Realising the right to health in Nigeria: Incongruities between international obligations and domestic implementation

Andra le Roux-Kemp, City University of Hong Kong

Available at: https://works.bepress.com/andra-leroux-kemp/17/
Realising the Right to Health in Nigeria: Incongruities between International Obligations and Domestic Implementation

Andra le Roux-Kemp

ABSTRACT
This article critically examines the role and responsibility of the judiciary in the realisation and concretisation of health rights in Nigeria. The gulf between the formal recognition of the right to health in international instruments — such as the International Covenant on Economic, Social and Cultural Rights and the African Charter on Human and People’s Rights — and the Nigerian Constitution, and the enforceability thereof, will shape the thrust of the discourse. It is argued that the judiciary in Nigeria is not engaging meaningfully with the true substantive content of health rights, and adequate notice and guidance is not taken from the provisions of international human rights instruments — like the ICESCR and the ACHPR. This is regrettable as courts can be valuable arenas and catalysts for the realisation and enforcement of health rights in the concrete contexts of specific cases.

1 INTRODUCTION
This article focuses on the formal recognition of the right to health in international instruments: (International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and People’s Rights (ACHPR)) and the Nigerian Constitution, and how this fundamental right to health is interpreted by Nigerian courts. Some of the Constitutional obstacles that currently hinder the true realisation of health rights in Nigeria will be considered, as well as the gulf that exists between the formal recognition of the right to

* LLD (Stell), BMus (UNISA), CML (UNISA), BA and LLB (Stell). Part-time lecturer, Stellenbosch University and Ema2sa Scholar, Freie Universität Berlin. This is a reworked version of a paper prepared for the International Conference on Realising the Rights to Health and Development for All, 26–29 October 2009, Hanoi, Vietnam. Email: andra@sun.ac.za
health and its enforceability in the Nigerian context. This article will only focus on the right to health in Nigerian constitutional law and, due to the potentially vast scope of this topic, examples referred to will be limited to HIV/AIDS and other current emerging public health threats. The article will demonstrate that the provisions with regard to the right to health ring hollow as health care delivery in Nigeria still lacks progressive and true realisation. While the perceived benefits and legitimate expectations of the right to health remain universal, this investigation into the contextualisation of the right in Nigeria will serve as an illustration that by merely being a signatory to an international instrument or explicitly incorporating particular provisions and values in a constitution, a State notifies its people and the world at large, that it is willing to be judged according to these norms.¹

In section two of this article, the right to health, as it is provided for in the ICESCR and ACHPR, will be analysed in order to establish a coherent understanding of health rights as a benchmark for the specific purposes of this study.² In section three, the right to health, as implemented in the Nigerian Constitution and interpreted by the courts in Nigeria will be considered. The article will conclude with a critical discussion on the realisation of health rights in Nigeria, and specifically the role of the courts in the concretisation of these rights.

2 DEFINING THE RIGHT TO HEALTH

Fundamental human rights, like the right to health, constitute a set of normative principles and standards, often invoked to justify a variety of fundamental political, social, economic and cultural claims.³ While individuals are the rights-holders of these claims, simply by virtue of being human, human rights, including the right to health, impose

¹ By appending its signature to a treaty, covenant or international instrument, a state often denotes the intent to ratify and be bound by the particular provisions of the international instrument. Christof Heyns and Frans Viljoen, ‘Current Developments: Constitutional Human Rights Law in Africa’ (2006) 22 South African Journal of Human Rights 674.

² See the next section for an exposition on the methodology of analysing relevant international instruments relied upon in this article, and the reason why the ICESCR and ACHPR were specifically chosen. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966) 993 UNTS 3; African Charter on Human and Peoples’ Rights (adopted 27 June 1981) CAB/LEG/67/3 rev. 5.

obligations on governments. These obligations, in terms of human rights law, include the obligation to respect, to protect and to fulfil fundamental human rights. The obligation to fulfil includes the duties to facilitate, provide and promote human rights. The obligation to respect requires governments to refrain from interfering directly or indirectly with the enjoyment of these rights, and the obligation to protect, requires governments to take measures that prevent third parties from interfering with human rights guarantees. However, these formal obligations of governments with regard to human rights do not necessarily ensure that rights-holders enjoy the full protection and realisation of these rights in practice, as governments are often constrained in their ability to fully realise fundamental human rights for their citizens.

As there is no universally accepted list constituting a numerous clausus (reserved number) of fundamental human rights, there is likewise no consensus on their scope and nature. Any attempt to provide an exact and universal definition for the right to health is consequently a cumbersome and almost impossible task. The essence of what the right to health really involves, who the rights-holders are, how the right is enforced and what the actual and direct effect of this right is on the lives of people, all depend on the specific understanding and interpretation of what the right to health actually entails. In addition, since no government can actually guarantee a person’s absolute health status, the right to health is usually described in terms of creating opportunities for people to reach their full health potential, either through a right of access to health care, or through rights to the underlying conditions necessary for health, such as clean water, adequate food etc.

---

6 Art 33 of the CESCR General Comment 14 (n 4).
7 Tarantola et al (n 3).
8 Heyns and Viljoen (n 1) 682.
The right to health is recognised in numerous international,\textsuperscript{11} regional\textsuperscript{12} and national instruments. But these instruments have not been consistent in their formulation of the right to health, and some scholars have therefore criticised the notion of a right to health as merely convenient shorthand for the protection of various aspects related to health.\textsuperscript{13} For the purposes of this article, the right to health as expressed in the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples’ Rights (ACHPR) will be considered. These two international instruments are of particular importance, as the ICESCR contains the most comprehensive formulation of the right to health in international human rights law,\textsuperscript{14} and the ACHPR is an authoritative regional human rights instrument for countries on the African continent.\textsuperscript{15} It will be against this conception of the right to health in the Nigerian jurisprudence that will be evaluated.

2.1 \textit{International Covenant on Economic, Social and Cultural Rights}

The right to health is articulated in Article 12 of the International Covenant on Economic, Social and Cultural Rights and requires that State parties to the Covenant recognise the right of everyone to enjoy the highest attainable standard of physical and mental health.\textsuperscript{16} Article 12(2) also provides for the necessary steps to be taken to achieve the full realisation of this right.\textsuperscript{17}


\textsuperscript{14} Art 2 of the CESCR General Comment 14 (n 4).

\textsuperscript{15} Nigeria ratified the ACHPR on 22 June 1983. Accession to the ICESCR was on 29 July 1993. The ICESCR is legally binding for ratifying states and theoretically enforceable in domestic courts.

\textsuperscript{16} ICESCR art 12(1) (n 2).

\textsuperscript{17} Ibid art 12(2).
These steps include the following:

- The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;\(^{18}\)
- The improvement of all aspects of environmental and industrial hygiene;\(^{19}\)
- The prevention, treatment and control of epidemic, endemic, occupational and other diseases;\(^{20}\) as well as
- The creation of conditions which would assure to all medical service and medical attention in the event of sickness.\(^{21}\)

Clear obligations are furthermore placed on State parties to undertake these steps, individually and through international assistance and/or co-operation to progressively achieve the full realisation of these rights, to the maximum of its available resources.\(^{22}\)

To clarify the nature of State parties’ legal obligations in terms of the Covenant and to ensure that socio-economic rights has an impact on the lives of those most vulnerable, the idea of a minimum core to each fundamental right, is expressed in international law and specifically by the UN Committee on Economic Social and Culture Rights (CESCR) in General Comment 3: The Nature of States Parties Obligations.\(^{23}\) In Article 10, State parties are required to ensure that, at the very least, minimum essential levels of each right are met. This minimum core obligation for the realisation of economic, social and cultural rights also creates a threshold against which State performance can be measured.\(^{24}\) With regard to the right to health, the minimum core is said to refer to the minimum basic resources that are necessary to allow individuals to be free from threats to their survival and to achieve a minimal level of well-being.\(^{25}\)

---

\(^{18}\) Ibid art 12(2)(a).
\(^{19}\) Ibid art 12(2)(b).
\(^{20}\) Ibid art 12(2)(c).
\(^{21}\) Ibid art 12(2)(d).
\(^{23}\) Art 10, CESC General Comment 3 (n 22); David Bilchitz, ‘The Right to Health Care Services and the Minimum Core’ (2006) 7(2) ESR Review 2–6; In General Comment 3 it is also stated (in arts 1 and 2) that rights contained in the Covenant should be exercised without discrimination and that deliberate, concrete and targeted steps should be taken towards the full realisation and progressive achievement of the rights contained in the ICESCR. In art 3 it is also stated that the adoption of legislative measures by signatories is an indispensable step towards the realisation of the right to health.
\(^{24}\) Bilchitz (n 23) 2–6.
\(^{25}\) Ibid; According to Articles 55 and 56 of the UN Charter, international cooperation for the development and the realisation of human rights is an obligation of all states.
The prohibiting effect that resource constraints may have on State parties’ ability to fulfil their minimum core obligations, are also taken into consideration,\(^\text{26}\) but it is also clear that resource constraints do not eliminate State parties’ obligation to progressively realise the widest possible enjoyment of the relevant rights under the prevailing circumstances, and to devise strategies and programmes for the promotion of these rights.\(^\text{27}\) Article 2 paragraph 1 of the Covenant maintains, for example, that State parties should demonstrate that every effort has been made to use all resources at its disposal in an effort to satisfy, as a matter of priority, their minimum obligations.\(^\text{28}\)

In addition, the resources that are at a State party’s disposal are not limited to those resources existing within a state. Resources available from the international community through cooperation and assistance are also included and State parties may therefore request appropriate and specific international assistance for the realisation of the rights included in the ICESCR.\(^\text{29}\)

Thus, while the realisation of the right to health (and all other fundamental rights) is subject to notions of progressive realisation and resource constraints, the right to health includes specific core obligations that should be met with immediate effect. Without these minimum core essentials, the right would be deprived of its *raison d’être*.\(^\text{30}\) However, this notion of a minimum core to each fundamental human right necessitates a clear definition of minimum and basic resources, as well as a clarification on what can be regarded as a minimal level of well-being. Moellendorf described the potential pitfalls of the minimum core approach as follows:

The cost of providing needed medical resources to all citizens, unlike the cost of providing universal housing and access to food and water, may be limitless since the costs of new technology are high and resources needs continue to grow as new treatments become available. If the cost of providing needed medical resources to all citizens is limitless, then clearly available resources are insufficient to meet all claims and a system of rationing available resources is needed.\(^\text{31}\)

\(^{26}\) Art 10 and 12 of the CESCR General Comment 3 (n 22).
\(^{27}\) Ibid art 11.
\(^{28}\) Ibid art 10.
\(^{30}\) Twinomugisha (n 29) 259.
In addition, it is also suggested that if expenditure is focused purely on health-care services that meet survival needs, then a failure to meet other basic needs will ensue which in turn will also have an adverse impact upon the health of individuals.\textsuperscript{32}

To address these shortcomings and to recognise the interrelatedness of health with other determinants, the CESCR followed a pragmatic minimum core approach in its General Comment 14.\textsuperscript{33} In this document, the right to health is described as a fundamental human right, indispensable for the exercise of other human rights.\textsuperscript{34} The right to health is said to embrace a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and includes underlying determinants of health, such as food and nutrition; housing; access to safe and portable water and adequate sanitation; safe and healthy working conditions and a healthy environment.\textsuperscript{35} Other determinants of health include: resource distribution; gender differences; socially related concerns such as violence and armed conflict; formerly unknown diseases such as Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS), and other diseases that have become more widespread, such as cancer; as well as the rapid growth of the world population.\textsuperscript{36} The recognition of these underlying determinants to health requires health rights to be understood as an entitlement to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health.\textsuperscript{37}

Article 12 of General Comment 14 also identifies four interrelated and essential elements of the right to health.\textsuperscript{38}

- The first essential element relates to the availability of health care services. Availability in this context includes functioning public health and health care amenities, as well as goods, services and programmes in sufficient quantity for all citizens. It should be noted that the precise nature of how ‘availability’ is understood in the healthcare realm will obviously vary depending on the underlying socio-economic factors and determinants as identified in the previous paragraph.\textsuperscript{39}
- The accessibility of health care facilities is the second element to the right to health and refers not only to the accessibility of general health care facilities, but also to goods, services and the underlying determinants of health. These amenities must be affordable, within

\textsuperscript{32} Bilchitz (n 23) 2–6.
\textsuperscript{33} CESCR General Comment 14 (n 4).
\textsuperscript{34} Art 1, ibid.
\textsuperscript{35} Arts 3 and 4, ibid.
\textsuperscript{36} Arts 9 and 10, ibid.
\textsuperscript{37} Arts 9 and 10, ibid.
\textsuperscript{38} Art 12, ibid.
\textsuperscript{39} Art 12(a), ibid.
safe physical reach for all sectors of the population and accessible to everyone without any discrimination. Information accessibility should also receive special attention according to the requirements of this element to the right to health.40

- Acceptability of health care services and facilities, as an essential element for the right to health, requires due concern and respect for cultural differences, medical ethics and confidentiality.
- The final essential element, quality, requires cognisance of applicable scientific and medical standards in the health care realm, including skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and portable water, and adequate sanitation.41

It is evident from this concise exposition of the general principles contained in General Comment 14 that a comprehensive clarification and a broad definition of the right to health and related health rights is provided for, as well as detailed guidance on the minimum responsibilities of governments for the full realisation of the right to health. General Comment 14 includes an exposition on the four essential and interrelated elements of the right to health,42 a non-exhaustive catalogue of examples of required State action,43 and an exposition of State parties’ obligations, as well as core obligations.44 General Comment 14 furthermore provides directions for the practical application of Article 12 by including a monitoring framework that provides for examples of how State responsibility in terms of the ICESCR can be implemented through national law.45 By recognising the interrelatedness of health with various underlying determinants, including its socio-economic preconditions, it becomes evident that many of the ideals for the full realisation of the highest attainable standard of health cannot exclusively and immediately be provided for by State parties. A government can neither guarantee good health, nor can it provide protection against every possible cause of ill health.46 States that are consequently seeking exemption from liability for not meeting their minimum obligations with regard to the right to health on the ground of lack of resources, will have to demonstrate that they have used their available resources to satisfy the minimum essential levels of socio-economic rights in general (due to the interrelatedness

40 Art 12(b), ibid.
41 Art 12(c) and (d), ibid.
42 Art 12, ibid.
43 Art 12(2), ibid.
44 Arts 43 and 44.
45 Tarantola et al (n 3) 4.
46 Art 9 of the CESCR General Comment 14 (n 4); Bilchitz (n 23) 2–6.
of health with other socio-economic rights) as a matter of priority and not only with regard to the right to health.47

All these pragmatic standards have, however, been criticised for not meeting people’s primary health needs. It is argued that the approach suggested in General Comment 14 loses sight of the urgency that certain interests may have for individuals, irrespective of resource constraints.48 And while all human rights discourse may inevitably involve the allocation of resources, the rationing of resources in health care probably has the most dismal effect of all.49

The ICESCR, read together with General Comment 3 and 14 of the CESCR, is regarded as the most comprehensive exposition on the fundamental right to health. Both the principle-based approach described in General Comment 3, and the more pragmatic approach against which State actions can be measured, and which is described in General Comment 14, have their own advantages and drawbacks in relation to successful adjudication and enforcement of socio-economic rights.50 This article will not delve into the debate on which of these two approaches best reflect the true intention and maximal outcome of socio-economic rights adjudication. The focus in this article will rather be on the current outcomes of socio-economic rights

48 Bilchitz (n 23) 2–6.
49 Tarantola et al (n 3) 3; For a discussion on health rights and resources, see Marius Pieterse, ‘Health Care Rights, Resources and Rationing’ (2007) 124 South African Law Journal 514.
adjudication (particularly the right to health) in Nigeria, within the framework provided for by the ICESCR. It will become evident from the discussion that Nigeria essentially fails to honour the stipulations of this international instrument. This disregard results in the questioning of the value of human rights for health.

2.2 African Charter on Human and Peoples’ Rights

The drafters of the African Charter on Human and Peoples’ Rights were guided by the notion that the Charter should reflect the African notion of human rights. The economic and social rights recognised in the Charter, for example, have an ‘African specificity and translate the African concern for economic development within the context of group solidarity’. As opposed to the centrality of individuality in conventional human rights discourse, the African philosophy of existence can be summed up as: ‘I am because we are, and because we are, therefore I am’. This notion of collectivity is also present in the preamble of the Charter where it is affirmed that it is the duty of everyone to ‘achieve the total liberation of Africa, the people of which are still struggling for their dignity and genuine independence’.

The Charter makes provision for two main types of rights, the rights of individuals and the rights of peoples. The latter, the rights of peoples, includes all social, economic and cultural rights in Articles 19–24 (this reference to peoples also reflects the notion of collectivity pivotal to the African notion of human rights discourse). Many of the provisions


Singh et al (n 51) 521.

Also known as the Banjul Charter on Human and Peoples’ Rights in honour of the drafting history of the Charter.


Okere (n 54) 147.


in the African Charter mirror that of the ICESCR, however, there are also significant differences between these two instruments. While the ICESCR defines socio-economic rights with such qualifications as ‘progressive realisation’ and ‘available resources’, the African Charter does not. For example, Article 16 of the African Charter reads:

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

Based on the exposition in the previous section and the discussion of a principle-based approach and a pragmatic approach to the right to health, it seems as though the right to health as envisioned by the African Charter on Human and Peoples’ Rights actually favours an immediate rather than a progressive approach. Yet, the question whether a reasonable test (pragmatic approach) or the minimum core obligations approach should be applied has to date also not been dealt with satisfactorily by the African Commission.

In the case of Social and Economic Rights Action Centre (SERAC) and the Centre for Economic and Social Rights (CESCR) v Nigeria, the African Commission did not provide effective guidance on the standard for measuring compliance by states with regard to their positive obligations in relation to socio-economic rights under the Charter. In this case, the African Commission merely stated that all rights under the African Charter generate the duties to respect, protect, promote and fulfil those rights. This decision would have made a greater impact if the obligation to fulfil third generation rights was scrutinised in detail, in terms of a state’s obligation to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures

58 Mbazira (n 47) 15–18.
60 The African Commission for Human and Peoples’ rights is established in articles 30–46 of the African Charter and is a quasi-judicial body responsible for promoting and protecting the human rights guaranteed in the African Charter.
61 Social and Economic Rights Action Centre (SERAC) and the Centre for Economic and Social Rights (CESCR) v Nigeria, Communication 155/96. This case involved alleged violations resulting from the oil-field operations of the state owned Nigerian National Petroleum Corporation (NNPC) and its joint-venture partner, Shell Petroleum Development Corporation (SPDC).
62 Mbazira (n 47) 15.
63 Ibid.
towards the full realisation of the right to health. However in *Free Legal Assistance Group and Others v Zaire* the African Commission held that the failure of the Government of Zaire to provide basic services necessary for a minimum standard of health, such as safe drinking water and electricity and the shortage of medicine constituted a violation of the right to enjoy the best attainable state of physical and mental health and the obligation of the State to take the necessary measures to protect the health of its people as set out in Article 16 [of the ACHPR].

In this latter judgment some guidance on what might be included in a minimum core for the right to health was provided, and the interrelatedness of the right to health to other underlying determinants was also recognised. It should, however, be noted that decisions by the Commission are not binding on State parties.

In the case of *Purochit and Moore v The Gambia* (Communication 241/2001) the African Commission provided, for the first time, a more comprehensive definition of the right to health under the African Charter and also elaborated on the nature of positive obligations of State parties in relation to socio-economic rights in general. The complainants in this case (mental patients at a psychiatric unit in The Gambia and existing and future mental patients detained under the Mental Health Acts of the Republic of The Gambia) alleged that the provisions of the Lunatic Detention Act of The Gambia and the manner in which mental patients were being treated amounted to a violation of various provisions of the African Charter, including the right to health. The Act allegedly did not provide any safeguards for patients who were suspected of being mentally ill at the time of their diagnosis, certification and detention. The Act also made no provision for a review or appeal procedure and did not provide for any remedy for erroneous detentions. In addition, it was alleged that no provision existed for the independent examination of the administration, management and living conditions within the psychiatric unit of The Gambia itself.

---

68 Mbazira (n 47) 16.
69 Mbazira (n 47) 16.
The African Commission found The Gambia to be in violation of numerous Charter rights, including the right to health. The Commission held that the right to health includes ‘the right to health facilities, access to goods and services to be guaranteed to all without discrimination of any kind’. And mental health patients, according to the African Commission, deserve special treatment because of their condition and by virtue of their disability. The Commission also took note of the prohibiting effect limited resources may have for the realisation of health rights and commented on the realities that African countries face in their aim to fulfil their human rights obligations. It observed that:

...millions of people in Africa are not enjoying the right to health maximally because African countries are generally faced with problems of poverty which renders them incapable to provide the necessary amenities, infrastructure and resources that facilitate the full realization of this right. Therefore, having regard to this depressing but real state of affairs, the African Commission would like to read into Article 16 the obligation on the part of State parties to the African Charter to take concrete and targeted steps, while taking full advantage of its available resources to ensure that the right to health is fully realized in all its aspects without discrimination.

The interrelatedness and interdependency of human rights was ultimately emphasised by the Commission, which described the right to health as vital to all aspects of a person’s life and well-being, as well as crucial for the realisation of all the other fundamental human rights and freedoms. This interrelatedness and interdependency of human rights is especially evident in the context of health rights. Tarantola et al observe that:

Rights relating to autonomy, information, education, food and nutrition, freedom of association, reproduction, equality, sexuality, participation and non-discrimination are integral and indivisible elements of the achievement of the highest attainable standard of health. So too is the enjoyment of the right to health, inseparable from the enjoyment of most other rights.

Thus, while the right to health is increasingly understood in terms of the complex synergy of all human and socio-economic rights, and there is recognition that health is far more than health care, strategies to secure the commitment and resources required to overcome inequities in access to these determinants of health remains lacking. Although
the idea of a minimum core to each fundamental right is expressed in international law in an attempt to concretise State obligations for the realisation of such rights, fundamental rights have also been limited by various pragmatic considerations, including that of resource scarcity. The commitment of courts to truly give effect to content and obligations of health rights, and to hold governments accountable for their responsibilities to the people, are consequentially of vital importance.

3 THE REALISATION OF HEALTH RIGHTS: THE CASE OF NIGERIA

The discussion will now turn to an evaluation of the interpretation, implementation and realisation of the right to health in Nigeria, and against the background of the ICESCR and the ACHPR. The right to health and/or other health rights included in Nigeria’s Constitution will be analysed, and thereafter the adjudication of those health rights will be critically discussed. Due to the potentially vast scope of this topic, examples referred to in this section will be limited to HIV/AIDS and other current emerging public health threats.

The 1999 Constitution of Nigeria makes provision for civil and political rights in chapter four, while social, economic and cultural rights (including the right to health) are provided for in chapter two. The rights in chapter two, however, are not regarded as fundamental rights but are rather described as Fundamental Objectives and Directive Principles of State Policy. Fundamental Objectives in this context refers to the ideals and objectives towards which the nation should strive, while Directive Principles lay down the policies that should be pursued in the efforts to realise these national ideals. The following broad categories of objectives and directive principles can be identified:

- Fundamental obligations of Government;
- Fundamental obligations of Government and the people;
- Political objectives;
- Economic objectives;
- Social objectives;
- Foreign policy objectives;
- Directive on Nigerian culture;
- Obligations of the mass media; and
- National ethics.

79 For instance, the right to life (s 33), the right to a fair trial (s 34), the right to freedom of expression and the press (s 35) etc. This chapter is also referred to as the Bill of Rights.


81 Ibid 215.
The executive, legislative and judicial tiers of the Nigerian Government are furthermore only required to observe these fundamental objectives and directive principles, and to apply them, in order to promote the welfare and advancement of society.82

With regard to social objectives, s 17 of the Constitution (chapter two) declares that the Nigerian State is founded on the ideals of freedom, equality and justice.83 The equality of rights, obligations and opportunities are emphasised and respect for the sanctity of the human person and human dignity reiterated. Governmental action is urged to be humane and the independence, impartiality, integrity and accessibility of the Nigerian courts guaranteed.84 According to s 17(3) the State is required to direct its policy towards ensuring that the health, safety and welfare of citizens in employment are safeguarded and not endangered or abused,85 and that there are adequate medical and health facilities for all.86 Whereas the fundamental rights contained in chapter four of the Constitution are enforceable by citizens against the Government in Nigerian courts, the socio-economic rights contained in chapter two do not entitle citizens to actionable claims and are non-justiciable.87 This is reflected in s 6(6)(c) where the judicial powers of Nigerian courts is explicitly ousted and declared not to ‘extend to any issue or question as to whether any act or omission by any authority or person or as to whether any law or judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in chapter two of this Constitution’.88

The absence of justiciable rights in the Nigerian Constitution makes it difficult (if not impossible) to enforce any socio-economic rights, to measure the reasonableness of the Government’s actions, and to determine whether the Nigerian Government is fulfilling its international obligations in terms of the ICESCR and the ACHPR.89 Okere submits that this unjusticiability of the socio-economic rights, which are included as fundamental objectives and directive principles in chapter two, renders the rights as nothing more than ‘moral precepts, fond hopes and pious wishes’.90 In addition, s 12(1) of the Nigerian Constitution provides that no international treaty to which

82 This is similar to the Constitutions of India, Namibia, Uganda, Ghana and Malawi. Onyemelukwe (n 59) 470–471.
83 Okere (n 80) 217–218.
84 Okere (n 80) 218.
85 Section 17(c).
86 Section 17(d).
87 Section 6(6)(c); Onyemelukwe (n 59) 464; Odinkalu (n 5) 193.
88 Also see s 13 of the Constitution; Odinkalu (n 5) 187; Okogie v Attorney General of Lagos State (1981) 1 NCLR 218; Adeyinka Badejo v Federal Minister of Education and Others Suit No M/500/88 of High Court of Lagos State (ruling delivered on 4 November 1988).
89 Onyemelukwe (n 59) 466.
90 Okere (n 80) 223.
Nigeria may be a State party will be enforceable unless it has been enacted as domestic law by the National Assembly. While Nigeria has ratified both the ICESCR and the ACHPR, only the ACHPR has been enacted as domestic law. In terms of the hierarchy of laws in Nigeria, this enacted law, although viewed as above other legislation in the country, remains subject to the Constitution. Thus, the enacted law cannot introduce justiciable socio-economic rights as it is set out in the ACHPR, since these rights have already been declared unjusticiable in chapter two of the Constitution and in terms of s (6)(c). While a distinction is consequently made between the African Charter and other domestic laws based on the Charter's international law origin and binding nature, the supremacy of the Constitution over the African Charter prevails.

Moreover, the courts of Nigeria generally do not apply or take judicial notice of the African Charter (nor the ICESCR) when giving meaning to the fundamental rights and directive principles and fundamental objectives in Chapters Four and Two of the Constitution respectively. With regard to the culture of public law litigation in Nigeria, the following obstacles to the adjudication of socio-economic rights should also be noted:

- Due to particular legal processes and requirements in Nigeria, public law litigation can encounter considerable delay, often lasting up to ten years;
- And, there is no guarantee of enforcement or compliance with a judgment in cases involving the Government or public officials as defendants. This is especially apparent in cases where the decision affects the assets of Government.

According to Onyemelukwe, this stance in Nigerian jurisprudence effectively means that international human rights treaties, even when domesticated, offer no greater protection against human rights violations other than the safeguards accorded in the Nigerian

---

91 Compare with s 39 of the South African Constitution, 1996.
92 African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Cap 10 Laws of the Federation of Nigeria 1990; Onyemelukwe (n 59) 467; Odinkalu (n 5) 185.
93 Odinkalu (n 5) 187 and 195; General Sani Abacha and Others v Gani Fawehinmi (2000) 6 NWLR 228 (Supreme Court of Nigeria).
94 Onyemelukwe (n 59) 468; Also see Abacha v Fawehinmi (28 April 2000).
95 Onyemelukwe (n 59) 468; For isolated instances where cognisance was taken on the African Charter, see Frans Viljoen, 'The Application of the African Charter on Human and Peoples' Rights in Domestic Courts in Africa' (1999) 43 Journal of African Law 1–17; Peter Nemi v Attorney General of Lagos State and others (1996) 6 NWLR (Pt 452) 42; Agbakoba v Director, SSS (1994) 6 NWLR (Pt 351) 475.
96 Odinkalu (n 5) 190; The Sheriffs and Civil Process Act requires the consent of the Attorney General at the federal or State level before for the enforcement of decisions involving State assets.
Constitution. She further argues that this interpretation of the Nigerian Constitution and the acceptance by the judiciary that all socio-economic rights are non-justiciable amounts to a contracting out of international obligations with regard to fundamental human rights; obligations which Nigeria had voluntarily accepted by ratifying and domesticating the African Charter and the ICESCR. However, the mere non-justiciability of the chapter two rights in the Nigerian Constitution, as well as the prohibition provided for in s 12(1) against the enforceability of international law, does not completely divest the right to health of all legal value for Nigerians, and ‘even though disregard of these principles cannot affect the validity of the legislation, a bold judiciary may yet vest them with legal significance’.

An excellent example of robust court action, regardless of constitutional limitations, is the case of *Festus Odafe and Others v AF Federation and Others*. In this case HIV-positive detainees in prison custody alleged that they were being denied the necessary medical attention by the prison administration in a manner that unlawfully discriminated against them on grounds of their HIV status. The detainees also alleged that this violated their inherent dignity as human beings. The Nigerian Federal Court relied on the ACHPR rather than the Nigerian Constitution to protect the right to health and held that Article 16(2) of the Charter requires State parties to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick. The court also held that while the high cost of medical treatment is appreciated, statutes also have to be complied with and the State has a duty to honour its obligations in terms of these legislative instruments. The trial judge consequently ordered the authorities to relocate the detainees to a medical facility where they could receive treatment and awarded costs in their favour. But not all Nigerian courts are this free-thinking in their approach to matters concerning health law and rights. A court in Nigeria, for example, has barred a HIV positive person from attending a trial in which she was a party, based on the risk of her infecting other people in the courtroom.

---

97 Onyemelukwe (n 59) 468.
98 Ibid 469.
99 Ibid 466; Okere (n 80) 223.
101 Ibid para 11; Odinkalu (n 5) 213.
102 *Festus Odafe* (n 100) para 13; Odinkalu (n 5) 213.
103 Odinkalu (n 5) 213.
104 Georgina Ahamefule v Imperial Medical Centre and Dr Alex Molokwu, Unreported, Suit No ID/1627/2000, Ruling of Honourable Justice of the High Court to Lagos, 5 February 2001; Odinkalu (n 5) 213–214.
In fact, Nigerian courts have been criticised for having disabled themselves from intervening through a combination of both judicial timidity and self-imposed constraints, including the doctrinal exclusion of socio-economic rights from the scope of their judicial powers, narrow and exclusionary rules of standing to sue, a crippling epidemic of interlocutory appeals and prolonged delays in court proceedings. As a consequence, Nigerian jurisprudence on socio-economic rights is described as sparse, episodic and incoherent and the health status and indicators in Nigeria are definitely not indicative of the full realisation of health rights for Nigerian nationals.

It is submitted in this article that the courts in Nigeria are not engaging meaningfully with the true substantive content of health rights. Although the right to health is not explicitly incorporated in Nigeria’s Constitution, provision is made for access to health care, as well as all the other underlying socio-economic rights associated with health and well-being. The absence of an explicit right to health consequently does not bar the adjudication and enforcement of this right by the courts. A mere legal recognition of the right to health is not sufficient, and detailed provisions are necessary to clarify to society what can be expected in terms of health-related services and facilities. In addition, further progressive realisation of health rights, over and above the minimum essential levels of health care that must be available, should also be explicitly provided for and anticipated by society. It is evident from this article that Nigerian courts generally do not offer any clarification on the nature, scope and content of socio-economic rights such as the right to health. This allows many to argue, quite convincingly, that socio-economic rights are vague, costly, aspirational and, therefore, non-justiciable.

It is also evident that the judiciary in Nigeria does not sufficiently consider how the right to health is interpreted and implemented in other African (and/or foreign) countries. In addition, courts do not take adequate notice of how international instruments, such as the ICESCR and the ACHPR, have defined the right to health and the underlying socio-economic rights necessary for the true realisation of this fundamental human right. Nigeria, as a state party to the ICESCR and the ACHPR, is under an obligation to respect, protect, and fulfil the rights guaranteed under the Covenants and also the

105 Odinkalu (n 5) 218.
106 Odinkalu (n 5) 219.
107 Marius Pieterse in Stu Woolman and Michael Bishop (eds), Constitutional Conversations (Pretoria University Law Press 2008) 342; Onyemelukwe (n 59) 470.
108 Twinomugisha (n 29) 259.
110 Twinomugisha (n 29) 272.
African Charter, in strict fidelity to the principle of *pacta sunt servanda.* It is submitted that healthcare concepts, and standards on progressive realisation, maximum available resources and core obligations, including the manner in which such concepts have been interpreted and applied in other jurisdictions, need closer conceptual and operational attention.

4 CONCLUSION

Judges are frequently criticised for being too conservative in their approach to socio-economic rights cases and for not making strong enough orders against governments to meet their obligations. Although true, one cannot ignore the difficulties faced by judges when adjudicating such claims, the most problematic issue being the difficulty in navigating between the traditional domains of the distinct organs of government in order to respect the principle of separation of powers. It is for this reason that the application of the minimum core standard is usually avoided; as courts can easily overstep the boundary and enter the realm of policy-making when applying this approach. In Nigeria, restrictive judicial attitudes, narrow constructions of standing, stringent judicial procedures as well as corruption is said to limit the effectiveness of the Nigerian courts in adjudicating socio-economic rights claims. This article, however, considered the refusal of Nigerian courts to truly deal with the substantive content of socio-economic rights which has discouraged further litigation on fundamental human rights.

Courts can be valuable avenues and catalysts for the realisation of fundamental rights, such as the right to health, through their interpretation and vindication of such state obligations in the concrete contexts of particular cases. A comparative and reflective approach would actually also generate new options and possibilities in a given jurisdiction, taking the right to health beyond rhetoric and towards the practical success of the realisation of health rights in the African continent.

---

111 Nwobike (n 64) 133. The principle of *pacta sunt servanda* implies that agreements should be honoured by the parties.
112 Backman et al (n 109) 2052.
115 Ibid 32.
116 Odinkalu (n 5) 190.
118 Liebenberg (n 50) 324.
Marius Pieterse instructively observes that:

If the realization of the right to health is to become more than a pipe dream, law (and especially constitutional jurisprudence) should increasingly acknowledge the social and material dimensions of health status and should develop a multi-dimensional conception of individual autonomy that affirms these dimensions.\(^\text{119}\)