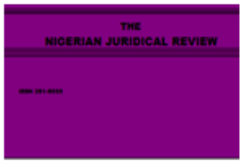

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IMPROVING NIGERIA'S POOR HEALTH INDICES: WHAT ROLE FOR THE LAW?

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Abstract

Health is a fundamental driver of economic growth and development and is believed, along with education, to be an important factor for human capital development and the basis of an individual's economic productivity and poverty reduction. Because of this prime position occupied by health in the life of man, international governmental and non-governmental organizations periodically assess the performance of states in the area of health care provision for their citizens. Nigeria has consistently posted abysmally poor indices in these periodic evaluations. This paper seeks to find out whether and how the law can change this narrative and reverse the unenviable trend. Adopting the doctrinal method of research, the paper critically analyzes the major legal frameworks on health in Nigeria. It finds that, though Nigeria has laws that can help her improve on her performance in the area of health care, certain in-built clogs in these law as well as extra-legal operational problems may make this difficult, if not out-rightly impossible, unless they are adequately addressed.

Keywords: health, health law, health indices, role of law, Nigeria

1. Introduction

When the United Nations Development Programme (UNDP), in 2011, ranked Nigeria 156 out of 187 countries analysed in the area of health and healthcare, many Nigerians, would have seen it as yet another of the devices of the developed countries to present Nigeria in bad light[1]. However, when this poor rating was reaffirmed in 2012-2013 by the World Economic Forum (WEF) which ranked Nigeria 142 out of 144 countries in terms of her health and primary education performance, it would have gradually begun to dawn on Nigerians that the 2011 diagnosis was probably correct and that the health sector

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[1]UNDP, 'Human Development Report: Health Index 2011' < hdr.undp.org/en/content/health-index> accessed on 20 March 2022.

needed some more therapeutic attention than it was then receiving[2]. Then, when a report by the World Health Organisation[3] showed that as at 2015, the life expectancy of the average Nigerian at birth was 53 years, in males, and 54 years, in females, a figure that was lower than the Sub-Saharan Africa's average of 56 years, it probably became clear to most Nigerians that the health sector was, literarily already bed-ridden. It is worthy of note that the World Economic Forum subsequently ranked Nigeria 146th out of 148 countries in 2013-2014, 143rd in 2014-2015[4] and, again, 143rd in 2017-2018.[5] With a cumulative maternal mortality ratio for the period, 1990 to 2015, standing at 814 per 100,000 live births, Nigeria prides herself with the unenviable position of having the second highest maternal mortality ratio in the world, with 800 women dying every day during pregnancy or childbirth, while 800 new born babies die during their first month of life. This reveals an infant mortality ratio of 88 deaths per 1000 live births, and child mortality of 143 deaths per 1000 live births, the highest in Africa and second highest in the world[6]. It goes without saying that this startling statistics does not speak well of the state of health and health care in Nigeria, in spite of her parade of an avalanche of laws and policies for the realization of right to health.

The World Health Organisation (WHO) identified Nigeria as one of the 46 African countries that had failed to meet the Abuja Declaration[7], 13 years after the Declaration, and one of the 38 countries that were off-track in meeting the health-related Millenium Development Goals (MDGs) by 2015[8]. Much earlier, in the year 2000, Nigeria was ranked187 out of 191 countries under the WHO Report on Health Care Delivery while, in the area of human development (which includes healthcare delivery for the citizens), the Human Development

[2]See World Economic Forum (WEF), Global Competitiveness Report (GCR): Nigeria <reports.weforumm.org/global-competitiveness/report-2012-2013/#section=country-economy-profiles-nigeria> accessed on 28 December 2023.

[3]WHO, World Health Statistics 2015 [2015]131.

[4]WEF, 'Global Competitiveness Report 2013-2014: Sub-Saharan Africa' <reports.weforum.org/global-competitiveness-report-2014-2015/sub-saharan-africa/> accessed 28 December 2023.

[5]WEF, 'Global Competitiveness Report 2017-2018' <www.weforum.org/docs/GCR2017-2018/05FullReport/TheGlobalCompetitivenessReport2017-2018.pdf.> accessed 28 December 2019.

[6]WHO, Health in 2015: From MDGs to SDGs <http://apps.who.int/iris/bitstream/10665/200009/1/ 9789241565 110_eng.pdf?ua=1>accessed 20 September 2023.

[7]Adopted by the African Union in April 2001 to increase government's annual funding for health to at least 15%.

[8] IW Oyeniran and SO Onikosi-Alliyu, 'An Assessment of Health-Related Millenium Development Goals in Nigeria', *Asian Journal of Rural Development,* 5:12-18. <http://scialert.net/abstract/?doi=ajrd.2015.12.18>. accessed 21/5/2023.

Report of 2007/2008 ranked Nigeria158 out of 177 countries assessed.[9] It has equally been reported that in 2005, only about 48% and 35% of children aged between zero to one year in Nigeria received full immunization against tuberculosis and measles, respectively, while only 28% of Nigerian children aged 5 years who suffered from diarrhea between 1998 and 2005 had access to adequate treatment. Also, only 35% of births in Nigeria between 1997 and 2005 were attended to by qualified health professionals.[10] Akingbade[11] writes that in 1986, well over 1,500 health professionals left Nigeria for foreign land and ten years later, the UNDP reported that 21,000 Nigerian medical personnel were plying their trade in the United States of America and the United Kingdom while Nigeria was experiencing acute shortage of these professionals. Poor sanitation, acute food insecurity and HIV/AIDS prevalence were also common features in the health sector of Nigeria within the period, 1990 to 2004[12].

Pharm Access Foundation's Nigerian Health Sector Market Study Report[13] reveals that the estimated total health care expenditure in 2014 was USD 18.3 billion and that household out-of-pocket expenditure remained the major source, constituting 70.3% of the total healthcare expenditure (THE) in 2009. Government expenditure as a percentage of GDP was reported to be below the average for Sub-Saharan Africa while less than 5% of Nigerians were covered by any form of social insurance at the end of 2013. It is submitted that the foregoing situation does not appear to have changed. In the area of maternal health, it has been reported[14] that Nigeria loses about 145 women of child-

[9] AMO Agba and EM Ushie and NC Osuchukwu, 'National Health Insurance Scheme (NHIS) and Employees' Access to Healthcare Services in Cross River State, Nigeria' [December 2010](10)(7) *Global Journal of Human Social Science* 9.

[10]See generally, UNICEF, *State of the World's Children 2007* (New York: UNICEF 2007); World Bank, *World Development Indicators* (Washington DC: World Bank, United Nations Educational, Scientific and Cultural Organisation 2007), and UNDP, *Human Development Report 2007/2008 on Fighting Climate Change: Human Solidarity in a Divided World* (New York: Palgram Macmillan 2008), all cited in Agba AMO *et al, (*n 11).

[11] B Akingbade, 'Meeting the Challenges of Human Capital Development in Nigeria-The Case for Reforms in the Educational Policies and System', being a paper presented at the Alumni Convocation Lecture of the University of Nigeria, Nsukka in 2006.

[12] The UNDP Report (note 12) also stated that only 39%(in 1990) and 44%(in 2004) of Nigerians had access to sanitation while during the periods, 1990-1992 and 2002-2004, 13% and 9%, respectively, were undernourished.

[13] Pharm Access Foundation, 'Nigerian Health Sector Health Market Study Report', (Pharm Access Foundation, Report of a Study of the market of the Nigerian health sector carried out by Pharm Access Foundation for Dutch companies and published in March 2015. The aim of the study was to understand the needs of the health providers and other stakeholders within the Nigerian health sector and provide insight into possible investment opportunities for Dutch health companies.

[14] Nigeria Health Watch, 'Giving Birth in Nigeria: The Staggering Odds Facing Pregnant Women' [August 16, 2017] *Nigeria Health Watch*. See also Society for

bearing age every day, making her the second largest contributor to the global rate at which mothers die. At 576 deaths per 100,000 live births, according to the 2013 Nigeria Demographic Health Survey, Nigeria parades one of the worst maternal date statistics in the world, second only to India. According to a joint report by the WHO, UNFPA, UNICEF, and the World Bank, 58,000 Nigerian women lost their lives to pregnancy and childbirth- related causes in 2015 alone.[15] In Nigeria, health insurance, which is, unarguably, the fastest way to achieve Universal Health Coverage (UHC), does not seem to be making the required impact on the health sector since its establishment in 2005.[16] In contrast to the 50% growth which it's contemporary, the Ghanaian National Health Insurance Scheme[17] has achieved, Nigeria's National Health Insurance Scheme had achieved only about 3% coverage before the introduction of compulsory health insurance under the new National Health Insurance Authority Act 2022. Researches have also shown that out-of-pocket expenditure has continued to top the list of sources of health financing in Nigeria[18]. At well over 72% of the total health expenditure (THE), Nigeria's out-of-pocket (OOP) expenditure is the highest in the continent and one of the highest in the world,[19] with even poorer Sub-Saharan African countries,[20] and those afflicted with conflicts[21] doing better than Nigeria. Earlier in 2013, the World Bank had reported that life expectancy at birth in Nigeria was 52 years, which was below the Sub-Saharan Africa's average of 56 years. The report also showed infant mortality rate as 39 in every 1,000 live births, under-five mortality rate as 124 in every 1,000 live births, while maternal mortality rate was estimated at 630 in every 100,000 live births.[22] The COVID 19 pandemic[23] which ravaged the whole world further

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Family Health, Nigeria, 'Maternal and Child Health' <www.sfhnigeria.org/maternal-and-child-healthcare/> accessed on 18/6/2018.

[15] Punch Editorial Opinion, 'Nigeria and the Challenge of Universal Health Coverage' *The Punch Newspaper, Newspaper*, (Lagos, 11 April, 2018) 10.

[16] Ibid.

[17] Which started the same year as that of Nigeria. See also *ThisDay Newspaper* [Lagos 21 December 2017].

[18] Ibid. See, also Pharm Access Foundation,(n 16).

[19] AI Okpani and S Abimbola, 'Operationalizing Universal Health Coverage in Nigeria through Social Health Insurance. [2015 Sep-Oct] (56) (5) *Niger Med J* 305 <http://www.nigerianmedj.com/text.asp? 2015/56/305/170382>. accessed on 19 May 2019.

[20] Such as Kenya and Gabon which post 26% and 22% coverage, respectively. See Okpani and Abimbola (n 22.)

[21]Ibid. Such as South Sudan (54% coverage) and Sierra Leone (61% coverage).

[22] The World Bank, 'The World Databank: Sub-Saharan Africa (developing only), 2012' http://data.worldbank.org/indicator.

[23]See DJ Cennimo, 'What is COVID 19?' <www.medscape.com> , accessed on 22 February 2021, where the author states that COVID 19 is an illness caused by a novel coronavirus now called severe acute respiratory syndrome coronavirus2(SARS-CoV 2), which was first identified in Wuhan City, Hubei Province, China. It was reported to the

exposed the embarrassing inadequacies in the Nigerian health sector, such as grossly inadequate infrastructural facilities and health human capital as well as poor health governance. As at 18 February 2021, Nigeria had recorded 149, 860 confirmed cases of COVID 19 infections and 1,787 deaths. It should be noted that Nigeria was grossly under-tested as a result of the gross inadequacy of testing facilities[24].

Today, this ugly situation can hardly be said to have changed substantially. The current life expectancy as at 2024 is 56.05 years, slightly above the 55.75 years figure of 2023, which itself was grudgingly above the 2022 figure of 55.54 years. In 2023, Nigeria was, again, ranked 157th out of 167 in Health and Health Systems Ranking of Countries Worldwide. Singapore topped the global list while Seychelles came first among African countries, followed by Algeria and Cape Verde who came 2nd and 3rd, respectively. Earlier, in 2017, the WHO ranked Nigeria 187th out of 190 in World Health Systems, only ahead of the Democratic Republic of Congo, Central Africa Republic and Myanmar. France, Italy, San Marino, Andora, and Malta topped the list, in a descending order. The Performance Indicators used were: Overall level of health, Distribution of Health in Populations, Responsiveness, and Distribution of health Finance. Later, in 2018, a Lancet Study of Global Health Access and Quality ranked Nigeria's health system 142 out of 195 countries. In this article, 'health' is used as provided in the Preamble to the Constitution of the World Health Organisation 1946 which sees it as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[25] 'Indices' is used to mean the measures, figures or positions assigned to something after an assessment or evaluation or in comparison to other things either of the same class or of different classes. 'Health indices' means the measures, figures, or positions returned by the various aspects of the health sector after evaluation, assessment, or comparison. By 'role' this article refers to the part, or function, or duty. The law is used here to mean statutes, legislation enacted by the National Assembly and includes international legal instruments to which Nigeria is a signatory.

2. Factors Responsible for Nigeria's poor health indices

Researches have shown that the factors responsible for Nigeria's poor showing in the periodic assessment of country performances in the various aspects of health and healthcare include; inadequate government financing for health, inadequate and skewed provision of health infrastructure, gross inadequacy and

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World Health Organisation on 31 December 2019. The WHO on 30 January 2020 described it as a global health emergency and on March 11 2020, it declared COVID 19 a global pandemic.

[24] See generally, KO Akinyemi and others, 'Intrigues and Challenges Associated with COVID 19 Pandemics in Nigeria' [2020](12) *Health* 954. < https:doi.org/10.4236/health.2020.128072.> Accessed 22 February 2021.

[25] Preamble to the Constitution of the World Health Organisation 1946.

skewed distribution of health human capital, poor health service delivery, poor implementation of health policies and programmes, weak health governance, insufficient public knowledge and awareness of the National Health Act 2014.

Health care in Nigeria is poorly funded. Government expenditure on health as a percentage of total government expenditure (budget) has averaged at about 7% over the years. This is, by far, less than the 15% stipulated by the Abuja Declaration, to which Nigeria is a chief-signatory.[26] This meager government spending on health amounts to just about $118 per capita annually (lower than that of Sudan ($130), and much less when compared to those of South Africa ($570), United Kingdom ($3,935), Norway ($2,698), United States ($9,403) and Switzerland ($9,674). Nigeria spends less than 6% of its Gross Domestic Product(GDP) on health care, lower than those of many other African countries: South Africa (>7.5%); DR Congo(7.9%); Sierra Leone(22.9%); Gambia(14.9%); Malawi(12.8%); Rwanda (11%), and Namibia(8.3%). The following are the respective budgetary allocations to health by Nigeria from 2014 to 2018: 2014=N264bn(5.63%); 2015=N260bn(5.78%); 2016= N267bn(4.23%); 2017=N340bn(4.15%); and 2018= 20340bn(3.95%). The 2024 budget is not any different from the previous budgets, in terms of inadequate provision for the health sector. With a budget of N1,228,100,390,7659 (only 4.47%) of the total budget inclusive of N125,737,146,031sum set aside for the Basic Health Care Provision Fund.

Nigeria's health financing is principally borne by out-of-pocket (OOP) expenditure which constitutes about 73% of the total health expenditure (THE).[27]

Corruption has also been identified as one of the serious problems confronting the health sector in Nigeria.[28] As a result of corruption, health policies are not properly implemented as the officials responsible for the implementation of such policies may be people who are unqualified for such jobs but who were employed either because they are related to the people responsible for the recruitment of health human capital or they have bribed their way through to get the jobs.[29] Policies are poorly monitored and hardly ever effectively evaluated. Funds meant for the provision of health equipment and infrastructure often find

[26]World Health Organization, 'Global Health Observatory Data Repository 2015' < http://www.apps.who.int/gho/data/node.country.country-NGA> Accessed on 26 August 2023.

[27]See generally, Tunji Olaopa, 'Health Financing and the Crisis of Healthcare System in Nigeria' *This Day*, March 15 2019.

[28]II Omoleke and BA Taleat, 'Contemporary Issues and Challenges of Health Sector in Nigeria' [October/December 2017(5)(4) *Res. J. of Health Sci.* <https://www.ajol.info.article>view> accessed on 15 May 2023.

[29] J Chinawa, 'Factors Militating against Effective Implementation of Primary Health Care(PHC) System in Nigeria' [2015] *Annals of Tropical Medicine and Public Health*. <https://www.semanticscholar.org> accessed on 4 December 2022.

their way into the private pockets of public officials and the hospitals are left without the necessary infrastructural facilities.[30] There have also been cases of the theft of drugs by health service workers. Corruption, ineptitude, indolence and general lack of knowledge leads to poor health governance.[31] Health care resource allocation in Nigeria is inequitably skewed in favour of secondary and tertiary care as against primary health care. By this is meant that the provision of the necessary health resources (human and infrastructural) is done in favour of the secondary and tertiary health care outfits to the gross disadvantage of the primary health care institutions. As a result of this, many people bypass primary healthcare facilities to seek primary care at secondary and tertiary facilities. The organisation of the health system in Nigeria is such that certain services and health issues are necessarily left for the primary health care facilities to attend to. It is only when there is the need for the services of a secondary health facility, with respect to any patient, that such a patient, through a well-coordinated referral system is referred to a secondary health facility for attention. In the event that a secondary health facility is faced with a health issue that can only be handled at a tertiary level, a referral is made for the patient to go to a tertiary health facility to receive the required attention. A situation where people bypass primary care facilities and move straight to either secondary or tertiary facilities for health issues that should, ideally, be handled at the primary level is both inefficient and promotes inequities. This is because the cost of primary care provision at secondary and tertiary level is higher. This amounts to economic inefficiency. It also leads to overcrowding of the tertiary institutions and promotes inefficiency at such tertiary centers. It is submitted that people take such decisions because primary healthcare centres are ill-equipped, poorly staffed, and are mainly patronized by poor people (especially in rural areas) who can either not access or afford care at higher health facilities.

There is, also, a deficiency in qualified health professionals, particularly in the poor rural communities. Because of poor conditions of service, Nigeria has been losing hundreds of thousands of health human capital to brain drain yearly.[32] The Medical and Dental Council of Nigeria has reported that only 58,000 out of the 130,000 registered medical doctors in Nigeria renewed their practice licence in 2023, constituting only 45%. The Registrar of the Council, Dr. Fatima Kyari who disclosed this, attributed it to the brain drain in the health sector.[33] As a

[30] S Tumba, 'Addressing Health Challenges in Nigeria' <https:// minervastrategies.com>blog>accessed on 25 July 2024.

[31]B Aregbeshola, 'Health Care in Nigeria: Challenges and Recommendations' [7 February 2019] <https://socialprotection.org>blog> accessed on 20 April 2024.

[32] Joyce Imafidon, 'One Way Traffic: Nigeria's Medical Brain Drain, A Challenge to Maternal Health and Public Health System in Nigeria?'[2018] <https://escholarship.org/item>accessed on 26 January 2019.

[33] *Punch*, "58,000 out of 130,000 Doctors renewed licence in 2023" says Medical and Dental Council of Nigeria. *Punch* 27 April 2024. <punchng.com> accessed 8 July 2024.

result of this, the health system has a dearth of health professionals to provide the highly needed health services for Nigerians both in urban and rural areas.[34] The doctor-to-person ratio in Nigeria as at 2021 was put at 0.395 per 1,000 people. What this means is that Nigeria, the world's most populous black nation has only between 55,000 and 58,000 medical doctors to cater for the health needs of her well over 220,000,000 population. Also, large disparities, in terms of infrastructural facilities, exist between urban and rural areas(in favour of the urban areas) and health professionals are usually more favourably disposed towards taking up jobs with better-paying Federal and State health facilities located in the urban areas to the detriment of the majority poor rural populace who bear a greater burden of disease. In 2019, the Nigerian Health Facility Register, produced by the Federal Ministry of Health, put the total number of health facilities in Nigeria (primary, secondary, and tertiary) at 40,821, broken down into 34,675 primary health facilities; 5,780 secondary care facilities; and 166 tertiary care facilities. Out of these, only 28,448 primary facilities, 1,232 secondary facilities, and 105 tertiary facilities were government-owned (public health facilities). The rest were owned by various faith-based organizations and private outfits. It is submitted that this is grossly inadequate, given the geographic character and demographic size of Nigeria.

Nigeria is signatory to the global mandate for universal access to quality health care devoid of risk of financial catastrophe, otherwise called universal health coverage(UHC). A vital feature of this mandate is the availability of prepayment for health care costs. Nigeria's National Health Insurance Scheme (NHIS), which was the operative social health insurance programme in Nigeria before 2022 when the current health insurance regime came into effect, was only able to cover about 3% of the population. The NHIS, through Health Maintenance Orgaisations (HMOs) and other stakeholders of the scheme, provided health coverage to only Federal public sector workers, their families and workers of large organizations in the organized private sector. As a result of this limited coverage, the large majority of Nigerians, especially in the informal sector, remained without any form of coverage. In addition to this, there was little or no social security for vulnerable groups and state governments were hesitant in the uptake of social insurance regulated by NHIS.

As a result of this, the bulk of health expenditure in Nigeria (over 70%) comes from household and personal pockets. More than 75% of Nigerians work in the informal sector and about 40% live below the poverty line[35]. In this situation of prevalent poverty and informal employment, the currently high health financing

[34] CN Okolo and others, 'Challenges of Establishing Universal Health Coverage in Enugu, South East Nigeria' (2019) 9(4) *Developing Country Studies* < https://www.researchgate.net> accessed on 27 June 2020.

[35] The World Bank, 'Nigeria Releases New Report on Poverty and Inequality in Country' [May 28 2020] <https://www.worldbank.org/brief> accessed 5 September 2020.

burden on the Nigerian household is a recipe for further impoverishment and denial of proper health care services. Out-of-pocket payment is the most expensive, least equitable, least efficient and least inclusive health financing method. It weighs heavily on household budgets and forces many into poverty due to unpredictable catastrophic health expenditure. It has been shown severally that poor health and poverty are two intertwined bedfellows whose relationship leads ultimately to a vicious cycle of further impoverishment and eventual death. While poor health limits the ability to escape the poverty trap, the existence of poverty hinders access to good health. This situation is made even more complex by the factor of distrust on the part of the people. In a situation where trust is lacking, the willingness to prepay for health care remains low among the largely uninformed populace because people are unsure of the benefits from a product or service in the future against a payment today.

3. The Law to the Rescue?

Analyses of the requisite provisions of the National Health Act 2014, the National Health Insurance Authority Act 2022, the African Charter on Human and People Rights(Ratification and Enforcement) Act, the Constitution of the Federal Republic of Nigeria 1999(as amended) and other health-related ancillary laws reveal that a proper application and effective implementation of these provisions will surely take Nigeria to the top on the various global lists on the assessment of country performances in the various departments of the health sector.

3.1 The National Health Act 2014 and the National Health Insurance Authority Act 2022

The National Health Act 2014 which makes no pretensions, through its various provisions, about its express recognition of the right to health as provided in the foremost international human rights instruments, is made up of seven parts with a total of 65 sections. Part I of the Act, entitled 'Responsibility for Health, Eligibility for Health Services and Establishment of National Health System' provides for the establishment of the National Health System which is conferred with the authority to define and provide a framework for standards and regulation of health services in the country.[36] The National Health System encompasses public and private providers of health services[37] and shall provide the best possible health services within the limits of available resources for persons living in Nigeria.[38] It can, therefore, be seen that, from the onset, the National Health Act 2014 leaves no one in doubt about the quality of health services it mandates the National Health System to provide for the citizens and the fact that it recognizes health as a human right in Nigeria. It is noteworthy that section 1(1)(c) of the Act echoes the provisions of Article 2 of the

[36] The National Health Act 2014 s 1(1).
[37] Ibid s 1(1)(a).
[38] Ibid s 1(1)(c).

International Covenant on Economic, Social and Cultural Rights(ICESCR) 1966 with respect to the role of resource availability to the realization of the right to health. While it is hoped that Nigeria will not hide under the excuse of resource unavailability to shy away from fulfilling her duty under this Act, it should be noted that a lack of resources cannot justify a state's failure to take steps to realise the right to health by providing quality health care services to its citizens or to fulfil the minimum core obligations placed on it by the International Covenant on Economic, Social and Cultural Rights as interpreted by the UN Committee on Economic Social and Cultural Rights under the General Comment No. 14. Another interesting feature of this section is the provision that the beneficiaries of the best available health services shall be 'persons living in Nigeria'. What this means is that the health services shall be extended to all persons living in Nigeria without distinction as to their nationality or on any other ground. It is submitted that this provision speaks to the requirements of article 5 of the Convention on the Elimination of All Forms of Racial Discrimination (CERD).

It may appear, however, that residency in Nigeria is a condition precedent for qualification to benefit from the various services which the National Health System will provide. The question may then be posed whether a patient on medical tourism from any other country can successfully enforce a right of action in a Nigerian court against the System or any of its components that fails in its obligation under this Act. In addition to setting out the rights and obligations of health care providers, health workers, health establishments and users[39], the National Health System shall, importantly, give adequate protection, promotion and fulfilment to the rights of Nigerian people to have unhindered and unimpeded access to health care services[40]. Section1(1)(e), again, echoes the interpretation of the duties of States Parties under the ICESCR as stated by the UN Committee on Economic and Social Rights in General Comment No. 14, identifying three levels of obligations for the States Parties. This provision is very important as it has a very strong bearing on the realization of the right to health. The provision, however, raises another curious question: whether the duty to protect, promote and fulfil the right to access to health services applies only to 'the people of Nigeria' or whether it extends to foreigners in Nigeria. If it applies to only the people of Nigeria, to the exclusion of foreigners in Nigeria, Nigeria would be contravening the provisions of article 5 of CERD. It is submitted that 'the people of Nigeria', should be interpreted to include not only people living in Nigeria(including non-Nigerians) but also persons , though not resident in Nigeria, but who are in Nigeria on medical tourism. It is further suggested that the Act be amended to reflect this interpretation.

[39] Ibid s 1(1)(d).
[40] Ibid s 1(1)(e).

The composition of the National Health System is another commendable feature of the Act which speaks to comprehensive inclusivity of all health stakeholders. It provides that the National Health System shall be composed of the Federal Ministry of Health;[41]the Ministry of Health in every state and the Federal Capital Territory Department responsible for Health;[42] parastatals under the federal and state ministries of health;[43]all local government health authorities;[44]the ward health committees;[45]the village health committees[46] private health care providers;[47]traditional health care providers[48]; and alternative healthcare providers[49]. Worthy of mention is the comprehensive character of the composition, especially as it includes traditional and alternative health care providers. In addition, the inclusion of ward and village health committees in the composition of the System implicates grass-root representation and speaks to an improvement in the Primary Health Care system, a section of the national health system that has, for a long time received poor attention from government. It has been noted that the growth, development, efficacy and reliability of the Indian, Chinese and Brazilian health care systems are traceable to their combination of traditional systems with orthodox medical practice.[50] It is hoped that Nigeria will learn from the experiences of those countries.

The Act also makes elaborate provisions for the functions of the Federal Ministry of Health, which include ensuring the development of national health policy and issuing guidelines for its implementation,[51] promoting adherence to norms and standards for the training of human resources for health,[52] ensuring the continuous monitoring, evaluation and analysis of health status and performance of the functions of all aspects of the National Health System.[53] Ensuring the provision of tertiary and specialized hospital services[54], promoting availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water,[55] and issuing guidelines and ensuring the

[41] Ibid s 1(2)(a).
[42] Ibid s 1(2)(b).
[43] Ibid s 1(2)(c).
[44] Ibid s 1(2)(d).
[45] Ibid s 1(2)(e).
[46] Ibid s 1(2)(f).
[47] Ibid s 1(2)(g).
[48] Ibid s 1(2)(h).
[49] Ibid s 1(2)(i).
[50]P Ukeyima and M Emmanuel and KF Aondona, 'Health Care Policies in Nigeria Since Independence: Issues, Challenges and Prospects' [June 26 2016] *Katsina – Ala Multidisciplinary Journal* 67.
[51]Ibid s 2(1)(a).
[52] Ibid s 2(1)(d).
[53] Ibid s 2(1)(e).
[54] Ibid s 2(1)(i).
[55] Ibid s 2(1)(l).

continuous monitoring, analysis and good use of drugs and poisons including medicines and medical devices [56] are also among the functions of the Federal Ministry of Health. All these provisions and many others in the Act have profound implications for the improvement of the poor health indices which has been the bane of Nigeria over the years.

With the intention of making health care services available to even the most vulnerable in Nigeria, the Act provides for people who can be exempted from paying for health services in public health outfits in Nigeria as well as the conditions which such people will satisfy in order to be eligible for such benefits[57]. It provides that, in addition to the fact that a basic minimum package of health care services is, by this Act, a statutory entitlement of all Nigerians, the Minister of Health has the power, after consulting with members of the National Council on Health, to come up with conditions which certain other people will satisfy to qualify them to be further entitled to free medical services in Nigeria's public health institutions.[58] In prescribing such conditions, the Act makes it mandatory for the Minister to, among other considerations[59], have regard to the needs of the groups of people who are usually regarded as vulnerable people. These groups include disabled persons, old persons, women and children[60]. It is noteworthy that the new National Health Insurance Health Authority Act 2022 makes provision for the free provision of health insurance for the vulnerable groups.[61] These are very laudable lofty provisions which, if properly implemented, will be a good step towards the realization of the right to health, achieving Universal Health Coverage (UHC), realising the health and health-related sustainable development goals(SDGs) and, ultimately improving Nigeria's performance on the global assessment of national health systems, as this solves the problem of access to basic health care by Nigerians.[62] The National Health Act is, however, silent on what constitutes that basic minimum package of health care services to which all Nigerians are entitled. It can be argued that such an omission may be deliberate, bearing in mind that the Minister, by the powers conferred upon him by the Act can define the basic minimum package in regulations drawn up under the Act. This article is of the view that the Minister should be required to make wide consultations with, and receive informed inputs from, stakeholders each time such regulations are to be made or amended. This Part also provides for the establishment and

[56] Ibid s 2(1)(m).
[57] Ibid s 3(1).
[58] Ibid. s 3(1).
[59] Ibid s 3(2)(a)(b)(c) Such considerations include the range of exempt health services currently available; the categories of persons already receiving exemption from payment for health services; and the impact of any such condition on access to health services.
[60] Ibid s 3(2)(d).
[61] National Health Insurance Authority Act 2022 ss. 25(1) and 26.
[62] C Onyemelukwe-Onuobia, 'Nigeria's National Health Act and the Promise of Universal Health Coverage' [March 20 2015] C*held,* 14.

composition of the National Council on Health[63] which shall be the highest policy making body in Nigeria on matters relating to health[64] and whose major functions include, inter alia,(a)the protection, promotion, improvement and maintenance of the health of the citizens of Nigeria, and the formulation of policies and prescription of measures necessary for achieving these responsibilities;[65] (b) ensuring the delivery of basic health services to the people of Nigeria and prioritize other health services that may be provided within available resources;[66](c) issuing, and promoting adherence to, norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of people;[67](d) ensuring that children whose ages are between zero and five years as well as women who are pregnant receive immunization immunized with vaccines against infectious diseases;[68] and (e) coordinating health services rendered by the Federal Ministry with health services rendered by the States, Local Government, Wards, and private health care providers and provide such additional health services as may be necessary to establish a comprehensive national health system[69]. The foregoing duties of the National Council on Health are particularly related to the realization of the right to health as they bear much semblance to the obligations to ensure the protection, promotion and fulfillment of the rights of the Nigerian people as provided under Article 2 of the ICESCR and as interpreted in the UN CESCR's General Comment No. 14. It is strongly hoped that if the foregoing provisions are strictly applied and implemented, the disappointing health indices repeatedly posted by Nigeria will be reversed.

Another major innovation introduced into the Act, with direct implications for achieving success in the efforts to reverse the current trend of unenviable health indices and for the realization of the right to health, is the provision for the establishment of a National Basic Health Care Provision Fund[70] which is to be funded from Federal Government Annual Grant of not less than one per cent of its Consolidated Revenue Fund[71]; grants by international donor partners[72]; and funds from any other source.[73] Using the instrumentality of the National Health Insurance Scheme (NHIS), 50% of the fund shall be expended on providing the statutory basic minimum health care package to the people in all primary or

[63]Ibid s 4(1).
[64] Ibid s5(1).
[65] Ibid s 5(1)(a).
[66] Ibid s 5(1)(c).
[67] Ibid s 5(1)(e).
[68] Ibid s 5(1)(i).
[69] Ibid s 5(1)(j).
[70]Ibid s 11 (1).
[71] Ibid s 11(2)(a).
[72] Ibid s 11(2)(b).
[73] Ibid s 11(2)(c).

secondary health care outfits that are eligible to be used[74] while 20% of the fund shall go to qualified primary health care facilities through the provision of the necessary and required drugs and vaccines as well as other consumables needed in those primary health care facilities[75]. Also, eligible primary health care facilities shall be provided with facilities, equipment and transportation, using 15% of the fund,[76] while 10% shall go into the development of health human capital for Primary Health Care[77] and the remaining 5% of the fund shall be used for Emergency Medical Treatment to be administered by a Committee appointed by the National Council on Health.[78] To ensure that the funds are effectively distributed among the requisite Local Government and Area Council Health Authorities, the National Primary Health Care Development Agency shall, through the State and Federal Capital Territory Primary Health Care Boards, disburse the funds to provide for the required drugs, vaccines and other consumables for use in qualified primary healthcare facilities and for the maintenance of the facilities, equipment as well as transportation for eligible primary healthcare facilities. It will also be used for the development of Human Resources for Primary Health Care.[79]

Importantly, the Act provides that the National Primary Health Care Development Agency shall not disburse funds to any Local Government Health Authority if it is not satisfied that the money earlier disbursed to that authority was applied judiciously as provided in the Act.[80] Also, any State or Local Government that fails to contribute its counterpart funding shall not benefit from the funds[81]. States and local governments that fail to implement the national health policy, norms, standards and guidelines prescribed by the National Council on Health shall be denied the enjoyment of the funds[82]. The National Primary Health Care Development Agency is further mandated to develop appropriate guidelines for the administration, disbursement and monitoring of the fund with the approval of the Minister. It is submitted that the establishment of the National Basic Health Care Provision Fund is a great milestone towards improving the poor health indices that Nigeria keeps posting to the whole world as it is aimed at achieving universal health coverage and the resultant realization of the right to health in Nigeria. Among several other benefits of the National Health Act, individuals and families will have more disposable income through reduction in catastrophic health expenditure

[74] Ibid s11 (3)(a).
[75] Ibid s 11(3)(b).
[76] Ibid s 11(3)(c).
[77] Ibid s 11(3)(d).
[78] Ibid s 11(3)(e).
[79] Ibid s 11(4).
[80] Ibid s 11 (6)(a)
[81] Ibid s 11(6)(b) The counterpart fund required from the State or Local Government shall not be less than 25% of the total cost of the projects.
[82] Ibid s 11 (6)(c).

occasioned by very high out of pocket expenditure when the mandatory social health insurance scheme provided under the National Health Insurance Authority Act 2022 and supported by the NHA, especially as it affects the vulnerable groups, is implemented. Worthy of mention, also, is the fact that the provisions of section 11(6) (a) (b) and (c) of the National Health Act are intended to ensure probity, accountability and transparency in the use of public funds. These are important attributes of good governance which are very essential for the realization of the right to health and the ultimate reversal of the poor showing by the Nigerian health sector in comparison with those of other countries of the world.

However, this article is of the view that the provisions on the National Basic Health Care Provision Fund are not without some shortcomings. First, the basic minimum package of health services to which 50% of the National Basic Health Care Provision Fund is allocated is not defined by the Act. Rather, what constitutes that package is left at the discretionary decision of the Minister of Health. Second, the said 50% shall be expended through the National Health Insurance Scheme (NHIS). What this implies is that it is only those covered under the NHIS that can enjoy the basic minimum health services to be provided with the 50% of the NBHCPF meant for all Nigerians. Meanwhile, only a negligible class (workers) of the Nigerian population was covered under the previous National Health Insurance Scheme. The new National Health Insurance Authority Act 2022, which makes health insurance compulsory in Nigeria, specifically requires the following to get health insurance: all employers and employees in the public and private sectors with five staff and above[83], informal sector employees[84], and all other residents in Nigeria.[85] Even under the said 2022 Act, there is no assurance that all Nigerians will be covered under the scheme given the level of poverty in Nigeria, the difficulty in getting those in the informal and private sector to key into the programme, as well as the unwillingness or reluctance of State governors to establish their own State Insurance schemes as mandated by the NHIA Act 2022. This amounts to nothing short of inequity and discrimination. Third, the implementation of the requirement for counterpart funding by states and local governments under the NHA 2014 may prove problematic. This article expresses the fear that the requirement for counterpart funding by both the state and Local Government Councils in order for them to be entitled to disbursement of money from the National Health Care Provision Fund will work against the delivery of health care services to all Nigerians, particularly the large population of the poor in the rural areas. It is doubtful that the states will be able to promptly satisfy this condition precedent. It is even more doubtful that the local government councils will be able to raise such amounts, given the fact that it is the least financially

[83]Ibid s 14(2)(a).
[84] Ibid s 14(2)(b).
[85] Ibid s 14(2)(c).

comfortable of the three tiers of government.[86] The immediate past arrangement whereby states and local government councils ran joint accounts which were principally controlled by the states made dimmer the hope of a local government meeting that requirement. The recent judgement of the Supreme Court of Nigeria granting financial autonomy to local government councils is of great relief. It is hoped that this decision of Nigeria's apex court will be immediately enforced and implemented by the requisite authorities. Also, the present governmental structure of the country can present a ready excuse for an unwilling state government to resist to be controlled by the mandatory provisions of the NHA 2014 and the NHIA Act 2022, such as the one under discussion. Nigeria runs a Federal structure of government and health is in the Concurrent Legislative List. Corruption and lack of the political will can make an unwilling state find excuse in the so-called federalism and autonomy of executive and legislative competences to renege on the duty imposed on it by some provisions of this NHA. Unfortunately, the Act is silent on what punishments shall befall states and local government councils that fail to contribute their own counterpart funds to the National Basic Health Care Provision Fund. It is submitted that, given the foregoing shortcomings, the NBHCPF may, eventually not be able to achieve its purpose, that is, making basic health services available to all Nigerians, particularly the rural and urban poor, who constitute the majority of the beneficiaries of primary health care and among whom are the most vulnerable members of society: women, children, old people and the disabled. By necessary implication, the dream of achieving universal health coverage (UHC) and the health-related Sustainable Development Goals (SDGs) for Nigerians may never be realized, unless, among other things, the present provisions in the laws regarding the size, disbursement and use of the NBHCPF are amended to adequately take care of the overall health interests of all Nigerians.

Part II of the NHA which is entitled 'Health Establishment and Technologies' sets out a process for regulating health establishments and technologies and ensuring quality and standards. For the purpose of regulating and monitoring the practice in health establishments, the Act empowers the Minister-in-Council to, by regulation, classify all health establishments and technologies into such categories as may be appropriate, based on a number of specified criteria[87] To ensure the maintenance of standards in health care provision, the Act provides that health establishments will now need to have a Certificate of Standards which defines how many beds and what technologies they can have[88]. According to the Act, any person, entity, government or organization who

[86] K Obembe, 'National Health Act and Other Challenges before Political Parties' (Text of a press conference at the Nigerian Medical Association's National Secretariat, Abuja on February 4 2015).
[87] The National Health Act 2014 s 12(1)(a) and (b).
[88] Ibid s 13(1)(a),(b),(c),(d).

operates a health establishment without a Certificate of Standards 24 months after the Act has been passed is guilty of an offence and shall be liable, on conviction, to a fine of not less than N500,000.00 or, in the case of an individual, to imprisonment for a period not exceeding two years or both.[89] It is noteworthy that the Act, in establishing, by the foregoing provisions, a system for ensuring quality of healthcare services in public and private facilities through the certification of standards will reduce quackery, ensuring that appropriate and acceptably-equipped healthcare establishment with adequate facilities and personnel attend to the needs of users. Part II also provides mechanisms for public hospitals to retain a proportion of the revenue they generate (subject to minister and in states, commissioner discretion). According to the Act, the Minister, in respect of a tertiary hospital, and the Commissioner, in respect of all other public health establishments within the State in question, may determine the range of health services that may be provided at the relevant public health establishments and, in consultation with the relevant Treasury(Federal or State), determine the proportion of revenue generated by a particular public health establishment classified as a hospital that may be retained by that hospital, and how those funds may be used[90]. This provision appears to have aimed at ensuring that revenues generated by public health establishments are judiciously utilized and that the establishments have enough funds for the day-to-day running of the services. It also provides that the minister, in consultation with the National Council, may come up with certain conditions which certain people may be required to fulfill in order to qualify for free health care services in public health outfits[91]. Subsection 3 of this section goes on to reiterate that all citizens of Nigeria shall receive a basic minimum package of health services as a matter of rightful entitlement. To further guarantee quality and high standards in health care services at locations other than health establishments, such as schools and other public places, the Act authorizes the Minister-in-Council to prescribe minimum standards and requirements for the provision of health services in such locations[92]as well as penalties for any contravention of or failure to comply with any such standards or requirements[93]. This authority extends to traditional health practices to ensure the health and well-being of persons who are subject to such health practices[94]. This reflects some of the important features and characteristics of the right to health. Importantly, the Act provides for the evaluation of services of health establishments to ensure that they comply with the quality requirements and standards prescribed by the National Council on Health[95] relating to human

[89] Ibid s 14
[90] Ibid s15(1)(a) and (b).
[91] Ibid s 15(2)
[92] Ibid s 16(1)(a)
[93] Ibid s 16(1)(b)
[94] Ibid s 16(3).
[95] Ibid s 19(1).

resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.[96] It is submitted that this is one of the major provisions in this Act that have the capacity to work towards the realization of the right to health and the elevation of Nigeria's position on the health indices list of the world. One of the essential elements of the right to health is quality with respect to human resources for health, infrastructure, drugs, and delivery of health services. It may, therefore, be correct to say that, having put adequate mechanism in place for ensuring the maintenance of quality in health establishments, the Act may well have taken a positive step towards the realization of the right to health and achievement of universal health coverage in Nigeria, all things being equal.

Part III of the Act, entitled 'Rights and Obligations of Users and Health Personnel', provides for the criminalization of refusal by any health worker or health establishment to avail a patient emergency medical services for any reason whatsoever[97]. The punishment for such an offence is a fine of N100,000 or 6 months imprisonment or both. However, except for psychiatric patients, a health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her, and in such a case the health care provider must report the incident to the appropriate authority.[98] This section is a great innovation and a welcome development as against the hitherto practice whereby health workers refused to treat patients, even on emergency, unless and until specified amounts of money had been paid by the patients. Also, it is now mandatory for health establishments to attend to gun-shot or accident victims and other cases of emergency without, first, insisting on the production of police reports or fulfilment of other conditions before attending to such victims. It is, however, humbly submitted that the provision for the circumstances under which a health care provider may refuse to treat a patient possesses the potential of being flagrantly abused by lazy, decidedly-wicked and pathologically-irritant health care providers.

This part also sets out the rights of healthcare personnel and indemnifies them from claims where they have not been negligent.[99]

Healthcare workers are now under an obligation to give users relevant information (health status, diagnosis and treatment options and risks and benefits, right to refuse treatment)as to their state of health and treatment, unless there are exceptional circumstances.[100].It should be noted that the obligation under this section is not a function of, or, dependent on, a formal request or

[96] Ibid s 19 (2).
[97] Ibid s 20(1) and (2).
[98] Ibid s 21(3).
[99] Ibid s 22.
[100] Ibid s 23(1)(a-d).

demand by the user. In addition to the foregoing, health establishments are now under an obligation to clearly define their services, complaints processes and timetables[101] and to keep records on each user, maintaining high confidentiality standards.[102]

Part IV of the Act, entitled 'National Health Research and Information System' establishes the National Health Research and Information System[103] with a 13 member National Health Research Committee established to promote research and ensure that it aligns to priorities.[104] Section 32 of the Act provides the conditions to be satisfied before any research experimentation using living human subjects can be carried out. One of such conditions is the prior consent of the subject or his representative.[105] Commendably, the Act establishes a National Health Research Ethics Committee[106] with 17 members, one of whom must be a woman[107], and any institution, health agency or establishment carrying out research is required to have an ethics committee.[108]

This Part also requires the Federal Minister of Health to facilitate the creation of a comprehensive National Health Information Management System and to prescribe data for collection at every level of the health system.[109] Public and private establishments are required to establish and maintain a health information system, which will be a requirement for the award of certificate of standards.[110] The Minister and commissioners of health are required to publish annual reports on the state of the health of the citizenry and the health system.[111]It should also be noted that the Act mandates the National Council on Health to ensure the widest possible catchments for the National Health Insurance Scheme throughout the Federation.[112] This is very important, if Nigeria intends to achieve universal health coverage (UHC) as well as realise the health-related sustainable development goals.[113]

Part V makes elaborate provisions on human resources for health and requires the National Council on Health to develop policy and guidelines for the training

[101] Ibid s 24.
[102] Ibid ss. 25 and 26.
[103] Ibid s 31(1).
[104] Ibid s 31(2)(a). Section 31(5) defines the duties of the Committee.
[105] Ibid s 32(1) and (2).
[106] Ibid s 33(1).
[107] Ibid s 33 (2).
[108] Ibid s 34.
[109] Ibid s 35(1) and (2).
[110] Ibid s 38 (1)(a) and (b).
[111] Ibid s 35(3).
[112] Ibid s 40.
[113] It does not appear that the Council has made any visible effort to realise this statutory mandate.

and distribution of health workers[114]. In relation to strikes, health services are classified as essential services[115] and the Minister is required to apply all reasonable measures to ensure return to normalcy after disruption within 14 days.[116] This speaks to the years of persistent industrial disputes bedeviling the health sector. The Act, therefore, provides for zero tolerance for all manner of disputes that result in total disruption of health services delivery in public institutions of health throughout the country. This part also bars all public officers from medical check up, investigation or treatment abroad at public expense, except in exceptional cases approved by a medical board and Minister or Commissioner.[117]

Part VI which is entitled, 'Control of Use of Blood, Blood Products, Tissue and Gametes in Humans' establishes the National Blood Transfusion Service,[118] outlines procedures for obtaining consent before the removal of tissue, blood or blood products from humans[119] and provides that a person who contravenes the provisions of this section or fails to comply therewith is guilty of an offence and liable on conviction as follows: (a) a two-year term of imprisonment or a N1,000,000 fine or even both the term of imprisonment and the fine; and (b) in the case of blood or blood products, a N100,000 fine or, in the alternative, an imprisonment for a term not exceeding one year or both the fine and the imprisonment.[120] It also bans the sale of blood and tissue and prohibits the manipulation of genetic material ("cloning")[121].In addition to the provisions on the removal and transplantation of human tissues in hospitals,[122] this Part also makes provision on payment in connection with the importation, acquisition or supply of tissue, blood or blood product,[123] allocation and use of human organs[124] and donation of human bodies and tissues of deceased persons[125]. This Part specifies that transplantation can only be done with the approval of a medical practitioner[126] and also establishes a process for living wills for organ donation.[127]

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[114] Ibid s 41(1).
[115] Ibid s 45(1).
[116] Ibid s 45 (3).
[117] Ibid s 46.
[118] Ibid s 47(1),(2), and (3).
[119] Ibid s 48(1) and (2).
[120] Ibid s 48(3)
[121] Ibid s 50(1) Note that any person who contravenes a provision of this section or who fails to comply therewith is guilty of an offence and is liable on conviction to imprisonment for a minimum of five years with no option of fine.
[122] Ibid ss. 51 and 52.
[123] Ibid s 53.
[124]Ibid s 54.
[125] Ibid s 55.
[126] Ibid s 52.
[127] Ibid s 55.

It is the view of this research that this Part raises a lot of very critical ethical issues some of which may even seem to violate some fundamental human rights and work against the realization of this right.[128] Part VII concerns itself with regulations and miscellaneous provisions[129].

One key provision in this Part of the Act capable of improving standards and outcomes is the provision for an annual National and State Stakeholders Consultative Forum for health to discuss health outcomes, challenges, prospects and policies. This is made mandatory and the stakeholders are expected to include user groups, civil society groups, donor groups and healthcare providers[130]. Such a forum will provide opportunities for interaction and user inputs, advocacy, enlightenment and policy impact assessment. This makes it possible for the public to participate in discussing issues related to their health, a very vital feature of all human rights, in general and the right to health, in particular.

3.2 The Constitution of the Federal Republic of Nigeria 1999 (as amended) and the African Charter on Human and Peoples Rights (Ratification and Enforcement) Act Cap 10 LFN 1990.

One of the major reasons usually adduced by scholars and stakeholders for Nigeria's poor health indices is the apparent non-justiciability status that health enjoys along with the other so-called fundamental objectives and directive principles of state policy provided under Chapter Two of the 1999 Constitution(as amended). It is the view of this article that not only is health adequately provided for and recognized as a human right under the law in Nigeria, it is also judicially enforceable. Section 17 of the Constitution which provides for a cluster of Economic, Social and Cultural Rights, including the right to health, generally entitled "Social Objectives", among other things, enjoins the government to ensure that its policies are geared towards protecting and safe-guarding the health, safety and welfare of all workers,[131] as well as ensuring that adequate medical and health facilities are provided for the people.[132] Nigeria domesticated the African Charter on Human and Peoples' Rights (ACHPR) via the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act[133] which makes equally justiciable all the rights therein contained (including the right to health) without discriminating between civil and political rights and ESC rights[134] The combined application of

[128] This assertion shall be discussed in details subsequently.

[129] Ibid ss.59-65.

[130] Ibid s 61(1).

[131] Sec. 17 (3)(c).

[132] Sec. 17(3)(d).

[133]Cap 10 Laws of the Federation of Nigeria 1990

[134] This view has been given judicial recognition by Bello CJ in Peter *Nemi v The State* [1994] 1 LRC 376 at 385 C-D where he stated that in so far as the Charter had become part of our domestic law, the enforcement of its provisions like all other laws, falls

section 4(2) of the Constitution of the Federal Republic of Nigeria 1999(as amended), the exception clause of section 6(6)(c) of the Constitution of the Federal Republic of Nigeria 1999(as amended), and Item 60(a) of the Exclusive Legislative List, Part I of the Second Schedule to the Constitution of the Federal Republic of Nigeria 1999 (as amended) clearly reveals that provisions of Chapter 2 of the Constitution are capable of being enforced by the courts. Justice Niki Tobi held as much in *Federal Republic of Nigeria v. Alhaji Mika Anache & Ors,*[135] when he stated that the non-justiciability of section 6(6)(c) of the Constitution is neither total nor sacrosanct as the sub-section provides a leeway by the use of the words 'except as otherwise provided by this Constitution' The National Assembly has exploited this leeway and enacted statutes which provide for the judicial enforcement of the provisions of Chapter 2 of the 1999 Constitution(as amended).[136] It is, therefore, no longer in doubt that the right to health and indeed, all the other so-called fundamental objectives and directive principles of state policy provided under Chapter 2 of the Constitution of the Federal Republic of Nigeria 1999 (as amended) are justiciable rights under the Nigerian law. The rights status enjoyed by health is of great advantage in the efforts to reverse Nigeria's poor health indices, if the Nigerian Bar will become more courageous and the Bench, less timid.

4. Shortcomings of the Laws

It is not clear whether it was a product of innocent inelegant drafting or a function of deliberate dubious inclusion that the sections of the National Health Act 2014 that have to do with the removal, use, transplantation and sale of tissue, blood or blood products from a living human being are couched the way they are. It would appear that section 48(1)(b) of the Act permits a person to remove the tissue, blood or blood product from another living person without his informed consent for medical investigations and treatment in emergency cases. Interestingly, the phrases 'medical investigations' and 'treatment in emergency cases' are not specifically interpreted in the Act. It is also not clear whether the 'medical investigations' or 'treatment in emergency cases' are for the benefit of the person from whom the tissue, blood, or blood product is

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within the judicial powers of the courts in Nigeria .See also, F Viljoen, *Application of the African Charter on human and Peoples' Rights by Domestic Courts in Africa*[1999](43) *J AFR L* 10.

[135] (2004) 14 WRN 1 – 90, 61.

[136] These statutes include the Independent Corrupt Practices and Other Related Offences Commission Act, which justicializes section 15(5) of the Constitution; the National Human Rights Commission of Nigeria Act, which makes justiciable all the human rights provided under the Constitution as well as all the rights recognised under any international human rights instrument to which Nigeria is a signatory; the African Charter on Human and Peoples Rights(Raification and Enforcement) Act, which provides for the equal judicial enforcement of all the three generations of human rights therein contained; and the National Health Act 2014 which expressly sees health as a fundamental right of Nigerians.

removed or for the benefit of any other person. It is submitted that because of its vagueness and the resultant ambiguity, this provision can provide a criminal leeway for dubious practitioners who, hiding under the cover of carrying out "medical investigations" or 'treatment in emergency cases' could forcefully remove the tissue, blood, or blood product of a non-consenting living person and use same for the treatment of any other person and for a fee.[137]. Similarly, section 48 (2) of the Act provides that "a person shall not remove "tissue" which is not replaceable by natural processes from a person younger than 18-years", implying that a person can remove tissue (whether replaceable or non-replaceable by natural processes) from persons who are 18 years and above. In the characteristic ambiguity of this Part of the Act, section 49 states that a person shall use "tissue" removed or blood or a blood product withdrawn from a living person, even without his or her consent (as long as reasonable payments are made in the appropriate health establishment for the procurement), only for such medical or dental purposes as may be prescribed. Again, the interpretations of the word "tissue" and phrase "medical or dental purposes" are not provided in the interpretation section of the Act neither is it made clear who should make the prescription. Sections 51, 52 and 53 are equally controversially couched. Section 53 specifically authorises the sale or trade in human tissues provided that 'reasonable payments are made in an appropriate health establishment for the procurement of tissue, blood or blood products". This article holds the view that sections 48(1) (b), 48(2), 49, 51, 52 and 53 of the National Health Act 2014 which permit, inter alia, the removal of the tissue, blood or blood product from another living person without his or her informed consent for "medical investigations" and "treatment in emergency cases" and the sale of and trading in human tissues and blood products are in violation of the constitutionally-protected human rights to life;[138] dignity of the human person;[139] privacy[140] -protected human rights to life;[141] dignity of the human person;[142] privacy[143] and freedom of thought, conscience and religion.[144] They also violate Articles 2, 4, 5, 6 and 8 of the African Charter on Human & Peoples Rights (Ratification Enforcement) Act.[145] Since all hospitals and other medical establishments have been mandated to admit and treat all persons in emergency situations, the National Assembly may have inadvertently licensed medical personnel to engage in unauthorized surgical operations for the purpose of

[137] Sonie Ekwowusi, 'Why the National Health Act is Unconstitutional' *The Guardian* (Lagos, 9 March 2015) 24; F Falana *Nigerian Law on Socioeconomic Rights* (2017) 12.
[138] Constitution of the Federal Republic of Nigeria 1999 (as amended) s 33.
[139] Ibid s 34.
[140]Ibid s 37
[141] Constitution of the Federal Republic of Nigeria 1999 (as amended) s 33.
[142] Ibid s 34.
[143]Ibid s 37
[144]Ibid s 38.
[145] Cap 10 Laws of the Federation of Nigeria 1990.

removing vital organs of living persons. Even though there are penalties for commercializing any organs removed from any living person, why should the consent of the donor be dispensed with?

These provisions should therefore be amended, as allowing them to continue the way they are presently presented means doing great violence and harm to the overall intention of the National Health Act 2014.[146] Other pitfalls of the National Health Act 2014 include: loose provision on medical tourism abroad in section 46, which makes it prone to abuse and encourages official corruption; multiplicity of committees and duplicity of functions; very poor penalties for offences under the Act; no clearly defined roles for the lower tiers of government; difficulty in the payment of counterpart funds for the National Health Care Provision Fund and; the Minister of Health's enjoyment of the sole prerogative of prescribing what constitutes the basic minimum package of health services. It is submitted that, in the last case, to be able to capture the actual disease burden that should make the list on the minimum package of health services, based on the prevalence, cost and seriousness of such diseases, the National Council on Health should take over that responsibility from the Minister.

5. Conclusion

In conclusion, it is suggested that Nigeria should adopt the rights-based approach in the implementation and enforcement of laws, policies and programmes that have to do with health. That approach is more productive, more effective, and faster in achieving the required results. In addition to the various suggestions made in the main text of this article and in order to see that they are put into effect, it is suggested that the relevant and offending provisions of the National Health Act 2014, the National Health Insurance Authority Act, 2022, and the National Human Rights Commission Act, 2004 be amended so that they will be better equipped to be used in reversing Nigeria's unenviable trend of posting poor health indices. Importantly, health, and indeed all the other socio-economic rights are too fundamental to human life and the overall existence of man to be left in a cold and obscure corner of the Constitution, as mere 'directive principles'. Chapter 2 of the Constitution of the Federal Republic of Nigeria 1999 (as amended) should, therefore, be amended to make all the rights thereunder contained as justiciable as those under Chapter 4. That way, Nigeria will be on the right path towards improving her poor health indices.

[146] Falana (n 137) ; Sonnie Ekwowusi (n 137).