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“It is my aspiration that health will finally be seen not as a blessing to be wished for; but as a human right to be fought for.”1

Abstract

This article analyses the difficulties surrounding justiciability of the right to health care in Nigeria and the implications for access issues. It argues that claims denying justiciability on the grounds of the absence of a legal foundation and / or paucity of resources are misplaced. This reasoning derives from an interrogation of the rationale for and the consequences of the designation of what ought to be the right to health care as a Directive Principle, kleptocracy as an impediment to actualizing the right to health care, and the impact of the domestication of the African Charter on Human and Peoples’ Rights. Projecting into the future, the article analyses the challenges that would confront courts in Nigeria grappling with the normative content of the right to health care, arguing that the difficulties are not insurmountable and that, given the seemingly intractable nature of the issues, the courts should adopt a proactive interpretive approach.

INTRODUCTION

Though advocates for health care and other economic and social rights (socio-economic rights) in Nigeria are increasingly gaining momentum, the pace has been exceedingly lethargic. Despite widespread condemnation of the present state of affairs and promises by the government of a new way forward, people's yearnings, hopes and aspirations remain largely unmet.

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Progress recorded so far is at best minimal, as there continues to be a vacuum of serious commitment to the right to health care or any other substantive socio-economic right. All this is comprehensible in the context of a natural reluctance on the part of the state to accept new obligations toward its citizens and, to a lesser extent, paucity of resources. However, it also demonstrates some of the obstacles confronting those claiming rights, who are attempting to navigate an intricate maze of legal rules, wittingly or unwittingly designed to maintain the status quo. These obstacles are particularly onerous in cases of claims to a novel legal entitlement, especially where there is no clear legal foundation on which such claims could be asserted. A classic illustration is the right to health care in Nigeria.

While Nigeria’s constitution guarantees civil and political rights, the right to health care and other socio-economic rights enjoy no legal protection. Chapter II of the 1999 constitution, as did its predecessor, characterizes what should be the right to health care as one of the “Fundamental Objectives and Directive Principles of state policy” (“Directive Principles”), that is, an aspirational or hortatory goal as opposed to a legally binding entitlement. The rationale behind this characterization was that discharging obligations imposed by the chapter requires significant resources which, it is claimed, the government lacks. To emasculate the right to health care further, section 6(6)(c) of the constitution precludes the courts’ jurisdiction with respect to matters set out in chapter II. In essence, codification as a Directive Principle means that the right to health care is not justiciable under the constitution or, for that matter, any other law in Nigeria. Consequently, courts have generally refrained from exercising jurisdiction in such matters. Health care advocates are also limited to campaigning using methods other than legal action, as to institute legal proceedings to seek enforcement of health care related rights is largely perceived as an exercise in futility.

This article examines the difficulties surrounding justiciability of the right to health care in Nigeria and the implications for access issues. It argues that claims denying justiciability on the grounds of (a) an absence of a legal foundation and/or (b) paucity of resources are misplaced, and that there are legitimate reasons compelling a contrary conclusion. Reaching a different verdict would necessarily raise at least one key concern: the challenges that would confront courts in Nigeria which are asked to determine the content and scope of a claimant’s right to health care.

The first part of the article discusses the constitutional obstacles to adjudicating the right to health care in Nigeria. The focus is on the concept of Directive Principles: their meaning, scope, application and ouster of the jurisdiction of courts. The second part contends that kleptocracy, rather

3 The Constitution of the Federal Republic of Nigeria 1979, chap II.
4 The terms “Directive Principles” and “chapter II of the constitution” are used interchangeably in this article to refer to socio-economic interests or goods enumerated in the constitution.
than finite resources, is the major impediment to justiciability and enforceability of the right to health care and that, until corruption is eradicated and good governance instituted, actualization of this right and of other Directive Principles will remain otiose. Part three demonstrates the powerful impact of the African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act\(^5\) on the Directive Principles, particularly its bearing on the right to health care. It argues that the act has introduced new possibilities for amenability of the right to the jurisdiction of Nigerian courts and that, placed in proper perspective, the act fulfils the constitutional requirement for justiciability of not only the right to health care but also other socio-economic interests included in the constitution. The final section of the article analyses the challenges that would confront Nigerian courts that inevitably have to grapple with the question of the normative content of an applicant’s right to health care. While not denying the monstrosity of the challenges, it argues that courts can competently address potential questions that might arise during the interpretive process without necessarily breaching the ethos of separation of power.

Generally speaking, the right to health comprises a wide spectrum of entitlements, each of which falls within the rubric of two main branches, namely health care and underlying or social determinants of health.\(^6\) Health care denotes health services provided at clinics, hospitals and physicians’ offices by physicians, nurses and other allied health professionals. Underlying determinants of health, on the other hand, consist of a gamut of conditions and services necessary for health, such as housing, nutrition, employment, education, potable water and adequate sanitation facilities. While the two branches are interlinked, equally important and generally not desegregated in this article, the main focus is on health care.\(^7\)

**DIRECTIVE PRINCIPLES OF STATE POLICY AND THE RIGHT TO HEALTH CARE**

Chapter II of Nigeria’s constitution embodies the Fundamental Objectives and Directive Principles of state policy. Though not evident from the reports of the constitution drafting committee, it is believed that the

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concept was borrowed from India. According to the committee, “Fundamental Objectives” consist of ideals toward which the nation is expected to strive, whilst “Directive Principles” identify the policies which are expected to be pursued in the nation’s efforts to realize national ideals. The chapter enumerates several economic, social and cultural interests pertaining to, among others, food, shelter, work, education, public assistance, environment, culture and health care.

Directive Principles of state policy in chapter II have arguably attracted more controversy than the provisions of any other chapter of the constitution. Evidently, the source of this controversy lies in the fact that the chapter enumerates but does not guarantee socio-economic rights; rather, what ought to comprise socio-economic rights are not designated “rights” but “Directive Principles”. Enumeration of these principles without clear provisions on enforcement mechanisms has resulted in two disparate constructions of their significance and justiciability status. In this regard, three provisions are noteworthy.

The first, section 13, provides: “It shall be the duty and responsibility of all organs of government, and of all authorities and persons, exercising legislative, executive or judicial powers, to conform to, observe and apply the provisions of this Chapter of this Constitution.” (Emphasis added.) A critical examination of this provision raises the following questions: What is the import of “duty and responsibility” of all organs of government et al to comply with the chapter? Does it mean that an aggrieved party can challenge the government or other authorities for failing to “conform to, observe and apply” the enumerated provisions of the chapter? If so, where? The section provides no clear answers.

The second provision relates to access to health care. Section 17(3) requires that the state shall direct its policy toward ensuring that: “(c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; (d) there are adequate medical and health facilities for all persons.”

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10 Because “Directive Principles” are not rights in the strict sense, this article employs the term “interest” or “goods” in reference to the Directive Principles of chap II of the constitution.

11 Equivalent, in part, to art 37 of the Indian 1949 constitution which not only describes Directive Principles as “fundamental in the governance of the country” but also imposes a duty on the state to “apply these principles in making laws”.

Can a court in Nigeria grant a remedy for violations of the “duty and responsibility” with respect to these provisions? Can a patient, for example, relying on section 17(3)(d), seek a court order claiming entitlement to medical care suitable for his condition? As to the last two questions, the response seems clear, yet convoluted. This is because of the ouster clause in the constitution. By virtue of section 6(6)(c), the jurisdiction of the court: “shall not except as otherwise provided by this Constitution, 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 any judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution.”

This provision raises yet additional questions. If issues concerning whether acts or omissions detract from or contravene the Directive Principles are not amenable to judicial scrutiny, how would the fruits of the provisions be realized? The significance of this question is underscored by the fact that the duties and responsibilities expressed in the chapter are couched in mandatory terms. For instance, section 16(2)(d) provides that the state shall direct its policy toward ensuring that shelter, food, workers’ compensation and social security are provided for all its citizens. The import of section 6(6)(c) would then be that, although there may be a credible claim of a violation of section 16(2)(d), there is no legal recourse open to an aggrieved party. This reasoning was the basis for the decision of the Court of Appeal in Badejo v Federal Minister of Education. The lower court declined to exercise jurisdiction in an action challenging the government’s university admission policy on the ground that the action sought to establish a right to education. The court held that education is a not a right.

12 For some authors though, there is no convolution. In the opinion of O Agbakoba and W Mamah, as far as the justiciability of socio-economic rights in Nigeria is concerned, the constitution is clear; sec 6(6)(c) simply means that an aggrieved party cannot take the government to court based solely on violation of chap II of the constitution: Towards a Peoples’ Constitution in Nigeria: A Civic Education Manual for the Legal Community (2002, Human Rights Law Service) at 43.
13 This provision is analogous to art 37 of the Indian constitution. Nevertheless, as shown below, courts in India, unlike their Nigerian counterparts, have consistently assumed jurisdiction and vigorously enforced the right to health care. Paradoxically, Indian courts have the added burden of justifying enforcement of Directive Principles (hence their reliance on the rights to life and human dignity as enforcement vehicles), a burden which Nigerian courts no longer need to shoulder since the domestication of the African Charter.
14 The word “Directive” in the title of the chapter implies an order or command, meaning that the provisions of the chapter are mandatory and create obligations for the government. Nonetheless, even though the Directive Principles are not taken into account in formulating and implementing national policies, the courts in Nigeria are yet to intervene.
15 [1990] LRC (Const) 735. See also Archbishop Okojie v The Attorney General of Lagos State (1981) 2 NCLR 337 which relied, inter alia, on the Indian case of State of Madras v Champakan Dorairajan AIR 1951 SC 226 (which held that caste quotas for admission to state medical school were unconstitutional).
but a Directive Principle, unenforceable under the constitution. The appellate court affirmed.

The third intriguing provision is the stipulation in section 22 that the mass media shall at all times be free to uphold the provisions of the chapter and “uphold the responsibility and accountability of the Government to the people”. Does the phrase “uphold the responsibility and accountability of the Government” imply that the mass media has the right to bring a court action to compel compliance on the part of the government in regard to the Directive Principles? The prevailing perspective is that section 6(6)(c) effectively forecloses that possibility. This deliberate deprivation of a mechanism to enforce the provisions of chapter II of the constitution has led to concerns about the value of the Directive Principles. What is the rationale for elevating to constitutional status values purportedly underpinning governmental actions but which at the same time offer no protection against non-compliance? These vexed questions may be answerable by considering two competing theories on the precepts of human rights, namely the restrictive and liberal schools.

Restrictive construction of Directive Principles

For proponents of the restrictive school, codification and, a fortiori, enforcement are central to the existence of human rights. A claim can only become a right if vested with prior recognition by law; otherwise it cannot be legitimately considered a right. Devoid of legal vestiture, such a right has been equated to “simple nonsense: natural and imprescriptible rights, rhetorical nonsense, nonsense upon stilts”.16 By this thesis, only civil and political rights are human rights; that is, in so far as the constitution or statutory law declares them as such. Since socio-economic rights generally lack this quality of prior legal recognition, they cannot properly be regarded as human rights. At best, they are moral imperatives but certainly not legal rights capable of attracting sanctions upon breach. As such, any action purporting to enforce them will be tantamount to nothing more than an exercise in futility: *ex nihilo nihil fit* [from nothing comes nothing]. Therefore, by this view, Directive Principles under Nigeria’s constitution encapsulate socio-economic interests, not human rights: since health care related interests are Directive Principles under the constitution, they are neither justiciable nor enforceable.

In the opinion of a leading scholar on constitutional law in Nigeria, it is “inappropriate” to incorporate socio-economic rights in a constitutional bill of rights given that these rights are, in his view, not justiciable.17 His

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17 B Nwabueze *Constitutional Law of the Nigerian Republic* (1964, Butterworths) at 408. He would prefer that such socio-economic rights were Directives Principles as opposed to rights capable of immediate enforcement. He asserts that, although not legally enforceable, the benefit of such principles is that they provide a yardstick for the
reasoning, which accords with the tenet of the restrictive school, was that it would be silly to compel a state by means of a judicial fiat to allocate resources which it does not have.\textsuperscript{18} This probably explains why, as noted earlier, the committee that drafted Nigeria's 1999 constitution considered, but rejected, the inclusion of socio-economic rights amongst the guaranteed fundamental rights and freedom, preferring to relegate them to the status of Directive Principles.

Defending this view, Akande argues that, since Nigeria is not yet a welfare state in the same sense as western countries, “all the provisions for welfare assistance must remain unattainable goals or ideals”.\textsuperscript{19} With respect, it is submitted that her view misrepresents the spirit of the constitution and the provisions on Directive Principles. As the Supreme Court subsequently explained: “The Constitution itself has placed the entire Chapter II [on Directive Principles] under the Exclusive Legislative List. By this, it simply means that all the Directive Principles need not remain mere or pious declaration... [T]here is nothing strange or that can be said to be wholly unattainable by expressly placing the entire Chapter II of the Constitution under the Exclusive Legislative List.”\textsuperscript{20}

Obviously, Akande's reasoning rests on the assumption that, given the disparity in wealth and development, Nigeria cannot afford to provide a comparable level of welfare assistance to its citizens, as can wealthier industrialized countries like Canada, Australia and the United Kingdom. But this assumption suffers a troubling analytical deficiency in that it fails to heed the gradual nature of the institutional and normative changes that transformed western countries into welfare states and, more importantly, disregards the fact that, as presently configured, levels of benefit afforded to citizens are not static but fluctuate constantly and are adjusted depending on prevailing fiscal and other

\textsuperscript{18} Nwabueze Constitutional Law, above at note 17 at 408.
\textsuperscript{19} Akande The Constitution of the Federal Republic of Nigeria, above at note 8 at 18. Although the book focuses on the 1979 constitution, it is widely regarded as an authoritative source of interpretation of the 1999 constitution, in respect of those subjects where the provisions of both constitutions are similar, such as chap II.
\textsuperscript{20} Uwaifo J, in Attorney General of Ondo State v Attorney General of the Federation & Ors [2002] 9 NWLR (pt 772) 222 at 382 paras A–B.
Moreover, at their inception, welfare experiments in these countries were rudimentary at best and, in spite of considerable advances, still suffer serious systemic limitations and inadequacies, notwithstanding that the experiment began several decades ago.

The point is that a country desirous of adopting a social welfare model must start from somewhere. It must start from a level sustainable by its economy and other considerations and make necessary improvements or adjustments as circumstances change. At present, Nigeria might not be able to operate the social welfare model of affluent western industrialized countries, but it can certainly provide at least some basic services such as primary health care.

Thus, even though it is highly debatable the extent to which Nigeria can afford to guarantee basic social goods to its citizens, the point that was missed by professor Akande is that the constitution has already declared that Nigeria is a welfare state. The primary purpose of the Nigerian government was constitutionally defined as “the security and welfare of the people” and the governance of the country is mandated to be based upon “the principles of democracy and social justice”. As a welfare state, therefore, it behoves the government to create access to the benefits bestowed by the constitution. Specifically, the government in a welfare state is obliged to “ensure the creation and sustaining of conditions congenial to health”.

In other words, ensuring the availability of health care for the population is an essential obligation of government and this
can only be discharged by providing adequate health and other social measures.27

The purpose of chapter II is to provide the necessary framework upon which to march progressively toward the “eldorado” world of the western countries against which the professor juxtaposed Nigeria. Even if a comprehensive benefit package is presently beyond the reach of the government, this does not constitute an exculpatory factor, as it does not preclude the pursuit of other measures that may not require extensive resource allocation. While obviously impossible to attend to all the demands of the citizens, there must be credible evidence that concrete steps are being taken in that direction and that more will be done as resources become available. Common sense policies and programmes specifically targeting realizable goals must be established, developed and seriously pursued. The fact that government resources might be inadequate to support comprehensive health care should not mean that the provision of basic health care must, as stated by Akande, “remain unattainable goals”,28 since basic health care is arguably within reach of the government.29

Another way to evaluate objections that financial constraints prevent the government from being responsive to the needs of the people is to view the claim from the prism of good governance. Sections 15 and 16 of the constitution cogently illustrate the Nigerians’ expectations of their government: national integration;30 abolition of corruption and abuse of power;31 and management of the economy for the benefit of Nigerians.32 These are reasoned and eloquent articulations of the essential components of good governance and will, if implemented as a constitutional imperative, nudge the country forward in the direction of a true welfare state, sufficiently in tune with at least the basic needs of its people. However, as this article will show, failure of governance in the form of kleptocratic tendencies of successive administrations in Nigeria may be the principal factor militating against the pursuit of welfare policies and the realization of socio-economic rights, including the right to health care.

29 Most states are capable of providing basic health care with “relative ease, and without significant resource allocation”. See Maastricht Guidelines, above at note 7 at para 10. Providing basic health care is a minimum core obligation binding on state parties to the International Covenant on Economic, Social and Cultural Rights (“ICESCR”). General comment no 14, above at note 6 at paras 43 and 47. Nigeria ratified the covenant on 29 July 1993. Table of country ratifications available at: <http://www.ohchr.org/english/countries/ratification/3.htm> (last accessed 22 June 2007).
30 Sec 15(3).
31 Sec 15(5).
32 Sec 16(1)(b).
Be that as it may, the prevailing view among academics, lawyers and even activists in Nigeria is that the Directive Principles are “toothless bulldogs” in that, while laudable, there is no concrete mechanism for realizing the benefits of the provisions. Given the challenges of justiciability and enforceability therefore, chapter II has come to represent an embodiment of ideals worthy of realization in the future but, for all practical purposes, connotes nothing. However, this view is increasingly being challenged. Led principally by human rights advocates, an emerging view is for a progressive interpretation that would hold the government responsible for the provision of social goods, irrespective of the formal justiciability or otherwise of socio-economic rights. This view dovetails with the liberal school of thought.

Reconceptualization of the Directive Principles: the liberal approach

For liberal theorists, legal formalization is not a necessary condition for the existence and enjoyment of human rights. Whilst the so-called moral rights (as contained in chapter II) may not be guaranteed human rights, at least not in the same tenor as civil and political rights, they are nonetheless indispensable to the enjoyment of fundamental rights. Projecting fundamental rights in isolation of complementary socio-economic rights leaves a gaping hole which seriously undermines the value and robustness of the former. To contend that an individual possesses the right to life in the absence of the ingredients necessary for its sustenance (such as health care) is, on many levels, vacuous. Enjoyment of the right to health is not only vital to all aspects of a person’s life and well-being, it is also crucial to the actualization of all the other fundamental rights and freedoms. Thus, in liberal thinking, the right to life, to be worthwhile, must also incorporate the right to health care, and the right to such medical services as may be necessary to overcome illness and restore health. Therefore, Directive Principles connote something: the foundation for and integral to claiming and enjoying guaranteed civil and political rights. In the words of Bhagwati J, arguably the most ardent advocate of this view:

“There are millions of people in the country who are steeped in poverty and destitution, and for them these civil and political rights have no meaning. It was realized that to a large majority of people who are living in almost subhuman existence ... and for whom life is one broken story of want and destitution, notions of individual freedom and liberty, though representing some of the most cherished values of a free society would sound as empty words bandied about in the drawing rooms of the rich and well-to-do and the only solution for making these rights meaningful to them was to remake the material conditions and usher in a new social order where socio-economic justice would inform all institutions of public life so that the pre-conditions of fundamental liberties for all may be secured ... 

33 Agbakoba and Mamah *Towards a Peoples’ Constitution*, above at note 12 at 42.
Fundamental rights are no doubt important and valuable in democracy, but there can be no real democracy without social and economic justice to every one which is the theme of Directive Principles …”34

This pronouncement by the chief justice of the Supreme Court of India highlights the often neglected salience of Directive Principles: they lay the general framework within which fundamental rights find meaning and expression. And the result should be the same for Nigeria, not only because its concept of Directive Principles originated from the Indian constitution35 but more so given the striking similarity in prevailing socio-economic conditions in both countries, particularly in terms of oligarchic insensitivity to human suffering, wanton deprivations and widening disparity in life expectancy between the less-privileged and affluent individuals.

Notwithstanding their non-justiciability, Directive Principles are expressive of the hopes and expectations of the people from their government. They are aspirations and ideals, not in the sense of unattainable goals, but promises made by the state that the welfare of its citizens would be paramount and underpin state actions.36 These principles signify recognition that, in order meaningfully to enjoy civil and political rights, the state must secure socio-economic justice for all and chart a course of action which will ultimately lead to the fulfilment of at least the basic needs of its citizens.37 Admittedly, the realization of the promises would be constrained by resources but continuous progress must be made in tandem with available resources.

In their book Towards Peoples’ Constitution in Nigeria: A Civic Educational Manual for the Legal Community, Agbakoba (a leading human rights advocate) and Mamah derided as lame the excuse that the resources may not be available to ensure compliance with the Directive Principles in the constitution.38 Their perspective is that there is no reason why a country gifted with as many natural resources as Nigeria cannot implement at least some of the Directive Principles.39 They assert that the major “problem has been corruption and the diametrically insensitive capitalist system, where individuals, using State power have continued to amass so much wealth” for themselves and their cronies, at the expense of the common good.40 Indeed, for years, massive misappropriation of public funds deprived Nigeria of resources that could have otherwise been deployed toward

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35 See note 8.
36 Sec 14(2)(b), 1979 and 1999 constitutions.
37 The concept of Directive Principles is based on the philosophy that, in a welfare state, individuals have rights to basic needs that make life worthwhile and the state has a duty to meet those needs. S Sharma Directive Principles and Fundamental Rights: Relationship and Policy Perspectives (1990, Deep & Deep Publications) at 9.
38 Above at note 12 at 43.
39 Ibid.
40 Ibid. See also Laskar Directive Principles of State Policy, above at note 17 at 119.
ensuring that there is at least some reasonable degree of compliance with the provisions of chapter II of the constitution. While the nation is teetering on the brink of collapse and overall quality of life is deteriorating precipitously, the brazenness and intensity of the scramble to dispossess the country of its resources by those entrusted with the security and welfare of the people are skyrocketing to new heights. Unbridled pursuit of personal enrichment has surreptitiously assumed the order of official business of government and as yet, shows no signs of abating. The result: accelerating morbidity and mortality as a consequence of lack of access to health care occasioned by predatory disposition of the elite ruling class. In other words, the insidious culprit at the core of this seemingly intractable problem is kleptocracy.

KLEPTOCRACY AS AN IMPEDIMENT TO REALIZATION OF THE RIGHT TO HEALTH CARE

In addressing the centrality of good governance to the effective implementation of human rights, the UN Committee on Economic, Social and Cultural Rights (Committee on “ESCR”) stressed that, to be successful, a national health strategy and plan of action should be anchored on the principles inter alia of “accountability” and “transparency”.41 Conversely, bad governance, in terms of an accountability and transparency void, as quite often typified by corruption and economic mismanagement, can have a devastating impact on human rights particularly socio-economic rights;42 in contradistinction to civil and political rights, the realization of socio-economic rights is wholly dependent on availability, and proper allocation and efficient utilization of resources, and misuse often results in severe hardship and deprivation for the recipients.43 Given its furtive ability to stunt economic growth and thus availability of resources, the presence or absence of corruption is a critical determinant of the extent to which socio-economic rights and general development goals are realizable within a particular jurisdiction. This probably explains why nearly every malaise in Nigeria finds a ready culprit in corruption. While this is somewhat exaggerated and scarcely sustainable, it is the key to understanding the genealogy and intractable nature of current challenges facing the country, particularly within the health sector. Moreover, since the contention that kleptocracy, more so than a dearth of resources, poses a greater threat to

41 General comment no 14, above at note 6 at para 55.
43 For a brief but incisive account of multi-country kleptocracy as well as its relationship with socio-economic rights, see U Effeh “Sub-Sahara Africa: a case on how not to realize economic, social and cultural rights and a proposal for change” (2005) 3 North Western University Journal of International Human Rights 2 at 10–14.
actualizing the right to health care in Nigeria is central to my thesis, a little more than a scanty overview of the subject seems appropriate.

Though post independence Nigeria was tainted with corruption, the scale and impact were relatively insignificant, as corruption amongst public officials was somewhat restricted to junior office holders, being almost absent at the upper echelons of governmental power.\textsuperscript{44} Virtually all ministries and parastatals received adequate support for their operations and management. Adequate funds were allocated to academic institutions, hospitals, clinics and other social service agencies. Access to education and medical services were either free or substantially subsidized.

All this changed in 1985 on the assumption of power by Ibrahim Babangida, an army general, via a coup d’état. Among several reasons advanced by the general to justify a change in government were corruption and the need to protect human rights.\textsuperscript{45} However, by the end of his administration, corruption was firmly embedded in all facets of political and socio-economic life of the country, human rights bastardization became unprecedentedly rampant, the erstwhile vibrant economy and social infrastructure were devastated and consequently the capacity of government agencies and institutions to deliver critical services began to decline.\textsuperscript{46} Successive military regimes fared no better. As Ribadu noted, the regimes of Babangida, Sanni Abacha and Abubakar Abdulsalami witnessed the institutionalization of kleptocracy as the sole guiding principle of governance:\textsuperscript{47} “The decline we notice in the education sector today also started in that period. The shameless rot in the aviation sector, the absence of an efficient public transport system, the collapse of our public schools, the thievery in the ports and the decay in our health care delivery system all

\textsuperscript{44} For instance, though widespread corruption at “every level of government” was reported during the Gowon administration (1967–75), there was no evidence of any involvement by top administration officials. See United States Library of Congress, Country Studies “Nigeria: crime, corruption, and political turbulence”, available at: \url{http://lcweb2.loc.gov/cgi-bin/query/r?frd/cstdy:@field(DOCID+ng0044)} (last accessed 19 May 2007).


\textsuperscript{46} UNCHR “Questions of the violation of human rights”, above at note 42 at para 62. While it is true that economic downturn began a few years prior to Babangida’s presidency, the corrupt style of his leadership frustrated and defeated subsequent attempts at economic recovery: an unfortunate legacy that was bequeathed to his successors.

of which huge sums had been budgeted and spent are a direct reflection of the poverty of leadership of that era."48

Although there is strong evidence that the days of unwarranted foray of the military into political governance in Nigeria are now buried in the abyss of history, its aftermath, the fragile and debilitated infrastructure left behind, still haunt the nation, a sentiment forcefully captured in a recent article:

“Nigeria, once heralded as the beacon of Africa, has fallen somewhat short of this potential. Years of kleptocratic repressive dictators and military rule, coupled with widespread corruption, have resulted in large-scale neglect and deterioration of public services. Nowhere is this more apparent than within the health sector: Government-run health-care services barely function...[in] a country that is more than capable of providing effective services...The challenges to the new civilian government are monumental, and it is yet to show any solid commitment to improving the health of Africa’s biggest nation.”49

To be sure, available health indicators are appalling, particularly in comparison to other African countries, even those with fewer or comparable resources. For instance, life expectancy at birth for Nigerians in 2004 was 45 years, compared to 54 years and 55 years respectively for Togo and Senegal,50 two neighbouring west African countries classified with Nigeria by the World Bank as low-income economies.51 Nigeria has an abysmal infant mortality rate, reported to be 86 deaths per 1,000 live births in 2000.52 In 2005, the figure stood at 11153 but slightly declined to 97 in 2006.54 Worse still, Nigeria was among twelve countries identified in a recent report by the African Development Bank (“ADB”) as regressing from,

49 S Hargreaves “Time to right the wrongs: improving basic health care in Nigeria” (2002) 359 The Lancet 2030 at 2030. According to the UNCHR, “[a]s a consequence of the massive misappropriation of national resources, critical service sectors of the nation are in acute dysfunction. Power, water and fuel are in severely short supply and unavailable in many areas of the country ... Access to health care ... is largely unavailable for most of the population of the country”: UNCHR “Questions of the violation of human rights”, above at note 42 at para 62.
53 Ibid.
and in danger of not meeting, the 2015 Millennium Development Goal of reducing infant mortality by two-thirds. The maternal mortality rate, as a key index for assessing the survival of women in Nigeria, is equally dismal. Noted by WHO as “one of the highest in the world”, the country records 800 deaths per 100,000 live births. All these are direct and collateral vestiges of a never-ending quest and appetite for conversion of public resources to private assets. However, as deplorable as these figures are, they are merely representative of just one of the albatrosses, a token of the many legacies bequeathed by years of misrule, misappropriation and mal-utilization of national resources, one of the many faces of kleptocracy in Nigeria.

Interestingly, it was not until the recent experiment in democracy that Nigeria took a stout stance against corrupt enrichment by public officials. Following relentless pressure by creditor countries, the federal government finally moved to clamp down on graft, inflation of government contracts and other forms of corruption. In 2000, the National Assembly enacted the Corrupt Practices and Other Related Offences Act, criminalizing the gift or acceptance of gratification, pecuniary or otherwise, and vesting enforcement responsibility in an independent commission. Two years later, another commission, the Economic and Financial Crimes Commission (“EFCC”) was established and entrusted with wide ranging powers to enforce the provisions of the Economic and Financial Crimes Commission Act as well as the provisions of other statutes dealing with economic and financial crimes.

57 UNCHR “Questions of the violation of human rights”, above at note 42 at para 59.
58 Nuhu Ribadu, chairman of the Economic and Financial Crimes Commission (“EFCC”) stated in an interview: “pressure came from abroad that we establish a new body to fight money laundering...EFCC was established to fight the crime”: 20 June 2006 (Elendu Reports), available at: <http://elendureports.com/index.php?option=com_content&task=view&id=227&Itemid=29> (last accessed 9 July 2007). Similar pressure was resisted by previous military administrations and might have been responsible for the refusal of International Monetary Fund and creditor countries to reschedule Nigeria’s foreign debt. See the UN Economic Commission for Africa “Country report on Nigeria”, available at: <http://www.uneca.org/aisi/NICI/country_profiles/Nigeria/nigeriab.htm> (last accessed 9 July 2007).
60 The Independent Corrupt Practices and Other Related Offences Commission.
62 Comprising the following: (a) Money Laundering Act 1995; (b) Advance Fee Fraud and Other Fraud Related Offences Act 1995; (c) Failed Banks (Recovery of Debts) and Financial Malpractices in Banks Act 1994, as amended; (d) Banks and other Financial Institutions Act 1991, as amended; (e) Miscellaneous Offences Act 1985; and (f) any other law or regulations relating to economic and financial crimes. See Sec 6(2) of the EFCC Act.
Whilst there is nothing in either statute precluding their application against corrupt private individuals, an examination of their records indicates that their operations are primarily directed against public officials. The reason is quite simple. Notwithstanding its pervasiveness, private sector corruption is relatively miniscule in comparison to collusion by state office holders. While undeniable that corruption among private individuals is socially corrosive and can detrimentally impact the economy, such impact is arguably less deleterious than outright misappropriation of public funds.

In its annual report on the human rights situation in Nigeria, the Committee for the Defense of Human Rights (“CDHR”) revealed that two corrupt military dictators remain free, despite determinations of financial impropriety against them by independent investigative bodies. It is thought that, since these investigations preceded the establishment of either of the commissions, there is nothing barring reopening the inquiry into the scandal, particularly in the light of a widespread belief that the sums converted to private use during the two administrations are staggering. Lamentably, apart from the Inspector General of Police and a few governors, none of the other high office holders allegedly implicated in financial impropriety has been prosecuted by the EFCC, and this is feeding a growing scepticism about the integrity, forthrightness and focus of the commission. Selective prosecution and continued laxity on the part of the commission to bring high profile corrupt leaders to justice smirks of hypocrisy and lends credence to an increasing barrage of charges of a politically motivated campaign against, and “scapegoating” of, political adversaries of the presidency.66

63 For activities of the commission, see the “Economic and Financial Crimes Commission”, available at: <http://www.efccnigeria.org/> (last accessed 24 June 2007).
65 Tafa Balogun, the inspector general, was found guilty of corruption and sentenced to six months imprisonment. See “Ex police chief convicted over fraud”, available at: <http://www.nigeriafirst.org/article_5116.shtml> (last accessed 24 October 2007). Though he was in the job for only two years, investigators discovered $52 million hidden in several bank accounts he operated. See T Ayodele et al “African perspective on aid: foreign assistance will not pull Africa out of poverty” (14 September 2005) 2 Cato Institute Economic Development Bulletin 2.
An interesting scenario to watch would be whether recovered ill-gotten wealth will actually find its way to the national treasury or be re-misappropriated. This postulation is not in the least beyond the realm of possibility, given the kleptocratic history of governance in Nigeria. However, an optimistic view would hold that recovered funds would be reinvested in the economy, shoring up under-funded sectors. The impact of such investment would be anything but minimal. Let me illustrate. Known records of the last three administrations can be summarized thus: during the Babangida regime, $12.2b in oil revenue was embezzled and $6b stashed in foreign banks; an estimated sum of $5b to $10b was stolen while Abacha was in office; and questionable contracts worth $4.6b were awarded by Abubakar. To put it in proper perspective, during the three regimes, a total sum of between $27.8b and $32.8b was misappropriated. These figures mostly represent credible findings of panels constituted by the government.

In August 2005, Nigeria’s total debt stood at $31b and, under a deal reached with the Paris Club Creditors, this debt could be wiped out if Nigeria were able to pay $12b within the stipulated period. In other words, Nigeria’s foreign debt (the major financial drain) was nearly equal to the amount embezzled by its leaders between 1985 and 1999. According to a UN report, the sum of $1.4 billion in cash and property recovered from Abacha’s estate and his national security adviser is far greater than the total budget for education, health, social welfare, transportation and power generation for two consecutive years (1997 and 1998). This, in a nutshell, is

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67 For instance, out of the US$983 million recovered from Abacha’s family, only $12 million was found to have been deposited in the Central Bank of Nigeria, raising questions as to the whereabouts of the balance. Ayodele et al “African perspective on aid”, above at note 65, citing G Ayittey African Unchained: The Blueprint for Africa’s Future (2005, Palgrave Macmillan) at 439.

68 CDHR Annual Report, above at note 64 at 146; UNCHR “Questions of the violation of human rights”, above at note 42 at para 61.

69 CDHR Annual Report, above at note 64 at 148.

70 Id at 145.

71 Id at 148. Abubakar was in office for less than a year (9 June 1998 – 29 May 1999).


73 L Riefel “Nigeria’s Paris Club debt problem” (policy brief no 144, the Brookings Institution, August 2005), available at: <http://www.brook.edu/comm/policybriefs/pb144.htm> (last accessed 24 July 2007). The Paris Club is an association of wealthy industrialized countries, including France, Germany, Japan, the United Kingdom and the USA, which provides debt relief to debtor nations, usually through restructuring or cancellation.

74 UNCHR “Questions of the violation of human rights”, above at note 42 at para 60.
the nexus between kleptocracy and the present state of health care in Nigeria: a strong and clear rebuttal of the resource deficit argument.

Rising external debt has had a stranglehold on the nation’s economy for over two decades. Since 1985, the country has repaid a total of more than $35b (principal plus interest) to creditors even though the original loan was less than $15b.75 Because it stifles growth and hampers economic development, debt servicing (likewise the corruption which led to it in the case of Nigeria) deprives the government of resources that could have been employed in addressing vital needs of different sectors of the economy. Hopefully, upon discharge of the debt burden and, consequently, improvement in public resources, the government will take another look at chapter II of the constitution. Perhaps, by adopting sound economic policies, arresting corruption and pursuing good governance, the government will become responsive to the needs of its citizens and comply with the obligations imposed by the Directive Principles.76 Clearly, it would be difficult to make a compelling argument based on resource deficit under such circumstances.

FROM NON-JUSTICIABILITY TO JUSTICIABILITY (THE IMPACT OF THE AFRICAN CHARTER ON HUMAN AND PEOPLES’ RIGHTS)

As discussed above, none of the provisions of chapter II of the constitution, including health care interests, is subject to judicial review. No action may be instituted seeking enforcement of any of the provisions, as they are Directive Principles. However, notwithstanding the provisions of section 6(6)(c) barring the jurisdiction of courts, health care related interests may be justiciable if the National Assembly elects to exercise its legislative prerogative under the constitution. Section 4 of the constitution provides:

“(1) The legislative powers of the Federal Republic of Nigeria shall be vested in a National Assembly for the Federation, which shall consist of a Senate and a House of Representatives.

(2) The National Assembly shall have power to make laws for the peace, order and good government of the Federation or any part thereof with respect to any matter included in the Exclusive Legislative List set out in Part I of the Second Schedule to this Constitution.” (Emphasis added.)

Part I of the second schedule to the constitution (the exclusive legislative list) extends the authority of the National Assembly to include: “60. The establishment and regulation of authorities for the Federation or any part thereof (a) To promote and enforce the observance of the Fundamental Objectives and Directive Principles contained in this Constitution.”

75 Riefel “Nigeria’s Paris Club debt problem”, above at note 73.
76 CDHR Annual Report, above at note 64 at 149.
What item 60(a) seems to suggest is that the National Assembly may, by legislative fiat, confer justiciability status to the Directive Principles in chapter II of the constitution. The impact of such a measure would be to abrogate completely the application of section 6(6)(c), thus allowing state organs to “conform to, observe and apply the provisions” of the Directive Principles as stipulated in section 13. The combined effect of sections 4(1) and (2) and item 60(a) on the exclusive legislative list may be interpreted as follows: the National Assembly may (a) enact legislation declaring the provisions of chapter II legally enforceable and therefore justiciable, and/or (b) repeal section 6(6)(c), thus conferring jurisdiction on the courts. Option (a) could be implemented in two ways, namely (i) by enacting a new statute through the regular legislative process or (ii) by domesticating a treaty to which Nigeria is a party. Ultimately, it is immaterial whether a new statute is enacted or a treaty is domesticated; the effect is the same: both are legally enforceable and enjoy the same legal imprimatur as other statutes duly passed by the National Assembly.

The purpose for including the Directive Principles in the Exclusive Legislative List under item 60(a) was, as explained by Uwaifo J of the Supreme Court: “to show by and large that they can in letter be turned into enactments within the competence of the National Assembly as far as practicable when the need should arise.”

In March 1983, the National Assembly enacted the African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act (“African Charter Act”), thereby incorporating the African Charter on Human and Peoples’ Rights (“African Charter”) into domestic law. Thenceforth, the provisions of the African Charter “have force of law in Nigeria and shall be given full recognition and effect and be applied by all authorities.” Interestingly, the incorporating act did not desegregate the rights but imported, word for word and letter for letter, the full text of the charter, meaning that all the rights accorded recognition by the charter (civil and political, socio-economic and cultural as well as solidarity rights) presently constitute part of the domestic law of Nigeria.

It is not clear how courts in Nigeria would grapple with provisions of a charter whose scope of application is not clearly delineated or deal with the

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77 Unless enacted into law by the National Assembly, a treaty does not have the force of law in Nigeria. The federal legislature enjoys far-reaching powers in this regard, extending to matters not included within the exclusive legislative list. See secs 12(1) and (2) of the constitution.

78 Attorney General of Ondo State v Attorney General of the Federation & Ors, above at note 17 at 408 para H – 409 para A.

79 Chap 10, LFN 1990. Note that, although the National Assembly enacted the statute in March 1983, it entrusted the president with the power to set a commencement date for the statute, but the civilian president was overthrown in a military coup before he could set the date. However, the revised edition of the LFN includes the statute, its commencement date appropriately backdated to 17 March 1983. See U Umozuruike The African Charter on Human and Peoples’ Rights (1997, Kluwer Law International) at 111.

80 African Charter Act, sec 1.
fact that the African Charter lacks a specific enforcement procedure applicable in a domestic forum. This is an important concern for, while there is a specific procedure for enforcing civil and political rights in Nigeria, none yet exists in regard to socio-economic rights. This, however, does not constitute an obstacle to enforcing the socio-economic rights of the African Charter. As noted below, there is room for the courts to be innovative in giving effect to all the African Charter rights irrespective of nomenclature or categorization. Indeed in *Nemi v The State*,\(^81\) the Supreme Court of Nigeria held that the absence of an enforcement procedure in the African Charter does not constitute an impediment to the enforcement of the rights contained in it. According to Bello CJ: “Since the Charter has become part of our domestic law, the enforcement of its provisions like all our other laws falls within the judicial powers of the courts as provided by the Constitution and all other laws relating thereto.”\(^82\) Although this case related to the enforcement of civil and political rights, there is no reason barring application of the rationale to socio-economic rights, such as the right to health care.\(^83\)

Current court procedural rules governing the enforcement of fundamental human rights (hitherto confined to civil and political rights) were promulgated by the chief justice of the Supreme Court of Nigeria in 1979.\(^84\) The two most important provisions relate to jurisdiction and remedy. Original jurisdiction is vested in the High Court,\(^85\) which may “make such orders, issue such writs, and give such directions” as it “may consider just or appropriate” for the purposes of enforcing or securing the enforcement of the rights.\(^86\) It is striking that the rules follow basic legal orthodoxy: to succeed, an aggrieved applicant must commence proceedings before a court having requisite competence (a) to hear the matter and (b) to grant remedy. This author believes that this would hold true regardless of whether the right violated was, for instance, the right to fair hearing (a civil and political right) or the right to health care (a social right). Accordingly, since the procedure required under the rules for enforcing civil and political rights is capable of being applied to socio-economic rights, there is

\(^81\) [1994] 1 LRC 376.
\(^83\) See O Eze and E Onyekpere *Study on the Right to Health in Nigeria* (1998, Shelter Rights Initiative) at 45, arguing that Nigeria entered no reservations with respect to socio-economic rights of the African Charter, as it could have if a bifurcated application were intended.
\(^84\) See the Fundamental Rights (Enforcement Procedure) Rules 1979, part B special instruction no 1 of the supplement to Official Gazette no 64, vol 66 (20 December 1979); entered into force 1 January 1980.
\(^85\) Order 1 rule 2(1). The High Court of a state and the Federal High Court have concurrent original jurisdiction with respect to enforcing fundamental rights. An applicant is at liberty to seek leave from, and commence proceedings in, either court. See secs 46(1) and 252(1) of the constitution.
\(^86\) Order 6 rule 1(1).
no lacuna in terms of enforcement of the socio-economic rights contained in the African Charter.

It might perhaps be necessary to clarify the applicability of the rules to the newly recognized corpus of rights, for instance by re-wording the text of the 1979 rules, mutatis mutandis. But there is certainly no reason for adopting a new set of procedural rules devoted solely to enforcing socio-economic rights.\(^{87}\) Regardless of whether or not the current rules are modified, an applicant seeking enforcement of the right to health care under the African Charter can commence an action by way of the current rules, a writ or any other form of action.\(^{88}\) The maxim \textit{ubi jus ibi remedium} [where there is a right, there is a remedy] holds true, as the court will not permit challenges based solely on adjectival law that tend only to impede the attainment of justice.\(^{89}\) Moreover, in its seminal ruling in \textit{Ogugu v State},\(^{90}\) the Supreme Court rejected the contention that a void exists in the African Charter with respect to domestic enforcement of its provisions in Nigeria. In the words of Bello CJ: “However, I am unable to agree ... that because neither the African Charter nor its Ratification and Enforcement Act has made a special provision like Section 42 of the Constitution for the enforcement of its human and peoples’ rights within a domestic jurisdiction, there is a lacuna in our laws for the enforcement of these rights.”\(^{91}\)

The court held further that the rights enumerated in the African Charter are enforceable by High Courts depending on the circumstances of each case and in accordance with the rules, practice and procedure of each court. The Supreme Court did not see fit to draw a distinction based on the category of rights for enforcement purposes. Thus, it cannot legitimately be argued that technical procedural requirements constitute a bar or impediment to justiciability or enforcement of the right to health care in Nigeria, at least since the domestication of the African Charter in 1983.

Earlier cases on the status of the African Charter vis-à-vis regular statutes yielded mixed results. For some inexplicable reasons, judicial interpretations were inconsistent even in cases with similar or identical facts.\(^{92}\)

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87 The present constitution reconfirms the authority of the chief justice to make rules for enforcing human rights. Sec 46(3) empowers Nigeria’s chief justice to “make rules with respect to the practice and procedure of a High Court for the purposes” of enforcing fundamental human rights.

88 \textit{General Sanni Abacha & Ors v Chief Ganni Fawehinmi (“Fawehinmi”) (2000) 6 NWLR (pt 660) 228 at 293 para E – 294 para A.}

89 \textit{Fajunmi v The Speaker, Western House of Assembly (1962) 1 SCNLR 300; Saude v Abdulahhi (1989) 4 NWLR (pt 116) 387; Minister of Internal Affairs v Shugaba (1982) 3 NWLR 915 at 997; Ogugu v State (1994) 9 NWLR (pt 366) 1 at 293 paras E–F and 321 paras B–D.}

90 \textit{Ogugu v State}, above at note 90 at 26–27.

91 Id at 26–27; and \textit{Fawehinmi}, above at note 88 at 293, paras F–G, quoting \textit{Ogugu v State}, above at note 90 at 26–27.

92 \textit{Garba v Lagos State Attorney General (“Garba”) held that the African Charter supersedes the provisions of a military decree and therefore the court had jurisdiction notwithstanding contrary provisions in the decree: suit ID/599M/91, judgment of 31 October 1991, High Court of Lagos State (unreported); Femi Falana, “Application of fundamental human rights in Nigeria” (unpublished paper presented at a workshop on Law, Legal
Fortunately, these misconceptions were finally laid to rest in 2000. The Supreme Court was unequivocal, holding that the African Charter is a special genus of law in the Nigerian legal and political system, and that it has some international flavour and, in that sense, cannot be amended, watered down or sidetracked by any Nigerian law. According to Ogundare J: “Being so, therefore I would think that if there is a conflict between it [African Charter Act] and another statute, its provisions will prevail over those of that other statute for the reason that it is presumed that the legislature does not intend to breach an international obligation.”

The decision makes it clear that the African Charter is superior to ordinary statutes and will prevail over inconsistent statutory provisions. It follows therefore that, unless the African Charter is repealed, statutory law cannot be invoked to shield the government from its obligations with respect to the right to health care. Nonetheless, the African Charter is not superior to the constitution and its international flavour cannot preclude the legislature from removing it from the laws in force in Nigeria simply by repealing it.

Recently, a Federal High Court heard a case that centred on claims to rights, one of which is recognized by the African Charter but not the constitution. In Jonah Gbemre & Ors v Shell Petroleum Development Company of Nigeria Ltd & Ors, the applicants sought a declaration that the constitutionally guaranteed fundamental rights to life and dignity of the person as enshrined in sections 33(1) and 34(1) of the constitution and articles 4, 16 and 24 of

93 Fawehinmi, above at note 88.
95 Fawehinmi, above at note 88 at paras E–F.
96 Suit FHC/CS/B/153/2005, Federal High Court, Benin City, judgment of 14 November 2005 (unreported), available at: <http://www.climatelaw.org/media/gas.flaring.suit.nov2005> (last accessed 26 June 2007) (“Gbemre v Shell”). Note that, though an earlier case to which Nigeria was a party had previously established the right to a healthy environment, the decision was by the African Commission. As such, its value as a precedent is not clear. See The Social and Economic Rights Action Center and the Center for Economic and Social Rights v Nigeria (“SERAC”) African Commission on Human and Peoples’ Rights comm no 155/96 (2001), which found there had been a violation of the right to health.
97 Right to life.
98 Right to health care.
99 Right to satisfactory environment.
the African Charter Act include also the right to a healthy environment. Probably, as a result of the novelty of the claim to environmental rights in Nigeria, and also given that the constitution does not explicitly guarantee such rights, the applicants bolstered their claim by also relying upon the African Charter Act. The respondent contended that the African Charter was inapplicable, as articles 4, 16 and 24 do not create fundamental rights enforceable by regular court procedure (the Fundamental Rights Enforcement Procedure Rules). Nwokorie J held, rejecting the argument, that the African Charter is applicable irrespective of a lack of enforcement procedure and that the rights to life and dignity of the person as recognized in the provisions cited above inevitably include the right to a clean, poison-free, pollution-free and healthy environment.

The case is significant in three respects. It was the first time that a Nigerian court upheld the right to a healthy environment. Second, prior to the decision, the right to life and the right to dignity of the person had never been construed as incorporating the right to a healthy environment. Third, and most significant, the case illuminates the proper application of the African Charter in enforcing fundamental rights as well as its relationship with the Directive Principles. By reinforcing constitutional provisions with African Charter rights, the applicant is assured that the broadest possible remedy will be granted, in the event that the application is successful. This is not to suggest that, in this case for instance, exclusive reliance could not have been maintained on the African Charter but, for the reason stated, a two-prong approach has a greater prospect of eliciting better results.

Though the court did not rely exclusively on the African Charter Act, it is clear that there are no reasonable grounds upon which such reliance, had the court so chosen, could have been faulted. Having concluded that the African Charter was applicable, it seems unlikely that the court would reject relief sought in reliance on it, especially since the status of the African Charter as an enforceable domestic law has been firmly established by prior cases. However, the court’s reliance on both constitutional and charter provisions was justified by the terms of the declaration sought. Moreover, there was scarcely any reason necessitating a choice between the regimes, particularly since the rights to life and dignity of the person are enshrined in both. But, because the right to a healthy environment is not constitutionally guaranteed, it was necessary for the applicants to

100 Sec 20 casts the government obligation regarding environmental protection as a Directive Principle.
101 Compare with Nemi v The State, above at note 81.
102 Gbemre v Shell, above at note 96.
103 The court did not indicate whether art 16 (right to health) and art 24 (right to a healthy environment) are free standing rights, capable of being adjudicated and enforced on their own, but this was probably because the question was not one of the issues submitted for determination.
reinforce the claim by pleading article 24 of the African Charter, which guarantees that right.

Nevertheless, counsel for the applicants missed an important opportunity here in that he was not mindful of the applicability and utility of section 20 of the constitution to his case. This section stipulates that “[t]he State shall protect and improve the environment and safeguard the water, air and land, forest and wildlife of Nigeria”. Perhaps, counsel thought that being a Directive Principle, section 20 did not add weight to his case, apparently oblivious of the impact of domestication of the African Charter. This was a significant oversight, given that section 20 imposes specific obligations on the government, unlike article 24 of the African Charter which merely provides that all “peoples shall have the right to a general satisfactory environment favourable to their development”104 but conspicuously fails to indicate corresponding measures necessary to effect that right. This failure (“obligation gap”) is a major deficiency which is potentially curable by the obligatory terms of section 20. As such, section 20 should not have been glossed over, but employed to demonstrate the true relationship between the African Charter and Directive Principles. First, the two regimes are complementary as illustrated by the interface between section 20 of the constitution and article 24 of the African Charter. Second, the charter reinforces or fortifies claims to human rights where the constitution, as in the case just considered, or any other law does not recognize the right in question.

In a nutshell, therefore, the legal impact of the domestication of the African Charter is that the National Assembly bestowed legislative imprimatur of justiciability to those Directive Principles of the constitution that are also enshrined in the African Charter. Although the Directive Principles are not justiciable per se under the constitution, the government has bound itself to their being enforced through the domestic adoption of the African Charter.

NORMATIVE CONTENT OF THE RIGHT TO HEALTH CARE

Conceptual difficulties
What does the right to health care mean in practice? What substantive legal claim would an applicant before a court in Nigeria be seeking to enforce? These are neither simple questions nor do they permit simple resolution. The history and emergent nature of the right in Nigeria impede a clear understanding of its scope and content. Also, there is no legislative guidance. Section 17(3)(d) of the constitution merely requires the government to direct its policy toward ensuring that “there are adequate medical

104 Thus, like many provisions on socio-economic rights, the article attracts criticism as being vague and imprecise, thus diminishing its value as a foundational basis for a human rights claim.
and health facilities for all persons” but does not give any indication as to what the term “adequate medical and health facilities” means. Neither the interpretive sections of the constitution nor any other subsidiary legislation provide any clues. Because its focus is exclusively on the health of “persons in employment,” section 17(3)(c) is not helpful either.

Similarly, the African Charter provides no guidelines. Article 16 provides: “(1) Every individual shall have the right to enjoy the best attainable state of physical and mental health. (2) States 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.”

The African Charter does not define what is meant by the “best attainable state of physical and mental health” or what specific measures states parties must adopt in protecting the health of their citizens. Moreover, the term “best attainable state of physical and mental health” is overly broad and imprecise; as such, it does not easily lend itself to a consummate legal interpretation. Indeed, such omnibus provisions, lacking in conceptual clarity, greatly hinder recognition not only of the right to health care but other socio-economic rights as well, and present a difficult challenge that must be overcome as a preliminary step toward actualizing these rights.

In seeking judicial cognizance and enforcement, it is crucial that the specific content of the right in question is clearly defined; otherwise there would be no legitimate reason to accord the status of “right” to a claim whose “normative content could be so indeterminate as to allow the possibility that the right holders possess no particular entitlement to anything”.

Admittedly, the right to health care is tainted with insufficient conceptual clarification, quite unlike civil and political rights. But the handicap is merely a reflection of the novelty of socio-economic rights: a handicap which normally characterizes emerging norms. History bears witness that civil and political rights underwent a similar transformative process and, even though, the rights gradually evolved to what is today cavalierly described as “fundamental rights” inherent in all human beings, the rights were not originally conceptualized as such. The English Magna Carta, one of the early codes from which modern human rights instruments drew inspiration, reserved its rights exclusively to free men, and so did the constitution of the United States of America before

105 See sec 318.
107 P Alston “Out of the abyss: the challenge confronting the new UN committee on economic, social and cultural rights” (1987) 9 Human Rights Quarterly 332 at 352–53; Gomez “Social economic rights and human rights commissions”, above at note 106 at 164.
the abolition of slavery. It was only recently that international law, via the Universal Declaration of Human Rights, proclaimed human rights as belonging to everyone, whether free or in bondage “without distinction of any kind”.

Current understanding of the meaning, scope and contours of civil and political rights was not achieved overnight but followed concerted social re-engineering, involving a multitude of actors on different levels and spanning several centuries. Most, if not all, of the recognized rights have had a long history of twists and turns in meaning and scope of application in various legal systems; even to this day, courts in both civil and common law traditions are still struggling to assign appropriate meanings to and delimit the boundaries of rights long recognized as inalienable. The process of re-engineering and refining of these rights, in order to suit the evolving needs of contemporary society better, is still ongoing. The right to health care is undergoing a similar evolutionary transformation. In this process, the task of crafting an acceptable legal meaning does not reside with the courts alone. The concerted efforts of courts, quasi-judicial bodies, academics, advocates and other stakeholders are, ultimately, what is needed to shed the right of continued vagueness and imprecision.

109 Dred Scott v John FA Sandford 60 US 393, which held that blacks, whether free or slave, could never become citizens of the United States and therefore could not sue in the Federal Court; and Plessy v Ferguson 163 US 537 (1896), which upheld racial segregation. It was the thirteenth amendment to the US constitution that abolished slavery, following ratification by the required three-quarters of the states, on 18 December 1865.


111 Art 2.

112 ICJ “Justiciability of economic, social and cultural rights”, above at note 21.

113 For instance, it was only in 1973 that the right to privacy in the United States was redefined to include a woman’s right to abortion. Roe v Wade 410 US 113 (1973). See also R. v Morgentaler [1988] 1 SCR 30, in which the Canadian Supreme Court struck down sec 251 of the Criminal Code (which restricted abortion) as unconstitutional, in that it violated a woman’s right to security of the person under sec 7 of the Canadian Charter of Rights and Freedoms. Until 1988, sec 7 had never been understood to confer a right to abortion.

114 Gomez “Social economic rights”, above at note 106 at 161–63. Referring to the difficulty of enforcing socio-economic rights, Yacoob J held, “[t]his is a very difficult issue which must be carefully explored on a case-by-case basis”: Government of the Republic of South Africa v Grootboom (“Grootboom”) 2001 (1) SA 46 (South African Constitutional Court – “S Afr Const Ct”) at para 20. In order to ensure that courts overcome this difficulty and vigorously scrutinize violations and uphold accepted standards, the legal profession needs to be resourceful in interpreting the law. See Y Mokgoro “The implementation of socio-economic rights in Africa – a strategy for the eradication of poverty” (2000) Oct – Dec Africa Legal Aid Quarterly 8 at 9; general comment no 14, above at note 6 at para 70; and Maastricht Guidelines, above at note 7 at para 28. It has been stated that the reason for the present difficulties regarding justiciability of socio-economic rights is not a result of their inherent complexity but due principally to the
While conceptual difficulties might have constituted a serious barrier to enforcing socio-economic rights some years ago, and justifiably so, continued reliance on such an excuse is becoming increasingly tenuous as a substantive corpus of interpretive work on these rights continues to evolve, particularly on the international plane, and this could be tapped into by domestic courts. Conceptual clarifications of the norms of socio-economic rights are gradually evolving through the efforts of experts in the field and non-governmental organizations. Some of the results of these efforts include the adoption in 1987 of the Limburg Principles, followed by the Maastricht Guidelines a decade later and a collaborative publication by the American Association for the Advancement of Science and the Human Rights Information and Development Systems International in this area in 1999. In addition, the work of the special rapporteur appointed by the UN Commission on Human Rights to address key issues affecting these rights provides yet another useful interpretive tool.

With regard to health care, a significant source of interpretation derives from article 12(1) of the International Covenant on Economic, Social and Cultural Rights (‘‘ICESCR’’) and the jurisprudence developed in general

115 A Chapman “Indicators and standards for monitoring economic, social and cultural rights”, available at: <http://hdr.undp.org/docs/events/global_forum/2000/chapman.pdf> (last accessed 19 June 2007). The landscape is changing. As noted by the UN special rapporteur on the right to health, despite attracting more international, regional, non-governmental and academic attention, socio-economic rights are not yet at par with civil and political rights, but the deficit has shrunk. P Hunt “Ten years after the Vienna world conference on human rights” (unpublished presentation, 16 October 2003), available at: <http://www2.essex.ac.uk/human_rights_centre/rth/docs/FIAN.doc> (last accessed 29 July 2007). See also the UN Food and Agriculture Organization (“FAO”) “Justiciability of the right to food”, information paper IGWG RTFG/INF 7 (October 2004) at 13 at para 66.

116 See note 7 above.

117 Ibid. The drafters were unequivocal about its use as a tool, particularly for “monitoring and adjudicative bodies” interpreting socio-economic and cultural rights. See preambular provisions and para 5.


comment no 14 by the Committee on ESCR\textsuperscript{120} which is widely construed as an authoritative source of interpretation of the nature and scope of the right as well as corresponding obligations on the part of states parties to the covenant. But, although Nigeria has ratified the ICESCR, it is yet to incorporate the treaty into domestic law, so the strength of authority of interpretations based on it is not clear.\textsuperscript{121} However, it could be argued that, given the domestication of the African Charter, Nigerian courts could legitimately apply such interpretations in their adjudicatory proceedings, notwithstanding the incorporation status of the ICESCR. By virtue of article 60 of the African Charter, the African Commission can apply not only human rights principles adopted by the UN, such as those contained in article 12(1) of the ICESCR, but also the “provisions of various instruments adopted within the Specialized Agencies of the United Nations” such as general comment no 14.\textsuperscript{122} Furthermore, since one of the consequences of the domestication of the African Charter is that municipal courts in Nigeria became vested with the judicial powers and obligations of the African Commission, it follows that these courts can conform to or observe the commission’s procedural rules (including article 60) unless there is a statutory provision to the contrary. There is none.

Be that as it may, courts in Nigeria invited to adjudicate the right to health care will undoubtedly face formidable challenges in crafting an appropriate meaning and, in particular, tailoring its scope of application to suit the country’s specific circumstances. The court will be deprived of the benefit of legislative guidance, as neither the constitution nor African Charter Act made any attempt either to articulate a definition or to delineate a resource-oriented level of obligation. The regional body charged with implementing the African Charter, the African Commission, is yet to address the subject in any substantive manner and, notwithstanding the

\textsuperscript{120} See note 6.

\textsuperscript{121} See note 29.

\textsuperscript{122} This view was affirmed by the African Commission in 2001. See SERAC, above at note 96 at para 49. Relying on this provision, the commission has borrowed extensively from the experience of other international human rights adjudicatory bodies in resolving petitions brought before it. For instance, it relied on general comment no 9 (adopted by the Committee on ESCR in 1998, on the domestic application of the ICESCR, E/C.12/1998/24, at para 3) in its ruling that, while non-domesticated treaties may not be directly enforceable in Zambian national courts, such treaties nonetheless impose obligations on the country. See \textit{Legal Resources Foundation v Zambia}, African Commission on Human and Peoples’ Rights comm no 211/98 (2001) at para 59. See also paras 63 and 70: the commission cited UN Committee on Human Rights general comment nos 18 (XXXVII/1989) and 25 (XXXVII/1996). Also, in holding that the rule requiring prior exhaustion of domestic remedy as a precondition for admissibility of communications means that such domestic remedy must be available, adequate and effective in the state concerned, the commission relied on a petition decided by the Inter-American Court on Human Rights: \textit{Velasquez Rodriguez Case}, judgment of 29 July 1988, Inter-Am.Ct.H.R (Ser.C) no 4 (1988). See \textit{Liesbeth Zegveld and Messie Ephrem v Eritrea}, African Commission on Human and Peoples’ Rights, comm no 250/2002 (2003) at para 36.
jurisprudence developed under the auspices of the UN, foreign jurisprudence on the right is still limited;\textsuperscript{123} therefore, the ability of the court in Nigeria to avail itself of the benefit of prior decisions from other jurisdictions is severely circumscribed.

Regardless of how daunting the challenge is, however, the court cannot shirk its constitutional obligation as the arbiter and guardian of human rights.\textsuperscript{124} The court is well resourced to embark upon the interpretive journey. This is so notwithstanding the so-called “lack of institutional capacity” argument.\textsuperscript{125} In carrying out this very important function, the court should be cognizant of the genesis of the right to health care in Nigeria, and that resource constraints was the principal reason advanced for the initial exclusion of health care from the fundamental rights in the constitution. Though this author believes that kleptocracy is the key factor obstructing recognition and realization of this right, that does not diminish the fact that resource limitation is also a significant factor. As such, the court would be better served in its interpretive role if it strove toward the goal of striking an appropriate balance between the interests of claimants and the capacity of the government to meet them while, at the same time, remaining mindful of its obligation to “forge new tools and shape innovative remedies” as may be necessary to give meaning to the right.\textsuperscript{126}

**Legislative guidance**

The legislative history of the right to health care in Nigeria should be approached with caution given that the expressed desire of the constitution drafting committee was to deny legal force to the right. To this extent, the usefulness of the debates that preceded its designation as a Directive Principle is quite limited. Nonetheless, some of the concerns expressed by


\textsuperscript{124} See Bate J in *Cheranci v Cheranci* (1960) NRNLR 24.

\textsuperscript{125} This argument refers to the view that the doctrine of separation of power precludes the courts’ jurisdiction in matters revolving around resource allocation, that courts lack the capacity to weigh and balance the complex issues involved and concomitantly ought to refrain from entertaining such cases. But this view is increasingly under attack, as demonstrated by decisions emerging from several jurisdictions. Regarding the approach adopted by courts in India, see below at notes 167–68. Even South African courts, despite their self-imposed restraint, are cognizant of the judicial prerogative to entertain such cases. While recognizing the need for each of the three branches of government to deal with matters that are pre-eminently within their domain, the Constitutional Court does not construe this as meaning that courts are precluded from making orders that have policy ramifications. Where a state policy is inconsistent with its constitutional obligation, the court is within its powers to say so. Though such action might constitute an intrusion into the domain of the executive, “it is an intrusion mandated by the Constitution itself”. See *Minister of Health v Treatment Action Campaign* No. 2 (“TAC”) 2002 (5) SA 721 (S Afr Const Ct) at paras 98 and 99. See also notes 161–65 below. For additional reasons sustaining this view, see FAO “Justiciability”, above at note 115 at 13 at para 68.

\textsuperscript{126} *Fose v Minister of Safety and Security* 1997 (3) SA 786 (S Afr Const Ct) at para 69.
the committee might be insightful. For instance, in rejecting the justiciability of the right to health care and other socio-economic rights, the committee felt that, by their nature, these are: “rights which can only come into existence after the government has provided facilities for them. Thus, if there are facilities for education or medical services one can speak of the “right” to such facilities. On the other hand, it will be ludicrous to refer to the “right” to education or health where no facilities exist.”\(^{127}\)

A literal reading of the committee’s concern would lead to absurd conclusions. First, governmental action is not a necessary prelude to the coming into being of a human right. To borrow the language of the committee, “it will be ludicrous” to argue, for instance, that Nigerians’ civil and political rights ceased to exist during the protracted years of military dictatorship. Notwithstanding the suspension of fundamental rights by military decrees at the time, those rights remained intact, although the courts’ jurisdiction was ousted.\(^{128}\) Existence of a right is a different question from its enforceability. While the government may decide to alter, modify or even go as far as abolishing the human rights of individuals subject to its jurisdiction, that fact in itself does not materially affect the existence of those rights. The status of the rights in terms of enforceability will certainly be adversely affected but the rights nonetheless remain extant.

Second, there is no denying that government disposition toward human rights is important, but perhaps of greater significance is what the government ought to be doing in securing these rights. Entitlement to a right is unaffected by whether or not there is an existing infrastructure capable of being deployed toward its satisfaction. It is the claim of an extant right that provides the impetus, the ultimate catalyst that galvanizes government to action. To analogize, the inadequate supply of hospital beds, pharmaceutical drugs or physicians does not ipso facto mean that the right of access to these facilities or services does not exist. Rather, their unavailability might constitute a potential violation of that right and an application before the court and subsequent judicial pronouncement might validate the existence of the right.\(^{129}\)

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128 See for instance the Constitution (Suspension and Modification) decree no 107 of 1993 which not only suspended the constitution but also stipulated that no decree promulgated after December 1983 could be challenged in a court in Nigeria. The decree was subsequently held to constitute a breach of art 7 (right to be heard) and art 26 (obligations to establish and protect the courts) of the African Charter. See Civil Liberties Organization v Nigeria African Commission on Human and Peoples’ Rights, comm no 129/94 (1995).

129 For the purposes of justiciability, it is sufficient that judicial or quasi-judicial proceedings took place on the basis of a complaint alleging a violation of the right to health and that the complaint formed the basis for the decision. See B Toebes The Right to Health as a Human Right in International Law (1999, Intersentia / Hart) at 170.
Human rights are immutable and predate political institutions; their existence is not dependent on government benevolence or recognition or, in the case of socio-economic rights, the provision of the facilities or services needed for their enjoyment. To hold otherwise would be absurd, a result that could not have been intended by the constitution drafting committee. Most likely, the statement was simply demonstrative of a profound eagerness on the part of the committee to lay the foundation for a sustainable democratic process by insulating the infantile government from being saddled with the enormous burden of defending legal claims to entitlements that it might otherwise be ill-equipped to satisfy. A correct understanding of the committee's concern seems to be that, in order for the right to health care to be meaningful, judicial interpretation must be anchored on current political and socio-economic realities. A useful judicial inquiry must therefore be sensitive to the interplay between claims for health services and competing budgetary demands upon the government.

Indubitably, a transitional government, struggling to balance its budgets, liquidate the national debt, reverse kleptocratic tendencies of its predecessors and chart an enduring course for democracy, as is the current government in Nigeria, can ill afford to be burdened with excessive demands on its lean resources. However, an important indicator for assessing a government, regardless of its difficulties, is its responsiveness to the needs of its citizens. But, as Akande rightly argued, rather than organize society and govern in such a way that would maximize general welfare, governments in third world countries “have tended to be preoccupied with power and its material perquisites”. Nevertheless, there is a minimum threshold of obligations demanded of responsible governments; otherwise their continued existence can become a legitimate political question.

Minimum core obligations

Regarding socio-economic rights enumerated in the ICESCR, every state party is required to satisfy a threshold known as “core obligations”, a standard first adopted in 1990 but which underwent further elaboration and refinement in 2000. Having ratified the covenant without reservations on 29 July 1993, Nigeria is subject to interpretations of the provisions issued by relevant judicial or quasi-judicial bodies such as the Committee on ESCR. In general comment no 14, the Committee on ESCR affirms that a minimum core obligation requires governments to ensure

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131 By the Committee on ESCR, general comment no 3, UN COMM. ESCR, 5th Session, supp no 3, annex III, UN doc E/1991/23(1990), para 10.

132 General comment no 14, above at note 6.

133 See note 29.
the satisfaction of, at the very least, minimum essential levels of each of the rights enumerated in the ICESCR, including essential primary health care. This core comprises at least the obligations inter alia of ensuring:

- the right of access to health facilities;
- access to the minimum amount of essential food;
- access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- the provision of essential drugs, as defined from time to time by the WHO’s Action Programme on Essential Drugs;134
- equitable distribution of health facilities, goods and services; and
- a national public health strategy and plan of action on the basis of epidemiological evidence, addressing the health needs of the entire population.135

Similar measures, dubbed the “primary health care” approach, were also emphasized in the declaration of Alma-Ata136 and to some extent reiterated in the programme of action of the United Nations International Conference on Population and Development.137

“Minimum threshold” denotes non-derogable obligations of the government with respect to health care as well as underlying determinants of

134 What constitutes “essential drugs” is not defined by the Committee on ESCR. But the WHO defines the term to comprise medicines that satisfy the priority health care needs of the population. They are selected with due regard to relevance to public health, evidence on efficacy and safety, and comparative cost-effectiveness. Essential medicines are intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and the community can afford. The implementation of the concept of essential medicines is intended to be flexible and adaptable to many different situations. Determining what constitutes essential medicines is a national responsibility. See the WHO “Essential Medicines”, available at: <http://www.who.int/topics/essential_medicines/en/> (last accessed 31 July 2007). Allowing countries some margin of discretion in determining what constitutes essential medicines within their respective territories seems to recognize that, given the variations in types and incidence of diseases in different countries, it is prudent for each government to set its own priorities. For instance, since malaria and tuberculosis are ravaging Africa, determinations of essential drugs in Africa ought to be skewed toward medicines that are indicated for the treatment of these two diseases. The WHO publishes a list of essential medicines that has been updated every two years since 1977. The current version, the 15th, dates from March 2007 and is available, in addition to three other editions, at: <http://www.who.int/medicines/publications/essentialmedicines/en/> (last accessed 3 August 2007).

135 See general comment no 14, above at note 6 at para 43.

136 See the Declaration of Alma-Ata, above at note 22 at para VII. Note that adopting and implementing a primary health care programme as recommended by the declaration would satisfy the minimum core obligations.

health. Under no circumstances may a government justify its non-compliance with these core obligations, not even on grounds of scarcity of resources. The rationale for non-derogation derives from the notion that compliance will not impose unbearable costs upon governments and could be satisfied with relative ease. It was thought that no sovereign nation is so penurious as to be incapable of providing basic health services to its population. In determining the national resources of a country, all resources at the disposal of the country including foreign aid are included and must be utilized in meeting core requirements.

Notwithstanding the significance of core obligations and attendant non-derogability, the reality is that, in order to realize the benefits of the right to health care, the standard may have to be tweaked to a certain extent in order to accommodate resource concerns. A purposive, and not literal, interpretation, taking into account fiscal realities and competing demands upon national resources, would afford greater protection to the right to health care. As the African Commission noted, “due regard” should be paid “to this depressing but real state of affairs” in Africa. This means that judicial interpretation of the substantive content of an applicant’s right should be devoid of vacuousness and reflect the result of a diligent consideration of the totality of government resources and its sufficiency or otherwise in meeting the claim for provision of health services.

A decision reached on this basis would be of greater value to applicants. Conversely, a decision that flows from an insufficient appraisal of resource availability would probably guarantee non-compliance and thus yield no practical dividend. Indeed, as pointed out by the Constitutional Court of South Africa, given scarcity of resources and significant demands on those resources, an unqualified obligation to meet public needs would not be capable of being fulfilled. A balance must be struck between the goal and

138 General comment no 14, above at note 6 at para 47. This represents a striking departure from general comment no 3, which permits derogation from core obligations in the event that the government can demonstrate the impossibility of compliance even after all available resources have been deployed, as a matter of priority, for the purpose: see above at note 131.

139 Non-derogation from core obligations was also reiterated by the Maastricht Guidelines, above at note 7 at para 9.


141 The Limburg Principles, above at note 7 at para 26.

142 Ngwena and Cook “Rights concerning health”, above at note 140 at 118. This dovetails with the original intent of the drafters of the ICESCR. Art 2 speaks of “progressively” realizing the rights recognized in the covenant by all appropriate means.


144 Per Chaskalson P in Soobramoney v Minister of Health of KwaZulu-Natal (“Soobramoney”) 1997 (12) BCLR 1696 (S Afr Const Ct) at para 11, cited with approval per Yacoob J in Groothboom, above at note 114 at para 46.
the measures adopted toward its attainment, such measures being calculated to attain the goal expeditiously and effectively. Ultimately therefore, what is important is that judicial decisions must be based upon a principled and reasonable evaluation of the congruency between public needs and expectations, and the capacity of the government to satisfy them. In this case, since the obligations, core obligations, relate to the provision of basic health care, the cost of which is arguably not beyond reach, states are precluded from raising arguments centred on finite resources. As was held in *Free Legal Assistance Group and Others v Zaire*, government failure to provide basic services such as medicine constitutes a violation of the right to health care; so too would denial of access to physicians to a detainee. This may be an appropriate point for Nigerian courts to start a judicial inquiry into the normative content of the right to health care, an inquiry that must necessarily be constructed in such a way as not to result in an “official sanctioning of a violation of an international obligation” of the country.

**Proactive or restrained judicial interpretation?**

Despite widespread acceptance and enthusiastic embrace of the minimum core standard by the human rights community, its application by national courts has, for the most part, been luke-warm. Some courts explicitly reject core obligations, adopting what is deemed pragmatic in individual circumstances. A notable example is the Constitutional Court of South Africa. Though the South African constitution is generally acclaimed as progressive, for entrenching, inter alia, the right to health care and other socio-economic rights, the provisions on these rights are not construed as entitling anyone to demand that the minimum core be provided. Rather, in an action challenging the failure of the government to meet the positive obligation imposed by the constitution, the question the court would have to consider is whether the measures adopted are reasonable. In the words of the court: “It is necessary to recognize that a wide range of possible measures could be adopted by the state to meet its obligations. Many of these would meet the requirement of reasonableness. Once it is shown that the measures do so, this requirement will be met.”

The court suggested, however, that minimum core can be employed as a basis for evaluating whether the action taken by the government in fulfilling its obligation is reasonable, but not as a self-standing right conferred on everyone. It noted that determining what constitutes

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145 *Grootboom*, above at note 114 at para 46.
146 Maastricht Guidelines, above at note 7 at para 10.
149 Maastricht Guidelines, above at note 7 at para 24.
150 *Grootboom*, above at note 114 at para 41.
151 TAC, above at note 125 at paras 34 and 39.
“minimum core obligation” with respect to the right to adequate housing presents difficult questions, particularly whether the term should be defined generally or skewed to meet the needs of specific groups of people; therefore the “real question” is whether the measures adopted by the state to realize the right are reasonable.\textsuperscript{152} This standard, known as the reasonable test approach, seems to impose a lower threshold of obligation than the core standard, as its prime concern is the rationale for decisions or actions taken once the government has decided to provide services.\textsuperscript{153} For instance, it would seem that the South African government would not be in violation of the right to health care if it could demonstrate that it has done all it could reasonably do in the circumstances, even though inadequate to satisfy the claim in question. The reverse is equally true, as illustrated by the decision of the court in the following cases.

In \textit{Soobramoney},\textsuperscript{154} the appeal failed because measures adopted by the government in respect of the provision of renal dialysis to chronically ill patients at public hospitals were found to be reasonable. The reasoning was that to remove restrictions placed on qualification for acceptance into a dialysis programme, as sought by the appellant, would not be feasible, given not only the limited number of dialysis machines but also the shortage of clinical personnel. In \textit{Grootboom},\textsuperscript{155} on the other hand, the state’s housing policy was held to be unreasonable in that it failed to make reasonable provision within available resources for people lacking access to housing and living in intolerable conditions.

A third case revolving around the reasonableness test was \textit{TAC}.\textsuperscript{156} The question was whether the measures adopted by the government with respect to the prevention of mother-to-child transmission of HIV were reasonable.\textsuperscript{157} The government had confined the administration of nevirapine (a drug that prevents intrapartum mother-to-child transmission of HIV) to designated pilot sites, rather than throughout the country, claiming concern about the safety and efficacy of the drug. This claim was inconsistent with a determination by the WHO and the Medicines Control Council (a drug safety organ of the government) that the drug is safe and efficacious.\textsuperscript{158} The court held that the government’s policy, in so far as it excluded a significant segment of the population (the poor and vulnerable), was unreasonable and violated its constitutional obligations.\textsuperscript{159} The contention by the government that it did not have sufficient health

\textsuperscript{152} \textit{Grootboom}, above at note 114 at para 33.
\textsuperscript{153} For a critique of the “reasonableness test” paradigm at the S Afr Const Ct, see Forman “Ensuring reasonable health”, above at note 123 at 9–11.
\textsuperscript{154} Above at note 144.
\textsuperscript{155} Above at note 114.
\textsuperscript{156} Above at note 125.
\textsuperscript{157} Id at para 44.
\textsuperscript{158} Id at paras 60 and 61.
\textsuperscript{159} Id at paras 68 and 80.
workers to provide the necessary complementary services was roundly rejected by the court.160

By adopting the reasonableness test in its approach to adjudicating and enforcing socio-economic rights, the court seems to recognize that, in certain cases, the doctrine of separation of power demands that courts refrain from making decisions better suited to other branches of government.161 Given the intricacies, complexities and prioritizations involved, it is thought that choices relating to financing and delivering health care ought to be made within the political sphere by politically accountable bodies. This is sometimes described in terms that courts lack the requisite institutional capacity in resource allocation matters and should be cautious in dealing with such cases.162 According to the court, “difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum number of patients” but “that is not a judgment which the Court can make”.163 As noted in TAC, the role of the court, as envisaged in the constitution, is a restrained and focused evaluation of the measures and reasonableness thereof taken by the state to fulfill its constitutional obligations.164 The result of such avowed judicial deference by the South African Constitutional Court has been a restrained construction of the meaning and scope of the right to health care.165

The jurisprudence of the Indian Supreme Court, on the other hand, reveals a more vibrant and proactive interpretation. In contrast with South Africa but similar to Nigeria, the right to health care is not a fundamental right but a Directive Principle, not amenable to judicial enforcement. Thus, as with courts in Nigeria, the jurisdiction of Indian courts does not extend to matters pertaining to the right to health care.166 However, notwithstanding the proscription of its jurisdiction, courts in India have developed innovative means of adjudicating such matters. This involves a creative and broader interpretation of a key fundamental right: the right to life. Over the years, Indian courts have reconceptualized the right to life as encapsulating the right to health care and proceeded on that basis to advance a positive right to health care. For instance, in Paschim Banga Khet

160 Id at para 68.
161 “A court will be slow to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters”: per Chaskalson P in Soobramoney, above at note 144 at para 29. Referring to the decision of the court below, he explained that a danger of judicial intrusion into the allocation of scarce medical resources, for instance, is that a court order might have the undesirable effect of denying those resources to other patients for whom a better outcome could have resulted (at para 30).
162 Id, per Sachs J at para 58; TAC, above at note 125 at para 37.
163 Soobramoney, above at note 144 at para 30, quoting Sir Thomas Bingham MR in R v Cambridge Health Authority, ex parte B, [1995] 2 All ER 129 (CA) at 137 d–f.
164 Above at note 125 at para 38.
165 Soobramoney, above at note 144 at para 29.
166 See note 13 above.
Mazdoor Samity v State of West Bengal\textsuperscript{167} the Indian Supreme Court not only found that the right to life in article 21 of the constitution incorporates the right to emergency medical treatment but issued detailed guidelines on the implementation of its decision and invited other states which were not parties to the case to adopt remedial measures necessary to bring their systems into compliance with the decision.\textsuperscript{168} The court held further that article 21 imposes an obligation on the state to safeguard human life, that hospitals operated by the state must provide medical assistance to those in need and failure on the part of such hospitals to provide timely medical treatment constitutes a violation of the right to life. Particularly significant is the fact that the court held that, while availability of resources (in this case, hospital beds) is an important consideration, resource constraints do not justify non-compliance with constitutional obligations, as the state is required to do whatever is necessary in order to achieve the purpose.

Given the relative novelty of the right to health care and other socio-economic rights in Nigeria, local jurisprudence on these rights is virtually non-existent. That being the case, it is not clear whether Nigerian courts would adopt the jurisprudence of the South African Constitutional Court in terms of a restrained cautious approach or the more activist stance of the Indian Supreme Court. However, passivity on the part of courts in Nigeria has, in the past, contributed to executive inaction, and court orders have repeatedly been flouted by the government. For instance, in Ganni Fawehinmi v State,\textsuperscript{169} an international passport belonging to the applicant human rights activist was confiscated by the secret service on the ground that he was a “security risk”. As a result of inability of the government to substantiate the allegation, Fafiade J of the Lagos State High Court ordered the government to release the passport to the applicant, but the order was ignored.

In fairness, it must be pointed out that the government at the time was a military dictatorship and quite naturally adverse to democratic precepts. Nonetheless, there is no basis to hold that the present democratic administration has completely ridden itself of the arrogance and abuse of

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\item \textsuperscript{168} See MC Mehta v State of Tamil Nadu & Others [1996] 6 SCC 756. As in Samity, the Indian Supreme Court issued far-reaching remedial orders, in a case concerning child labour.
\item \textsuperscript{169} Suit no M/76/78, Lagos State High Court (unreported). In Ojukwu v Governor of Lagos State (1986) NWLR (pt 18) 621, while the court was still adjudicating the matter, government agents, disregarding an interim injunction to maintain the status quo, forcibly entered the property and ejected the plaintiff. Tawogbade v Oyo State Government is yet another case in which the government ignored a court order, prompting the court to warn: “It is unfortunate if the impression is created that there is a separate law binding on the citizens from that binding on the government. It is all the more dangerous if government tends to create a posture indicating that it may choose not to obey certain orders of court. That will be tantamount to executive recklessness which may lead to lawlessness.” (1991) 2 NWLR (Part 171) 52 at 60.
\end{itemize}
Beyond primary health care

Although establishing the right to basic health care is promoted as a reasonable starting point of judicial inquiry into the right to health care in Nigeria, the exercise need not stop there. Basic or primary health care, as the term indicates, should not be seen as an end but the first level of contact with the health system and the foundational point of a continuing process that would eventually lead to the establishment of a comprehensive health care programme, incorporating secondary and tertiary levels of care. As the economy expands and greater wealth is generated, the courts in appropriate cases must re-examine what “goes in and out of” the health care basket. This is not to diminish the immutability of the right to health care, but merely reflects what is trite but nonetheless true: that, in terms of realizing socio-economic rights such as the right to health care, the pendulum would, as a matter of necessity, swing in tandem with the availability or otherwise of resources. The existence of socio-economic rights, like their counterpart civil and political rights, is sacrosanct, but in terms of fulfilment involves different considerations, namely questions pertaining to positive obligations revolving primarily around resource availability and allocation. Thus, according to Flood, Tuohy and Stabile, as a country develops, its medical care system should advance beyond the core demanded by international human rights conventions to incorporate a much larger core. Therefore, a wealthier, technologically advanced Nigeria would mean an expansion of the right to health care basket, translating into coverage of more health benefits and significantly improved services.

This is not a novel idea. In providing health care services to their citizens, even governments of wealthier countries have consistently sought to strike an acceptable balance between public health needs and fiscal considerations. And this is so irrespective of the type of health system, public as well

170 Though the right to health and medical care is a fundamental right under art 21 of the Indian constitution, a reduction of employee entitlement to medical benefit on grounds of scarcity of state resources does not constitute a violation of the constitution: Consumer Education and Research Centre v Union of India (1995) 3 SCC 42.

171 For a working definition of primary health care, see note 22.

172 See the Declaration of Alma-Ata, above at note 22 particularly art VI; and National Health Policy of Nigeria (2004, Federal Ministry of Health) chap 4, secs 4.1 and 4.2.


as privately funded systems, and whether access is founded on government policies or backed with legal entitlement. For instance, a recent infusion of funds into the National Health Service in the United Kingdom was, in the words of prime minister Tony Blair, based on “predicted economic growth”.

A favourable economic outlook in the United States was also a significant factor in the enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 which, for the first time ever, allowed Medicare recipients, irrespective of income, to have access to prescription drug coverage. Cost is always a formidable concern, looming over policy manoeuvres, and this, to a large extent, informs and underlies the expansion or contraction of health care baskets. Since no economy can sustain the provision of all health benefits upon demand, it follows that rationing of care is not incompatible with but integral to a human rights approach to health care, provided such rationing is fair and equitable.

CONCLUSION

In this discourse, two concerns were implicitly raised but not comprehensively addressed. However these concerns are critical to the thrust and significance of this article, particularly in terms of providing an accurate contextual background to questions pertaining to the justiciability of the right to health care in Nigeria and justifications for the various positions espoused, some of which, by reason of necessity, stray from dominant traditions. First, critics might question whether the court system is the proper mechanism for ensuring access to health care and related goods and services. Reference might be made to jurisdictions where courts are generally passive not only in claims pertaining to health care but also in other resource allocation matters. In these countries, the argument goes, there is no constitutional or statutory right to health care, yet citizens enjoy robust access to health services. Why not endorse a similar system for Nigeria?


176 The prescription drug coverage went into effect on 1 January 2006. For explanations as how the statute affects medical coverage, see “Want to learn more about the new prescription drug coverage?” available at: <http://www.medicare.gov/medicareereform/drugbenefit.asp> (last accessed 23 July 2007).

177 Concern about the rising cost of health care is a constant feature of policy debates in all systems. In the United States, for instance, it is estimated that federal spending on social security, Medicare and Medicaid will jump from 9% to 28% of gross domestic product in 2050 if spending is maintained at current levels. M Barone “Slouching towards France” (17 April 2006) US News & World Report, available at: <http://www.usnews.com/usnews/news/articles/060417/17barone.htm> (last accessed 24 July 2007).

178 Sachs J in Soobramoney, above at note 144 at para 52.
It is true that constitutionalization or statutory recognition of the right to health care is not a necessary condition for access to adequate health services. Admittedly, there are jurisdictions with robust access to health services without a constitutionally or statutorily entrenched right to health care. In these jurisdictions, access is operationalized in the form of state programmes or policies, reinforced by ancillary rights embodied quite often in a human rights instrument. A shared characteristic of all these systems is political sensitivity of the governments, as a result of which there is little or no need for a constitutional or statutory guaranteed right to health care. However, in emerging democracies such as Nigeria and similarly situated countries, actualizing the right to health care and other socio-economic benefits is fraught with a plethora of difficulties, the least of which is not that the government is, for the most part, unresponsive and insensitive to the needs of the people. Consequently, it is necessary in these

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179 Neither is juridical validation. Though undeniable that judicial recognition of the right to health care will probably not translate into the immediate availability of the core elements needed for its enjoyment, it does achieve an important goal. It marks the beginning of a tripartite dialogue in which the judicial and legislative (having enacted the law) arms are on one side, inviting participation of the executive branch: an invitation that a responsible government (or one so aspiring) can ill-afford to ignore. This is the context that brings to the fore the importance of firm judicial presence in human rights discourse, particularly in relation to its role as an arbiter of socio-economic rights disputes.

180 For instance, the Committee on ESCR, being cognizant of varying socio-political situations in different jurisdictions, allows each state party to the ICESCR wide latitude of discretion in determining the appropriate means of implementing its obligations under the covenant. The undertaking “to take steps” in art 2 (1) of the ICESCR means that any system that could operationalize the right to health care through appropriate means (legal, administrative, financial, educational or social measures) is deemed to be compliant with the covenant. See general comment no 3, above at note 131 at para 7; general comment no 14, above at note 6 at para 53; Maastricht Guidelines, above at note 7 at para 6; Limburg Principles, above at note 7 at paras 7–20.

181 A typical example is the Canadian system. While the Canada Health Act contains far-reaching provisions on access to health care (medical insurance coverage to all Canadians on the basis of need as opposed to ability to pay), it is not a human rights code conferring a right to health care (RSC 1985, c. C-6). However, its operation is heavily influenced by the Canadian Charter of Rights and Freedoms (schedule B to the Canada Act 1982 (UK) 1982, c. 11). Since its enactment, the charter has been consistently invoked and relied upon to determine the propriety of government action with respect to access to physician, hospital and related services. Eldridge v British Columbia [Attorney General] [1997] 3 SCR 624 (Canadian Supreme Court) held that a failure to provide medical interpreter services for deaf patients violated equality rights under sec 15(1) of the charter); Auton (Guardian ad Litem of) v British Columbia (Attorney General) [2004] 3 SCR 657, 2004 SCC 78 (Canadian Supreme Court) held that a failure to fund applied behavioural therapy for autistic children did not violate the children’s sec 15 equality rights; Chaoulli v Quebec (Attorney General) [2005] 1 SCR 791, 2005 SCC 35 (Canadian Supreme Court) held that a prohibition of private health insurance violates the right to life and security of persons under the Quebec Charter of Human Rights and Freedoms.
countries that access to health services be imbued with the normative force of a right, recognized at least statutorily but preferably constitutionally. Moreover, adopting a rights-based approach redefines and recasts access issues in terms of claims, obligations and violations, placing claimants on a firmer footing upon which to challenge governmental actions infringing their rights.

Because policies can be unilaterally modified, whittled down or completely abrogated by an incoming or even the extant government at any time (without legal repercussions), a statutory or constitutional regime is the preferred option. Similarly, given that it is comparatively less onerous to amend or repeal statutes, the ideal choice for securing health care needs in Nigeria is via constitutionalization, as it is a truism that a constitutional right provides the strongest basis for a claim to an entitlement.

Second, some commentators are not enamoured with what they perceive to be usurpation by courts of roles traditionally reserved for political organs of government and in fact question the legitimacy of such actions. Their perspective is that courts lack the requisite institutional capacity essential in resource allocation matters and as such ought to be wary of wading into and questioning decisions made by competent politically accountable bodies. The response to this concern is not complicated. Ideally, as suggested earlier, the role of the judiciary should mirror the ethos of separation of power, in that deference must be given to executive and legislative actions unless they are exercised improperly. This derives from a tacit understanding of cooperation and mutuality of purpose interlinking the three branches of government in addressing the needs of the people from whom they derive legitimacy.

But then again, in developing countries, the legislative and executive branches have, for reasons some of which were discussed above, unabashedly ignored the welfare of the people. Over the years, financial constraints became a perennial subterfuge for irresponsible governance. Yet, as the Committee on ESCR unequivocally stated, no sovereign nation is incapable of providing basic health services for its citizens. This verdict is keyed to an understanding that the cost of goods and services needed to achieve compliance dictates that its provision will not overwhelm national resources.

Manifestation of overt judicial activism by courts in India, enthusiastically endorsed in this article, merely recognizes the failure of the other two branches in discharging their constitutional obligations. This failure creates a void which the court must step in to fill. From this perspective, therefore, a more proactive judicial role ought not be challenged but encouraged as crucial and fundamental in forestalling what has become an endemic feature of third world countries: failed governance.

182 Maastricht Guidelines, above at note 7 at para 10.
183 Ibid.
Ultimately, the crux of the matter is larger than doctrinal theorization of the proper judicial role in the overall scheme of governance. For the poor and oppressed millions, most of whom are miserably toiling and languishing in third world countries, the possibility of judicial attentiveness to their needs represents perhaps their best chance: the only legitimate hope and real means of accessing the most vital, yet basic, of human needs, namely health care. After all, as liberal theorists would argue, without good health, what value is life? Reduced to its lowest common denominator, therefore, the gravamen of this article is social justice in health care and the most pragmatic mechanism for its actualization. This is the issue and essence of justiciability of the right to health care, at least in Nigeria.