherently limited by its inability to be a sufficient basis upon which to make a well-considered judicial intervention on the responsibilities of the State to fulfil socio-economic rights and whether that duty has been met.⁷³⁴ The test is inadequate for determining the rightness of systemic interventions to the short-, medium- and long-term needs of the people. This is because the test of reasonableness is largely a case-by-case analysis of the decision of the State. As such, invariably, the determination of the "rightness" of the State's actions may not have much to do with the substance of the right in question and may be more about a procedural or administrative action and the consideration of its fairness on the face of it, as was the case with *Soobramoney*. However, the test of reasonableness may be best suited to situations where the

⁷³³ See n50.

⁷³⁴ Bilchitz, David. "Giving socio-economic rights teeth: The minimum core and its importance." *S. African LJ* 119 (2002): 484.

obligations of the State are clear and certain. In this instance, the test would only be used to appraise the State's actions against its already clearly laid out obligations.

And so, while reasonableness was made to prevent judicial overstep, it has invariably led to it because the application of the test of reasonableness is too subjective and dependent on too many contextual variables. As such, it is better to have clarity and clear barometers against which the State will be held to account, which is what a minimum core provides.

The relevance of the test of reasonableness to the Nigerian context

In South Africa, where it was created, the application of the reasonableness test is deeply entrenched in a presumption of good intent by the State and a proclivity to accede to the State on both its assertions on means and scope. There is a readiness to give the State the benefit of the doubt in its decision making. However, this approach by the courts has been strongly criticised as naïve.⁷³⁵ Regardless of the merits of a reposition of faith in the State, to make such a call on the Nigerian State would be a mistake the Nigerian courts cannot afford to make. This seeming pessimism is justified in the context of persistent systemic denial of social goods and health benefits to the Nigerian people as shown in previous chapters, with any and every other seemingly conflictual issue taking precedence over the realisation of the right to health for the people. Invariably, it is the populace that is forced to sacrifice a little more every time the Nigerian State gets the short end from an ill thought or executed economic policy or international event that limits its resources; especially when the ruling class do not partake of the austerity such reduced fortunes bring. Rather they are quick to sink the nation and commonwealth further into foreign debt with worse terms.⁷³⁶

Beyond this point, is the fact that despite the flaws in its formulation and application, the test of reasonableness may be justifiable in the context of South Africa.⁷³⁷ This analysis is possible, when one considers that the language of reasonableness is drawn from the wording of the South African Constitution which provide that the State has an obligation to “take reasonable legislative and other measures”, per Articles 26(2) and 27(2), which provide for the right to housing and healthcare respectively.⁷³⁸ In this manner, the use of the test of reasonableness is contextual to both the domestic

⁷³⁵ Ibid.

⁷³⁶ In the last few years, the country has taken loans more and more and the price of crude oil has constantly reduced, and it has been unable to properly diversify its resources. See Camillus Eboh, “Nigeria's Buhari seeks parliamentary nod on \$23 billion in foreign loans”, *Reuters*, 29 November 2019, available at <https://www.reuters.com/article/nigeria-borrowings-idUSL8N2895O9>, accessed on 10 October 2020.

⁷³⁷ See n728.

⁷³⁸ Constitution of the Republic of South Africa, 1996.

law as it is to the larger political, economic and social context of South Africa. The Nigerian courts should therefore not be in a hurry to adopt the test hook, line and sinker. While being guided by international law and principles, the Nigerian courts needs to start from the place of its own domestic provisions to provide the necessary clarity on the nature of the right to health. A reading of the Nigerian Constitution and the NHA together will show a preference for the enshrining of a minimum core. Section 17(3)(d) of the Constitution for example speaks of the obligation of the Nigerian State to provide “adequate medical and health facilities for all persons”. The requirement of adequacy and its scope of “all persons” would mean that there is a benchmark for determining adequacy as well as the fact that such a benchmark will accrue to all and this will be non-derogable. This view is then further reinforced in Section 3 the NHA, which expressly states that “all Nigerians shall be entitled to a *basic minimum package*⁷³⁹ of health services.”⁷⁴⁰ For the avoidance of doubt, subsection 3 of that section — which provides for this “basic minimum package” — is prefixed by the assertion that “without prejudice to the prescription of the minister in Section 3(1)” meaning that regardless of the extra discretion given to the minister as to who may receive extra concessions and health services, every citizen can expect to enjoy that minimum package of healthcare.

Another challenge with the reasonableness test, which is especially disadvantageous in the Nigerian context, is the fact that it is the burden of the litigant to prove the unreasonableness of the State’s program.⁷⁴¹ This further entrenches the already powerful State as the right-thinking, well-intentioned actor, and the litigant as the greedy, ever needy citizen constantly begging for more, despite the State already doing all it can. While this presumption is often wrong on the merits of the case, more than that, such framing serves to reinforce the already skewed power dynamics and aligns the judiciary with the already powerful State, contrary to its mandate of being an impartial arbiter and last hope of the common man. It also makes the burden of proof unnecessary high on the litigant. Alternatively, it should be the State for whom the primary duty to realise the right to health lies that should be made to come show that it has taken the right and necessary action as originally intended in the creation of the minimum core in General Comment 3.

Ultimately, while I agree that the courts are not best suited to make determinations on quantity in the decision about the content of the minimum core, they have a duty to require the State to do so in a manner that holds it to a high standard as laid out in international human rights principles and in line

⁷³⁹ Emphasis mine.

⁷⁴⁰ Act No. 8 of 2014.

⁷⁴¹ See n728.

with the aspirations of the people and then in line with the resources of the State, which itself must be objectively determined and not taken on the word of the State.

As time has shown with the provision of ARVs in South Africa, they have invariably become a part of the minimum core of health goods of the South African populace by virtue of State practice. Also, in the case of *Mazibuko*, while the State won, it subsequently reviewed the amount of free basic water upwards. These instances show that more is possible if more is demanded of the State. The journey of progressive realisation of the right to health is a long one that requires all parties to constantly hold each other to account, while making concessions where necessary. While the beneficial outcome of the *Treatment Action Campaign* case was a result of a “confluence of individual interests, general welfare, and affordability considerations”,⁷⁴² which made it possible for the court to reach its decision, such a dependence on luck should not be the case in making determinations about the welfare and healthcare of the people. While windows of opportunity must constantly be identified and maximised by health advocates and the masses, the absence of the ‘perfect storm’ cannot become a crutch for the inability to address systemic deprivation, as the dependence on a confluence of favourable factors is not a sustainable approach.⁷⁴³

Progressive realisation

The nature of progressive realisation

Despite the best intentions of the ICESCR and the General Comments to expound on it, universal access is still a challenge. And while there is a recognition that universal access is often not possible at the outset, it is for this reason that the mandate on States to “progressively realise” socio-economic rights is featured prominently in the framing of the State’s duties. Concerning the right to health specifically, Article 12 of the ICESCR provides that State parties are to take steps to achieve the full realisation of the right. General Comment 14 is clear that the obligation to progressively realise the right to health must not be interpreted to mean that States have no clear and pressing obligations.⁷⁴⁴ Rather, the obligation means that States have specific and ever-rolling obligations that require them to act expeditiously and with the most effective route in mind for the realisation of their health goals

⁷⁴² See n721 at 176.

⁷⁴³ Bilchitz agrees with me on the need for clear standards and benchmarks. As he puts it, “one right can involve different levels of provision; the state can be obligated to provide a minimum threshold of a right whilst having to increase its level of provision progressively over time”. See n50.

⁷⁴⁴ Paragraph 31, General Comment 14, 2000.

as mandated by Article 12 of the ICESCR.⁷⁴⁵ In seeking to meet these goals, States must be conscious of their obligations to respect, protect and fulfil.⁷⁴⁶ For the most part, the obligations to respect and protect are largely the starting point of the realisation of the right to health and form an important part of the minimum core by ensuring State accession and non-retrogression of the peoples' right and access to healthcare. Much of the work of progressive realisation is in the domain of fulfilment, which requires States to "adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health"⁷⁴⁷

This mandate is clear that the progressive realisation of the right to health will have to be clearly outlined in legislative intervention, programmed in necessary administrative action, given commitment in budgetary allocation, implemented in clear action and promotion, and held up to scrutiny by judicial intervention. In this sense, the progressive realisation must be clear not just in the requirement for intervention but also in its implementation. The requirement for legislation as a step in the fulfilment of the right to health is to have clarity. Clarity on the nature of rights that accrue is essential to the enjoyment of the right to health, as identified by scholars like Chenwi who point out that the progressive realisation of health is made up of three key elements. They are that (1), there must be tangible and immediate progress in the realisation, (2) the State may not introduce retrogressive steps that take away from the already existing range of rights and benefits being enjoyed, which is important for health policy formulation and implementation and (3) in the progressive realisation of socio-economic rights, the needs of vulnerable and disadvantaged groups need to be put in place, with measures to address them.

The need for clear, tangible, and immediate progress

In the progressive realisation of health, the plan on how to execute it must be specific with a reasonable timeframe given within which to realise the plan. Part of this clarity means that the necessary State apparatus must be in place and given the requisite powers and funding needed to meet the obligations laid out in the State's plans. Health governance is central to this and there must be a system in place that maximises the existing hierarchies while enabling necessary decentralisation of power as well as innovation. There must also be room for feedback loops that ensure necessary course correction and policy modification where necessary. All of this is to ensure that more than anything, the interventions put in place are effective and impactful.

⁷⁴⁵ Ibid.

⁷⁴⁶ Ibid at Paragraph 33.

⁷⁴⁷ Ibid.

Non-retrogression in the realisation of the right

Paragraph 32 of General Comment 14 states that retrogressive measures in relation to the right to health are not permissible. The very nature of “progressive” realisation already implies that the steps taken to meet health goals will be forward looking and not made to retract from progress already made. More than that is the recognition of the fact that retrogression can often be used as a punitive measure to deny access to segments of the populace for political reasons. This is not permissible in the progressive realisation of the right to health. The only time such action will be justified is when it is done as a means of correcting an existing error or wrong and is a temporary step back to enable a greater leap forward. Retrogression is permissible where it is necessary for achieving equity and addressing structural imbalances.⁷⁴⁸ More than anything, it is important to ensure that actions taken in any direction are not particularly averse to the marginalised and vulnerable.⁷⁴⁹

Cognisance of the needs of vulnerable members of society

General Comment 14 gives specific emphasis to protecting the needs of the vulnerable in the realisation of health goods. This protection goes beyond acknowledging them and respecting their rights, but also translates into taking into cognisance their unique needs in the steps taken to fulfil the right to health. Paragraph 18 of General Comment 3, for example, is clear that “even in times of severe resource constraints, the vulnerable members of society must be protected by the adoption of relatively low-cost targeted programmes”.⁷⁵⁰ The State must not just factor in the needs of the marginalised and vulnerable, but as noted above, must also rectify the structural injustice that has kept them marginalised in the first place. Systemic interventions must be put in place to address the social, economic, and environmental factors that contribute to the adverse health outcomes of vulnerable groups and which may make them susceptible to disease. In this manner, special emphasis will often have to be placed on the interconnected nature of social injustices that may be perpetuated by factors outside of healthcare, strictly speaking. Economic ventures that decimate communities and render their water sources unsafe and go on to lead to hunger and disease must, for example, not be

⁷⁴⁸ Liebenberg, Sandra. *Socio-economic rights: Adjudication under a Transformative Constitution*. Cape Town: Juta & Co. Ltd., 2010.

⁷⁴⁹ Ibid.

⁷⁵⁰ General Comment No. 3.

seen as just environmental issues.⁷⁵¹ Paragraph 34 of the same General Comment also makes this point where it states:

States should also refrain from unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure, e.g. during armed conflicts in violation of international humanitarian law.⁷⁵²

These environmental and humanitarian issues must also be understood as a right to health issue and must be incorporated into the broader human right claim of those communities, for whom the State has both a responsibility to protect as well as to fulfil obligations to aid in clean ups, rectification, and onward sustainable and healthy practice.

This kind of State intervention will often require active community participation, which itself is an essential element of ensuring that health rights are acceptable. It is not enough to make them available and accessible. As paragraph 12 of General Comment 14 has pointed out, health goods and services must be respectful of the cultural practices of the people for whom it is intended. It must be sensitive to their nuance as individuals that are gendered and as a community. And as paragraph 17 of the Comment notes, one important way to do this is to further population participation in the provision of both preventive and curative health services. In addition to this, the political decisions affecting the organisation of the health sector, the insurance scheme and funding mechanisms must carry along communities at every level.

The challenge or resource allocation in the progressive realisation of health

Progressive realisation without the resources to realise it or alternatively within the only the scope of available resources run the risk of justifying State inaction⁷⁵³ While General Comment 14 recognises that the actions of States will largely be dependent on the availability of resources,⁷⁵⁴ the State needs to maximise those available resources. This thus means that whatever is available must be judiciously applied for the maximum good of the maximum number. This also inherently precludes graft and corrupt practices that undermine what is possible with the limited resources available. However, more

⁷⁵¹ See n655.

⁷⁵² *General Comment No. 3.*

⁷⁵³ See n688.

⁷⁵⁴ Paragraph 39, General Comment 14, 2000.

than the judicious allocation of scarce resources is an expectation that the State will steadily increase its ability to do more. In this manner, the increment of capacity is itself an element of progressive realisation. It is not enough to have a budget for what the State will do in the present. It must be clear about what it intends to do over time, along with a realistic timeline of how it intends to build the capacity to do it. In this manner, the claim that progressive realisation is invariably just aspirational is not true to the original intent of its formulation.

Progressive realisation in the Nigerian context

As shown above, the obligation to progressively realise the right to health requires various kinds of action vis á vis programmatic intervention as well as the nature of their substantive value and quality. In this manner, Nigeria not only needs to lay out its plans for realising its health goals, but it must also take the necessary steps to implement these plans to make health goods and services, available, accessible, and of good quality. While considerable effort has been made over the years to increase availability and remove the physical barriers to accessibility, it has been hampered in various degrees by increasing unaffordability for the Nigerian populace, which have made health goods and services economically inaccessible, especially for better quality care. This inability to afford good care is compounded by the generally receding quality of care available and provided especially in the health centres that are more ‘accessible’ to the everyday Nigerian, due to ineffective funding structures. The effect of this is that even when services are ‘available’ and access to them is largely unhampered, it is of little effect in the face of empty shelves, unavailable beds, and overworked health workers with little incentive to give their best. In a similar vein, while the State has taken the right step to provide legislative impetus to the right to health and to lay out its policies, the important task of realising the mandate of the law and policies have gone largely unmet. And while the mandate of the Abuja Declaration⁷⁵⁵ has persistently gone unmet, there is still no clarity on how the Nigerian State intends to rectify its health funding deficit and put in place a sustainable funding mechanism that will preferentially be aimed at the realisation of universal health care goals. The type of systemic reform mandated by the NHA has also not garnered much uptake, as critical aspects of health governance are still over politicised and focused on issues that do not form part of the State’s health priorities. All this foot dragging is sadly enabled by a fractured accountability mechanism as required for meaningful progressive realisation. And while the NHA now provides the kind of substantive legislation that may

⁷⁵⁵ *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*. AHG/228 (XXXVII) Annex I (2001).

now be litigated, the lack of clarity on the nature of the State's obligations still makes it difficult to hold the State up to scrutiny.

Conclusion

From the exposition of the concepts of the minimum core, reasonableness, and progressive realisation, it becomes evident that for the right to health to be of any actual merit, it needs to be concrete and clear, with staggered layers or steps of progressive realisation, which are realised by deliberate and quantifiable State action and are subject to structures of accountability. As Forman puts it, the core concept and intent of the minimum core has much potential for advancing the prioritisation of essential health needs in both domestic and international health policy, programming, service delivery as well as adjudication.⁷⁵⁶ However, for it to fully yield its potential, it will need to address its flaws and resolve them. How the concept of reasonableness is juxtaposed with the minimum core, if at all, will reveal whether the seemingly hard line drawn in the sand by the minimum core has been wiped away by larger political and economic considerations. The concept of the minimum core still has much to offer in terms of utility. The failure to maximise its utility thus far is not due to an inherent lack of value but rather due to the constant lack of fidelity to it.

However, whether by the application of the minimum core or progressive realisation, the Nigerian State is grossly lacking in the fulfilment of its duties. There is a need to rethink the reframing of the State's obligations to the populace as both necessary and immediate. To do this, there is need for an effective system of accountability. While accountability may be by pressure groups and engagement, ultimately, the courts must be used not only to right immediate wrongs but to establish the kind of precedence that transcends the immediate and compels the State to start the journey to systemic intervention for the good of all. However, this kind of accountability will be best reached by a rethinking of the legal concepts discussed above. They must be understood as principles that give the State temporary respite on the long journey to the full fulfilment of the right to health and not as a final resting place. The protection of the life, health and dignity of the average Nigerian, and especially the vulnerable and weak with little individual access to power must be the central focus of all attempts at ensuring State accountability. In the pursuit of State accountability, it is not enough to scoff and declare that the country is resource rich and its only challenge is mismanagement. The reality is that while the resources may be mismanaged, it is from the already scarce amount that is inadequate. The question then becomes, how we can navigate this reality to negotiate a clear, definite, ever

⁷⁵⁶ See n700.

progressive kernel for the right to healthcare in Nigeria that is front and centre in the correct ideological basis of realising the health and dignified life of every Nigerian? In the subsequent chapters, I posit that this is possible through a contextual framing of human dignity that sees the right to health as a legitimate claim on the State, which is consequently upheld by the courts holding the State accountable.

Chapter 7

Human dignity as the basis of the right to health

Introduction

The notion of human dignity has been at the core of the philosophical, moral, and legal ethos of humanity for over half a century.⁷⁵⁷ The events of the Second World War sparked a recognition by some States that that human atrocity can and should no longer go unchecked. This would become the guiding principle upon which the international community of nations would come to recognize human rights with human dignity at the core. While notions of personhood and dignity predate the modern global legal and political regime, its recognition and observance were largely subject, and conditional to, the whims of the powerful, who often exerted their power against marginal groups based on race, gender, sexual orientation, or economic class. The notion of dignity as central to our perception of all human life has also seen it become a major arbiter of social justice, political freedoms, and economic redistribution of resources.

There has, however, been criticism of this turn to human dignity, based on an assertion that it is a largely vague concept,⁷⁵⁸ and the argument that it is incapable of the type of universality that could form the basis of a global moral and legal order.⁷⁵⁹ As an alternative to the perceived limitations of human dignity as a foundational concept, scholars have opined for alternatives to “dignity language” in ethical discourse and health intervention.⁷⁶⁰ In the face of these criticisms, concerted effort has been made to clarify the nature and substance of human dignity, with a revival of the concept in the past decade.⁷⁶¹ This has invariably led to various schools of thought with differing notions of what dignity means or ought to mean in pursuit of human flourishing. The exploration of the virtues of dignity have informed any number of fields of study, ranging from philosophy to linguistics.⁷⁶² It has also enjoyed significant resonance in areas of study that lay emphasis on the ways human beings are treated and cared for. In this regard, it has informed perceptions about the role of medical sciences

⁷⁵⁷ Habermas, Jürgen. "The concept of human dignity and the realistic utopia of human rights." *Diánoia* 55.64 (2010): 3-25.

⁷⁵⁸ Macklin, Ruth. "Dignity is a useless concept." *British Medical Journal* 327.7429 (2003): 1419-1420.

⁷⁵⁹ Ibid.

⁷⁶⁰ See n757.

⁷⁶¹ Winter, Sebastian F., and Stefan F. Winter. "Human dignity as leading principle in public health ethics: a multi-case analysis of 21st century German health policy decisions." *International journal of health policy and management* 7.3 (2018): 210-224.

⁷⁶² Shultziner, Doron. "Human dignity: Functions and meanings." *Perspectives on human dignity: A conversation*. Eds. J. Malpas, and N. Lickiss. Dordrecht: Springer, 2007. 73-92

vis á vis the treatment of persons, either as subjects of research or as beneficiaries of medical care.⁷⁶³ Even more broadly, the pursuit of dignity and the possibility of balancing conflicting interests has been at the centre of public health reform and interventions.⁷⁶⁴ There is a resurging recognition of the need to return to human dignity as the foundational basis upon which public health interventions and scholarship is done.⁷⁶⁵ All of these dignity-based interventions for human health are nested in the larger recognition of the individual's right to health. In this manner, every subsequent personal or public health interventions is in pursuance of this larger project.

As I have shown in the preceding chapters, the realisation of the right to health has persistently been met by challenges. A shaky legal framework exacerbated by resource constraints has left the right to health in Nigeria largely unrealised. Considering this reality, this chapter examines the nature of human dignity and its role in understanding the right to health. It examines key theories around human dignity to see what answers they can provide in founding a valid claim on the State. Consequently, I discuss the origins of dignity as the core of the right to health, showing its provision in international law. I consider the capabilities approach, which is a modern expansion on the western ideology of human dignity that traces its roots to Emmanuel Kant's work on the subject. I then examine the limitations of this framing of dignity, especially in the Nigerian context and make the case for an exploration of human dignity outside of the otherwise hegemonic western lens.

Defining human dignity

Human dignity is the core philosophical notion around the nature of human worth. It is the basis upon which our conceptions of human personality, identity and freedom are shaped.⁷⁶⁶ It is the basis upon which social justice is sought, Constitutions are formulated and measured, and international human rights are evoked.⁷⁶⁷ The notion of human dignity serves as the North Star for society's attempts at

⁷⁶³ Dresser, Rebecca. "Human dignity and the seriously ill patient." *Human Dignity and Bioethics*. Ed. B.T Lanigan. New York: Nova Science P Inc., 2008. 505-512.

⁷⁶⁴ Jacobs, Barbara Bennett. "Respect for human dignity: a central phenomenon to philosophically unite nursing theory and practice through consilience of knowledge." *Advances in Nursing Science* 24.1 (2001): 17-35. See also, Gostin, Lawrence O., and Madison Powers. "What does social justice require for the public's health? public health ethics and policy imperatives." *Health Affairs* 25.4 (2006): 1053-1060.

⁷⁶⁵ See n761.

⁷⁶⁶ Hughes, Anne. *Human Dignity and Fundamental Rights in South Africa and Ireland*. Pretoria: PULP, 2014.

⁷⁶⁷ Ibid.

being better and more just.⁷⁶⁸ Dignity represents what it means to be human and it is from this moral principle that subsequent legal recognition, as a human right, flows.⁷⁶⁹

Ackermann has described human dignity as,

... the capacity for and the right to respect as a human being that arise from all those aspects of the human personality that flow from human intellectual and moral capacity; which in turn separate humans from the impersonality of nature, enables them to exercise their own judgment, to have self-awareness and a sense of self-worth, to exercise self-determination, to shape themselves and nature, to develop their personalities and to strive for self-fulfilment in their lives.⁷⁷⁰

In this description of dignity, several key concepts that form the basis of our rationalisation of dignity are incorporated. Being defined as both a capacity and a right, it highlights both the inherent nature of dignity as well as the autonomy and agency that flow therefrom, as well as its various uses in the shaping of both the individual's life and society around them. At its core is the premise that human dignity is the most basic attribute of humanity.⁷⁷¹ Due to the centrality of dignity to the conception of what it means to be human, it is connected to ideas of sanctity, autonomy, personhood, flourishing, and self-respect.⁷⁷² From these various conceptions, the determinations on if, when and how that human nature is to be expressed or curtailed, is at the core of various disciplinary pursuits and attempts at creating and regulating society⁷⁷³

Despite a widespread acknowledgement of dignity as the starting point in our conception of human nature, there is a persistent pushback against it as a viable descriptor. This is because, while it is useful as a descriptor of a phenomenon, it is incapable of definition in and of itself. To the critique of dignity, it is not enough to say dignity is what makes us human. What is the quality of said dignity? How is it identified? What is it about the concept that makes it not another vague qualifier used to describe an unquantifiable phenomenon? It is these kinds of questions that lead to its dismissal as "a loose cannon, open to abuse and misinterpretation".⁷⁷⁴ This grouse with the concept of dignity is at the root of

⁷⁶⁸ Ibid.

⁷⁶⁹ Steinmann, Rinie. "The core meaning of human dignity." *PER: Potchefstroomse Elektroniese Regsblad* 19.1 (2016): 1-32.

⁷⁷⁰ Ackermann, Laurie WH. "Equality and Non-Diminution: Some Analytical Thoughts." *South African Journal on Human Rights* 22.4 (2006): 597-612 at 602.

⁷⁷¹ See n769.

⁷⁷² Weisstub, David N. "Honor, dignity and the framing of multiculturalist values." *The concept of human dignity in human rights discourse* (2002): 263-294.

⁷⁷³ Riley, Stephen. "Human Dignity and the Rule of Law." *Utrecht Law Review* 11.2 (2015): 91-105.

⁷⁷⁴ Gearty, Conor A. *Principles of Human Rights Adjudication*. Oxford: Oxford UP, 2004 at 85.

various attempts to both appropriately expound on its nature as well as calls for further elaboration in the instance where there is hesitance to apply it.⁷⁷⁵ And, while the concept of dignity is used interchangeably in other disciplines to convey various goals, its seeming lack of definition is particularly problematic for many in the context of a legal tradition that requires clarity and certainty.⁷⁷⁶ As a result, many of the most vocal criticisms come from those who find it an unwieldy beast in its assignment of capturing human worth and the kind of justice required to preserve it. A particularly scathing view of the concept of dignity is that it is essentially a piece of jurisprudential Lego – to be used in whatever shape or form is required by the LEGOLAND designs of the judicial designer.⁷⁷⁷

If dignity is so fraught with flaws, why is there an ever-constant resort to it? What is it about the concept of dignity that drives society to use it as a core arbiter for the determination of what is just? Why do we continue to seek for the treatment of all with dignity? What is at its core that, despite the “*dissensus regarding a definition*”,⁷⁷⁸ makes it attractive as the basis of moral law? Frowein explains that ideas of dignity have been at the core of the development of international law over time, and from as early as the 16th century been a foundational value for quests to rectify the wrongs of the world at various scales.⁷⁷⁹ Grant credits it as providing impetus for the push to abolish slavery in the 19th century.⁷⁸⁰ It would also serve as the basis of the recognition of the many injustices of the two world wars, especially the second as exemplified in the holocaust.⁷⁸¹

Human dignity as the core of the modern international legal order

The use of human dignity in public international law has come to represent the marker for our understanding of the moral, legal and political discourse of human rights.⁷⁸² While conceptions of it have been used before in history, the notion of dignity as not merely a moral imperative or philosophical tool of analysis but as a concrete legal principle were clearly established in the Universal

⁷⁷⁵ Steinmann provides various cases in various jurisdictions around the world, where the courts have described the concept of dignity as problematic and unwieldy. See n769.

⁷⁷⁶ Ibid.

⁷⁷⁷ Davis, D. M. "Equality: the majesty of Legoland jurisprudence." *S. African LJ* 116 (1999): 398.

⁷⁷⁸ See n769.

⁷⁷⁹ Frowein, Jocheim A. "Human Dignity in International Law." *The Concept of Human Dignity in Human Rights Discourse*. Eds. D. Kretzmer, and E. Klein. The Hague: Kluwer Law International, 2002. 121-132.

⁷⁸⁰ Grant, Evadné. "Dignity and Equality" *Human Rights Law Review* 7(2007):299-329.

⁷⁸¹ Ibid.

⁷⁸² See n773.

Declaration of Human Rights of 1948 (UDHR).⁷⁸³ The formulation of the UDHR took place when the foundations of the international legal and political order were undergoing massive upheaval and there was a clear and pressing need for a unifying and universalising moral principle to shape a new world order. And so, in the choice of human dignity as that principle, the concept would move from the philosophical to the normative.⁷⁸⁴

The preamble to this critical milestone document provides 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”⁷⁸⁵

Here, the UDHR qualifies its conception of dignity as being “inherent”, as well as being the basis of the need for equal rights for all, which must be realised as inalienable and not subject to qualifiers. The Declaration provides that it is through the pursuit of human dignity that the collective effort towards human freedom and flourishing will be sought and ultimately achieved. The mandate of the international human rights regime is clear: the Charter’s intention is not only to regulate the relations of States for the prevention of further wars, but to establish the foundations of a new world order that is built on the unequivocal recognition of the universal and equal dignity of the whole of humanity.⁷⁸⁶

The international covenants that follow maintain the same tradition in their recognition of the centrality of human dignity in the pursuit of human rights recognition and fulfilment. Interestingly, both covenants that provide for civil and political rights as well as socio-economic rights recognise the centrality of human dignity in the pursuit of the rights they provide for.

The preamble of the International Covenant on Civil and Political Rights (ICCPR)⁷⁸⁷ states that its provisions are nested in,

...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, ...

Recognizing that these rights derive from the inherent dignity of the human person ...⁷⁸⁸

⁷⁸³ UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

⁷⁸⁴ See n773.

⁷⁸⁵ UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III).

⁷⁸⁶ See n773.

⁷⁸⁷ UN General Assembly, *International Covenant on Civil and Political Rights*, 16 December 1966, United Nations, Treaty Series, vol. 999, p. 171. GA res. 2200A (XXI), 21 UN GAOR Supp (No 16) at 52, UN Doc.A/6316 (1966); 999 UNTS 171; 6 ILM 368 (1967).

⁷⁸⁸ Preamble, International Covenant on Civil and Political Rights, 1966.

In pursuance of this mandate, the preamble goes on to state:

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights.⁷⁸⁹

It also states that the obligations of the State in the fulfilment of these goals will require both the “promotion of universal respect for, and observance of human rights and freedoms.”⁷⁹⁰

An important point to note from the provisions of the ICCPR is that, despite providing for civil and political rights that are often framed as “negative” rights, it recognises that civil and political rights are interdependent and interconnected with socio-economic rights as well as the fact that both categories of rights require respect as well as observance. This declaration on the implications of dignity aid in understanding the concept as transcending State respect of human autonomy and agency, which itself is central to an understanding of dignity.

The International Covenant on Economic, Social and Cultural Rights (ICESCR),⁷⁹¹ which provides specifically for the right to health, shares a materially similar preamble to the ICCPR in grounding socio-economic rights in inherent human dignity, providing that,

Recognizing that, in accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his economic, social and cultural rights, as well as his civil and political rights ...⁷⁹²

This provision is important because it explains that the “freedom” of the person is largely conditional on their ability to be free from fear and lack. In this manner, both the apprehension caused by lack as well as the actual lack have a debilitating effect on a person’s ability to operate as a functional and productive member of society. To address this, the provision requires that States create the conditions that make it possible to enjoy the various socio-economic and cultural rights provided for in the Covenant. In a similar fashion to the ICCPR, it provides that the obligations of this Covenant require respect as well as consequent observance.⁷⁹³ It also provides for the State’s duty to create enabling

⁷⁸⁹ Ibid.

⁷⁹⁰ Ibid.

⁷⁹¹ UN General Assembly, *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3. GA res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 49, UN Doc. A/6316 (1966); 993 unts 3; 6 ILM 368.

⁷⁹² Preamble, *International Covenant on Economic, Social and Cultural Rights*, 1966.

⁷⁹³ Ibid.

conditions; a fact that must be noted specifically. This framing is important for an understanding of dignity that is not seen as an abdication of personal responsibility to a nanny State, which is an often-heard criticism of the nature of socio-economic rights. The mandate on the realisation of human dignity as expressed in human rights means that the State may not merely rely on non-interference as a fulfilment of its obligation, while also recognising that, upon the guaranteeing of the right conditions, the utilisation and maximisation of those given opportunities rests on the individual. The nuance of this important part of the understanding of dignity must be noted and will be discussed further in unpacking ideas of dignity.

The assertion of a recognition of personal agency is seen in a subsequent paragraph of the ICESCR's preamble, which provides that "the individual, having duties to other individuals and to the community to which he belongs, is under a responsibility to strive for the promotion and observance of the rights recognized in the present Covenant."

In this portion of the preamble, the seeds of a relational understanding of rights are sown, as well as the juxtaposition of rights with duties; a theme that is given much more exposition in the African Charter.

As Steinmann puts it, dignity as formulated in the international human rights regime represents three essential values. They are that (1) dignity is an ontological claim that speaks to man's qualities, which give him his value; (2) this dignity requires recognition and respect by society, which is shown in the kind of laws it creates; and (3) the individual, his dignity and his rights, are at the core of social ordering and so the State is created for the individual and not the other way around. As an extension of the use of the State, its primary role is to progressively provide existential minimum living conditions to the various individuals that constitute it and give it legitimacy.⁷⁹⁴ These three values often overlap depending on who is using it, why they are using it and in what context.⁷⁹⁵

The critique of dignity as the core of the international human rights regime

The centrality of dignity in the three foundational international human rights instruments lends credence to the fact that, in spite of the political negotiations that necessitated the creation of two separate covenants, there was a recognition that human dignity requires not only respect and non-interference of personal autonomy but also requires action by the State to guarantee a dignified life

⁷⁹⁴ See n769.

⁷⁹⁵ Ibid.

for its people. In this manner, the realisation of human dignity is the starting point, the pathway, as well as the eventual destination of humanity's pursuits.

However, the assertion of the centrality of human dignity have been dismissed as superfluous. It has been described as a non-existing ethical core in the absence of an agreed upon religious or moral ethos.⁷⁹⁶ This critique is rooted in the belief that the very thing that gives it a claim to universality is the thing that deprives it of any real substance, and that is that it is amorphous. This critique asserts that it is for this reason that dignity remains undefined by the very human rights instruments that extoll it and make it the basis of all human right engagement. To define dignity, it is argued, would be to expose it as lacking the very claim to universality upon which it is based.⁷⁹⁷ Conversely, its seeming lack of definition is not seen as a detriment to its normative utility. For this school of thought, it is enough that there is global accession to the assertion that there is such a thing as human dignity and that said assertion is strong enough to warrant global buy in into the idea of universal human rights despite varied religions and creeds.⁷⁹⁸ As such, it is enough that dignity is accepted as the inherent characteristic that gives human nature its value.⁷⁹⁹ As a result, to question its centrality would be to question the value of humanity, which would in turn call for an external factor outside of human's nature to be the basis upon which value for the human is derived. The problem with such an external value outside of inherent human nature is that such a value may simply be taken in the same token as it was given; seeing it as external and not inherent.

However, the critique of dignity's indeterminacy remains at the core of the quest for legal clarity and certainty. This critique has been responded to in a few ways. Some scholars have posited that the very nature of dignity precludes it from definition. For them, it is as the air and the wind; more felt than seen.⁸⁰⁰ They support this assertion with the claim that the reason the centrality of human dignity has remained through the decades is because in spite of its seeming lack of definition, there lies at its heart a common understanding of its nature in every human in whom it is inherently reposed and it is for this reason that it does not in fact require strict definitions.⁸⁰¹ This school of thought has however

⁷⁹⁶ Beitz, Charles R. "Human dignity in the theory of human rights: Nothing but a phrase?" *Philosophy & Public Affairs* 41.3 (2013): 259-290.

See also, Carmi, Guy E. "Dignity-The enemy from within: A theoretical and comparative analysis of human dignity as a free speech justification." *U. Pa. J. Const. L.* 9 (2006): 957.

⁷⁹⁷ Schachter, Oscar. "Human dignity as a normative concept." *American Journal of International Law* 77.4 (1983): 848-854.

⁷⁹⁸ Bernardini, Paola. "Human dignity and human capabilities in Martha C. Nussbaum." *Iustum Aequum Salutare* 6 (2010): 45.

⁷⁹⁹ Hughes, Glenn. "The concept of dignity in the universal declaration of human rights." *Journal of Religious Ethics* 39.1 (2011): 1-24.

⁸⁰⁰ See n797.

⁸⁰¹ Ibid.

been critiqued as showing the same intellectual disingenuity that resulted in the choice of dignity in the first place and its subsequent lack of definition.⁸⁰² The question raised in counter is that, if it is so ubiquitous that every human being instinctively feels it, surely that commonality should make it easier to clearly define. As a result, those in opposition assert that this definitional quagmire is actual proof that contrary to the claim of universality, dignity is inherently subjective; meaning different things to different people and as such cannot be a reliable basis for a claim to universal, inalienable human rights.⁸⁰³ Other scholars kick against this assertion, stating that while dignity may mean different things to different people, what is universal about dignity is actually not its nature but its existence.⁸⁰⁴ In this manner, it is almost like the sun; how it is felt is dependent on any number of factors ranging from time of day to region to intended purpose of its use, but what remains central is that the sun indeed exists. As a counter, those opposed to the notion of human dignity as nothing more than an aspirational platitude state that if dignity is dependent on context, it lacks the legal certainty upon which to base the global human rights legal order.⁸⁰⁵

Amid this persistent back and forth, there are scholars that have somewhat reconciled themselves to the fact that dignity, as with any other concept, is not without its flaws and as such do not seek to hold it up as infallible.⁸⁰⁶ For them, the notion of human dignity is sufficient to hold two truths up at the same time; the first being that there is a universal acceptance of the existence of human dignity and the second being that what said dignity means may vary in various contexts.⁸⁰⁷ What is important in this sense is that regardless of the contextual understanding, the respect of the fact that everyone has dignity merely by virtue of being human is at its core. Based on this concession, there have been various schools of thought on the contextual nature of dignity. These intellectual traditions predate the international human rights regime and apply to our times to guide us in our quest to determine what our goals ought to be in the pursuit of human flourishing based on human dignity. In the western philosophical tradition, the conception of dignity goes as far back as the works of Aristotle, down to Christian morality and the more positivist view of dignity strictly speaking.⁸⁰⁸ These paradigms over time, while not necessarily being the same, have influenced subsequent iterations that follow them. They provide us with methodological tools as well as a historical lens for our present conceptions of

⁸⁰² Ibid.

⁸⁰³ McCrudden, Christopher. "Human dignity and judicial interpretation of human rights." *European Journal of International Law* 19.4 (2008): 655-724.

⁸⁰⁴ See n799.

⁸⁰⁵ Botha, Henk. "Human dignity in comparative perspective." *Stellenbosch Law Review* 20.2 (2009): 171-220.

⁸⁰⁶ See n769.

⁸⁰⁷ Ibid.

⁸⁰⁸ Andorno, Roberto, and Antonio Pele. "Human dignity." *Encyclopedia of global bioethics* (2015): 1-11.

dignity.⁸⁰⁹ And so, while dignity itself is not an enforceable norm in and of itself, it has significant symbolic importance.⁸¹⁰

In the absence of clear definition, where does the notion of human dignity as expressed in the international human right legal order stem from? Grant argues that it draws from three main sources. The first and most common being the immediate atrocities that occurred in the Second World War, the second being the philosophical traditions that evolved over the centuries as well as the thinking of the drafters of the documents who were themselves influenced by these scholarly traditions. Key among these scholarly traditions and probably the most prominent is the one that draws from the work of Emmanuel Kant, which places emphasis on rationality. His work has gone on to influence the more recent concept of dignity as capability, which itself has gained much traction and will now be discussed.

Human dignity, as the “capability” to enjoy the right to health

Historically, the development of human dignity in the western philosophical and cultural tradition is inherently tied with the emergence of individualism. From its earliest Greek traditions, its conception is rooted in an acceptance of human’s capacity for reason and from that capacity, an ability to exercise agency and consequent autonomy.⁸¹¹ As a result of the fact that all persons have the capacity for reason, they are equal in worth and deserving of respect.⁸¹² It is this characteristic that was seen as separating humans from animals and justified their treatment separate from that of animals and others that were, at various points in time, defined as being closer to animals than to humans.⁸¹³ While the Christian roots of dignity would centre inherent value in the human being’s “creation in the image of God”,⁸¹⁴ even this God, like nature, would be reserved for some.⁸¹⁵ The acquiescence to true universality of human dignity that is not conditional upon anything other than being human would be established in the UDHR as discussed above. However, even this new acquiescence would itself be rooted in the centuries of accretion of thought on the nature of human dignity. As Grant states, it

⁸⁰⁹ Ibid.

⁸¹⁰ See n773.

⁸¹¹ See n780.

⁸¹² Ibid.

⁸¹³ See n773.

⁸¹⁴ Genesis 1, 27, *The Holy Bible, King James Version*. Massachusetts: Hendrickson Publishers, 2004.

⁸¹⁵ Christianity was also used as a justification for slavery. See Wells, Shaniqua Janeè. *A Basis of the Civil War: The Theological Views of Nineteenth Century Christians on the Justification of Slavery*. Honors Thesis, University of Southern Mississippi (2015).

would be the western tradition that would inform the formulation of the conception of human dignity and its centrality to the human rights order.⁸¹⁶

The exploration of human dignity as the capacity to enjoy the right to health would form the foundations for the scholarship around the larger concept of human capability. Formulated by Amartya Sen and Martha Nussbaum in the 1980s, the notion of capabilities emerged as an approach to assess social arrangements and to determine whether they were just. The measure for determining the justice of those arrangements was an analysis of whether they guaranteed each citizen the entitlement to his basic capabilities; a state from which human functioning drew.⁸¹⁷ According to Sen, functioning's are beings and doings⁸¹⁸ as well as those things which the individual may value doing or being.⁸¹⁹ For Nussbaum, justice may be said to exist in society to the extent in which it guarantees every individual a Constitutionally guaranteed entitlement to a list of basic capabilities, which according to her are ten in number.⁸²⁰

According to Nussbaum, the capability approach is primarily a human rights approach, which is particularly grounded in the specific concept of human dignity. In this manner, all persons ought to acknowledge and respect the entitlements of others to live lives that are commensurate with their human dignity.⁸²¹ In this sense, rights are enjoyed because others acknowledge them and respect them. This relational understanding of dignity is central to her framing of dignity as not only the right to exercise one's capabilities, but also as the right to have that ability be respected and unhindered. She also makes the point that the notion of dignity ought to be understood as the exercise of agency, but in the context of being related with other abilities.⁸²² For Nussbaum, human beings have a worth that is inalienable, because of their capacity for various types of activities and striving, and capacities are dependent on the world for their full development and for their conversion into actual functioning.⁸²³

Venkatapuram expends considerable effort exploring the possibilities of achieving health justice through the capabilities approach, positing that every person has a moral entitlement to a capability

⁸¹⁶ See n780.

⁸¹⁷ Claassen, Rutger. "Human dignity in the capability approach." *The Cambridge Handbook of Human Dignity*. Eds. M. Duwell, et al. Cambridge: Cambridge UP, 2014. 240-249.

⁸¹⁸ Sen, Amartya. "Capability and well-being." *The Quality of Life*. Eds. M. Nussbaum, and S. Amartya. Oxford: Clarendon P, 1993.

⁸¹⁹ Ibid.

⁸²⁰ Nussbaum, Martha. "Human dignity and political entitlements." *Human dignity and bioethics* (2008): 351-380.

⁸²¹ See n819.

⁸²² Nussbaum, Martha. *Creating Capabilities: The Human Development Approach*. Harvard: Harvard UP, 2011. 17-45.

⁸²³ Ibid.

to be healthy.⁸²⁴ For him, the central core of health policy and advocacy should be in the rectification of health inequity through a deliberate distribution of public goods and access to healthcare.⁸²⁵ Interestingly, he posits that this can be achieved through a better understanding of capacity. This, for him, will involve the creation of an enabling environment for people to optimise their lives. Venkatapuram recognises that the health of individuals is intimately informed by social arrangements and policies, which determine the degree of their capability, pointing out that there are millions dying from unrecognised systemic issues that are not seen for what they are as unjust but are rather framed as sad, tragic, unlucky, natural occurrences or in the extreme as products of personal choice.⁸²⁶ He makes the important point, echoed by Forman,⁸²⁷ that ill health cannot be seen as a sad happenstance or a lack of personal responsibility, but rather as a product of policy failure to create an enabling environment.⁸²⁸ He thus suggests that while the focus on resource distribution is desirable, it needs to be supported by an understanding that it is not enough. He explains that this understanding of the requirements of the right to health is more in line with the original intent of the formulation of the right to health, which is to guarantee every citizen with the means to seek optimal health for themselves.⁸²⁹

While there is no denying the place of personal responsibility and the need to allow it flourish, such flourishing is only possible in a conducive environment. It is for this reason that I read Article 12 of the ICESCR as two pronged, with subsection (1) acknowledging the right of everyone to enjoy the highest possible standard of health, while subsection (2) requires the State to take certain actions to make the full realisation of the “capability”, recognised in subsection 1 possible. As such, the fulfilment of the first part is co-dependent on the fulfilment of the second. Unfortunately, the framing of capability appears to only stop at highlighting the fact that there is in fact disparity in capability, without addressing how it can be resolved. The lingering question then is how does society balance the recognition that capacity is not equitable, while allowing said capability to thrive without undue State interference? To address this concern, Venkatapuram posits that there are four key factors that are core determinants of the capacity to maximally realise human capability. They are (1) an individual’s biological needs, which change over time (2) the social conditions which include material resources

⁸²⁴ Venkatapuram, Sridhar. *Health Justice: An Argument from the Capabilities Approach*. New York: John Wiley & Sons, 2013.

⁸²⁵ Ibid.

⁸²⁶ Ibid.

⁸²⁷ Forman, Lisa. ““ Rights” and wrongs: what utility for the right to health in reforming trade rules on medicines?” *Health & Hum. Rts.* 10 (2008): 37-52.

⁸²⁸ See n824.

⁸²⁹ Venkatapuram, Sridhar. “On Health Justice. Some Thoughts and Responses to Critics.” *Bioethics* 30.1 (2016): 49-55.

like healthcare (3) the physical environment and (4) individual agency to 'convert' own endowments, needs and conditions (physical and social) into health functioning's.⁸³⁰ Venkatapuram shows the link between societal issues and health outcomes and makes the case that a capabilities approach may enable attempts at addressing the concerns of health injustice. Unfortunately, he does not provide a template for how this could be done and how the underlying social inequalities can be resolved by more than non-interference. The alternative might be to enquire how the agency that comes from capability is channelled. As Sen has stated, an agent is someone who acts to bring about change and whose actions may be evaluated in terms of their own values and goals. In this manner, capabilities may be a useful framework for the kind of activism and litigation that is required for ensuring that the State plays its part in enabling the maximisation of human capability. As Sabina notes, agency brings with it the responsibility of participation, public debate, democratic practice and empowerment.⁸³¹ This framing of the capabilities approach to human dignity as a basis for right to health claims faces some criticism, which is discussed below.

Criticisms of capability

Dean argues that there are three central problems with the capability approach, which are that: it does not adequately take into context the realities of human interdependency; it has a hegemonic liberal conception of the public realm; and it obscures the extent of capitalism's global reach and the exploitative relations of power upon which it is based.⁸³² Tied to the first critique is the fact that the capabilities approach is premised on a notion that appears to be in contradiction with the claim that dignity is inherent. Seeing dignity as capacity presumes the manifestation of action or at least the capability to manifest those actions as proof of its existence.⁸³³ As Matthews explains, a situation where a person is seen as a conscious being with dignity based on their capacity to knowingly and wilfully act, inadvertently rules out other human beings who are not meaning seekers or are unable to have desires of self-worth.⁸³⁴ In this manner, a critical flaw of the capabilities approach is that it has become conditional, as is the case with the Kantian framing, which it seeks to correct.⁸³⁵ Even worse is that it not only precludes those who do not acknowledge their capacity, but it further excludes those

⁸³⁰ See n824.

⁸³¹ Alkire, Sabina. "Capability and functionings: Definition and justification." *Human Development and Capability Association Briefing Note, September* (2005).

⁸³² Dean, Hartley. "Critiquing capabilities: the distractions of a beguiling concept." *Critical social policy* 29.2 (2009): 261-278.

⁸³³ Ibid.

⁸³⁴ Mathews, Pia. "Book review: 'Human dignity in contemporary ethics' by David G. Kirchhoffer." *New Blackfriars* 96.1061 (2014): 122-124.

⁸³⁵ See n761.

without said capacity.⁸³⁶ The very essence of human dignity is that regardless of context, with nothing added and nothing proved, every human being is born with inherent dignity. The essence of human dignity is “intrinsic value” of every human being. This intrinsic value thus warrants unconditional respect.⁸³⁷

The second criticism of Dean is rooted in the observation that the capabilities approach is inherently based on a western neo-liberal ethos of individual autonomy and non-interference. The primary imperative is the guarantee of the freedom to live as one reasonably chooses on their own terms. In the case of the right to health, it majorly means being able to pursue the achievement of goods and services that guarantee one’s health. While this framing may not be inherently problematic on its own, especially as it also reflects the provisions of Article 12, it is unfortunately a limited reading of dignity. It is in this manner constrained to the State’s obligation to respect and guarantee non-interference of the enjoyment of the right to health.

By extension, the third criticism is that, because the capabilities approach inherently presumes availability, it places an undue amount of focus on the exercise of personal agency without adequate consideration for the larger social, economic, and even political context within which that agency is exercised.⁸³⁸ In the absence of the important element of availability and accessibility of health goods and services, its implication is an undue responsabilisation of the right holder. There is no doubt that the State cannot ‘guarantee’ that every member of society enjoys optimal health, as there are factors beyond its control in health seeking behaviour and eventual health outcomes. What the State owes its populace is access to the means to enjoy that optimal health. There is also widespread acceptance that personal agency in lifestyle choices plays a significant role in health outcomes. However, the capabilities approach falls prey to its individualistic ideological roots by presuming that what is required for the citizen to enjoy good health is to be left alone to do so. In the same regard, its blind spot is an assumption that all the existing preconditions are on all fours. And while proponents like Venkatapuram encourage us to examine the societal inequalities within which personal agency is exercised, it is short on approaches to rectifying the divide, which he himself identifies as injustice. An expectant mother who does all in her power to eat the right meals, go for antenatal treatment, and take all the right precautions to have a safe delivery of a healthy new-born is limited by the access she has to quality healthcare and, in that circumstance, all of her personal responsibility may sadly come to nought, in the face of an ill-equipped health facility with no available doctor and an overworked nurse who has been forced to be at work because the union she belongs to has been threatened by

⁸³⁶ Ibid.

⁸³⁷ Ibid.

⁸³⁸ See n823.

the government to resume or be terminated, despite being owed months of salary. While scholars such as Burchardt and Hick argue that the capabilities approach aims to guarantee a minimum standard for all,⁸³⁹ they also provide no indication as to how such a minimum standard for all will be achieved. These kinds of answers are particularly important for countries like Nigeria in search of better ways to realise the health goods of their people.

Capability can thrive in the context of a State structure where the central role of the State is to step back and not interfere with people's legitimate, social and economic pursuits. Here, the State's duty is to allow people live their full lives and maximize their capabilities, of which their resources are an extension. Such an approach of non-interference may not be best suited to the context of State structure where the resources are primarily owned and managed by the State. This is especially so when private enterprise is more closely related to State patronage. Said patronage may be through formal commercial channels or through the more insidious channels of graft, corruption and nepotism that are often rife when political and economic power is overly centralised. Perhaps, capability may even be stretched to a larger logical conclusion of having a more decentralised State with less political and economic power; in which case, the capabilities approach would be well suited. However, in the face of an unwilling State structure, with a ruling class vested in retaining political and economic power, an appeal to capability would inevitably be tantamount to an abdication of State duty. Sen himself notes that the histories of different countries have shown considerable variations over time as well as between different groups within those countries. He states that the task of weighing various capabilities should be left to the ethical and political considerations of each society based on public reasoning.⁸⁴⁰ As Dean puts it eloquently:

the capabilities approach is well suited to a consensual approach, but a politics of need should be about struggle, not consensus: the struggle for the recognition of unspoken needs; the struggle for more direct forms of political participation; the struggle against exploitation and the systemic injustices of capitalism.⁸⁴¹

In the face of the highlighted limitations of the predominantly western ideology of the capabilities approach, I consider the possibilities of an alternative African conception of dignity in the next chapter.

⁸³⁹ Burchardt, Tania, and Rod Hick. "Inequality, advantage and the capability approach." *Journal of Human Development and Capabilities* 19.1 (2018): 38-52.

⁸⁴⁰ Sen, Amartya. "Human rights and capabilities." *Journal of human development* 6.2 (2005): 151-166.

⁸⁴¹ See n823 at 275.

Conclusion

Human dignity is the foundation of all human rights and it is the basis upon which the fulfilment of these rights is constantly sought. Despite much of the critique about its seemingly nebulous nature, the international human right regime recognises it as the basis of current social ordering. However, in the absence of an immutable definition, theories like that of capability have helped in our understanding of the nature of human dignity and what is required for its realisation. Unfortunately, much of capabilities foundational premise is overly liberal and western in outlook; making it ill-suited to a context where the realisation of socio-economic rights requires more than State non-interference. And so, while it recognises the importance of human agency and autonomy and the necessity to enable its optimisation, the socio-economic context in which said maximisation will take place can unfortunately not be fully realised through the capabilities outlook. As such, there is need to examine an alternative reading of human dignity to see how it may help us answer some of the contextual challenges in the realisation of the right to health; which will in turn aid in the maximisation of human capability. This I do by considering a communitarian outlook to human dignity, as well as its implications in an African, and particularly Nigerian context, in the next chapter.

Chapter 8

The African conception of dignity and its use as a claim on power

Introduction

The African conception of dignity is an offshoot of a larger scholarship around humanism and its philosophical roots.⁸⁴² It also finds a place in a larger body of scholarship concerned with relational theory and the examination of how rights structure relationships and determine the power dynamics that arise from the allocation of rights and duties.⁸⁴³ Relational theory seeks to place constructive relationships at the heart of social, legal and political dynamics, as a relationship can either mandate strict compliance to rules or empower useful participation and cooperation where both parties are shared stake holders. This African conception of dignity is grounded in defining autonomy through the lens of how said autonomy 'relates' with the autonomy of others and is either empowered or stifled in that relationship.⁸⁴⁴ In essence, relational theory recognises that rights do not exist in a vacuum and proposes that the relationships that determine rights, and how they are realised, be closely examined to better understand how they determine eventual outcomes.

If we can understand poverty and socio-economic lack as inherently degrading, it is suggested, we have a pointer to the existence of human dignity.⁸⁴⁵ The task therefore is to identify the nature of the systemic lack in society so as to ground interventions in a coherent, applicable conception of dignity.⁸⁴⁶ Building from this work, in this chapter I examine the claim that a conception of human dignity in a relational sense that is cognisant of the needs of poor and vulnerable exists in African philosophical thought. Engaging with the conceptions of human nature and human relationships in African communitarianism, I explore how it frames rights and how these rights in turn shape the relationship of right holders with their societies. I also engage with the criticisms of the African communitarian ethic and explore how they square up against the predominant understanding of rights as being the primary duty of the State to fulfil. I consequently examine the relevance of the communitarian ethic of human dignity to the Nigerian context, bearing in mind its Constitution and legislative approach to providing for the right to health. I then consider how this application to the Nigerian legal regime may be crafted in a manner that is cognisant of the country's socio-economic and political realities and is

⁸⁴² De Gruchy, John W. "The humanist imperative in South Africa." *South African Journal of Science* 107.7-8 (2011): 11-13.

⁸⁴³ Nedelsky, Jennifer. *Law's relations: A relational theory of self, autonomy, and law*. Oxford: Oxford UP, 2011.

⁸⁴⁴ Ibid.

⁸⁴⁵ See n601.

⁸⁴⁶ Ibid.

grounded in the human right agitations of Nigeria's every increasing poor and vulnerable; most in need of protection. To this end, I conclude with an examination of how human dignity in the African and specifically Nigerian context ought to be understood as a legitimate claim on power and the resources that come with said power. I argue that such an understanding of human dignity and the right to health that flows from it is at the heart of any meaningful attempt to understand resource allocation, policy priorities, political action, and any subsequent attempts to enforce systemic reform that benefits right holders.

The African communitarian ethic

The notion of an African communitarian ethic is more commonly embodied in the concept of *Ubuntu*. *Ubuntu* as a moral philosophy is encapsulated in the expression, "A person is a person through other persons".⁸⁴⁷ Another variant of this expression is "I am because we are." These expressions convey the ideology that humanity is most expressed in relation to others. In this sense, one is a 'full' person when they conduct their affairs in a manner that strives for the good of the whole.⁸⁴⁸ This embodies, personhood (your notion of yourself in this world), selfhood and humanness (recognition of the rights of others).⁸⁴⁹ While *Ubuntu* and its other phonological variants largely draw from Southern African societies and their philosophical thought, the underlying principles encapsulated in the expression resonate across most African societies. In Western Africa, the Yoruba convey similar sentiments in the description of an individual as an *Omoluwabi* (good person)⁸⁵⁰ Similarly, in Igbo culture, there is the saying that "[w]hen an animal needs to scratch its back, it runs to a tree and scratches its back against it; but when humans need to scratch their back, they run to fellow humans."⁸⁵¹

In these diverse expressions of the ideal socialised member of society, what lies at the heart is a communitarian view that the existence of human dignity is dependent upon its recognition by others and in relationship to others, for the fullness of its expression. Human dignity and the rights and relationships that flow from it thus ought to be understood as having their full expression in conduct that is worthy of that dignity and treats others as equally worthy. Here, human dignity is not valuable

⁸⁴⁷ See n601 at 536.

⁸⁴⁸ Metz, Thaddeus. "An African theory of dignity and a relational conception of poverty." *The humanist imperative in South Africa* (2011): 233-242.

⁸⁴⁹ See n601.

⁸⁵⁰ Fayemi, Ademola Kazeem. "Human personality and the Yoruba worldview: An ethico-sociological interpretation." *The Journal of Pan African Studies* 2.9 (2009): 166-176.

⁸⁵¹ Obioha, Uwaezuoke Precious. "Radical communitarian idea of the human person in African philosophical thought: A critique." *Western Journal of Black Studies* 38.1 (2014):13 at 13.

only because it is inherent, or because it can spur action. Rather, its highest value is in how it can be used for the good of not just the dignity holder, but also for the good of those around him/her who have acquiesced to his/her dignity. Therefore, the optimal utilisation of human agency is not simply for self-realisation but is rather towards the larger goal of optimisation for the good and benefit of others. It is in the optimal utilisation of the agency, capacity, and ability inherent in the individual that the fullest expression of their dignity is validated.

Broadly speaking, while recognising the diversity of African societies, proponents of African communitarian thought suggest that African societies have a similar value system that places communal relationships as being the core of social ordering.⁸⁵² Africans emphasise groupness, sameness, and commonality; and, rather than survival of the fittest and control over nature, the African worldview is tempered with the general guiding principle of the survival of the entire community and a sense of cooperation, interdependence, and collective responsibility.⁸⁵³ It is suggested that the modern notion of human rights may be understood and realised through this lens.

Perhaps the clearest evidence of the uptake of this African conception of human dignity and human rights is exemplified in the African Charter. Its preamble provides that while the fundamental nature of human rights is non debatable, they stem from the basic nature of human beings and the attributes they possess, meaning that respect for them should be guaranteed. In essence it implies that to deny human rights is to deny the humanity of people.⁸⁵⁴ The preamble goes on to state that the recognition of this humanity implies that since humans do not live or operate in isolation, the enjoyment of their rights requires the performance of certain duties by everyone.⁸⁵⁵ Importantly, the preamble of the Charter provides that the essential focus is on development, civil and political rights as well as economic, social and cultural rights, which must be guaranteed in a way that ensures collective side-by-side growth for all.

The African conception of human dignity is a promising rival to the Kantian conception, which is the basis of the western conception of human dignity. This is because while the western ethic places emphasis on the individual and the maximisation of individual autonomy and freedom,⁸⁵⁶ while the African communitarian ethic recognises individuality at the same time as encouraging its expression

⁸⁵² See n601.

Wiredu, Kwasi. "Social philosophy in postcolonial Africa: Some preliminaries concerning communalism and communitarianism." *South African Journal of Philosophy* 27.4 (2008): 332-339.

⁸⁵³ Cobbah, Josiah AM. "African values and the human rights debate: An African perspective." *Hum. Rts. Q.* 9 (1987): 309.

⁸⁵⁴ The Preamble, African Charter on Human and People's Rights, 1982.

⁸⁵⁵ Ibid.

⁸⁵⁶ See n600.

to be for the common good and shared goal of the community. In the communitarian ethic, individual autonomy, and the power to exercise it largely draws from society's recognition of that autonomy. And so, in the communitarian ethic, there is an underlying social contract where, in exchange for recognition of an individual's dignity, that individual is reasonably expected to reciprocate by utilising their pursuits for the common good of all. Here, it is one's dignity that grants them their autonomy, but it is also that dignity that "self regulates" how their autonomy is exercised. So, the assertion that 'a person is a person' is a call to develop one's (moral) personhood.⁸⁵⁷

Ubuntu, however, is not limited to the philosophical explorations of human nature. A balanced communitarian framing of dignity can be an appropriate ethical basis for a country's laws and approach to social ordering.⁸⁵⁸ The South African Constitution has been posited as an example of such an endeavour, with the country's Constitution setting out to promote human dignity, equality and human rights, explicitly recognising the value of *Ubuntu*.⁸⁵⁹ In this manner, as a Constitutional ethic, there is a recognition of individual rights while aspiring for their application through and for the betterment of the whole. This distinction, while being subtle is important for addressing the claims that a negative of communitarianism is the erasure of personal agency and its subsuming to the will of the collective.⁸⁶⁰ The question of how and when to balance the rights of the individual with that of the collective form a significant portion of the varied criticisms of communitarian thought, which will now be examined.

Debates about the communitarian ethic

The African communitarian ethic has been criticised as being vague, collectivistic and anachronistic.⁸⁶¹ Proponents of this approach have countered that *Ubuntu* and its variants are not vague, but are rather that they represent a fluid and evolving concept that is able to accommodate people's lived realities as functioning members of society.⁸⁶² In a similar vein, there is push back against the criticism that it is collectivist, with scholars, like Metz arguing that communitarianism rather draws its strength from

⁸⁵⁷ Ibid.

⁸⁵⁸ Mokgoro, Yvonne. "Ubuntu and the Law in South Africa." *Buffalo Human Rights Law Review* 4.1 (1998): 15-23.

⁸⁵⁹ Ibid.

⁸⁶⁰ Ilesanmi, Simeon O. "Human rights discourse in modern Africa: a comparative religious ethical perspective." *The Journal of Religious Ethics* (1995): 293-322.

⁸⁶¹ Metz states these three as the major flaws Oyowe tries to point out from his work to make a case for *Ubuntu* and the moral basis for the African reading of rights. See Metz, Thaddeus. "African values and human rights as two sides of the same coin: A reply to Oyowe." *African Human Rights Law Journal* 14.2 (2014): 307-321.

⁸⁶² Ibid.

voluntary accession as opposed to imposition.⁸⁶³ On the point of being anachronistic the counterargument is made that morality is a timeless construct that ensures the continuation of right action, without which there is no basis for its continuance.⁸⁶⁴

Despite the strong defence of communitarianism as a legitimate framework for understanding human nature and the human rights that flow therefrom, scholars like Oyowe have argued that the essence of communitarianism is in fact fundamentally opposed to the notion of human rights.⁸⁶⁵ The reason for this position is that, by their intrinsic nature, the individualistic reading of human rights is both the original intent behind the formulation of rights as well as the most appropriate way to understand them.⁸⁶⁶ As such, to adopt the communitarian framing of human rights would be to subsume rights under an ubiquitous concept of the greater good. The counter to this critique is that it conflates the nature of human rights with its ends. Alternately, the goal of the communitarian reading of human rights is rather to protect dignity while seeking to optimise its utility for the greatest good of the greatest number.⁸⁶⁷ In a sense therefore, *Ubuntu* is primarily a means to an end, as it is one other way to understand dignity, which is universally accepted as the basis of rights.

Another searing critique of the communitarian approach is that it opens the door to relativist readings of rights⁸⁶⁸ and in doing so threatens the very premise of rights as universal and inalienable.⁸⁶⁹ The argument is that through the lens of communitarianism, rights are only accruable as long as they do not interfere with the prevailing social perception of what is right and acceptable, which is an antithesis of rights and what they represent. According to these critiques, once rights are not grounded on the universality and inalienability that makes them sacrosanct, almost any whittling of rights can be justified, leading to a slippery slope of dictatorship by self-appointed custodians of the communal ethos.⁸⁷⁰ To this criticism, what is mistaken as relativism is rather a contextual framing of

⁸⁶³ Ibid.

⁸⁶⁴ Ibid.

⁸⁶⁵ Oyowe, Anthony O. "Strange bedfellows: Rethinking Ubuntu and human rights in South Africa." *African Human Rights Law Journal* 13.1 (2013): 1-22.

⁸⁶⁶ Ibid.

⁸⁶⁷ See n861.

⁸⁶⁸ Clamour for a relativist interpretation of rights by some has been criticized as excuses to push political agendas and perpetuate patriarchal authority. See, Bayefsky, Anne F. "Cultural sovereignty, relativism, and international human rights: New excuses for old strategies." *Ratio Juris* 9.1 (1996): 42-59.

See also, Tesón, Fernando R. "International Human Rights and Cultural Relativism." *Va. j. Int'l L.* 25 (1984): 869-900.

⁸⁶⁹ Parmet, Wendy E. "Liberalism, communitarianism, and public health: Comments on Lawrence O. Gostin's lecture." *Fla. L. Rev.* 55 (2003): 1221. See also, Gostin, Lawrence O. "When terrorism threatens health: how far are limitations on human rights justified." *The Journal of Law, Medicine & Ethics* 31.4 (2003): 524-528.

⁸⁷⁰ Communism and the German Third Reich under Adolf Hitler were given initial legitimacy by making a claim to be representing the collective ethos of the people. See Brugger, Winfried. "Communitarianism as the social and legal theory behind the German Constitution." *Int'l J. Const. L.* 2 (2004): 431.

rights and recognition that human rights are enjoyed within society and not in a vacuum. In this sense, liberty is to be understood in a context. i.e., in relation to others in society. If this is the case, one may state that communitarianism does not actually seek to impose a hegemonic value judgment on rights. Rather, by recognising that societal nuance exists, we are better able to identify different societies' underlying values and to use the lens of our understanding to determine what each right will entail in that society's context. This argument pushes back against a top-down determination of rights and tries to better understand how the right holders themselves perceive their own dignity and the rights they reasonably expect to enjoy by virtue of that dignity.

Beyond the above listed critiques of *Ubuntu*, in both its own terms and as regards its transposition for our understanding of rights, it shares a critical flaw with the western inspired capabilities approach to which it is meant to be an alternative. This flaw is its propensity to be used as a tool for the responsabilisation of the right holder. While in the case of a capabilities framing of dignity, the right holder is imbued with agency, which is then expected to be used in pursuit of ensuring the respect of his capabilities and subsequent functioning, in the case of communitarianism, the responsabilisation is further compounded by at least three identifiable layers, that are drawn from the reading of the nature of the communitarian ethic. On one level, the right holder in the communitarian ethic is seen as imbued with commensurate duties as s/he is with rights, with the enjoyment of one being co-dependent on the right exercise of the other.⁸⁷¹ On another level, these duties are reasonably expected to be fulfilled for the benefit of the community and not necessarily for personal benefit with the condition that it does not infringe upon others (an ability the western ideology conveniently accepts and encourages). Third and perhaps most damning is that in the quest for collective action and cohesion, with every individual working for the common good, often, the solutions that appear to emerge are in circumscription of the State in its modern conception. In this sense, the communitarian ethic more often leads to a resort to self-help, just of a larger kind at the communal level but still outside of the ambit of the State and its apparatus. The cumulative effective of these three layers is the subsequent expectation and glorification of grassroots solutions of self-help, upon recognition and tacit acceptance of the failure of the State. This is particularly evident in the kind of solutions posited in pursuit of the realisation of socio-economic rights, particularly the right to health, which include interventions like citizen-led health boards and community-based health funding schemes. While these interventions are by themselves beneficial, they often are a temporary fix to an endemic problem that the right holders' local resources cannot adequately resolve. Often, the systemic issues that local citizen-led interventions step into address would be best addressed by the State, which has

⁸⁷¹ See n865.

the resources and structures to provide sustainable resolution to the concerns and it is the State that has the resources and systemic apparatus to deliver these goods to the right holder. While all of the three levels of action implicit in the communitarian framing of human rights and human relations are inherent goods in and of themselves and are embedded with virtues that can move society forward when applied correctly, they are incomplete and potentially dangerous in the absence of an adequate framing that incorporates the State and its duties to the communitarian ethos. The question then is if and how African communitarian thought can adequately be used as a tool for holding the State accountable for its duties.

State duties within the communitarian ethic

In the western ideological tradition, the central role of the State in the fulfilment of human dignity is that of respect, recognition, and non-interference and, as discussed above, while these duties are important, they are not enough in the quest for the realisation of the right to health. In the case of the African notion of communitarianism, while there is an acknowledgment of State duties, it often appears to be a trade off with the individual for their rights. In the communitarian ethic, the emphasis is less on each individual and more on the aggregate needs of society. As such, one key duty of the State is to balance individual needs with broader needs and to make determinations around priorities. In the communitarian ethic, a key duty of the State is to provide social goods that maximise and enable the fulfilment of the communitarian ethos. In doing this, the focus ought to be on endeavours that are more likely to foster, or otherwise respect, communal relationships.⁸⁷² In the specific application of a communitarian lens of State action for the right to health, London et al have suggested that the social solidarity ingrained in the communitarian ethic can be useful for informing health interventions and balancing individual health needs with broader public health goals of society.⁸⁷³ They point out that a public health perspective, which understands health inequities at a systemic level regarding the social processes that generate that discrimination, is necessary.⁸⁷⁴ Upon identification, the duty of the State would be to focus on a collective approach to resolving the issues and not just an individualised solution, framed by individual interests. The focus should thus be on building broad-based health system resilience, which in turn will strengthen it to better deliver on individual care. The goals of the collective must be informed by an aggregation of individual needs and through evidence-based public health research, health priorities that cater to the largest portions of society can be prioritised with

⁸⁷² See n848.

⁸⁷³ See n49.

⁸⁷⁴ Ibid.

appropriate resources channelled at their effective use.⁸⁷⁵ Himonga has, similarly, advocated for the application of *Ubuntu* in the realisation of the right to health to include using it as a basis for resolving conflicts between individual and collective rights in the fulfilment of the right to health.⁸⁷⁶ She makes the case that at an administrative and policy making level, communitarian principles can be used as the basis of broad-based health system interventions.⁸⁷⁷ From these policies and their implementation, advocates can further use the communitarian approach in strategic litigation as well as judicial reasoning applied by the courts in those case.⁸⁷⁸

There is no doubt that the application of communitarian ethics would require significant judicial accession where the need arises. In such instances, it is important for the courts to be inclined to the notion of *Ubuntu* in its reading of human rights. Understanding human dignity through an Afro-centric communitarianism, would thus involve a fundamental recognition of a minimal concept of distributive justice that would require the provision of the essential needs of everyone.⁸⁷⁹

In an African context therefore, the major consideration would be what is dignifying for the person based on the morality and ethos of the people. To therefore view the realisation of socio-economic rights purely as individual rights, would thus be to create an isolating and unreal perception. As Sachs puts it:

We live in communities. We need communities. We get our identity, our personality from our interaction with other people. In South Africa, we use the concept of *Ubuntu*, a very central notion from African philosophy. It means, I am a person because you are a person. *I can't separate my humanity from yours- from a mutual acknowledgment of humanity.*⁸⁸⁰

Another possibility of framing the State's duties is to see it as a 'community' in and of itself. In the context of human rights discourse, the delineation of what amounts to community is important in helping us position the individual as the right holder within the larger plot. To define a grouping as a community, the group must be able to exert moral suasion and extract a measure of compliance from their members. Therefore, communities are necessarily, by definition, coercive as well as moral,

⁸⁷⁵ Ibid.

⁸⁷⁶ Himonga, Chuma. "The right to Health in an African Cultural Context: The Role of Ubuntu in the Realization of the Right to Health with Special Reference to South Africa." *Journal of African Law* 57.2 (2013): 165-195.

⁸⁷⁷ Ibid.

⁸⁷⁸ Ibid.

⁸⁷⁹ Liebenberg, Sandra. "The value of human dignity in interpreting socio-economic rights." *South African Journal on human rights* 21.1 (2005): 1-31.

⁸⁸⁰ Sachs, Albie. "Enforcement of Social and Economic Rights." *Am. U. Int'l L. Rev.* 22 (2006): 673 at 705.

threatening their members with the stick of sanctions if they stray, offering them the carrot of certainty and stability if they do not.⁸⁸¹ By this definition, while the community can be used to describe traditional notions of community along tribal, cultural, and professional lines, this same definition may indeed be extrapolated to refer to the State. According to Cudworth, a State is a political organisation with a centralised government with a monopoly on the legitimate use of force in any geographical territory.⁸⁸² This definition asserts the powers of the political structure of the State to enforce compliance from its members. Constitutions of States are the embodiment of the values and ethos of the people enshrined as the guiding principles that guide their union and efforts at strengthening said union. They provide the guiding moral compass of the State, which subsequently influences its laws as the tangible embodiment of what is sacrosanct in the governance of its people. By this, rights would then be the 'carrot' of certainty on what members can expect to benefit from being compliant law-abiding members of the community.

In this framing of the State and its citizens as the community, part of the State's roles would be to set out the health agenda as well as organise the pool of funds required to realise that agenda, while also contributing to it. But this financial obligation often poses a challenge for States to fulfil. The State must thus be willing to explore means of sourcing for funds to fulfil its functions. While various forms of taxation are often established to increase the State's source of funds even this avenue can be adopted to be in conformity with a communitarian approach. This would be through equitable financing which entails having those with the least resources pay the least, not just in absolute terms but also in proportion to their resources.⁸⁸³ It also means that their lack of resources will not restrict their receipt of services that are recommended, based on prevailing norms and best practices.⁸⁸⁴ Equitable funding has the propensity to increase access to healthcare for the poor and close to poor. This will ultimately result in better health for a larger number in society and as a result allow for a larger number in society to earn a living and by this, ultimately reduce poverty by protecting and providing for those who are most vulnerable from further illness and poverty.⁸⁸⁵ However, for this model of equitable financing to be sustainable, it must pool together different members of society; from the healthy to the less healthy, the rich and the poor, the skilled and unskilled, to spread costs.⁸⁸⁶

⁸⁸¹ Pearson, David E. "Community and sociology." *Society* 32.5 (1995): 44-50.

⁸⁸² Cudworth, Erika, et al. *The Modern State: Theories and ideologies*. Edinburgh: Edinburgh UP, 2007.

⁸⁸³ Braveman, Paula, and Sofia Gruskin. "Poverty, equity, human rights and health." *Bulletin of the World Health Organization* 81 (2003): 539-545.

⁸⁸⁴ Ibid.

⁸⁸⁵ Ibid.

⁸⁸⁶ Ibid.

Such a task, however requires building public consensus, as well a commitment by the State and all other stakeholders to equity and human rights.⁸⁸⁷

Perhaps the most effective use of an Afro-centric communitarian ethic in the realisation of the right to health for the furtherance of human dignity is in the recognition that good health transcends only healthcare specifically. As a result, the duty of the State in the communitarian ethic should be construed to include the recognition of the social determinants of the health of communities, and not having a biomedical lens to healthcare. In this case, having a more system-focused look at the challenges that lead to poor health outcomes can lead to wider preventive interventions, which most often require widespread communication, and communal buy in. Vaccination programs for example that have proven to be one the public health's most effective interventions can be encouraged through collaboration with religious and community leaders. This kind of collaborative effort is also important for building trust, especially where communities have previously been unduly taken advantage off under the disguise of healthcare.⁸⁸⁸

Another consideration is agenda setting and health priorities. Often, health programs in developing States are driven by donor interests,⁸⁸⁹ with the acquiescence of governments eager to show some form of achievement. While many of these programs are beneficial, the approach of formulation and implementation does not always involve a lot of interaction with the affected host communities for which these programs are intended. Without their input, it is often difficult to fully know what they feel are their needs and their problems⁸⁹⁰ and the ways in which these problems can be addressed. In addition, they often do not involve the promotion of long-term benefits through the promotion of the socio-economic wellbeing of these societies, which will take them out of the circumstances that resulted in them having those problems in the first place.⁸⁹¹

Beyond specific interventions, an afro-centric communitarian approach may be used as the basis of an approach that addresses the fundamental issues linked with poverty and ill-health and the disempowerment of portions of society that have perpetuated this cycle of lack, which can ultimately result in long-term health improvements. It is imperative to understand that "health systems are not a mechanical structure; rather, they are core social institutions that function at the interface between

⁸⁸⁷ Ibid.

⁸⁸⁸ In 1996 in Northern Nigeria, Pfizer under the guise of providing aid for meningitis had carried out experimental research without consent and with dire results for those who were tested on. See n74.

⁸⁸⁹ Doyle, Cathal, and Preeti Patel. "Civil society organisations and global health initiatives: problems of legitimacy." *Social Science & Medicine* 66.9 (2008): 1928-1938.

⁸⁹⁰ Ibid.

⁸⁹¹ Ibid.

people and the structures of power that shape their broader society.”⁸⁹² In considering health this way, it becomes desirable to reflect better local cultural values, especially in developing countries.⁸⁹³ For this, communities must be allowed to ‘own’ both their health problems and the solutions to these problems.⁸⁹⁴ Communities should determine how resources are allocated on the basis of how they determine what is important to them, what are relevant criteria for allocating healthcare resources, and how we they see various different groups’ or individuals’ strengths of claims for the resources involved. It is quite likely that communities will want more than simple health improvements.

Communities can also create a local accountability system for the State, because where domestic mechanisms exist and function, they are often quicker and easier to access than regional or international mechanisms.⁸⁹⁵ Political mechanisms, such as democratic processes, and the monitoring and advocacy performed by NGOs also contribute to accountability. Civil society organisations are increasingly using monitoring methods based on indicators, benchmarks, impact assessments and budgetary analysis to hold governments accountable in relation to the right to health. The *Treatment Action Campaign* case,⁸⁹⁶ is a good example of mixing advocacy with judicial accountability.⁸⁹⁷ The result of all the above may practically speaking, look like what has been done in some Latin American countries, where social participation for public sector issues or specifically for healthcare has been based on communitarian associative structures, such as municipal health councils, at the municipal level. These participative structures extend beyond sex, race and ethnic groups to include social movements and civil society organisations.⁸⁹⁸ Other examples include patient associations that typically operate at the national level as political actors in regular dialogue with governments.⁸⁹⁹ As Jonathan Mann argues, “it ought to be clear that since society is an essential part of the problem, a societal-level analysis and action will be required.”⁹⁰⁰ This kind of societal framework for health necessitates a collective right to public health, obligating States to address the systematic and social conditions that underlie disease.⁹⁰¹

⁸⁹² Etzioni, Amitai. "The common good and rights: A neo-communitarian approach." *Geo. J. Int'l Aff.* 10 (2009): 113.

⁸⁹³ Ibid.

⁸⁹⁴ Ibid.

⁸⁹⁵ See n581.

⁸⁹⁶ *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC).

⁸⁹⁷ Ibid.

⁸⁹⁸ de Andrade, Luiz Odorico Monteiro, et al. "Social determinants of health, universal health coverage, and sustainable development: case studies from Latin American countries." *The Lancet* 385.9975 (2015): 1343-1351.

⁸⁹⁹ Ibid.

⁹⁰⁰ Mann, Jonathan M. "Human Rights and AIDS: The Future of the Pandemic." *AIDS Education: interventions in Multi-Cultural Societies*. Eds. I. I. Schenker, et al. G. Boston, MA: Springer, 1996. 1-7 at 3.

⁹⁰¹ Meier, Benjamin Mason. "Advancing health rights in a globalized world: responding to globalization through a collective human right to public health." *The Journal of Law, Medicine & Ethics* 35.4 (2007): 545-555.

While there appear to be considerable benefits in approaching human dignity and the right that flows from it in a relational manner that is communitarian in outlook, such an outlook will have to be supported not just in philosophical rhetoric but must be backed by law and the subsequent social ordering. A communitarian ethic that is only applied on the local level without State adoption will be tantamount to self-help at a communal level. The kind of social ordering that reflects the ideals of the formal State structure is manifested primarily in its laws. And so, even philosophical concepts that aid us in our understanding of the issues must be nested in the context of the existing legal framework of the State. The analysis of the legal regime is consequently to aid us in bringing conformity between intent and actual substance of the law and to identify areas where there is a lack of congruence in order to provide the necessary solutions. As such, I now examine the framing of human dignity in Nigerian law and juxtapose it with the larger social, economic, legal and political context of the country and its present democratic dispensation. I examine if and where it aligns with the larger African communitarian ethic, as well as the implications that has on the framing of the right to health and the actions necessary to realise it.

Human dignity and national constitutions

While the symbolism of dignity serves as a guiding principle in international law, and at the regional and domestic level, its normative implications become more precise when examined in a national context.⁹⁰² The nature of dignity, and the philosophical traditions it is aligned with, become more apparent when examined against a nation's broader political, social, and legal contestations. And while dignity may be provided for as a specific right in a Bill of Rights, its place in the social ordering of a society is often shown in the preamble of its Constitution as well as its wider scope on and its stance on other matters of State and its relationship with the populace.⁹⁰³ Human dignity is often featured or at least alluded to as an unexpressed value of the country and how it is to be run. Any meaningful analysis of the place of dignity in a country's social ordering will therefore have to be a contextual Constitutional analysis that is cognisant of the place of human dignity in the hierarchy of ethical imperatives and political priorities outlined in the Constitution. And so, while centrality of human dignity as a foundational value may be evident in the South African Constitution or German Constitution, for example,⁹⁰⁴ the respect and protection of human dignity may be a secondary concern in a larger legal scheme based on different terms of political compromise in a different country and

⁹⁰² See n773.

⁹⁰³ See n772.

⁹⁰⁴ See n766.

context. Hughes therefore argues that while every Constitution is value based, the real task is to understand what values it is based upon and, from there, to calibrate the proximity of human dignity to that core value.⁹⁰⁵ It is an understanding of that value that can help us better contextualise the nature of human dignity within it, if it is not already clearly stated as the guiding ethos as in the case of the South African Constitution.⁹⁰⁶ As she rightly points out, human dignity cannot be assumed to function in a normative vacuum. And so, armed with her injunction, the task is to better understand the context of human dignity in the Nigerian legal and socio-political order as well as the role of the State, if any, in upholding this framing of dignity. On this understanding, it would then be incumbent to empower the judiciary to interpret the laws including subsequent sections of the Constitution and the bill of rights in step with the values of the country's Constitution and its conception of human dignity therein.⁹⁰⁷

This kind of Constitutional analysis would have to both be on its substantive content as well as the larger and longer historical, social, economic, and legal order within which it is nested. A proper examination of a nation's Constitution can show both its philosophical leanings, as well as its aspirational goals. It is this kind of analysis that has warranted the description of the South African Constitution as being a transformative Constitution.⁹⁰⁸ In the same vein, the ends of the Nigerian Constitution, as well as its conception of human dignity ought to be understood through a more robust analysis of the country's persistent inequalities, as well as the structures that sustain them and the possibilities for a remedy.

Human dignity in the Nigerian context

Ultimately, Constitutions are a product of a country's history and political contestations and eventual compromises. The framing of dignity in any Constitution must be understood in that context. The question then is, what is the central ethos of the Nigerian Constitution vis á vis its conception of human dignity and how is that to be understood and upheld.

The preamble of the Nigerian Constitution provides:

We the people of the Federal Republic of Nigeria having firmly and solemnly resolve, to live in unity and harmony as one indivisible and indissoluble sovereign nation under God, dedicated

⁹⁰⁵ Ibid.

⁹⁰⁶ Ibid.

⁹⁰⁷ Ibid.

⁹⁰⁸ Chaskalson, Arthur. "Dignity as a constitutional value: A South African perspective." *Am. U. Int'l L. Rev.* 26 (2010): 1377.

to the promotion of inter-African solidarity, world peace, international co-operation and understanding And to provide for a Constitution for the purpose of promoting the good government and welfare of all persons in our country, on the principles of freedom, equality and justice, and for the purpose of consolidating the unity of our people.⁹⁰⁹

The Constitution is clear that its primary value is the protection of the unity of the State of Nigeria. As a by-product of this stated goal, it recognises that the unified State will have to provide good governance and ensure the welfare of people of its constitutive units, who are to be treated with equality and guaranteed justice in their dealings with each other and the Nigerian State. In this framing by the Constitution, human dignity is neither mentioned nor alluded to as a guiding imperative and while equality is sometimes used interchangeably with dignity, one may argue that equality is in fact an offshoot of a recognition of dignity for all. Dignity itself is only first provided for in the Constitution in its Fundamental Objective Principles, with Section 17 providing:

17. (1) The State social order is founded on ideals of Freedom, Equality and Justice.

(2) In furtherance of the social order-

(b) the sanctity of the human person shall be recognised and human dignity shall be maintained and enhanced;⁹¹⁰

Here, dignity is crafted as relational to freedom, equality, and justice. The State has a duty to “recognise” its sanctity. It however is required to also “maintain” that sanctity of human dignity and to go on further to “enhance” it. This provision may be clearly read as a recognition of the fact that human dignity is inviolable and in line with that reality, the State is required to not just acknowledge it, it must also be deliberate in preserving it and improving it. In determining what improving this human dignity will entail, subsection 2(d) provides that “exploitation of human or natural resources in any form whatsoever for reasons, other than the good of the community, shall be prevented.”⁹¹¹ Here, there is a recognition of an undercurrent of the communitarian ethic in understanding the ends of the State in the fulfilment of its duties to realise human rights. The Nigerian constitution caters for a reading of dignity in both individualistic terms, as a protection against the violation of human autonomy, as well as a larger binding ethic of social ordering.

⁹⁰⁹ Preamble, Constitution of the Federal Republic of Nigeria, 1999.

⁹¹⁰ Section 17, Constitution of the Federal Republic of Nigeria, 1999.

⁹¹¹ Ibid.

The maximisation of the human endeavour is further provided for in subsection 3 of Section 17, which states that all citizens without discrimination have equal opportunities to seek out a living and work in humane conditions, while having access to facilities that make it possible to enjoy social, religious, and cultural life. This is to be buttressed and enabled by the provision of adequate medical and health facilities for all.

There is also a recognition of the place of culture in Nigeria's various ethnic groups and Section 21(a) tasks the State to "protect, preserve and promote the Nigerian cultures which enhance human dignity and are consistent with the fundamental objectives." In this manner, the various cultures in the country are to be upheld to the extent to which they promote human dignity. And while it is unclear whether the kind of dignity they are expected to uphold is an individualistic or communitarian conception, it may be argued that the expectation is that a balance is struck. To buttress this provision, Section 24(c) goes on to provide that every citizen has a duty to "respect the dignity of other citizens and the rights and legitimate interests of others and to live in unity and harmony and in the spirit of common brotherhood."

Dignity is also provided for as a right. In this case, the provision states:

- 34. (1) Every individual is entitled to respect for the dignity of his person, and accordingly –
 - (a) no person shall be subject to torture or to inhuman or degrading treatment;
 - (b) no person shall be held in slavery or servitude; and
 - (c) no person shall be required to perform forced or compulsory labour.⁹¹²

In this instance, dignity is primarily conceived off as a right to freedom from the might of the State being used unduly against one's person. In this instance, the emphasis is on ensuring that the integrity and sanctity of human autonomy is not unduly trampled upon. This particularly makes sense when one considers the years of military rule and the abuse of human rights that occurred across the nation before the return to democratic rule and the formulation of the current Constitution.

A reading of all these key sections of the Constitution together points to a recognition of dignity as both individualistic autonomy that ought not to be unduly interfered with, as well as being based on a communitarian ethic ingrained into the fabric of society and the cultures that make up the country. To this end, the conception of dignity as laid out in the Nigerian constitution must be understood in the larger socio-political context of the terms of the continued union of Nigeria, as well as the aspirational values on which the union is based. Hence, the constitution provides that "exploitation of

⁹¹² Section 34, Constitution of the Federal Republic of Nigeria, 1999.

human or natural resources in any form whatsoever for reasons, other than the good of the community, shall be prevented". The provision of healthcare as a fundamental right is therefore an integral part of the social compact upon which the Nigerian State is based, and its unity secured.

Perhaps the place of dignity in the ordering of the Nigerian State is most exemplified in a speech given by Dr Nnamdi Azikiwe, who was the first native Governor-General and later President of the country when it became an independent republic. This speech titled "Respect for Human Dignity" was given as his inaugural address in his new post as Governor-General and Commander in Chief of the nation.⁹¹³ In this speech, Dr Azikiwe made it clear that respect for the rule of law is a foundational principle upon which the union and governance of Nigeria is built. With the adoption of this principle at independence, respect for individual freedom is a key anchor of the democratic union. Emerging from the colonial heritage of Nigeria and Africa at large, Dr Azikiwe was adamant that representative democracy was the ultimate expression of human dignity. It represented the express buy-in into the national project as well as the expression of that individual's will. For him "[t]he challenge of Nigeria as a free State in twentieth century Africa is the need to revive the stature of man in Africa and restore the dignity of man in the world."⁹¹⁴

While an important part of this task, according to him, included rejecting any doctrine that sought to deny the equality of all persons and to demarcate Africans as inferior, he asserted that beyond that was a need for African States to themselves respect the rights of all. To do this, the newly independent States like Nigeria would have to show clear and definite commitment to education, welfare, and healthcare for all. He also made the point that upon independence, Nigeria was translated from a mere geographical expression⁹¹⁵ to a historical reality that was now bound together by a shared social and economic interest. The quest for human dignity would consequently have to be sought within the rubric of this new national identity and would form part of its social contract.

As such, in the Nigerian legal and socio-political context, the place of human dignity is one that sees a person as a valuable individual being who is nested within a larger community from which he derives and enjoys rights, regardless of tribe or creed and whose affairs are inextricably tied to the economic

⁹¹³ Azikiwe, Dr. Nnamdi. *Respect for Human Dignity: An Inaugural Address Delivered by His Excellency Dr. Nnamdi Azikiwe, Governor-General and Commander in-Chief, Federation of Nigeria*. 16. 11. 1960. Government Press (1960).

⁹¹⁴ Ibid at 7.

⁹¹⁵ One of the earlier critics of the nation was that the country was nothing more than a geographical expression with no binding ethos that was indicative of being a true nation State. These sentiments were expressed by Chief Obafemi Awolowo who was also one of the nation's founding fathers. See Awolowo, Obafemi. *Path to Nigerian freedom*. London: Faber & Faber Limited, 1966. See also Akinyele, R. T. "From 'geographical expression' to 'Nation space': Nigeria and the challenge of nation building." *contemporary experiences: Journal of African Humanities* 1.1 (2013): 63.

project of Nigeria, in relation to which that person is both a contributor where possible and a beneficiary, regardless. With this understanding of human dignity in the Nigerian context, I now examine how this conception of human value can translate into steps to ensure State action at all levels for the fulfilment of its own part of the social compact, vis á vis the right to health particularly.

Dignity as a claim on power

In the fight for the fulfilment of the right to health, it is vital to remember that rights are not gifts or favours, either motivated by love or pity, for which an outpouring of gratitude is owed the State in response.⁹¹⁶ A right is rather a claim upon which a person can stand on, and for which s/he can demand and insist upon its fulfilment without fear or shame.⁹¹⁷ In the face of non-fulfilment of a person's right, they are entitled to their indignation, which should only be assuaged by its eventual realisation, with no expectation of gratitude in return, seeing as it is only their only due that has now rightly been accorded to them. Right holders and claimers are dignified objects of respect in both their own eyes and in the view of others with whom they either claim with or claim against.⁹¹⁸ Human dignity therefore serves as the regulative idea, that guides the application of the politics of the State and the contestations for its resources.

As discussed above, historical, and sociological trends are important for understanding human dignity and its role in law and politics. The first and most obvious thing to engage with is the shifts in hierarchical societies either due to race or class to more democratic societies where there is an emphasis on the equal status and rights of all. Understanding the sociological shifts that accompany the political restructuring are also crucial for framing the competing functions of human dignity in political discourse.⁹¹⁹ Human dignity and the rule of law must therefore work in tandem to fully express the links between political contestations and the legal frameworks that regulate them, as well as co-regulate each other. The rule of law is important not only as an expression of self-restraint in politics but also as a necessary condition of having an accommodating politics of human agency, choice and self-creation.⁹²⁰ It should factor in the economic negotiations upon which the State itself

⁹¹⁶ Cohen, Jean L. "Rethinking human rights, democracy, and sovereignty in the age of globalization." *Political theory* 36.4 (2008): 578-606.

⁹¹⁷ Ibid.

⁹¹⁸ See n773.

⁹¹⁹ See n773.

⁹²⁰ Human dignity and the rule of law are intended precisely to express the importance of links between politics and law and the co-regulation of the two. The rule of law is important not only as an expression of self-restraint in politics but also as a necessary condition of a *permissive* politics of human agency, choice, and self-creation.

and its consequent legal structures are built upon. It must adequately frame the individual and their place in their larger social context, while factoring the opportunities available to them to fully exercise their agency, while being a productive member of society. The person's autonomy is of little effect when constantly beset by socio-economic circumstances that make their daily existence undignified, with little recourse to the kind justice that ensures the necessary recompense for their deprivation.

While the libertarian ethic will have us believe that a person's dignity is best realised when left to their own whims, communitarian thought reminds us that a human being does not exist for themselves alone and that rights are indeed most beneficial when acknowledged and enjoyed by all. It is thus the task of the State to recognise this duality and nurture it. While its legal order is its most potent expression of that value, it amounts to empty rhetoric in the absence of economic commitment, and distribution in line with the agreed upon terms of the union. By understanding what the Nigerian Constitution says about human dignity, as well as what it says about the ends of the State, we can marry the two together to yield an understanding of how the State's duties in recognition of this dignity ought to look like for the realisation of the right to health for all. In this case, it is one of a social compact wherein the Nigerian State has committed to both respecting as well as fulfilling the welfare of its citizens in exchange for their loyalty to the Nigerian State, on the individual, communal, and regional level. There is an accession to a common goal of equal development which is hinged on commensurate contribution and equitable distribution. These are the terms of the federation. On recognising the terms of the social compact, it is possible to understand non-realisation by the Nigerian State as not just a consequence of poor governance or an offshoot of corruption but as a rescinding of the compact upon which the unity of the Nigerian State is conditional upon. But as with most contracts, there is often a power imbalance that makes it difficult to hold the State accountable to its own part of the 'bargain'. Democracy is built on a relationship between those in positions of authority and the populace. New forms of power are constantly emerging on either side to counter that of the other side. The dignity of the governed is an essential bulwark against the State in that power struggle. While it is in the interest of the elite to drive interventions that predominantly favour them, the overarching need to maintain social and political stability also means that they are required to meet their obligations to the populace to retain their political legitimacy. The task is therefore to balance the need of the ruling class to centralise power and ensure the unity of the commonwealth with the proper use of the shared benefits of that accrued from that continued union.⁹²¹ The question then becomes how to enforce the terms of the contract or to alternatively renegotiate those terms.

⁹²¹Fuller, Robert W., and Pamela Gerloff. *Dignity for All: How to Create a World Without Rankism*. Oakland: Berrett-Koehler Publishers, 2008.

This kind of framing of health right claims is however not the norm. Scholars that investigate health policy and planning are late to the exploration of the place of power and politics in the formulation and implementation of the subject of their interest, being health⁹²² The work of exploring the place of power comes at the heels of more intersectional work around health inequalities and how they are exacerbated by skewed governance structures, both internationally and domestically and through globalisation. Recent world events, heralded by the continuing politicisation of a global pandemic and the various responses to it, serve as a fresh reminder that health governance, health interventions and the health systems that carry them out are deeply embedded in larger power dynamics at the local and global level. However, amid this emerging interest in the role of power in the framing of health governance, there is a growing recognition that human rights offer an important set of tools that can be used to address the lingering issues. And while human rights discourse can often be treated as separate from health policy scholarship, growing interdisciplinary work is beginning to maximise the existing normative frameworks in both health rights discourse as well as health system's scholarship and global health governance.

However, to adequately push for better policies and stronger implementation, the laws and the political settings in which they are to be realised must be understood, so as not to be blind-sided by more savvy political actors, whose interests may not necessarily align with what is in the interest of the majority of the population. In this endeavour however, the human rights normative framework serves as a critical tool for the articulation of valid claims, as well as the nature of their urgency. This is especially because, while the law itself is not the only problem in delivering on health goods and often cannot be the only solution, the ability of legal and political interventions to more robustly engage with the underlying challenges of resource allocation and their implications on the delivery of health goods will be dependent on a proper understanding of how those resources are generated and managed. As discussed earlier, the concentration of economic and political resources in the central Nigerian State also means that interventions for adequate resource allocation for the realisation of health care rights must adequately frame the demands for realising quality health care for all. In this regard, a recourse to dignity as an interpretative lens for framing the existence of a right to health care with a minimum core as well as the immediacy of its fulfilment, provides an important entry point into the justification of that demand. And, while reiterating that these rights are due on the basis of the inherent dignity of the right holders will not in and of itself guarantee State compliance, it can serve the important task of helping right holders better understand the validity of their claims and reposition their efforts to hold the State accountable. The call to recentre dignity at the heart of the

⁹²² Forman, Lisa. "What do human rights bring to discussions of power and politics in health policy and systems?" *Global Public Health* 14.4 (2019): 489-502.

attempts to hold the state accountable to its duties are such that they offer up the opportunity to determine the as yet undetermined minimum core of the right to healthcare in Nigeria and to use that as a starting point for a much broader claim for a right to health in its fullest expression.

While there is growing recognition of power relations in global health, which is especially prominent in the events leading up to and following the fragmented global response to the Covid 19 pandemic, not enough work is being done to understand the local power structures and their roles in shaping health priorities and spending. As in Nigeria, the manifestation of power relations in health is however not limited to the global health regime and Nigeria's relationship with supranational bodies and non-state actors. Rather, it is a complex mix of local contestation interwoven with the co-opting of international actors and their own agendas in a bid to determine health priorities and the funding that attends them. Unfortunately, a lack of reflexivity that allows the operations of power to continue to flow unconsciously with little interrogation continue to relegate health needs to secondary status, even where there are gaping needs. Unfortunately, while biomedical studies and public health researchers and advocates grapple with the challenges of Nigerian healthcare, legal scholars interested in the operationalisation of the right to health are bogged down by legalistic arguments rooted in a mistaken belief that more laws will fix the problem. Those in social sciences are also often quick to identify corruption as the all-encompassing Achilles heel of the efforts at nation building, while economists grapple with distributional choices of scarce resources, aiming to balance their maximisation with distributional equity concerns. In all this, the place of power, those who wield and the ends to which they wield it are often forgotten. Interventions are made on a premise that they are applied in a neutral and benign context where all that is required is a better thought-out solution. This blind spot does not consider that rather, in fact any scholarship that is done is inherently nested in the pre-existing contestations for power in that given society and context. As a result, their ability to yield the intended results are largely dependent on who co-opts the interventions and for what end.

Understanding this reality is especially important in a country like Nigeria where power has been significantly co-opted by the State and ruling class; in which case the populace either must thrive on their rent seeking or alternatively must navigate the fringes of the existing power structure. In this framework, even the realisation of the NHA and the necessary reform it provides for is dependent on the expression of political will, which will consequently bring with it the necessary resources for its implementation. In the face of a persistent hesitance by the Nigerian State to show sustained political will, there is need for legal and political mobilisation that demands necessary action. As Forman notes, any serious effort to reduce health inequities must involve changing the distribution of power within society and empowering individuals and groups to strongly represent their needs and interests. Doing this will also mean empowerment to challenge and ultimately change the unfair and skewed

distribution of social resources. As a result, a more explicit focus on power as a tool for analysis of the political determinants of health are important for better understanding how actors create and subsequently exploit disparities to serve their own interests.

Human rights already provide us with the language that recognises social injustice and creates norms to address them.⁹²³ It entrenches dignity as the core of rights, as well as expressing the universality and inalienability of rights. However, this same dignity that is the foundation of rights, calls for action to be taken to ensure its recognition. In this pursuit, whether through an application of the agency that derives from a capability lens of human dignity or through the kind of social action that is nested in a communitarian ethic, rights holders must begin to identify the right to health as their due and take definite steps to hold the State accountable to its duties. While our individual right to health calls us to hold the health system to account when it fails us, our communitarian values urge us to strive for the welfare of our most vulnerable and in need. Most importantly, it requires an understanding of us that our ability to live dignified lives is directly linked to our ability to enjoy the benefits that accrue from being citizens of Nigeria; a status that is equal for all even if power currently isn't. What the law offers is the chance to begin to enforce that equality in both practice as it is in aspiration. As Yamin has pointed out, "power vests in the extent to which rights suggest, if not encode, certain definite conceptions of power, agency, causality, and responsibility."⁹²⁴ Language frames our conception of problems as well as the tools we choose to apply to solve those problems.⁹²⁵

As such, in the context of Nigeria, the right to health must be conceived of as a point of legal and political contestation, where the establishment of a non-negotiable minimum core of the right to health is the first step in a larger and ever-increasing range of claims on the Nigerian State and the resources it holds in trust for the people. In turn, the immediacy of this non-negotiable minimum core must make it so that it is demandable by everyone, either in their personal capacity or in conjunction with others, when bearing in mind the interconnectedness of health outcomes. In this manner, the realisation of the right to healthcare must be understood as being nested in the economic and political context of the concentration of economic power in the hands of the State. Subsequent fulfilment of a clearly established minimum core must be framed by a communitarian ethos that countenances the social and cultural ways of being of the Nigerian people and is a reflection of what is collectively understood as being necessary for living a dignified life as a member of society. It must not be subject to a framing made by the State in accordance to what it claims are the limits of its capacity, as such a

⁹²³ Yamin, Alicia Ely. "Defining questions: situating issues of power in the formulation of a right to health under international law." *Hum. Rts. Q.* 18 (1996): 398-438.

⁹²⁴ *Ibid* at 403.

⁹²⁵ See n922.

concession would lead to a replication of the mistakes made in the South African context. In addition, such a framing would be an accession of power to the already powerful State which, without the right legal and political tools for compelling action, is likely to fail in its duties to act in the interest of the people for whom it is a custodian of their commonwealth. Any subsequent demands for State accountability at all levels must therefore begin from this vantage point in order to determine the kind of actions being taken to ensure fulfilment of the State's duties. Due to the fact that these claims are fundamentally legal in nature, interventions to ensure accountability must also consider legal intervention, especially by the judiciary who have the important role of being an impartial enlightened arbiter.

Conclusion

Dignity's multiple meanings are rooted in the diverse sources of the idea.⁹²⁶ It has been used to declare the existence of and promotion of human rights of the individual as well as collective rights upon which we are to live in community. The discourse of the 'human person,' often associated with human dignity in international law, captures the mixture of formal personhood and embodiment or vulnerability.⁹²⁷ And while inherently complex, the notion of human dignity provides us with a range of possibilities that arise from seeing dignity as both a right as well as being a guiding ethical principle upon which other rights are based.⁹²⁸ Conceptualising human dignity as foundational is therefore central to bonding the existing body of human rights law with a moral claim that guarantees their force as moral, just and legal (positive) claims.⁹²⁹

Donnelly reminds us that dignity is at the heart of human rights. The realisation of the most dignified existence is what informs the various other rights and what makes them inalienable; as the loss of one greatly diminishes the understanding and enjoyment of the others.⁹³⁰ One may posit that opposition to a communitarian reading is in a sense, a presupposition that there is only one way of thinking about things, which perpetuates the tyranny of a few, which is precisely the criticism often levelled against communitarianism itself. As such, what is required is room for a pluralistic reading of rights in the first place. One that identifies with the dynamics of various societies. Such an approach should be based on the problems each community faces and the approach to addressing their problems should also be

⁹²⁶ See n769.

⁹²⁷ See n757.

⁹²⁸ See n773.

⁹²⁹ Ibid.

⁹³⁰ Donnelly, Jack. "Human rights and human dignity: An analytic critique of non-Western conceptions of human rights." *The American political science review* 76.2 (1982): 303-316.

based on their socio-cultural and economic dynamics and geographical spread.⁹³¹ In the case of Nigeria, the central imperative is the preservation of the union. This union is however conditional upon the constituent portions of the Nigerian State enjoying equitable distribution of the resources of the State for the welfare of the people. Ultimately, this welfare is to trickle down to every individual who is supposed to be assured of at least, a minimum standard package of healthcare. Anything short of this is a rescinding of the terms of the union and a betrayal of the aims of the nation's Constitution. What capacity gives us is agency. What communitarianism gives us is solidarity and what the Constitution gives us is conditional unity and a contextual understanding of our rights as relational on a personal, tribal, and federal level. The task therefore is to use the institutions of the State to ensure compliance, which is the critical role the nation's courts play, and which will be examined in the next chapter.

⁹³¹ Rosenfeld, Michel. "Can Human Rights Bridge the Gap between Universalism and Cultural Relativism-A Pluralist Assessment Based on the Rights of Minorities." *Colum. Hum. Rts. L. Rev.* 30 (1998): 249.

Chapter 9

Judicial enforcement of a dignity framed right to health.

Introduction

The recognition of State's duties for the realisation of the right to health comes with acknowledging that the State can and should be held responsible for its duties if it fails to realise them. The accountability mechanism built into the human rights framework is an essential counterbalance to the powers of the State. In the quest for accountability, several political, social, and moral steps can, and often are, employed to either compel, cajole or, in the extreme, shame the State into action. In more responsive systems, a collaborative approach to State action often leads to an emphasis on evidence-based reform and State action. And while there may be a need for theoretical approaches that focus on the identification of windows of opportunity, as well as the necessary actors with various levels of power, to influence their choices and actions, these interventions are often based on the premise that change and right action is possible under the right circumstances, with the correct sets of information. In all of this, legal action is often seen as a last resort when all other channels for ensuring change have been exhausted.⁹³² This is complicated by the adversarial style of litigation entrenched in the legal system of many jurisdictions that practice a common law-style of jurisprudence.

However, the need for jurisprudential intervention by the courts goes beyond the settling of disputes and goes also to the provision of legal clarity on any number of knotty issues. In the jurisprudence on the right to health, the nature, manner, and context of judicial intervention has had varying effects across various jurisdictions. In Latin American countries, there have been varying degrees of success with some setbacks for long-term public health objectives.⁹³³ The outcomes of the increased judicialisation of health right claims have been explored at length with various reasons given for both

⁹³² Haskett, Dianne L. "Locus standi and the public interest." *Can.-USLJ* 4 (1981): 39.

⁹³³ Fleury, Sonia, et al. "Right to health in Latin America: beyond universalization." (2013).

See also, Cubillos, Leonardo, et al. "Universal health coverage and litigation in Latin America." *Journal of Health, Organisation and Management* 26.3 (2012): 390-406. Bergallo, Paola. "Courts and the Right to Health: Achieving Fairness Despite "Routinization" in Individual Coverage Cases." *Litigating Health Rights: Can Courts Bring More Justice to Health?* Eds. A.E. Yamin, and S. Gloppen. Harvard: Harvard UP, 2011. 43-75. Flood, Colleen M., and Aeyal Gross. "Litigating the right to health: What can we learn from a comparative law and health care systems approach." *Health & Hum. Rts. J.* 16 (2014): 62. Yamin, Alicia Ely, and Oscar Parra-Vera. "Judicial protection of the right to health in Colombia: From social demands to individual claims to public debates." *Hastings Int'l & Comp. L. Rev.* 33 (2010) : 431-460.

Vargas-Peláez, Claudia Marcela, et al. "Right to health, essential medicines, and lawsuits for access to medicines— a scoping study." *Social Science & Medicine* 121 (2014): 48-55.

the uptake as well as the short- and long-term outcomes.⁹³⁴ In African countries, litigation on the right to health has also had different levels of success, with outcomes largely dependent on the extent of legislative and Constitutional recognition of the right to health as well as how said right is crafted.⁹³⁵ In States like Uganda, without express provision for the right to health, there has been considerable success with creative litigation tying the right to health to other more established civil and political rights.⁹³⁶ Conversely, in South Africa where the right to health is expressly provided for, there have been great highs with considerable gains made in seminal cases like the *Treatment Action Campaign* case,⁹³⁷ while also experiencing ‘disappointing’ outcomes where the courts have been hesitant, as a result of deference to the executive, as discussed in previous chapters above.⁹³⁸

In this vast landscape of jurisprudence on the right to health and the varying approaches to the enforcement of State duties, Nigeria stands at a crossroads. The country comes from a jurisprudence of long being ‘handicapped’ by a lack of legal recognition of the right to health. Now, with a clear legal impetus for a justiciable claim to the right to health, even if currently limited in scope, it must chart the course of its jurisprudence; preferably with the hindsight of other jurisdictions that have dealt with the relevant issues already. In this chapter I discuss new ways in which the right to health may be adjudicated, bearing in mind the passing of the National Health Act (NHA).⁹³⁹ I also examine a number of interventions that have been put in place to address various limitations to optimal judicialisation of rights. I argue that the role of the courts goes beyond being an impartial arbiter of conflicting claims,

⁹³⁴ Biehl, João, et al. "Judicialization 2.0: understanding right-to-health litigation in real time." *Global public health* 14.2 (2019): 190-199.

See also, Vargas-Peláez, Claudia Marcela, et al. "Right to health, essential medicines, and lawsuits for access to medicines—a scoping study." *Social Science & Medicine* 121 (2014): 48-55.

Yamin, Alicia Ely. "The right to health in Latin America: the challenges of constructing fair limits." *U. Pa. J. Int'l L.* 40 (2018): 695.

Pinzón-Flórez, Carlos Eduardo, et al. "Prioritization of strategies to approach the judicialization of health in Latin America and the Caribbean." *Revista de saude publica* 50 (2016): 56.

⁹³⁵ McInerney-Lankford, Siobhán, and Moses Mulumba. "The Right to Health and Development: The Case of Uganda." *World Bank Legal Rev.* 5 (2014): 545.

See also, Yamin, Alicia Ely. "The right to health: where do we stand and how far have we come?" *Human Rights Quarterly* 35.2 (2013): 509-517.

⁹³⁶ Namusobya, Salima. "Litigating the Right to Health in Uganda: The Necessity for innovation and activism." *Litigating the Right to Health in Africa: Challenges and Prospects*. Ed. E. Durojaye. London: Routledge, 2015. 119-39.

See also, Mubangizi, John C., and Ben K. Twinomugisha. "The right to healthcare in the specific context of access to HIV/AIDS medicines: What can South Africa and Uganda learn from each other?" *African Human Rights Law Journal* 10.1 (2010): 105-134.

⁹³⁷ Mbali, Mandisa. "The Treatment Action Campaign and the History of Rights-Based, Patient-Driven HIV/AIDS Activism in South Africa." *Democratising Development: The Politics of Socio-Economic Rights in South Africa*. Eds. P. Jones, and K. Stokke. Leiden: Martinus Nijhoff Publishers, 2005. 213-243.

⁹³⁸ See, *Soobramoney v Minister of Health (Kwazulu-Natal)* 1998 (1) SA 765 (CC), for the reasoning of the Court in that matter.

⁹³⁹ Act No. 8 of 2014.

but goes to the heart of the political, legal, and economic contestations that have persistently shaped the relationship of the Nigerian State to its citizens. I argue that in this struggle for power, the right to health is more than a legal claim but is an important site of contestation, in which the Nigerian judiciary has an important role to play, which it must do with a contextual and progressive eye.

The new possibilities in litigating the right to health in Nigeria.

As discussed in earlier chapters, the non-justiciability of several socio-economic rights have largely hampered the extent to which judicial intervention may be made by the Nigerian judiciary. Cases like *Archbishop Okogie v The Attorney-General of Lagos State*⁹⁴⁰ have clearly laid out the position of the courts on the judicialisation of socio-economic rights. As such, while they have refrained from either questioning the validity of the Constitutional provisions that limit the scope of their powers, they have stated expressly that while their hands may be tied, if and when legislative clarity is provided, they will intervene to both interpret the role of the State as well as hold it to account on its responsibilities. The passing of the NHA has thus opened a new world of jurisprudential possibilities, which litigants and the courts must fully maximise going forward.

The possibilities for a more robust judicialisation of the right to health are imminent in the case of *Legal Defence and Assistance Project (LEDAP) GTE & LTD v Federal Ministry of Education & Anor*⁹⁴¹ where the right to education — another important socio-economic right — came up for consideration. While the previous case of *Okogie*, which also concerned the right to education, had previously been shut down by the court, stating that its hands were tied due to the nature of education as an FODP, a similar position was not necessary in the *LEDAP* case. Because specific legislation had been passed on the nature and scope of the right to education in the Compulsory, Free Universal Basic Education Act of 2004,⁹⁴² the Federal High Court in 2017 found “that with the enactment by the National Assembly of the Compulsory, Free Universal Basic Education Act, 2004, the specific provisions covered by that Act have become justiciable or enforceable by the Courts.”⁹⁴³

The court heavily relied on the decision of the Supreme Court in *A.G Ondo State v A.G Federation*⁹⁴⁴ where it quoted Uwaifo, J.S.C. who stated:

⁹⁴⁰ (1981) 2 NCLR.

⁹⁴¹ FHC/ABJ/CS/978/15.

⁹⁴² Compulsory, Free Universal Basic Education Act, 2004.

⁹⁴³ *Legal Defence and Assistance Project (LEDAP) GTE & LTD v Federal Ministry of Education & Anor* FHC/ABJ/CS/978/15 at 13.

⁹⁴⁴ (2002) 9 NWLR (Pt. 772) 222 at 382.

As to the non-justiciability of the Fundamental Objectives and Directive Principles of State Policy in Chapter 11 of our Constitution, Section 6 (c) says so (sic). While they remain mere declarations, they cannot be enforced by legal process but would be seen as a failure of duty and responsibility of state organs if they acted in clear disregard of them, the nature of the consequences of which having to depend on the aspect of the infringement and in some cases the political will of those in power to redress the situation. But the Directive Principles (or some of them) can be made justiciable by legislation. This is the point Chief Babalola seemed to have elaborated upon when he said that the Fundamental Objectives and Directive Principles had lain dormant in our Constitution since 1979 and that the Act was the first effort to activate just one aspect of them in order that there may be good and transparent government throughout the Federation of Nigeria.⁹⁴⁵

The court further quoted Uwaifo, J.S.C. who stated:

We do not need to seek uncertain ways of giving effect to the Directive Principles in Chapter II of our Constitution. The Constitution itself has placed the entire chapter II under the Exclusive Legislative list. By this, it simply means that all the Directive Principles need not remain mere or pious declarations. It is for the Executive and the National Assembly, working together, to give expression to anyone of them through appropriate enactment as occasion may demand believed this is what has been done in respect of section (15(5) by the present Act.⁹⁴⁶

In view of its finding that the Act, expanding on the nature of the right to education, was indeed justiciable and ought to be read in conjunction with the previously non-justiciable Section 18 (1) and (3) of the Constitution, the Court held that “failure to adopt and implement free, compulsory and Universal Primary education and free junior secondary education is a breach of Constitutional obligation of the government.”⁹⁴⁷

However, perhaps indicative of the courts’ tradition of hesitance to be unduly political, the Court also stated that the portion of the plaintiff’s pleadings, which stated that the “failure to adopt and implement free, compulsory and universal primary education and free junior secondary education is a breach of the Constitution by the executive head of the government that failed to do so” was “tinged with political undertone.”⁹⁴⁸ And to the prayer seeking a declaration that the breach of the State’s

⁹⁴⁵ *A.G Ondo State v A.G Federation* (2002) 9 NWLR (Pt. 772) 222 at 382 (paragraphs A - D).

⁹⁴⁶ *Ibid* at 391 (paragraphs F - H).

⁹⁴⁷ *Legal Defence and Assistance Project (LEDAP) GTE & LTD v Federal Ministry of Education & Anor* FHC/ABJ/CS/978/15 at 5.

⁹⁴⁸ *Ibid* at 15.

obligation was an impeachable conduct, the Court stated that this was not a purely legal issue and as such refrained from answering it. Even though the court desisted from making such a ‘bold’ declaration, doing so would in fact have gone to the heart of the social contract and why State failure to meet its right obligations is more than a mere failure to act, which is at the crux of the Constitution as presently set up. Nonetheless, this case solidifies the case that the NHA, as a legislative expression of the right to health in the Constitutions FODP, can and should be fully litigated on, reading in also the provisions of the African Charter.

Procedural progress in the adjudication of right claims in Nigeria

In 2009, the Fundamental Rights (enforcement procedure) Rules (FREP rules)⁹⁴⁹ promulgated by the Chief Justice of Nigeria, came into force. This seminal procedural guideline for the litigation and adjudication of human rights was made in accordance with the powers granted under Section 46(3) of the Constitution, to replace the former 1979 rules and address many of the procedural challenges faced in the litigation of human rights in the country. The FREP Rules address issues pertaining to the commencement of action,⁹⁵⁰ proceedings,⁹⁵¹ right to be heard,⁹⁵² and the kind of orders the court may give.⁹⁵³

In determining the scope of human rights that are covered by the FREP Rules, Section 3(a) of the preamble states:

The Constitution, especially Chapter IV, as well as the African Charter, shall be expansively and purposely interpreted and applied, with a view to advancing and realising the rights and freedoms contained in them and affording the protections intended by them.

This is followed up by Section 3(b) that seeks to incorporate any other necessary Acts, when it states:

For the purpose of advancing but never for the purpose of restricting the applicant’s rights and freedoms, the Court shall respect municipal, regional, and international bills of rights cited to it or brought to its attention or of which the Court is aware, whether these bills constitute instruments in themselves or form parts of larger documents like Constitutions. Such bills include;

- (i) The African Charter on Human and Peoples’ Rights and other instruments (including protocols) in the African regional human rights system,

⁹⁴⁹ Fundamental Rights (Enforcement Procedure) Rules, 2009.

⁹⁵⁰ Ibid at ORDER II.

⁹⁵¹ Ibid at ORDER IV.

⁹⁵² Ibid at ORDER XIII.

⁹⁵³ Ibid at Section 3 (c), Preamble, and Order XI.

- (ii) The Universal Declaration of Human Rights and other instruments (including protocols) in the United Nations human rights system....

The intention of the FREP Rules is thus to ensure the widest possible conception of human rights for the protection of the Nigerian people. As Amechi⁹⁵⁴ notes, the FREP Rules lay to rest many of the previously lingering issues around the justiciability of socio-economic rights as well as the nature of litigants that may bring such human right claims before it. Section 3(e) is clear in its express provision that expands upon the previously narrow definitions around *locus standi*. It provides:

The Court shall encourage and welcome public interest litigations in the human rights field and no human rights case may be dismissed or struck out for want of locus standi. In particular, human rights activists, advocates, or groups as well as any non-governmental organisations, may institute human rights application on behalf of any potential applicant. In human rights litigation, the applicant may include any of the following:

- (i) Anyone acting in his own interest;
- (ii) Anyone acting on behalf of another person;
- (iii) Anyone acting as a member of, or in the interest of a group or class of persons;
- (iv) Anyone acting in the public interest, and
- (v) Association acting in the interest of its members or other individuals or groups.

This welcome development overturns previous judgments that limited plaintiffs' actions based on lack of lack of *locus standi*. The issue of locus and its effects on the outcome of a case are apparent in the case of *Oronto-Douglas v Shell Petroleum Development Company Ltd and 5 others*.⁹⁵⁵ Here, the plaintiff who was an environmental activist, sought to compel the respondents to comply with provisions of the Environmental Impacts Assessment (EIA) Act before commissioning their project (production of liquefied natural gas) in the volatile and ecologically sensitive Niger Delta region of Nigeria. In that case, the court dismissed the suit on the grounds, *inter alia*, that the plaintiff had shown no legal standing to prosecute the action.⁹⁵⁶ Probably even beyond the removal of the limitations on *locus standi* is the more proactive stance of the judiciary where the courts are now required to "encourage and welcome public interest litigations in the human rights field,"⁹⁵⁷ which also includes the intervention of *Amici curiae*.⁹⁵⁸

⁹⁵⁴ Amechi, Emeka Polycarp. "Litigating right to healthy environment in Nigeria: An examination of the impacts of the Fundamental Rights (Enforcement Procedure) Rules 2009, in ensuring access to justice for victims of environmental degradation." *Law Env't & Dev. J.* 6 (2010): 320.

⁹⁵⁵ (1988) LCN/0053(CA).

⁹⁵⁶ See n955.

⁹⁵⁷ Section 3(e), Preamble, Fundamental Rights (Enforcement Procedure) Rules, 2009.

⁹⁵⁸ Ibid at Section 2, ORDER XIII.

Furthermore, the Rules provide for an easier mode of commencing fundamental rights enforcement actions.⁹⁵⁹ The FREP Rules simplify the mode for commencing fundamental rights actions by dispensing with the need for obtaining leave as well as a verifying affidavit.

Judicial intervention for State accountability in Nigeria.

For the realisation of State accountability especially in the context of the fulfilment of State obligations, the Nigerian courts may invariably have to adjudicate matters brought before it even when they concern competing needs and claims on State resources.⁹⁶⁰ Section 3(d) of the FREP Rules already state that “[t]he Court shall proactively pursue enhanced access to justice for all classes of litigants, especially the poor, the illiterate, the uninformed, the vulnerable, the incarcerated, and the unrepresented.”⁹⁶¹

The FREP Rules also gives the courts considerably wide powers in the kind of remedies it can order. Order XI provides:

At the hearing of any application, under these Rules, the Court may make such orders, issue such writs, and give such directions as it may consider just or appropriate for the purpose of enforcing or securing the enforcement of any of the Fundamental Rights provided for in the Constitution or African Charter on Human and People’s Rights (Ratification and Enforcement) Act to which the applicant may be entitled.⁹⁶²

As Nolan et al discuss, complex mandatory orders have been issued in various jurisdictions around the world even by their highest courts.⁹⁶³ In these cases, those courts have been quite clear that it is well within their powers to exercise supervisory jurisdiction over other arms of the State. This has in fact included a willingness of the courts to identify a minimum core, either explicitly or implicitly, when called upon to do so.⁹⁶⁴ And while this approach has been rejected in other jurisdictions such as that

⁹⁵⁹ Order II, Fundamental Rights (Enforcement Procedure) Rules, 2009.

⁹⁶⁰ Nolan, Aoife, Bruce Porter, and Malcolm Langford. "The justiciability of social and economic rights: an updated appraisal." (2009).

⁹⁶¹ Fundamental Rights (Enforcement Procedure) Rules, 2009.

⁹⁶² Ibid.

⁹⁶³ *M.C. Mehta v State of Tamil Nadu and Others* [1996] 6 SCC 756 in India, *Doucet-Boudreau v Nova Scotia* [2003] 3 S.C.R. 3. 3. in Canada and in *Minister of Health v Treatment Action Campaign* (2002) 5 SA 721 (CC), In South Africa.

⁹⁶⁴ Nolan, Aoife, Bruce Porter, and Malcolm Langford. "The justiciability of social and economic rights: an updated appraisal." *CHRGJ Working Paper No. 15* (2009). Citing the Swiss case of *V v Einwohnergemeine X und Regierungsrat des Kantons Bern* (BGE/ATF 121 I 367, Federal Court of Switzerland, of 27 October 1995).

of South Africa,⁹⁶⁵ the point has been that to make such a determination would not inherently be an illegality. Otherwise, in the instance of insufficient clarity on the rightness of such action, a nuanced and progressive approach to remedies may mean asking the State to provide the necessary policy or legislative clarity on the minimum core of the right in question. In the case of the right to health and the inconclusive position of the minimum standard package of health of the NHA, the courts would do well to make such a finding as well as holding the State to account to the obligations it commits to.

However, the courts must be careful not to allow the minimum core to become the ceiling, especially when the State makes the claim of insufficient resources, which, while often true, may not always be the case or represent the full picture of State resources in context. If we agree that the Constitution is the primary document that regulates the relationship between the State and the citizens,⁹⁶⁶ a key role of the judiciary would be to arbitrate that relationship both based on the agreed upon terms of that relationship as well as in consideration of the contexts in which that contract is to be fulfilled.

While the NHA has been passed, there is no new judgment to test the nature of the State's obligations as well as the requirements necessary for being seen to have met its obligations as provided for by the NHA. Perhaps a good and necessary starting point is an order to provide clarity on the nature of the State's obligations as well as timelines for how it intends to realise these obligations. Importantly also, the courts need to, from the start, balance the nature of individual health right claims against public health needs that affect the broader health system. In this regard, while being late to the game, the Nigerian judiciary has the benefit of the plethora of case law and scholarship from various jurisdictions, examining where, and how such a balancing act may be achieved. The court should try and find middle ground and grant preference to cases that both answer immediate right claims but also lay the foundation for more broad-based systemic reform that is sorely needed.

While the judiciary has an important role to play, it is important to remember that ultimately, it is litigants who determine the disputes that reach the courts as well as how the courts are petitioned and how intensively those cases are pursued.⁹⁶⁷ As discussed in the previous chapter, right holders have both the right, as well as the duty to claim what is their rightful due and this must be carried over into the kind of cases that are brought before the courts. This process has been made considerably easier through the FREP Rules, which have taken away many of the previous obstacles that stood in the way of human right claims. The culture of public law litigation in Nigeria must be revisited with

⁹⁶⁵ *Lindiwe Mazibuko & Others v City of Johannesburg & Others*, Case CCT 39/09, [2009] ZACC 28

⁹⁶⁶ Kenechukwu Osuji, "Economic and Social Cultural Rights in Nigeria: justiciability or otherwise", available at https://www.academia.edu/37634551/ECONOMIC_AND_SOCIAL_CULTURAL_RIGHTS_IN_NIGERIA_JUSTITIABILITY_OR_OTHERWISE, accessed on 10 October 2020.

⁹⁶⁷ See n955.

many of the key organisations persistently doing the thankless work of social advocacy and public interest litigation being given both necessary material support as well as the necessary intellectual input that is a product of sustained research and data gathering.

In addition to the goals of reform, increased social justice litigation increases the participatory capabilities of otherwise marginalised portions of society who many times are not consulted when interventions that affect their lives are made. Through litigation, not only do they get to participate in governance, but they also get to shed light on their challenges. In this sense, litigation becomes an extension of agency in its exercise as well through consequent action that follows therefrom. It is thus through litigation that our individual and collective commitment to social justice is lived out. The outcomes of robust litigation are not limited to participation for the litigants or accountability from the State, as they also include the enriching of the nation's jurisprudence and wider policies that come about as an offshoot which will benefit generations yet unborn.

Socio-economic right adjudication does not always bring about structural reform. While such an outcome would be preferential, an inability to do that does not make it an inherently invalid intervention. What is most important is that socio-economic rights litigation brings about affirmative strategies that have the capacity to yield transformation with time; especially when matched by persistent pursuit.⁹⁶⁸ Part of the process of doing this is ensuring the maximal use of procedural remedies that actually allow litigants to make their case before the courts in a timely manner and without undue cost to them.⁹⁶⁹ This often means that the scope of the courts have to evolve beyond what is more commonly obtainable.⁹⁷⁰ In an analysis of the approach of the South African courts to socio-economic right litigation, they have been adjudged as being relatively sterile, being focused only on "whether the policies and programmes are rational, coherent, inclusive, and comprehensive."⁹⁷¹ This overly cautious approach has been criticised as limiting of the otherwise largely transformative potential of socio-economic rights jurisprudence. However, in order to maximise this transformative potential, the courts would have to consider larger political and socio-economic contexts that go beyond the immediate cases before them but are nonetheless reflective of those larger trends.⁹⁷²

⁹⁶⁸ See n133.

⁹⁶⁹ Anderson, Michael. "Access to justice and legal process: making legal institutions responsive to poor people in LDCs." *WDR 2000 Conference* (1999).

⁹⁷⁰ See n133.

⁹⁷¹ Stewart, Linda. "Adjudicating socio-economic rights under a transformative constitution." *Penn St. Int'l L. Rev.* 28 (2009): 487-512.

⁹⁷² Ibid.

Conclusion

A central tenet of human rights law is the recognition that anyone who has had their human rights violated has the right to have that violation remedied.⁹⁷³ This however presumes that the wrong must first be acknowledged for what it is; an infringement on a right, with the subsequent and preferably laid out procedure for redress and recompense. The notion of what is 'justiciable' is largely determined by assumptions about the role and competence of courts, and these assumptions themselves must be subject to question. The question of what rights or components of rights should be subject to adjudication and remedy by courts or other bodies raises critical questions about how governments are to be made accountable, in practical terms, to human rights norms.⁹⁷⁴ In this task, the role of the judiciary must be assessed in terms of their implications for right holders.⁹⁷⁵ In order to make this possible and profitable, the usual criticisms of judicial intervention must be addressed head on. This means ensuring that the courts have the necessary information, range and expertise to make informed decisions, as well as ensuring their independence at arriving at decisions, along with the enforcement of procedural rules that make right claims easier, faster and more given to permitting and instigating systemic reform. This must also be backed by ensuring the ability of the courts to issue the kind of remedies that adequately address the socio-economic right claims brought before them and ensuring the consequent State accountability that necessitated said action. The legal system must offer an arena in which people can hold political leaders and public officials to account, protect themselves from exploitation by those with more power, and resolve conflicts that are individual or collective.⁹⁷⁶ In this vein, access to justice is central to the move for State accountability.

However, all the suggestions on what the judiciary ought to do are largely dependent on the proper functioning of the judiciary in a democratic society. The Nigerian judiciary has however had varying levels of progress and retrogression. Tied to the specific issue of socio-economic rights litigation is the larger issue of the sanctity of the judiciary and the respect of its role as the final arbiter. For this however, there must be a widespread perception of incorruptibility that allows for accession by all parties to the decisions of the court at any given time. This will be central to the ability of the judiciary to effectively fulfil its role in the democratic project. A comparative and reflective approach would also generate new options and possibilities, taking the right to health beyond rhetoric and towards the practical success of the realisation of health rights for the Nigerian people.⁹⁷⁷ As Olowu insightfully

⁹⁷³ Article 2 (3) International Covenant on Civil and Political Rights, 1966.

⁹⁷⁴ See n961.

⁹⁷⁵ Ibid.

⁹⁷⁶ See n142.

⁹⁷⁷ See n201.

admonishes: “[t]he task therefore lies in building a State in which governance rests on the foundation of both elite processes to maintain political settlements and societal efforts to hold those elites accountable from day-to-day.”⁹⁷⁸

⁹⁷⁸ Olowu, Dejo. “Constitutional governance, democratisation and military legacies in post-independence Nigeria.” *Constitutionalism and Democratic Governance in Africa: Contemporary Perspectives from Sub-Saharan Africa*. Eds. M. K. Mbondenyi, and T. Ojienda. Pretoria: PULP, 2013. 315-335.

Chapter 10

Conclusion

In this thesis, I have argued that the right to health is an essential human right that goes to the heart of the ability to live a dignified life. I have shown that incremental progress over time has created a much more favourable legal environment to push for the validation and implementation of the right to health in Nigeria. The maximization of this newly favourable environment is important in the face of decades of mismanagement, which has left the Nigerian health system, at all levels, in a poor state and in dire need of systemic reform. The implication of this situation is that it is grossly incapable of meeting its primary responsibility of being the conduit through which the country's narrowly defined right to health is met. As a result of this incapacity, any attempts to successfully hold the Nigerian State accountable will have to factor in these limitations and seek remedies that help spark much-needed systemic reform. Such an approach to the right to health demands that it be viewed as not simply an individual right claim, but a public health claim with broad-based impact. This, in turn, should inform the strategies the Nigerian populace, as right holders, take to ensure State fulfilment of their right to health.

In the thesis, I have identified strategic litigation as one important intervention, necessary for holding the Nigerian State accountable, and argued that for such litigation to have the most effect, it needs to be centred on the intrinsic linkage between the right to health and the ability to live a dignified life. Such an approach, I argue, ought also to be rooted in the unique socio-political context of the country and its Constitution, which specifies the benefits owed to the populace. The provision of these benefits is a key element to the continued legitimacy of the Nigerian State as it is presently constituted. In similar fashion, I argue that it is important for the courts to be on board with this nuanced understanding of the centrality of the right to health as fundamentally tied to the right to dignity for every person. Recognition that the Nigerian State indeed owes a duty to fulfil its own stated obligation of a minimum standard package of healthcare for all, must not be bogged down by likely claims of limited resources and futuristic fantasies of progressive realisation. In my discussion of the nature and content of the minimum core of the right to health, I have made the argument that various steps must be seen as mandatory and demanding of immediate action. In the specific case of Nigeria, this entails specifying the nature and content of the minimum standard package that every citizen can be expected to enjoy. Alternately, in the face of a failure or hesitance to clearly lay out the contents of this package, the Nigerian courts must be willing and ready to hold the State accountable and compel action. This is a task that I have shown is now possible, by virtue of the passing of the National Health

Act, which serves as the legislative expression of the right to health, previously curtailed by its framing as a Fundamental Objective Principle in the Constitution.

In this thesis, I also press on the need for the judiciary to be cognisant of its important role as an arm of the Nigerian State. I argue that this judicial duty goes beyond merely adjudicating between conflicting claims, but rather goes to the heart of being a necessary bulwark against the ever-increasing power of the executive and the political ruling class at large. As such, I argue that the judiciary cannot afford to be a pawn of the State and, regardless of bureaucratic constraints that may tempt it to undue reliance on State patronage, it has a duty to assert its independence in both form and function. A critical part of such an act of independence and accountability would be not to make a similar mistake as the South African courts, by being unduly deferential to the State and its framing of the issues concerning the inability to fulfil its obligations vis á vis the realisation of the right to health. Beyond this, I argue that the judiciary's intervention in the realisation of the right to health will need to be focused on systemic interventions and not just on individual right claims. While such an outcome is largely dependent on the kind of litigation brought before the court, it also has the ability and even duty to be circumspect in its rulings and to provide judicial remedies that have the cascading effect of spurring much-needed systemic reform in the health system. To fulfil this task, the courts must not be bogged down by contradictory claims that, by holding the State accountable to its duties to provide an effective and functioning health system capable of making healthcare, affordable, available, accessible and of good quality, it is engaging in judicial overreach and usurping law-making powers in contravention of the legal principle of separation of powers. In the thesis, I have shown that, while the Nigerian courts are often prone to this kind of conservative thinking, they have also shown in the past that they are capable of progressive adjudication that is more focused on providing substantive justice than focusing on procedural hurdles. I have argued that the Nigerian courts making decisions that compel the Nigerian State at all levels to fulfil its stated mandate in the National Health Act is far from judicial overreach but is rather a necessary step in giving the aspirations of the Act true meaning in the lives of everyday people who are owed that right as a matter of course. The call on the judiciary to act as a legal mechanism of accountability is therefore not one that assumes that law in and of itself is a magic bullet to solve the problems of lack of political will and years of systemic rot in the Nigerian health system. Rather, the thesis has argued that the implications of dignity as a "philosophically sounder" approach ought to be that it provides the basis of a renewed fervour for holding the Nigerian State accountable and not falling into the identified mistakes of the South African courts in being too supplicant to the State's own framing of its ability to meet its obligations for the realisation of the right to health. The State and the courts ought to decide on what the yet to be determined minimum core of the right to health in Nigeria is in line with the NHA. To this end, this

thesis has advocated that in determining what is a dignified minimum core of the right to health, a communitarian ethic would require the provision of health services that the State can and should be mandated to provide for all, as opposed to the provision of services that only benefit a few, whether determined by class, gender, or their determination to be “productive members of society” per the capabilities approach.

In this thesis, I have argued that while human rights are by nature, fundamentally individual claims, there is philosophical and contextual justification in the communitarian ethic for an approach that integrates systemic interventions which benefit communities and the population as a whole. The task of realising the right to health as both an individual claim and as a call to systemic health reform, will require persistent and sustained advocacy and litigation as resources and the political will to allocate them meaningfully have proven to be sparse over the years. In this regard, the language of human rights and human dignity is a potent tool to lay claim on the State’s power, and by extension its resources, which it holds in trust for the Nigerian people. This will be no easy task, as the ruling class have persistently prioritised their own needs and comforts over that of the larger population. However, per the terms of the Nigerian Constitution, the realisation of socio-economic rights and the welfare of the Nigerian people is a central part of the social contract that upholds the nation’s unity and legitimises the State. In view of this, ensuring the realisation of the right to health is an important focal point for laying a legitimate claim to the Nigerian State’s otherwise overtly centralised power; a power which, first and foremost, draws from the acquiescence of the Nigerian population and ought to be used for its welfare. The realization of human dignity must act as the north star that guides and frames all interventions for the realisation of the right to health. This human dignity is both vested in every individual, as well as in communities. As such, the right to health must also be realized for every individual but with an eye for system wide health system reform. In the quest for the realisation of the right to health, the needs of society’s weakest and most vulnerable must be central to quest to meet the health needs of the populace. The centrality of human dignity therefore must entrench the equality of human value and must inform priority setting, budgetary allocation, as well as judicial interventions to compel the necessary interventions.

In the quest for dignity based socio-economic rights, strategic litigation is an important tool in a larger arsenal. Litigation provides a catalyst for change in law so that its application can reach beyond the individual case in such a way that its outcome affects many people. Equally, litigation can easily generate public awareness over an issue. This is particularly true in the case of class actions where a case is brought on behalf of many people on an issue. By taking such matters before the court it may

generate publicity and gain the attention of the public on a hitherto unnoticed issue. This may lead to public support or sympathy on such an issue. Litigation must thus be increasingly used to hold a government accountable for its failure to realise the right to health. People and institutions entrusted with powers and responsibilities have the obligation to justify that those powers and responsibilities have been used appropriately. While elections remain the most vital and legitimate means of holding a government accountable in a democracy, because of their infrequent nature, and the fact that they may be subject to manipulation, they cannot be the only way to hold elected officers and their appointees at all levels accountable. Therefore, litigation can provide an alternative and relatively more immediate means of holding governments accountable to their responsibilities regarding the right to health. To this end, considerable focus must be placed on increasing the capability of litigants either as private individuals or as public interest litigants. In addition, these actors must hone their ability to transition from favourable judgments to clearly articulated agitations that translates into State action and policy. This ability to leverage legal victories for political power and ultimately health system reform is central to the goal of ensuring the respect and protection of the dignity of these litigants and all health users in general. The ultimate focus must therefore move from the pyrrhic victory of having the jurisprudence of the right to health expanded upon to having the practical and tangible merits of the right to health realised for litigants and the populace at large. While the focus of the lawyer may be to establish jurisprudence and in that lies the victory, such victory may be short lived in the long run, especially for the right holder who has gone along with the process of litigation, with the hopes that the outcome will finally birth the realisation of their rights in concrete terms. As such, the end goal of activism and litigation must also be on having outcomes that recognize and restore the dignity of the litigant. This ought to translate into tangible health interventions that address the needs of the litigants and restore them to a state of health that is compatible with their human dignity. However, effective litigation and judicialisation of the right to health is considerably limited in Nigeria because of years of limited legislative backing and failure to acknowledge its justiciability. Going forward, considerable effort will have to be channelled at increasing capacity for both litigants and judges, if the emergent jurisprudence on the right to health and the measures taken to ensure State accountability are to be robust, contextual, and instigative of sustained systemic reform.

Finally, while some of experiences of other countries have led to some pessimism on the long-term effect of the judicialisation of socio-economic rights and its ability to yield practical gains for rights holders, judicial intervention remains a good entry point into the kind of sustained civil engagement and clamour for State accountability in Nigeria that will ultimately lead to the provision of the right to health. First, there must be a clearly stated minimum standard package of healthcare for the populace,

which is provided. Subsequent add-ons may then be made over time based on the principle of progressive realisation as the means become available. However, because courts are predominantly reactive institutions that respond to cases brought before them rather than acting on their own steam, it is important to better facilitate the process from whence claims emerge. In addition to this, there are intrinsic power imbalances between many public interest litigators and the marginalised groups they represent. Care must thus be taken not to subsume the needs of right holders within other agendas. Litigators and activists must be careful not to foist their own agendas and must be cognisant of the fear, cultural distance, and rejection of the formal legal system as irrelevant and illegitimate, which sometimes permeate the communities they claim to speak and act for. A progressive social rights judgment does not in itself mean that the situation will change on the ground or that the judgment will be complied with or reflected in legislation or social policy. What takes place in court is only one aspect of the accountability process, and the social and political implications of winning (or losing) a social rights case in court depends as much on out of court mobilisation, as on the judgment itself. The processes are not separate. At every stage of the litigation process, the legal strategies and their outcomes can influence broader mobilisation and public debate around the issues. Public participation in social, political, and economic decisions that affect people, is itself a key tool for the expression of human agency. The quest for the realisation of health rights, centred in human dignity must therefore compel all relevant actors to constantly explore ways in which the processes of realizing the health goals are themselves dignity affirming. The processes used to compel the fulfilment the right to health must be as cognizant of the human dignity of right holders, as the final product being sought after, which are the goods and services provided by the health system. These goods and services must also be of such a nature that is dignity affirming. This means that it cannot be enough for the State to make them simply available. They must be accessible, affordable and of good quality. Litigation as a key tool in the quest for realising this type of dignity centred right to health for all must therefore be *with* rights holders and not simply *for* them.

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