A Right to Universal Health Coverage in Nigeria?
A Transformative Proposal from a Comparative Perspective

Uchechukwu Ngwaba

LLB (Honours) (University of Jos); BL (Nigerian Law School);
LLM (University of Lagos)

Macquarie Law School
Macquarie University
Sydney, Australia

This thesis is presented for the degree of Doctor of Philosophy in Law
February 2017

TABLE OF CONTENTS

TABLE OF CONTENTS iii

ABSTRACT vii

DECLARATION viii

ACKNOWLEDGEMENTS ix

CHAPTER 1: INTRODUCTION 1
- 1.0 Preamble 1
- 1.1 Background 4
- 1.2 Theoretical Framework 6
- 1.3 Problem Statement 7
- 1.4 Concept and Meaning 9
  - 1.4.1 What is Being Transformed? 10
  - 1.4.2 By Whom? 11
  - 1.4.3 To What End? 11
  - 1.4.4 How? 12
- 1.5 Research Methodology 12
- 1.6 Scope of the Thesis 13
- 1.7 Structure of the Thesis 13

CHAPTER 2: THE RIGHT TO HEALTH AS 'LEGAL POSITIONS' 17
- 2.0 Introduction 17
- 2.1 The Paradigm of Legal Positions 20
  - 2.1.1 The Basic Structure of Legal Positions 23
  - 2.1.2 The Subject-Matter of Legal Positions 28
  - 2.1.3 The State as Addressee 36
  - 2.1.4 Summary 37
- 2.2 Universal Health Coverage: Problems, Promise, Strengthening and Convergence 37
  - 2.2.1 The Problem with the Framing of Universal Health Coverage 38
  - 2.2.2 The Promise Offered by Universal Health Coverage 40
  - 2.2.3 Imperatives for Strengthening Universal Health Coverage 42
  - 2.2.4 The Case for Converging Universal Health Coverage with the Right to Health 43
  - 2.2.5 Summary 43
- 2.3 State Organs, Domestic Social Activism and Legal positions on the right to health 44
  - 2.3.1 The Context of Domestic Social Activism 45
  - 2.3.2 State Organs and Legal positions on the right to health 49
  - 2.3.3 Summary 53
- 2.4 Securing Legal positions on the right to health through a Synergy of Strategies 54
  - 2.4.1 Legal Positions in the International Context 55
  - 2.4.2 Legal Positions in the Constitutional Context 56
  - 2.4.3 Legal Positions in the Policy and Legislative Context 57
  - 2.4.4 Legal Positions in the Judicial Context 57
  - 2.4.5 Summary 57
- 2.5 Conclusion 58

CHAPTER 3: NIGERIA, THE COMPARATORS, AND HEALTH INDICATORS 61

3.0 Introduction 61
3.1 Rationale for Choice of Comparators.....61
3.1.1 Demographic Considerations 63
3.1.2 Political Considerations.....64
3.1.3 Geo-political Considerations 64
3.1.4 Economic Considerations.....65
3.1.5 Legal Considerations 65
3.1.6 Institutional Considerations.....65
3.2 Situating Nigeria and the Comparators 66
3.2.1 Geography and Demography.....66
3.2.2 The Political Context.....75
3.2.3 The Geo-Political Context.....77
3.2.4 The Economic Context 79
3.2.5 The Legal Context 81
3.2.6 The Institutional Context.....83
3.3 Health Indicators 84
3.3.1 The Health-related Millennium Development Goals 84
3.3.2 Trends in Health Financing 98
3.4 Conclusion.....105

CHAPTER 4: THE INTERNATIONAL CONTEXT 107
4.0 Introduction 107
4.1 Institutional Liberalism and Why States Comply with International Treaties 109
4.2 The Universal Periodic Review (UPR) Mechanism 112
4.2.1 Nigeria's First UPR Cycle.....113
4.2.2 Nigeria's Second UPR Cycle 116
4.2.3 Brazil's First UPR Cycle 118
4.2.4 Brazil's Second UPR Cycle.....120
4.2.5 India's First UPR Cycle.....121
4.2.6 India's Second UPR Cycle 124
4.2.7 South Africa's First UPR Cycle 125
4.2.8 South Africa's Second UPR Cycle.....127
4.2.9 Reflective Summary 130
4.3 State Parties' Report to Treaty-based Bodies on Health 135
4.3.1 The Ratification of Treaties and Fulfilment of Reporting Obligations ..135
4.3.2 The Report to Treaty Bodies 138
4.3.3 Reflective Summary 149
4.4 Engagement with Regional Mechanisms on the Right to Health.....149
4.4.1 Brazil and the Inter-American System 150
4.4.2 Nigeria, South Africa and the African Union System.....156
4.4.3 Reflective Summary 157
4.5 Conclusion.....158

CHAPTER 5: THE CONSTITUTIONAL CONTEXT.....161
5.0 Introduction 161
5.1 Deconstructing Constitutional Rights Norms 162
5.1.1 Norm versus Normative Statement 163
5.1.2 Criteria for Identifying Constitutional Rights Norms 166
5.1.3 Constitutional Rights Norms as Prior.....166
5.1.4 Constitutional Normative Statements Devoid of Meaning 169
5.2 Constitutional Rights Norms and Rights.....172
5.2.1 Rights against the Legislature 172

5.2.2 Rights against the Executive 178
5.2.3 Rights against the Judiciary 179
5.3 The 'Radiating Effect' of Constitutional Rights Norms 179
5.3.1 The Radiating Effect on the Legislature 180
5.3.2 The Radiating Effect on the Executive 181
5.3.3 The Radiating Effect on the Judiciary 181
5.3.4 The Radiating Effect on Domestic Social Actors 182
5.4 Conclusion 182

CHAPTER 6: THE POLICY AND LEGISLATIVE CONTEXT 185
6.0 Introduction 185
6.1 Policy and Legislation on the Right to Health 186
6.1.1 Health Policies and Legislation in Nigeria 188
6.1.2 Health Policies and Legislation in Brazil 195
6.1.3 Health Policies and Legislation in India 203
6.1.4 Health Policies and Legislation in South Africa 207
6.2 Implications for Legal positions on the right to health 217
6.3 Implications for Health Financing 219
6.4 Conclusion 220

CHAPTER 7: THE JUDICIAL CONTEXT 223
7.0 Introduction 223
7.1 The Literature 225
7.1.1 Litigating Health Rights 226
7.1.2 First Assumption on the Health System 228
7.1.3 Second Assumption on the Legal System 235
7.2 The Jurisprudence 237
7.2.1 Nigeria's Jurisprudence 237
7.2.2 Brazil's Jurisprudence 238
7.2.3 India's Jurisprudence 239
7.2.4 South Africa's Jurisprudence 240
7.3 Taxonomy on the Effect of Judicialisation of the Right to Health 242
7.3.1 The Courts as Enabling the Right to Health 242
7.3.2 The Courts as Amplifying the Right to Health 243
7.3.3 The Courts as Impeding the Right to Health 243
7.3.4 The Courts as Ambivalent Towards the Right to Health 245
7.4 Conclusion 246

CHAPTER 8: CONCLUSION 249
8.0 Introduction 249
8.1 Summary 249
8.1.1 Findings from the International Context 250
8.1.2 Findings from the Constitutional Context 252
8.1.3 Findings from the Policy and Legislative Context 255
8.1.4 Findings from the Judicial Context 256
8.2 Recommendations: a Blue Print for Transforming the Health System of Nigeria through the Right to Health 258
8.2.1 Recommendations for the International Context 258
8.2.2 Recommendations for the Constitutional Context 259
8.2.3 Recommendations for the Policy and Legislative Context 260
8.2.4 Recommendations for the Judicial Context 260

BIBLIOGRAPHY 263
A *Articles/Books/Reports* 263

B *Cases* 284
C *Legislation* 285
D *Treaties* 287
E *Others* 288

ABSTRACT

Utilising comparative legal methodology, this thesis develops a framework for transforming the health system of Nigeria through the right to health. It argues that by conceiving the right to health as a set of legal positions to universal health coverage and applying this framework across the international, constitutional, policy and legislative, and judicial domains, the health system of Nigeria can be transformed to achieve better health outcomes. It conceptualises better health outcomes as significant reductions in the mortality and morbidity ratio, in the incidence of communicable and non-communicable diseases; and improvements in underlying determinants of health.

Informing the thesis problem is the marginal position of health and the poor treatment of the right to health in Nigeria. This is evidenced by way the right has been poorly engaged with at the international level, the weak framing of the right in the constitution, the non-enforcement of legislative provisions guaranteeing the right, and the reluctance of the courts to interpret the right in a way that secures its legal effect. In addition, health outcomes in the country, as revealed by key health indicators kept by the World Health Organisation and other international institutions, show that the health system of Nigeria performs poorly when compared to those of Brazil, India and South Africa, which serve as comparators to Nigeria.

Using the mixed-method approach to examine a variety of data sources, the thesis finds that the health outcomes recorded for Nigeria and the comparators largely reflect their level of engagement with the right to health in the international, constitutional, policy and legislative, and judicial domains. Brazil and South Africa, which show better levels of engagement with the right to health than Nigeria and India, also achieve better health outcomes. The significance of this finding is that it shows that by strengthening the right to health across these four domains, better health outcomes are likely to be achieved in Nigeria. The thesis maps a blueprint for transforming the Nigerian health system by bolstering engagement with the right to health across these domains.

DECLARATION

I certify that the work in this thesis 'A Right to Universal Health Coverage in Nigeria? A Transformative Proposal from a Comparative Perspective' has not been submitted for a degree at any other university or institution other than Macquarie University.

I also certify that the thesis is an original piece of research and has been written by me. Any help and assistance that I have received in my research work and in the preparation of the thesis have been appropriately acknowledged.

In addition, I certify that all information sources and literature used are acknowledged in the thesis.

Uchechukwu Ngwaba
Student No: 43528155
Date: 17 February 2017

ACKNOWLEDGEMENTS

I owe an eternal debt of gratitude to Professor Epiphany Azinge SAN, whose generousity and support made it possible for me to commence the first year of my candidature. I also thank Macquarie University for the generous iMQRES scholarship that funded the last two years of my candidature.

I am deeply indebted to my supervisors, whose steady guidance made it possible for the thesis to take its final shape. I am particularly grateful to Professor Brian Opeskin who started out as my principal supervisor and remained with me till the very end, taking up a role as my adjunct supervisor when he moved to the University of Technology, Sydney. I owe a debt of gratitude to Associate Professor Carlos Bernal-Pulido for taking up the role of my principal supervisor after Professor Opeskin left, and guiding me through a critical phase of my work. I am grateful to Associate Professor Sonia Allan who served as my associate supervisor throughout the course of the thesis, continuing to work with me even after she left Macquarie University.

This thesis is dedicated to my wonderful family who have shown me such untiring love: Ebube Chineke and the Ngwabas (Linus, Monica, Chidinma, Nnaemeka, Deborah, Esther, Daniel, Nicholas and the rest of the *Amala*). They have been a steady source of support, love and encouragement to me throughout the years. The discipline they instilled in me in the early years of my life has been a ready resource upon which I have drawn while undertaking this thesis.

I acknowledge my family in Australia, the wonderful members of Sydney West University Bible Fellowship and Macquarie University Bible Fellowship. They were a much-needed pillar of support through the course of this thesis.

My brother Charles Nwasor, and his wonderful family made this tedious journey more tolerable. Professor Obiora Okafor, Waripamo Azorbo, Gesilayefa Azorbo and many others who I cannot mention here have my eternal gratitude for their mentorship and friendship.

This thesis was edited by Elite Editing, and editorial intervention was restricted to Standards D and E of the *Australian Standards for Editing Practice.*

Now to the hopeless and distraught in ‘my fatherland’, may this work bring you desperately needed succour by inspiring efforts to transform the health system to achieve better health outcomes.

CHAPTER 1: INTRODUCTION

1.0 Preamble

This thesis makes the claim that if the 'right to health'—understood as a set of legal positions to universal health coverage—is implemented in Nigeria, better health outcomes are likely to result. The means suggested for its implementation is by compliance and engagement with the relevant international treaty framework, constitutional entrenchment, legislation and policy and judicial enforcement driven by domestic social activism. The better health outcomes envisaged include significant reductions in mortality rates and morbidity ratio and in the incidence of communicable and non-communicable diseases; and improvements concerning underlying determinants of health.

The thesis adopts a comparative approach to its inquiry that situates the health system of Nigeria with respect to those of Brazil, India and South Africa ('the comparators'). These countries have been specifically chosen for several reasons, including their similarities and differences in the way they have structured their health and legal systems vis-à-vis Nigeria.[1] The choice of human rights as a framework for transforming the health system of Nigeria situates the thesis against a backdrop of controversies characterising claims about the right to health in international law, where the right first emerged and gained traction; and in domestic legal systems, where the right has witnessed increasing levels of uptake and has been used by social activists and other stakeholders in a number of countries to push for health system reform.[2]

These controversies have often raised doubts about the internal logic and normative basis of the right to health.[3] In refuting these doubts, health law scholars and activists have often invoked arguments around social solidarity to justify the campaign for public health through the right to health.[4] However, such invocations do not state in precise terms the specific measures that states need to adopt to bring about a transformation of their health

---

1 Chapter 3 introduces the comparative aspect of the thesis and offers a detailed discussion of the motivations behind the choice of Brazil, India and South Africa as comparators of Nigeria.

2 Examples of countries where this has happened include Argentina, Brazil, Colombia, Costa Rica, India, South Africa, Thailand etc.

3 See for instance James Griffin, *On Human Rights* (Oxford University Press, 2008); and Onora O'Neill, 'The Dark Side of Human Rights' (2005) 81(2) *International Affairs* 427.

4 See for instance Jennifer Prah Ruger, 'Towards a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18(2) *Yale Law Journal of Law & the Humanities* 273; Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter* (University of Pennsylvannia Press, 2016); Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2005).

systems, through the right, to achieve better health outcomes. One major reason for this is that the right to health, as a right deriving principally from the *Constitution of the World Health Organization 1946*[5] and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR)[6] has not been framed in terms that are sufficiently precise to support such a response. The difficulties with consensus building at the international level, particularly around the negotiation of economic and social rights covenants,[7] may explain why the right to health in international law is loosely framed.

Nonetheless, the right remains relevant to the campaign for public health because of its potential to change the discourse and empower health rights campaigners.[8] The problem, however, is that the international system is not well suited for appropriately framing the power relations that arise when claims are made about the right to health due to the absence of effective enforcement mechanisms at that level. This is the basis for the argument made in this thesis that domestic systems need to lead the charge in specifying meaning, content and the enforcement of the right to health based on what they perceive to be the most pressing health needs of their system. In the context of Nigeria, the thesis identifies the most pressing health needs to be the high mortality rates and morbidity ratio,[9] the increasing incidence of communicable and non-communicable diseases, and the poor situation with respect to underlying determinants of health.

In appropriately framing the power relations arising from the right to health in the context of Nigeria, the thesis draws from Robert Alexy's constitutional theory explicating constitutional rights as legal positions that involve a tripartite relationship between beneficiaries of rights, the subject-matter of rights and the addressees of rights.[10] The beneficiaries of the right to health are those who can claim the right, namely the general population of Nigeria. The subject-matter involves the entitlements inuring to beneficiaries as a result of the right to health. In this regard, universal health coverage, as

---

5 *Constitution of the World Health Organization* Preamble, 62 Stat. 2697, 14 U.N.T.S. 185 (22 July 1946).

6 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) art 12(1).

7 For the difficult drafting history of the ICESCR see John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012); for that of the *WHO Constitution* see World Health Organization, *The First Ten Years of the World Health Organization* (1958).

8 Alicia Yamin rightly argues that human rights notions 'implicitly embody perceptions of power'. See Alicia Ely Yamin, 'Defining Questions: Situating Issues of Power in the Formulation of a Right to Health Under International Law' (1996) 18 *Human Rights Quarterly* 398, 400.

9 Also sometimes referred to as morbidity rate, this refers to 'the frequency with which a disease appears in a population'. See Investopedia, *Morbidity Rate* (2017) <http://www.investopedia.com/terms/m/morbidity-rate.asp>.

10 See Robert Alexy, *A Theory of Constitutional Rights* (Julian Rivers trans, Oxford University Press, 2002) 120.

framed by the World Health Organization (WHO),[11] is identified as the subject-matter of the right to health. The thesis suggests that universal health coverage should be understood as a means to achieving better health outcomes in Nigeria; in that sense, it goes beyond the clinical focus offered by WHO's conception as 'the availability of health services, to the people who need them, at a cost to whosoever must pay'.[12] By linking universal health coverage to better health outcomes, the thesis aims to avoid the imprecision that characterised earlier iterations of the right to health in international law.[13] The thesis further identifies the Nigerian state as an addressee of the right to health. Organs of state in Nigeria (the legislature, executive and judiciary) play a major role in formulating and implementing policies that influence health in the country. By focusing on the state, as opposed to private actors, as the addressee of the right to health, the thesis does not thereby suggest that only the state influences legal positions on the right to health. The focus on the state is because even in instances where private actors are involved in the health system, the state retains an overarching control over how those private actors behave.

To drive this framework, the thesis argues that strong state organs or, in their absence, active domestic social actors, are required. The state organs in contemplation are those controlled by the legislature, executive and judiciary which influence health outcomes. However, the thesis argues that state organs in Nigeria are either weak or unwilling to act in the best interest of citizens, especially with regard to the fulfilment of the right to health. In these circumstances, the thesis suggests that domestic social actors need to mobilise to drive this framework by engaging and socialising citizens; encouraging active citizenship; providing alternative accountability mechanisms to make up for the weakness or lack of interest of state organs; and serving as a constant reminder to the political elites that in democratic systems, real power lies with the people and not the state organs controlled by the political elites.

---

[11] See *Sustainable Health Financing, Universal Coverage and Social Health Insurance,* WHA Res 58.33, 9th plen mtg, Doc A58/20 (25 May 2005).

[12] See World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) 2; The linkage of universal health coverage with better health outcomes is absent from WHO's formulation of universal health coverage. WHO's framing does not also explicitly connect universal health coverage with the right to health.

[13] For a time, until the clarification offered by the Committee on Economic Social and Cultural Rights (CESCR), the definition of the right to health as the 'right to the highest attainable standard of health' by art 12(1) of the ICESCR was a serious area of criticism of the right. See Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000) [8].

The thesis further claims that the framework of the right to health as legal positions to universal health coverage needs to be engaged with through a synergy of strategies that encompass the international, constitutional, policy and legislative, and judicial contexts. In each of these contexts, the thesis uses the comparative method to take account of the experiences of Nigeria and the comparators, and on this basis, suggest measures that Nigeria can take to strengthen legal positions on the right to health in its system. Through this process, the thesis argues that universal health coverage can be attained, and better health outcomes are likely to result.

1.1 Background

Nigeria's health system is performing poorly, and this has been the case for some time now. This conclusion is informed by the analysis of data sets on a number of key health indicators widely accepted as a measure of the status of health and healthcare delivery in different countries;[14] it is also informed by the view of scholarship on the ground in Nigeria.[15] The data sets used are from sources such as the WHO, the World Bank and other international institutions whose work influences the broad field of international public health. While Nigeria is by no means the only country whose health system is not performing well, its context is unique because of its position as the most populous country on the African continent[16] and because it has one of the fastest growing populations in the world;[17] is recognised as an economic and political power house within and beyond the African continent;[18] and is blessed with abundant human and natural resources.

---

[14] See Chapter 3 for this discussion.

[15] A survey of the literature on the situation of health and health care delivery in Nigeria reflects a great deal of unanimity on the view that it is not performing so well. See for instance: Ogoh Alubo, 'Power and Privileges in Medical Care: An Analysis of Medical Services in Post-Colonial Nigeria' (1987) 24(5) *Social Science & Medicine* 453; Dennis Ityavyar, 'Health Services Inequalities in Nigeria' (1988) 27(11) *Social Science & Medicine* 1223; Sally Hargreaves, 'Time to Right the Wrongs: Improving Basic Health Care in Nigeria' (2002) 359 *The Lancet* 2030; Mike Asuzu, 'The necessity for a health systems reform in Nigeria' (2004) 16(1) *Journal of Community Medicine & Primary Health Care* 1; Rufus Ngowu, James Larson and Min Su Kim, 'Reducing Child Mortality in Nigeria: A Case Study of Immunization and Systemic Factors' (2008) 67 *Social Science & Medicine* 161; Sunday Adedini et al, 'Barriers to Accessing Health Care in Nigeria: Implications for Child Survival ' (2014) 7 *Global Health Action* 1.

[16] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, World Population Wallchart.* ST/ESA/SER.A/378.

[17] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* ESA/P/WP.241, 4.

[18] BBC, 'Nigeria Becomes Africa's Biggest Economy', *BBC NEWS Business* 2014 <http://www.bbc.com/news/business-26913497>; in 2016, Nigeria lost this position to South Africa following a recession that affected its economy. See Obinna Chima, 'S'Africa Overtakes Nigeria as Africa's Biggest Economy', *THISDAY* 11 August 2016 <http://www.thisdaylive.com/index.php/2016/08/11/safrica-overtakes-nigeria-as-africas-biggest-economy/>.

Interventions in the health system of Nigeria by the political elites has often taken the form of newly constructed or refurbished hospital complexes, recently purchased hospital equipment or fortuitous triumph over a serious epidemic or disease burden[19] put forward as demonstrating positive changes to the health situation in the country. While these interventions and occurrences are necessary, they barely scratch the surface—at best, they are 'bandaid' solutions masking a deeper malaise. They do not address the structural and systemic inadequacies that characterise healthcare delivery in Nigeria, nor do they remedy the 'pathologies of suffering and vulnerability'[20] in the health system. For instance, until 2014, when the *National Health Act 2014* of Nigeria was promulgated,[21] there was no framework legislation setting down the basis for standards and specifying the roles and responsibilities of all stakeholders in the health system. The long-term absence of such legislation is argued in this thesis to be symptomatic of the peripheral, as opposed to central, position of health concerns in the country—a position that this thesis maintains has changed little despite the triumph of finally securing a national health legislation.

Constitutionally speaking, although health is one of the economic and social rights guaranteed in the Fundamental Objectives and Directive Principles of State Policy in Chapter II of the *Constitution of Nigeria*,[22] it is not a justiciable right.[23] While another avenue opens up for the justiciability of the right to health in Nigeria through the *African Charter on Human and Peoples' Rights* ('the African Charter'),[24] which has been incorporated into Nigeria's domestic law by the *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* ('the African Charter Act'),[25] this avenue has not gained much ground in the country. Pronouncements of Nigeria's Supreme Court, the highest court in the land, indicate that although the African Charter Act 'possesses a

---

19 In 2014 when Nigeria succeeded in stopping the spread of the Ebola Virus Disease that was brought into the country by a Liberian visitor (Patrick Sawyer) through the Lagos International Airport, this accomplishment was widely publicised and used by the former President, Goodluck Jonathan, to campaign for votes in the 2015 Presidential elections.

20 Here the thesis borrows from Paul Farmer who writes about the 'pathologies of power' and how it has affected the health and human rights of the poor. See Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2005)4.

21 See *National Health Act 2014* (Nigeria).

22 See *Constitution of Nigeria 1999*, s 17(3)(d).

23 Ibid s 6(6)(c).

24 *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986), art 16 guarantees the right to health.

25 *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria); s 12(1) *Constitution of Nigeria 1999* requires international treaties to be enacted into law by the National Assembly before they can have domestic effect. As such *the International Covenant on Economic Social and Cultural Rights* (the main international treaty guaranteeing the right to health) which is yet to be incorporated into Nigeria's domestic law, does not have the force of law in the country.

"greater vigour and strength" than any other domestic statute',[26] it ranks below the constitution and thus conflicts between the constitution and the African Charter must be resolved in favour of the constitution.[27]

In addition to the foregoing, the constitutional scheme allocating responsibility for health in the country is confusing and ineffective. First, it specifies that local government councils (the least funded tier of government in the country)[28] are the primary entities with responsibility for health;[29] second, it grants the federal legislature exclusive powers to promote and enforce the economic and social rights (including the right to health) contained in Chapter II of the *Constitution of Nigeria*;[30] and third, it grants state governments residual powers to provide for the functions of local government councils (including health functions).[31] Under this constitutional scheme, no direct responsibility is conferred on the federal and state governments for the provision and maintenance of health services. This is the background that has inspired this thesis.

1.2 Theoretical Framework

Robert Alexy's constitutional theory on *legal positions*[32] is used in this thesis to strengthen the broad framework for transforming the health system of Nigeria, through the right to health, to achieve better health outcomes. Also relevant to the thesis is the concept of *transformation* underpinning the engagement with the right to health. In Section 1.4, transformation theory is discussed to clarify its purpose in the thesis.

Alexy's legal positions deconstruct the power relations at play in the claim of 'a right to something'. Three key elements are identified by Alexy to interact in such a claim: the beneficiary of the right to something; the subject-matter of the right to something; and the addressee of the right to something.[33] Building on this theory, the thesis argues that claims about the right to health in Nigeria should be understood as identifying the general population of Nigeria as the beneficiaries; an expanded vision of universal health coverage as the subject-matter; and the Nigerian state as the addressee of the right to

---

26 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).
27 Ibid.
28 *Allocation of Revenue (Federation Account, Etc.) Act 1982* (Nigeria) s 1.
29 *Constitution of Nigeria 1999*, Fourth Schedule, s 2(c).
30 Ibid Second Schedule, Part I, Item 60(a).
31 Ibid s 7(1) and Fourth Schedule, s 2(c).
32 Alexy, above n 10; Alexy's framework draws important concepts from Jeremy Bentham (see Jeremy Bentham, *Of Laws in General* (Athlone Press, 1970)); Lars Lindahl (see Lars Lindahl, *Position and Change: A Study in Law and Logic* (D Reidel Publishing, 1977)); and Georg Jellinek (see Georg Jellinek, *System der subjektiven öffentlichen Rechte* (Mohr Siebeck, 1905)).
33 Alexy, above n 10.

health. The thesis further argues that such a claim is operable in four key sites: the international, constitutional, policy and legislative, and judicial contexts. In this regard, the thesis goes beyond the constitutional construct offered by Alexy's theory. To drive this framework, the thesis identifies the essential contributions to be made by strong state organs[34] and/or active domestic social actors. In this sense, Alexy's concept of positive rights is central to the thesis.

A key aspect of the framework of legal positions developed by the thesis is the link created with better health outcomes. In this regard, the thesis argues that (a) if strong state organs are able to fulfil their roles as obligated entities in a framework of the right to health as legal positions to universal health coverage; (b) or in the event of weakness or unwillingness of such state organs, domestic social actors are able to mobilise to canvass for legal positions on the right to health; (c) then universal health coverage can be attained and better health outcomes are likely to result.

1.3 Problem Statement

The recognition of a right to health in international law and its subsequent uptake in the constitutional, policy and legislative framework of many states throughout the world was expected to secure for the population of those states opportunities to achieve the 'highest attainable standard of health'.[35] Unfortunately this has not been the case, as the right to health framework has suffered from 'imprecise standards, many of which are only progressively realisable and often unenforceable'.[36] Despite this weakness, the right to health framework is still widely acknowledged as best suited (more than any other framework) to help states achieve health justice.[37] This is because when employed in the campaign for public health, it 'forces one to see individual faces among the ubiquitous pools of misery'[38] in society.

---

34 Whenever used, this refers to the legislature, executive and judiciary, or any institution under them.

35 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) art 12(1).

36 Lawrence O. Gostin, *Global Health Law* (Harvard University Press, 2014) xv; see also *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) art 2(1).

37 See for instance Gostin, above n 36; Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter* (University of Pennsylvannia Press, 2016)4; Andrew Clapham, Mary Robinson and Scott Jerbi (eds), *Realizing the Right to Health*, Swiss Human Rights Book (ruffer & rub, 2009); Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia - Hart, 1998).

38 Yamin, above n 8, 398.

Nigeria is among the states to have ratified the ICESCR and other international treaties guaranteeing the right to health.[39] However, Nigeria's implementation of that right in its domestic system through constitutional guarantees, policy and legislative enactments, and/or judicial enforcement has been less than ideal. What is more, Nigeria's health system is performing poorly when measured against universally accepted indicators of well-performing health systems; it also fails to measure up against those of the comparators. The thesis claims that what is common to the comparators, and missing in the context of Nigeria, is that to varying degrees, they have paid better attention to the uptake and implementation of the right to health in their domestic systems.

A number of scholarly works have examined contributions that the right to health can make to secure health justice and better health outcomes in different countries. Many of these works approach this issue from the perspective of health rights litigation at the national and international level. For instance, *Courting social justice: judicial enforcement of social and economic rights in the developing world,* edited by Varun Gauri and Daniel Brinks,[40] undertakes a comparative study of litigation on health and education in five countries: Brazil, India, Indonesia, Nigeria and South Africa. It examines the dynamics of this litigation, identifying legal opportunity structures (i.e., legal processes and their effects on the design and implementation of public policy on health) and factors enabling social rights litigation; the effect of court decisions, whether they result in the redistribution of social and economic resources; and the ethical value of using courts to address questions of social and economic injustice. *Litigating health rights: can courts bring more justice to health?*[41] edited by Alicia Ely Yamin and Siri Gloppen, examines the circumstances under which health rights litigation is a good thing and who benefits from it.

On the other hand, there are a number of sceptical scholarly literature on the desirability of investing courts with powers to review or render final decisions concerning economic and social rights guarantees in the constitution. Scholars such as Nicholas Haysom and D M Davis who respectively advanced this view during the drafting process of South Africa's Constitution, questioned whether economic and social rights could be given a

---

39 Further discussion about Nigeria's ratification status of treaties on the right to health is offered in Chapter 4.

40 Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008).

41 Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011).

meaningful role in a constitutional democracy;[42] or whether by investing courts with these powers, judges would not inevitably overstep the boundaries of their legitimate function.[43]

These studies, and many more, lay a strong foundation for the work undertaken in this thesis. However, their focus on the litigation of the right to health limits the view on how the implementation of that right can occur without necessarily involving the courts, or using the courts as a last resort. For instance, how can the uptake of the right to health be inspired by the activities of state organs and/or domestic social actors pushing for stronger legal positions on the right to health? Should there be only one approach—litigation—to the implementation of the right to health or should there be a synergy of approaches that combines other sites of action to achieve the core objectives of the right to health? In the context of Nigeria, what does it mean to push for the implementation of the right to health and how can it be applied to the policy landscape to transform the poor fortunes of the health system?

In terms of comparative methodology, this thesis contributes to the above discourse by developing a taxonomy for classifying the effects of the litigation of the right to health. The thesis suggests that the resort to litigation in the campaign for public health yields one of four possible outcomes for the right: it may result in the courts enabling the right to health (e.g. India); it may position the courts as amplifiers of the right to health (e.g. South Africa); it may result in the courts impeding the effective realisation of the right to health (e.g. Brazil); and/or it may lead to the characterisation of the courts as ambivalent towards the right to health (e.g. Nigeria). The thesis also claims that while these outcomes may manifest individually in the jurisprudence of these states, often they coincide and complicate our understanding of judicial interventions in this area. This therefore calls for vigilance by courts in their encounter with the right to health through the litigation process.

1.4 Concept and Meaning

Theories about *transformation* cut across different disciplines, bearing meanings informed by and applicable to disciplinary contexts.[44] As engaged with in this thesis,

---

42 Nicholas Haysom, 'Constitutionalism, Majoritarian Democracy and Socio-Economic Rights' (1992) 8 *South Africa Journal on Human Rights* 451.

43 D M Davis, 'The Case Against the Inclusion of Socio-Economic Demands in a Bill of Rights Except as Directive Principles' (1992) 8 *South Africa Journal on Human Rights* 475.

44 Examples of disciplines where transformation theories abound include: Mathematics - Edward Kasner, 'The General Transformation Theory of Differential Elements' (1910) 32(4) *American Journal of Mathematics* 391; Education - Jack Mezirow, 'Understanding Transformation Theory' (1994) 44(4)

transformation is grounded on political science and social theory where scholarly contributions have been quite extensive.[45] The transformation debate gained ground in post-communist societies that were in transition from one political and economic order to another. Transformation theory during this period focused on how to explain what was going on in these societies. For instance, on what theoretical assumptions did social actors involved in the transformation process in these societies base their actions; who produced and who needed transformation theory; and what was being transformed, by whom and to what end.[46] As employed in this thesis, transformation bears a different and more nuanced meaning; namely how the normative framework on health in Nigeria can be reordered to bring about better health outcomes in the country. While this may be so, some of the framing questions in the traditional scholarship on transformation remain relevant to the context of the thesis; to wit, what is being transformed, by whom, to what end and how?

1.4.1 What is Being Transformed?

The health system of Nigeria is the object of the transformation project. What is being transformed is the normative framework on health. Social theory contributes to this discourse by enabling the understanding of why and how Nigeria's normative framework on health has come into existence.[47] As Coleman rightly notes, norms are important because of how they:

Adult Education Quarterly 222; Engineering - Peter Heuberger and Thomas de Hoog, 'Transformation Theory' in Peter S.C. Heuberger, Paul M.J. Van Den Hof and Bo Wahlberg (eds), *Modelling and Identification with Rational Orthogonal Basis Functions* (Springer 2005) 337-358; sociology - Roberto Mangabeira Unger, *Social Theory, its Situation and its Task* (Cambridge University Press, 1987) etc.

45 See for example: Walter Garrison Runciman, *The Methodology of Social Theory* (Cambridge University Press, 1983); Roberto Mangabeira Unger, *Social Theory, its Situation and its Task* (Cambridge University Press, 1987)44; James S. Coleman (ed), *Foundations of Social Theory* (Harvard University Press, 1990); Donald M. MacRalid, *Social Theory and Social History* (Palgrave Macmillan, 2004); Jonathan Joseph, *Marxism and Social Theory* (Palgrave Macmillan, 2006); David C. Bell, *Constructing Social Theory* (Rowman & Littlefield Publishers, 2009); Anthony Elliott, *Contemporary Social Theory: An Introduction* (Routledge, 2014).

46 See Andreas Pickel, 'Transformation Theory: Scientific or Political?' (2002) 35 *Communist and Post-Communist Studies* 105; see also David Stark, 'From System Identity to Organizational Diversity: Analyzing Social Change in Eastern Europe' (1992) 21(3) *Contemporary Sociology* 299; John Pickles and Adrian Smith (eds), *Theorising Transition: The Political Economy of Post-Communists Transformations* (Routledge, 1998); Andreas Pickel, 'Bewteen Social Science and Social Technology: Towards a Philosophical Foundation for Post-Communist Transformation Studies' (2001) 31(4) *Philosophy of the Social Sciences* 459.

47 James S. Coleman, 'The Demand for Effective Norms' in James S. Coleman (ed), *Foundations of Social Theory* (Harvard University Press, 1990) 241-265; James S. Coleman, 'The Realization of Effective Norms' in James S. Coleman (ed), *Foundations of Social Theory* (Harvard University Press, 1990) 266-299.

> specify what actions are regarded by a set of persons as proper or correct, or improper or incorrect. They are purposively generated, in that those persons who initiate or help maintain a norm see themselves as benefitting from its being observed or harmed by its being violated. Norms are ordinarily enforced by sanctions, which are either rewards for carrying out those actions regarded as correct or punishments for carrying out those actions regarded as incorrect.[48]

Norms therefore play a very important role in the hierarchical ordering of principles guiding society. In the context of health, a weak normative framework on health is more likely to be ignored or frequently violated than a strong one. An understanding of how this manifests in Nigeria is vital to mapping out the transformation framework for the health system of Nigeria.

1.4.2 By Whom?

Pickel writes that '[a]ny transformation theory needs to identify the major agents of change. Transformation theory in the political sense has to do so in order to mobilise and empower certain groups and individuals'.[49] There is much sound logic behind this view. The transformation of the health system of Nigeria requires the identification of those who are to drive this process, to establish how they can be mobilised and empowered. Without this process of identification, mobilisation and empowerment, it is difficult to envisage how the transformation project can succeed. It is for this reason that the thesis has identified strong state organs and/or domestic social actors as the agents to be empowered to drive the transformation of the health system of Nigeria. This process needs to occur through appropriate changes to the normative framework on health to advance legal positions on the right to health.

1.4.3 To What End?

The transformation project should have measurable objectives, otherwise it is unlikely to succeed. In defining these targets, this thesis identifies *better health outcomes* as the ultimate goal of the transformation of the health system of Nigeria. Without more, such a conception leads to ambiguity. What is 'better' in terms of health outcomes is relative to existing conditions that offer a basis for comparison. Therefore, the thesis identifies the most pressing areas where poor health outcomes are being experienced in the country,

---

48 Coleman, above n 47, 242-243.
49 Pickel, above n 46, 109.

and argues that better health outcomes should seek to bring about significant improvements in those areas.

1.4.4 How?

This question calls for the clarification of the methods and strategies that have been proposed in the thesis for the transformation of the health system of Nigeria to achieve better health outcomes; and it is addressed throughout the thesis. Essentially, a synergy of four approaches is suggested by this thesis. They call for the engagement of the international, constitutional, policy and legislative, and judicial contexts in a bid to transform the healthcare system of Nigeria to achieve better health outcomes. In each of these sites, specific strategies are outlined for adoption by Nigeria. It is suggested that when adopted, they should result in the mobilisation and empowerment of transformation agents who will drive and manage the transformation of the healthcare system of Nigeria to achieve better health outcomes. Parallels of how a transformative constitutional system can be developed for Nigeria are found in the example of South Africa, whose constitution has been identified as a transformative document 'redressing past harm and developing the society into a future founded on social justice'.[50]

1.5 Research Methodology

A mixed-method approach was adopted for this thesis, informed by the need for flexibility in engaging with a variety of sources and approaches to achieve the research objectives of the thesis. A mixed-method approach to social enquiry, according to Jennifer Green et al., 'involves the planned use of two or more different kinds of data gathering and analyses techniques, and more rarely different kinds of inquiry designs within the same study or project'.[51] In gathering data for this thesis, secondary quantitative data from institutional sources such as WHO were collected and used to carry out broad country comparisons of the situation regarding health in Nigeria and the comparators. In addition, the doctrinal approach—involving the analysis of textual material from primary sources such as constitutional texts, treaties, statutes, decisions of courts, resolutions of international

---

[50] David Bilchitz et al, *Assessing the Performance of the South African Constitution* (International Institute for Democracy and Electoral Assistance, 2016) 9; see also David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press, 2007).

[51] Jennifer C. Greene, Holly Kreider and Ellen Mayer, 'Combining Qualitative and Quantitative Methods in Social Inquiry' in Bridget Somekh and Cathy Lewin (eds), *Research Methods in the Social Sciences* (SAGE Publications, 2005) 274.

bodies, policy documents of government bodies and relevant institutions and so on—was used to further the priorities of the thesis.

The broad focus of the thesis on the right to health, as a set of legal positions to universal health coverage that will likely lead to better health outcomes in Nigeria, situates the thesis as an applied research. One of the aims of applied research is to develop solutions to problems facing society.[52] In addition, the evaluation of past events and developments in global health and the health system of Nigeria, to inform future action in the country, also situates the thesis as historical research.[53]

1.6 Scope of the Thesis

The thesis is limited to a focus on the health system of Nigeria and the effects of state organs and domestic social actors on the framework of the right to health as legal positions. The thesis has not considered the significant influence of private actors[54] or the role of foreign governments and international not-for-profit organisations, whose contributions also affect the right to health in Nigeria.[55] The reason for this exclusion is to keep the thesis within manageable limits so that it adequately addresses the problem it has framed.

1.7 Structure of the Thesis

The research question at the heart of this thesis is whether there are any specific approaches in theory or general law that can be used to strengthen the weak framing of the right to health, such that the right can form the basis for transforming the health system of Nigeria to achieve better health outcomes. The thesis claims that by framing the right to health as a set of legal positions to universal health coverage, and deploying it in international, constitutional, policy and legislative, and judicial contexts, the desired strengthening of the health system of Nigeria can be achieved, and better health outcomes are likely to result.

---

52 Rajendra Kumar, *Research Methodology* (APH Publishing Corporation 2012) 7.

53 Ibid 10.

54 For a work acknowledging the tension between the public and private domain in the quest to achieve the right to health, see Colleen Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide* (Cambridge University Press, 2014).

55 An example of a foreign government assistance to the health system of Nigeria is the work of the Canadian International Development Agency (this agency was merged with the Department of Foreign Affairs in 2013 by the Stephen Harper government) that made extensive contributions, at various occasions, to maternal and child health projects in some states of Nigeria. See Government of Canada, *Project Profile: Accelerating the Reduction of Maternal and Newborn Mortality* (on file with Author); see also Government of Canada, *Project Profile: Enhancing the Prevention of Mother-To-Child Transmission of HIV* (on file with Author).

The justification for this claim is the argument that the weak framing of the right to health in international law has led to an absence of clarity about the specific obligations imposed on states by the right to fulfil in their domestic system. This argument is based on the following premises:

a) that the international context, wherein lies the treaty framework of the right to health, is a site where Nigeria should become more engaged to push for global action on its most pressing health needs, and secure necessary technical and financial assistance to meet its domestic health obligations;

b) that the constitutional context, as the primary site for establishing the normative framework of rights in Nigeria, needs to be reorganised such that only norms that advance legal positions on the right to health are elevated by the constitution, while those that derogate from legal positions on the right to health are expunged from the constitution;

c) that the policy and legislative context where legal norms on the right to health are given effect need to privilege hard law instruments, such as legislation, over soft law instruments, such as policy statements—for the simple reason that hard law instruments create more binding obligations on state organs and thereby strengthen legal positions on the right to health;

d) that the judicial context, which influences legal positions on the right to health by enabling the right, amplifying the right, impeding the right and/or creating uncertainty about the right, should work towards enabling and amplifying the right and as much as possible, avoid impeding or being ambivalent towards it; and

e) that state organs should drive the uptake and strengthening of the right to health as a set of legal positions to universal health covrage; and in the event of unwillingness and/or incapacity of state organs, domestic social actors need to mobilise and drive this process.

These premises are developed throughout the chapters of this thesis as follows.

Chapter 2 develops a framework for the right to health as a set of legal positions to universal health coverage likely to lead to better health outcomes in Nigeria. In doing so, it establishes the basic structure of legal positions and discusses the beneficiaries, subject-matter and addressees of legal positions on the right to health in Nigeria. The chapter then examines the problem with the current framing of universal health coverage, the promise for health systems strengthening, and the case for its convergence with a re-invigorated paradigm of the right to health to secure better health outcomes. The chapter also

discusses how strong state organs and/or active domestic social actors can drive this framework in international, constitutional, policy and legislative, and judicial contexts.

Chapter 3 introduces Brazil, India and South Africa as the comparators for Nigeria, and explains why they have been chosen to serve as comparators. It identifies demographic, political, geo-political, economic, legal and institutional factors as some of the reasons informing the selection of these countries. The chapter also presents data sets on the performance of health systems in Nigeria and the comparators across a number of health indicators. These serve as the basis for assessing the situation regarding health outcomes in Nigeria and the comparators; and provides a reference point for the discussion in other chapters.

Chapter 4 examines the engagement and compliance of Nigeria and the comparators with the right to health obligations they have assumed in the international treaty framework. Engaging *liberal institutionalism*, the chapter argues that there is a strong correlation between states' domestic commitment to the right to health and their engagement and response to treaty obligations in respect of that right. This is because the actions of states on the world stage is shaped by the preferences of political institutions, interest groups, and state actors. The chapter proceeds to document the manifestations of this phenomenon in Nigeria and the comparators; and makes a case for greater engagement and compliance by Nigeria.

Chapter 5 examines how the normative framework of rights in the *Constitution of Nigeria* creates rights enforceable by the population against state organs. It also examines the radiating effect of constitutional rights norms on state organs and domestic social actors—how this radiating effect provides guidelines and impulses for an objective order of principles guiding the uptake and implementation of the right to health in Nigeria and the comparators.

Chapter 6 discusses how the commitment of Nigeria and the comparators to advancing legal positions on the right to health can be gauged by considering whether they have given preference to hard law instruments (like legislation), as opposed to soft law instruments (like policy pronouncements) in their legal systems; and whether they have made clear arrangements by legislation for the financing of their health systems.

Chapter 7 develops a taxonomy for understanding the equity effects of judicial involvement in the right to health. It identifies four outcomes as likely resulting from the litigation of the right to health: that courts enable the right; amplify the right; impede the

right; or are ambivalent towards the right. It discusses these relevant outcomes in the context of Nigeria and the comparators.

Chapter 8 concludes the thesis, providing a summary of its main findings and recommending a number of strategies as a blueprint for the transformation of the health system of Nigeria through the right to health, so that universal health coverage can be achieved and better health outcomes might result.

CHAPTER 2: THE RIGHT TO HEALTH AS 'LEGAL POSITIONS'

2.0 Introduction

Building on the work of Robert Alexy, this chapter develops a framework for the right to health as a set of *legal positions*[1] to universal health coverage that can lead to significant reductions in mortality rates and the morbidity ratio, reductions in the incidence of communicable and non-communicable diseases, and improvements in the situation regarding underlying determinants of health in Nigeria (hereafter 'better health outcomes'). By developing this framework, the chapter invigorates scholarly discourse on the right to health by identifying the domestic (as opposed to the international) system as the proper site where the meaning, content and/or overarching objectives of the right to health should be resolved. The chapter suggests that viewing the right to health as a set of legal positions to universal health coverage facilitates the right to serve as a *bridge to* better health outcomes in Nigeria. It also suggests that strong state organs and, in their absence, active domestic social actors, are required to fortify and/or drive the campaign for public health, across the bridge offered by the right to health as legal positions.

In addition to the foregoing attainments, the chapter sets out to address the concerns of scholars who reject appeals for the right to health as a 'starting point in the inquiry into just health or health care'.[2] It does so by offering a clarification of legal positions, as the lens through which this thesis has viewed and/or engaged with the right to health across four key dimensions: the international treaty framework,[3] constitutional entrenchment, legislation and policy and judicial enforcement. By offering this clarification, the chapter suggests that the framework for the right to health used in this thesis departs, in many respects, from the 'imprecision' of international law where the right has been

---

1 Robert Alexy, *A Theory of Constitutional Rights* (Julian Rivers trans, Oxford University Press, 2002) 120.

2 Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press, 2008) 15.

3 As noted in Chapter 1, the treaty framework in this thesis refers to *Constitution of the World Health Organization* Preamble, 62 Stat. 2697, 14 U.N.T.S. 185 (22 July 1946); *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) art 25; *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) (ICESCR) art 12; *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) (CEDAW) art 12; *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) (CRC) art 24; *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986) (African Charter) art 16; *American Declaration of the Rights and Duties of Man, (*adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948) art XI; and *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador',* opened for signature 17 November 1988, 69 OASTS (entered into force 16 November 1999) art 10.

characterised in terms of achieving 'the highest attainable standard of health'[4] and/or 'health for all'.[5] The idea of 'better health outcomes' advanced by this thesis as the appropriate end goal of universal health coverage in Nigeria reflects the view that more measurable and attainable health goals need to benchmark the assessment of whether universal health coverage has been achieved in the country.

The literature offering theoretical justifications for the right to health has either taken a minimalist approach that reduces the right to what is necessary to achieve 'just health outcomes',[6] or a broad view of the right, as 'an ethical demand for equity in health and the need for the internalisation of public moral norms to progressively realise it'.[7] Both theoretical perspectives have focused predominantly on the international human right to health articulated in the treaty framework. Falling through the cracks is the development of a framework that clarifies what the right to health means for domestic systems like Nigeria. This clarification is argued by this thesis to be necessary because it shifts the campaign for public health from the international system where it is currently bedevilled by seemingly intractable controversies,[8] to domestic systems, where the real impact of

---

4 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976), art 12.

5 World Health Organization and United Nations Children's Fund, *Alma Ata 1978 Primary Health Care* (1978) <http://www.unicef.org/about/history/files/Alma_Ata_conference_1978_report.pdf>.

6 See for instance Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press, 2008); Edmund Pellegrino, 'The Social Ethics of Primary Care: The Relationship between a Human Need and an Obligation of Society ' (1978) 45 *Mount Sinai Journal of Medicine* 593; Tom Beauchamp and Ruth Faden, 'The Right to Health and the Right to Health Care' (1979) 4(2) *The Journal of Medicine and Philosophy* 118; Allen Buchanan, 'Justice: A Philosophical Review ' in Earl Shelp (ed), *Justice and Health Care* (D Reidel Publishing Co, 1981) 3; Martin Golding, 'Justice and Rights: A Study in Relationship' in Earl Shelp (ed), *Justice and Health Care* (D Reidel Publishing Co, 1981) 23; Allen Buchanan, 'The Right to a Decent Minimum of Health Care' (1984) 13(1) *Philosophy & Public Affairs* 55; William Ruddick, 'Why Not a General Right to Health Care' (1989) 56(3) *Mount Sinai Journal of Medicine* 161; Thomas Bole and William Bonderson (eds), *Right to Health Care* (Kluwer, 1991); Kristen Hessler and Allen Buchanan, 'Specifying the Content of the Human Right to Health Care' in Allen Buchanan (ed), *Justice and Health Care: Selected Essays* (Oxford University Press, 2009) 203.

7 Jennifer Prah Ruger, 'Towards a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18(2) *Yale Law Journal of Law & the Humanities* 273, 326.

8 Controversies have trailed the documentation of the history and emergence of the right to health (see for e.g. Socrates Litsios, 'The Long and Difficult Road to Alma-Ata: A Personal Reflection' (2002) 32(4) *International Journal of Health Services* 709; Mary Ann Glendon, 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea' (2003) 16 *Harvard Human Rights Journal* 27; Paolo G Carozza, 'From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights' (2003) 25 *Human Rights Quarterly* 281; Daniel J Whelan and Jack Donnelly, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight ' (2007) 29(4) *Human Rights Quarterly* 908; Alex Kirkup and Tony Evans, 'The Myth of Western Opposition to Econmic, Social, and Cultural Rights?: A Reply to Whelan and Donnelly' (2009) 31(1) *Human Rights Quarterly* 221; Daniel J Whelan and Jack Donnelly, 'Yes, a Myth: A Reply to Kirkup and Evans' (2009) 31(1) *Human Rights Quarterly* 239; Benjamin Mason Meier, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health For Public Health Advancement' (2010) 46(1) *Standford Journal of International Law* 1); the meaning and content of the right to health (see for e.g. Daniel Callahan, 'The WHO Definition of 'Health'' (1973) 1(3) *The Hastings Center Studies* 77; Thana Cristina de Campos, 'Health as a Basic Human Need:

poor health outcomes are being felt.[9] This gap in the literature is what this thesis sets out to fill by its conception of the right to health as a set of legal positions to universal health coverage that can likely result in better health outcomes for the health system of Nigeria. In mapping out the epistemic geography of this framework, three preliminary questions arise: What is the basic structure of legal positions employed by this thesis? What is the *subject-matter* and who are the *addressees* of legal positions? The second and third questions regarding the subject-matter and addressees of legal positions are deliberately combined to feed into the debate about the role that strong state organs and/or active domestic social actors can play in advancing human rights, particularly in the global south.[10] In this regard, the thesis argues that domestic social activism, when grafted onto legal positions, can fortify it against unwilling and/or weak state organs, and may result in a strengthened framework for achieving universal health coverage and better health outcomes in Nigeria. The thesis also offers a paradigm of universal health coverage that is conducive for securing better health outcomes when converged with the right to health.

Section 2.1 maps out the paradigm of legal positions, as developed by Alexy. It integrates into that paradigm content that makes it useful for advancing health rights as the framework for achieving universal health coverage and better health outcomes in Nigeria. Section 2.2 examines the problems with the current framing of universal health coverage, the promise it offers to health systems like that of Nigeria, and the possibilities that arise when it is converged with the right to health to secure better health outcomes. Section 2.3 examines how strong state organs, and/or domestic social actors, can fortify and/or drive the campaign for public health via the bridge offered by the framework of the right to

---

Would This Be Enough?' (2012) 40 *Journal of Law, Medicine & Ethics* 251; Sissela Bok, 'WHO Definition of Health, Rethinking the' in Kris Heggenhougen and Stella Quah (eds), *International Encyclopedia of Public Health* (Academic Press, 2008) vol 6, 590; Lawrence O Gostin, 'The Human Right to Health: A Right to the "Highest Attainable Standard of Health"' (Hastings Center Report, March-April 2001 2001); Katharine G Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 *The Yale Journal of International Law* 113); and the conceptual foundations of the right to health (see for e.g. James Griffin, *On Human Rights* (Oxford University Press, 2008); Onora O'Neill, 'The Dark Side of Human Rights' (2005) 81(2) *International Affairs* 427.)

9 In Chapter 3 where the state of health in Nigeria, Brazil, India and South is discussed, the consequences of poor health outcomes in these countries is brought into focus.

10 The idea of the 'South' in this thesis aligns with the geography of the 'third world' as framed by scholarly discourse of 'Third World Approaches to International Law' (TWAIL). TWAIL scholars understand the third world 'more as a "chorus of voices" with broadly similar historical experiences and concerns (of subordination and suffering in an international legal order that fails to capture and protect their interests), and less as a "fixed geographical space"'. See Obiora Chinedu Okafor and Uchechukwu Ngwaba, 'The International Criminal Court as a 'Transitional Justice' Mechanism in Africa: Some Critical Reflections ' (2014) 9(1) *International Journal of Transitional Justice* 90, 92; Balakrishnan Rajagopal, 'Locating the Third World in Cultural Geography ' (1999) 15(2) *Third World Legal Studies* 1; Obiora Chinedu Okafor, 'Newness, Imperialism, and International Legal Reform in Our Time: A Twail Perspective ' (2005) 43(1/2) *Osgoode Hall Law Journal* 171.

health as legal positions to universal health coverage. Section 2.4 presents the argument that if the right to health is understood as a set of legal positions to universal health coverage, it creates the basis for its further articulation and implementation in Nigeria through a synergy of strategies that combines the international, constitutional, policy and legislative, and judicial domains, and could lead to better health outcomes . Section 2.5 concludes the chapter, offering a summary of the key arguments articulated within.

2.1 The Paradigm of Legal Positions

In his work *A theory of constitutional rights*, Alexy argues that in analysing constitutional rights, a significant distinction needs to be drawn between *a norm* and *a position*.[11] According to Alexy, a norm expresses the rights an individual has in something.[12] In the context of health, for instance, a norm may spell out that an individual has a right to emergency medical treatment. As a practical illustration of this point, s 20(1) of the *National Health Act 2014* of Nigeria provides that:

> A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason.[13]

For our purposes, let us overlook the fact that this provision is not a constitutional provision, but a statutory provision (and thus a statutory norm).[14] Following Alexy's argument, if the above provision were a constitutional provision, then the guarantee it offers of emergency medical treatment is a norm that every Nigerian can claim in an emergency, against those named by the norm. In the context of s 20(1) of the *National Health Act 2014,* those named are healthcare providers, health workers and health establishments.

At a second level of analysis, Alexy argues that the above norm can be formulated to read as follows: '*x* shall not be refused emergency medical treatment for any reason by a health care provider, health worker or health establishment'. According to Alexy, if the second norm statement applies, then *x* is in a legal position against a healthcare provider, health worker or health establishment, not to be refused emergency medical treatment.[15] Thus, if the norm is a valid one—in the sense that it has actually been stated in the constitutional

---

11 Alexy, above n 1, 114.
12 Ibid.
13 *National Health Act 2014* (Nigeria), s 20(1).
14 As would be later argued, the framework of legal positions developed in this thesis goes beyond the constitution, and in this sense, is an improvement on the work done by Alexy.
15 Alexy, above n 1, 114.

document (or, in our case, statutory document)—then *x* finds himself in the legal position of having a right to emergency medical treatment against those named by the norm.[16]

Alexy thus identifies a 'three-point relation' as arising from the above normative statement.[17] The first element of that relation is the beneficiary or a right-holder of emergency medical treatment (*x*); the second is the addressee of the right (*y*) (in our example above, the healthcare provider, health worker or health establishment); and the third is the subject-matter or object of the right (*G*) (in our example above, emergency medical treatment). Alexy expresses this three-point relationship as '*R*'; accordingly the 'general form of a statement of a right to something can be expressed as *RxyG*'.[18] Using this scheme, a variety of rights can be deconstructed into their most basic form to better understand the legal position of the parties in relation to each other, and the subject-matter that has been protected by that legal position. In sum '[t]he subject-matter of a right to something is always an act of an addressee'.[19]

By way of argument, the logical coherence of a legal position depends on the presence of all three elements. Taking any of the elements out of the equation results is an incoherent normative statement. For instance, in the example given above, if the addressees of the right to emergency medical treatment were to be removed from that equation, what results is an incoherent normative statement without real value to the right-holder:

> *x* shall not be refused emergency medical treatment for any reason.

The reason why this new version of the norm statement is incoherent is that it does not tell us who owes *x* the obligation to offer emergency medical treatment; thus *x*, as the right-holder, cannot really enforce the right against anyone, as no one has been addressed by the norm declaring that right.[20] A further argument is that incoherence may manifest in two principal ways: it may take the form of the absence of an addressee (as in the example given above); or the absence/weakness of the subject-matter of the right. This latter situation is argued to be the case with the international expression of the right to health in the ICESCR. Article 12(1) of the ICESCR reads as follows:

---

16 Ibid; as will be later demonstrated, the fact that the norm is expressed in negative terms, and in terms of a duty to offer emergency medical treatment, does not take away from the fact that a right has been created by that norm.

17 Alexy, above n 1, 120.

18 Ibid 120-1.

19 Ibid 121.

20 Alexy however makes the point that even with such norms that appear to only have 'a two-point relation between a right-holder and an object…[s]uch a right would correspond to what in classic terminology is called a "*ius in rem*" and can be contrasted with a "*ius in personam*"…for reasons of simplicity it is often better to speak of rights in the sense of relations between a legal subject and an object." See Alexy, above n 1.

> The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.[21]

The right-holders to this treaty (everyone) are owed by the addressees of the right (State Parties) the subject-matter of the right (recognition of the right to the highest attainable standard of physical and mental health). A right of 'recognition' is argued to be a weak right that will not likely amount to much. This is argued to be the case notwithstanding the art 12(2) provision of the ICESCR itemising specific steps that should be taken by State Parties to achieve the full realisation of the right. It is suggested that a better framing of the right to health under the ICESCR, using legal positions, would occur if the subject-matter of the right were strengthened by integrating the measures itemised in art 12(2) with art 12(1) so that it reads as follows:

> The State Parties to the present Covenant recognise the right of everyone to (a) the provision for the reduction of the stillbirth rate and of infant mortality, and for the healthy development of the child; (b) the improvements of all aspects of environmental and industrial hygiene; (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; (d) the creation of conditions that would assure access to all medical services and medical attention in the event of sickness.

This integrated version is suggested to be a better framing of the right in art 12(1) of the ICESCR because it establishes a more direct three-point relational link that lies at the heart of legal positions. However, it is acknowledged that the weakness of the art 12(1) provision of ICESCR may have been by deliberate design, to allow its widespread acceptance and ratification by State Parties.[22] Two serious critiques of the above application of legal positions to the ICESCR are envisaged. First, one may fault the methodology of applying a framework designed for domestic constitutions to a treaty operative in the international arena. The force of logic of this critique is unquestionable: the way legal norms emerge and are applied in the international arena and in domestic systems are quite different; as such what holds true for one may not hold true for the other. Thus, while the art 12(1) provision may appear incoherent in a domestic setting, for the international setting where it was negotiated, agreed upon and operates, it is a milestone treaty provision. The immediate response to this critique, however, is that the intention is

---

[21] *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976), art 12(1).

[22] For more about the drafting history of the ICESCR, see John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012); Daniel J Whelan and Jack Donnelly, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight ' (2007) 29(4) *Human Rights Quarterly* 908; Alex Kirkup and Tony Evans, 'The Myth of Western Opposition to Econmic, Social, and Cultural Rights?: A Reply to Whelan and Donnelly' (2009) 31(1) *Human Rights Quarterly* 221.

not to suggest that a normative framework for constitutions should be used to interpret those of international treaties. On the contrary, the point of the analysis is mainly to highlight why the framing of legal norms (whether at the domestic or international level) in the manner conceptualised by legal positions is significant for clarifying the nature and extent of the right that results for beneficiaries.[23] As Alexy rightly argues, it is important that the subject-matter of the 'right to something' addresses, and/or pays attention to the way it has addressed the act of the addressee of the right.[24]

A second critique may arise in response to any impression that this thesis is captive to legal norms appearing in legal texts; that is, the formalities of law. The subtext of such a critique is the view that, according to this thesis, if the legal positions of Nigerians on the right to health are strengthened in its constitution and/or legislative enactments to guarantee universal health coverage, then better health outcomes will likely result. Such a critique would be inconsistent with the motivations behind the adoption by this thesis of legal positions as the primary framework for health system transformation in Nigeria. The motivations behind the adoption of legal positions is to develop a method for allocating responsibility for the implementation of the right to health that does not rely on moral invocations[25] or appeals to social solidarity[26] in the campaign for public health in Nigeria. It is conceded that there may have been sound justifications for such invocations and appeals;[27] however, in the context of a domestic system like Nigeria, a different paradigm addressing the peculiarities of the context is argued to be urgently required.

2.1.1 The Basic Structure of Legal Positions

The basic structure of legal positions, according to Alexy's paradigm, comprises two aspects. The first is the negative aspect (defensive rights) involving the right to non-obstruction of acts, the right to non-affecting of characteristics and situations, and the

---

23 When norms are framed as law, the consequence is that a violation of such norms carries with it the weight of legal sanctions. In addition, the field of argument why such norms will not be complied with (by the addressees of the norm) is quite limited, and the hands of right-holders is thereby strengthened to demand the vindication of such norms.

24 Alexy, above n 1, 121.

25 Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (University of California Press, 2005).

26 Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter* (University of Pennsylvannia Press, 2016).

27 For instance, it has already been suggested that the approach to the right to health in the international system may not necessarily be well suited for domestic systems in view of the different institutional mechanisms available to both systems and the context of the application of those mechanisms. Domestic systems have a greater variety of enforcement mechanisms than the international system.

right to non-removal of legal positions.[28] The second is the positive aspect involving the right to positive acts. The sub-categories here are the rights to positive factual acts and the rights to positive normative acts.[29]

2.1.1.1 Negative Aspects

(a) *Right to Non-obstruction of Acts*. This contemplates situations where the rights of a right-holder are interfered with. This may happen either by the *prevention* of the right to health or the *interference* with the right to health.[30] The difference between prevention and interference is illustrated by Alexy as follows: 'an act of *x* is *prevented* by *y* when *y* brings about a state of affairs, which make it impossible as a matter of fact for *x* to do the act'.[31] To illustrate this point, let us refer back to the right to emergency medical treatment in s 20(1) *National Health Act 2014* discussed above. Assuming a government directive is issued that all health facilities in a particular locality should be closed down—and as a result of that directive, *x* who is in need of emergency medical treatment, is unable to secure that treatment—there is no doubt here that the government's directive has prevented *x* from accessing emergency medical treatment. Legal positions in this context suggest that *x*'s right to emergency medical treatment should not have been prevented by such a directive from the government. Translated into the language of 'violations of rights' the government's directive violated *x*'s right to emergency medical treatment. By using legal positions in this way, we are able to specifically address the action of the government, and appropriately frame it as a violation of *x*'s right to emergency medical treatment.

On the other hand, *interference* occurs if the government 'creates a state of affairs that discourages *x*' from accessing medical treatment.[32] To illustrate this point, let us assume that the directive issued by the government was for health facilities in the locality in question to operate for only five hours during the day (as opposed to the 24-hour cycle in which they usually operate). Assuming that this directive has made it very difficult for *x* to access health facilities in the locality when he needs them, although the government's directive has not prevented *x* from accessing health facilities (because the facilities are still allowed to operate), it has interfered with his access to those facilities by virtue of

---

28 Alexy, above n 1, 122-6.
29 Ibid 126-7.
30 Ibid 122.
31 Ibid.
32 Ibid.

the directive restricting access to just five hours of the day.[33] Legal positions, in this sense, still enable us to identify and frame this directive in terms of a violation of *x*'s right to emergency medical treatment guaranteed by s 20(1) *National Health Act 2014.*

(b) *Right to Non-affecting of Characteristics and Situations*. This second category of defensive rights states that 'the state should not try to *affect* certain characteristics and situations of the right-holder'.[34] To refer back to the example used here, the government is not expected to do anything that would make *x* require emergency medical treatment if he would ordinarily not have required it. A practical illustration follows from the environmental effect of the exploration of crude oil in the Niger Delta area of Nigeria. Uncontrolled gas flaring and oil spillages by oil companies, without practical measures by the government to effectively regulate the activities of these oil companies and clean up the environment, has severely affected the health and wellbeing of many communities of the Niger Delta area.[35] Legal positions in this instance can help us identify and frame these negative environmental impacts on the health of these communities, which require them to seek emergency medical treatment when they would not ordinarily have needed it, as a violation of their right to health. In this sense, the violation is not a denial of emergency medical treatment; rather it arises from the environmental pollution that has placed them in a position where they have to seek emergency medical treatment.

(c) *Right to Non-removal of Legal Positions*. This category of defensive rights states that 'the state should not remove certain legal positions of the right-holder'.[36] Alexy identifies several ways in which this can play out. In the context of our example, we illustrate it with a situation where the law that guarantees emergency medical treatment is amended to whittle down its effects or is repealed altogether. In either situation, *x*'s legal position to secure emergency medical treatment would be compromised by such amendment or repeal. By identifying the effects of such an amendment or repeal on the legal position of *x* to secure emergency medical treatment, state organs such as courts can strike down the amending or repealing law through the process of judicial review; in the event of unwillingness and/or judicial incapacity[37] to strike down such legislative

---

[33] Alexy identifies other ways in which this distinction can play out but those are not of relevance to the purpose of this thesis.

[34] Alexy, above n 1, 124.

[35] A O Atubi, 'Effects of Oil Spillage on Human Health in Producing Communities of Delta State, Nigeria' (2015) 4(8) *European Journal of Business and Social Sciences* 14; Kadafa Adati Ayuba, 'Environmental Impacts of Oil Exploration and Expliotation in the Niger Delta of Nigeria' (2012) 12(3) *Global Journal of Science Frontier Research* 1.

[36] Alexy, above n 1, 125.

[37] This is a loaded word with many ramifications that may stem from the system or the personal limitations of judicial officials. It would be explored in more detail in the next section of this chapter.

measures, domestic social actors are able to mobilise and canvass against such legislative measures in a way that ensures that the legal position of *x* to secure emergency medical treatment is not compromised.

2.1.1.2 Positive Aspects

(a) *Right to a Positive Factual Act*. Alexy identifies the interest behind this right to be the satisfaction of a particular need without much attention to how that occurs:[38] '[t]he irrelevance of the legal form of the state intervention for the satisfaction of the right is the criterion for distinguishing between positive factual and positive normative acts'.[39] The need, in our example, is emergency medical treatment. Let us assume *x* visits a particular health facility seeking emergency medical treatment and because the nurses and doctors are very busy attending to other patients, they cannot attend to *x*. If in those circumstances a licensed nurse who is not a staff member of that hospital is permitted by the hospital to attend to *x*, then it is irrelevant that the nurse is not a staff member of the hospital in question. The provision of the law entitling *x* to emergency medical treatment would have been satisfied by the hospital provided *x* is able to secure emergency medical treatment. In a broader policy context, legal positions, framed in the form of a positive factual act, seeks to ensure that health goods and/or service are delivered, without paying much heed to the means by which this is done. This becomes practically relevant where for instance the right to emergency medical treatment is a state legislative provision, as opposed to a federal legislative provision, and it is the federal government and not the states that has enabled the fulfilment of the right to emergency medical treatment. In such circumstances, *x* will have no grounds to proceed against the state government for not fulfilling its obligations under the statute, provided the obligation has been fulfilled through the intervention of the federal government.

(b) *Right to Positive Normative Acts.* On the other hand, the right to a positive normative act means the state must create certain legal norms that would enhance the legal position of *x*.[40] An example of a legal norm that may need to be created, assuming the right to emergency medical treatment were a constitutional (as opposed to statutory) right, would be a norm prohibiting discriminatory behaviour of health professionals that results in the denial of emergency medical treatment to *x*. A practical instance of how this denial can occur is where *x* is involved in a car crash and is rushed to hospital but the

---

38 Alexy, above n 1, 126.
39 Ibid.
40 Ibid 126.

attending physician refuses to treat *x* because *x* belongs to a tribe despised by the physician. In this instance, this norm would have been violated.

Another sense in which this right can be deployed is where it is used to canvass for the promulgation of norms that protect the right to health either in the constitution or in policy and legislation; especially where such norms are not already in place. In the context of Nigeria, the decade-long advocacy culminating in the promulgation of the *National Health Act 2014*, while not couched in terms of legal positions, illustrates what can happen if legal positions are used to ground activism for health system reform.[41]

Figure 2.1 illustrates the above discussion of the basic structure of legal positions, showing how the basic structure of a 'right to something' is decomposed into its negative and positive aspects. Each of these aspects is further decomposed into sub-categories that illustrate the various spaces and situations in which legal positions can be deployed to assert that an individual has the right to health.

[41] See Wole Oyebade, 'A National Health Bill to Rescue, Save All', *The Guardian* Thursday, 12 June 2014 <http://www.ngrguardiannews.com/features/science/165535-a-national-health-bill-to-rescue-save-all>; Lagun Akinloye, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', *Think Africa Press* 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>; Alexander Chiejina, 'Jonathan Finally Signs National Health Bill into Law', *BusinessDay* 9 December 2014 <businessdayonline.com/2014/12/president-jonathan-finally-signs-national-health-bill/#.VMH4AUeUd8H>.

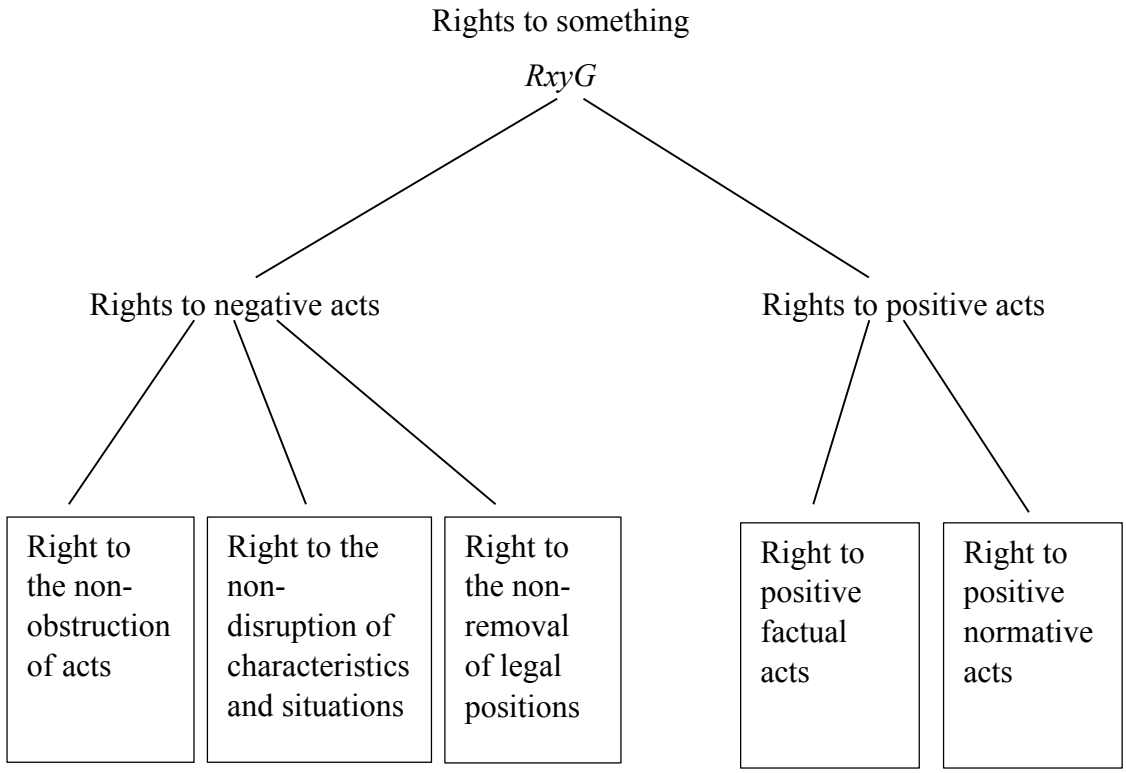

Figure 2.1: Illustration of the basic structure of legal positions (Source*: A Theory of Constitutional Rights*, p 128)

2.1.2 The Subject-Matter of Legal Positions

The subject-matter of legal positions is one of the cardinal elements in the three-point relationship arising from legal positions. The other two, identified above, include the beneficiary of the right to something and the addressees of that right. In the context of the right to health, enquiries about the subject-matter of the right to health turns our attention to scholarly discourse on the core content of that right: When an international treaty, constitutional provision and/or statutory enactment says that the right to health is guaranteed, what specifically has been guaranteed by such provision? Is there a unified understanding of the content of the right to health, either in the treaty framework and/or scholarly discourse that can help us identify the subject-matter of that right for the purpose of legal positions in domestic systems like Nigeria?

These questions strike at the heart of unresolved controversies about the meaning and content of the right to health in international law. Neither the treaty framework, nor scholarly discourse, offer a unified understanding of the meaning and content of the right to health. The way the right has been defined in the major international treaties guaranteeing the right reflects the absence of unanimity about its content. In scholarly

discourse, views diverge considerably on what constitutes the content of the right to health.

2.1.2.1 The Dissonance of the Treaty Framework

The dissonance of the treaty framework emerges when one reviews the definition of the right to health in the major international instruments that have defined the right.[42] The WHO Constitution, which offers the first definition of the right in international law,[43] states that '[h]ealth is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'.[44] It further states that the 'enjoyment of the highest attainable standard of health' is 'one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social conditions'.[45] However, the WHO Constitution does not specify the content of the right to health. While this definition has been much criticised by scholars,[46] the understanding of health as 'a state of complete physical, mental and social well-being' remains unchanged,[47] although very often ignored in favour of the definition offered by the ICESCR.

In defining the right to health, the ICESCR does not follow WHO's definition of health, although it aligns with that definition in other respects, such as in the idea that the right involves achieving the highest attainable standards of health. The ICESCR focuses on the socio-economic factors that lead people to live a healthy life, including underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[48] As the principal international treaty defining the right to health, the

---

42 These instruments are those identified as the treaty framework above.

43 For more about the drafting history of the *Constitution of WHO* see World Health Organization, *The First Ten Years of the World Health Organization* (1958); Tobin, above n 22.

44 *Constitution of the World Health Organization* Preamble, 62 Stat. 2697, 14 U.N.T.S. 185 (22 July 1946).

45 Ibid.

46 Daniel Callahan identifies WHO's definition of health as problematic because there is no evidence that 'medicine has anything more than a partial grasp of the sources of human misery'; secondly, the definition attempts to make the medical profession 'the gatekeeper for happiness and social well-being'; and finally, the definition moves health from the medical to the moral arena. 'What can no longer be done in the name of "morality" can now be done in the name of "health": human beings labelled, incarcerated, and dismissed for their failure to toe the line of "normalcy" and "sanity"'. See Callahan, above n 8, 74; for other critics, see de Campos, above n 8; and Bok, aboven 8.

47 Sissela Bok documents the several attempts at redefining the meaning of health by scholars and the Executive Board of WHO. The attempt by the latter to offer a redefinition of health contrary to the extant definition in the WHO's Constitution in 1998 was rejected by a Committee of the World Health Assembly in 1999. See Bok, above n 8, 594-95.

48 Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000) [4].

ICESCR states that it is a right to 'the highest attainable standard of physical and mental health'.[49] In clarifying the meaning and content of the right, the Committee on Economic, Social and Cultural Rights (CESCR) indicates that the right is not to be understood as a right to be healthy, rather it contains 'interrelated and essential elements' that have to be applied by each state on the basis of prevailing conditions.[50]

Other international treaties that have dealt with the right to health have either avoided defining the right and/or specifying its content, or have emulated the framing of the right in the ICESCR.[51] The consequence is that the international treaty framework does not speak with one voice as to the meaning and content of the right to health. In the context of legal positions, this is quite problematic because the subject-matter of the right to health has to be very clearly defined to achieve a strengthened legal position.

2.1.2.2 The Divergence of Scholarly Discourse

Scholarly discourse on the content of the right to health is bound up with the discourse on the minimum core content of economic and social rights. The discourse about the minimum core content of economic and social rights is organised along essentialist, positivist and institutionalist lines.[52] The 'minimum core', as Katharine Young rightly observes, 'seeks to establish a minimum legal content for the notoriously indeterminate claims of economic and social rights'.[53] The essentialist approach aims for a moral standard 'for prescribing the most promising content to the minimum core, such as how the liberal values of human dignity, equality, and freedom, or … more technical measures of basic needs are minimally sustained within core formulations of rights'.[54] It is an

---

49 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) art 12(1).

50 Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000) [12]; this particular interpretation takes into account the fact that by article 2(1) ICESCR, the right to health and other rights in the Covenant are to be progressively realised by states on the basis of maximum available resources.

51 For instance, the CEDAW does not define the right to health. It merely obligates states to eliminate discrimination against women in the field of health care to ensure they have access to 'health care services, including those related to family planning'. See *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) art 12(1); the CRC follows the ICESCR by recognising the right of the child to enjoy the 'highest attainable standard of health'. See *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24; and the African Charter also follows the ICESCR by describing the right to health as a right to 'the best attainable state of physical and mental health'. See *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986) art 16.

52 Young, above n 8, 116-7.

53 Ibid 113.

54 Ibid 116; Gerald L Neuman, 'Human Rights and Constitutional Rights: Harmony and Dissonance' (2003) 55(5) *Standford Law Review* 1863, 1868-9.

approach most favoured by those seeking an absolute foundation for economic and social rights.[55] Yet, as Young rightly argues, its weakness is that it may result in 'abstract interpretations that fail to resonate with rights-claimants' or that fail 'to provide the much-needed detail of the priorities and politics behind rights formulations, or give a reliable measure for effective enforcement or supervision in positive law'.[56]

Under the positivist approach, the minimum core concept 'gains universal credibility by tying its fortunes to the basic—and not hypothetical—consensus reached within the communities constituting each field'.[57] Thus, according to this view, the basic consensus of states about what the minimum core of the right to health involves becomes its minimum content. This approach, according to Young, brings together 'the themes of legitimacy and self-determination common to both international and constitutional law and is consistent with the practice-bound determinations of the Committee', which has generally relied on 'the accretion of content from state reports to formulate the minimum core' of economic and social rights.[58] The weakness of this approach is its tendency to propel 'international and constitutional formulations along different and uncertain paths' that end up limiting 'the capacity for guidance of each in establishing appropriate—and appropriable—content for the minimum core'.[59]

The institutionalist approach 'locates the minimum core in the content of the obligations raised by the right, rather than the right itself'.[60] Most evident in the recent General Comments of the CESCR, this approach pays the greatest attention to 'the institutional aspects of supervising, enforcing, and claiming rights', which the essentialist approach deliberately defers and the positivist approach only implicitly fosters.[61] Thus, Young points to the divisions between core and non-core obligations as explicitly addressing 'the institutional competence of the international organ declaring noncompliance, or of the domestic court declaring a violation of a justiciable obligation,' and such declarations 'may factor in pragmatic considerations of costs and feasibility in assessing which obligations to treat as core'.[62] However, as Young rightly points out, practical constraints arise from this approach in instances where 'the supervisory competence of the

---

55 Ibid 116-7
56 Ibid 117.
57 Ibid.
58 Ibid; Committee on Economic Social and Cultural Rights, *General Comment No 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 5th sess, UN Doc E/1991/23 (14 December 1990).
59 Young, above n 8, 117.
60 Ibid.
61 Ibid.
62 Ibid.

Committee, or the jurisdictional competence of a court … ultimately carry it too far from its normative ambitions'.[63]

A better approach is identified in Young's suggestion to reverse the inquiry 'by searching not for content to the minimum core concept, but rather new concepts to facilitate the rights' "content" operating as law'.[64] By disaggregating the approaches to the minimum core concept, the root of the conceptual confusion can be better understood, leading to clarity on how to better address issues.[65] Thus, supervisory and enforcement work can be deferred to 'benchmarks and indicators'; analysis about obligations can be left to 'assessment of causality and responsibility'; and the normative and political work can be left to 'more open expressions of economic and social rights'.[66]

This thesis agrees with Young's suggestion that searching for 'new concepts to facilitate rights, operating as law', rather than content to the minimum core concept is a better approach in the circumstance. Another area of agreement is in the recognition of the role that indicators and benchmarks can play in better addressing issues. As such, the idea of better health outcomes as the ultimate objective of universal health coverage in Nigeria aligns with Young's argument that 'theoretically informed practical action, captured by the concept of praxis can clarify the institutional potentials of the right to health as well as its limitations'.[67]

The thesis also agrees with scholars who suggest that the minimum core concept should inform decisions of domestic courts in securing economic and social rights such as the right to health. David Bilchitz, who prominently makes this case, suggests that the role of the courts, in dealing with abstract level rights, is to 'give content to the right' by 'specifying the general principles that define the obligations placed upon the state'.[68] Bilchitz argues in this regard that 'a minimum core obligation … does not represent any particular means by which a socio-economic right can be realised; rather, it represents, the standard of socio-economic provision necessary to meet people's minimal interests'.[69] However, in adopting a minimum core standard, care must be taken to avoid the kind of

---

63 Ibid.
64 Ibid.
65 Ibid 175.
66 Ibid 118.
67 Katharine G Young, 'Securing Health Through Rights' in Thomas Pogge, Matthew Rimmer and Kim Rubenstein (eds), *Incentives for Global Public Health: Patent Law and Access to Essential Medicines* (Cambridge University Press, 2010) 357.
68 David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press, 2007) 198.
69 Ibid.

objection raised by the Constitutional Court of South Africa in the *Gootbroom*[70] and *TAC*[71] judgments where the court stated that domestic courts are not as well positioned as the CESCR to be able to make assessments about the needs and opportunities necessary to determine what the minimum core content should be.[72] It is suggested that universal health coverage, when complemented by underlying determinants of health, could enable courts determine what the content of the minimum core should be.

The minimum core content, as an idea incubated and hatched at the international level, may not always account for the context-specific nature of health needs unless it is adjusted to suit the local conditions of each state. In many cases, much more than the specified standards in the minimum core content expressed at the international level may be required to meet the reasonable health needs of a particular state, or section of a state. Thus, care must to taken to avoid situations where framing health obligations in terms of a minimum core content serve to release states from what should be a necessary requirement to achieve better health outcomes in a particular indicator, for a particular segment of the population.[73] Lack of attention to this issue will weaken the legal positions of the beneficiaries of the right to health in such states. In addition, state organs such as courts would be unable to be of much help in the circumstance; neither would domestic social activism assist much as the state can legitimately point to its compliance with internationally recognised minimum core standards as discharging its obligations as an addressee to the right to health. In this context, Alexy's conception of the right to health as principle is argued to be quite beneficial to domestic systems like Nigeria, as it can reinforce the framing of the minimum core content of the right to health. Alexy's conception is connected to the use of proportionality, which is widely recognised as an appropriate standard for the enforcement of human and constitutional rights.[74] Equally relevant, as earlier suggested, is the inclusion of underlying determinants of health to the framework of universal health coverage.

---

70 *Government of the Republic of South Africa v Grootboom* [2001] 1 SA 46 (Constitutional Court).

71 *Minister of Health v Treatment Action Campaign* (No. 2) [2002] 5 SA 721 (Constitutional Court).

72 Bilchitz, above n 68, 197.

73 In the context of Nigeria for instance, the North-Eastern part of the country has the highest levels of poor health outcomes and the lowest concentration of medical establishments. What is required to achieve better health outcomes in this area would be significantly higher than what is required in the context of the South-Western parts of the country where majority of medical establishments are concentrated and better levels of health outcomes are experienced.

74 Alexy, above n 1, 352-58; see also Mattias Kumm, 'Democracy is not Enough: Rights, Proportionality and the Point of Judicial Review' (2009) *New York University Public Law and Legal Theory Working Papers* 118.

2.1.2.3 Universal Health Coverage as Subject-Matter

The divergence of scholarly discourse on the content of the right to health in international law opens up the space for domestic systems like Nigeria to map out content for the right to health based on the health needs of the country. In this regard it is suggested that universal health coverage—understood not as an end in itself, but as a means to an end—should be the specific guarantee that the right to health should secure for the population of Nigeria. The argument here is that the right to health as legal positions should secure for the population of Nigeria universal health coverage by offering a synergy of strategies that strengthen legal positions in various sites that influence health (such as the international, constitutional, policy and legislative, and judicial domains); when this occurs, it is likely that better health outcomes will be achieved in the country. In this regard, this thesis differs slightly from the current advocacy for universal health coverage by some global health scholars.

The current advocacy for universal health coverage stems from WHO's resolution *WHA58.33, 2005* (*sustainable health financing, universal coverage and social health insurance*),[75] which urges member states, among other things:

> to ensure that health-financing include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care.[76]

In a further clarification, the *World health report 2010* identifies the essential core of universal health coverage as involving 'the availability of health services, to the people who need them, at a cost to whosoever must pay'.[77] Although the right to health was not explicitly used to justify or frame the objectives of universal health coverage by WHO, this has not prevented a number of scholars from drawing links between the objectives of the right to health and universal health coverage, and arguing for a convergence of both frameworks.[78] Gorik Ooms et al., who are among scholars to have made such a case,

---

75 *Sustainable Health Financing, Universal Coverage and Social Health Insurance,* WHA Res 58.33, 9th plen mtg, Doc A58/20 (25 May 2005).

76 Ibid.

77 World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage* (2010) 2.

78 Gorik Ooms et al, 'Universal Health Coverage Anchored in the Right to Health' (2013) 91(2-2A) *Bulletin of the World Health Organization* 1; Gorik Ooms et al, 'Great Expectations for the World Health Organization: A Framework Convention on Global Health to Achieve Universal Health Coverage' (2014) 128 *Public Health* 173; Lawrence O. Gostin et al, 'The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health' (2011) 8(5) *PLoS Medicine* 1.

argue for a *Framework Convention on Global Health* ('the Framework Convention') that could set standards 'throughout the dimensions of the right to health, including ensuring sufficient and sustained financing for a robust version of universal health coverage, thus guiding government action and bolstering civil society advocacy'.[79]

While these scholars appear to support the view that universal health coverage should be foundational to the development of a post-Millennium Development Goals (MDG) framework for global health rooted in the right to health,[80] the problem is that they appear to have very high expectations for what universal health coverage can achieve for states. Certainly there is merit in the view that universal health coverage should enable the allocation of responsibilities for funding health; close the funding gap between high and low income countries; close the increasing and persistent levels of global and national health inequities; and assist in clarifying the international assistance and cooperation—economic and technical—that can be rendered to resource-constrained states by the international community to enable them to achieve the objectives of universal health coverage.[81] However, without anchoring these expectations to a framework that transcends universal health coverage, they are likely to go the way of the 'great expectations' that followed the initial articulation of the right to health in international law. While converging universal health coverage with the right to health is a step in the right direction, it is not enough. The right to health framework itself needs to be rejigged to achieve the specified objectives that reflect the most serious health needs of the Nigerian population. Legal positions is thus advanced to serve this purpose; and universal health coverage is offered as the subject-matter of legal positions on the right to health. Framed in this way, the right to health is argued to be capable of serving as a *bridge* and a *vehicle* to better health outcomes.

The bridge[82] and vehicle metaphor is used to describe the various roles the right to health is expected to play: as a bridge, the right to health is expected to serve as a fixed passage connecting two opposite points (poor health outcomes and better health outcomes) separated by a chasm (the absence of universal health coverage). The bridge, in this sense,

---

79 Ooms, above n 78, 176.

80 Gostin, above n 78.

81 Ooms, above n 78.

82 The use of the 'bridge' metaphor is owed to David Bilchitz's presentation on 'Fundamental Rights as a Bridge' at the legal processes and human rights workshop organised by Macquarie University Research Centre for Agency, Values and Ethics. See David Bilchitz, 'Can Fundamental Rights Bridge the Divide Between Ideal Justice and the South African Reality' (Paper Presented at Legal Processes and Human Rights Workshop, Macquarie University Research Centre for Agency, Values and Ethics, 26 April, 2016).

assures travellers that the obstacle posed by the chasm would not hinder them from reaching their desired destination. The limitation of the bridge, however, is that being static, it is not dynamic enough to respond to all the obstacles that may arise over the course of the journey. It is for this reason that the 'vehicle' serves as a useful descriptive metaphor for the dynamism also expected of the right to health in responding to the challenges preventing the Nigerian population from achieving better health outcomes. Vehicles 'in good working condition'[83] are built to be manoeuvrable. This feature allows them to move across different terrains, avoiding obstacles or changing course where necessary but ultimately conveying a traveller from a point of origin to a desired point of destination—in this case, universal health coverage.[84]

2.1.3 The State as Addressee

The idea that the state—meaning the organs of governance at all levels in a country—is the entity to which the right to health, as a set of legal positions, is addressed is not to suggest that only the state is responsible for the implementation of that right in Nigeria. Indeed, given the fragmentation of the healthcare system in Nigeria where multiple actors (public and private) are involved in the provision of healthcare services,[85] it is an oversimplification to suggest that only the state should be bound by a provision such as s 20(1) of the *National Health Act 2014*. Yet this thesis focuses on the Nigerian state as the addressee of legal positions on the right to health. The principal basis for this is informed by the fact that although the Nigerian state is not the only player in the provision of healthcare services in the country, it is the only player with the capacity to develop the framework of laws, as well as the appropriate institutional mechanisms to bring about much-needed improvements in health outcomes in Nigeria. Moreover, the Nigerian state remains the biggest player in the public health system (and this is the case in many other countries), and equally represents the interests of everyone in the international community. It is for this reason that the Nigerian state is the addressee of legal positions on the right to health in this thesis.

---

83 This qualification acknowledges the obvious fact that it is possible to have a vehicle that is not in good working condition.

84 The metaphor of the right to health as a vehicle to universal health coverage will be further developed in the next section of this chapter.

85 See for instance Omoleke Isola, 'The "Relevance" of the African Traditional Medcine (Alternative Medicine) to Health Care Delivery System in Nigeria' (2013) 47(1) *The Journal of Developing Areas* 319.

2.1.4 Summary

The paradigm of the right to health as a set of legal positions to universal health coverage developed in this section involves three elements: the beneficiaries of the right to health; the subject-matter of the right to health; and the addressees of the right to health. Although the beneficiaries of the right to health were not discussed in the development of this paradigm, it is clear that the beneficiaries, in the context of Nigeria, mean the population of the country who are expected to have the right to health. The subject-matter of that right, on the other hand, is argued to mean universal health coverage as an objective that leads to better health outcomes. In this sense, as conceived in Alexy's theory, the right to health is an 'optimisation requirement' of universal health coverage. It requires that every citizen should prima facie be entitled to receive from the state universal health coverage with only proportional limitations deriving from legal and factual (financial) possibilities.[86] The addressee of the right, which is the entity that is obligated by the right, has been argued to be the Nigerian state; although in putting forth this argument, it has also been conceded that other actors may also be addressees of the right because of the way they influence the legal positions of right-holders. However, the Nigerian state remains the most important addressee of the right (and thus the focus of this thesis) because of its responsibility in promulgating and implementing the framework of laws that affect legal positions on the right to health in the country. Overall the right to health as a set of legal positions to universal health coverage is argued to be capable of serving as a bridge that can lead to better health outcomes in Nigeria. An important characteristic identified by this thesis that is also crucial to the right to health as legal positions is 'manoeuvrability'. In this regard, it has been argued that the right to health also needs to be capable of assuming the character of a vehicle that can avoid obstacles on the path to achieving better health outcomes in Nigeria. This attribute leads to a discussion about the contributions state organs and/or domestic social actors can make to operationalise the framework of the right to health as legal positions to universal health coverage, which are addressed in Section 2.2.

2.2 Universal Health Coverage: Problems, Promise, Strengthening and Convergence

How does the current framing of universal health coverage make it susceptible to repeating the shortcomings of previous frameworks such as the 'right to health' and

[86] Alexy, above n 1, 387-414.

'health for all'? What is the promise for strengthening the health system of Nigeria through bolstering universal health coverage with the right to health? Can the clarification of targets for universal health coverage, and convergence with a re-invigorated paradigm of the right to health, using legal positions, better situate the health system of Nigeria to achieve better health outcomes? These questions are examined in this section.

2.2.1 The Problem with the Framing of Universal Health Coverage

The first problem with universal health coverage is the way it has been framed with an excessive focus on clinical outcomes to the exclusion of underlying determinants of health.[87] The non-engagement with underlying determinants of health is reflective of the fact that the right to health has not adequately informed the framework of universal health coverage.[88] When one considers the preparatory work leading to the adoption of the Sustainable Development Goals (SDGs), this view is confirmed. As Claire Brolan and others observe, with respect to the work done on the SDGs, the right to health was 'everywhere but not specifically somewhere'.[89] A pointer to the focus on clinical outcomes is SDG 3, the health goal providing for universal health coverage. SDG 3.8 states its target to be to '[a]chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.'[90] It is argued that this focus on clinical outcomes by SDG 3.8 dismantles advances recorded in mainstreaming human rights rhetoric into international public health discourse.[91] SDG 3.8 fails to take account of the now settled understanding that health outcomes are not determined solely by medical factors such as health care services, drugs and vaccines, but by a combination of health and non-health factors.[92] Similarly, SDG 3.8 plays into the hands of states, such as Nigeria, that may be dis-inclined to engage with human rights in promoting health

---

87 For scholarly support of this thinking see Lisa Forman et al, 'What Do Core Obligations Under the Right to Health Bring to Universal Health Coverage?' (2016) 18(2) *Health and Human Rights Journal* 23.

88 Lisa Forman, Gorik Ooms, Claire E. Brolan, 'Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?' (2015) 4(12) *International Journal of Health Policy and Management* 799.

89 Claire E. Brolan, Peter S. Hill and Gorik Ooms, '"Everywhere but not Specifically Somewhere": A Qualitative Study on Why the Right to Health is not Explicit in the Post-2015 Negotiations' (2015) 15(22) *BMC International Health & Human Rights* 1.

90 World Health Organization, *Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals*, (World Health Organization, 2015)

91 Benjamin Mason Meir, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement' (2010) 46(1) *Standford Journal of International Law* 1

92 Committee on Economic Social and Cultural Rights, *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd Sess, Un Doc E/C.12/2000/4 (11 August 2000).

equity in their health system. It does so by potentially lowering the bar for such states, with respect to the extent of their responsibilities for health.[93]

The second problem with universal health coverage is its lack of clarity on targets. This is observable from the changing definition of its subject-matter, commencing in 2005 when it first emerged on the global health agenda with a primary focus on health financing and insurance; to its most recent iteration in the SDGs where its focus appears to have shifted to health financing and clinical outcomes. The 2005 World Health Assembly resolution introducing universal health coverage defined it as 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.'[94] This focus on health financing was further reinforced by the appeal to states 'to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care.'[95] The 2010 *World Health Report,* where it next appeared, did little to clarify the content of the services brought under universal health coverage. Rather the 2010 report identified three dimensions to be covered, based on a cube designed by Reinhard Busse et al,[96] namely: the range of health services available, the proportion of costs of services covered, and the proportion of the population covered.[97] In 2012, the UN General Assembly offered a fuller multidimensional definition of universal health coverage that 'affirmed in explicit and detailed terms everyone's right to health and recognised the responsibility of governments to urgently and significantly scale up efforts towards access to affordable and quality health-care services'[98]. The resolution required that

> [a]ll people have access, without discrimination, to nationally determined sets of the needed promotive, curative and rehabilitative basic health services and essential, safe, affordable,

---

93 In this respect, Lisa Forman et al, note the 'danger of universal health coverage reducing health care downwards, without specifying a floor for essential health care itself'. See Forman et al, above n 87, 31.

94 World Health Assembly, *Sustainable Health Financing, Universal Health Coverage and Social Health Insurance,* WHO Doc. WHA58.33 (2005); World Health Organization, *Social Health Insurance: Sustainable Health Financing, Universal Coverage and Social Health Insurance,* Report by the Secretariat, WHO Doc. A58/20 (2005), para. 2.

95 World Health Assembly, *Sustainable Health Financing, Universal Health Coverage and Social Health Insurance,* WHO Doc. WHA58.33 (2005).

96 R. Busse, J. Schreyögg, and C. Gericke, *Analyzing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach* (World Bank, 2007)

97 See World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage*, (2010) xvi.

98 Forman et al, above n 87, 25.

> effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalised segments of the population.[99]

It is argued that this lack of consistency and clarity in the targets of universal health coverage is reminiscent of the experiences with the iteration of the *right to health* in international law, and the unfulfilled aspirations of the *Alma Ata Declaration* and its campaign for *health for all*. It is further argued that without a clearer specification of targets, the global campaign for universal health coverage is likely to go the way of those of the right to health and health for all. Moreover, it is suggested that any attempt to specify targets for universal health coverage that fails to inculcate underlying determinants of health into its framework would make it 'susceptible to exploitation, particularly within the market driven global environment'[100] and this will not augur well for health systems such as that of Nigeria.

2.2.2 The Promise Offered by Universal Health Coverage

Despite its problems, universal health coverage holds a lot of promises for health systems strengthening, particularly for a country like Nigeria. Perhaps its greatest contribution is the specific focus it brings to addressing situations of lack of access to health care, either by reason of the unavailability of health goods and services, or the unavailability of financial resources to pay for health goods and services – two critical areas where Nigeria's health system is troubled. There are certainly other areas where universal health coverage can make positive impact for Nigeria, however, focus is restricted to these two areas because they are the most consequential for the health system.

2.2.2.1 Refocusing the Discourse on Availability of Health Goods and Services

Lack of access to health occasioned by unavailability of health goods and services is by many accounts one of the most serious challenges facing the health system of Nigeria.[101] Many factors account for this problem. They are loosely categorised as institutional, geographical, and/or human resource factors.

(a) *Institutional Factors.* By institutional factors, it is meant policies of state institutions that hinder specific or whole segments of the population from accessing health. For instance, during Nigeria's first universal periodic review cycle in 2008,

---

99 UN General Assembly, Global Health and Foreign Policy, UN Doc. A/67/L.36 (2012) para. 10.

100 See Forman et al, above n 87, 31; People's Health Movement et al, *Global Health Watch 4: An Alternative World Health Report* (Zed Books, 2014) 82.

101 See Chapters 1 and 3 for further treatment of this issue.

barriers to obtaining quality maternal care created by user fees were identified as contributing to poor maternal outcomes in the country.[102] The framework of universal health coverage, with its emphasis on the availability of health goods and services, is likely to bring new urgency to this issue, and many others bedeviling the health system of Nigeria.

(b) *Geographical factors*. Geographical factors such as where one lives, are now well acknowledged as determinative of one's ability to access health. Thus people who reside in urban areas are more likely to have access to the best health goods and services than people who reside in rural areas. It is conceded that this problem is not restricted to the health system of Nigeria. The global campaign for universal health coverage, with its emphasis on equity in conditions surrounding how people access health, is likely to make significant impact on this area of need in Nigeria.

(c) *Human resource factors*. The migration of health workers is an issue that affects all countries, resulting in inequitable access to health care within and between them. Some health workers leave their home countries looking for better working and living conditions, as well as career opportunities abroad. Others leave rural areas for urban ones. While freedom of movement is a fundamental human right in international and domestic law,[103] the unrestrained movement of health workers has significant implications. When health workers migrate from resource-constrained[104] states in the global south,[105] to resource-adequate[106] states in the global north the lack of critical health services available to people in the global south is exacerbated. This in turn contributes to high levels of suffering, illness and death. The spread of infectious disease due to inadequate health services in the global south can also rapidly move across borders and threaten world health. Challenges are thus faced around the world to manage migration and to increase health worker retention. By drawing attention to the need for global action in respect of

---

102 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(c) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/3 (27 November 2008) paras. 50-55.

103 A number of international law instruments guaranteeing freedom of movement to migrant workers, while domestically, most constitutions containing Fundamental Rights provisions, often account for the freedom of movement.

104 'Resource-constrained' loosely refers to countries classified as low-and-middle-income countries by the World Bank.

105 The north/south dichotomy used in this thesis draws from TWAILIAN sensibilities (TWAIL is the scholarly perspective identified as 'Third World Approaches to International Law'). TWAILIAN discourse map the geography of the south according to the way international law impacts 'the governed, no matter where they are spatially located'.

106 'Resource-adequate nations' include countries classified by the World Bank as high income countries.

the availability of health goods and services, universal health coverage stands to make an important contribution to stemming this problem.

2.2.2.2 Addressing the Issue of Financing for Health

As Figure 3.21 below indicates, Nigeria and the comparators, with the exception of South Africa, are to varying degrees plagued by high out-of-pocket expenditure for health goods and services. This raises the specter of catastrophic health spending.[107] Universal health coverage directly tackles this issue by canvassing for 'a method for prepayment of financial contributions for health care, with a view to sharing risk among the population'.[108] This is thus another area where the health system of Nigeria will likely be strengthened by universal health coverage.

2.2.3 Imperatives for Strengthening Universal Health Coverage

The imperatives for strengthening universal health coverage is argued to be made out by the discussion of the problems facing that framework (ie excessive focus on clinical outcomes, and lack of clarity about its targets). There is more to be gained from including underlying determinants of health in the framework work of universal health coverage than from excluding it. Such a measure is also likely to gain the support of human rights institutions already working to mainstream the right to health in global health praxis. It is argued that a solely clinical or financial view of the health system is a more difficult position to defend than one that advocates for the inclusion of underlying determinants of health in the framework of universal health coverage.

In order to overcome the imprecision of the current framing of universal healt coverage, and the potential pitfalls arising from such imprecision, it is suggested that the target of universal health coverage should be *better health outcomes* – and not merely strengthening the delivery of care, and/or the system of health financing. What is 'better' in terms of health outcomes is relative to existing conditions that offer a basis for comparison. In this regard, attention is drawn to the most pressing areas where poor health outcomes are being experienced in Nigeria,[109] and the view advanced that better health outcomes should seek to bring about significant improvements in those areas. By holding

---

[107] Further discussion on this is offered in Chapter 3.

[108] World Health Assembly, *Sustainable Health Financing, Universal Health Coverage and Social Health Insurance,* WHO Doc. WHA58.33 (2005).

[109] Chapter 3 undertakes a detailed examination of the areas where poor health outcomes are being experienced in the health system of Nigeria.

to this view, this thesis invariably disagrees with the *universalistic paradigm* for universal health coverage canvassed by the likes of Lisa Forman et al.[110]

2.2.4 The Case for Converging Universal Health Coverage with the Right to Health

As previously noted in Section 2.1.2.3, there is much scholarly support for converging universal health coverage with the right to health. The likes of Gorik Ooms et al, who prominently canvass this view (in the context of the health-related MDGs), argue that 'universal health coverage anchored in the right to health, while building on efforts to meet the present health-related MDGs, would raise the bar for improving health care overall'.[111] It is argued that this view still holds true for the SDGs. However, this thesis is not convinced that the current framework of the right to health in international law is well-grounded to provide the much needed bolstering to universal health coverage. It is for this reason that its is argued that the engagement with Alexy's paradigm of legal positions to strengthen the right to health is the most promising way out of this quandary.

2.2.5 Summary

By concieving the right to health as a set of legal positions to universal health coverage, we are able to overcome the paralysing debate about the meaning and content of the right to health that has led to the dissipation of so much energy at the international level, without meaningful consensus or progress for global health. Legal postions can clarify the connection between the beneficiaries, subject-matter and addressees of the right to health. It can place clearly articulated duties on the doorsteps of state organs, and empower beneficiaries of the right to health to seek the fulfilment of that right through activism and recourse to the judicial process. Where this can benefit universal health coverage is that there is opportunity to frame the subject-matter of the right to health as *universal health coverage that should lead to better health outcomes*. Thus the duty of state organs does not stop at providing access to health goods and services; it also extends to ensuring that the underlying conditions required to bring about improvements in health outcomes are also addressed.

Legal positions can also create a *radiating effect* in resource-constrained nations.[112] The main benefit of the radiating effect theory lies in the idea that constitutional rights norms framing the right to health as legal positions to universal health coverage can provide

---

110 Forman et al, above n 87, 25.
111 Ooms, above n 78.
112 Further discussion on the radiating effect theory is offered in Chapter 5.

guidelines and impulses for the legislature, executive and judiciary. It can also empower domestic social actors with the required tools for advancing the situation of the right to health, and the uptake of universal health coverage in Nigeria.

2.3 State Organs, Domestic Social Activism and Legal positions on the right to health

Two important elements of the framework offered in this chapter are the presence of strong and willing state organs, and the presence of a vibrant community of domestic social actors. These two elements are argued to be essential to the uptake of the right to health as legal positions to universal health coverage in Nigeria. This is because through its organs, states respond to the right to health as addressees of that right. Yet in many instances, state organs, especially in Nigeria, are bedevilled by challenges such as incapacity and/or unwillingness to give effect to economic and social rights.[113] The courts, for example, play a key role in the enforcement of economic and social rights either through the litigation process, or through the judicial review of the activities of other arms of government responsible for implementing economic and social rights.[114] Scholarly works in this area have identified the need for 'compliance with rule of law requirements'[115] as foundational to the effectiveness of the judicial review process. Unfortunately this is not always the case in Nigeria[116] where powerful executive bodies often ignore or override judicial review outcomes. Given the context of Nigeria, the framework of laws (that is the formal law) is argued to be inadequate to advance legal positions on the right to health in the country. Much more is required to fortify and/or secure the right to health as legal positions to universal health coverage involving the 'living law',[117] so that instances of genuine government incapacity can be dissociated

---

[113] Aart Hendriks, 'The Right to Health in National and International Jurisprudence ' (1998) 5 *European Journal of Health Law* 389, 393; this claim of incapacity and/or unwillingness of states institutions in Nigeria to give effect to economic and social rights, including the right to health, is one that will be developed throughout the breadth of this thesis.

[114] For a general reading on the necessity of judicial review for the enforcement of economic and social rights, see Bilchitz, above n 68.

[115] On this point, see Mark Tushnet, *Weak Courts, Strong Rights: Judicial Review and Social Welfare Rights in Comparative Constitutional Law* (Princeton University Press, 2007); Rosalind Dixon, 'Creating Dialogue About Socioeconomic Rights: Strong-Form Versus Weak-Form Judicial Review ' (2007) 5(3) *International Journal of Constitutional Law* 391.

[116] In Nigeria, compliance with the rule of law often depends on the temperament of the individual who is President at a material point in time. It is not unusually to hear about the executive arm refusing to obey an order of court or disregarding the judgment of the Supreme Court on an issue.

[117] By the living law is meant the law in action in the daily encounters between citizens and state organs. In the literature, it is understood more broadly as the law which dominates social life despite not being posited as a legal proposition applied by the courts. See generally Roger Cotterrell, 'Ehrlich at the Edge of Empire: Centres and Peripheries in Legal Studies' in Marc Hertogh (ed), *Living Law: Reconsidering Eugen Ehrlich* (Hart Publishing 2008) 75-123; David Nelken, 'Eugen Ehrlich, Living Law, and Plural Legalities' (2008) 9(2) *Theoretical Inquiries in Law* 443.

from government unwillingness[118] to give effect, as addressees, to the right to health.[119] In this section, attention is paid to what domestic social activism can offer as an additional layer of support to bolster the work of state organs such as courts in giving effect to legal positions on the right to health. The discussion on what needs to be done at an institutional level to bring about the actualisation of legal positions on the right to health is taken up in the next section.

2.3.1 The Context of Domestic Social Activism

Human rights, in many contexts, owes its advance to the activities of domestic social actors. Recent literature has come to recognise the link between human rights and social activism.[120] However, as Neil Stammers argues, not much has been done to build understanding about the nature of the link between human rights and domestic social activism.[121] A number of benefits can be derived from domestic social activism (or 'social activism'), which can (i) offer an essential layer of support to legal positions on the right to health by mobilising citizens and socialising them about the offerings of legal positions on the right to health; (ii) provide a compelling basis for individuals to become 'active citizens'[122] interested and invested in how the actions and/or inactions of state organs affect their legal positions on the right to health; (iii) offer alternative accountability mechanisms based on the lived experiences of the people themselves, and not remote ideas conceptualised and implemented by the political elites, which have no bearing on the day-to-day experiences of the people; (iv) and be a constant reminder to the political elites that in the final analysis, the role of the state is to serve the interests of the people and not the other way around. Each of these ideas requires further explication.

---

118 Aart Hendriks, above n 113.

119 For a general reading of the role of domestic social movements in the Third World, see Neil Stammers, 'Social Movements and the Social Construction of Human Rights' (1999) 21(4) *Human Rights Quarterly* 980; Balakrishnan Rajagopal, *International Law From Below: Developments, Social Movements and Third World Resistance* (Cambridge University Press, 2003).

120 For an example of this literature, see Burns H Weston, 'Human Rights: Concepts and Content' in Burns H Weston and Anna Grear (eds), *Human Rights in the World Community: Issues and Action* (University of Pennsylvania Press, 4th ed, 2016) 7.

121 Stammers, above n 119, 980-81.

122 Active citizenship suggests that Nigerians can no longer stand aloof and expect the political elites to be reasonable and live up to the electoral promises they have made. The Nigerian citizenry needs to insist that such promises are fulfilled and on their part, citizens should be prepared to perform the necessary civic duties that are essential to the flourishing of the state e.g. paying of taxes. For a broad reading of the literature in this area, particularly in the context of active citizenship among minority groups in Europe, see Cristiano Bee and Dimitra Pachi, 'Active Citizenship in the UK: Assessing Institutional Political Strategies and Mechanisms of Civic Engagement' (2014) 10(1) *Journal of Civil Society* 100; Cristiano Bee and Roberta Guerrina, 'Participation, Dialogue, and Civic Engagement: Understanding the Role of Organized Civil Society in Promoting Active Citizenship in the European Union ' (2014) 10(1) *Journal of Civil Society* 29.

2.3.1.1 The Mobilisation and Socialisation of Citizens

When citizens mobilise, structures of power are radically transformed for good or bad. This much has been demonstrated by the so-called 'Arab Spring' of 2011 that led to the toppling of many regimes in North Africa and the Middle-East.[123] The reference to the Arab Spring is not to endorse civil revolt as the strategy to fortify legal positions on the right to health in Nigeria; it is merely to draw attention to the potential power of the people that becomes quite consequential when awakened by difficult circumstances. A more positive example of how the mobilisation and socialisation of citizens can be used as a force for good to transform the ill fortunes of the health system of Nigeria is seen in the experience of Brazil in the period leading up to the adoption of its health rights-rich constitution in 1988. The reform that led to the emergence of Brazil's Unified Health System (*Sistema Único de Saúde*, SUS) was driven by activism that involved a widespread social movement bringing together different sections of society, from grassroots sectors to middle-class populations and trade unions, and left-wing political parties.[124] These disparate segments of Brazilian society were unified by the ideology that health was not 'an exclusively biological issue to be resolved by medical services, but a social and political issue to be addressed in public'.[125] On the basis of this shared aspiration, the health reform movement in Brazil successfully secured a strong legal position on the right to health in its constitution and subsequent legislative enactments.[126]

In the context of Nigeria, parallels can be found in the labour-led struggles for economic and social rights in the form of the fight against the privatisation of the downstream sector of the petroleum industry during the regime of President Olusegun Obasanjo from 1999 to 2007.[127] On the basis of this labour-led struggle, citizens were successfully mobilised and socialised about the dangers of the neo-liberal policies of privatisation of the downstream sector. Through the resistance of the labour movement (involving strikes and peaceful demonstrations) the process of privatisation was significantly slowed down such

---

[123] For further readings on this see Jean-Pierre Filiu, *The Arab Revolution: Ten Lessons From the Democratic Uprising* (Oxford University Press, 2011); Erzsébet N Rózsa, 'Arab Awakening, or a New Regional Order Emerging in the Middle East?' (2011) 20(2) *International Issues & Slovak Foreign Policy Affairs* 3.

[124] See Andrea Cornwall and Alex Shankland, 'Engaging Citizens: Lessons From Building Brazil's National Health System' (2008) 66 *Social Science & Medicine* 2173; and Jairnilson Paim et al, 'The Brazilian Health System: History, Advances, and Challenges' (2011) 377 *Lancet* 1778.

[125] Paim above n 124, 1784.

[126] The right to health is well protected in the Constitution of Brazil. See *Constitution of Brazil, 1988*, arts 194, 196-200; see also *Law No 8.080 of 19 September 1990* (Brazil), art 2.

[127] See Obiora Chinedu Okafor, 'Irrigating the Famished Fields: The Impact of Labour-led Struggles on Policy and Action in Nigeria (1999-2007)' (2009) 27(2) *Journal of Contemporary African Studies* 159.

that the full-scale privatisation that was initially intended by the Obasanjo administration did not happen.

The point to these examples of domestic social activism is to draw attention to its potential to mobilise citizens around an ideology that can be used to secure legal positions for the population. In the context of Brazil, the ideology was that health is a right that should be guaranteed by its constitution. In the context of Nigeria's labour-led resistance, it was that the privatisation of the downstream sector was a neo-liberal agenda that would harm the economy of the common person. In both instances, domestic social activism succeeded in bringing about strengthened legal positions in circumstances where state organs such as courts would have failed. It is thus argued that domestic social activism can be usefully deployed to mobilise and socialise the Nigerian population about the need to push for the uptake and strengthening of the right to health as a set of legal position to universal health coverage so that better health outcomes can be realised in the country.

2.3.1.2 The Encouragement of Active Citizenship

Domestic social activism, as previously argued, is capable of promoting active citizenship, and thus strengthening legal positions on the right to health. The concept of 'active citizenship' is one that focuses on how individuals can stay engaged with the democratic process beyond the casting of votes during elections. This discourse has been particularly relevant in the context of increasing the political participation of minority groups in European societies.[128] Citizenship, broadly speaking, is addressed to 'the relationship between the individual and the political community, as well as the broader interconnections between individuals and social groups'.[129] Attached to the idea of citizenship is 'a sense of obligation with other members of a community, as well an understanding of the role and contribution of the individual in that specific community'.[130] The relevance of the discourse on active citizenship to the framework of legal positions on the right to health is that it offers the only sure guarantee that political institutions will work to the benefit of citizens—without citizen engagement in the democratic project, the project is likely to fail. Active citizenship thus suggests both rights and obligations: the rights are those to which citizens become entitled by virtue of the framework of laws and institutions in place to secure a good life for citizens.[131] The

---

128 See Bee and Pachi, above n 122; Bee and Guerrina, above n 122.

129 See Bee and Pachi, above n 122, 101; see also Keith Faulks, *Citizenship* (Routledge, 2000) 1-13.

130 See Bee and Pachi, above n 122, 101.

131 Some interpretations of Aristotle's work have argued that he identifies 'human flourishing' as the end of all political activity. See Ruger, above n 7, 288; Aristotle himself wrote that: 'It belongs to the

obligations are those that arise in the context of making the necessary civic contributions to ensure the flourishing of the society as a whole. Active citizenship ensures that the political elites are constantly engaged by the populace, thus severely limiting the political elites' opportunity to completely abandon objectives that can strengthen the legal positions of citizens on the right to health.

2.3.1.3 The Provision of Alternative Accountability Mechanisms

Domestic social activism can offer alternative mechanisms for holding political actors to account by problematising the daily health struggles of citizens and drawing attention to the health issues that affect them the most. This potential emerges from the discussion above on how the social mobilisation of citizens has influenced the political and policy spaces of Brazil and Nigeria. The argument here is that in the absence of effective institutional accountability mechanisms, domestic social actors are able to offer ad hoc accountability mechanisms that respond to unfavourable state action(s) and/or influence state action in the direction that properly responds to the pressing health problems of the people.

A number of critiques may, however, follow the use of domestic action as an alternative to state institutional accountability mechanisms. First, domestic social actors may act with an agenda in mind. To illustrate with the health reform movement of Nigeria that brought about the promulgation of the *National Health Law 2014*, there was a perception in some quarters, rightly or wrongly, that the activism championed by medical doctors for the promulgation of a national health law was to secure for themselves a leadership position in the medical profession of Nigeria.[132] A second critique involves the choice of issues that are the subject-matter of domestic social activism. It may be that only issues that would make for good press will tend to be selected by domestic social actors for problematisation, even though they are not the priority areas requiring attention. Notwithstanding these potential shortcomings, domestic social action in a complex political environment like Nigeria remains an attractive alternative to weak state organs for ensuring that political actors remain accountable to the people for advancing legal positions on the right to health.

---

excellent legislator to see how a city, a family of human beings…will share in the good life and in the happiness that is possible for them.' See Aristotle, *Nicomachean Ethics* (Terence Irwin trans, Hackett Publishing Co., 2nd ed, 1999) 1094.

[132] See for instance Lagun Akinloye, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', *Think Africa Press* 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>.

2.3.1.4 Domestic Social Activism as a Reminder of Citizen Power

One clear fact that emerges when domestic social actors mobilise is that the political elites are reminded that power lies with the people and not exclusively with the organs of state that the political elites control. Thus, political actors must ensure that state organs serve the interests of the people and not the other way round. The consequence of neglecting 'citizen power' is quite eloquently demonstrated by the regime toppling that occurred across the Middle-East world as a result of the democratic uprising that swept through that region in 2011. In the context of Nigeria, citizen power can be exercised through the ballot box when political actors who have failed to meet the expectations of citizens in terms of safeguarding legal positions on the right to health are voted out of office.

In sum, domestic social activism can operate in a variety of areas and serve as an effective catalyst for securing legal positions on the right to health. As a result of its dynamism, social activism is argued to be capable of providing an additional layer of support, and/or serving as an alternative framework to weak or reluctant state organs in securing legal positions on the right to health.

2.3.2 State Organs and Legal positions on the right to health

Ideally, state organs should bear the responsibility for securing or advancing legal positions on the right to health. This section examines how this can occur across the different branches of government—the legislature, executive and judiciary. These branches of government are collectively responsible for the actions and inactions of the organs of state that affect legal positions on the right to health. As such they are pivotal to the circumstances of the right to health as a set of legal positions to universal health coverage leading to better health outcomes.

2.3.2.1 The Legislature and Legal positions on the right to health

As the branch of government responsible for law making in Nigeria's presidential system of government, Nigeria's federal legislative body the National Assembly has a very important role to play in securing legal positions on the right to health for the Nigerian populace. In the first place, the task of law making and constitutional amendment to guarantee the right to health falls principally within the legislative competence of the National Assembly.[133] In addition, the National Assembly exercises important oversight

[133] See *Constitution of Nigeria 1999*, ss 4 and 9; as noted in Section 1.1, the Second Schedule, Part I, item 60(a) of the constitution vests exclusive legislative competence on the National Assembly to enforce ecnonmic and social rights in the country.

functions in the activities of various ministries and agencies of the executive branch and is the approving authority for the expenditure of public funds.[134] Through this process, the National Assembly can ensure that the executive branch of government is doing all that is possible to fulfil the right to health. However, the National Assembly is currently not doing enough (either in terms of the passage of health rights-oriented laws, or scrutinising executive action or inaction regarding health) to strengthen the framework of the right to health. Perhaps with the promulgation and uptake of the *National Health Act 2014*, a new posture will be adopted by the National Assembly that would lead to the strengthening of legal positions on the right to health in the country.

2.3.2.2 The Executive and Legal positions on the right to health

The strengthening of the right to health as legal positions requires the presence of an efficient, dynamic and responsive executive branch of government. This is because the executive branch is the implementing authority and most visible branch of government. When laws are made or money bills are approved by the National Assembly, it is the executive branch that is saddled with the responsibility of implementing such laws or appropriation legislation.[135] An efficient, dynamic and responsive executive branch demands that the ministries, agencies and departments of government that are responsible for executing government policies and programmes in the area of health are able to exhibit these positive attributes in their daily encounters with the Nigerian populace; thus strengthening legal positions on the right to health. Unfortunately, this is not currently the case in Nigeria as the narrative is one of corruption, inefficiency, unresponsiveness and in many cases, outright dereliction of duties.[136]

2.3.2.3 The Judiciary and Legal positions on the right to health

The *Constitution of Nigeria* vests the judicial powers of the federation in the courts.[137] These powers include, among other things, the 'inherent powers and sanctions of a court

---

[134] Ibid ss 80-89.

[135] Ibid s 5.

[136] Isa Ali Pantami, 'Nigeria's Civil Service: An Engine of Corruption', *Premium Times* March 23 2012 <http://www.premiumtimesng.com/opinion/4355-nigeria_s_civil_service_an_engine_of_corruption_by_isa_ali_panta.html>; Emmanuel Aziken, Clifford Ndujihe and Charles Kumolu, 'How Corruption Hit Civil Service - Asiodu', *Vanguard* 10 August 2015 <http://www.vanguardngr.com/2015/08/how-corruption-hit-civil-service-asiodu/>; Levinus Nwabughiogu, 'Poverty of Ideas, Corruption, Inefficiency Killing Civil Service, Says Buhari', *Vanguard* 8 September 2015 <http://www.vanguardngr.com/2015/09/poverty-of-ideas-corruption-inefficiency-killing-civil-service-says-buhari/>; Premium Times, 'Governor Dickson Suspends Nine Bayelsa Teachers for Dereliction of Duty', *Premium Times* 14 December 2013 <http://www.premiumtimesng.com/regional/ssouth-east/151478-governor-dickson-suspends-nine-bayelsa-teachers-dereliction-duty.html>.

[137] *Constitution of Nigeria 1999*, s (6)(1).

of law';[138] and the power to determine civil rights and obligations involving persons or government or authority.[139] As earlier noted, courts influence legal positions on the right to health in two principal ways: first, through the litigation process; and second, through the process of judicial review. The discussion of the former is taken up briefly in the next section and more extensively in Chapter 7. In this section, the focus is on how legal positions on the right to health can be influenced by the judicial review process.

The power of judicial review is an inherent power vested by s 6(6)(a) of the *Constitution of Nigeria* on courts in Nigeria. This power enables the courts to review decisions and actions of the other branches of government to determine whether there has been compliance with constitutional provisions. With a few notable exceptions, scholarship in this area has developed to the point where it is no longer debated whether judicial review is appropriate for the enforcement of economic and social rights.[140] What is still debated is what should be the appropriate limits for the judicial review process to avoid situations where the courts are perceived to be overturning the 'reasonable alternative view of the majority'.[141] Thus the tension here is between constitutionalism and democratic self-governance.

Mark Tushnet identifies *strong-form* and *weak-form* judicial review as alternative forms of judicial review arising in these circumstances.[142] The former, he argues, is concerned with constitutionalism and demands that the decisions and actions of other branches of government are in line with constitutional provisions (the United States [US] is offered as a prime example of this model of judicial review).[143] A limitation of strong-form review is the tension created between constitutionalism and democratic self-governance. Nonetheless, David Bilchitz is among scholars who favour a strong form of judicial review on the basis that it 'gives teeth' to economic and social rights.[144]

---

138 Ibid s 6(6)(a).

139 Ibid s 6(6)(b).

140 The United States of America is a notable jurisdiction where the appropriateness of judicial review for economic and social rights is still fiercely debated – on this point see Tushnet, above n 89; for scholarly works embracing judicial review in the area of economic and social rights, see Marius Pieterse, 'Coming to Terms with Judicial Enforcement of Socio-Economic Rights' (2004) 20 *South Africa Journal on Human Rights* 383; Mark S Kende, 'The South African Constitutional Court's Embrace of Socio-Economic Rights: A Comparative Perspective' (2003) 6 *Chapman Law Review* 137; Mark S Kende, 'The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics' (2004) 19 *Connecticut Journal of International Law* 617.

141 Tushnet, above n 115, 22.

142 Ibid.

143 Ibid.

144 See David Bilchitz, 'Giving Socio-Economic Rights Teeth: The Minimum Core Content and its Importance' (2002) 119 *The South African Law Journal* 484; see also David Bilchitz, 'Towards a

On the other hand, Tushnet argues that weak-form judicial review (prevalent in Commonwealth countries such as New Zealand, the United Kingdom and Canada) avoids the tension between constitutionalism and democratic self-governance by providing mechanisms for people to respond to decisions they 'reasonably believe mistaken'; these mechanisms can be deployed more rapidly than constitutional amendment or judicial appointment processes, which are the main ways that Tushnet identifies for avoiding the tension created by strong-form judicial review.[145] Tushnet further argues that weak-form judicial review can balance the competing values of constitutionalism and democratic self-government by 'promoting real-time dialogue between courts and legislatures'.[146] Rosalind Dixon, who agrees with Tushnet on the essentiality of dialogue to the judicial review process, develops a theory of 'constitutional dialogue' according to which 'commitment to constitutional dialogue should be the most desirable model of cooperation between courts and legislatures in the enforcement of economic and social rights'.[147] Dixon differs from Tushnet in arguing that under the constitutional dialogue model, 'courts should have a much greater capacity and responsibility to counter legislative blockages to the realisation of constitutional rights'.[148]

The immediate relevance of this debate for securing legal positions on the right to health in Nigeria is limited. This is because the debate contemplates 'constitutional systems that generally comply with rule-of-law requirements'.[149] Nigeria's constitutionalism does not fit that description because in many respects, compliance with the rule of law depends on the temperament of the political elites. It is not uncommon for the decisions of courts to be ignored by the executive branch.[150] Ignoring for a moment that the rule of law is not often observed in Nigeria, this thesis agrees with Bilchitz's argument that economic and social rights need to be given teeth by courts to ensure their enforcement.[151] This suggests a preference for strong-form judicial review for the furtherance of legal positions on the right to health in Nigeria. On the other hand, there is much merit to Dixon's argument that constitutional dialogue, fortified by the capacity and responsibility of the courts to

---

Reasonable Approach to the Minimum Core: Laying the Foundation for Future Socio-Economic Rights Jurisprudence' (2003) 19 *South Africa Journal on Human Rights* 1.

145 Tushnet, above n 115, 23.

146 Ibid 43.

147 Dixon, above n 115, 393.

148 Ibid.

149 Tushnet, above n 115, ix.

150 For instance, the present administration of President Muhammdau Buhari has developed a negative reputation for disobeying court orders; while that of Late President Umaru Musa Yar'Adua (2007-2009) was widely acknowledged for adhering to the rule of law. Before them, the administration of President Olusegun Obasanjo (1999-2007) was also notorious for disobeying court orders.

151 This position has been treated fully in Section 2.1.2.2.

counter legislative blockages, should be engaged to realise constitutional rights. The advantage of dialogue as promoting more amicable and interest-driven—rather than adversarial and territorially driven—responses to the enforcement of economic and social rights is quite apparent.[152] While this may be the case, Nigeria is argued not to have attained the level of constitutional maturity required to be able to derive immediate benefits from this idea of constitutional dialogue. Current realities in Nigeria require that the judicial review process is strong enough to strengthen existing mechanisms for the enforcement of legal positions on the right to health. In these circumstances, recourse to dialogue in the judicial review process may be wrongly construed as *weakness* of the courts by the political elites. Another value of strong-form judicial review in the Nigerian context is that judicial decisions declaring the acts of the other branches of government to be a violation of legal positions on the right to health become an immediate currency that domestic social actors can cash in their activism for better health outcomes in the country.

Yet it must be equally acknowledged that strong-form judicial review is not without its shortcomings. Some of these short comings which inform the case for weak-form judicial review is that it requires judges to make decisions on the finances of the state when they may not be qualified to do so. Another weakness is how it may negatively impact the overall policies of the state in the area of health. Even accounting for this potential weakness, the price to be paid in the resort to strong-form judicial review is less than what results when health interests are completely abandoned to the political elites of Nigeria. As experience shows, these elites when given this level of liberty, deal with the right at the fringe of state policy formulation and implementation and not as one of its central concerns.

2.3.3 Summary

The operationalisation of legal positions on the right to health has been argued to require the cooperative action of strong state organs and domestic social actors. State organs comprising the three branches of government have been identified as the ideal drivers of legal positions on the right to health as they are responsible for the formulation and implementation of policies that affect the right to health as a set of legal positions to

[152] Katharine Young is another scholar who develops a dialogue model to judicial review in order to 'open up the relationship between courts and the elected branches and lower the political energy that is required in order to achieve a rights-protective outcome. See Katharine G Young, 'A Typology of Economic and Social Rights Adjudication: Exploring the Catalytic Function of Judicial Review' (2010) 8(3) *International Journal of Constitutional Law* 385.

universal health coverage. Each branch of government is expected to play a specific role to ensure that legal positions on the right to health are strengthened to benefit the population. However, the analysis shows that Nigeria does not present an ideal case where state organs can effectively serve as drivers of the right to health as legal positions. A range of incapacities (with the bureaucracy and the observance of the rule of law) militate against this prospect. Thus institutional mechanisms such as judicial review are unable to yield immediate benefits to the population as they are ineffective against the ruling elites. Consequently, domestic social activism has been identified as an alternative and/or further driver of legal positions on the right to health. The argument here is that domestic social activism can offer an essential layer of support to legal positions on the right to health by, among other things, mobilising citizens, socialising them about what legal positions means for them and creating alternative accountability mechanisms by which the political elites can be held to its fulfilment. When this is coupled with a strong form of judicial review, domestic social actors can then have an immediate currency that can be cashed in when seeking better health outcomes in the country.

2.4 Securing Legal positions on the right to health through a Synergy of Strategies

The main argument put forth in this section is that the framework of legal positions on the right to health developed in this chapter needs to be strategically deployed in four key sites, to wit: the international, constitutional, policy and legislative, and judicial contexts. The reasoning here is that for legal positions to effectively strengthen the way the right to health is articulated and fulfilled in Nigeria, these four sites need to be part of the framework of legal positions developed by this thesis. Where this is the case, legal positions invariably responds to the needs in each site in a manner that meets the specific shortcomings that need to be addressed. There is dynamism and pragmatism to this process, which is outcome focused. In each of these sites, the framing question is worded as follows: How can legal positions strengthen the right to health in this context so that universal health coverage can be attained and better health outcomes can result, in the health system of Nigeria? The principles discussed in this section offer a tentative response to this framing question. This response is developed more extensively in later chapters of this thesis.

2.4.1 Legal Positions in the International Context

Ordinarily, one should not apply a framework designed for domestic constitutions in the international context.[153] Nonetheless, as previously argued, we need to discuss legal positions in all sites that influence the right to health, to identify the extent of the right that beneficiaries can claim and the specific addressees against whom such claims can be made. In the international context, where state actors are both the beneficiaries (the benefits arise when states use international rights norms to secure advantage for themselves) and addressees of the right to health, legal positions assume a different dimension on the basis of the needs arising from that context. Therefore, the first step in this regard is to identify Nigeria's interest with respect to the way with which discourse about the right to health is engaged in the international context.

As the discussion in Section 2.1.2.2 demonstrates, the right to health remains a highly contested right in the treaty framework and among scholars. However, state actors like Nigeria have a responsibility to progressively realise the right on the basis of available resources.[154] Arguments about resource constraints do not completely obviate Nigeria's obligations to fulfil the right.[155] Moreover, when regard is had to Nigeria's strategic position as one of the economic giants of the African continent,[156] it is doubtful that claims about lack of resources to meet health obligations would be considered credible. However, Nigeria remains in need of international assistance, both financial and technical, to meet the health needs of its population. What this means is that Nigeria is likely to benefit from a favourable interpretation of the international right to health if it can push for greater international assistance (of a financial and technical nature)[157] on the basis of the right to health. Such a favourable interpretation is unlikely to occur if Nigeria stands aloof and unengaged with the politics and processes of the right to health in international discourse and in the United Nations (UN) system. By becoming deeply

---

153 A response has been provided to this potential critique in Section 2.1.

154 See *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976), art 2(1).

155 See Committee on Economic Social and Cultural Rights, *General Comment No 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)*, 5th sess, UN Doc E/1991/23 (14 December 1990).

156 BBC, 'Nigeria Becomes Africa's Biggest Economy', *BBC NEWS Business* 2014 <http://www.bbc.com/news/business-26913497>; although in 2016, Nigeria lost its place as the largest economy on the African continent when its economy went into recession. See Michael Eboh, 'Nigeria in Recession as Economy Shrinks by 2.06%', *Vanguard* 31 August 2016 <http://www.vanguardngr.com/2016/08/nigeria-recession-economy-shrinks-2-06/>; Omololu Ogunmade and Obinna Chima, 'IMF Warns Nigeria Heading Towards Recession', *THISDAY* 20 July 2016 <http://www.thisdaylive.com/index.php/2016/07/20/imf-warns-nigeria-heading-towards-recession/>.

157 Ooms et al, above n 78.

engaged at this level, Nigeria can advance an agenda that strengthens its legal position on the right to health internationally by attracting critically needed technical and financial assistance to its domestic system, thereby strengthening its ability to meet its health responsibilities in the domestic system.

What the foregoing suggests is that in the international context, legal positions refer to the ways Nigeria can advance its strategic interests in health to bolster its ability to address domestic health responsibilities. This interpretation of legal positions as *engagement* in the international context is driven by the peculiar health needs of Nigeria and an attempt to respond to those needs.[158] It is not overly concerned with staying true to Alexy's framing of legal positions in constitutional theory.

2.4.2 Legal Positions in the Constitutional Context

In the constitutional context, the response to the framing question on how legal positions can strengthen the right to health so that universal health coverage can be attained and better health outcomes result suggests that attention needs to be paid to the normative framework of rights in the *Constitution of Nigeria* to ensure that only norms that advance legal positions on the right to health are elevated by the constitution.[159] The point here is that due to the effects of constitutional rights on the entire normative framework of rights in Nigeria, it is best to ensure that the right to health in the constitution has not been framed in a manner that allows derogation from that right.[160] This emphasis on the constitutional framing of the right to health is not made on the basis that simply because the right to health is contained in the constitution, it will necessarily be enforced. On the contrary, as the study by Eleanor Kinney and Brain Clark shows, not all countries having provisions for health and healthcare in their constitutions 'have in practice lived up to these mandates'.[161] Nonetheless, it does not hurt to have such provisions, especially when one contemplates how domestic social actors can be empowered to seek better health outcomes through a strengthened legal position on the right to health.

---

[158] These ideas are more extensively discussed in Chapter 4 of this thesis.

[159] This discussion is treated more extensively in Chapter 5 of this thesis.

[160] As would be argued in Chapter 5, the current framing of the right to health in the Constitution of Nigeria is such as to allow for derogation from this right.

[161] Eleanor D. Kinney and Brian Alexander Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) 37 *Cornell International Law Journal* 285, 294.

2.4.3 Legal Positions in the Policy and Legislative Context

Legal positions in the policy and legislative context interrogate how legal norms affecting the right to health are promulgated and implemented in the country. The objective here is first to understand the kind of policies and legislation concerning health that have been promulgated, and the choice of legal instrument for doing so: whether preference has been shown for soft law policy instruments as opposed to hard law legislative instruments. The significance of legal positions has to do with the nature of the rights created for beneficiaries of the right to health under such policy or legislative instruments; and the nature of the obligations created by such instruments for addressees of the right to health.[162]

2.4.4 Legal Positions in the Judicial Context

In Section 2.2.2.3, the discussion focused on how judicial review can influence the uptake of legal positions on the right to health. In this section, a different aspect of judicial influence is considered, namely how 'health rights litigation'[163] can affect legal positions on the right to health. A taxonomy is offered here suggesting that when courts engage with the right to health through the litigation process, they either enable the right, amplify the right, impede the right or act with ambivalence towards the right. These categories are not mutually exclusive; thus it is possible that two or more of these outcomes may manifest at any particular time, and this complicates our understanding of the contributions being made by the courts in strengthening legal positions on the right to health. Courts in Nigeria should strive to enable or amplify the right to health and avoid impeding or being ambivalent towards the right to effectively strengthen legal positions on the right to health for the Nigerian populace.

2.4.5 Summary

This section has suggested that securing legal positions on the right to health would require a synergy of strategies that involves the international, constitutional, policy and legislative, and judicial contexts. In each of these contexts, a number of strategies have been identified for adoption by Nigeria. They are based not on firm adherence to theoretical principles, but on pragmatic considerations of how the specific needs of Nigeria can be addressed in each of these sites.

---

[162] These arguments are more fully treated in Chapter 6 of this thesis.

[163] This is used interchangeably with the 'judicialisation of the right to health' in this thesis.

2.5 Conclusion

The framework of the right to health as a set of legal positions to universal health coverage developed in this chapter is based on the ideas espoused by Alexy's constitutional theory. In adopting Alexy's theory in this thesis, a number of important modifications have been introduced. First, the theory is extended beyond the constitutional domain that Alexy contemplates, to also include the international, policy and legislative, and judicial contexts. Legal positions, as expressing the nature of the relationship created between right-holders and obligated persons/entities, offer a basis for this thesis to suggest the reinvigoration of the right to health in the domestic system of Nigeria; and its convergence with the framework of universal health coverage. Thus, in developing the framework of the right to health as legal positions, the chapter focused on the Nigerian condition and what needs to be done in the country to strengthen the right to health so that it can position the health system to achieve universal health coverage and likely lead to better health outcomes.

In many respects, the chapter is foundational to the argument of this thesis. This is because it describes the unique lens—legal positions—that informs the way the right to health is viewed. It also identifies universal health coverage as an objective that is not an end in itself but should lead to better health outcomes in Nigeria. In this regard, better health outcomes reflect the commitment to bring about significant reductions in mortality rates and the morbidity ratio, reductions in the incidence of communicable and non-communicable diseases, and improvements in the situation regarding underlying determinants of health in Nigeria. By defining better health outcomes in this way, the chapter places an emphasis on the fact that there has to be a target to be achieved by the right to health as legal positions to universal health coverage; otherwise it will fall into the error of being another right that captures the imagination but achieves very little.

The chapter also identifies the important role that strong state organs can play in giving effect to the right to health as a set of legal positions to universal health coverage. These institutions are those controlled by the three branches of government in Nigeria. However, recognising that state organs in Nigeria are weak and often unable to meet the reasonable expectations of the population, the chapter advocates for domestic social actors to mobilise and offer alternative frameworks to drive the uptake of the right to health as legal positions to universal health coverage.

Finally, the chapter identifies the need for a synergy of approaches, involving the international, constitutional, policy and legislative, and judicial contexts where legal positions need to drive the reinvigoration of the right to health. In each of these contexts, specific issues are addressed as part of a broader strategy to ensure that no ground is left uncovered in seeking ways to transform the health system of Nigeria to achieve better health outcomes.

CHAPTER 3: NIGERIA, THE COMPARATORS, AND HEALTH INDICATORS

3.0 Introduction

This chapter commences the comparative section of this thesis and spans five chapters.[1] The primary purpose to this comparison is to highlight the unique features of Nigeria and the comparators which make them better able or unable to secure legal positions on the right to health in their domestic legal systems. Some of the specific considerations that have featured in this regard are for instance whether existing legal and political structures of of these countries can help explain why legal positions on the right to health has been attained or not attained. As the chapter finds, there are a variety of factors that interact to determine whether a country's health system thrives or fails to thrive; and to that extent, whether legal positions on the right to health is secured or not secured. As such, the main purpose of this chapter is to bring these considerations to light to further deepen the discussion in this thesis.

Section 3.1 identifies the countries selected as comparators for Nigeria and provides an account of the considerations informing the choice of these countries. Section 3.2 discusses the demographic, political, geo-political, economic, legal and institutional contexts of Nigeria and the comparators, highlighting areas of similarities and differences. Section 3.3 presents data sets indicating the performance of Nigeria and the comparators with respect to a number of health indicators. The objective is to interpret these data sets against the backdrop of the broader discourse in the thesis on the right to health as a set of legal positions to universal health coverage that will likely lead to better health outcomes in Nigeria. Section 3.4 concludes the chapter, identifying the key findings from the data analysis and highlighting how these findings contribute to our understanding of the framework of the right to health as legal positions. Overall, the chapter serves as a reference point for the discussion in other chapters in the thesis.

3.1 Rationale for Choice of Comparators

Broadly speaking, in the choice of Brazil, India and South Africa as comparators of Nigeria, careful consideration has first been given to the research question and objectives of the thesis as identified in Chapter 1, and how the comparators strengthen the basis for

[1] Namely Chapters 3, 4, 5, 6 and 7.

responding to the question and objectives.[2] In facilitating a response to the research question and objectives, the comparators have been chosen because in different ways they provide a basis for comparing how the right to health, as a set of legal positions to universal health coverage, manifests in the different conditions offered by the comparators—across legal, economic, demographic and other lines.

The second rationale for the choice of comparators in this thesis is the need to 'adhere to inference-oriented case-selection and research-design standards', which emphasise the 'making of valid inferences that go beyond the particular observations collected'.[3] The broad context of the thesis, focused on outcomes in the health system of Nigeria, has necessitated adherence to a rigorous process of case selection and research design. This process, as Ran Hirschl observes, 'goes beyond mere description, classification, or normative justification'[4] and offers a basis for inference to be drawn as to the validity of the hypothesis that the right to health, as a set of legal positions to universal health coverage—if implemented by means of compliance and engagement with the relevant international treaty framework, constitutional entrenchment, legislation and policy and judicial enforcement, driven by domestic social activism—can lead to better health outcomes in Nigeria.

Third, the choice of the comparators is informed by the need to explain, rather than describe, how health outcomes in Nigeria trace back to the normative framework of rights and the institutional mechanisms for their enforcement. In bringing about this attainment, 'common rules of causal inference' have been used to select case studies (the comparators) 'in a theory-minded fashion that follows clearly articulated methodological principles'.[5] Hirschl identifies these methodological principles as involving:

> (i) formulation of testable hypotheses, models, or a priori plausible arguments concerning possible causal links among well-defined variables; (ii) support or disconfirmation of these hypotheses, models or arguments through pertinent research design, data collection, and analysis; and (iii) generation of conclusions that are likely to be true based largely on inductive inference.[6]

---

2 Ran Hirschl, 'Case Selection and Research Design in Comparative Constitutional Studies ' in *Comparative Matters: The Renaissance of Comparative Constitutional Law* (Oxford University Press, 2014) 225-6.
3 Ibid 226, 230.
4 Ibid 227.
5 Ibid 226, 228.
6 Ibid 243.

In adhering to these principles, the hypothesis offered by this thesis is suggested to be one that is testable because it offers (1) a possible causal link between well-defined variables relating to the right to health, to support or reject the hypothesis and (2) the opportunity for engaging with data on the experiences of Nigeria and the comparators across the dimensions identified in the hypothesis. Consequently, the framework that emerges is suggested to be one that can support or disconfirm the hypothesis that a potential link exists between the right to health as a set of legal positions to universal health coverage, and better health outcomes in Nigeria.

In addition to the foregoing theoretically grounded reasons informing the choice of the comparators, Brazil, India and South Africa have also been chosen as comparators for Nigeria on pragmatic grounds that include demographic, political, geo-political, economic, legal and institutional considerations. These pragmatic considerations also account for why a country like Colombia, that has worked through the courts in ordering large-scale transformation of the public health care system in the direction of broader coverage, was omitted. Further clarification of these considerations are offered below.

3.1.1 Demographic Considerations

Demography is concerned with the dynamic of change in a given population (e.g. trends in fertility, mortality and migration). It studies man and society, operating in the 'real world of people and places'.[7] As a discipline, it locates itself within the construct of the sciences and is dedicated to 'the scientific study of populations'.[8] Historically, demography and public health have had a close relationship.[9] It is, however, in the area of public health preparedness that the 'tools and techniques of population sciences' have been found to be most relevant.[10] This is because effective public health preparedness has required the systematic integration of key methods of demography.[11] Demography's essential contribution is the tool it provides for measuring health and healthcare needs of populations through knowledge of their size and other characteristics.[12] In effect this means that populations of countries have different characteristics based on their size and other demographic features; these affect their ability to meet the health and healthcare

---

7 Hervé Le Bras, *The Nature of Demography* (Princeton University Press, 2008) 1.

8 Ibid 3.

9 Benedict J. Duffy and H. Behm, 'Demography and Public Health' (1964) 42(2) *The Milbank Memorial Fund Quarterly* 276.

10 Heather Allen and Rebecca Katz, 'Demography and Public Health Emergency Preparedness: Making the Connection' (2010) 29(4) *Population Research and Policy Review* 527.

11 Ibid 528.

12 Emily Grundy, 'Demography and Public Health' in Roger Detels et al (eds), *Oxford Textbook of Public Health* (Oxford University Press, 5th ed, 2009) vol 2, Section 7.2.

needs (or standards of public health preparedness) of their people. It is for this reason that the choice of Brazil, India and South Africa (three countries with disparate demographic features) as comparators for Nigeria is important for this thesis: it allows the assessment of how the peculiar characteristics of the population of these countries affect their public health systems (and patterns of health and ill-health) and provides a useful metric for assessing the situation in Nigeria.

3.1.2 Political Considerations

Brazil, India and South Africa are constitutional democracies, each organised into a federal system comprising federating units and a central government exercising executive and legislative authority.[13] To this extent, they compare with Nigeria, a country that is also a constitutional democracy operating a federal system of government.[14] The main question raised by this consideration is whether the right to health, as a set of legal positions to universal health coverage, is better served if responsibility for health is left to the federating units (e.g. as in India and Nigeria);[15] or whether it is a matter better handled jointly by the central government and federating units (e.g. as in Brazil and South Africa).[16]

3.1.3 Geo-political Considerations

Geo-political considerations address the narrow question of how membership (or non-membership) of regional human rights bodies, by the comparators and Nigeria, influence the domestic situation regarding the right to health in these states. In this regard, South Africa's membership of the African Union Human Rights System ('the AU System') alongside Nigeria provides an assessment criterion for gauging the influence of that membership on the domestic situation regarding the right to health in the two states. On the other hand, Brazil's membership of the Inter-American Human Rights System ('the Inter-American System') is strategic for the opportunity it provides to compare and contrast the experiences of Nigeria with South Africa (under the AU System) and Brazil (under the Inter-American System). Further, India's non-membership of a regional human rights body offers a unique opportunity to observe how unaffiliated states like India are performing in the absence of the 'moral imperative' offered by such bodies.

---

13 See *Constitution of Brazil, 1988*, arts 1 and 2; *Constitution of India*, art 1; and *Constitution of South Africa 1996*, s 1.

14 See *Constitution of Nigeria 1999*, ss 1, 2 and 3.

15 See *Constitution of India*, art 246(3) and Seventh Schedule, List II, s 6; *Constitution of Nigeria 1999*, s 4(2) and Fourth Schedule, s 2(c).

16 See *Constitution of Brazil, 1988*, art 23(II); *Constitution of South Africa 1996*, ss 44(1)(ii) and 104(4).

3.1.4 Economic Considerations

The right to health, as a set of legal positions to universal health coverage, is as much an *economic* question as it is a *human rights* question. As such the economic situation in Brazil, India and South Africa is an important factor in the decision to use them as comparators of Nigeria. The key question advanced by this consideration is whether the relative progress (or lack thereof) of Nigeria and the comparators in achieving the mandate of the right to health as a set of legal positions to universal health coverage is in any way shaped, influenced or determined by the economic situations of these states.

3.1.5 Legal Considerations

There are similarities and differences in the way Brazil, India and South Africa have organised their legal systems. For instance, Brazil's legal system, unlike Nigeria's, is strongly influenced by the civil law tradition known for prioritising legislative enactments over judicial decisions. As such, judicial pronouncements by the top courts in Brazil lack *erga omnes* effect, in the sense that individual cases do not set precedents for others similarly situated.[17] India and South Africa, on the other hand, like Nigeria, are influenced by the common law tradition where, although legislation plays an important role as a source of law, judicial pronouncements interpreting legislation are equally important sources of law with *erga omnes* effect.[18] The consideration here is whether these patterns of organisation of the legal system of Nigeria and the comparators influence the context of the right to health, as a set of legal positions to universal health coverage; if so, it is important to understand the nature of this effect arising from the 'judicialisation'[19] of the right to health in Nigeria and the comparators.

3.1.6 Institutional Considerations

These considerations examine how Brazil, India and South Africa have organised their healthcare systems in comparison with Nigeria: whether they have created a unified healthcare system established on the basis of principles of universal health coverage (e.g. Brazil and South Africa); or a fragmented healthcare system with multiple actors in financing and provision (e.g. India and Nigeria).[20] The question advanced by this

---

17 Siri Gloppen, 'Litigating Health Rights: Framing the Analysis' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) 19.

18 Ibid.

19 In Chapter 7, a number of phrases are used interchangeably to refer the phenomenon of increased recourse to the courts and the legal process in states, to enforce the right to health. These phrases include: 'judicialisation of the right to health' and 'litigation of the right to health'.

20 Gloppen, above n 17, 19-20.

consideration is whether (and how) these patterns of organisation of the health systems in Nigeria and the comparators affect the situation with respect to the right to health in these states.

In summary, each of these considerations offers a unique perspective in the broad discourse undertaken by this thesis. They are important because they draw attention to how different factors influence the right to health in Nigeria and the comparators. In areas of similarity between Nigeria and the comparators, the thesis assesses what Nigeria has done 'rightly' or 'wrongly' compared to the comparators, and on that basis conclusions are made on how this may have affected health outcomes in these countries. In areas of difference, the thesis points to how the unique contexts of Nigeria and the comparators may have contributed to differences in health outcomes between them.

3.2 Situating Nigeria and the Comparators

Building on the previous section, which offered a panoramic view of the theoretically grounded and pragmatic considerations informing the choice of the comparators, this section undertakes a more detailed discussion of these considerations. It examines the specific contexts of Nigeria and the comparators in the areas outlined in Section 3.1. This aspect of the discussion highlights the interconnections and/or effects of demographic, political, geo-political, economic, legal and institutional factors on the situation regarding the right to health, in Nigeria and the comparators. In doing so, the section draws on the observations in other chapters where more detailed discussions have been carried out.

3.2.1 Geography and Demography

The geography, population size, population distribution, trends in population change and fertility rate of the comparators and Nigeria are examined in this section. The purpose of this examination is to provide a basis for situating Nigeria against the comparators, and each country against the other. This is relevant for contextualising the discourse on the right to health, as a set of legal positions to universal health coverage, in line with the peculiar context of each country.

3.2.1.1 Geography

The geographical features of Nigeria and the comparators are relevant to the discussion in this section because they deepen knowledge on how specific features of these countries influence their need for health services. In addition, this provides a better understanding of why certain strategies might work in one country and not another.

Nigeria is a country on the West Coast of Africa with a land mass of 910,770 square kilometres[21] lying 5º north of the equator and between 3º and 4º east of the Greenwich Meridian. The country is bordered on the south by the Gulf of Guinea and the Atlantic Ocean, on the north by the Republics of Niger and Chad, on the east by the Republic of Cameroun and on the west by the Republic of Benin.[22] It is the 31st-largest country in the world by land area[23] and is geographically smaller than the comparators.

Brazil, home to the world-acclaimed Amazon Rainforest, is located in South America.[24] Brazil's fascinating geography in addition to the Amazon Rainforest includes highlands, vast stretches of coastline, mangroves, lagoons, dunes and spectacular coral reefs.[25] Brazil's total surface area is 8,358,140 square kilometres,[26] making it the fifth-largest country in the world (by land area). It occupies almost half of the entire South American continent.[27]

India, covering an area of 2,973,190 square kilometres,[28] is the seventh-largest country in the world (by land area) and is located in South Asia.[29] The country has three distinct geographic regions: the Himalayan region in the north, which has some of the highest mountains in the world; the Gangetic Plain in the north central area stretching westward; and the plateau region in the south and central part.[30]

South Africa, which is part of the Southern African sub-region, has a land area covering 1,213,090 square kilometres[31] and is the 25th-largest country in the world (by land area).[32] South Africa's physical features include bushveld, grasslands, forests, deserts, mountain peaks and coastal wetlands.[33]

---

21 World Bank, *Land Area (Sq. km): Overview Per Country* (<http://data.worldbank.org/indicator/AG.LND.TOTL.K2>.

22 Federal Ministry of Health (Nigeria), *National Strategic Health Development Plan 2010-2015*, November 2010 20.

23 World By Map, *Land Area of All Countries of the World* (<http://world.bymap.org/LandArea.html>.

24 Brazil, *Brazil Geography Introduction* (<http://www.brazil.org.za/brazil-geography-into.html>.

25 Ibid.

26 World Bank, above n 21.

27 Brazil, above n 24.

28 World Bank, above n 21.

29 Facts About India.com, *Geography Facts About India* (<http://www.facts-about-india.com/Geography-facts-about-india.php>.

30 Infoplease, *India* (<http://www.infoplease.com/country/india.html>; Negi Mohita, *Indo-Gangetic Plain: 3 Divisions of the Ganga Plain in India* (<http://www.yourarticlelibrary.com/geography/indo-gangetic-plain-3-divisions-of-the-ganga-plain-in-india/13796/>.

31 World Bank, above n 21.

32 World By Map, *Land Area of All Countries of the World* (<http://world.bymap.org/LandArea.html>.

33 South African Government, *Geography and Climate* (<http://www.gov.za/about-sa/geography-and-climate>.

3.2.1.2 Demography

(a) Population size. The *World population prospects 2015*, published by the Population Division of the United Nations Department of Economic and Social Affairs, shows India as having the largest population among Nigeria and the comparators, at 1,311,051,000.[34] Brazil follows India with 207,848,000;[35] Nigeria has 182,202,000;[36] South Africa has the smallest population, with 54,490,000[37] and is the only country among the comparators with a population smaller than that of Nigeria.

There are a number of important points to note about these figures. First, India's population surpasses that of the other comparators and Nigeria combined. This is quite significant for what it says about the nature of the responsibility for India to achieve universal health coverage in the country. Second, Brazil's population surpasses that of Nigeria by 25,646,000. When compared to the difference between Nigeria and South Africa's population—which is 127,712,000— Brazil is the country with the closest population size to that of Nigeria.

(b) Population distribution. The way a country's population is distributed with respect to age and gender is important for health governance because different population groups have different health needs. A country with more males than females would have different health priorities than a country with more females than males. By the same token, a country with a large ageing population will have different health needs to one with a large youthful population.

Nigeria has 104 males per 100 females;[38] Brazil has 97 males per 100 females;[39] India has 108 males per 100 females;[40] and South Africa has 97 males per 100 females.[41] Thus, only India has a higher male to female sex ratio than Nigeria (the highest among the four countries), and Brazil and South Africa have the same sex ratio as one another.

With respect to age distribution, in Nigeria, persons aged 0–14 years account for 43.2% of the population; persons aged 15–24 years account for 19.3% of the population; persons aged 25–54 years account for 30.5% of the population; persons aged 55–64 years account

---

34 United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, World Population Wallchart.* ST/ESA/SER.A/378.
35 Ibid.
36 Ibid.
37 Ibid.
38 United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* ESA/P/WP.241, 16.
39 Ibid 13.
40 Ibid 15.
41 Ibid 17.

for 3.9% of the population; and persons aged 65 years and above account for 3.1% of the population.[42] Nigeria's population pyramid, shown in Figure 3.1 is a perfectly shaped triangle. It differs markedly in shape from those for Brazil and South Africa but is similar to that of India, which also has a triangular shape, although bulging in the middle. Nigeria's perfectly triangular population pyramid is consistent with its population comprising more young people than people of middle or old age; it also reflects a country with a population that is growing at a very rapid pace—a trait it shares with India. This interpretation aligns with the findings of the *World population prospects 2015*, which projects that India will overtake China as the most populous country in the world within seven years;[43] and Nigeria, currently the seventh most populous country in the world, is projected to surpass the population of 'the United States of America by about 2050, at which point it would become the third largest country in the world'.[44]

In Brazil, persons under 15 years account for 23.8% of the population; persons aged 15–24 years account for 16.5% of the population; persons aged 25–54 years account for 43.7% of the population; persons aged 55–64 years account for 8.4% of the population; and persons aged 65 and above account for 7.6% of the population.[45] The population pyramid for Brazil in Figure 3.2 is characteristic of a country that has made the transition from a young to a middle-aged population; with more people in the bracket of middle age than in young (under 25 years) or old age (above 65 years). This also implies a population with an active workforce and growing demand for healthcare goods and services to meet present and future health needs.[46]

---

42 Index Mundi, *Nigeria Age Structure* (30 June 2015 <http://www.indexmundi.com/nigeria/age_structure.html>.

43 United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* ESA/P/WP.241, 4.

44 Ibid.

45 Index Mundi, *Brazil Age Structure* (30 June 2015 <http://www.indexmundi.com/brazil/age_structure.html>; United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Volume II: Demographic Profiles.* ST/ESA/SER.A/380, 136.

46 Index Mundi, above n 45.

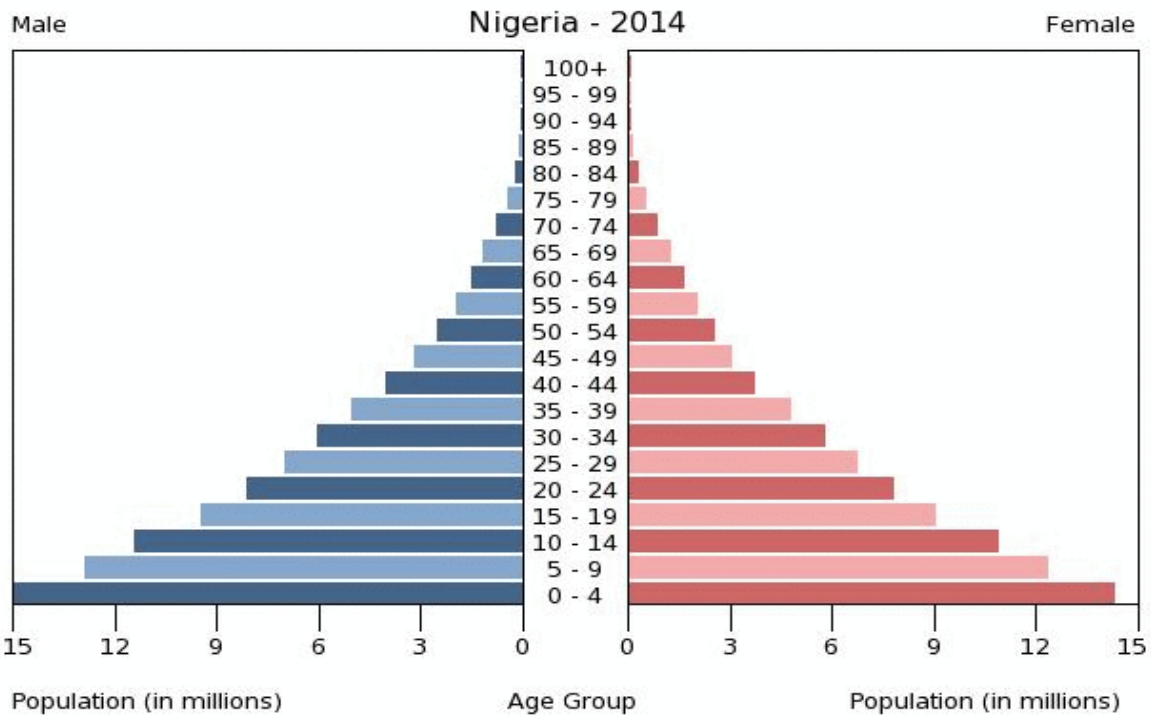

Figure 3.1: Population pyramid for Nigeria (Source*:* Index Mundi, 2014)

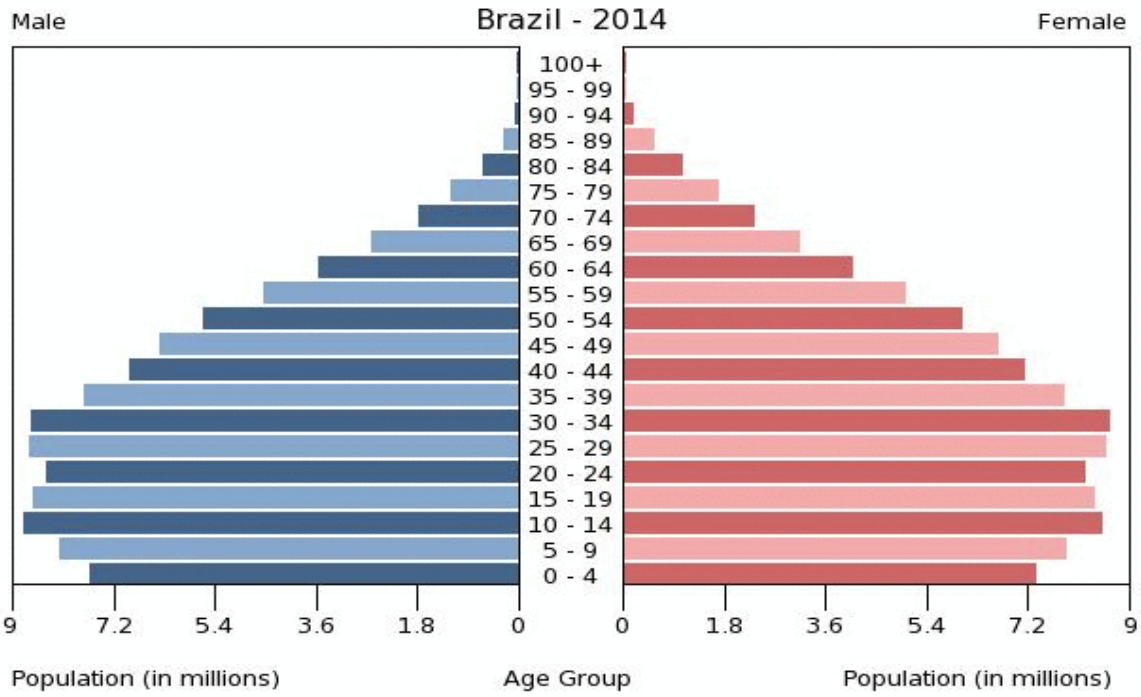

Figure 3.2: Population pyramid for Brazil (Source*:* Index Mundi, 2014)

In India, persons under 15 years account for 28.5% of the population; persons aged 15–24 years account for 18.1% of the population; persons aged 25–54 years account for 40.6% of the population; persons aged 55–64 years account for 7% of the population; and

persons aged 65 years and above account for 5.8% of the population.[47] The population pyramid for India in Figure 3.3 is indicative of a country with a sizeable number of very young people and a large middle age group (here it matches some of the characteristics of the population of Brazil). India's population pyramid reflects a country with a population that is growing at a rapid pace[48] and that is younger than that of Brazil.

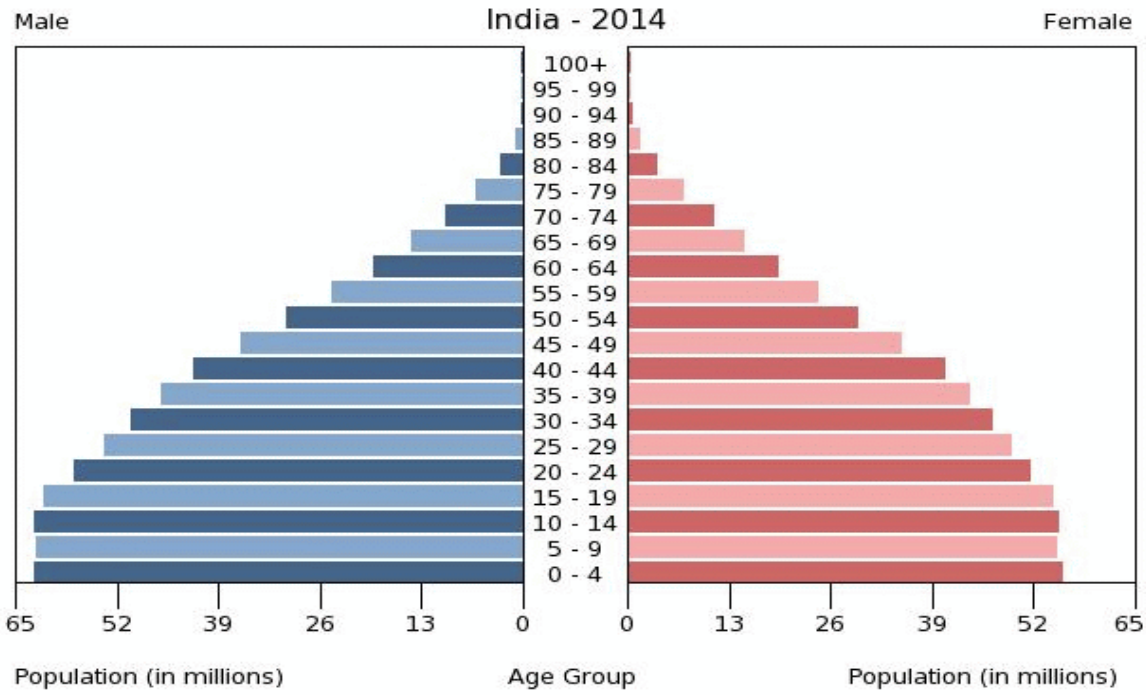

Figure 3.3: Population pyramid for India (Source*:* Index Mundi, 2014)

In South Africa, persons under 15 years make up 28.3% of the population; persons aged 15–24 years make up 20.2% of the population; persons aged 25–54 years make up 38.2% of the population; persons aged 55–64 years make up 7.1% of the population; and persons aged 65 years and above make up 6.3% of the population.[49] The population pyramid for South Africa in Figure 3.4 is indicative of a country with a relatively youthful population. It also reflects a population experiencing an unusually rapid decrease in both male and female population numbers around the ages of 29–44 years.[50] This phenomenon becomes meaningful when viewed against the backdrop of the significant health risks faced by

---

47 Index Mundi, *India Age Structure* (30 June 2015 <http://www.indexmundi.com/india/age_structure.html>; United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Volume II: Demographic Profiles.* ST/ESA/SER.A/380, 377.

48 Index Mundi, above n 47.

49 Index Mundi, *South Africa Age Structure* (30 June 2015 <http://www.indexmundi.com/south_africa/age_structure.html>; United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Volume II: Demographic Profiles.* ST/ESA/SER.A/380, 697.

50 Index Mundi, above n 49.

women in South Africa, arising from the 'four colliding epidemics of HIV and tuberculosis; a high burden of chronic illness and mental health disorders; deaths related to injury and violence; and a silent epidemic of maternal, neonatal, and child mortality', which Bongani Mayosi et al. note to be bedevilling the health system of South Africa.[51] The high incidence of HIV/AIDS and some non-communicable diseases in South Africa may thus explain the decreases in the population size on the male and female axes of Figure 3.4.

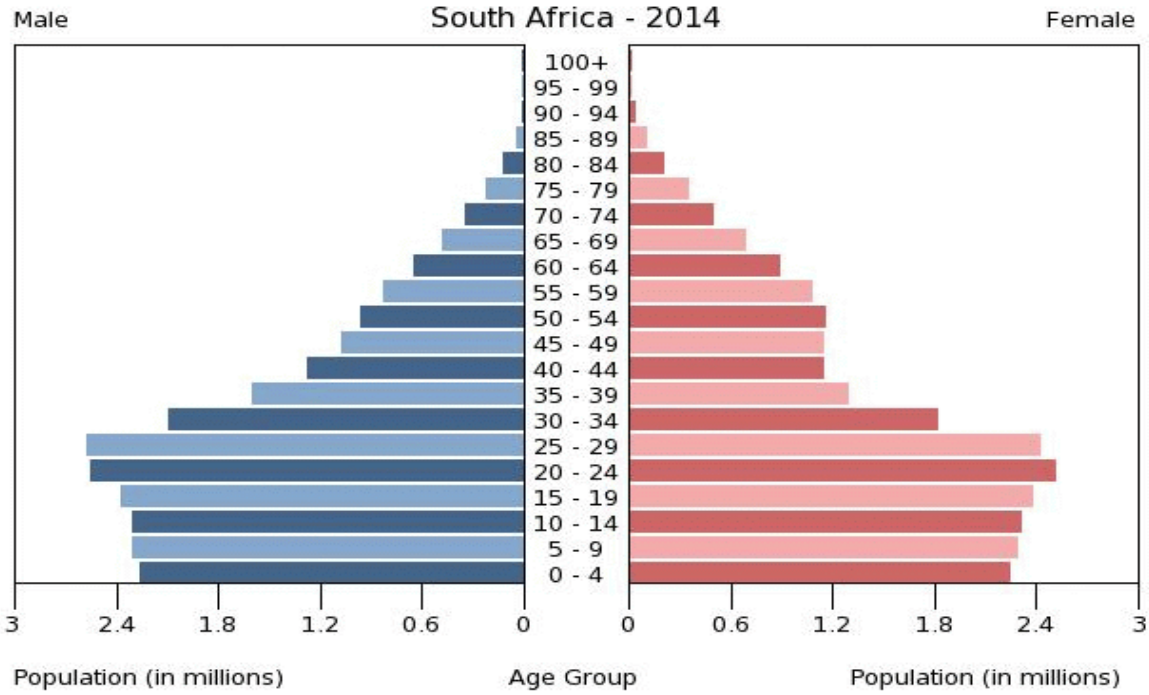

Figure 3.4: Population pyramid for South Africa (Source*:* Index Mundi, 2014)

(c) Trends in population change. This indicator, known as the 'average annual rate of population change', measures in percentage terms how fast the size of a population is changing through time.[52] It is a fundamental indicator for national decision makers and a key factor in measuring the sustainability of a country's growth patterns: rapid population growth places a significant burden on a country's ability to deal with a wide variety of issues, principal among which is health service delivery. On the other hand, the rapid decline in a country's population growth rate suggests potential economic challenges in the future, as workforce shortages may affect the economy. It may also suggest that the country in question may face a higher burden in meeting the health needs of its ageing

[51] Bongani Mayosi et al, 'Health in South Africa: Changes and Challenges Since 2009' (2012) 380 *Lancet* 2029, 2030; for more detailed discussion on the health situation of South Africa, see Chapter 6 of this thesis.

[52] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables.* ST/ESA/SER.A/379.

population as it may lack the economic vibrancy offered by a youthful and working population.[53]

Figure 3.5 depicts the trend in the average annual rate of population change for Nigeria and the comparators for the 25 years from 1990 to 2015; between 1990 and 1994 Nigeria's rate of population change was 2.51%. From 1995 to 1999 it dipped to 2.5%, then rose to 2.55% in 2000, further rising to 2.65% in 2005–2009. Its current rate of 2.67% for the period 2010–2015 is its highest average. Figure 3.5 shows that Nigeria since 1990 has consistently maintained a higher average annual rate of population change than the comparators. Following Nigeria is India, then South Africa and lastly Brazil. This trend accords with the finding that Nigeria is among the nine countries likely to experience significant population growth 'during 2015 to 2050'.[54]

Figure 3.5 also shows that Brazil maintained an even rate of population change of 1.58% from 1990 to 1994, dipping slightly to 1.54% from 1995 to 1999. It subsequently experienced a steady decrease in its rate of population change. It recorded its lowest rate of 0.91% in the period 2010–2015—placing the growth rate of Brazil's population below that of the other comparators and Nigeria.

In the case of India, Figure 3.5 shows a change rate of 1.97% for the period 1990–1994. This rate decreased to 1.84% in the period 1995–1999. From that point onwards, India has experienced a steady decrease in the rate of its population change. The most recent figure, for 2010–2015, is 1.26%, which is India's lowest figure in the period captured. Despite this, India still has a higher average annual rate of population change than both South Africa and Brazil.

Figure 3.5 shows that South Africa had an initial population change rate of 2.37% from 1990 to 1994. After 1995, South Africa's population change rate dropped to 1.61%, which it maintained until 1999. In 2000, this dropped further to 1.48% and since then, South Africa has experienced a steady rate of decrease in the rate of its population change. South Africa's most recent figure, for 2010–2015, is 1.08%. This places South Africa ahead of Brazil, but behind India and Nigeria in this indicator.

---

53 Ibid.

54 United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* ESA/P/WP.241, 4.

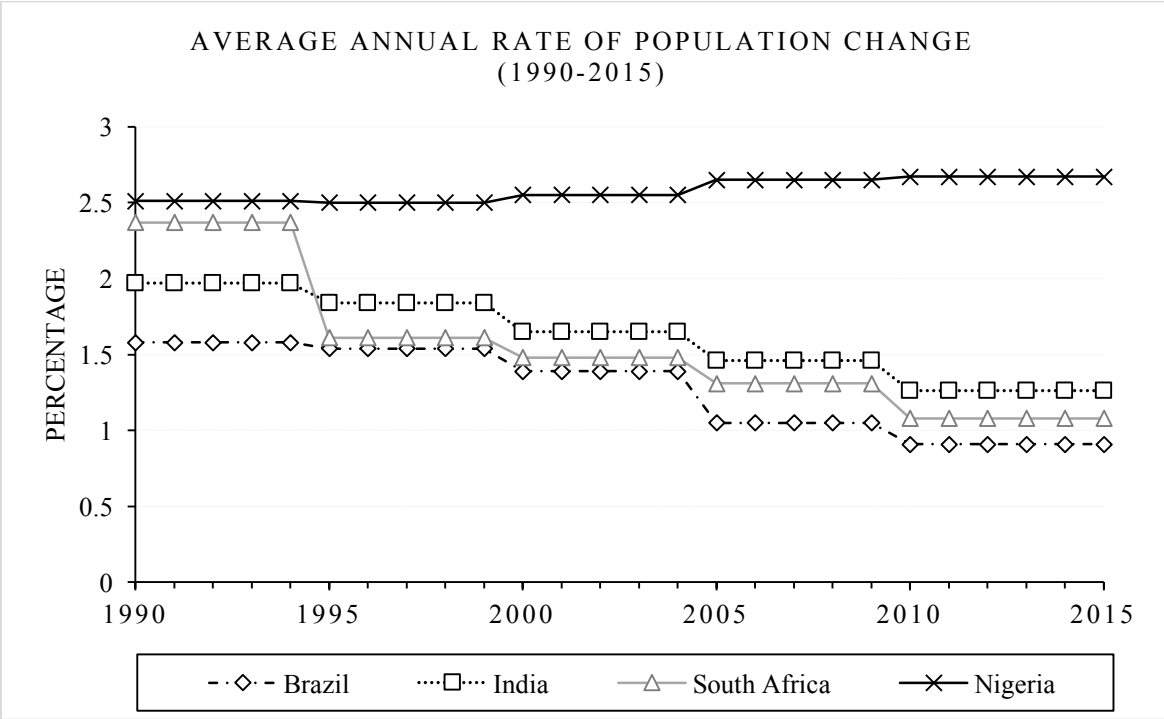

Figure 3.5: Trends in population change in Nigeria and the comparators (Source*:* United Nations Department of Economic and Social Affairs/Population Division) *World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables*

(d) *Fertility rate.* This indicator measures the fertility rate in Nigeria and the comparators by providing estimates of the total number of children per woman in each of these countries.[55] Figure 3.6 shows during 1990–2015, Nigeria consistently surpassed the comparators in this indicator. It began the recording period with an average of 6.37 children per woman in 1990, which had dipped slightly to 5.74 children per woman by 2015. India, coming second to Nigeria, began at 3.83 but has since decreased to 2.48 children per woman. South Africa started at 3.34 children per woman in 1990, which decreased to 2.40 by 2015. Brazil has maintained the lowest fertility rate of all four countries, starting out in 1990 with 2.60 children per woman, and decreasing to 1.82 children per woman by 2015.

[55] United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables.* ST/ESA/SER.A/379, 124.

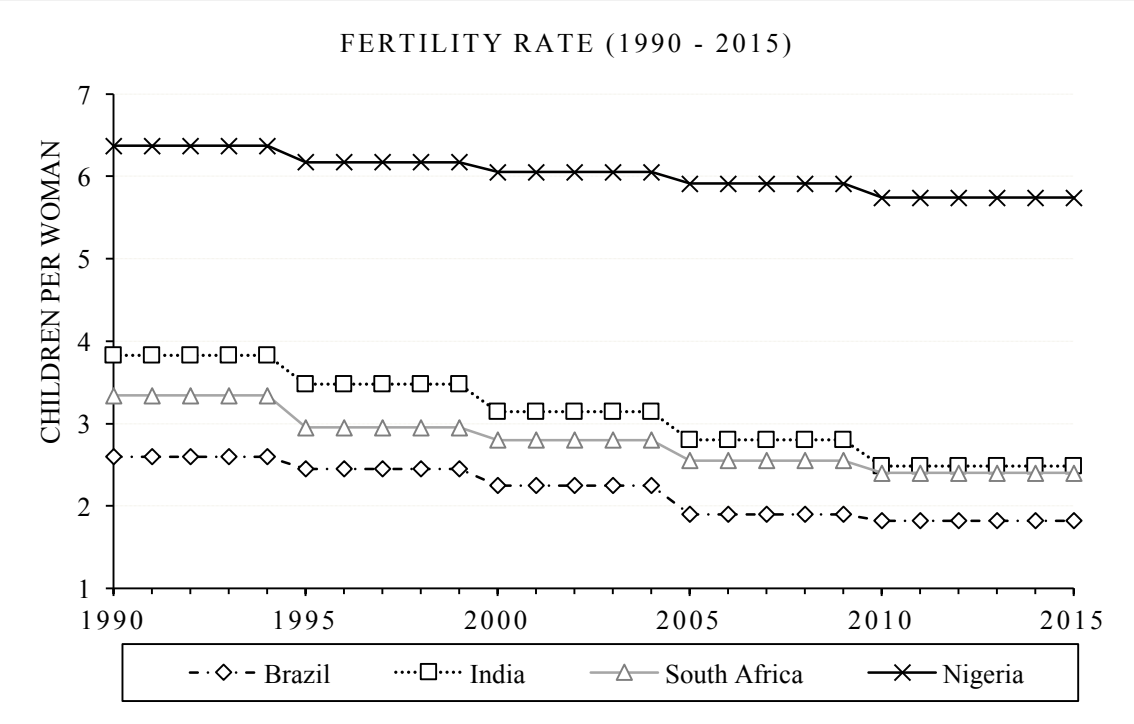

Figure 3.6: Fertility rates in Nigeria and the comparators (Source*:* United Nations Department of Economic and Social Affairs/Population Division) *World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables*

3.2.2 The Political Context

The political context is concerned with how the political system of Nigeria and the comparators—particularly the way they have structured government and distributed responsibilities for health in the constitution—affects the right to health as a set of legal positions to universal health coverage. This matter is extensively dealt with in Chapters 5 and 6. The findings from Chapter 5, for instance, show that in Brazil and South Africa, health is a matter jointly handled by the central government and federating units. All arms of government are mandated to work together to promote the constitutional mandate on the right to health. The effect in these countries of this unified approach to health is most readily felt in the policy arena where, as the discussion in Chapter 6 shows, Brazil and South Africa have done much to promulgate policies and legislation that strengthen legal positions on the right to health.[56]

In India and Nigeria, where health is a matter left to the federating units (i.e., the states) under the constitution,[57] the development of the right to health has been greatly influenced—and not necessarily for good. In India, for instance, responsibility for health

[56] See the discussion in Chapter 6.
[57] See the discussion in Chapter 5.

is restricted to state governments, which has severely limited the scope of involvement of the Union Government in this area. This, in turn, has adversely affected the policy arena where, to date, India has been unable to promulgate national legislation protecting the right to health in the country.[58] In Nigeria, on the other hand, where considerable delays occurred before the first national health legislation was promulgated in 2014,[59] a major factor suggested to have been responsible for this delay is the peripheral treatment of health in its constitution. Primary responsibility for health in the constitution is vested in poorly funded local government councils in the country. In addition, as the discussion in Section 5.2.1.2 illustrates, it is unclear whether the federal or state government is responsible for health. This has enabled the states and federal government to push health to the background in budgetary allocations and other aspects of governance. Even though Nigeria has now enacted a national health legislation, it is doubtful that this measure, on its own, is sufficient to strengthen legal positions on the right to health and lead to better health outcomes in the country; an appropriate constitutional amendment needs to take place to make the right to health a justiciable right and vest responsibility for health service delivery to all tiers of government in the country (federal, state and local government). As argued in Chapter 7, the fact that the *African Charter on Human Rights,* which guarantees the right to health,[60] is also part of Nigerian law[61] does not obviate the need for constitutional amendment guaranteeing this right. This is the surest way of bringing about a strengthened legal position on the right to health for the Nigerian population; it is also suggested as the answer to the current position of the Supreme Court of Nigeria in treating the African Charter's economic and social rights provisions as lacking in constitutional flavour, thus ranking it below provisions of the constitution in importance.[62]

---

58 See the discussion in Chapter 6; see also Ministry of Health and Family Welfare (India), *National Health Policy 2015 Draft,* December 2014 56.

59 Although there have been other national legislations affecting health in the country (e.g. *National Health Insurance Scheme Act 1999* (Nigeria)) before this time, this was the first legislation that set out to establish a framework for standards allocating responsibilities to all stakeholders in the health system. It took about 10 years of negotiations, debates and false starts for this law to be enacted. See generally Lagun Akinloye, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', *Think Africa Press* 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>.

60 *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986), Art. 16.

61 *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria).

62 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

3.2.3 The Geo-Political Context

Does membership of a regional human rights body contribute in any meaningful way to advancing and/or strengthening legal positions on the right to health in states with such membership (e.g. Brazil, South Africa and Nigeria)? How do states that are members of a regional human rights body compare with other states that are not members of such bodies (e.g. India) in terms of the extent of protection of the right to health in such states? These are the questions raised and answered by the geo-political context and treated in Chapter 4 of this thesis.

Chapter 4 advances the claim that a strong correlation exists between states' response to treaty obligations on the right to health and their domestic treatment of that right. Chapter 4 further suggests that regional human rights bodies provide an additional layer of support to member states' efforts to protect and fulfil the right to health, thus advancing legal positions in respect of that right. These bodies do so through instruments and mechanisms that they offer citizens and stakeholders from member states seeking redress for violations of their right to health. These instruments and mechanisms are particularly useful in cases where those available in the domestic legal system of member states are either inadequate or inaccessible.

However, Chapter 4 draws attention to differences in the level of maturity of the AU System (of which Nigeria and South Africa are part) and the Inter-American System (of which Brazil is part).[63] In the Inter-American System, where Brazil is fully engaged, a plethora of instruments and mechanisms are available to the Brazilian population to enforce their right to health and/or seek redress for violations of that right. In contrast, the AU System lacks the procedural sophistication and the plethora of instruments and mechanisms available in the Inter-American System. In addition, many of the member states of the AU System, Nigeria and South Africa included, are not fully engaged with the instruments and mechanisms available in that system.[64]

To the extent that regional human rights bodies provide an additional layer of support to efforts to protect and fulfil the right to health in member states, India's non-membership of such a body is suggested to hinder the strengthening of legal positions on the right to health in India. However, as the discussion in Chapter 7 shows, India appears to have largely mitigated this adverse effect through the activism of its apex court. This activism

---

[63] African Commission on Human and Peoples' Rights, *State Reporting Procedure* (<http://www.achpr.org/states/reporting-procedure/>.

[64] Ibid.

has enabled the right to health to emerge from the shadows of non-justiciability in the *Constitution of India* to the limelight of justiciability in case law, where it is now routinely cited as a fundamental right protected under the *Constitution of India*.[65]

It is pertinent, at this juncture, to draw attention to constitutional principles regarding the domestic application of international law in Nigeria, Brazil and South Africa, where the regional human rights system applies. These constitutional principles are highly influential in the level of engagement of these states with the regional human rights system, and may account for why Brazil seems to be more engaged than Nigeria, and to some extent, South Africa. In dualist states[66] such as Nigeria,[67] regional human rights treaties like the African Charter do not create rights that can be directly enforced by individuals in the absence of incorporation of the treaty into the domestic system by the legislature.[68] In Brazil and South Africa, the position is more complex, as both legal systems reflect elements of monism and dualism.[69] While it is suggested that Brazil's constitutional treatment of international treaties ratified by Brazil makes them more easily applicable in the domestic system of Brazil than is the case for Nigeria, the similarity of South Africa's treaty-reception attitude to that of Brazil makes it difficult to explain why South Africa is not as engaged with the AU System as Brazil is with the Inter-American System. This demonstrates that there are complex factors at play and that there are many issues beyond the scope of this thesis that merit further investigation.

---

65 *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India).

66 These are states where international treaties do not have direct effect unless they have been incorporated into domestic law by an appropriate legislation passed by the legislative body of such states.

67 *Constitution of Nigeria 1999* s 12(1) requires treaties to be incorporated by an Act of the National Assembly before they can have the force of law in Nigeria.

68 As pointed out in Section 1.1, the *African Charter* has been incorporated into Nigeria's domestic system by the *African Charter Act.*

69 The *Constitution of Brazil, 1988*, art 5(3) provides that 'International human rights treaties and conventions which are approved in each House of the National Congress, in two rounds of voting, by three fifths of the votes of the respective members shall be equivalent to constitutional amendments'. With respect to treaties that have only been ratified by Brazil, but have not gone through this process, Yi Shin Tang suggests that they are 'generally considered to enjoy infraconstitutional status in the country (i.e. at a lower hierarchy than the constitution itself)' see Yi Shin Tang, 'International Justice Through Domestic Courts: Challenges in Brazil's Judicial Review of the Amnesty Law' (2015) 9 *International Journal of Transitional Justice* 259, 268; in South Africa, the *Constitution of South Africa 1996*, s 231(2) says international agreements require the approval of both the National Assembly and the National Council of Provinces. On the other hand, s 231(3) says 'international agreements of a technical, administrative or executive nature, or an agreement not requiring either ratification or accession, once entered into by the executive, binds the Republic without approval by the National Assembly and National Council but must be tabled before both bodies between a reasonable time.' See John Dugard, 'International Law and the South African Constitution ' (1997) 8(1) *European Journal of International Law* 77, 82.

3.2.4 The Economic Context

The economic context draws attention to how economic considerations, such as the size and strength of a country's economy, determine its ability to advance the right to health. Countries with strong economies unarguably have more financial resources that can be invested in the health system than countries with weak economies. For this reason, economic considerations affect the prospects of the right to health. An important question raised by this consideration is how to measure the strength of the economy of a country.

Traditionally, the Gross Domestic Product (GDP) is used to measure the strength or weakness of a country's economy. As a macroeconomic measure of output, the GDP 'helps analysts and investors get a better feel for whether a country is more or less productive and in turn whether it is headed for a recession or a bull market'.[70] The GDP offers estimates of 'the total value of goods and services produced in a country and aims to capture the true monetary value of the economy'.[71] As larger countries tend to have more economic activity, and therefore a higher GDP than smaller countries, GDP per capita is used to arrive at the real strength of an economy.

GDP per capita levels are obtained by 'dividing GDP at current market prices by the population. A variation of the indicator could be the growth in real GDP per capita, which is derived as the percentage of change in real GDP divided by the population'.[72] The unit of measurement for this indicator is US dollars.[73] The policy relevance of the GDP per capita is that it reflects changes in total wellbeing of the population: '[a]s a single composite indicator it is a powerful summary of economic development'.[74] It is also useful for carrying out broad comparisons of the performance of the economy of different countries.

---

70 InvestingAnswers, *Per Capita GDP* (<http://www.investinganswers.com/financial-dictionary/economics/capita-gdp-5096>; a recession is 'two consecutive quarters of declining GDP' – see InvestingAnswers, *Recession* (<http://www.investinganswers.com/node/2562>; on the other hand, 'a bull market is a period of several months or years during which asset prices consistently rise. The term is usually used in reference to the stock market, but it can describe specific sectors such as real estate, bonds or foreign exchange' – see InvestingAnswers, *Bull Market* (<http://www.investinganswers.com/node/922>.

71 Mehreen Khan, 'What Does GDP Really Tell Us About Economic Growth?', *The Telegraph* 15 October 2014 <http://www.telegraph.co.uk/finance/economics/11159277/What-does-GDP-really-tell-us-about-economic-growth.html>.

72 *Gross Domestic Product Per Capita* (<http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/econ_development/gdp_per capita.pdf>; InvestingAnswers, *Per Capita GDP* (http://www.investinganswers.com/financial-dictionary/economics/capita-gdp-5096.

73 United Nations Department of Economic and Social Affairs, above n 55.

74 Ibid.

Figure 3.7 shows the trend in the GDP per capita of the comparators and Nigeria. The trend indicates that Brazil has the highest GDP per capita among the comparators and Nigeria. It is followed by South Africa, Nigeria and India, in that order. Brazil's GDP per capita has more than doubled since 2000 when it was US$3,728.50, to around US$8,538.59 in 2015. Despite this massive improvement, Brazil's economy has been in recession since 2012. South Africa experienced a growth trajectory in its GDP per capita from 2002 to 2007, followed by a brief period of recession between 2007 and 2008. This was then followed by another period of growth from 2009 to 2011 when GDP per capita peaked at US$8,081.41. Since then, South Africa has experienced a recession and its GDP per capita for 2015 was US$5,691.68. Both Nigeria and India have a much lower GDP per capita than Brazil and South Africa. Between 2000 and 2009, the GDP per capita of Nigeria and India was almost the same. However, from 2010, Nigeria overtook India in this indicator and has continued to maintain this lead. However, since 2014, Nigeria's economy has been in recession. India, on the other hand, has maintained a steady but gradual improvement in its GDP per capita from 2000 to date. In addition, India, unlike Nigeria and the other comparators, has not experienced a recession in the period captured here. On the other hand, India has also not experienced the massive growth trajectory experienced by Nigeria and the other comparators.

The above findings have serious consequences for the prospects of the right to health in Nigeria and the comparators. With a stronger GDP per capita than Nigeria and India, Brazil and South Africa are better positioned to invest more resources in their health systems to bring about better health outcomes. This perception is supported by the health outcomes delivered by Nigeria and the comparators in Section 3.3. A major source of concern, however, is the trend indicating that the economies of Brazil, South Africa and Nigeria are in recession. This is not a positive development for the protection of legal positions on the right to health, and the attainment of better health outcomes in these countries.

In the case of Nigeria, particularly, since the start of 2016, the economy has fared badly.[75] The recession that began in 2014 has worsened significantly and led to the shrinking of

[75] The very serious decline in the state of Nigeria's economy has been exacerbated by the economic policies of the new administration of President Muhammdu Buhari who took over power from President Goodluck Jonathan on May 29, 2015.

the economy.[76] Many job losses have occurred over a short period.[77] These adverse economic developments have potentially negative effects on legal positions on the right to health in Nigeria, thereby worsening the already bad state of health outcomes in the country.

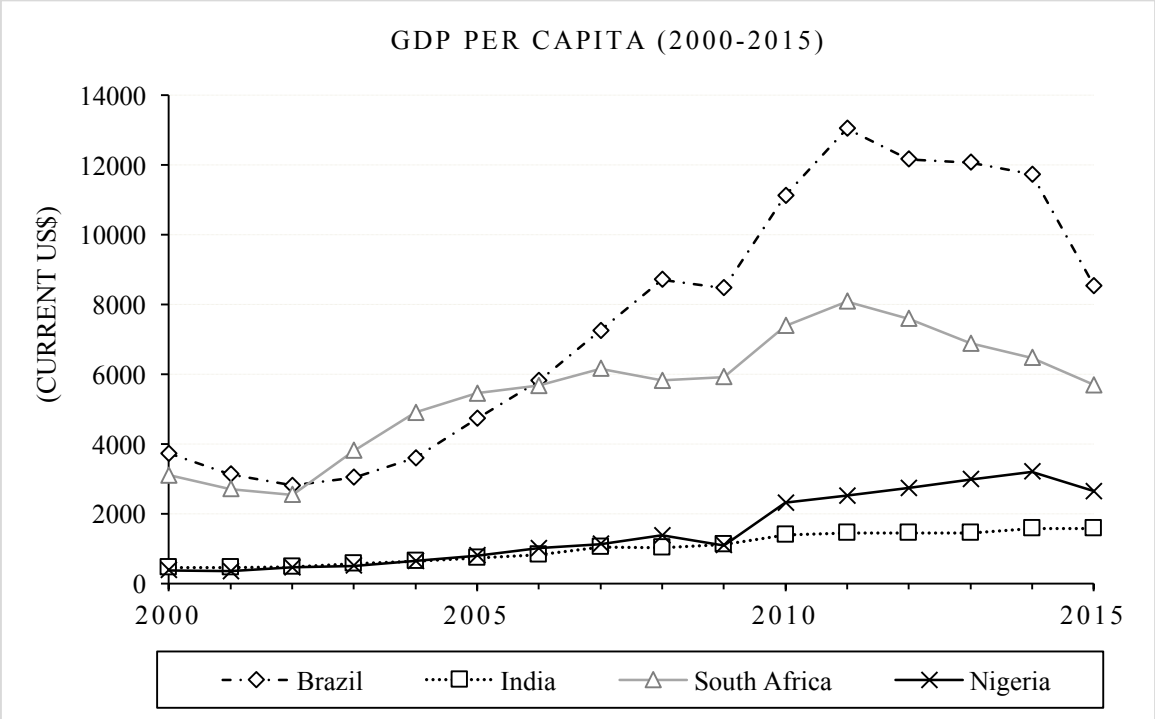

Figure 3.7: GDP per capita of Nigeria and the comparators (Source*:* The World Bank)

3.2.5 The Legal Context

The legal context invites consideration of how patterns of organisation of the legal systems of Nigeria and the comparators affect the right to health in these systems. The significance of this context is illustrated by the growing phenomenon of health rights

[76] Omololu Ogunmade and Obinna Chima, 'IMF Warns Nigeria Heading Towards Recession', *THISDAY* 20 July 2016 <http://www.thisdaylive.com/index.php/2016/07/20/imf-warns-nigeria-heading-towards-recession/>; Henry Umoru, 'Recession: The Future is Bright for Nigeria - Adeosun', *Vanguard* 24 July 2016 <http://www.vanguardngr.com/2016/07/recession-worst-adeosun/>; Michael Eboh, 'Nigeria in Recession as Economy Shrinks by 2.06%', *Vanguard* 31 August 2016 <http://www.vanguardngr.com/2016/08/nigeria-recession-economy-shrinks-2-06/>; Geoff Iyatse and Odusina Olutola, 'Nigerians Proffer Solutions to Economic Recession', *PUNCH* 21 September 2016 <http://punchng.com/nigerians-proffer-solutions-economic-recession/>; Emma Okonji and Obinna Chima, 'Udoma: Lack of Policy Implementation Forced Nigeria into Recession ', *THISDAY* 24 September 2016 <http://www.thisdaylive.com/index.php/2016/09/24/udoma-lack-of-policy-implementation-forced-nigeria-into-recession/>.

[77] Emeka Anaeto, '22.45m Nigerians Unemployed, as Job Loss Hits 710,693', *Vanguard* 22 March 2016 <http://www.vanguardngr.com/2016/03/22-45m-nigerians-unemployed-job-loss-hits-710693/>; Bassey Udo, '19,000 Nigerians Suffer Public Sector Job Losses in 6 Months', *Premium Times* 13 September 2016 <http://www.premiumtimesng.com/news/headlines/210329-19000-nigerians-suffer-public-sector-job-losses-6-months.html>.

litigation globally.[78] Courts are increasingly playing a central role in mediating claims on the violation of the right to health. Do courts, in every legal system, play similar roles in mediating such cases? Or do these roles vary from system to system? Chapter 7 delves into this discussion. In doing so, it engages with the literature and jurisprudence on health rights litigation, focusing on the experiences of Nigeria and the comparators. A key claim in the literature is that the dynamics of health rights litigation is affected, inter alia, by how the legal system is structured.[79] Chapter 7 puts this claim to the test by examining the experiences of Nigeria and the comparators. Chapter 7 confirms the finding in the literature that the way the legal system of Nigeria and the comparators is structured, in terms of whether a system of precedent is in place (or not) has implications for the nature and volume of health rights cases litigated in these systems.

Chapter 7 also develops a taxonomy on the effects of judicialisation of the right to health. Essentially, this taxonomy suggests that when courts intervene in cases dealing with violations of the right to health, they are either enabling the right, amplifying the right, impeding the right or being ambivalent towards the right. When this taxonomy is used to evaluate the engagement of the courts with the right to health in Nigeria and the comparators, India is found to exemplify a country in which the courts have largely enabled the right to health; South Africa is suggested as a country where the courts have amplified the right to health; Brazil appears to be a country where the courts are impeding the right to health; and Nigeria is suggested as representing a country where the courts have been ambivalent towards the right to health.

The legal context also offers an opportunity to reflect on what the claim of the right to health, really means: Is it about securing a judgment with lofty aspirational pronouncements by the courts on the right to health? Is it about individual litigants securing payments for expensive medicines or medical procedures? Or is it about providing a framework by which governments can be held accountable to the population whose right to health is at risk?[80] The discussion in Chapter 7 allows the assessment of how the jurisprudence of Nigeria and the comparators has situated these countries in their encounters with health rights litigation.

---

78 Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011).

79 Gloppen, above n 17.

80 Yamin and Gloppen above n 78.

3.2.6 The Institutional Context

The institutional context questions how the organisation of the health system of Nigeria and the comparators affects the right to health: whether 'a well-functioning universal public health care system' or a 'fragmented and competitive system of predominantly privately financed and/or provided health care' is in place.[81] From the discussion in Chapter 7, the design of the healthcare system and the direction of healthcare reforms in Nigeria and the comparators have been suggested to influence in a major way the general situation of legal positions on the right to health in these countries. For instance, Brazil and South Africa, whose health systems are unified and designed to achieve universal health coverage, have been able to secure access to health for a majority of their population. Although these countries continue to grapple with a number of challenges in their health system, they have largely succeeded in opening up the health system to a wide spectrum of their population. In the process, they have recorded positive health outcomes, as seen in the data presented in Section 3.3. A related effect of the pattern of organisation of their health systems is that they have strengthened legal positions on the right to health, and allowed health rights litigation to flourish. Thus, the courts in Brazil and South Africa have been able to hold state institutions accountable for commitments to achieve universal health coverage in these countries.

In contrast, in India and Nigeria, where there is no unified health system but a fragmented and competitive system of predominantly privately financed and/or provided care, access to health is limited by the financial means of individuals: persons without financial means depend wholly on dysfunctional and poorly stocked public health institutions. Those with financial means rely on private healthcare institutions, on the basis of what they can afford, and often beyond the economic means of the majority of the population. In addition, the litigation of the right to health in these systems is not as robust as the Brazilian and South African context. However, India differs in this regard because an activist Indian Supreme Court has ensured that the right to health is recognised and duly enforced. Nonetheless, without a system of universal health coverage in place in India, there are severe limitations on poorer segments of the Indian population of the effects of these important judicial decisions on the right to health.

To sum up, the foregoing discussion reveals that different factors, health and non-health, influence the right to health. In the case of Nigeria and the comparators, a number of these

[81] Gloppen, above n 17.

factors have been considered in this chapter. Their consideration offers a more rounded perspective on the situation regarding the right to health in Nigeria and the comparators. They draw attention to the fact that claims about the right to health often involve much more than may first be apparent: such claims require more than effecting constitutional amendments to recognise a justiciable right to health, promulgating legislation to recognise the right to health and/or securing from the courts judgments with lofty aspirational pronouncements on the right to health. Health rights claims involve a medley of considerations that interact in often unpredictable ways but require the unwavering commitment of state institutions and all stakeholders to ensure that the main objective of this right—better health outcomes—is secured. A suitable framework for bringing this about, and one that is suggested by this thesis, regards the right to health as a set of legal positions to universal health coverage and requires states like Nigeria to work towards its attainment in the international, constitutional, policy/legislative and judicial context—aided by the activities of strong state organs and/or active domestic social actors who should serve as drivers of this framework.

3.3 Health Indicators

This section examines the performance of the health systems of Nigeria and the comparators across 17 indicators grouped into two broad categories: the health-related MDGs, which expired in 2015 and have been replaced by the Sustainable Development Goals;[82] and trends in health financing. Despite their expiration, the MDG indicators remain useful for identifying the strengths and weaknesses of the health systems of Nigeria and the comparators.

3.3.1 The Health-related Millennium Development Goals

The progress made by states in achieving the health-related MDGs[83] was tracked by WHO, using a number of indicators. In this section an examination is made of how Nigeria and the comparators performed in these indicators: the under-five and infant mortality rate; the maternal mortality ratio; the unmet need for family planning; the contraceptive prevalence rate; the rate of antenatal care coverage; births attended by skilled health personnel; adults and children newly infected with HIV; anti-retroviral

---

82 World Health Organization, *Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals* (World Health Organization, 2015).

83 These are: Goal four – reduce child mortality; Goal five – improve maternal health; and Goal six – combat HIV/AIDS, malaria and other major diseases. See World Health Organization, 'Millennium Development Goals (MDGs)' (2014) <http://www.who.int/topics/millennium_development_goals/en/>.

therapy coverage among people with advanced HIV infection; pregnant women with HIV who received anti-retrovirals to prevent mother-to-child transmission; the incidence rate of malaria; and the incidence and prevalence rate of tuberculosis (TB).

3.3.1.1 Child Mortality (MDG 4)

Two indicators measure the performance of states in achieving this goal: the under-five mortality rate (the probability of dying by age five per 1000 live births); and the infant mortality rate (the probability of dying by age one per 1000 live births). States were expected to achieve a two-thirds (67%) reduction in their under-five mortality rate (from their 1990 baseline rate) by 2015.[84] Figure 3.8 shows that in 1990, Nigeria had the highest infant and under-five mortality rates among the four countries, with 126 and 213 deaths per 1000 live births, respectively; followed by India with 52 and 126 deaths, respectively. South Africa and Brazil had the lowest rates although South Africa's rates were slightly lower than those of Brazil: whereas Brazil recorded 52 and 62 deaths per 1000 live births, respectively, South Africa recorded 47 and 61 deaths per 1000 live births. By 2013, the last year of data captured in the *World Health Statistics*, Nigeria's rates had dropped substantially, to 74.3 and 117.4 deaths per 1000 live births. India followed with 41.4 and 52.7 deaths per 1000 live births respectively. South Africa lost its better performing position to Brazil, recording 41.4 and 43.9 deaths per 1000 live births. Brazil had the best performance with only 12.3 and 13.7 deaths per 1000 live births. The last report on the MDGs in the *World Health Statistics 2015* confirms that not only did South Africa not achieve MDG 4, it recorded only a 28% reduction in the under-five mortality rate despite the MDG 4 target of 67%. Nigeria, on the other hand, recorded 'substantial progress', with 45% reduction. India also made substantial progress, with 58% reduction. Brazil is the only country to have surpassed the target by achieving a 77% reduction in the relevant indicators, measured against the 1990 baseline.[85]

---

[84] Millennium Project, *Goals, Targets and Indicators* (2006 2002) <http://www.unmillenniumproject.org/goals/gti.htm>.

[85] World Health Organization, *World Health Statistics 2015* (2015) 26-30.

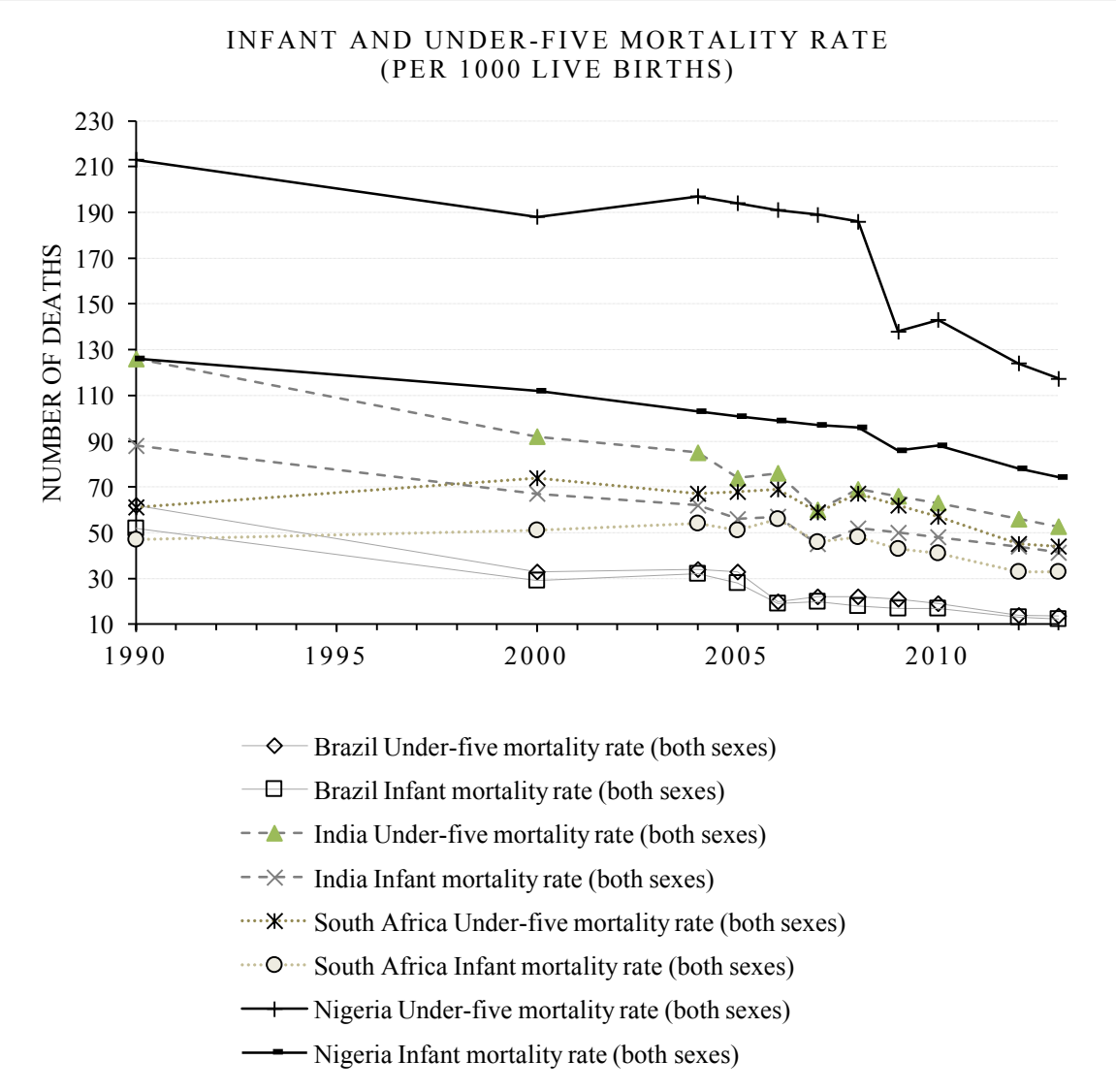

Figure 3.8: Performance of Nigeria and the comparators according to MDG 4 (Source*: World Health Statistics* 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2014, and 2015)

3.3.1.2 Maternal Mortality (MDG 5(a))

MDG 5(a) required Nigeria and the comparators to achieve a three-quarters reduction in the maternal mortality ratio between 1990 and 2015. Figure 3.9 shows that in 1990, Nigeria had the highest maternal mortality ratio, at 1,200 deaths per 100,000 live births. India followed with 560; then South Africa with 250; and Brazil had the lowest figure at 120 deaths per 100,000 live births. By year 2000, Nigeria, India and Brazil had achieved varying levels of reductions in their maternal mortality ratio, although Nigeria continued to dominate with a higher maternal mortality ratio, at 950 deaths, while the highest figure for the comparators was that of India at 370 deaths. During this period only South Africa experienced increasing levels of maternal deaths, with this figure rising to 330 deaths. By 2005, all four countries had lost some ground in their progress rate, as the trend shows a

general increase in maternal deaths. By 2008, the trend shows a resumption in the progress rate in all but South Africa, with substantial decreases occurring in Nigeria and India. By 2010, South Africa had begun pushing back and achieved substantial reductions, while Nigeria, India and to an extent Brazil, maintained their steady trend of decrease. By 2013, Brazil had the best outcome in this indicator with reductions to 69 maternal deaths per 100,000 live births, followed by South Africa with reductions to 140 deaths, and then India, where the number declined to 190 deaths. Nigeria came last with a reduction to 560 deaths (see Figure 3.9).

The *World Health Statistics 2015* shows that Brazil, India and Nigeria made *substantial progress* towards achieving MDG 5(a) but did not meet the target,[86] while South Africa made *limited progress* in achieving this target.[87] Regardless, in practical terms the position of the comparators, including South Africa, is better than that of Nigeria where the maternal mortality ratio of Nigeria remains very high at 560 deaths per 100,000 live births and surpasses those of the comparators, both individually and combined. When considered from this perspective, this is still a problematic area for the health system of Nigeria.

[86] MDG 5(a) target was for a 75% reduction to be achieved: India achieved a 66% reduction (and had the best outcome); Nigeria achieved a 53% reduction; and Brazil achieved a 43% reduction. See Ibid.

[87] South Africa achieved a 7% reduction. See Ibid. It should however be kept in mind that South Africa's 1990 figure was already very low and even better than what Nigeria eventually achieved at the end of the target period set for this goal.

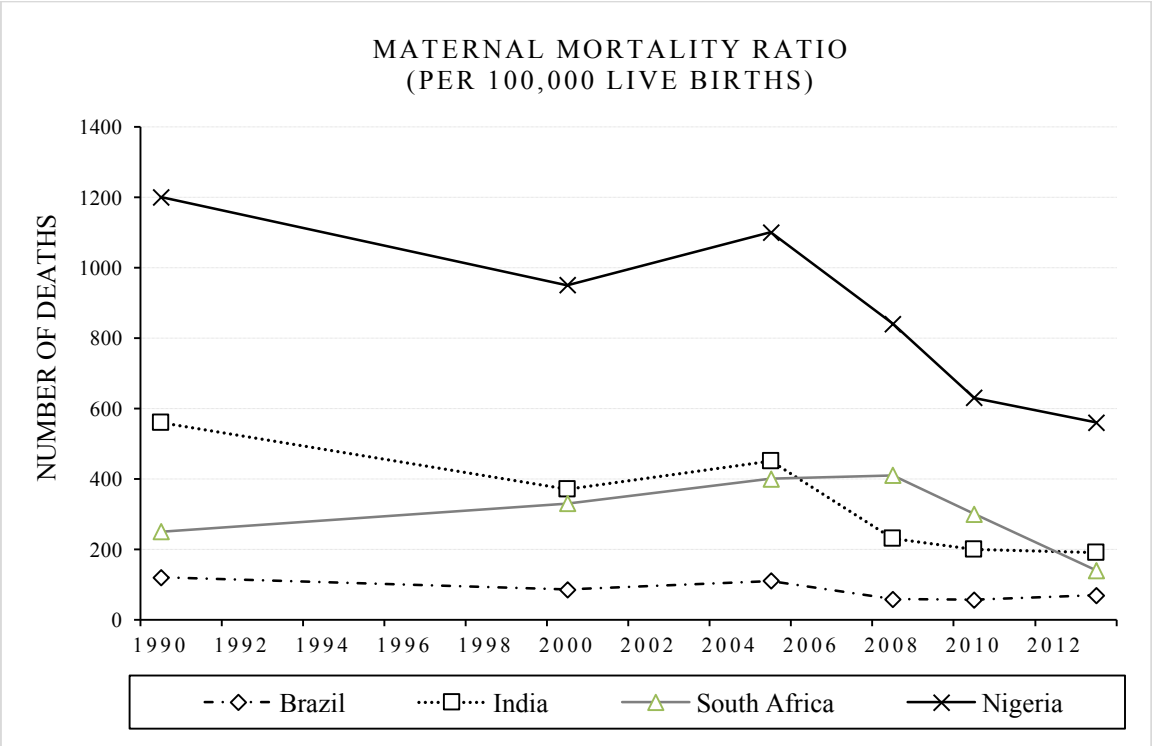

Figure 3.9: Performance of Nigeria and the comparators with respect to MDG 5(a) (Source*: World Health Statistics* 2008, 2011, 2012, 2014 and 2015)

3.3.1.3 Unmet Need for Family Planning (MDG 5(b))

The unmet need for family planning was the first indicator used by WHO to track the progress of states in achieving MDG 5(b) (universal access to reproductive health). A low percentage in this indicator meant progress, as states were expected to achieve 0% unmet need for family planning.[88] As Figure 3.10 indicates, between 2000 and 2004, Nigeria's unmet need for family planning, at 16.9%, was higher than those of the comparators. Brazil had the lowest unmet need at 6.0% throughout the entire period of available data (2000–2013). India and South Africa were almost on a par at 12.8% and 13.8%, respectively. However, from 2006 to 2013, India's unmet need rose to 21.0%, surpassing that of South Africa, which remained at 13.8% until 2009, the last year of available data. The rate in Nigeria rose to 19.0% between 2006 and 2013. Overall, Brazil had the best attainment in this indicator, followed by South Africa, Nigeria and then India. However, the target of 0% unmet need was not achieved by any of these states.

[88] Ibid 26.

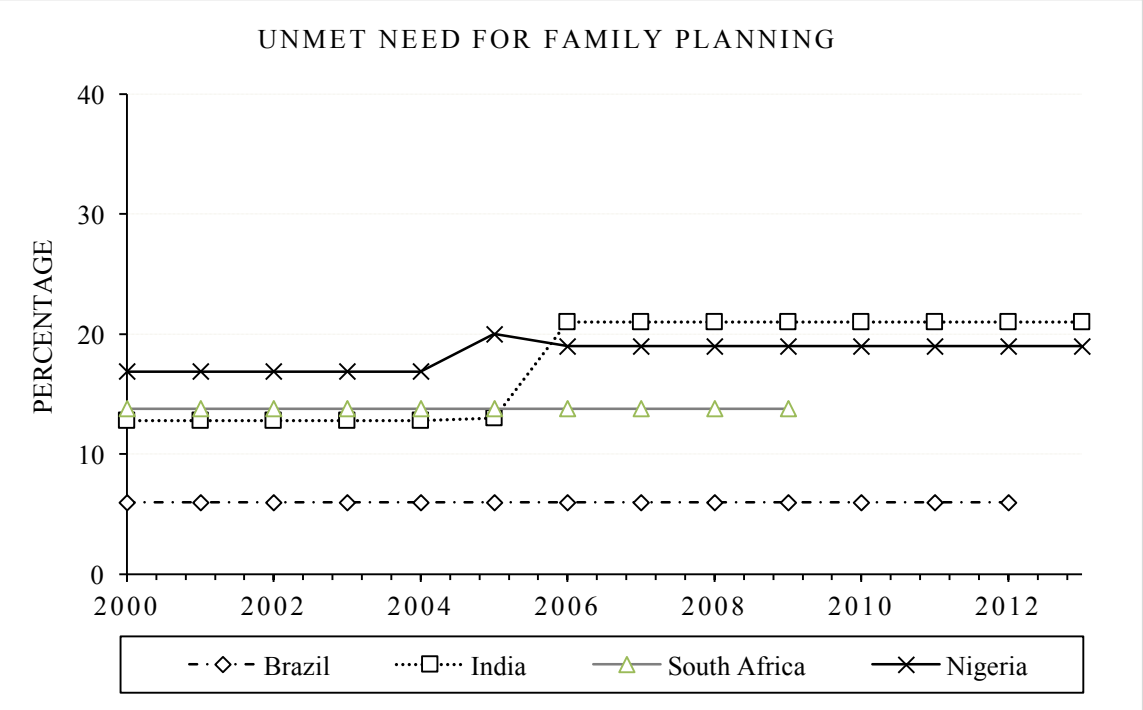

Figure 3.10: Performance of Nigeria and the comparators with respect to MDG 5(b)—Unmet Need for Family Planning (Source*: World Health Statistics* 2009, 2010, 2011, 2012, 2014 and 2015)

3.3.1.4 Contraceptive Prevalence (MDG 5(b))

The contraceptive prevalence rate was the second indicator used to track the progress of states in achieving MDG 5(b). It required states to make contraceptives more readily available to the population. A high contraceptive prevalence rate meant progress while a low contraceptive prevalence rate meant lack of progress. Figure 3.11 shows that Brazil had the best performance for this indicator, with a contraceptive prevalence rate of 70.0% in 1996, which rose to 80.3% between 2000 and 2010 before dipping to 80.0% in 2011–2012. South Africa followed with an initial contraceptive prevalence rate of 56.3% in 1998, which rose to 60.3% from 2000 to 2008, before dipping to 59.9% from 2009 to 2010. India began with a contraceptive prevalence rate of 48.2% in 1998, increasing to 56.3% from 2000 to 2010 and dipping slightly to 55.0% from 2011 to 2013. Nigeria's performance was far below those of the comparators in this indicator, beginning at 9.0% contraceptive prevalence rate in 1999, rising to 12.6% from 2000 to 2006, further rising to 14.7% from 2007 to 2010, and then slightly dipping to 14.0% in 2011 and 2012 before rising again to 15.0% in 2013. Although none of the comparators achieved a 100% contraceptive prevalence rate, their attainments in this indicator far exceed that of Nigeria.

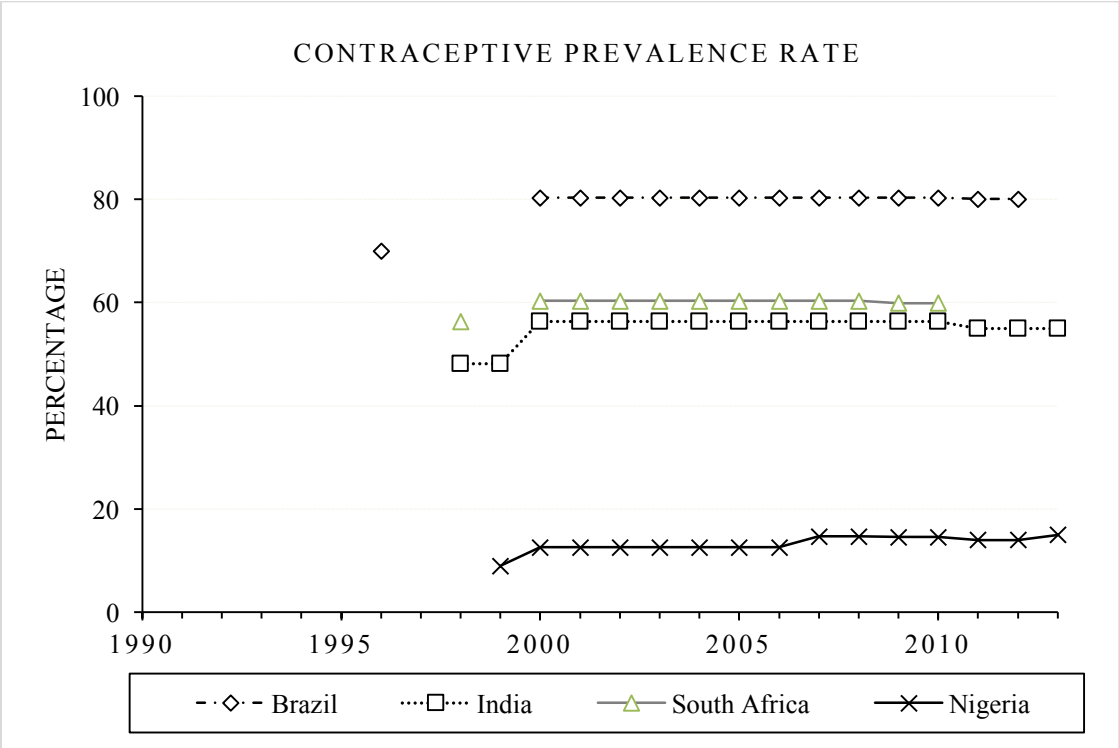

Figure 3.11: Performance of Nigeria and the comparators with respect to MDG 5(b)—Contraceptive Prevalence Rate (Source*: World Health Statistics* 2005, 2006, 2007, 2008 2009, 2010, 2011, 2014 and 2015)

3.3.1.5 Antenatal Care (MDG 5(b))

The percentage of antenatal care coverage was the third indicator used by WHO to track the progress of states towards achieving MDG 5(b). There were two components to this indicator: the number of pregnant women who made at least one hospital visit; and the number of pregnant women who made at least four hospital visits. The value of the indicator is what it tells us about the extent of antenatal care accessed by pregnant women in these countries. It is also a likely impact factor in the incidence of maternal and child mortality in these countries. An attainment of 100% was required for this indicator, to achieve MDG 5(b).[89] Figure 3.12 shows that Brazil and South Africa were the top performers with respect to the percentage of women who made at least one visit, at over 90% throughout the period captured (2000–2014). In India, the percentage of women who made at least one visit rose from 65% in 1998 to 75% in 2014. For Nigeria, this rose from 58% in 2000 to 61% in 2014. In terms of those who made at least four visits, Figure 3.13 shows Brazil and South Africa were also the top performers: Brazil began at 76% in 1990 and rose to 89% in 2014; South Africa went from 73% in 1990 to 87% in 2014; India, from 30% in 1990 to 72% in 2014; and Nigeria, from 47% in 1990 to 51% in 2014.

[89] Ibid.

Nigeria and the comparators did not achieve the 100% coverage targeted by this indicator, but the comparators performed better than Nigeria in the two trends captured by the indicator.

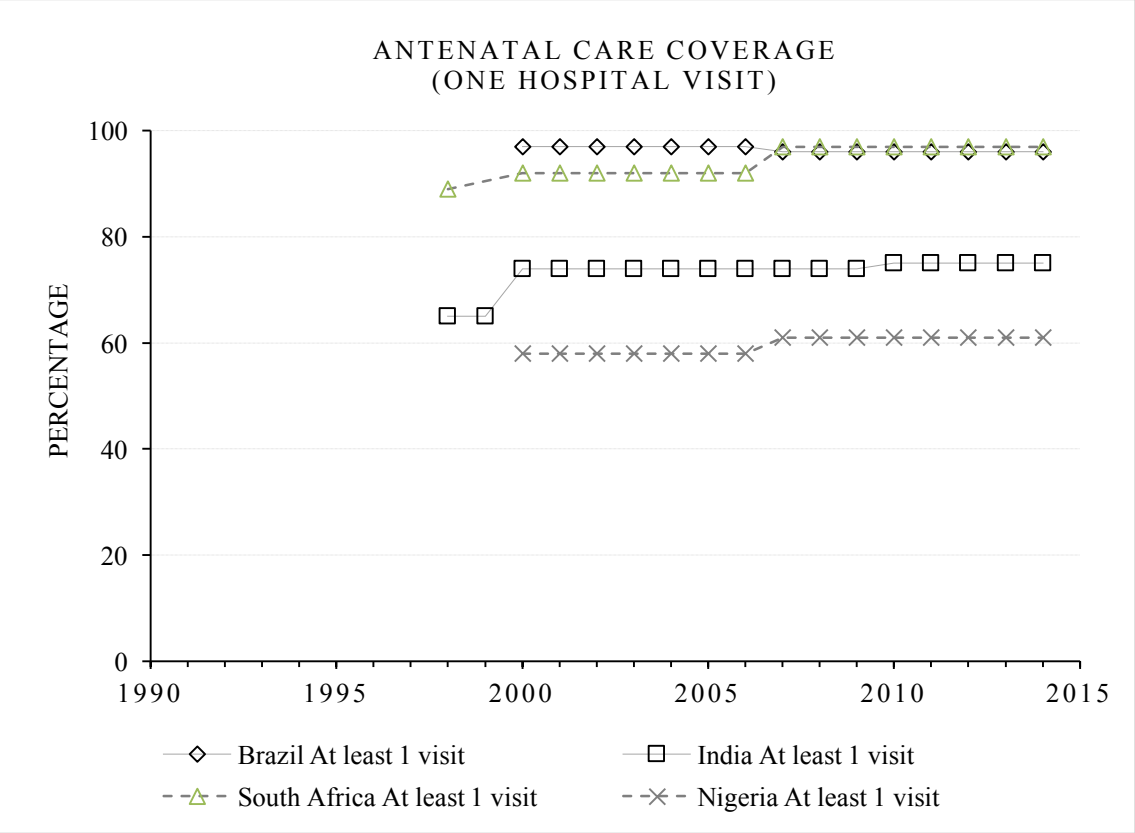

Figure 3.12: Performance of Nigeria and the comparators with respect to MDG 5(b)—Antenatal Care Coverage (Source*: World Health Statistics* 2006, 2007, 2008 2009, 2010, 2011, 2012, 2014 and 2015)

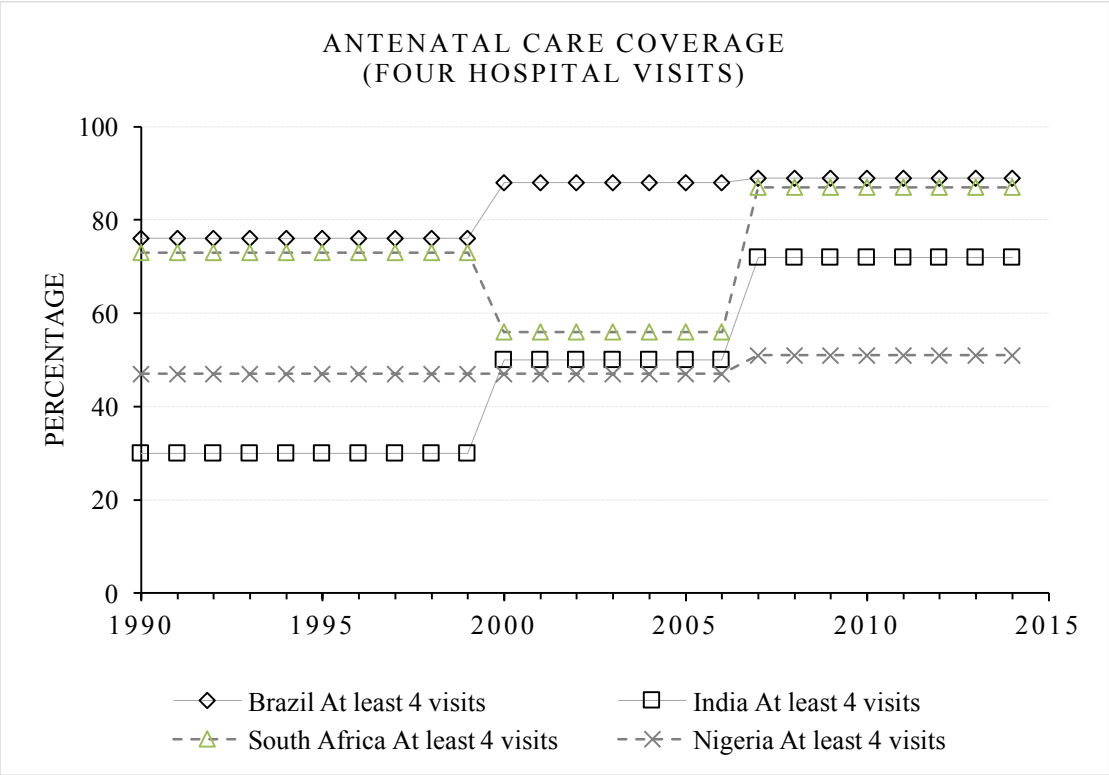

Figure 3.13: Performance of Nigeria and the comparators with respect to MDG 5(b)—Antenatal Care Coverage (Source*: World Health Statistics* 2006, 2007, 2008 2009, 2010, 2011, 2012, 2014 and 2015)

3.3.1.6 Births Attended by Skilled Personnel (MDG 5(b))

The percentage of births attended by skilled personnel was an important indicator for achieving universal access to reproductive health because it measured opportunities for safe delivery offered to women in labour. A high percentage in this indicator meant likely reductions in the maternal mortality ratio. Figure 3.14 shows that Brazil and South Africa were the top two performers in this indicator: from 1990 to 2014, Brazil's lowest percentage was 97% and its highest was 99%; South Africa's lowest was 84% and its highest was 94%; and India's lowest was 42% and its highest was 67%. Nigeria's lowest was 34% in 2011 and its highest was 42% (1990–1999). Thus, while the comparators were making progressive improvements, Nigeria either stagnated or decreased in performance. Brazil and South Africa surpassed the 90% target nominated for this indicator by WHO, while India (at 67%) and Nigeria (at 35%) did not achieve the target.[90]

[90] Ibid 26-30.

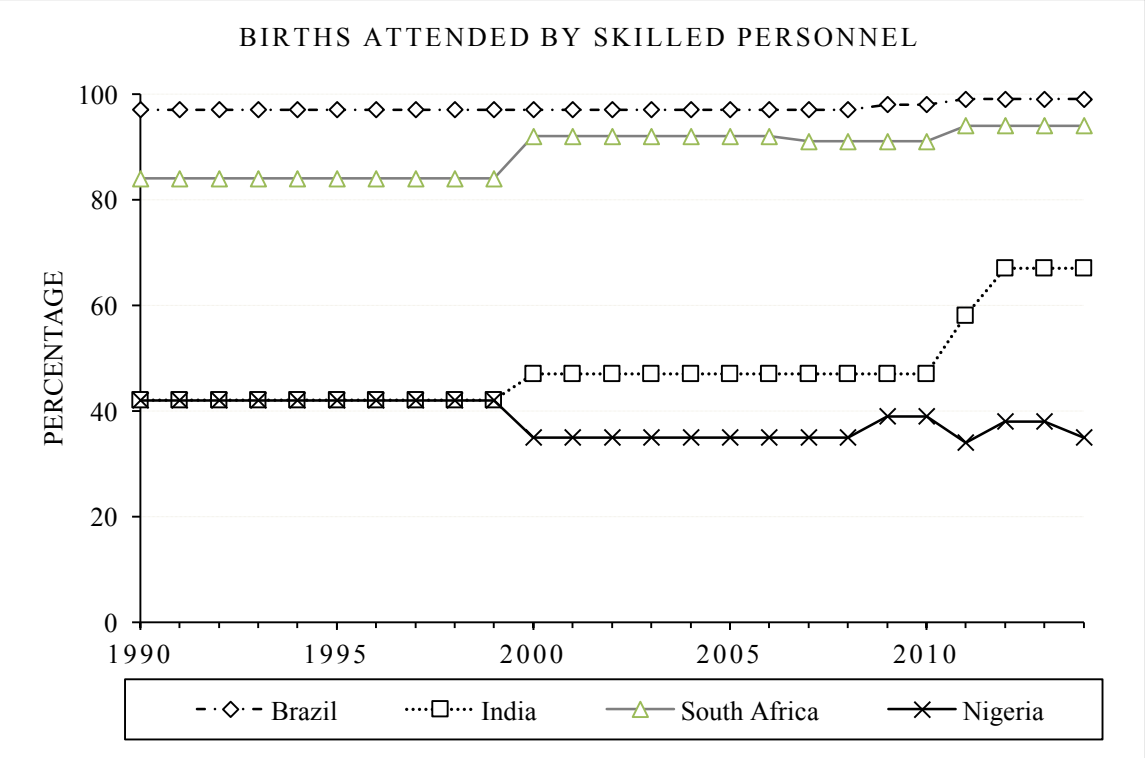

Figure 3.14: Performance of Nigeria and the comparators with respect to MDG 5(b)—Births Attended by Skilled Personnel (Source*: World Health Statistics* 2008 2009, 2011, 2012, 2014 and 2015)

3.3.1.7 HIV/AIDS Incidence (MDG 6(a))

Data sets available from the *World Health Statistics* over a period of 14 years (2000–2013) capture Nigeria, India and South Africa for only five years of the period, and Brazil's data are available only for 2013. The data show a huge disparity among Nigeria and the comparators in the incidence rate of HIV/AIDS. Although all four countries halted and began reversing the spread of the disease, South Africa's incidence rate was the highest throughout this period. For instance, in 2000, South Africa had an incidence rate of 1,437 per 100,000 population and by 2013, this had decreased to 647 per 100,000 population. Nigeria had the second highest incidence rate, starting out in 2000 with 229 per 100,000 population; by 2013, this had reduced to 126 per 100,000 population. India started out in 2000 with an incidence rate of 28 per 100,000 population; by 2013 this was down to 11 per 100,000 population. Brazil's sole figure (for 2013) was 22 per 100,000 population. Overall, this indicator confirmed that HIV/AIDS remains a problematic area for the health system of South Africa, although progress is being made in reversing the spread of the disease. India's very low incidence rate is remarkable considering all the

other challenges facing its health system. Nigeria's figures, while high, are not as bad as those for South Africa.[91]

3.3.1.8 Anti-retroviral Therapy Coverage (MDG 6(b))

Measures captured for this indicator by the *World Health Statistics* differed over time: the report for the period 2005–2012 captured data on anti-retroviral coverage 'among people with advanced HIV infection'; the 2012 and 2014 reports captured these data for HIV infected people 'eligible for treatment'; and the 2015 report, for 'people living with HIV'. This appears to be because of the progressive broadening of the categories of people who should be entitled to anti-retroviral therapy treatment, in the WHO's assessment. The need to accommodate the increasing demand for treatment and inevitable constraints on available resources may explain why the trend in Figure 3.15 shows initial rapid increases, followed by sharp decreases in the extent of anti-retroviral therapy coverage in Nigeria and the comparators. Regardless, Brazil had the strongest performance for this indicator, followed by South Africa, India and then Nigeria.

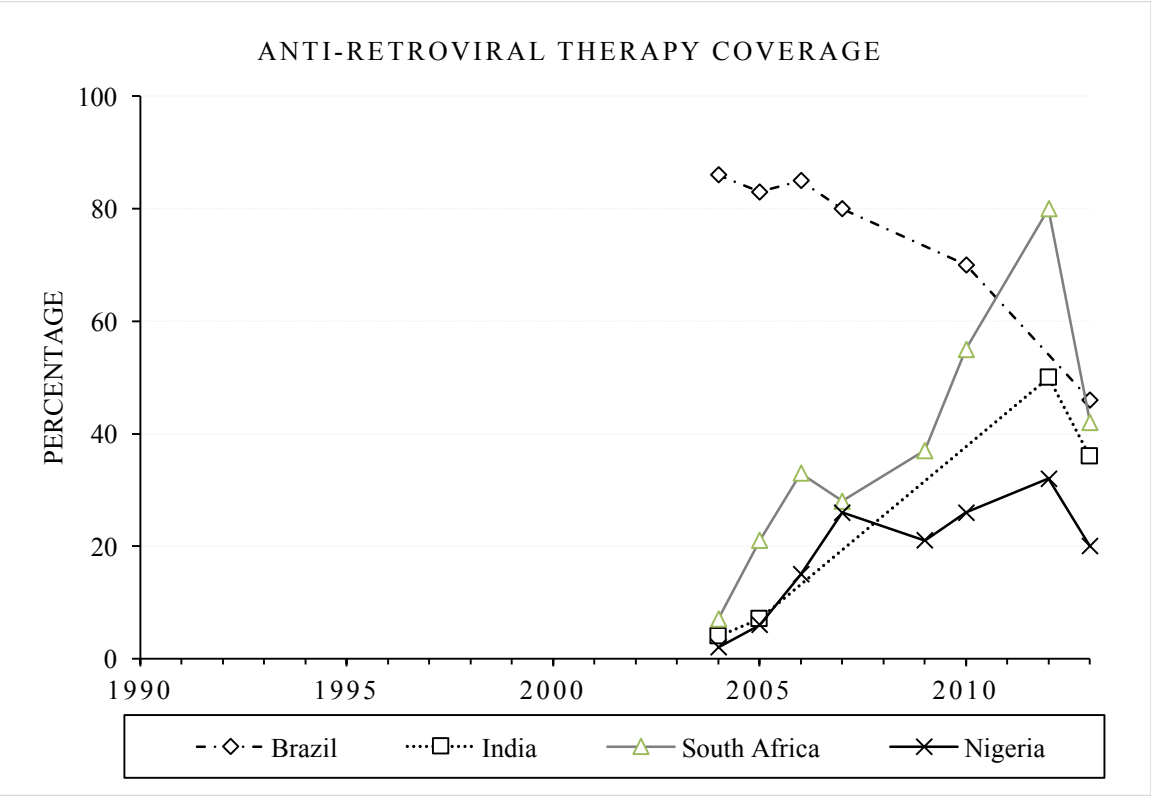

Figure 3.15: Performance of Nigeria and the comparators with respect to MDG 6(b)—Anti-retroviral Therapy Coverage (Source*: World Health Statistics* 2005, 2006, 2007, 2009, 2011, 2012, 2014 and 2015)

[91] World Health Organization, *World Health Statistics 2012* (2012) 67-79; World Health Organization, *World Health Statistics 2014* (2014) 75-87; World Health Organization, above n 85, 59-71.

3.3.1.9 Pregnant Women with HIV Receiving Anti-retrovirals (MDG 6(b))

This indicator captured data on pregnant women with HIV receiving anti-retrovirals to prevent mother-to-child transmission. The indicator was an important part of MDG 6(b)'s target of achieving universal access to treatment for HIV/AIDS for all those in need of it. It also had consequences for child health in view of the effect of HIV transmission by pregnant women to infants at birth. Figure 3.16 shows that South Africa and Brazil were the top performers for this indicator, while Nigeria and India were the low performers. Although data for Brazil are only available for two years, the country's lowest performance in 2005—48% of pregnant women receiving anti-retrovirals—far exceeds that of India (2%) and Nigeria (1%); and slightly exceeds that of South Africa (30%). South Africa's performance improved substantially from 2005, peaking at 95% in 2010 before decreasing to 90% in 2013. Brazil's performance for 2013 is the strongest at 95%, followed by South Africa at 90%. Nigeria and India occupy the lower spectrum of performance, with Nigeria achieving 27% in 2013, while India achieved 18%. Like Brazil, India had data for only two years in this period.

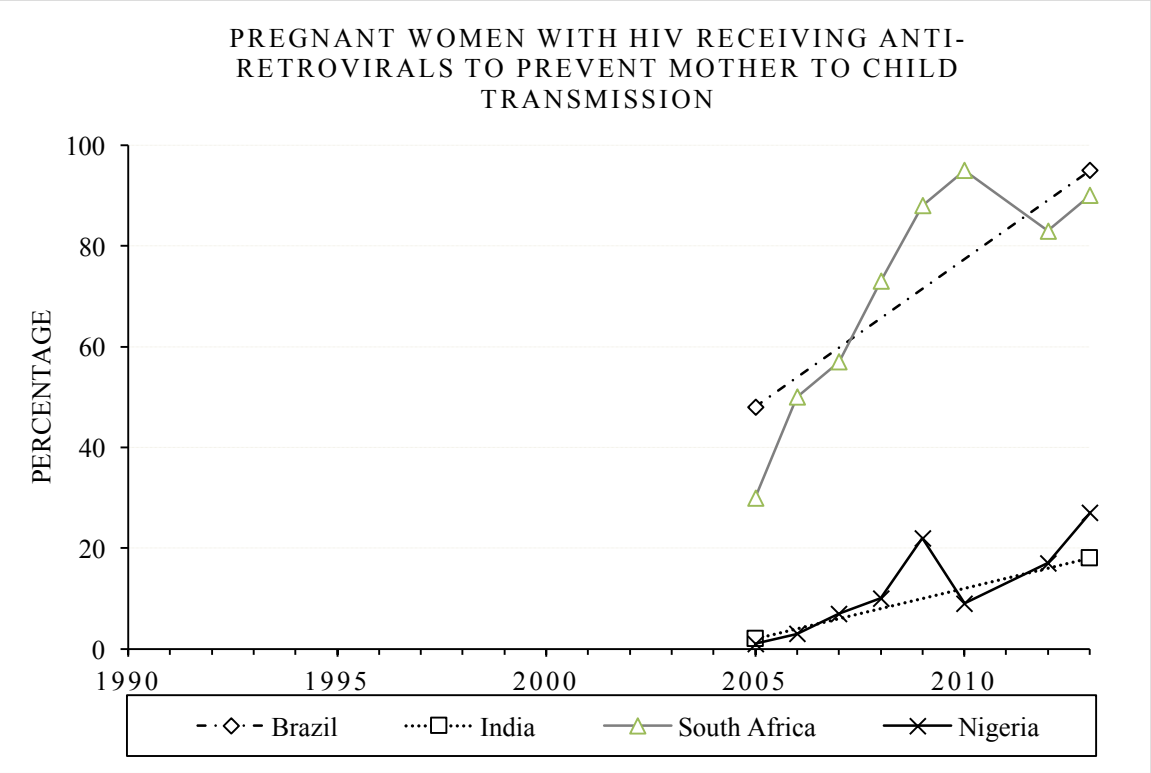

Figure 3.16: Performance of Nigeria and the comparators with respect to MDG 6(b)—Pregnant Women Receiving Anti-retovirals (Source*: World Health Statistics* 2007, 2008, 2009, 2010, 2011, 2012 and 2014)

3.3.1.10 Malaria Incidence (MDG 6(c))

MDG 6(c) required states to have halted by 2015, and begun to reverse, the incidence of malaria and other major diseases. Insufficient data are available for this indicator in the *World Health Statistics* to establish a trend for the comparators and Nigeria. However, data available for two years (2009 and 2012) show that malaria is a serious health issue for Nigeria and less so for the comparators. In 2009, Nigeria had a malaria incidence rate of 36,060 (per 100,000 population) and in 2012, this reduced to 28,430 (per 100,000 population); in the same period India had an incidence rate of 1,862 and 1,536 (per 100,000 population) for 2009 and 2012; Brazil had 202 and 156 (per 100,000 population); and South Africa had 32 (per 100,000 population) for both years. This confirms the situation on the ground in Nigeria where malaria is felt to be an epidemic to be 'rolled-back' and policy interventions in the health system have sought to achieve this outcome.[92] As Section 3.2.1.1 indicates, Nigeria's geography locates it in a part of the world where malaria is pandemic; thus Brazil's achievement in this area is notable.

3.3.1.11 Tuberculosis Incidence and Prevalence (MDG 6(c))

With respect to the incidence[93] and prevalence[94] rates of TB, Figures 3.17 and 3.18 show that this is a problematic area for South Africa's health system; in this respect it towers over Nigeria, Brazil and India. Brazil had the lowest incidence and prevalence rate with levels below 200 (per 100,000 population) for both; followed by India with levels also below 200 (per 100,000 population). Nigeria's situation, while better than that of South Africa, rose to a prevalence rate of 521 (per 100,000 population) in 2007, while the incidence rate was highest in 2013, at 338 (per 100,000 population). South Africa's highest incidence rate was 1003 (per 100,000 population) in 2012 and its highest prevalence rate was 998 (per 100,000 population) reached in 2006.

---

92 For example the National Policy on Malaria Diagnosis and Treatment 2011. See Federal Republic of Nigeria, *National Policy on Malaria Diagnosis and Treatment*, June 2011.

93 This public health concept refers to 'the rate of new (or newly diagnosed) cases of the disease. It is generally reported as the number of new cases occurring within a period of time (eg, per month, per year). It is reported as a fraction of the population at risk of developing the disease (eg per 100,000 population)'. See Advanced Renal Education Program, *Incidence and Prevalence* (2017) <http://advancedrenaleducation.com/content/incidence-and-prevalence>.

94 Prevalence refers to 'the actual number of cases alive, with the disease either during a period of time (period prevalence) or at a particular date in time (point prevalence). Period prevalence provides the better measure of the disease load since it includes all new cases and deaths between two dates, whereas point prevalence only counts those alive on a particular date.' Ibid.

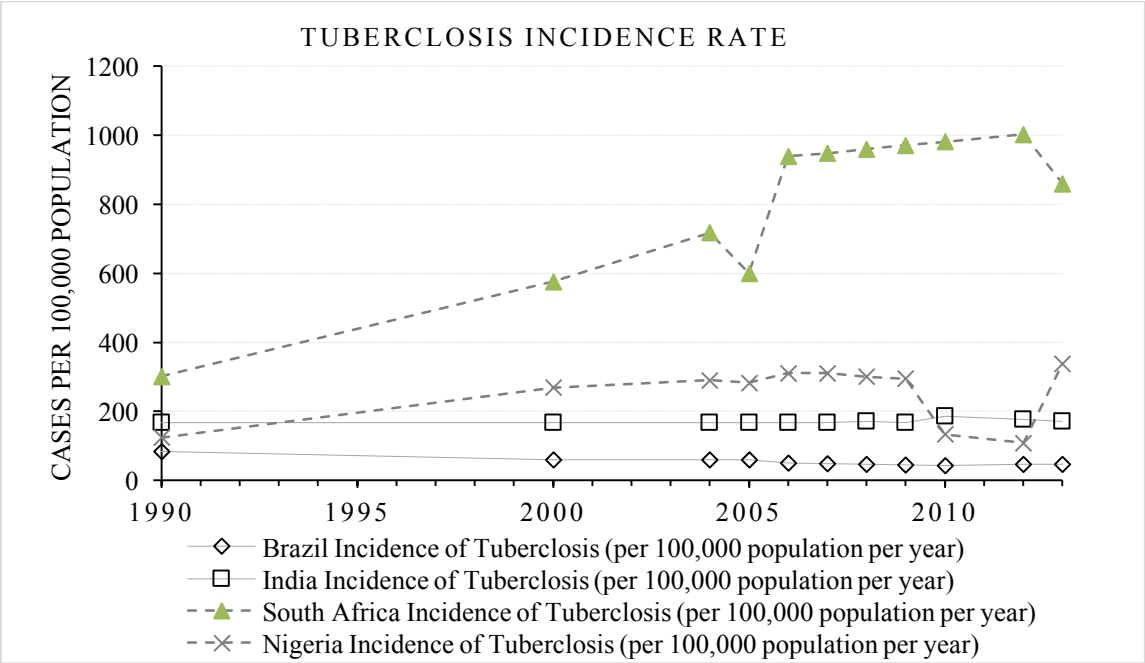

Figure 3.17: Performance of Nigeria and the comparators with respect to MDG 6(c)—Tuberclosis Incidence Rate (Source*: World Health Statistics* 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2014 and 2015)

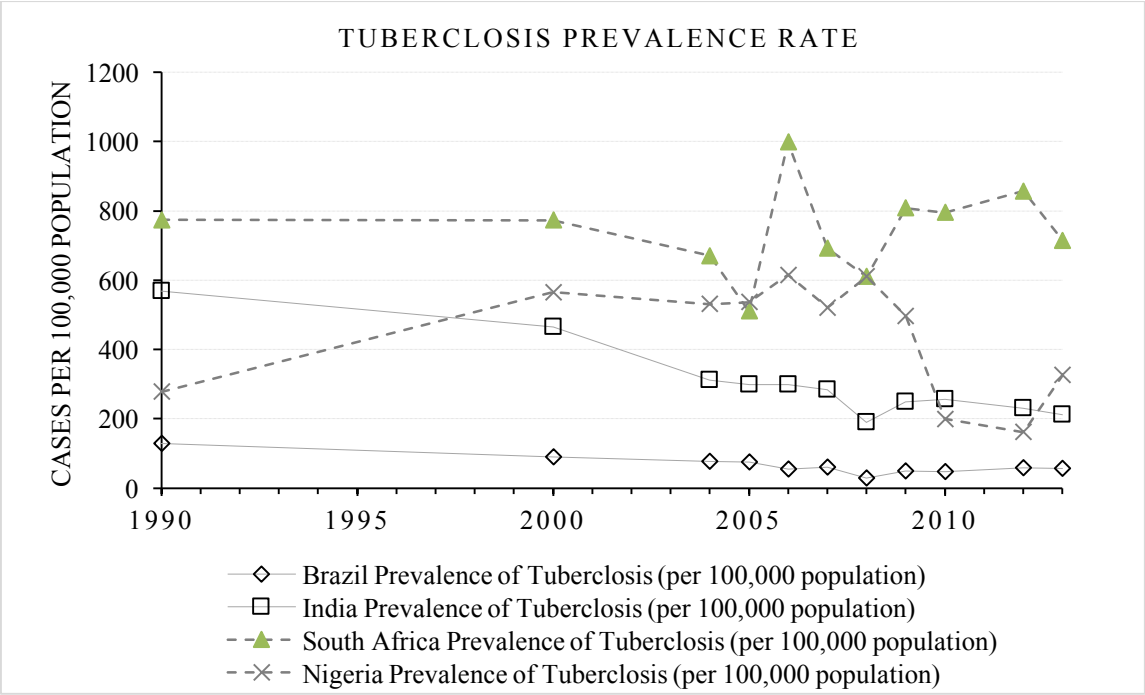

Figure 3.18: Performance of Nigeria and the comparators with respect to MDG 6(c)—Tuberclosis Prevalence Rate (Source*: World Health Statistics* 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2014 and 2015)

The data presented in this section reveal that in most of the indicators measuring the performance of Nigeria and the comparators in achieving the health-related MDGs in 2015, Brazil performed best, followed closely by South Africa, and then India and

Nigeria. The most problematic areas for Nigeria were the infant and under-five mortality rates and the maternal mortality ratio. In both areas, Nigeria's mortality indicators far exceeded those of the comparators. South Africa also faced serious difficulties in its health system, in the areas of HIV/AIDS and TB. On average, India performed better than Nigeria for some indicators, but performed below the levels of both Brazil and South Africa.

3.3.2 Trends in Health Financing

How health is financed is well recognised by national[95] and international institutions such as WHO and the World Bank[96] as an important basis for measuring the performance of health systems because of the important role played by finance in their development. In this section, six indicators dealing with health financing are considered, and the performance of Nigeria is measured against those of the comparators. These indicators are the per capita government expenditure on health; the per capita total expenditure on health; out-of-pocket expenditure as a percentage of private expenditure on health; private expenditure on health as a percentage of total expenditure on health; government expenditure on health as a percentage of total government expenditure; and total expenditure on health as a percentage of GDP.

3.3.2.1 Per Capita Government Expenditure on Health

This indicator provides an understanding of the relative levels of public spending on health for beneficiary populations, expressed in US dollars using the average exchange rate for the year.[97] As a measure of health financing, the indicator is important for assessing the priority given to health in the allocation and utilisation of national resources.[98] Figure 3.19 shows that Brazil, followed by South Africa, were top performers in this indicator, as more public resources were committed to health in these countries between 1995 and 2014, the last year of available data. Worthy of note is the period from

---

95 The WHO, through Health Accounts Country Platform, 'provides countries with the framework, tools and technical support to institutionalise and set up a harmonised, integrated platform for annual and timely collection of health expenditure data. See World Health Organization, *Health Accounts and Universal Health Coverage* (2016) <http://www.who.int/health-accounts/universal_health_coverage/en/>.

96 The WHO keeps data on health financing by country, WHO Region and World Bank Income group. See World health Organization, *Global Health Observatory Data Repository: Health Financing* (2016 2016) <http://apps.who.int/gho/data/node.main.484>; For data on health expenditure kept by the World Bank, see The World Bank, *Health Expenditure, Total (% of GDP)* (2016) <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>.

97 World Health Organization, *Per Capita Government Expenditure on Health at Average Exchange Rate (US$)* (2011 2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=109>.

98 Ibid.

2003 where there is a sharp increase in the levels of public spending on health in both countries, peaking in 2011 before declining (more steeply for South Africa) to 2014 levels. India and Nigeria, with similar performances, sit at the very bottom of the scale, completely overshadowed by Brazil and South Africa.

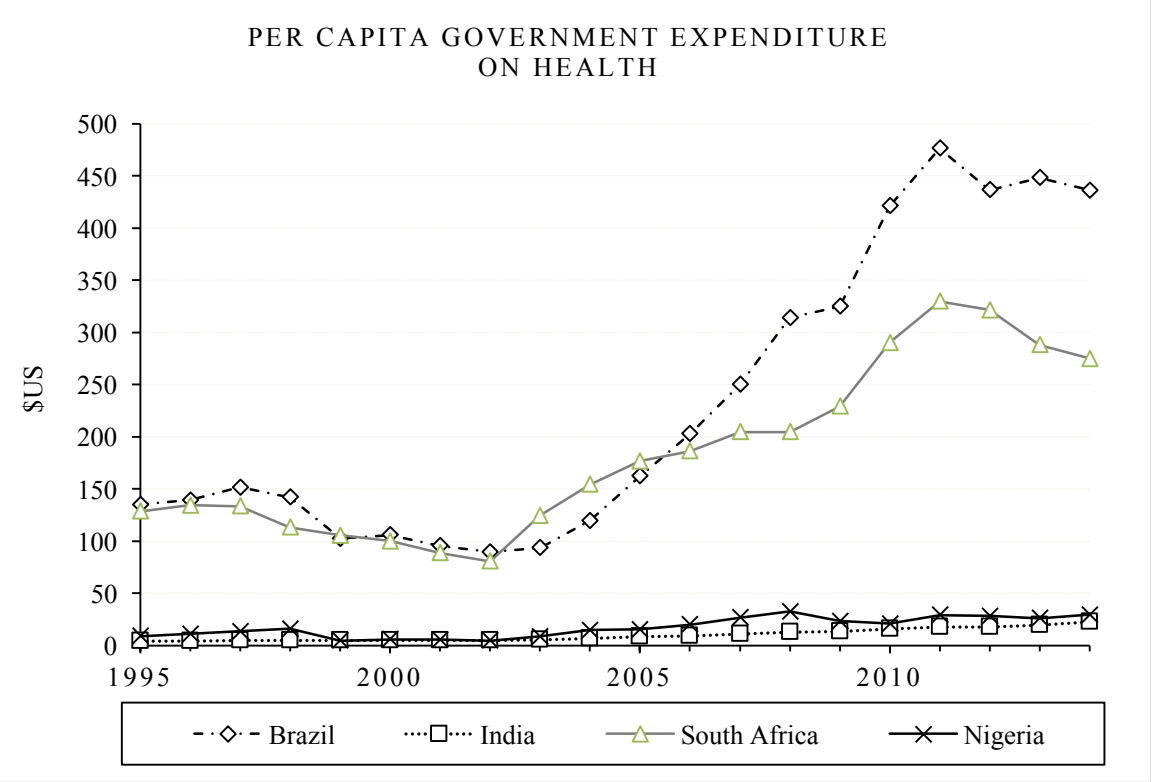

Figure 3.19: Per capita government expenditure on health $US (at average exchange rate) (Source*:* Global Health Observatory Data Repository 2016)

3.3.2.2 Per Capita Total Expenditure on Health

This indicator is used by WHO to understand the total expenditure on health, relative to beneficiary populations, and is expressed in US dollars using the average exchange rate for the year in question.[99] It captures the spending of all financing agents, both government and private, that manage funds to purchase health goods and services.[100] As such it gives an overall sense of how much is being committed to health in each country from any source. Figure 3.20 shows that Brazil and South Africa were the top performers in this indicator, while India and Nigeria, with similar levels of performance, sit at the bottom of the scale. It is interesting to note the striking similarities between the

[99] World Health Organization, *Per Capita Total Expenditure on Health at Average Exchange Rate (US$)* (2011 2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=111>.

[100] Ibid.

performance of the comparators and Nigeria for this indicator and that considered in Figure 3.19.

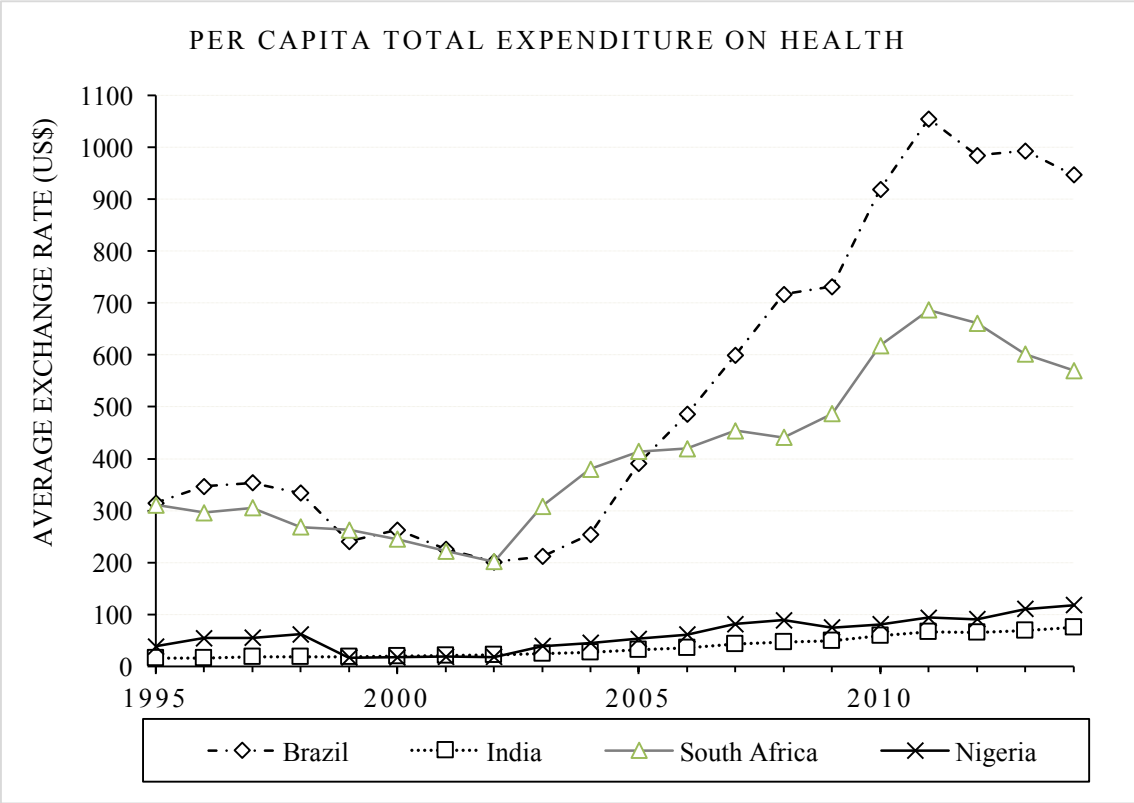

Figure 3.20: Per capita total expenditure on health at average exchange rate (US$) in Nigeria and the comparators (Source: Global Health Observatory Data Repository 2016)

3.3.2.3 Out-of-pocket Expenditure as a Percentage of Private Expenditure on Health

This indicator of health financing systems measures the relative weights of direct payments by households in total health expenditure. High out-of-pocket expenditures are strongly associated with 'catastrophic and impoverishing spending'.[101] As such, lower percentage levels—below 40%[102]—reflect greater levels of equity in the health system.[103] Figure 3.21 shows that only South Africa consistently maintained levels of out-of-pocket expenditure below 40% from 1995 to 2014, the last year of available data. South Africa's highest level was 29.88% in 1995 and its lowest level, 12.54%, was reached in 2014. Brazil began with 67.98% in 1995 to level out at 47.2% in 2014. India and Nigeria have maintained levels above 80% throughout this period: India began with 94.55% in 1995, which decreased to 89.21% in 2014; while Nigeria started with 94.55% in 1995 and

[101] Kei Kawabata, Ke Xu and Guy Carrin, 'Preventing Improverishment Through Protection Against Catastrophic Health Expenditure' (2002) 80(8) *Bulletin of the World Health Organization* 612.
[102] Ibid.
[103] World Health Organization, *Out-of-pocket Expenditure as a Percentage of Private Expenditure on Health* (2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=107>.

maintained that level, dipping slightly to 90.43% in 2002 before returning to its previous high. Nigeria's final level in 2014 was 95.74%. These high levels of out-of-pocket expenditure for India and Nigeria can be explained by the fact that neither country has an effective framework for health insurance coverage for the majority of the population; whereas in Brazil and South Africa, health insurance is entrenched in the health system. Thus, at the point of seeking care, payments do not have to be made out-of-pocket (see Chapter 6 for further discussion).

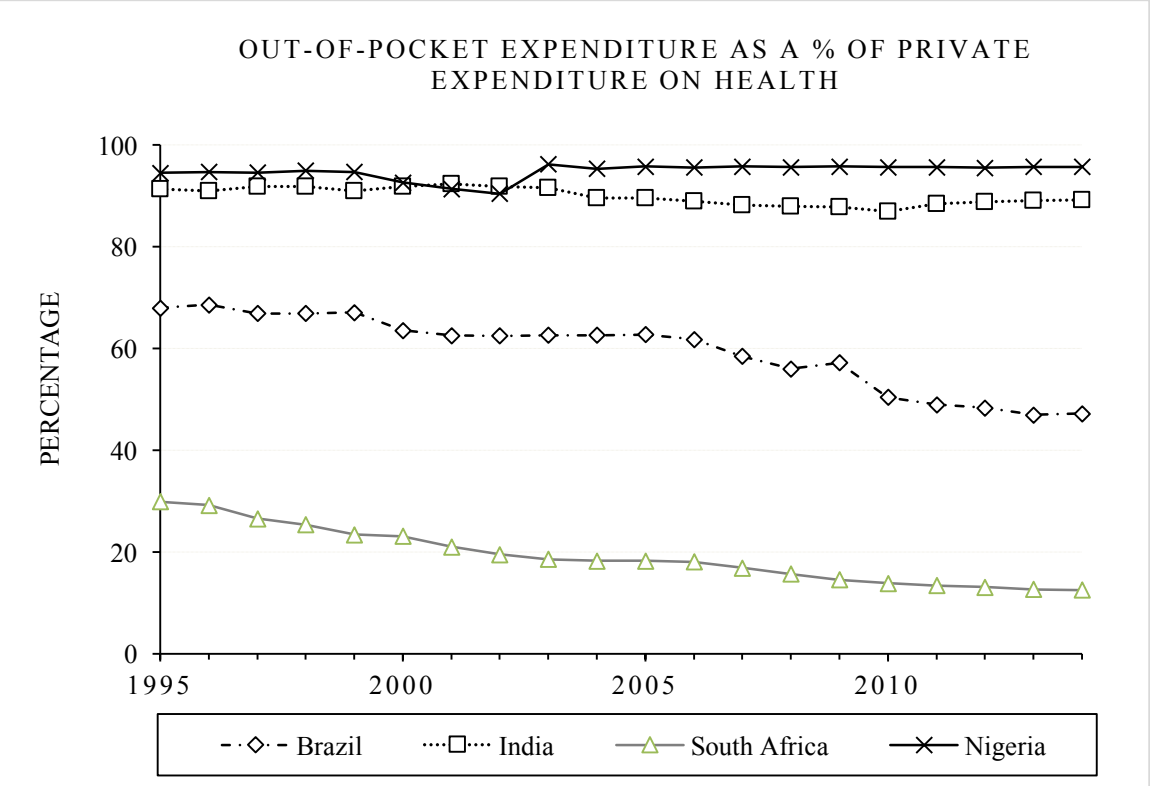

Figure 3.21: Out-of-pocket expenditure as a percentage of private expenditure on health in Nigeria and the comparators (Source*:* Global Health Observatory Data Repository 2016)

3.3.2.4 Private Expenditure on Health as a Percentage of Total Expenditure on Health

This indicator is used by WHO to understand the relative importance of private entities in total expenditure on health. It includes expenditure 'from pooled resources with no government control, such as voluntary health insurance, and direct payments for health by corporate entities (profit, not-for-profit and non-governmental organisations [NGOs]) and households'.[104] The importance of this indicator is that it shows the extent to which private financing agents, as opposed to government financing agents, are responsible for

[104] World Health Organization, *Private Expenditure on Health as a Percentage of Total Expenditure on Health* (2011 2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=119>.

health expenditure. Figure 3.22 shows that more private financing agents were involved in health in India and Nigeria than in Brazil and South Africa between 1995 and 2014, the last year of available data. Nigeria had more fluctuations in this indicator than the comparators, which showed relative stability and, in the case of Brazil and South Africa, a slightly decreasing trend towards 2014.

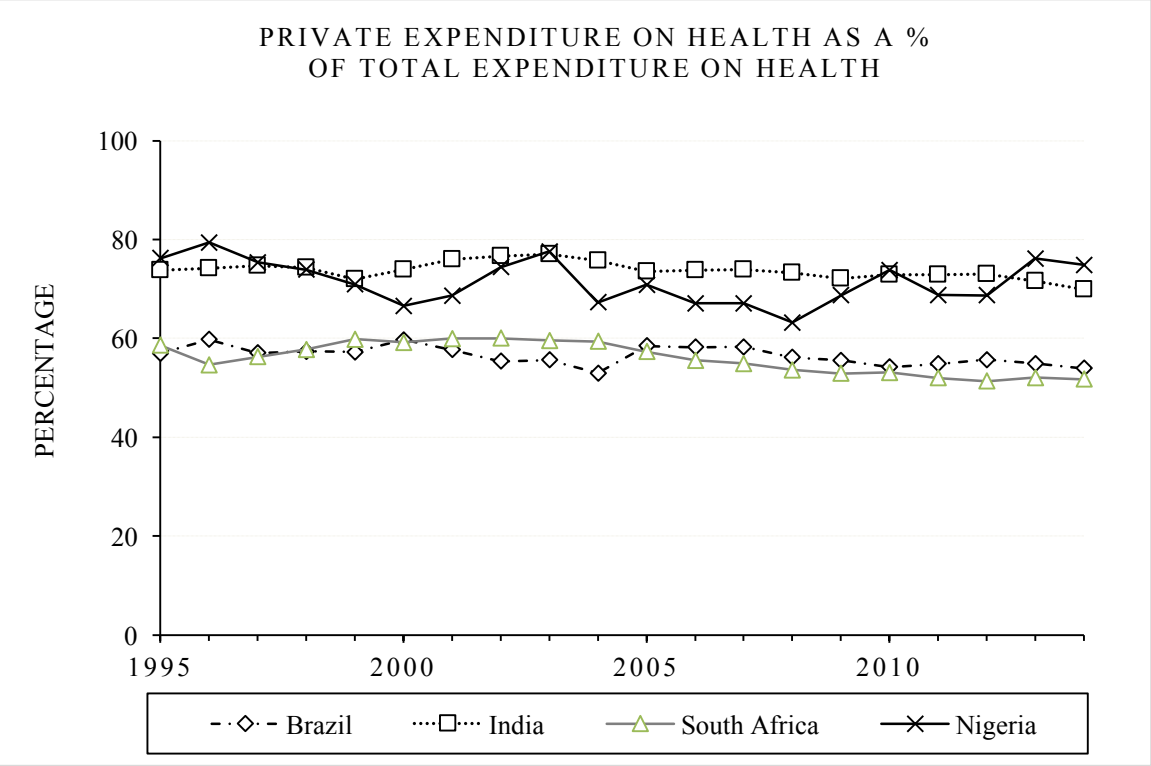

Figure 3.22: Private expenditure on health as a percentage of total expenditure on health of Nigeria and the comparators (Source*:* Global Health Observatory Data Repository 2016)

3.3.2.5 General Government Expenditure on Health as a Percentage of Total Government Expenditure

This core indicator of health financing systems 'contributes to understanding of the relative weights of public spending on health within the total value of public sector operations'.[105] It includes resources channelled through government budgets, expenditure on health by health parastatals, extra budgetary entities and the compulsory health insurance scheme;[106] in other words, 'resources collected and pooled by public agencies including all revenue modalities'.[107] The level of general government health expenditure

[105] World health Organization, *General Government Expenditure on Health as a Percentage of Total Government Expenditure* (2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=93>.
[106] Ibid.
[107] Ibid.

(GGHE) is expressed as a percentage of total government expenditure (GGE).[108] Figure 3.23 shows South Africa is a top performer in this indicator with levels of GGHE not falling below 12% from 1995 to 2014, the last year of available data. Nigeria and Brazil showed relative instability in this indicator, with Nigeria performing better than Brazil in some years and vice versa. Both countries approached but did not exceed 10%. India was the worst-performing country for this indicator. India's best performance was when it rose to 5.05% in 2014 and its worst was in 2003 when it fell to 3.60%.

3.3.2.6 Total Expenditure on Health as a Percentage of GDP

This core indicator of health financing provides information on 'the level of resources channelled to health relative to a country's wealth'.[109] The total health expenditure (THE) is expressed as a percentage of GDP.[110] As shown in Figure 3.24, South Africa and Brazil maintained higher percentages of THE than India and Nigeria from 1995 to 2014, the last year of available data. In some years during this period, South Africa and Brazil were on a par, but often South Africa performed slightly better than Brazil. India performed slightly better than Nigeria.

---

108 Ibid.

109 World Health Organization, *Total Expenditure on Health as a Percentage of Gross Domestic Product* (2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=122>.

110 Ibid.

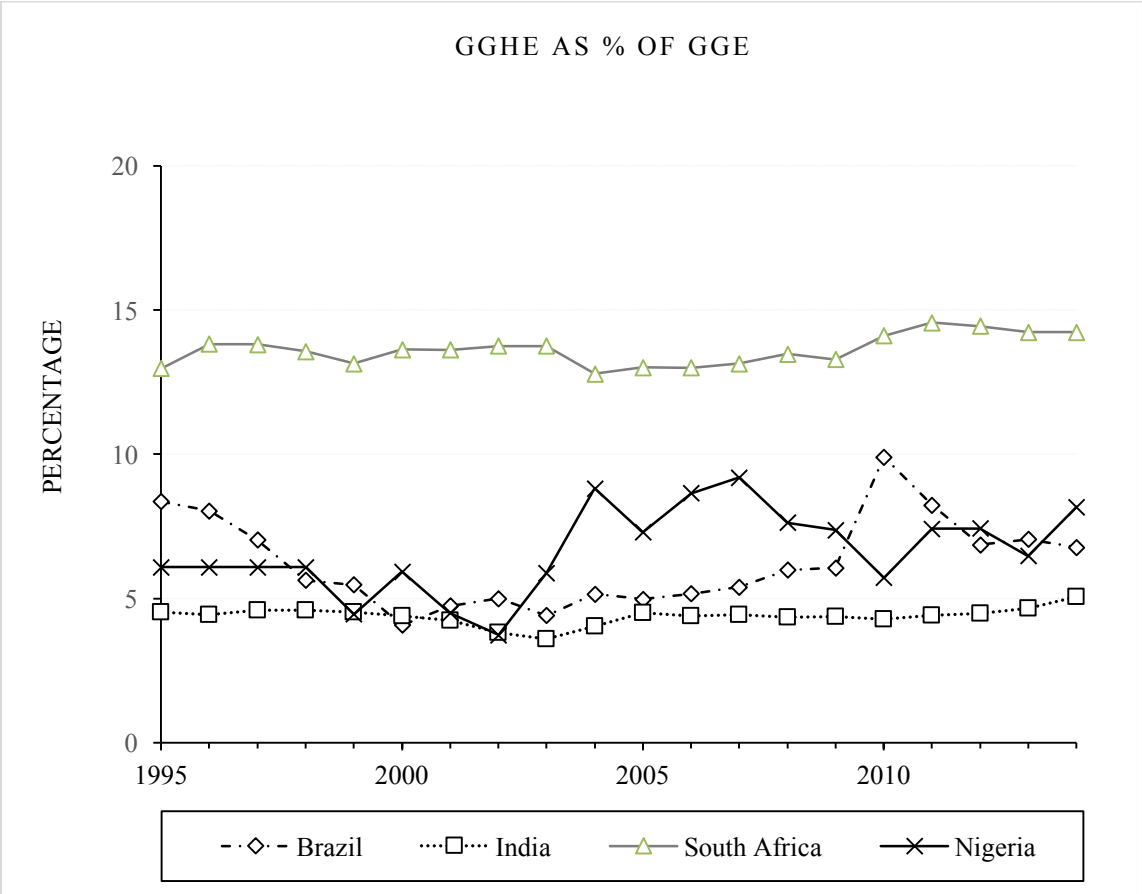

Figure 3.23: General government expenditure on health as a percentage of total government expenditure in Nigeria and the comparators (Source*:* Global Health Observatory Data Repository 2016)

In summary, this section reveals that the health systems of Brazil and South Africa are performing better than those of India and Nigeria in indicators showing the extent of commitment of public resources to health financing. A particularly worrying trend is that of out-of-pocket expenditure as a percentage of private expenditure on health. The data imply that Nigeria and India have very high levels of *catastrophic* health spending in this indicator, reflecting significant levels of inequities in health financing in these countries. South Africa is the only country that performed very well in this indicator. On the other hand, Brazil's out-of-pocket expenditure was shown to be higher than 40%, the point considered by WHO above which catastrophic health spending occurs.

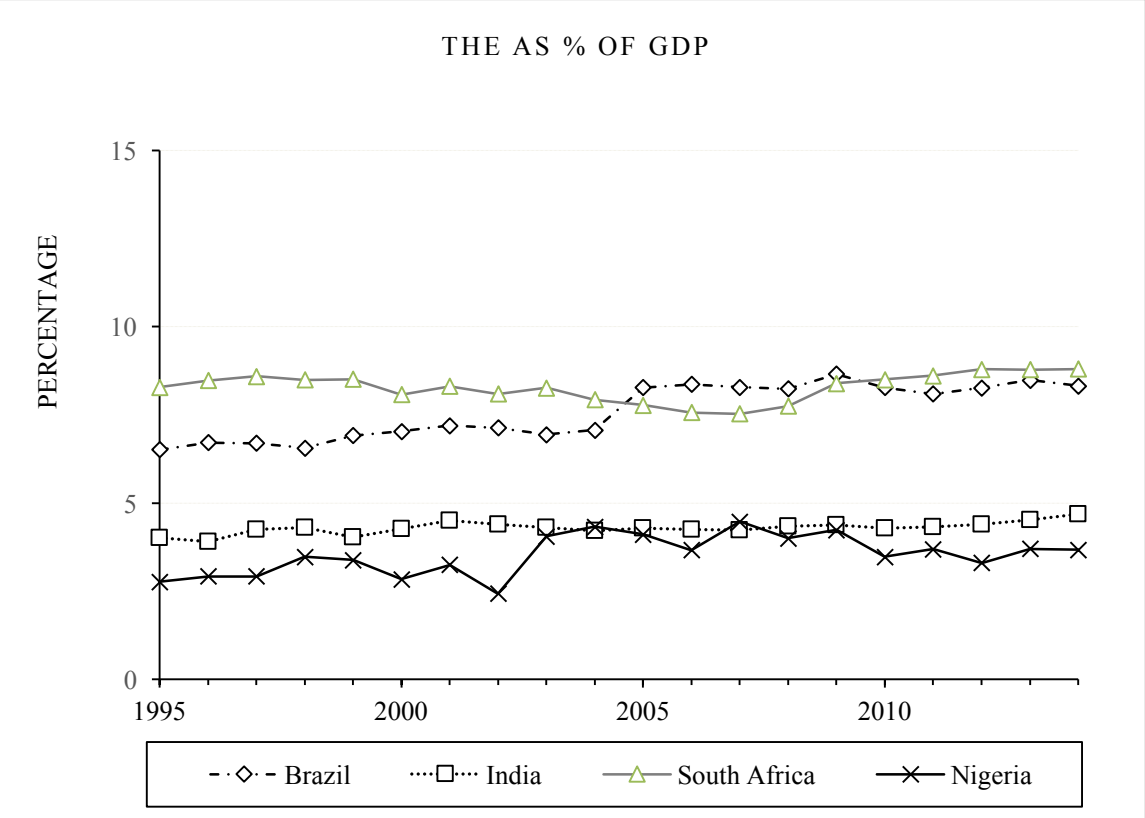

Figure 3.24: Total expenditure on health as percentage of GDP in Nigeria and the comparators. (Source*:* Global Health Observatory Data Repository 2016)

3.4 Conclusion

The first contribution of this chapter to this thesis is the insight it provides into the considerations informing the choice of Brazil, India and South Africa as comparators for Nigeria. The chapter identifies theoretically grounded and pragmatic considerations as informing this choice. One of the theoretical considerations is the need to answer the research question and objectives framing this research by the choice of comparators. On the other hand, the pragmatic considerations were identified as demographic, political, geo-political, economic, legal and institutional.

In the course of discussing these pragmatic considerations, attention was drawn to a wide variety of factors directly and indirectly connected with health, which have influenced and continue to influence the performance of the health systems in Nigeria and the comparators. For instance, India's population size, which is greater than the combined total population size of Nigeria and the other comparators, is a relevant factor in determining the nature and extent of the obligations confronting the government of India; and the levels of financial investments required by India to meet those obligations and strengthen legal positions on the right to health in India. Nigeria's position as a country

with one of the fastest growing populations in the world places some urgency on the need to transform its health system to achieve better health outcomes. South Africa's small population size, relative to Nigeria and the other comparators, sheds more light on why certain health policies and measures can easily take root in South Africa. Brazil's position as the country with the highest GDP per capita among the four countries considered may explain why it appears to have more resources to commit to its health system than the others.

The second contribution of the chapter is the panoramic view it provides on the performance of the health systems of Nigeria and the comparators in two important areas: the attainment of the health-related MDGs that expired in 2015; and the trend in health financing in these countries. The narrative that emerges after the consideration of the indicators in these two areas is one that shows the health systems of Brazil and South Africa to be performing better in many respects than those of India and Nigeria. The performance of the health systems of India and Nigeria have been found to be closely aligned at the bottom end of the scale in many of the indicators considered. However, India posted a slightly better performance than Nigeria, suggesting that India's health system is performing better than that of Nigeria, albeit in need of improvements in many areas. Further, even the health systems of Brazil and South Africa, which have been shown to be performing strongly, had areas of weakness where improvements are required. Overall, the findings here on the situation of Nigeria's health system confirm the view advanced in earlier chapters that health outcomes in Nigeria are poor.

The final contribution of the chapter is the foundation it provides, as a reference chapter, for the analyses to be undertaken in Chapter 4 (the international context), Chapter 5 (the constitutional context), Chapter 6 (the policy and legislative context) and Chapter 7 (the judicial context). In each of these chapters, a number of specific claims are advanced on how the right to health, viewed as a set of legal positions to universal health coverage, can be implemented in Nigeria across the international, constitutional, policy and legislative, and judicial domains; driven by the activities of strong state organs and/or active domestic social actors, so that better health outcomes can result for Nigeria.

CHAPTER 4: THE INTERNATIONAL CONTEXT

4.0 Introduction

This chapter examines the engagement and compliance behaviour of Nigeria and the comparators with respect to the right to health obligations they have assumed in the treaty framework. Utilising *institutional liberalism* (or sometimes '*liberal institutionalism*') as its theoretical lens, the chapter suggests the presence of a strong correlation between states' domestic commitment to the right to health and their responses to treaty obligations in respect of that right.[1] This is because states that are fully committed to the right to health in their domestic system are more likely to engage and comply with their international treaty obligations in fulfilling that right. The chapter argues that by engaging and being committed to the right to health in their domestic system, states increase the likelihood that they will engage and comply with the treaty framework on the right to health; in the alternative, the chapter argues that even where domestic commitment to the right to health is weak, the assumption of international treaty obligations in respect of that right can 'help domestic social actors set priorities, define meaning, make rights demands and bargain from a position of greater strength than would have been the case in the absence of their government's treaty commitment'.[2]

As a result of the foregoing, the chapter suggests that more opportunities are created for strengthening the right to health as a set of legal positions to universal health coverage through the engagement and compliance by states with their international treaty obligations on the right to health. This suggested strengthening can occur in two principal ways: first by allowing the international context serve in an agenda-setting role by drawing attention to areas of health needs of the population of states and offering opportunities for much-needed financial and technical assistance to meet those needs; second, by offering more opportunities beyond those available in the domestic system for state organs and/or domestic social actors to be able to ensure the fulfilment of the right to health as a set of legal positions to universal health coverage.

The chapter documents the manifestation of this phenomenon in Nigeria and the comparators by examining the degree of their engagement and compliance with the

---

1 For more of this theoretical perspective, see Beth A Simmons, *Mobilizing for Human Rights: International Law in Domestic Politics* (Cambrdige University Press, 2009) 125-48; Oona A Hathaway, 'Do Human Rights Treaties Make a Difference?' (2002) 111(8) *The Yale Law Journal* 1935; Benedict Kingsbury, 'The Concept of Compliance as a Function of Competing Conceptions of International Law' (1998) 19 *Michigan Journal of International Law* 345.

2 Simmons, above n 1, 126.

instruments[3] and mechanisms[4] developed by the treaty framework to advance the right to health in international law; and to that extent, how this has strengthened or not strengthened legal positions on the right to health in these states. The chapter suggests that Brazil and South Africa, which have stronger domestic records of engagement with the right to health than Nigeria and India, have also achieved better levels of compliance with the instruments and mechanisms of the treaty framework on the right to health. On this basis, the chapter suggests that for Nigeria to enjoy the potential benefits that arise from the treaty framework on the right to health, it needs to strengthen its domestic engagement with that right; by the same token, the chapter suggests that domestic social actors need to mobilise to make rights demands and bargain on the basis of treaties guraranteeing the right to health which Nigeria has ratified, and which can assist in setting priorities that strengthen the situation of that right in the country.

The structure of the chapter is as follows. Section 4.1 presents liberal institutionalism's account of why states comply with interntional treaties and contrasts it with the realist and institutionalist's account. The liberal institutionalist's account is important because it offers the theoretical lens informing the work done in the chapter. Section 4.2 examines the Universal Periodic Review (UPR) mechanism of the Human Rights Council in relation to Nigeria and the comparators. The aim is to establish how Nigeria and the comparators have performed under the scrutiny of that mechanism. Section 4.3 considers State Parties' reports to treaty-based bodies on health. The focus is on how fully Nigeria and the comparators have engaged with their reporting obligations in the treaty framework. Section 4.4 explores the compliance of Nigeria and the comparators with regional mechanisms on the right to health. Here, the engagement of Brazil with the Inter-American System, and Nigeria and South Africa with the AU System ('AU System') is brought to the spotlight.[5] Section 4.5 concludes the chapter, reiterating the overarching argument that a strong correlation exists between the domestic commitment of Nigeria and the comparators with the right to health, and their engagement and compliance with that right in the treaty framework. The impact of this finding is consequential for legal positions on the right to health as it determines whether more opportunities beyond those

---

3 Here it is meant the human rights instruments contained in the treaty framework.

4 Here it is meant the mechanisms developed and deployed by the international human rights system to monitor compliance with human rights obligations contained in treaties and other sources. These include the UPR mechanism, special procedures and reports to treaty bodies etc.

5 There is no equivalent regional mechanism which India can engage with; as such, it will not be one of the comparators to be examined in this aspect of the chapter.

available in these states will be available to domestic social actors seeking the attainment of universal health coverage.

The WHO governance framework might have been another site for assessing the engagement of Nigeria and the comparators with the right to health. However, the unavailability of information about the inner workings of the Health Assembly, (WHO's supreme decision making body) has led to its omission from this chapter.

4.1 Institutional Liberalism and Why States Comply with International Treaties

The work of Immanuel Kant, in particular, his essay *Perpetual Peace*[6] provides an important foundation for the theoretical perspective developed by institutional liberalism on why states comply with international treaties. In his essay, Kant argues that the first condition of perpetual peace is that 'the civil construction of every nation should be republican'[7] By this, Kant meant representative democracies, because they rely on the consent of the citizens to engage in war and must therefore 'consider all its calamities before committing themselves to so risky a game'.[8] Kant's claim was taken up by international relations scholars who claimed that although 'liberal' states engage in war, they do not engage in war with *one another*.[9] 'In its modern iteration', according to Oona Hathaway, 'liberal international relations theory has come to stand for the straightforward proposition that domestic politics matter'.[10]

The liberal approach holds that 'states are not unitary, but rather the sum of many different parts. Understanding those parts–the political institutions, interest groups, and state actors–is essential to fully understanding state actions on the world stage'.[11] Andrew Moravcsik aptly sums up this position to wit: 'Societal ideas, interests, and institutions influence state behaviour by shaping state preferences, that is, the fundamental social purposes underlying the strategic calculations of governments'.[12] Following liberal institutionalism, therefore, Nigeria and the comparators will comply with their treaty obligations on the right to health on the basis of the dynamics shaping the preferences of political institutions, state actors and interest groups (domestic social actors) in respect of

---

6 Immanuel Kant, 'Perpetual Peace' in Ted Humphrey (trans) *Perpetual Peace and Other Essays on Politics, History, and Morals* (1795) (Hackett Publishing Co) 107.
7 Ibid 112.
8 Ibid 113.
9 Michael W Doyle, 'Kant, Liberal Legacies, and Foreign Affairs' (1983) 12(3) *Philosophy & Public Affairs* 205, 213.
10 Hathaway, above n 1, 1952.
11 Ibid.
12 Andrew Moravcsik, 'Taking Preferences Seriously: A Liberal Theory of International Politics' (1997) 51 *International Organization* 513.

that right. It is argued that for this dynamics to yield positive results for the situation of the right to health in Nigeria and the comparators, legal positions should necessarily inform the relationship between and amongst political institutions, state actors and domestic social actors.

The liberal approach contrasts with the assumptions undergirding *realism* and *institutionalism.* According to classical realism, the approach which was dominant in academic and policy circles in the years following World War II, 'international law exists and is complied with only when it is in the interests of a hegemon or a few powerful states, which coerce less powerful states into accepting the regime and applying it'.[13] On this view therefore, 'international law is largely epiphenomenal'.[14] Much of this view no longer holds sway because 'its dismissal of international rights regimes ran into difficulty in the 1970s and 1980s when its predictions rapidly diverged from empirical reality'.[15] Classical realism has given way to a more nuanced approach termed 'neorealism' or 'structural realism' that shares with classical realism a conception of states as unitary actors and a focus on the international system as the relevant level of analysis.[16] Neorealism, as conceived in Kenneth Waltz's foundational *Theory of International Politics*,[17] holds the view that international politics take place in an international environment defined by anarchy and filled with states that are 'unitary actors who, at a minimum, seek their own preservation and, at a maximum, drive for universal domination.'[18] As Hathaway notes, 'both strands of realist theory face a difficult task when called upon to explain the existence of and compliance with human rights regimes'.[19]

Contrary to the realist models, institutionalism takes system-wide institutions seriously.[20] Notable institutionalists, such as Robert Keohane,[21] set out to explain why international institutions exist and how they influence state action. Institutionalism, like neorealism, for the most part views states as unified principal actors that behave on the basis of self-

---

13 Hathaway, above n 1, 1945.
14 Ibid.
15 Ibid; see Jeff Frieden, 'Sectoral Conflict and Foreign Economic Policy, 1914-1940' (1988) 42 *International Organization* 59.
16 Hathaway, above n 1, 1945.
17 Kenneth N Waltz, *Theory of International Politics* (Waveland Press, 1979).
18 Ibid 118.
19 Hathaway, above n 1, 1946.
20 Ibid 1947.
21 Robert O Keohane, *After Hegemony: Cooperation and Discord in the World Political Economy* (Princeton University Press, 1984).

interests.[22] It also shares neorealist assumptions that anarchy and the distribution of power among states are the underlying principles of world politics.[23] It is a daunting endeavour for institutionalist theory to explain states' compliance with human rights treaties. In the institutionalist view, 'compliance with human rights treaties is the result of rational self-interested behaviour on the part of states, the result of a reasoned weighing of the costs and benefits of alternative modes of action'.[24] Yet on this view, the benefits of human rights compliance is minimal while the costs often are not.[25] In the final analysis, the institutional model is left with 'reputation as the primary anchor of compliance for all but those countries for which compliance will not cost anything'.[26] On this view therefore, states comply with human rights treaties to uphold a 'reputation for for compliance and hence good international citizenship'.[27] If states change their behaviour in response to human rights treaties, 'it is largely because of concern for their reputation'.[28] This view does not explain why a state like Nigeria does not appear to place much value on its international image, or why despite international pressure, a state like South Africa took so long to ratify the International Covenant on Econcomic Social and Cultural Rights.

It is argued that the empirical evidence on the compliance behaviour of Nigeria and the comparators examined in Sections 4.2, 4.3 and 4.4 below lend credence to the view that liberal institutionalism provides the most promising account for why Nigeria and the comparators have engaged with the international treaties and instruments guaranteeing the right to health in the way they have done. Although it is conceded that liberal institutionalism is susceptible to the charge that it 'provides explanations for government actions after the fact, and finds it difficult to generate predictions ex ante',[29] nontheless, as Hathaway observes, it is 'better suited to explaining compliance with human rights treaties' than the realist, neorealist and/or institutionalist theories.[30]

---

22 Robert O Keohane, 'Institutional Theory and the Realist Challenge After the Cold War' in David A Baldwin (ed) *Neorealism and Neoliberalism* (Columbia University Press, 1993).

23 For an essay exploring the relationship between neoliberal institutionalism and neorealism, see Robert O Keohane, *International Institutions and State Power: Essays in International Relations Theory* (Westview Press, 1989).

24 Hathaway, above n 1, 1951.

25 Ibid.

26 Ibid.

27 Ibid 1952.

28 Ibid.

29 Ibid 1953.

30 Ibid 1954.

4.2 The Universal Periodic Review (UPR) Mechanism

All UN Member States, regardless of whether or not they are party to human rights treaties, are subjected to a public human rights review process called the UPR, with which they are required to cooperate.[31] The review is performed in cycles. The first cycle was held in 2008–2011, and 48 states were reviewed each year until the end of the cycle;[32] the second cycle was held from 2012 to 2016.[33] The review is conducted by the UPR Working Group consisting of the 47 Member States of the Human Rights Council. However, any UN Member State can take part in the discussion with reviewed states. Each review is assisted by a group of three states known as a 'troika', who serve as rapporteurs. The documents on which the reviews are based are those provided by states under review (i.e., their 'national report'); reports of independent human rights experts and groups (known as Special Procedures); reports of human rights treaty bodies and other UN entities; and information from other stakeholders, including national human rights institutions and NGOs.[34]

The review takes place through an interactive discussion between the state under review and other UN Member States. During this discussion, questions and/or recommendations are put to the state under review with a view to improving its human rights record. The troikas facilitate this process by grouping issues or questions to be shared with the state under review to ensure the proceedings are conducted in a smooth and orderly manner. The review addresses the extent to which states respect their human rights obligations in the UN Charter, the Universal Declaration of Human Rights, human rights instruments to which the state is party, voluntary pledges and commitments made by the state (e.g. national human rights policies and/or programmes), and applicable international humanitarian law.[35] This review ensures that states are held accountable for the human rights norms they have accepted; and they are not held accountable for human rights norms they have not accepted.

After the review by the Working Group, a report is prepared by the troika with the involvement of the reviewed state and assistance from the Office of the High

---

31 See UN General Assembly, *Human Rights Council,* GA Res 60/251, 60th sess, UN Doc A/RES/60/251 (15 March 2006).

32 Office of the High Commissioner for Human Rights, *Human Rights Council Universal Periodic Review* (<www.ohchr.org/EN/HRBodies/UPR/Documents/uprlist.pdf>.

33 Office of the High Commissioner for Human Rights, *Universal Periodic Review* (<http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>.

34 Office of the High Commissioner for Human Rights, *Basic Facts About the UPR* (<www.ohchr.org/EN/HRBodies/UPR/Pages/BasicFacts.aspx>.

35 Ibid.

Commissioner for Human Rights (the 'High Commissioner'). The report, known as the 'outcome report', provides a summary of the actual discussions consisting of questions, comments and recommendations made to the reviewed state, as well as its responses. The state has the primary responsibility to implement the recommendations in the outcome report. The UPR mechanism ensures that all states are responsible for the progress or failure to implement the recommendations in the outcome report. At the next review, states are expected to provide information on what they have done to implement the recommendations in the previous outcome report.[36] The Human Rights Council decides on what measures to take, in instances of persistent non-cooperation by a state with the UPR mechanism.[37]

To the extent that the UPR mechanism creates an opportunity for dialogue on the human rights situation of states, it is an outstanding institutional package in the repertoire of the UN human rights system.[38] However, a serious critique of the UPR mechanism is that offered by Hillary Charlesworth and Emma Larking, who describe it as the observance of 'rituals and ritualism'.[39] The suggestion here is that there is a sense in which the UPR mechanism loses its value as a human rights monitoring framework when states fail to fully engage with it in good faith.[40] Nigeria and the comparators have participated in two UPR cycles. The discussion in this section is a synthesis of the findings from these UPR cycles. Based on these findings, an assessment is made of the degree to which Nigeria and the comparators have engaged with the UPR mechanism.

4.2.1 Nigeria's First UPR Cycle

In Nigeria's first UPR cycle on 9 February 2009,[41] the right to health featured in the advance questions submitted by State Parties. Of particular note was the question submitted by Germany, asking what Nigeria was doing to improve the right of children for healthcare, adequate nutrition and housing.[42]

---

36 Ibid.

37 Human Rights Council, *Report of the Human Rights Council on its Seventh Organizational Meeting,* 7th org mtg, UN Doc A/HRC/OM/7/1 (4 April 2013).

38 For other institutional packages, see Human Rights Council, *Institution-building of the United Nations Human Rights Council,* HRC Res 5/1, 5th sess, UN Doc A/HRC/RES/5/1 (18 June 2007) Annex. These principles were reaffirmed in Human Rights Council, *Review of the Work and Functioning of the Human Rights Council,* HRC Res 16/21, 16th sess, UN Doc A/HRC/RES/16/21 (12 April 2011).

39 Hilary Charlesworth and Emma Larking (eds), *Human Rights and the Universal Periodic Review: Rituals and Ritualism* (Cambridge University Press, 2014).

40 Ibid 14-16.

41 Office of the High Commissioner for Human Rights, *Universal Periodic Review - Nigeria* (2009) <http://www.ohchr.org/EN/HRBodies/UPR/Pages/NGSession4.aspx>

42 Office of the High Commissioner for Human Rights, *Questions Submitted in Advance - Nigeria* (2009) <http://lib.ohchr.org/HRBodies/UPR/Documents/Session4/NG/NIGERIAAdd1.pdf>.

The report prepared by the High Commissioner, based on 10 stakeholders' submission to the UPR (hereafter 'the stakeholders' report'),[43] noted that the division of healthcare responsibilities among the three tiers of government in Nigeria (federal, state and local government) was a key structural issue contributing to the high maternal mortality rate of the country.[44] Other problems highlighted by the report included:

- barriers to obtaining quality maternal care created by user fees;
- the absence of adequate information and counselling on family planning, suggested to be a major contributory factor to the high maternal mortality rate of the country;
- the disproportionately higher risk of maternal death for women in the northern region of the country, in rural areas, with low income and without formal education; and
- the problem of widespread corruption and mismanagement resulting in over 80% of the annual budget of the three tiers of government being siphoned off by individuals, thereby depriving the populace of basic health goods and services.[45]

The report compiled by the High Commissioner based on information provided by treaty bodies, special procedures and comments by Nigeria (hereafter 'treaty bodies report') noted that Nigeria was not a party to a number of core human rights treaties.[46] In addition, economic, social and cultural rights are not justiciable in the country.[47] The report also noted the following about Nigeria's engagement with human rights treaty bodies and special procedures:

- there has been no follow up by Nigeria to the CESCR's concluding observations to Nigeria's first report—the concluding observations raised areas for attention by Nigeria;
- Nigeria's second periodic report to the CESCR has been overdue since the year 2000. Its report to the Committee on Civil and Political Rights (CCPR), the treaty body responsible for the *International Covenant on Civil and Political Rights* (ICCPR),[48] has been due since 1999;

---

43 The stakeholders include human rights bodies such as the National Human Rights Commission of Nigeria, Civil Society Organisations, Civil Liberties Organisations and other bodies involved in human rights work in Nigeria.

44 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(c) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/3 (27 November 2008) [49].

45 Ibid [50]-[55].

46 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/2 (5 January 2009) [1].

47 Ibid [2].

48 *International Covenant on Civil and Political Rights,* opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 28 establishes the CCPR.

- Nigeria only responded to 3% of letters of allegations and urgent appeals under the special procedures;
- Nigeria did not respond, within the deadline set, to any of the 12 questionnaires sent by special procedures mandate holders. Many of these questionnaires concerned the rights of women and children;
- the Committee on the Elimination of Discrimination Against Women (the 'CEDAW Committee'), which is the treaty body responsible for the *Convention on the Elimination of All Forms of Discrimination Against Women* (CEDAW),[49] expressed concern about the very high maternal mortality rate in Nigeria, noting it to be the second highest in the world. The CEDAW Committee regretted the lack of progress in this area; and
- the Committee on the Rights of the Child (the 'CRC Committee'), the treaty body responsible for the *Convention on the Rights of the Child* (CRC),[50] raised the problem of street children and the need to ensure that they are provided with adequate nutrition, housing and healthcare, among other things. Equally relevant is a report by a number of UN agencies showing that the limited knowledge in the country about how HIV is transmitted has created many AIDS orphans (~ one million), making Nigeria the country with the highest number of AIDS orphans worldwide.[51]

After the discussion of Nigeria's national report,[52] a number of recommendations were made by states and the Human Rights Council, namely:

- Nigeria should fast-track the ratification of all yet-to-be ratified human rights instruments;
- as a party to the ICESCR, Nigeria should consider making legal adaptations that would result in economic, social and cultural rights becoming individually enforceable rights, as opposed to mere national goals or aspirations;
- there should be an accelerated passage of all rights-based bills before the National Assembly;

---

49 *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) art 17 establishes the CEDAW Committee.

50 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 43 establishes the CRC Committee.

51 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/2 (5 January 2009) [47]-[51].

52 See Human Rights Council, *National Report Submitted in Accordance with Paragrapgh 15(a) of the Annex to the Human Rights Council Resolution 5/1: Nigeria,* 4th sess, UN Doc A/HRC/WG.6/4/NGA/1 (5 January 2009).

- Nigeria should consider putting in more effort to improve the socio-economic conditions of women, in particular in the area of reproductive healthcare services; and
- further measures need to be taken by Nigeria to strengthen the national health system.[53]

4.2.2 Nigeria's Second UPR Cycle

In Nigeria's second UPR cycle on 22 October 2013,[54] the discussion focused on the progress made, or lack thereof, in the human rights situation of Nigeria since the first UPR cycle four years previously. The stakeholders' report raised the following issues about the human rights situation of Nigeria as pertaining to health:

- Nigeria's budgetary allocation for health services remains low;
- basic medical supplies are lacking;
- there is no functional health insurance scheme in the country;
- the health sector is grossly under-funded and mismanaged and many hospitals lack basic facilities with patients being asked to buy medical supplies;
- the country continues to have one of the highest maternal mortality rates in the world;
- only 26% of adults living with HIV/AIDS are in receipt of anti-retroviral therapy;
- there is a challenge regarding misinformation in the family planning system; and
- there is a widespread problem of children suffering from malnutrition in the country.[55]

The treaty bodies report noted that since the first UPR, a number of human rights treaties (not dealing with the right to health) had been ratified by Nigeria, although the *Optional Protocol to the ICESCR* (dealing with the right to health) was yet to be ratified by Nigeria. The report also noted the following about Nigeria's human rights situation:

- Nigeria's periodic report to the CESCR is overdue, and has been overdue since 2000 (no changes here since the first UPR);
- the periodic report to the CCPR is overdue, and has been overdue since 1999 (no changes here either);
- the CEDAW Bill that was recommended for accelerated passage in the first UPR outcome report was still awaiting passage by the National Assembly;

---

53 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Nigeria,* 11th sess, UN Doc A/HRC/11/26 (5 October 2009) [103].

54 Office of the High Commissioner for Human Rights, *Universal Periodic Review Second Cycle - Nigeria* (<www.ohchr.org/EN/HRBodies/UPR/Pages/NGSession17.aspx>.

55 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1 and Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Nigeria,* 17th sess, UN Doc. A/HRC/WG.6/17/NGA/3 (31 July 2013) [89]-[95].

- a better record of cooperation with special procedures was observed, but not in the area of health;
- a better response by Nigeria to letters of allegations and urgent appeals was noted: 28 letters of allegations and urgent appeals were to Nigeria and it responded to six of them;
- Nigeria continues to have a high infant and maternal mortality rate in spite of new policies in the area of health;
- the number of children rendered orphans by HIV/AIDS remains very high; and
- the Special Rapporteur on the right to health sent a communication regarding environmental pollution in one of the northern states of the country.[56]

After the consideration of Nigeria's national report,[57] the Working Group on the UPR recommended in the outcome report that Nigeria should:

- sign and ratify the Optional Protocols to the ICESCR and the CRC on a communication procedure;
- ensure the enactment of the bill on CEDAW and incorporate into national law all international human rights treaties ratified by Nigeria;
- maintain ongoing cooperation with UN human rights institutions;
- further develop the health sector and continue serious efforts to improve the socio-economic status of women;
- improve access to quality healthcare for the people and continue implementing the *National Strategic Health Development Plan 2010–2015* for the development of the health sector;
- strengthen capacity to provide care for children orphaned by HIV/AIDS, as well as those infected;
- continue with policies on the right to health that will allow for full access to healthcare services by persons with disabilities; and
- pay serious attention to the rights of vulnerable people, in particular women and children.[58]

---

[56] Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1 and Paragraph 5 of the Annex to Council Resolution 16/21: Nigeria,* 17th sess, UN Doc. A/HRC/WG.6/17/NGA/2 (9 August 2013) [52]-[55].

[57] Human Rights Council, *National Report Submitted in Accordance with Pragrapgh 5 of the Annex to Human Rights Council Resolution 16/21: Nigeria,* 17th sess, UN Doc A/HRC/WG.6/17/NGA/1 (30 July 2013).

[58] Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Nigeria,* 25th sess, UN Doc. A/HRC/25/6 (16 December 2013) [135].

In assessing Nigeria's engagement with the UPR mechanism on the basis of the above record, the compelling evidence that emerges is that Nigeria has not been fully engaged and/or compliant with the UPR mechanism. What is more, Nigeria's domestic record of fulfilling the right to health is unconvincing and does not reflect the best performance of which it is capable. Thus Nigeria's poor domestic commitment to the right to health coincides with its poor engagement and compliance with the treaty framework in respect of that right.

4.2.3 Brazil's First UPR Cycle

In Brazil's first UPR cycle on 11 April 2008,[59] a number of states submitted advance questions for consideration by Brazil, but health or the right to health did not feature in any of them.[60]

The kind of advance questions submitted to a state for consideration during its UPR cycle offers a view of what the international community considers to be the most pressing human rights challenges facing that state. It is for this reason that the non-inclusion of health and the right to health in Brazil's advance questions is potentially significant.

The stakeholders' report, drawn from 22 submissions, commended Brazil for having some of the most progressive laws for the protection of human rights in the Latin American region.[61] However, the report raised a number of issues affecting the right to health, namely:

- social and economic inequalities giving rise to health challenges in some parts of the country;
- abortions in unsafe conditions due to its criminalisation;[62]
- the high rate of maternal mortality;
- inequalities in access to and quality of health for poor women and 'women of colour';
- the forced sterilisation of women, especially poor black women;

---

59 Office of the High Commissioner for Human Rights, *Universal Periodic Review - Brazil* (2008) <http://www.ohchr.org/EN/HRBodies/UPR/Pages/BRSession1.aspx>.

60 Office of the High Commissioner for Human Rights, *Advance Questions to Brazil* (2008) <lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL.pdf>; Office of the High Commissioner for Human Rights, *Advance Questions to Brazil - Addendum 1* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL-ADD1.pdf>; Office of the High Commissioner for Human Rights, *Advance Questions to Brazil - Addendum 2* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL-ADD2.pdf>.

61 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraphs 15(c) of the Annex to Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/3 (6 March 2008) [1].

62 Exceptions include cases of sexual violence or when a woman's life is endangered by the pregnancy. See Ibid [40].

- the increased rate of HIV infection of women; and
- the transmission of HIV from infected mothers to babies during pregnancy, childbirth or breastfeeding.[63]

Brazil's cooperation with international human rights mechanisms has been robust according to the assessment of the High Commissioner based on information provided in the treaty bodies report.[64] The treaty bodies report indicates that Brazil has ratified most of the core international human rights treaties on the right to health.[65] Its constitution incorporates and prioritises a wide range of human rights contained in treaties.[66] It has engaged fully with treaty bodies in the submission of its national reports, although some reports are overdue.[67] It maintains a standing invitation to special procedures and has facilitated many visits that affect the right to health.[68] It responded to 12.5% of communications (comprising letters of allegations and urgent appeal) sent by special procedures in 2004, 9.5% in 2005, 25% in 2006 and 100% in 2007.[69] It also responded to 3 out of 12 questionnaires sent by special procedures mandate holders since 1 January 2004.[70] On its own initiative, it created independent Special Rapporteurs with responsibility for monitoring economic, social and cultural rights in the country[71] and has responded in an exemplary manner to the HIV/AIDS problem.[72] Overall, the treaty bodies report gives a very positive assessment of Brazil's engagement with the right to health.

---

63 Ibid [39]-[42].

64 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/2 (31 March 2008) [6]-[7].

65 However, Brazil is yet to ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights which entered into force on 5 May 2013. See *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights,* opened for signature 10 December 2008, UNTC 14531 (entered into force 5 May 2013).

66 The CESCR for instance, notes that Brazil's Constitution incorporates a wide range of economic, social and cultural rights enshrined in the ICESCR; the Committee on the Rights of the Child commended Brazil for giving absolute priority to children's rights in its Constitution; while two other treaty bodies welcomed the adoption of laws by Brazil in favour of equality between men and women. See Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/2 (31 March 2008) [2]-[3].

67 Brazil has submitted a minimum of two reports (the initial and periodic reports) in respect of all the treaty bodies whose work impacts on the right to health. Ibid 4.

68 Ibid [6]-[7]; this is a particularly important way of assessing a state's engagement with the treaty framework because 'special procedures' involves independent human rights experts with mandate to report and advice on human rights from a thematic or country perspective. See Office of the High Commissioner for Human Rights, *Special Procedures of the Human Rights Council* (<http://www.ohchr.org/EN/HRBodies/SP/Pages/Welcomepage.aspx>

69 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/2 (31 March 2008) 5.

70 Ibid.

71 Ibid [24].

72 Ibid 10-11.

In the outcome report that followed Brazil's national report,[73] its efforts in promoting the health of its population were widely acknowledged.[74] However, concerns were raised about the poverty and inequality of access to health of its population of African descent and other minorities.[75] Brazil, on its part, promised to create new tools for the internal monitoring of human rights in the country. These would include a national system of human rights indicators, the elaboration of annual reports on the situation of human rights, and a follow up of the UPR exercise.[76]

4.2.4 Brazil's Second UPR Cycle

In Brazil's second UPR cycle on 25 May 2012,[77] no questions were raised about health or the right to health in the advance questions submitted by State Parties—just as was the case in the first UPR cycle.

The stakeholders' report based on 47 submissions raised a number of issues about the right to health. The first concerned Brazil's unfulfilled commitment from the first UPR cycle to establish a national plan implementing international and regional human rights recommendations.[78] The second was the high maternal mortality rate prevalent in marginalised communities due to challenges with the Unified Health System.[79] The third was the inadequate budget allocated to healthcare.[80] The fourth was the criminalisation of abortion[81] (an issue that was also raised at the first UPR cycle). The fifth was the health inequity of marginalised groups in the country.[82] The final issue concerned the violation of the right to healthcare and treatment of persons living with HIV/AIDS.[83] However, the report commended Brazil for the reduction in child mortality by two-thirds and the overall response to the HIV/AIDS pandemic.[84]

---

73 Human Rights Council, *National Report Submitted in Accordance with Paragraph 15(a) of the Annex to Human Rights Council Resolution 5/1: Brazil,* 1st sess, UN Doc A/HRC/WG.6/1/BRA/1 (7 March 2008).

74 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Brazil,* 8th sess, UN Doc A/HRC/8/27 (22 May 2008).

75 Nigeria raised this concern in its recommendation to Brazil on measures it should take to properly integrate vulnerable groups of Africans and African descendants into the society. See Ibid [66].

76 Ibid [85].

77 Office of the High Commissioner for Human Rights, *Universal Periodic Review Second Cycle - Brazil* (<www.ohchr.org/EN/HRBodies/UPR/Pages/BRSession13.aspx>.

78 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Brazil,* 13th sess, UN Doc A/HRC/WG.6/13/BRA/3 (14 March 2012) [11].

79 Ibid [53]; the marginalised communities of Brazil include poor black women and agricultural workers.

80 Ibid.

81 Ibid [55].

82 Ibid [56].

83 Ibid [57].

84 Ibid [56].

The treaty bodies report confirmed Brazil's continuous engagement with the human rights monitoring mechanisms of the UN system.[85] In the specific context of the right to health, similar issues to those raised by the stakeholders report were also raised. For instance, mention was made of the high maternal mortality rate of Brazil (especially in marginalised communities), HIV/AIDS and its effects on women, the criminalisation of abortion and its consequences for maternal health, and the poor delivery of health services to Indigenous communities. [86]

The outcome report that followed Brazil's national report[87] recommended that Brazil should:

- promote equal access to health;
- continue to implement the system of registering and monitoring pregnant women to prevent maternal mortality;
- reduce infant and child mortality and morbidity, and address malnutrition in children;
- continue its efforts to guarantee free and quality health services and improve measures to reduce the prevalence of HIV/AIDS.[88]

Overall, Brazil's engagement with the UPR mechanism is quite strong when compared with that of Nigeria. In addition, going by the comments of other states and stakeholders during the UPR process, Brazil has recorded a relatively strong performance in promoting the right to health domestically. Thus in the case of Brazil, there is a noticeable coincidence between its strong domestic commitment and its equally strong international engagement and compliance with the treaty framework on the right to health.

4.2.5 India's First UPR Cycle

In India's first UPR cycle on 10 April 2008,[89] Germany submitted an advance question on what India was doing to ensure access to medical services for the Dalits (also known as the 'untouchables') and other caste groups.[90] This question suggests that access to

---

85 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: Brazil,* 13th sess, UN Doc A/HRC/WG.6/13/BRA/2 (22 March 2012) 2-5.

86 Ibid [55]-[61].

87 Human Rights Council, *National Report Submitted in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: Brazil,* 13th sess, UN Doc A/HRC/WG.6/13/BRA/1 (7 March 2012).

88 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: Brazil,* 21st sess, UN Doc A/HRC/21/11 (9 July 2012) [119].

89 Office of the High Commissioner for Human Rights, *Universal Periodic Review - India* (<www.ohchr.org/EN/HRBodies/UPR/Pages/INSession1.aspx>.

90 See Office of the High Commissioner for Human Rights, *Advance Questions to India* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA.pdf>. The other

health for marginalised groups is considered by the international community to be a pressing human rights challenge for India.

A total of 37 submissions were made to the stakeholders' report[91] and raised concerns affecting the right to health in India. Some of these include:

- India's reluctance to cooperate with special procedures by extending a standing invitation to it;[92]
- the weak and uneven implementation of a policy meant to improve the reproductive health of women through access to health-related services;[93]
- the poor state of healthcare facilities, which, combined with other factors, such as unsafe abortions, results in high maternal deaths;[94]
- the poor situation for women in rural areas;[95]
- the high mortality rate of children in disadvantaged communities;[96] and
- lack of access to clean drinking water due to pollution of water resources and diversion for industrial purposes.[97]

The treaty bodies report found that India has ratified most of the human rights instruments on the right to health[98] and has a comprehensive constitutional and legal framework where international treaties are not self-executing.[99] The report also observed the following about India's human rights situation and engagement:

---

questions submitted did not raise issues about the right to health: see Office of the High Commissioner for Human Rights, *Advance Questions to India - Addendum 1* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA-ADD1.pdf>; Office of the High Commissioner for Human Rights, *Advance Questions to India - Addendum 2* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA-ADD2.pdf>.

91 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraphs 15(c) of the Annex to the Human Rights Council Resolution 5/1: India,* 1st sess, UN Doc A/HRC/WG.6/1/IND/3 (6 March 2008).

92 Ibid [6].

93 Ibid [41].

94 Ibid.

95 Ibid.

96 Ibid [42].

97 Ibid [44].

98 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: India,* 1st sess, UN Doc A/HRC/WG.6/1/IND/2 (27 March 2008) 2. However, India is yet to ratify the Optional Protocol to the ICESCR (*Optional Protocol to the International Covenant on Economic, Social and Cultural Rights,* opened for signature 10 December 2008, UNTC 14531 (entered into force 5 May 2013)); see also Optional Protocol to the CEDAW (*Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women,* opened for signature 6 October 1999, 2131 UNTS 83 (entered into force 22 December 2000).

99 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: India,* 1st sess, UN Doc A/HRC/WG.6/1/IND/2 (27 March 2008) 2.

- it has engaged with its reporting obligations to treaty bodies, although some reports are overdue;[100]
- no standing invitation has been issued to special procedures, although India received the Special Rapporteur on the right to health (between 22 November and 3 December 2007);[101]
- India responded to 19.3% of communications sent to it by special procedures between 2004 and 2007[102] but did not respond to any of the 12 questionnaires sent by special procedures mandate holders between 2004 and 2007;[103]
- the maternal mortality rate in rural areas of the country is among the highest in the world;[104]
- the privatisation of health services has further compounded the maternal mortality situation by adversely affecting women's access to health;[105]
- the under-five mortality rate among the scheduled castes and tribes[106] is 50% higher than the rest of the population; [107] and
- inequality of access to health facilities and reproductive health services is still the norm among disadvantaged groups.[108]

In the outcome report that followed India's national report,[109] recommendations were made on how India can increase its engagement with international human rights mechanisms such as special procedures and the UPR mechanism.[110]

---

100 Ibid 4.
101 Ibid.
102 Ibid.
103 Ibid.
104 Ibid [39].
105 Ibid.
106 According to art 367(24) of *Constitution of India*: '"Scheduled Castes" means such castes, races or tribes or parts of or groups within such castes, races or tribes as are deemed under article 341 to be Scheduled Castes for the purposes of this Constitution.' In addition, art 367(25) provides that: '"Scheduled Tribes" means such tribes or tribal communities or parts of or groups within such tribes or tribal communities as are deemed under article 342 to be Scheduled Tribes for the purposes of this Constitution.'
107 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: India,* 1st sess, UN Doc A/HRC/WG.6/1/IND/2 (27 March 2008) [39].
108 Ibid.
109 Human Rights Council, *National Report Submitted in Accordance with Paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1: India,* 1st sess, UN Doc A/HRC/WG.6/1/IND/1 (6 March 2008).
110 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: India,* 8th sess, UN Doc A/HRC/8/26 (23 May 2008) [86].

4.2.6 India's Second UPR Cycle

In the advance questions of India's second UPR cycle on 24 May 2012, Germany asked what India was doing to improve access for underprivileged minorities to medical treatment, while Slovenia enquired about the measures to give full effect to the ICESCR in India's domestic law, in accordance with the recommendations of the CESCR.[111] These questions demonstrate a continuing international concern for access to health for marginalised groups in India.

A total of 51 stakeholders made submissions to the stakeholders' report.[112] The report raised some issues from the first UPR such as India's non-ratification of the *Optional Protocol to the CEDAW* (allowing for individual complaints)[113] and the absence of a follow-up process to the first UPR.[114] New concerns included:

- the low level of public spending on health;[115]
- lack of access to health for vast numbers in villages;[116] and
- the high infant mortality rate,[117] the high number of maternal deaths (attributed to child marriages and unsafe abortion)[118] and the discriminatory operation of maternal health programmes with respect to women with more than two children and mothers aged less than 18 years.[119]

The treaty bodies report indicated no change to India's non-ratification of the Optional Protocols to the CEDAW and ICESCR.[120] However, it commended India's approach of interpreting its constitution to achieve justiciability of socio-economic rights, and recommended legal measures be taken to give full effect to the ICESCR in domestic law.[121] The report also noted India's continuing engagement with treaty bodies and special procedures, although no standing invitation had been issued to the latter.[122] The

---

111 Office of the High Commissioner for Human Rights, *Universal Periodic Review Second Cycle - India* (<www.ohchr.org/EN/HRBodies/UPR/Pages/INSession13.aspx>.

112 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: India,* 13th sess, UN Doc A/HRC/WG.6/13/IND/3 (12 March 2012).

113 Ibid [1].

114 Ibid.

115 Ibid [26].

116 Ibid.

117 Ibid [85].

118 Ibid.

119 Ibid.

120 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: India,* 13th sess, UN Doc A/HRC/WG.6/13/IND/2 (11 April 2012) 2.

121 Ibid [5].

122 Ibid 5.

other concerns raised about the right to health were similar to those raised in the stakeholders' report.[123]

Following the submission of India's national report[124] and the interactive dialogue of the UPR Working Group, the outcome report to India made the following recommendations:

- establish and implement a *National Human Rights Plan* to address access to health;
- address inequities based on the rural–urban divide, and gender imbalance;
- allocate more resources to health;
- continue efforts to improve the level of public health for better access to health;
- fulfil the commitment from the Common Minimum Programme of 2004 to dedicate 3% of India's GDP to health;
- take further practical steps to reduce the high level of maternal and child mortality; and
- take measures to eliminate discrimination in access to reproductive health services for all women.[125]

Overall, India's engagement with the UPR mechanism, while promising, has not been very strong, especially when compared to engagement by Brazil. Moreover, at the domestic level, a number of poor health outcomes, particularly among vulnerable and disadvantaged groups, point to gaps in the fulfilment of the right to health. Thus India, like Nigeria, has shown a poor domestic record of commitment to the right to health and this has coincided with its weak engagement with the right in the treaty framework.

4.2.7 South Africa's First UPR Cycle

South Africa's first UPR cycle on 15 April 2008[126] had an advance question from Germany enquiring about measures envisaged to improve equal access to healthcare and treatment for women suffering from HIV.[127] Portugal asked if South Africa had a timetable for the ratification of the ICESCR as an important player in the development of socio-economic rights.[128] Canada enquired about the inequities in access to HIV/AIDS

---

123 Ibid [58]-[60].

124 Human Rights Council, *National Report Submitted in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: India,* 13th sess, UN Doc A/HRC/WG.6/13/IND/1 (8 March 2012).

125 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: India,* 21st sess, UN Doc A/HRC/21/10 (9 July 2012) [138].

126 Office of the High Commissioner for Human Rights, *Universal Periodic Review -South Africa* (<www.ohchr.org/EN/HRBodies/UPR/Pages/ZASession1.aspx>.

127 Office of the High Commissioner for Human Rights, *Advance Questions to South Africa* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/QUESTIONSSOUTHAFRICA.pdf>.

128 Ibid.

treatment and support, especially for rural South Africans.[129] Germany's and Canada's questions reveal that HIV/AIDS is considered by the international community to be one of South Africa's most pressing human rights challenges, while Portugal's question is significant for what it says about South Africa's lack of involvement with the ICESCR regime.[130]

A total of 18 stakeholders made submissions to the stakeholders' report.[131] The report lauded South Africa's progress in developing a legislative and institutional framework for socio-economic rights, and for its progressive implementation.[132] However, it also raised the following concerns touching on the right to health:

- South Africa is yet to ratify the ICESCR;[133]
- extreme levels of poverty and other social problems have exacerbated the spread of HIV/AIDS and other threats to the health system;[134]
- gender-based violence is increasing women's risk of contracting HIV;[135]
- the country has the highest number of people living with HIV in Sub-Saharan Africa;[136] and
- the government's failure to provide access to anti-retroviral treatment across the country disappointed domestic and international expectations that it would respond proactively to the HIV/AIDS pandemic.[137]

The tenor of the stakeholders' report suggests that HIV/AIDS and the non-ratification of the ICESCR are considered by stakeholders as some of the most pressing challenges facing the fulfilment of the right to health in South Africa.

The treaty bodies report indicates that South Africa has ratified the CEDAW, the Optional Protocols to CEDAW and the CRC, but not the ICESCR.[138] The report also notes the following about South Africa's engagement:

---

129 Office of the High Commissioner for Human Rights, *Advance Questions to South Africa - Addendum 1* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/QUESTIONSSOUTHAFRICA-ADD1.pdf>.

130 This situation has now changed as South Africa ratified the ICESCR on 12 January 2015 after considerable pressure from the international community and domestic activists.

131 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(c) of the Annex to Human Rights Council Resolution 5/1: South Africa,* 1st sess, UN Doc A/HRC/WG.6/1/ZAF/3 (11 March 2008).

132 Ibid [1].

133 Ibid.

134 Ibid [24].

135 Ibid [29].

136 Ibid.

137 Ibid [30].

138 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: South Africa,* 1st sess, UN Doc A/HRC/WG.6/1/ZAF/2 (11 April 2008) 2.

- South Africa is engaged with its reporting obligations to treaty bodies in respect of treaties ratified, although some of its reports are overdue;[139]
- it has issued a standing invitation to special procedures;[140]
- it responded to 50% of communications sent to it by special procedures between 2004 and 2007, and 2 out of 12 questionnaires sent to it by special procedures mandate holders within the same period;[141] and
- the report confirms the dire situation of HIV/AIDS among the most vulnerable ethnic groups in the country.[142]

Following the submission of its national report,[143] an interactive dialogue with the UPR Working Group ensued, leading to recommendations being made to South Africa in the outcome report, where it was urged, among other things, to ratify the ICESCR at the earliest possible opportunity. It was also suggested that measures be taken to address inequities in access to HIV/AIDS treatment and support; and for efforts to be made to decrease the prevalence of HIV/AIDS as envisaged in the country's National Health Charter.[144]

4.2.8 South Africa's Second UPR Cycle

At South Africa's second UPR cycle on 31 May 2012,[145] the advance question of the United Kingdom queried what South Africa was doing to tackle its high maternal and infant mortality rates. [146] Norway asked what measures were being taken to strengthen the implementation of socio-economic rights guaranteed in the Bill of Rights, and when the ICESCR was to be ratified.[147] The recurrence of the question about the non-ratification of the ICESCR shows that in the intervening period following the first UPR, South Africa did not ratify the ICESCR as it promised.

---

139 Ibid 4.
140 Ibid.
141 Ibid.
142 Ibid [17].
143 Office of the High Commissioner for Human Rights, *South Africa's Country Report to the Human Rights Council's Universal Periodic Review Mechanism: 15 April 2008* (<lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/A_HRC_WG6_ZAF_1_E.pdf>.
144 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: South Africa,* 8th sess, UN Doc A/HRC/8/32 (23 May 2008), [67].
145 Office of the High Commissioner for Human Rights, *Universal Periodic Review Second Cycle - South Africa* (<www.ohchr.org/EN/HRBodies/UPR/Pages/ZASession13.aspx>.
146 Ibid.
147 Ibid.

The stakeholders' report had submissions from 19 stakeholders.[148] The report identified the need for South Africa to ratify the ICESCR and its Optional Protocol.[149] It also raised the following areas of concern:

- the lack of healthcare and proper housing for children belonging to the poorest and most vulnerable communities;[150]
- the continuing disparities in access to health services;[151]
- the increasing maternal mortality ratio arising from poor accountability and oversight mechanisms in the health system;[152]
- although progress was being made to expand access to treatment for HIV/AIDS, physical and economic barriers continue to affect access to health services for poor households;[153] and
- the deteriorating quality of health services and infrastructure in the country was resulting in increases to the infant and maternal mortality rates.[154]

The treaty bodies report confirmed the non-ratification of the ICESCR and its Optional Protocol by South Africa.[155] It also noted the following about South Africa's human rights engagement and situation:

- South Africa has maintained a standing invitation to special procedures and continues to submit its reports to treaty bodies;[156]
- the country is not yet on track to achieve the health-related MDGs in 2015;[157]
- the high rate of maternal and child deaths in the country is mainly due to HIV/AIDS and the poor implementation of existing packages of care;[158]
- women and girls are disproportionately affected by the HIV/AIDS epidemic;[159] and

---

148 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa,* 13th sess, UN Doc A/HRC/WG.6/13/ZAF/3 (12 March 2012).

149 Ibid 2; the Optional Protocol to the ICESCR opened for signature on 10 December 2008, after the conclusion of South Africa's first UPR cycle. See *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights,* opened for signature 10 December 2008, UNTC 14531 (entered into force 5 May 2013).

150 Human Rights Council, *Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa,* 13th sess, UN Doc A/HRC/WG.6/13/ZAF/3 (12 March 2012) [60].

151 Ibid [65].

152 Ibid [66].

153 Ibid [70].

154 Ibid [71].

155 Human Rights Council, *Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa,* 13th sess, UN Doc A/HRC/WG.6/13/ZAF/2 (23 March 2012) 2.

156 Ibid 5.

157 Ibid [47].

158 Ibid [48].

159 Ibid.

- the Special Rapporteur on the human rights of migrants recommended that, with respect to access to health, the government of South Africa should comply with the existing national framework, regardless of a person's status in the country.[160]

Following South Africa's submission of its national report,[161] the interactive dialogue concluding South Africa's second UPR cycle yielded a number of recommendations in the outcome report for South Africa's consideration. One recommendation was for South Africa to ratify the ICESCR and its Optional Protocol[162]—it is instructive to note that South Africa eventually ratified the ICESCR on 12 January 2015. However, it is yet to ratify the *Optional Protocol to the ICESCR*.[163] Other recommendations suggested that South Africa should:

- continue efforts to achieve the national priorities in health;
- strengthen efforts at HIV/AIDS prevention and treatment;
- reduce child and maternal mortality;
- continue efforts at achieving the health-related MDGs;
- take necessary measures to eliminate discriminatory barriers for access to HIV-related health services, especially for women and girls in rural areas; and
- seek ways to enhance the overall quality of health services in the country.[164]

In summary, South Africa has had relatively strong engagement with the UPR mechanism; especially in comparison with Nigeria and India. However, South Africa has not done as well as Brazil in this area. Overall, South Africa's domestic fulfilment of the right to health is bedevilled by a number of problems that indicate the need for strengthening legal positions on the right to health in South Africa. Nonetheless South Africa's record supports the view that a committed domestic record of engagement with the right to health is likely to coincide with a strong engagement with the treaty framework in respect of that right.

---

160 Ibid [49].

161 Human Rights Council, *National Report Submitted in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa,* 13th sess, UN Doc A/HRC/WG.6/13/ZAF/1 (7 March 2012).

162 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: South Africa,* 21st sess, UN Doc A/HRC/21/16 (9 July 2012) [124].

163 See *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976).

164 Human Rights Council, *Report of the Working Group on the Universal Periodic Review: South Africa,* 21st sess, UN Doc A/HRC/21/16 (9 July 2012) [124].

4.2.9 Reflective Summary

This section reflects on the extent of engagement of Nigeria and the comparators with the instruments and mechanisms promoting the right to health in the treaty framework. It also assesses the depth and breadth of that engagement. The objective of the section is to build understanding on the nature of the relationship, if any, between the engagement of Nigeria and the comparators with the instruments and mechanisms of the treaty framework, and legal positions on the right to health in their domestic system. The findings that emerge from the section largely confirm the theoretical framework offered by liberal institutionalism to the effect that domestic politics matter.

4.2.9.1 Engagement with Instruments and Mechanisms

Table 4.1 summarises how Nigeria and the comparators have engaged with the instruments and mechanisms promoting the right to health in the treaty framework. Table 4.1 reveals that Brazil has maintained a better record of engagement with the treaty framework than have Nigeria, India and South Africa. South Africa comes next, then Nigeria and lastly India. Based on the claim in the introduction to this chapter, that a strong domestic commitment to the right to health is likely to result in higher levels of engagement with the instruments and mechanisms of the treaty framework on the right to health it is suggested that Brazil's very active engagement with the right to health in the treaty framework cannot be easily divorced from its strong domestic record promoting that right. The same argument is made for South Africa, Nigeria and India to the degree of their domestic commitment vis-à-vis their engagement with the treaty framework. Section 4.1.9.2 offers an opportunity for further evaluation of this claim.

Table 4.1: Engagement with instruments and mechanisms of the treaty framework

Engagement		Nigeria	Brazil	India	South Africa
1	*Ratification of treaties on the right to health contained in the treaty framework*	Has ratified all but the *Optional Protocol to the ICESCR*	Has ratified all but the *Optional Protocol to the ICESCR*	Has ratified all but the Optional Protocols to the ICESCR and CEDAW	Has ratified all but the *Optional Protocol to the ICESCR*
2	*Submission of reports to treaty bodies*	Some reports are overdue	Some reports are overdue	Some reports are overdue	Some reports are overdue
3	*Maintains standing invitation to special procedures*	No	Yes	No	Yes
4	*Facilitated visits of special procedures mandate holders*	Yes	Yes	Yes	Yes
5	*Response to communications (comprising letters of allegations and urgent appeals) sent to the Human Rights Council by individuals and groups in the state*	3% response in first UPR to 27 communications ; 21% response in second UPR to 28 communications	12.5% in 2004; 9.5% in 2005; 25.0% in 2006 and 100% in 2007	19.3% overall response from 2004 to 2007	50% overall response from 2004 to 2007
6	*Response to questionnaires on thematic issues*	0/12 response rate recorded	3/12 response rate recorded	0/12 response rate recorded	2/12 response rate recorded
7	*Attitude to commitments made during the first UPR cycle*	Did not make any promise at first UPR; noticeable progress seen in some areas and lack of progress in other areas	Did not fulfil its promise to create tools internally for monitoring human rights	Did not make any promise at first UPR; absence of a follow-up process was noted	Did not promptly fulfil its promise to ratify the ICESCR

(*Source:* Office of the High Commissioner for Human Rights)

4.2.9.2 Assessment of the 'Depth and Breadth' of Engagement

The assessment category 'depth and breadth' measures the fundamental nature and widespread effects, respectively, of the relationship between domestic commitment and international engagement with the right to health by Nigeria and the comparators. Table 4.2 suggests that Brazil has a very good overall record of engaging with the right to health, followed by South Africa, which has a good record. Nigeria and India, on the other hand, have only performed fairly in this regard. This finding is the result of the situation analysis in five key areas presented in Table 4.2, namely:

(a) whether right to health concerns were raised by the international community during the UPR process, suggesting that the area of concern raised was regarded by the international community as a problematic area for the state involved. In this respect, all states with the exception of Brazil faced questions that touched on an aspect of the right to health;

(b) whether there are noticeable disparities in achieving access to health: Nigeria and all the comparators have one form of disparity or another hindering certain communities, groups or households from accessing healthcare services;

(c) whether there are institutional barriers hindering the fulfilment of the right to health: institutionally linked barriers were identified in Nigeria and all the comparators during the UPR process. In the case of Nigeria, widespread corruption and mismanagement of the annual budget of the three tiers of government (federal, state and local) is a key problem regarded as potentially affecting the access to and delivery of health services in the country; in Brazil, it is the criminalisation of abortion leading to abortion in unsafe conditions; in India, discriminatory maternal health practices and programmes against women and underage mothers have been identified; and in South Africa, it is systemic failure in the provision of anti-retroviral therapy for HIV/AIDS sufferers;

(d) whether there are robust laws promoting the right to health: Brazil and South Africa have robust constitutional and legislative regimes that promote the right to health; Nigeria and India, on the other hand, have a constitutional regime where the right to health is not justiciable. In addition, policy and legislation promoting the right to health is either non-existent (in India), or is inadequate (in Nigeria with respect to the recently promulgated *National Health Law 2014*).[165]

---

[165] Further discussion of the constitutional regime of Nigeria and the comparators on the right to health is offered in Chapter 5, while the discussion of the policy and legislative regime is offered in Chapter 6 of this thesis.

(e) whether there are shortcomings hindering the fulfilment of the right to health in Nigeria and the comparators: although Nigeria and the comparators exhibited shortcomings in their fulfilment of the right to health, those of Nigeria India and South Africa were more consequential for that right because they touched on the state of facilities for health service delivery in the country.

In the final analysis, the findings from Tables 4.1 and 4.2 support the claim that a strong domestic commitment to the right to health is likely to result in higher levels of engagement with the instruments and mechanisms of the treaty framework on the right to health. The findings show that Brazil and South Africa, which have shown stronger commitment to the right to health domestically than have Nigeria and India, have also engaged better with that right in the treaty framework. It is suggested that one benefit of the good international engagement with the right to health by Brazil and South Africa is that they have created more opportunities for domestic social actors, to hold the government accountable for the fulfilment of the right to health in the domestic system by referencing the government's human rights profession and/or record in the international system. It is further suggested that it is in this manner that the international system and its treaty framework can strengthen legal positions on the right to health in the domestic system. The suggestion is that a strong domestic commitment to the right to health can, and does indeed (in many cases), translate to an equally strong commitment to the fulfilment of that right in the treaty framework, and this creates more opportunities for domestic social actors to be able to hold the government accountable for its human rights commitments. There are obvious limitations to this claim, such as the unpredictability of the domestic system of individual states that may affect how international human rights norms are accepted and utilised to shape domestic human rights praxis. Notwithstanding this potential limitation, it is argued that the findings from the analysis on the engagement and compliance behaviour of Nigeria and the comparators with the treaty framework on the right to health supports the argument of this chapter which draws from liberal institutionalism to claim that domestic systems matter. Thus legal positions need to be strengthened at the domestic system to ensure that states like Nigeria and India become more engaged with the international treaty framework on the right to health.

Table 4.2: Depth and breadth of engagement

Situation		Nigeria	Brazil	India	South Africa
1	*Were right to health concerns raised by the international community during UPR?*	Yes	No	Yes	Yes
2	*Are there noticeable disparities in achieving access to healthcare?*	Yes; higher risks of maternal death due to poor access to health among women in the northern region, in rural areas, with low income and no formal education	Yes; present among women of colour and poor people	Yes; present among scheduled/caste groups, in rural areas, among disadvantaged groups, and among women	Yes; present in vulnerable communities and poor households
3	*Are there institutionally induced barriers to achieving the right to health?*	Yes; widespread corruption and mismanagement of the annual budget of federal, state and local governments	Yes; criminalisation of abortion leading to abortion in unsafe conditions	Yes; discriminatory maternal health programmes against women and underage mothers	Yes; systemic failure in the provision of access to anti-retroviral treatment
4	*Are there robust state laws promoting the right to health?*	No; the right is not well captured in the *National Health Law 2014*	Yes	No	Yes
5	*What are the shortcomings with respect to achieving the right to health?*	Infant/maternal mortality, HIV/AIDs, poor health facilities, poor child nutrition, poor housing and lack of health insurance	HIV/AIDS, maternal mortality, poor access to health for women of colour and poor people	Infant/maternal mortality, poor health facilities, privatisation of health and poor child nutrition	HIV/AIDS, extreme poverty, gender-based violence and deteriorating health services
6	*What is the overall record in promoting the right to health?*	Fair	Very good	Fair	Good

(*Source:* Office of the High Commissioner on Human Rights)

4.3 State Parties' Report to Treaty-based Bodies on Health

Another opportunity to examine the claim in this chapter that a strong correlation exists between states' domestic treatment of the right to health and its responses to treaty obligations in respect of that right arises in the context of the assessment of the behaviour of Nigeria and the comparators with respect to treaty-based bodies on health.[166] There are two aspects to this assessment: the first sets out to examine the ratification and reporting behaviour of Nigeria and the comparators with respect to the core treaties on the right to health,[167] and the second examines what the treaty reports depict about the situation regarding the right to health in Nigeria and the comparators. Overall, the objective of these assessments is to understand how Nigeria and the comparators have engaged with treaty-based bodies responsible for the core treaties advancing the right to health, and what this engagement reveals about the situation regarding the right to health in these states.

4.3.1 The Ratification of Treaties and Fulfilment of Reporting Obligations

The ICESCR, CEDAW and CRC are the core human rights treaties advancing the right to health in international law and are the focus of the discussion in this section. These treaties also have Optional Protocols, some of which are relevant to the right to health. Table 4.3 presents information about the ratification behaviour of Nigeria and the comparators with respect to these treaties. As Table 4.3 indicates, Nigeria, Brazil and South Africa have ratified more of these treaties than has India.

Table 4.3: Date of ratification of human rights treaties by Nigeria and the comparators

	Treaty	Nigeria	Brazil	India	South Africa
1	ICESCR	29 Jul 1993	24 Jan 1992	10 Apr 1979	12 Jan 2015
2	CEDAW	13 Jun 1985	1 Feb 1984	9 Jul 1993	15 Dec 1995
3	CRC	19 Apr 1991	24 Sep 1990	11 Dec 1992	16 Jun 1995
4	*Optional Protocol to CEDAW*	22 Nov 2004	28 Jun 2002	-	18 Oct 2005
5	*Optional Protocol to ICESCR*	-	-	-	-

(*Source:* United Nations Treaty Collection)

[166] This is different to the UPR process of the Human Rights Council discussed in Section 4.1.

[167] This issue was broadly dealt with in the discussion about the UPR process in Section 4.1. The objective in this section is to single out each of these treaties, which impact the right to health, for specific examination.

Each of these treaties mandates State Parties to submit two types of report: an initial report (within one or two years of ratification) and a periodic report (usually every four or five years thereafter)—the interval between submissions varies among treaties.[168] On the basis of these requirements it is possible to use the data in Table 4.3 to assess whether the comparators have fulfilled their reporting obligations promptly and fully. Table 4.4 presents the situation report in this regard.

Table 4.4: Reporting behaviour of Nigeria and the comparators up to 12 January 2017

Treaty	**Nigeria** Submission details			**Brazil** Submission details			**India** Submission details			**South Africa**[169] Submission details		
	ideal	actual	due	ideal	actual	due	ideal	actual	due	ideal	actual	due
ICESCR	5	1	yes	5	2	yes	7	5	yes	-	-	-
CEDAW	8	8	no	8	7	yes	6	5	yes	5	4	yes
CRC	5	4	yes	5	4	yes	5	4	yes	4	2	yes

(*Source:* Office of the High Commissioner for Human Rights)

Table 4.4 uses the information in Table 4.3 to establish the number of reports that should *ideally* have been submitted by Nigeria and the comparators based on the requirements of each treaty.[170] It then matches that information with what has *actually* been submitted by Nigeria and the comparators to the treaty bodies, and then specifies whether any report is *due* for submission. In this process, 'combined periodic reports' (single reports that states submit to cover for the current and missing years) were taken to have fulfilled the reporting obligations for all the years captured in the report.

Table 4.4 shows that Nigeria has no report due for submission to the CEDAW Committee. With respect to the CESCR, Nigeria's record is very poor as it has only submitted its initial report and has missed out on four periodic reports. This is not a good development for the right to health in Nigeria as the ICESCR is the core treaty that advances this right in international law. As such, Nigeria's poor engagement with the periodic reporting cycle

[168] For instance, the ICESCR and CRC both require the initial report submitted two years after entry into force (or ratification of the treaty) and the periodic report after every five years. On the other hand, the CEDAW requires it after one year, and four years, respectively. See Office of the High Commissioner for Human Rights, *The United Nations Human Rights System* (United Nations, 2012) 23.

[169] As noted in Section 4.1.8, South Africa ratified the ICESCR on 12 January 2015. Its initial report to the ICESCR will be due in 2017 when it marks two years of ratification.

[170] Office of the High Commissioner for Human Rights, above n 168.

of the ICESCR means that a vital process for monitoring progress being made in the country in fulfilling the right to health has not been taken up.

Brazil has missed out on one report due for submission to each of the CEDAW and CRC Committees. With respect to the CESCR, Brazil has only submitted two reports, with three outstanding reports being due for submission to that body. Brazil's reporting behaviour with the treaty bodies is not as impressive as its engagement with the UPR mechanism.

India has two reports due for submission to the CESCR. With respect to the CEDAW Committee, India has submitted five reports out of an ideal number of six, and has submitted four reports out of an ideal number of five to the CRC Committee. India appears to have skipped one report in each case in the course of its reporting cycle. India's reporting record with the treaty bodies system is an improvement over its record with the UPR mechanism.

As South Africa has only just ratified the ICESCR (on 12 January 2015) its initial report to that body will be due for submission in 2017. However, with respect to the CEDAW, South Africa has submitted four of an ideal number of five reports, and has one outstanding report for submission to the CEDAW Committee. South Africa has a poorer record with the CRC Committee as it has only submitted two out of four reports that ideally should have been submitted.

The Optional Protocols to CEDAW and ICESCR are not captured in these data sets due to the unavailability of information about them. It is unlikely any special reporting requirements have been made for the Optional Protocols outside the main treaty. In summary, the above findings on the treaty-reporting behaviour of Nigeria and the comparators is significant for two reasons. First, it neither provides further validation for, nor refutes the claim made in this chapter that the active engagement by states with the right to health in the domestic system is likely to translate to higher levels of commitment and engagement with that right in the international treaty framework. However, what it seems to suggest is that Nigeria and the comparators are struggling to keep up with their reporting obligations to treaty bodies. For instance, in many instances, Nigeria and the comparators were unable to submit all the reports ideally required of them by the ICESCR, CEDAW and CRC. One reason that has been advanced for this struggle is the frequency of the reporting obligations imposed upon states by the various human rights

treaties in the UN system, which makes it difficult for states to keep up.[171] Another reason might be limited expertise or capacity within state legal departments. Second, the above findings highlight the limitations of the framework employed by the thesis in this chapter, as they suggest that states may sometimes not engage fully with the right to health in the treaty framework for reasons other than the priority that they accord that right in their domestic system.

4.3.2 The Report to Treaty Bodies

While the report to treaty bodies by Nigeria and the comparators does not further validate the claim of this chapter, it contributes to deepening understanding on the situation of the right to health in the domestic system of these states. For this reason, this section briefly considers what the reports and other documents in the treaty bodies system depict about the right to health in the domestic system of Nigeria and the comparators.

4.3.2.1 The CECSR

(a) *Nigeria*. As Table 4.4 shows, Nigeria has submitted only its initial report to the CESCR, and this was done on 7 February 1996.[172] Among other things, the concluding observations of the CESCR raised concerns about the gross under-funding and inadequate management of health services that has led to the rapid deterioration of health infrastructure in the country; the poor funding for the health system that has resulted in the loss of critical health manpower; and the consistently diminishing funds for healthcare in the country, which has led to the introduction of hospital charges where they did not exist before.[173]

Considering that this report was submitted over 20 years ago, it fails to provide a current account of the state of the health system of Nigeria. However, its utility is what it tells us about how long Nigeria has battled some of the challenges affecting its health system. Moreover, the fact that Nigeria has not submitted subsequent reports to the CESCR suggests that it is not fully committed to the accountability mechanisms of the economic and social rights regime for which the CESCR stands. This suggestion gains force when

---

[171] This is a concern that has been discussed at the UN system and indeed suggestions have been put forth on how to tackle this problem. See *Strengthening and Enhancing the Effective Functioning of the Human Rights Treaty Body System,* GA Res 68/268, UN GAOR, 68th sess, 81st plen mtg, Agenda Item 125, UN Doc A/RES/68/268 (9 April 2014).

[172] Economic and Social Council, *Initial Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Nigeria,* UN Doc E/1990/5/Add.31 (7 February 1996).

[173] Committee on Economic, Social and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nigeria,* UN Doc E/C.12/1/Add.23 (16 June 1998) [28].

one considers that within the same period during which it has failed to submit any periodic report to the CESCR, Nigeria has been actively engaged with the CEDAW and CRC Committees.

(b) *Brazil*. At the submission of Brazil's initial report,[174] a list of issues[175] was produced by the CESCR for Brazil's consideration. The list included a number of concerns on the right to health such as the problem of HIV/AIDS among children and adults, clandestine abortion practices and health disparities that affect disadvantaged communities.[176] The concluding observations made recommendations for addressing these concerns.[177] In the second periodic report of Brazil,[178] the list of issues raised concerns about the high maternal mortality rate in remote areas as well as similar concerns to those raised in the initial report.[179] Brazil's response outlined the measures being taken to address the situation and the challenges facing it.[180] The concluding observations commended Brazil for progress made and recommended further improvements.[181]

With only two submissions to the CESCR out of an expected five reports,[182] Brazil's engagement with its reporting obligations to the CESCR is not much different from the poor engagement observed in Nigeria. This is a surprising turn for Brazil, considering its usually active engagement with economic and social rights issues, and the right to health in the treaty framework.

---

174 Committee on Economic, Social and Cultural Rights, *Initial Reports Submitted by State Parties Under Articles 16 and 17 of the Covenant: Brazil,* UN Doc E/1990/5/Add.53 (20 November 2001).

175 Committee on Economic, Social and Cultural Rights, *List of Issues to be Taken Up in Connection with the Consideration of the Initial Report of Brazil Concerning the Rights Referred to in Articles 1-15 of the International Covenant on Economic, Social and Cultural Rights* (E/1990/5/Add.53), UN Doc E/C.12/Q/BRA/1 (5 June 2002).

176 Ibid [43].

177 Committee on Economic, Social and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil,* UN Doc E/C.12/1/Add.87 (26 June 2003).

178 Committee on Economic, Social and Cultural Rights, *Second Periodic Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Brazil,* UN Doc E/C.12/BRA/2 (6 August 2007).

179 Committee on Economic, Social and Cultural Rights, *List of Issues to be taken up in Connection with the Consideration of the Second Periodic Reports of Brazil Concerning the Rights Covered by Articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/BRA/2),* UN Doc E/C.12/BRA/Q/2 (11 June 2008) [28]-[31].

180 Committee on Economic, Social and Cultural Rights, *Replies by the Government of Brazil to the list of Issues (E/C.12/BRA/Q/2) to be taken up in Connection with the Consideration of the Second Periodic Report of Brazil (E/C.12/BRA/2),* UN Doc E/C.12/BRA/Q/2/Add.1 (16 March 2009) [275]-[332].

181 Committee on Economic, Social and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil,* UN Doc E/C.12/BRA/CO/2 (12 June 2009).

182 See Table 4.4 above.

(c) *India*. The initial report from India[183] and the concluding observations[184] that followed it provide only general information about the situation regarding the right to health in India. The subsequent combined second to fifth periodic report by India[185] gives a more detailed account of the treatment of the right to health as 'an integral part of the right to life' under India's constitution.[186] A number of concerns were raised in the list of issues that followed that report that touched on the high prevalence of HIV/AIDS infections, the high rate of maternal mortality, lack of access to family planning services for women and girls, unsafe sterilisation of women and unsafe abortion resulting in maternal deaths.[187] In India's response to the issue about the maternal mortality rate, it pointed out that there was a decline in maternal mortality in the country, contrary to the claims in the list of issues.[188] The concluding observations noted positive aspects as well as factors impeding India's implementation of the ICESCR. Recommendations were made on measures India can take to address these concerns.[189]

With its five report submissions (initial and periodic reports) to the CESCR out of an ideal number of seven reports,[190] India has better engaged with the CESCR than have Brazil and Nigeria. This is quite different to what was observed in the context of the UPR, with which Brazil, South Africa and Nigeria performed better than India in their engagement.

---

183 Committee on Economic, Social and Cultural Rights, *Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant, Concerning Rights Covered by Articles 10 to 12: India,* UN Doc E/1980/6/Add.34 (30 May 1983).

184 Committee on Economic, Social and Cultural Rights, *Consideration of Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant Concerning Rights Covered by Articles 10 to 12,* UN Doc E/1984/WG.1/SR.6 (18 April 1984); Committee on Economic, Social and Cultural Rights, *Consideration of Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant Concerning Rights Covered by Articles 6 to 12,* UN Doc E/1984/WG.1/SR.8 (19 April 1984).

185 Committee on Economic, Social and Cultural Rights, *Periodic Reports Submittted by States Parties Under Articles 16 and 17 of the Covenant: Combined Second, Third, Fourth and Fifth Report of India,* UN Doc E/C.12/IND/5 (1 March 2007).

186 Ibid [474].

187 Committee on Economic, Social and Cultural Rights, *List of Issues to be taken up in Connection with the Consideration of the Combined Second, Third, Fourth, and Fifth Periodic Report of India Concerning the Rights Covered by Articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/IND/5),* UN Doc E/C.12/IND/Q/5 (14 September 2007) [39].

188 Committee on Economic, Social and Cultural Rights, *Replies by the Government of India to the List of Issues (E/C.12/Q/5) to be Taken Up in Connection with the Consideration of the Fifth Periodic Report of India (E/C.12/IND/5)* UN Doc E/C.12/IND/Q/5/Add.1 (18 March 2008) 10.

189 Committee on Economic, Social and Cultural Rights, *Concluding Observations of the Committee on Economic, Social and Cultural Rights: India,* UN Doc E/C.12/IND/CO/5 (8 August 2008).

190 See Table 4.4 above.

4.3.2.2 The CEDAW Committee

(a) *Nigeria*. The engagement of Nigeria with the CEDAW Committee is much more robust than its engagement with the CESCR.[191] Nigeria has submitted all eight reports required of it by the reporting guidelines of the treaty bodies system with respect to the CEDAW.[192] These include the initial report and seven periodic reports. The combined second and third reports of Nigeria touched on the sexual and reproductive rights of women, among other things.[193] The concluding observations raised concerns about the absence of information on AIDS and sexually transmitted diseases; the rate of maternal and infant mortality; the lack of medical facilities for women and children; and the need to make family planning services more readily available.[194]

The combined fourth and fifth periodic report submitted by Nigeria[195] earned a commendation from the CEDAW Committee for the high level of engagement demonstrated by Nigeria, in terms of the preparation of the report and the calibre of government representatives that appeared before the committee to defend the report.[196] In the submission of Nigeria's sixth report,[197] a similar high level of engagement by Nigeria's representatives was observed and commended by the CEDAW Committee in the concluding observations.[198] However, many of the right to health concerns that were raised in the previous reports were also raised in this report, suggesting that little progress had been made in addressing the issues. In addition, fresh concerns were raised about the plight of internally displaced women due to armed conflicts in the country.[199] Nigeria's combined seventh and eight periodic report was submitted in 2015 but has not yet been considered by the CEDAW Committee.[200]

---

191 See the discussion in Section 4.2.2.1.

192 Office of the High Commissioner for Human Rights, above n 141.

193 Committee on the Elimination of Discrimination Against Women, *Second and Third Periodic Reports of States Parties: Nigeria,* UN Doc CEDAW/C/NGA/2-3 (26 February 1997) [55].

194 *Report of the Committee on the Elimination of Discrimination Against Women*, UN GAOR, 53rd sess, Supp No 38, UN Doc A/53/38/Rev.1 (14 May 1998) [155]-[174].

195 Committee on the Elimination of Discrimination Against Women, *Combined Fourth and Fifth Periodic Reports of States Parties: Nigeria,* UN Doc CEDAW/C/NGA/4-5 (28 April 2003).

196 *Report of the Committee on the Elimination of Discrimination Against Women,* UN GAOR, 59th sess, UN Doc A/59/38 (18 March 2004) [282]-[316].

197 Committee on the Elimination of Discrimination Against Women, *Sixth Periodic Report of State Parties: Nigeria,* UN Doc CEDAW/C/NGA/6 (5 October 2006).

198 Committee on the Elimination of Discrimination Against Women, *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Nigeria,* 41st sess, UN Doc CEDAW/C/NGA/CO/6 (8 July 2008) [1]-[5].

199 Ibid [32]-[38].

200 Committee on the Elimination of Discrimination Against Women, *Seventh and Eight Periodic Reports of States Parties Due in 2014: Nigeria* UN Doc CEDAW/C/NGA/7-8 (7 October 2015).

Overall, women's rights issues have gradually taken centre stage in various sites of discourse in Nigeria. This is demonstrated by the high level of engagement by the government of Nigeria, with Nigeria's reporting obligations to the CEDAW Committee.[201] It is also evident in the high level of participation of civil society organisations (operating in Nigeria) that regularly submit 'shadow reports' to the CEDAW Committee, offering alternative accounts of the plight of women, and women's rights issues in Nigeria.[202]

(b) *Brazil*. A total of seven reports has been submitted to the CEDAW Committee by Brazil. Its combined initial, second, third, fourth and fifth periodic report[203] gives a detailed account of happenings in the area of women's health.[204] The concluding observations commended Brazil for its long-overdue report, and made recommendations for addressing the high maternal mortality rate, the problem of clandestine abortions due to lack of knowledge of contraceptive methods, and the further control of HIV/AIDS.[205] Brazil's sixth and seventh reports both highlight the progress it has made in the area of women's health.[206] The concerns emerging from these reports raised issues of access to health for rural women, abortion in secrecy leading to maternal deaths, forced sterilisation of women of African descent, and the effects of unwanted pregnancy among adolescents.[207] Brazil's response to the list of issues addressed areas of disagreements and

---

201 By so far submitting eight reports to the CEDAW Committee, Nigeria has fully complied with its reporting obligations to that treaty body. See Table 4.4 above.

202 See for example Center for Reproductive Rights, *Supplementary Information on Nigeria Scheduled for Review During the 41st Session of the CEDAW Committee,* (30 June 2008); and The Nigeria CEDAW NGO Coalition Shadow Report, *For Consideration by the CEDAW Committee in its Review of the Government of Nigeria 6th Periodic Country Report (2004-2008) on the Implementation of the CEDAW in Nigeria* (30 June 2008).

203 Committee on the Elimination of Discrimination Against Women, *Combined Initial, Second, Third, Fourth and Fifth Reports of State Parties: Brazil,* UN Doc CEDAW/C/BRA/1-5 (7 November 2002).

204 Ibid [159]-[172].

205 *Report of the Committee on the Elimination of Discrimination Against Women,* UN GAOR, 58th sess, Supp No 38, UN Doc A/58/38 (18 July 2003) [127].

206 Committee on the Elimination of Discrimination Against Women, *Sixth Periodic Report of States Parties: Brazil,* UN Doc CEDAW/C/BRA/6 (29 August 2005) 65-73; Committee on the Elimination of Discrimination Against Women, *Seventh Periodic Reports of States Parties: Brazil,* UN Doc CEDAW/C/BRA/7 (31 August 2010) [257]-[325].

207 Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions with regard to the Consideration of Periodic Reports: Brazil,* UN Doc CEDAW/C/BRA/Q/6 (26 February 2007) [23]-[25]; Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions with regard to the Consideration of Periodic Reports: Brazil,* UN Doc CEDAW/C/BRA/Q/7 (1 September 2011) [15]-[17].

areas of challenges.[208] The concluding observations contained the expected suggestions on how Brazil can resolve some of the concerns raised.[209]

Like Nigeria, Brazil has been very engaged with its reporting obligations to the CEDAW Committee. Although Brazil submitted its initial report quite late, it has since taken up its responsibilities seriously and remained consistent in fulfilling its reporting obligations with the CEDAW Committee. Unlike Nigeria, however, Brazil has only succeeded in submitting seven of the eight reports that it ideally should have submitted to the CEDAW Committee.[210]

(c) *India*. A total of five reports has been submitted by India to the CEDAW Committee. These include an initial report,[211] a combined second and third report,[212] and a combined fourth and fifth report.[213] Emerging from these reports are concerns about the incidence of HIV/AIDS, the enforcement of the prohibition against sex selection techniques, maternal deaths due to complications in pregnancy and childbirth, access to health for rural women, unsafe abortions leading to maternal deaths, and poor nutrition of women and girls.[214] India's response highlighted measures that are being taken to address these concerns.[215] The concluding observations commended India for its

---

[208] Committee on the Elimination of All Forms of Discrimination Against Women, *Response to the List of Issues and Questions with regard to the Consideration of the Sixth Periodic Report: Brazil,* UN Doc CEDAW/C/BRA/Q/6/Add.1 (4 May 2007) [22]-[24]; Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions with Regard to the Consideration of Periodic Reports: Brazil, Replies of Brazil to the List of Issues to be taken up in Connection with the Consideration of its Seventh Periodic Report (CEDAW/C/BRA/7)* UN Doc CEDAW/C/BRA/Q/7/Add.1 (20 February 2012) [162]-[181].

[209] Committee on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Brazil,* UN Doc CEDAW/C/BRA/CO/6 (10 August 2007); Committee on the Elimination of Discrimination Against Women, *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Brazil,* UN Doc CEDAW/C/BRA/CO/7 (23 March 2012).

[210] See Table 4.4 above.

[211] Committee on the Elimination of Discrimination Against Women, *Initial Reports of States Parties: India,* UN Doc CEDAW/C/IND/1 (10 March 1999).

[212] Committee on the Elimination of Discrimination Against Women, *Combined Second and Third Periodic Reports of States Parties: India,* UN Doc CEDAW/C/IND/2-3 (19 October 2005).

[213] Committee on the Elimination of Discrimination Against Women, *Combined Fourth and Fifth Periodic Reports of States Parties: India,* UN Doc CEDAW/C/IND/4-5 (30 October 2012); Committee on the Elimination of Discrimination Against Women, *Combined Fourth and Fifth Periodic Reports of States Parties, Addendum: India,* UN Doc CEDAW/C/IND/4-5/Add.1 (4 November 2013).

[214] Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions with regard to the Consideration of Periodic Reports: India,* UN Doc CEDAW/C/IND/Q/3 (8 August 2006) [21]-[24]; Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions in relation to the Combined Fourth and Fifth Periodic Reports of India,* UN Doc CEDAW/C/IND/Q/4-5 (28 October 2013) [15].

[215] Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions in Relation to the Combined Fourth and Fifth Periodic Reports of India: Replies of India,* UN Doc CEDAW/C/IND/Q/4-5/Add.1 (23 January 2014) [15].

achievements and made recommendations for resolving areas of concern raised by the committee.[216]

Overall, India has been quite engaged with its reporting obligations to the CEDAW Committee, having submitted five reports out of an expected total of six.[217] In this respect, India's engagement with its reporting obligations to the CEDAW Committee compares favourably with that of Brazil but less so than Nigeria.

(d) *South Africa*. The initial report from South Africa,[218] and its combined second, third and fourth periodic reports[219] to the CEDAW Committee provide an overview of the situation of women's health in South Africa. The concerns that arise from these reports are about access to adequate and efficient health services for girls, cases of maternal deaths, inadequate treatment and care for women affected by HIV/AIDS, unavailability of anti-retroviral therapy for HIV-positive pregnant women, and the largely ignored practice of female genital mutilation.[220] South Africa's response to these issues made important clarifications where they were required: for instance South Africa was able to clarify that female genital mutilation was not a practice among native South Africans, but may be practised by its migrant population from other parts of Africa.[221] The concluding observations commended South Africa's progress and made recommendations for further improvements.[222]

---

216 *Report of the Committee on the Elimination of Discrimination Against Women,* UN GAOR, 55th sess, Supp No 38, UN Doc A/55/38 (4 February 2000) [54]-[90]; Committee on the Elimination of Discrimination Against Women, *Concluding Comments of the Committee on the Elimination of Discrimination Against Women: India,* UN Doc CEDAW/C/IND/CO/3 (2 February 2007); Committee on the Elimination of Discrimination Against Women, *Concluding Observations of the Committee on the Elimination of Discrimination Against Women: India,* UN Doc CEDAW/C/IND/CO/SP.1 (3 November 2010); Committee on the Elimination of Discrimination Against Women, *Concluding Observations on the Combined Fourth and Fifth Periodic Reports of India,* UN Doc CEDAW/C/IND/CO/4-5 (24 July 2014).

217 See Table 4.4 above.

218 Committee on the Elimination of Discrimination Against Women, *Initial Report of States Parties: South Africa,* UN Doc CEDAW/C/ZAF/1 (25 February 1998).

219 Committee on the Elimination of Discrimination Against Women, *Combined Second, Third and Fourth Periodic Report of States Parties: South Africa,* UN Doc CEDAW/C/ZAF/2-4 (24 March 2010).

220 Committee on the Elimination of Discrimination Against Women, *List of Issues and Questions with regard to the Consideration of Periodic Reports: South Africa,* UN Doc CEDAW/C/ZAF/Q/4 (2 September 2010) 5.

221 Committee on the Elimination of Discrimination Against Women, *Responses to the List of Issues and Questions with regard to the Consideration of the Combined Second, Third and Fourth Periodic Reports: South Africa,* UN Doc CEDAW/C/ZAF/Q/4/Add.1 (10 January 2011) [142]-[162].

222 *Report of the Committee on the Elimination of Discrimination Against Women,* UN GAOR, 53rd sess, Supp No 38, UN Doc A/53/38/Rev.1 (21 August 1998) [133]-[134]; Committee on the Elimination of Discrimination Against Women, *Concluding Observations of the Committtee on the Elimination of Discrimination Against Women: South Africa,* UN Doc CEDAW/C/ZAF/CO/4 (5 April 2011) [35]-[36].

Unlike Nigeria, South Africa has a report due for submission to the CEDAW Committee, as its last submission was in 2010. Overall, South Africa has the same record as the other comparators, who also have one report outstanding for submission. However, South Africa's record with the CEDAW Committee is not as impressive as that of Nigeria, which has submitted all eight reports expected of it.

4.3.2.3 The CRC Committee

(a) *Nigeria*. Four reports out of an expected total of five have been submitted by Nigeria to the CRC Committee.[223] These include the initial report,[224] the second periodic report,[225] and the combined third and fourth periodic report.[226] In the concluding observations to the initial report, the CRC Committee, among other things, observed that the report was incomplete in its appreciation of the situation for children throughout Nigeria. The committee reminded Nigeria that the purpose of reporting was not only to indicate measures adopted by a state, but also progress made, priorities identified for action and difficulties encountered in guaranteeing the rights contained in the CRC.[227] The committee also raised a number of concerns about the situation with respect to health rights for children in Nigeria, such as the rising rate of child mortality, the unsatisfactory access of children to quality healthcare services, and the ineffectiveness of measures undertaken to avoid regional variations in the provision of healthcare services and medical supplies.[228]

The concluding observations to the second periodic report noted that many of the concerns raised in the concluding observations to the initial report had not been sufficiently addressed by Nigeria: among these was the concern about the poor delivery of child health services in the country.[229] In the concluding observation to the combined third and fourth periodic report, the committee reiterated its concerns about the high rate of infant and maternal mortality (noted to be the second highest in the world); the disparity

---

223 See Table 4.4 above.

224 Committee on the Rights of the Child, *Initial Reports of States Parties Due in 1993: Nigeria,* UN Docs CRC/C/8/Add.26 (21 August 1995).

225 Committee on the Rights of the Child, *Second Periodic Reports of States Parties Due in 1998: Nigeria,* UN Doc CRC/C/70/Add.24 (17 September 2004).

226 Committee on the Rights of the Child, *Third and Fourth Periodic Report of States Parties Due in 2008: Nigera,* UN Doc CRC/C/NGA/3-4 (5 January 2009).

227 Committee on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: Nigeria,* UN Doc CRC/C/15/Add.61 (30 October 1996) [2].

228 Ibid [16].

229 Committee on the Rights of the Child, *Concluding Observations: Nigeria,* UN Doc CRC/C/15/Add.257 (13 April 2005) [9].

in healthcare coverage between the northern and southern regions of the country; and new concerns about the high incidence of malaria, HIV/AIDS and diarrhoea.[230]

Two areas where Nigeria's engagement with the CRC Committee may be faulted are the lack of promptness in fulfilling reporting obligations (Nigeria's fifth periodic report, was due for submission in 2015 but this has not occurred) and the very slow progress in taking necessary measures to address areas of concerns raised from previous reporting cycles. These two concerns speak to Nigeria's commitment to the CRC regime.

(b) *Brazil*. A total of four reports (the initial and three periodic reports) has been submitted by Brazil to the CRC Committee. Brazil has missed out on one report in the course of its reporting cycle to the CRC Committee.[231] The initial report outlines the legal and policy framework for the protection of the health of children in Brazil.[232] The concluding observations following this report commend Brazil for reductions in the rate of child mortality and the incidence of HIV/AIDS among children; it also raises concern about inequities in access to health services and disparities in health outcomes for children in rural areas.[233]

The combined second to fourth periodic report gives a further account of the situation regarding the right to health of children in Brazil. An area of concern flagged in the report is the high rate of adolescent pregnancy among socially underprivileged segments of society; the mortality of children and adolescents due to external causes such as violence; and maternal mortality arising from inadequate healthcare during the prenatal period.[234] The concluding observations following this report commended programmes established by Brazil to improve the reach and quality of health services and called for more investment in this area; Brazil was also commended for the decrease in child mortality in line with MDG 4; however, concerns were raised about the high level of obesity among children and the increase in new HIV infections among adolescents, particularly boys.[235]

---

[230] Committee on the Rights of the Child, *Concluding Observations: Nigeria,* UN Doc CRC/C/NGA/CO/3-4 (21 June 2010) [58]-[64].

[231] See Table 4.4 above.

[232] Committee on the Rights of the Child, *Initial Reports of States Parties Due in 1992: Brazil,* UN Doc CRC/C/3/Add.65 (17 December 2003) [293]-[399].

[233] Committee on the Rights of the Child, *Concludinging Observations: Brazil,* UN Doc CRC/C/15/Add.241 (3 November 2004) [52].

[234] Committee on the Rights of the Child, *Combined Second to Fourth Periodic Reports of States Parties Due in 2007: Brazil,* UN Doc CRC/C/BRA/2-4 (8 December 2014) [188]-[199].

[235] Committee on the Rights of the Child, *Concluding Observations on the Combined Second to Fourth Periodic Reports of Brazil,* UN Doc CRC/C/BRA/CO/2-4 (30 October 2015) [53]-[64].

Overall, the above account shows that Brazil has a better record of engagement with the CRC Committee to the extent that it has no outstanding report for submission, and in terms of the robustness of the measures that Brazil has been noted to be taking to give effect to the right to health and other rights of children guaranteed by the CRC.

(c) *India*. A total of four reports, including the initial report, has been submitted by India to the CRC Committee.[236] Its initial,[237] second periodic,[238] and combined third and fourth periodic[239] reports map out the priority areas and challenges for the health of the child. Among the challenges identified are infant and neonatal mortality, rural–urban health disparities, under-nutrition, childhood diseases, vector-borne diseases, water-borne diseases, access to water and sanitation.[240] More concerns were raised in the list of issues to the third and fourth report[241] on measures India was taking to address maternal mortality, which affects children.[242]

The concluding observations to the initial report recommended that India should pay particular attention to the most vulnerable group of the population.[243] The concluding observations to the second periodic report noted with concern the 'unavailability and/or inaccessibility of free, high quality primary health care'; the slow decline in infant mortality; the worsening maternal mortality rates due in part to the large increase in unattended home deliveries; and the low immunisation rate, among other things. Recommendations were made by the CRC Committee for India to address these issues.[244] The concluding observations to the combined third and fourth report raised many of the same issues raised by the second periodic report, suggesting that India had not yet succeeded in addressing them.[245]

---

236 See Table 4.4 above.

237 Committee on the Rights of the Child, *Initial Reports of States Parties Due in 1995: India,* UN Doc CRC/C/28/Add.10 (7 July 1997) [161]-[166].

238 Committee on the Rights of the Child, *Second Periodic Reports of States Parties Due in 2000: India,* UN Doc CRC/C/93/Add.5 (16 July 2003) [443]-[576].

239 Ministry of Women and Child Development, 'India: Third and Fourth Combined Periodic Report on the Convention on the Rights of the Child' (2011).

240 Ibid 122-147.

241 Committee on the Rights of the Child, *List of Issues in relation to the Combined Third and Fourth Periodic Reports of India,* UN Doc CRC/C/IND/Q/3-4 (25 November 2013).

242 Committee on the Rights of the Child, *List of Issues to the Combined Third and Fourth Periodic Reports of India, Replies of India to the List of Issues,* UN Doc CRC/C/IND/Q/3-4/Add.1 (1 May 2014).

243 Committee on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: India,* UN Doc CRC/C/15/Add.115 (23 February 2000) [49]-[50].

244 Committee on the Rights of the Child, *Concluding Observations: India,* UN Doc CRC/C/15/Add.228 (26 February 2004) [52]-[53].

245 Committee on the Rights of the Child, *Concluding Observations on the Combined Third and Fourth Periodic Reports of India,* UN Doc CRC/C/IND/CO/3-4 (7 July 2014) [61]-[68].

In summary, India has been quite engaged with its reporting obligations to the CRC Committee. However, in terms of the practical benefits that the reporting process of the treaty bodies system is meant to confer on the health system of India, there is much room for improvement for India, especially in the area of children's rights, where India's record appears to be quite poor.

(d) *South Africa*. South Africa has submitted two out of four reports that it ideally should have submitted to the CRC Committee:[246] the initial report and the second periodic report.[247] The initial report depicts the fragmented and inequitable health system inherited from the apartheid regime in 1994 and sets out measures undertaken to restructure it and formulate a child health policy based on the principles of the CRC.[248] In the concluding observations, concerns were raised about the provision of health services in local communities and the effects of HIV/AIDS on adolescent health.[249]

In its second periodic report, South Africa highlights a number of policies it has put in place to advance children's rights. One of these is 'the adoption of primary health care as a vehicle for providing accessible and equitable services, with beneficiaries including children with disabilities'.[250] The concluding observations to this report raised concerns about the disparity in healthcare provision between rural and urban areas, as well as between the public and private sectors; the lack of a comprehensive policy and service delivery package on child health; and the low quality of healthcare services. Appropriate recommendations were put forth to the state on these and other issues that were raised in the concluding observations.[251]

The foregoing account reveals that South Africa has not been as prompt in keeping up with its reporting obligations to the CRC Committee as it ought to be. This is an area where Nigeria and the other comparators are performing better than South Africa.

---

[246] See Table 4.4 above.

[247] Committee on the Rights of the Child, *Initial Reports of States Parties Dues in 1997: South Africa,* UN Doc CRC/C/51/Add.2 (22 May 1998); Committee on the Rights of the Child, *Second Periodic Reports of States Parties Due in 2002: South Africa,* UN Doc CRC/C/ZAF/2 (17 March 2015).

[248] Committee on the Rights of the Child, *Initial Reports of States Parties Dues in 1997: South Africa,* UN Doc CRC/C/51/Add.2 (22 May 1998) [213]-[251].

[249] Committee on the Rights of the Child, *Concluding Observations of the Committee on the Rights of the Child: South Africa,* UN Doc CRC/C/15/Add.122 (22 February 2000) [29]-[31].

[250] Committee on the Rights of the Child, *Second Periodic Reports of States Parties Due in 2002: South Africa,* UN Doc CRC/C/ZAF/2 (17 March 2015) [216].

[251] Committee on the Rights of the Child, *Concluding Observations on the Second Periodic Report of South Africa,* UN Doc CRC/C/ZAFCO/2 (27 October 2016) [47]-[52].

4.3.3 Reflective Summary

In summary, the findings from the treaty bodies system partly confirm what has already been revealed about the state of health outcomes in the domestic system of Nigeria and the comparators, based on the discussion in Chapter 3. These findings indicate that each of Nigeria and the comparators have areas of weakness in their fulfilment of the right to health. A number of these areas intersect across these states: for instance, HIV/AIDS, maternal deaths and health disparities in disadvantaged communities. However, Nigeria and India appear to have more difficulties in some of these areas than do Brazil and South Africa. On the other hand, there are areas where Brazil and South Africa are doing poorly: for instance, Brazil is challenged in the area of maternal deaths due to the criminalisation of abortion, which has allowed clandestine abortion practices to thrive; while South Africa is not doing very well in the area of HIV/AIDS.

Although the assessment of the reporting behaviour of Nigeria and the comparators does not support the claim of this chapter that more domestic commitment to the right to health impacts the extent of engagement and compliance with the treaty framework in respect of that right, neither does it refute it. In addition, when the documents comprising the monitoring system of the treaty-based bodies are examined, the findings about the situation regarding the right to health in the domestic system of Nigeria and the comparators accords with the discussion on the UPR mechanism in Section 4.1. The findings also show that although Nigeria and the comparators do not have an unblemished record in fulfilling the right to health domestically, some (i.e., Brazil and South Africa) are better situated than others (i.e., Nigeria and India) in achieving the objectives of the right to health as a set of legal positions to universal health coverage that will likely lead to better health outcomes.

4.4 Engagement with Regional Mechanisms on the Right to Health

Brazil is a member of the Inter-American System,[252] one of the world's three regional human rights systems.[253] Nigeria and South Africa are members of the AU System.[254] India does not belong to any regional body on human rights. This section briefly examines the way Brazil, Nigeria and South Africa have engaged with regional instruments and mechanisms advancing the right to health.

---

[252] Organization of American States, *Member States* (<www.oas.org/en/member_states/default.asp>.
[253] The others are the African Union system and the European Union System.
[254] African Union, *Member States* (<www.au.int/en/member_states/countryprofiles>.

4.4.1 Brazil and the Inter-American System

The Inter-American System is a 'regional system for the promotion and protection of human rights' in the Americas.[255] It is responsible for monitoring and implementing the human rights guarantees in the 35 independent states of the Americas that are members of the Organization of American States (OAS).[256] Its principal organs are the Inter-American Commission on Human Rights ('the Commission') and the Inter-American Court of Human Rights ('the Court'). Both bodies have powers to decide individual complaints about alleged human rights violations and can issue emergency protective measures in situations of immediate risk of irreparable harm. The Commission also engages in a range of human rights monitoring and promotion activities,[257] while the Court may issue advisory opinions pertaining to the interpretation of the Inter-American instruments.[258]

A panoply of instruments and mechanisms advance the right to health and other socio-economic rights in the Inter-American System. These instruments include the *American Declaration of the Rights and Duties of Man* (the Declaration);[259] the *American Convention on Human Rights* (the Convention);[260] and the *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights* (Protocol of San Salvador).[261] The mechanisms include the system of rapporteurships, the system of petitions, the reporting system, precautionary measures and provisional measures.[262]

---

255 Inter-American Commission on Human Rights, *Petition and Case System: Informational Brochure* (Organization of American States, 2010).

256 International Justice Research Center, *Inter-American Human Rights System* (<www.ijrcenter.org/regional/inter-american-system/#Inter-American_Instruments>.

257 For instance, paying visits to member states, carrying out thematic activities and initiatives, preparing reports on the human rights situation in a certain country or on a particular thematic issue, adopting precautionary measures or requesting provisional measures before the Inter-American Court, and processing and analysing individual petitions with a view to determining the international responsibility of the States for the human rights violations, and issuing recommendations it deems necessary. See Inter-American Commission on Human Rights, above n 255.

258 International Justice Research Center, above n 256.

259 *American Declaration of the Rights and Duties of Man, (*adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948) art XI.

260 *American Convention on Human Rights, (*Adopted at San Jose, Costa Rica, 22 November 1969 at the Inter-American Specialized Conference on Human Rights) 36 OASTS (entered into force 18 July 1978) art 26.

261 *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador',* opened for signature 17 November 1988, 69 OASTS (entered into force 16 November 1999) art 10.

262 Inter-American Commission on Human Rights, above n 255.

4.4.1.1 The System of Rapporteurships

The system of rapporteurships allows the Commission to oversee human rights conditions in thematic areas of concern.[263] In 1990, the Commission began creating thematic rapporteurships to devote attention to certain groups, communities and peoples particularly at risk of human rights violations due to their state of vulnerability and historical experiences of discrimination.[264] There are currently eight thematic rapporteurships disseminating information on how different groups of people or rights are being protected in OAS member states.[265] Three of these rapporteurships bear some relationship to the right to health (none do so directly): Rapporteurship on the Rights of Women (created in 1994), Rapporteurship on the Rights of the Child (created in 1998), and the Unit on Economic, Social and Cultural Rights (created in 2012).[266]

4.4.1.2 The System of Petitions

Article 23 of the *Rules of Procedure of the Inter-American Commission on Human Rights* ('the Rules of Procedure') allows individuals and groups recognised in any OAS member state to submit complaints concerning alleged violations of the Declaration, the Convention and other regional human rights treaties.[267] The Commission receives approximately 1,500 petitions every year.[268] Petitions can be submitted to the Commission through an 'individual petition system portal' on its website.[269] The privacy surrounding the petitioning process makes it difficult to present data about the number of petitions submitted annually against Brazil in situations raising issues of human rights violations generally, and specifically on violations of the right to health.

---

263 International Justice Research Center, above n 256.

264 Inter-American Commission on Human Rights, *Thematic Rapporteurships and Units* (<http://www.oas.org/en/iachr/mandate/rapporteurships.asp>.

265 These include: Rapporteurship on the Rights of Indigenous Peoples, Rapporteurship on the Rights of Women, Rapporteurship on the Rights of Migrants, Special Rapporteurship for Freedom of Expression, Rapporteurship on the Rights of the Child, Rapporteurship on Human Rights Defenders, Rapporteurship on the Rights of Persons Deprived of Liberty, Rapporteurship on the Rights of Afro-Descendants and against Racial Discrimination, Rapporteurship on the Rights of Lesbian, Gay, Trans, Bisexual, and Intersex Persons, and Unit on Economic, Social and Cultural Rights. See Ibid.

266 International Justice Research Center, *Unit on Economic, Social and Cultural Rights* (<www.ijrcenter.org/regional/inter-american-system/unit-on-economic-social-and-cultural-rights/>; Inter-American Commission on Human Rights, above n 255.

267 Inter-American Commission on Human Rights, *Rules of Procedure of the Inter-American Commission on Human Rights* (<http://www.oas.org/en/iachr/mandate/Basics/rulesiachr.asp>.

268 International Justice Research Center, above n 256.

269 Inter-American Commission on Human Rights, *Individual Petition System Portal* (<http://www.oas.org/en/iachr/portal/>.

4.4.1.3 The System of Reporting

The system of reporting is an important aspect of the work of the Commission in promoting and protecting human rights in OAS member states. The reports allow the Commission to carry out in-depth analyses of the situation of human rights in these states. There are currently four types of reports in the reporting system of the Commission: annual reports,[270] country reports,[271] thematic reports[272] and reports on petitions and cases.[273] In addition, the Commission regularly publishes questionnaires on its website that allow states and civil society to submit information to it on topical human rights issues, which it then includes in its annual overview of the human rights situation in the hemisphere.[274] Of special relevance to this chapter is the report on petitions and cases brought against Brazil, of which a number were health-related.

The power of the Commission to prepare reports on the status of petitions being handled by it, or cases that it has referred to the Court, derives from art 18(c) of the *Statute of the Commission*.[275] There are currently six types of reports in this regard: admissibility reports; inadmissibility reports; friendly settlement reports; merits reports; archive reports; and cases in court.

Since 2004, the Commission has maintained a record of cases before the Court on its website.[276] During this period, seven cases involving Brazil have come before the Court.[277] One of these involved a violation of the right to health:[278] the *Damião Ximenes Lopes Case*[279] was submitted to the Court against Brazil rasing allegations about inhuman and degrading conditions during the hospitalisation of Damião Ximenes Lopes (the victim), a person with mental disabilities, at a health centre that operated within the framework of the single health system of Brazil. The victim suffered beatings and attacks

---

[270] Inter-American Commission on Human Rights, *Annual Reports* (<http://www.oas.org/en/iachr/reports/annual.asp>.

[271] Inter-American Commission on Human Rights, *Country Reports* (<http://www.oas.org/en/iachr/reports/country.asp>.

[272] Inter-American Commission on Human Rights, *Thematic Reports* (<http://www.oas.org/en/iachr/reports/thematic.asp>.

[273] Comisión Interamericana de Derechos Humanos, *Reports on Cases* (<http://www.oas.org/en/iachr/decisions/cases_reports.asp>.

[274] Inter-American Commission on Human Rights, *Questionnaires* (<http://www.oas.org/en/iachr/reports/questionnaires.asp>.

[275] Inter-American Commission on Human Rights, *Statute of the Inter-American Commission on Human Rights* (<http://www.oas.org/en/iachr/mandate/Basics/statuteiachr.asp>.

[276] Inter-American Commission on Human Rights, *Cases in the Court* (<http://www.oas.org/en/iachr/decisions/cases.asp>.

[277] The distribution is as follows: in 2004 one case; in 2005 one case; in 2007 two cases; in 2009 one case and in 2015 two cases. See Ibid.

[278] *Damiao Ximenes Lopes, Case 12.237* (Brazil) (1 October 2004).

[279] Ibid.

on his integrity while he was undergoing psychiatric treatment, and subsequently died. The Commission referred the matter to the Court, seeking, among other things, to establish international responsibility against Brazil for failing to comply with its international obligations under relevant provisions of the Convention.[280] Among the relief sought by the Commission against Brazil was an order for Brazil to perform a full, impartial and effective investigation of the related facts leading to the death of the victim, and the responsibility of all personnel of the hospital to determine an effective punishment; to pay effective compensation to the family of the victim; to adopt appropriate measures to prevent a recurrence of this situation in the future; and to pay the cost of legal expenses incurred by the family of the victim.[281]

A preliminary objection was filed by Brazil before the Court on the grounds that there had been a failure to exhaust domestic remedies contrary to art 46(1)(a) of the Convention. In its ruling, the Court dismissed the objection and agreed with the arguments of the Commission that it had been improperly raised as it ought to have been raised at the admissibility stage of proceedings before the Commission. The case was thus set down for full hearing by the Court.[282]

After conducting a full hearing on the case, the Court found the violations against the victim to be established and gave judgment against Brazil. In the unanimous ruling of the Court, Brazil was ordered, inter alia, to ensure within a reasonable time that the domestic proceedings instituted against those responsible for the victim's suffering and death were carried out; to publish in the *Official Gazette* and in another nationwide daily newspaper the judgment of the Court; to pay compensation to the victim's family in terms set out in the judgment; and other relevant reliefs.[283] In the Court's reasoned opinion, (per Antônio Augusto Cançado Trindade J) it was stated that:

> [t]he fact that the direct victim in this case was a mentally disabled person (the first case of this nature before the Court) characterises the case with an *aggravating circumstance.* In this Judgment, the Court recognises the 'special protection' required by particularly vulnerable people, bearers of a mental disability.

---

[280] These include: arts 4 (right to life), 5 (right to personal integrity), 8 (right to judicial guarantees) and 25 (right to judicial protection) *American Convention on Human Rights, (*Adopted at San Jose, Costa Rica, 22 November 1969 at the Inter-American Specialized Conference on Human Rights) 36 OASTS (entered into force 18 July 1978).

[281] *Damiao Ximenes Lopes, Case 12.237* (Brazil) (1 October 2004).

[282] *Case of Ximenes-Lopes v Brazil* (Preliminary Objection) (Judgment of 30 November 2005) (Inter-American Court of Human Rights).

[283] *Case of Ximenes-Lopes v Brazil* (Merits, Reparations and Costs) (Judgment of 4 July 2006) (Inter-American Court of Human Rights) [251]-[262].

> The protection obligations,—and even more in situation like this, where the victim had a high degree of vulnerability,— are characterised by their *erga omnes* aspect … also encompassing interindividual relationships, taking into account the obligation of prevention and due diligence of the State, mainly regarding to people under its care. Public health is a public asset, not a merchandise. In my many papers and Opinions in the core of this Court, I have expressed for so many years my understanding in the sense that all conventional obligations of protection have an *erga omnes* feature.[284]

From this case, one gets a sense of the robustness and effectiveness of the jurisdiction of the Court in cases where states like Brazil, that are part of the Inter-American System and have accepted the Court's contentious jurisdiction, fail to adopt measures that adequately address violations of the right to health in their domestic system. The availability of this framework to the Brazilian citizenry means a great deal for the strengthening of legal positions on the right to health in Brazil.

4.4.1.4 Precautionary Measures

This mechanism is established by art 25 of the Rules of Procedure. It enables the Commission, on its own initiative or at the request of a party, to request a state to adopt precautionary measures where there is serious risk of irreparable harm to persons or to the subject-matter of a pending petition or case before the organs of the Inter-American System.[285] The beneficiary (or beneficiaries) of such measures must be determinable by virtue of their geographic location or membership of a group.[286] The grant of such measures does not amount to a prejudgment of the violations of the rights protected by the Convention and applicable instruments.[287] Since 1996, the Commission has kept a record of precautionary measures requested of OAS member states to prevent violations (or further violations) of rights.[288] The record indicates that 33 precautionary measures were requested of Brazil by the Commission between 1996 and 2015,[289] 12 of which involved violations, or threatened violations, of the right to health.[290]

---

284 Ibid Separate Opinion of Judge A.A. Cancado Trindade [39]-[40].

285 Inter-American Commission on Human Rights, above n 267, art 25(1).

286 Ibid art 25(3).

287 Ibid art 25(8); Inter-American Commission on Human Rights, *Precautionary Measures* (<http://www.oas.org/en/iachr/decisions/precautionary.asp>.

288 Inter-American Commission on Human Rights, above n 287.

289 The distribution of years requests were made is as follows: 1996 four requests; 1998 three requests; 1999 one request; 2000 three requests; 2002 six requests; 2003 two requests; 2004 two requests; 2005 one request; 2006 three requests; 2007 one request; 2009 two requests; 2010 one request; 2011 two requests; and 2013 two requests. See Ibid.

290 For further details see: Inter-American Commission on Human Rights, *Precautionary Measures 1996* (<http://www.cidh.org/medidas/1996.eng.htm>; Inter-American Commission on Human Rights, *Precautionary Measures 2004* (<http://www.cidh.org/medidas/2004.eng.htm>; Inter-American

4.4.1.5 Provisional Measures

The *Rules of Procedure of the Inter-American Court of Human Rights* regulate the manner in which the Court may grant provisional measures in cases of extreme gravity and urgency, and when it is necessary to avoid irreparable damage to persons.[291] Under its provision, the Court may grant provisional measures on its own motion;[292] at the request of the Commission (in cases not yet before it);[293] or at the request of victims or their representatives (in contentious cases before it).[294] Since 1979, when the Court had its first sitting,[295] it has granted 33 provisional measures in cases involving Brazil, some of which involve violations of the right to health.[296]

The foregoing discussion demonstrates that Brazil is fully engaged with the Inter-American System. Moreover, it has ratified the Convention[297] and the Protocol of San Salvador.[298] It has also recognised the jurisdiction of the Court 'on all matters relating to the interpretation or application of the American Convention on Human Rights'.[299] What this means is that it is subject to the Court's contentious jurisdiction in accordance with art 62 of the Convention.[300] The import of the application of the contentious jurisdiction of the Court to Brazil is best appreciated in the light of the *Damião Ximenes Lopes Case* discussed in Section 4.3.1.3.

Commission on Human Rights, *Precautionary Measures 2005* (<http://www.cidh.org/medidas/2005.eng.htm>; Inter-American Commission on Human Rights, *Precautionary Measures 2006* (<http://www.cidh.org/medidas/2006.eng.htm>; Inter-American Commission on Human Rights, *Precautionary Measures 2007* (<http://www.cidh.org/medidas/2007.eng.htm>; *Persons Deprived of Liberty in the Polinter-Neves Penitentiary*, (Brazil) (PC 236/08); *Persons Deprived of Liberty in the Judicial Police Department (DPJ) of Vila Velha,* (Brazil) (PM 114-10); *People deprived of their freedom at Professor Aníbal Bruno Prison*, (Brazil) (PM 199/11); *Indigenous Communities of the Xingu River Basin, Pará,* (Brazil) (PM 382/10); *Persons Deprived of Liberty at the Porto Alegre Central Prison*, (Brazil) (PM 8/13) ; and *Persons Deprived of Liberty at the Pedrinhas Prison Complex,* (Brazil) (PM 367/13).

291 Rules of Procedure of the Inter-American Court of Human Rights, art 27(1).

292 Ibid.

293 Ibid art 27(2).

294 Ibid art 27(3).

295 Inter-American Court of Human Rights, *I/A Court History* (<http://www.corteidh.or.cr/index.php/en/about-us/historia-de-la-corteidh>.

296 For example see *Matter of the Penitentiary Complex of Curado regarding Brazil*, (Order of the Inter-American Court of Human Rights) (7 October 2015); and *Matter of of the Penitentiary Complex of Pedrinhas regarding Brazil*, (Order of the Inter-American Court of Human Rights) (14 November 2014).

297 Inter-American Commission on Human Rights, *American Convention on Human Rights "Pact of San Jose, Costa Rica"* (<www.cidh.oas.org/Basicos/English/Basic4.Amer.Conv.Ratif.htm>.

298 Inter-American Commission on Human Rights, *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador"* (<www.cidh.oas.org/Basicos/English/Basic6.Prot.Sn%20Salv%20Ratif.htm>.

299 Department of International Law: Organization of American States Washington DC, *General Information of the Treaty: B-32* (<www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights_sign.htm>.

300 International Justice Research Center, above n 256.

4.4.2 Nigeria, South Africa and the African Union System

This section examines Nigeria's and South Africa's engagement with the instruments and subsidiary mechanisms promoting the right to health in the AU System. The principal instruments are the *African (Banjul) Charter on Human and Peoples' Rights* ('the Banjul Charter')[301] the *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* ('the Maputo Protocol'),[302] and the *African Charter on the Rights and Welfare of the Child,* ('the African Child Charter').[303] The subsidiary mechanisms are the system of rapporteurships, committees and working groups created by the African Commission on Human and Peoples' Rights ('the African Commission').[304] In addition, member states are required to submit periodic reports to the African Commission and are subject to the scrutiny of the African Court on Human and Peoples' Rights ('the African Court'). With respect to the latter, this occurs where a member state has made a declaration under art 34 of the *Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights* ('the Protocol establishing the African Court' or 'the Protocol') accepting the competence of the Court to receive cases under art 5(3) of the Protocol.[305]

Nigeria and South Africa have both ratified all binding instruments in the AU System.[306] However, while South Africa is not up to date in the submission of its periodic reports (it currently has five reports overdue), Nigeria has done better in this area, as it has a 100% compliance record with its reporting obligations to the African Commission.[307] With respect to the African Court, although Nigeria and South Africa have both signed and ratified the Protocol establishing the African Court,[308] they are yet to make a declaration in accordance with art 34 of the Protocol accepting the competence of the African Court

---

301 *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986).

302 *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 1 July 2003 (entered into force 25 November 2005).

303 *African Charter on the Rights and Welfare of the Child,* OAU Doc CAB/LEG/24.9/49 (1990) (entered into force 29 November 1999).

304 African Commission on Human and Peoples' Rights, *Rules of Procedure of the African Commission on Human and Peoples' Rights* (<http://www.achpr.org/files/instruments/rules-of-procedure-2010/rules_of_procedure_2010_en.pdf>, Rule 23(1).

305 African Union, *List of Countries Which Have Signed, Ratfied/Acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights* (<http://en.african-court.org/images/Basic%20Documents/Statuts_of_the_Ratification_Process_of_the_Protocol_Establishing_the_African_Court.pdf>.

306 African Commission on Human and Peopls' Rights, *Binding Instruments Ratification* (<www.achpr.org/instruments/>.

307 African Commission on Human and Peopls' Rights, *States Reporting Map* (<www.achpr.org/states/>.

308 African Union, above n 305.

to receive cases under art 5(3) of the Protocol.[309] This has foreclosed any opportunity for the populations of Nigeria and South Africa to benefit from the jurisprudence of the African Court.[310] Thus, nothing can be written here on how the jurisprudence of the African Court has affected legal positions on the right to health in Nigeria and South Africa.

With respect to the reporting system of the African Commission where Nigeria has a 100% compliance rate, and South Africa has outstanding obligation to submit its reports, there is much to be admired about the extent of the rigorous scrutiny offered by that system. A frank assessment of the system, by the African Commission itself, is that it is still in its infancy. In expressing this view, the Commission observed that:

> The State reporting system of the African Commission is still in its infancy. Unlike the UN Human Rights Committee, the African Commission examines very few reports during each of its sessions. To develop this system further, the Commission would need the cooperation of States, NGOs and civil society.[311]

Thus, although Nigeria appears to have a better level of engagement than South Africa with the reporting obligations to the African Commission, the actual benefits for the health system of Nigeria as a result of this engagement may be minimal or non-existent. It is more likely the case that—as Charlesworth and Larking have warned in the context of the UPR mechanism—Nigeria is merely observing the 'rituals and ritualism' of periodic reporting in the AU System.[312] This interpretation is suggested to be more likely the case because the facts on the ground, in terms of the state of the domestic jurisprudence of Nigeria and South African on the right to health, reveal that what South Africa has failed to do in terms of engagement with the AU System, it has more than made up in the development of an effective domestic framework for strengthening legal positions on the right to health in the country.[313]

4.4.3 Reflective Summary

The regional system provides an additional layer of support for the advancement of the right to health as a set of legal positions to universal health coverage that will likely result in better health outcomes. This section shows that the Inter-American System has a very

---

[309] Ibid.
[310] *Femi Falana v. African Union* (Application No. 001/2011) Judgment.
[311] African Commission on Human and Peoples' Rights, *State Reporting Procedure* (<http://www.achpr.org/states/reporting-procedure/>.
[312] Charlesworth and Larking, above n 13.
[313] Further discussion of this framework is offered in Chapters 5, 6 and 7 of this thesis.

robust framework for protecting and advancing human rights in its member states. As a member state of that system, Brazil has been fully engaged with the instruments and mechanisms offered by the system and these have served as a powerful alternative accountability framework for the right to health and other human rights. On account of this framework, many Brazilians have successfully lodged allegations, filed petitions and/or instituted proceedings before the Inter-American Commission or the Inter-American Court, seeking redress against Brazil for violations, or threatened violations of the right to health. What is more, the Inter-American System has put in place a sophisticated framework for ensuring compliance with the decisions and judgments of the Commission and the Court, respectively. In this manner, the prospects of the right to health as a set of legal positions to universal health coverage in Brazil has been greatly enhanced.

In the context of the AU System, on the other hand, the instruments and mechanisms offered by this system for monitoring compliance by member states with the human rights obligations they have accepted within this system are neither as robust nor as sophisticated as those offered by the Inter-American System. Further, few states in the AU System are fully engaged with its instruments and mechanisms. South Africa is one such example. While Nigeria has a better record of engagement than South Africa, like South Africa, Nigeria has not accepted the contentious jurisdiction of the African Court. As such, a valuable opportunity for the jurisprudence of the African Court to influence legal positions on the right to health in Nigeria and South Africa has not been taken up by both states. However, as equally noted, South Africa's non-acceptance of the contentious jurisdiction of the African Court may be overlooked when regard is had to the robust domestic framework for human rights monitoring and redress in South Africa; a position that cannot be said to be the same for Nigeria.

All in all, the analysis in this section provides a limited and partial framework for substantiating the claim of this chapter. It is limited because the two regional systems examined operate at different levels of human rights maturity; it is partial because it only captures two of the three comparators chosen for this thesis.

4.5 Conclusion

In conclusion, this chapter has argued that there is a strong correlation between states' domestic treatment of the right to health and their response to treaty obligations in respect of that right. This is because states that are committed to the right to health domestically,

tend to be better engaged with international treaties promoting the right. This claim is based on the unique lens offered by institutional liberalism which holds that the actions of states on the world stage is shaped by the preferences of political institutions, interest groups, and state actors. To substantiate this claim, the chapter examined the UPR mechanism; the treaty-based system of the UN system; and two regional human rights systems (the Inter-American and AU Systems). At the end of this discussion, the UPR mechanism was found to strongly support the claim because Brazil, which has a better record of engagement with the UPR mechanism than do South Africa, Nigeria or India, has also performed better than these states in promoting the right to health domestically. Brazil is followed by South Africa in terms of engagement with the UPR mechanism and the extent of domestic engagement with the right to health. While no arguments about causality have been advanced on the basis of this finding, it is suggested that because of the active involvement of Brazil and South Africa with the right to health domestically, this has impacted on the way they have engaged with that right in the treaty framework. Furthermore, benefits have been created for the domestic system of these states by the creation of opportunities for state organs (such as the courts and other accountability mechanisms in these state) and/or domestic social actors, to hold the government accountable for the fulfilment of the right to health in the domestic system, referencing the government's human rights profession and/or record in the international system. It is further suggested that it is in this manner that the international system, and its treaty framework, have created opportunities for strengthening legal positions on the right to health in these states. In the context of Nigeria and India where the engagement has not been as robust, a vital opportunity for international law to benefit the domestic situation of the right to health in these states has not been taken up.

In the discussion of the treaty-based framework of the UN system, it was found that the treaty system does not generally support the claim of this chapter. However, what it suggests is that states may sometimes fail to fully engage with the right to health in the treaty framework for reasons that have little to do with the way they prioritise the right in their domestic system. A second consequential finding from this framework is that although Nigeria and the comparators do not have an unblemished record of fulfilling the right to health domestically, some (like Brazil and South Africa), are better situated than others (like Nigeria and India), in achieving the objectives of the right to health as a set of legal positions to universal health coverage that will likely lead to better health outcomes.

The discussion about the regional human rights system shows that significant human rights promotion and protection activities are taking place in the Inter-American System with which Brazil is fully involved. This has greatly benefitted the right to health, as a set of legal positions to universal health coverage in Brazil because the decisions and monitoring activities of the Inter-American Commission and Court have led to interventions in Brazil that directly redress violations (or threatened violations) of the right to health. With respect to the AU System, not enough work is going on in the promotion and protection of the right to health as a set of legal positions to universal health coverage. Overall, the regional discussion has provided only a limited and partial basis of support for the claim made in this chapter.

CHAPTER 5: THE CONSTITUTIONAL CONTEXT

5.0 Introduction

This chapter argues that constitutional rights norms have two significant effects on the legal system of Nigeria and the comparators, thereby defining the corresponding situation of legal positions on the right to health in these states. These effects include the way they influence legal relationships between the state and individuals in the form of rights against the legislature, executive and judiciary; and the radiating effect on the entire legal system by appealing to the concept of an objective order of values that applies to all areas of law and provides guidelines and impulses for the legislature, executive and judiciary.[1]

The chapter finds that constitutional rights norms have created a range of rights for the population of Brazil and South Africa through provisions that create fair hearing rights, and the rights to protective orders and just administrative action. These rights have formed the basis for judicial remedies against violations of the right to health. The chapter also finds that constitutional rights norms have radiated throughout the legal systems of Brazil and South Africa by, among other things, providing guidelines and impulses to their legislature to promulgate statutes that give further expression to the right to health. With respect to Nigeria, these positive outcomes were not observed because of the weak expression and poor enforcement of constitutional rights norms on health. In the case of India, a limited measure of these outcomes was observed due to the proactive interpretation of the *Constitution of India* by the Indian Supreme Court.

In developing the argument of this chapter the main objective is to clarify the theoretical framework of legal positions adopted by this thesis. The theory of legal positions, as Alexy observes, 'traces the variety of constitutional rights relationships back to positions and relationships of the most basic type, and in this way makes it possible to represent them precisely'.[2] As a specific theory of the constitutional right to health,[3] the framework of legal positions applied in this thesis adds a number of aspects to Alexy's theory. In

---

1 Robert Alexy, *A Theory of Constitutional Rights* (Julian Rivers trans, Oxford University Press, 2002)2, 351-52.

2 Ibid 4.

3 A distinction is drawn by Alexy between historical constitutional rights theories which explain the development of constitutional rights; philosophical theories, which justify constitutional rights, for this discussion see John Rawls, *A Theory of Justice* (Oxford University Press, 1971) and see Robert Nozick, *Anarchy, State, and Utopia* (Basic Books 1974); sociological theories which dwell on the functions of rights within a social system, on this see Niklas Luhmann, *Grundrechte als Institution* (Duncker & Htjmblot, 2nd ed, 1974); and a general legal theory of constitutional rights, see Alexy, above n 1, 5. Unlike Alexy however, the theory of constitutional rights developed by this thesis, in the context of the right to health, is argued to be a specific theory of the constitutional right to health.

Chapter 2, these additions were explained in terms of the extension to the international context. Although qualified by the limitations of that context, that extension was justified by the necessity to represent precisely the nature of rights obligations required to transform the health system of Nigeria. Other aspects to which the theory has been applied include the policy and legislative, and judicial contexts. All three contexts (i.e., the international, policy and legislative, and judicial contexts) draw their roots from the constitutional context because a country's constitution, as the basic law,[4] defines what happens in other contexts in a legal system.

Section 5.1, as a preliminary matter, deconstructs the idea of constitutional rights norms by adopting the semantic model of norms to establish criteria for distinguishing between norms and normative statements, and to identify when constitutional rights norms on health are being observed, respected and/or given effect in Nigeria and the comparators. Section 5.2 takes up the first arm of the 'two-effects' argument by examining the way constitutional rights norms influence the legal systems of Nigeria and the comparators through their effects on legal relationships between the state and individuals in the form of rights against the legislature, executive and judiciary. Section 5.3 highlights the radiating effect that constitutional rights norms have on the legal systems of Nigeria and the comparators through its appeal to the concept of an objective order of values that applies to all areas of law and provides guidelines and impulses for the legislature, executive, judiciary and domestic social actors. The chapter concludes by re-affirming the pre-eminent place of constitutional rights norms in strengthening legal positions on the right to health in Nigeria and the comparators.

5.1 Deconstructing Constitutional Rights Norms

As a preliminary matter, this section sets out to establish how we can know that a norm is indeed a constitutional rights norm. Does it depend on the fact that it has been expressed in a constitutional document, or are there other bases for establishing that a norm is indeed a constitutional rights norm? Can a norm said to be a constitutional rights norm emerge before its expression in a constitution or does its emergence depend on such expression?

[4] Much scholarly work abounds on the idea of the constitution as the basic law. See for eg: Hans Kelsen, *The Pure Theory of Law* (BL Paulson and SL Paulson trans, University of California Press, 2nd ed, 1967); Riccardo Guastini, 'The Basic Norm Revisited' in Luis Duarte d'Almeida, John Gardner and Leslie Green (eds), *Kelsen Revisited: New Essays on the Pure Theory of Law* (Hart Publishing, 2013) 43; William Ebenstein, *The Pure Theory of Law* (Augustus M. Kelley, 1969); and see Alexy, above n 1, 5-10.

These are the key questions examined in this section. In addressing them, the section begins by examining the concept of a norm as engaged with in scholarly discourse.

Across the humanities, and particularly in jurisprudence, the concept of a norm is one that is highly debated. It is used in a variety of ways, many of which are rather vague.[5] Georg Henrik von Wright draws attention to the difficulty in characterising norms when he writes that 'the field of meaning of "norm" is not only heterogeneous but also has vague boundaries'.[6] Yet the concept is central to notions of duties and obligations in jurisprudence. Part of the controversy is whether it is understood as the objective 'meaning of an act by which a certain behaviour is commanded, permitted, or authorised';[7] as 'counter-factually stabilised behavioural expectations';[8] as a command;[9] as a model of behaviour that is either followed, or if not followed has a social reaction as a consequence;[10] as an expression having a certain form;[11] or as a social rule.[12] While the enquiry as to the meaning of a norm is important for legal discourse, and thus is in need of further interrogation, it is not the focus of this chapter. For the purpose of this chapter, it is adequate, as Alexy suggests, that we adopt a model of norms 'which on the one hand, is rich enough to form the basis for further discussion, but which, on the other, is weak enough to be consistent with as many positions in the conceptual debate as possible'.[13] The 'semantic model' of a norm, as suggested by Alexy, is adopted in this chapter as the framework for further discussion of constitutional rights norms on health in Nigeria and the comparators.

5.1.1 Norm versus Normative Statement

The main objective of the semantic model is to enable a distinction to be drawn between a *norm* and a *normative statement*.[14] As will soon become clear, this distinction feeds into

---

5 Alexy, above n 1, 20.

6 Georg Henrik Von Wright, *Norm and Action: A Logical Enquiry* (Routledge and Kegan Paul, 1963).

7 Kelsen, above n 4, 5.

8 Niklas Luhmann, *A Sociological Theory of Law* (Elizabeth King-Utz and Martin Albrow trans, Routledge, 2nd ed, 2014) 33.

9 John Austin, *Lectures on Jurisprudence* (The Law Book Exchange, 5th ed, 1873) 98.

10 Theodor Geiger, *Vorstudien zu einer Soziologie des Rechts* (Duncker & Humblot 2nd ed, 1964) 61.

11 Jerzy Wróblewski, 'The Problem of the Meaning of the Legal Norm' in Aulis Aarnio (ed), *Meaning and Truth in Judicial Decision* (Juridica, 1979) 15.

12 H L A Hart, *The Concept of Law* (Oxford University Press, 3rd ed, 2012) 54.

13 Alexy, above n 1, 21.

14 This distinction is well drawn in scholarly discourse, although with varying terminologies applied. See for eg: Christiane Weinberger and Ota Weinberger, *Logic, Semantics, Hermeneutics* (Wolfgang G. Stock, 1979) 20, 108 where the norm *vs* normative statement distinction used by Alexy is also adopted; Ross draws a distinction between the 'linguistic form which expresses a directive' and the 'directive' itself (Alf Ross, *Directives and Norms* (Routledge & Kegan Paul 1968) 34); Wright speaks about 'norm formulation' and 'norm', but he does not agree with the thesis concerning normative statement and norm suggested by Alexy and used in this chapter (Wright, above n 6, 93); Kelsen uses the expression

the enquiry whether the formal expression of a constitutional norm necessarily translates into the enforcement of such norm. At a socio-legal level, this enquiry may be framed as 'law in the books and law in action.'[15] Alexy uses the example of art 16(2) of the *German Basic Law* which provides that 'No German may be extradited to a foreign country'.[16]

Alexy argues that the above provision 'expresses the norm that it is forbidden to extradite a German to a foreign country'.[17] On this basis, he concludes that 'a norm is the meaning of a normative statement'.[18] The examples below illustrate this point using relevant provisions of the *Constitution of Nigeria* and those of the comparators on the right to health.

Example 1 (Nigeria): s 17(3)(d) of the *Constitution of Nigeria*, which is the main guarantee of the right to health in the country, provides that:

> The state shall direct its policy towards ensuring that there are adequate medical and health facilities for all persons.[19]

Adopting Alexy's example in the context of the *German Basic Law*, the above provision is suggested to express the norm that it is the state's duty to ensure that there are adequate medical and health facilities for all persons in Nigeria.

Example 2 (Brazil): art 196 of the *Constitution of Brazil,* in providing for the right to health, says that:

> Health is a right of all and a duty of the state and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and other hazards and at the universal and equal access to actions and services for its promotion, protection and recovery.[20]

The norm expressed by the above provision suggests that it is the state's duty to guarantee the right to health in Brazil by developing social and economic policies that reduce the risk of illness and other hazards, ensure universal and equal access to actions and services that promote and protect health, and ensure recovery from illness. The robustness of this

---

'norm' differently to Alexy. For Kelsen, something is only a norm if it has 'objectively the sense of ought', which according to Kelsen, means that it can be derived from a basic norm giving rise to objective validity (Kelsen, , above n 4, 7).

15 For an interesting article examining this issue see Jean-Louise Halperin, 'Law in the Books and Law in Action: The Problem of Legal Change' (2011) 64(1) *Maine Law Review* 45; for an older article see Roscoe Pound, 'Law in the Books and Law in Action' (1910) 44 *American Law Review* 12.

16 *Basic Law for the Federal Republic of Germany*, art 16(2).

17 Alexy, above n 1, 21.

18 Ibid 22; see also Weinberger and Weinberger, above n 14, 108; as well as Ross in connection with the 'linguistic form which expresses a directive' and the 'directive': Ross, above n 14, 34.

19 *Constitution of Nigeria 1999*, s 17(3)(d).

20 *Constitution of Brazil, 1988*, art 196.

norm emerges by virtue of the range of specific measures it identifies for giving effect to the right to health. This is the basis for the suggestion that the Brazilian norm is stronger the Nigerian norm.

Example 3 (India): art 47 of the *Constitution of India* provides for the right to health in the following manner:

> The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties.[21]

The norm expressed by this provision suggests that it is the state's duty to raise the level of nutrition and standard of living, and improve public health in India. Compared to that of Nigeria, the Indian norm is suggested to be more robust because it specifically identifies measures that are required to be taken by the state to give effect to it. Against the Brazilian norm, the Indian norm is suggested to be less robust because it lacks the more extensive reach of the Brazilian norm in terms of the measures required to be taken by the state.

Example 4: (South Africa): s 27(1)(a) of the *Constitution of South Africa* guarantees the right to health, providing that:

> Everyone has the right to have access to health care services, including reproductive health care.[22]

The norm expressed by this provision suggests that it is the state's duty to provide access to healthcare services and this covers reproductive health services. The Brazilian and Indian norm are suggested to be more strongly expressed than the South African norm; whereas the Nigerian norm is almost similarly expressed, except the inclusion of reproductive healthcare services in the South African norm gives it a slight advantage over the Nigerian norm.

Going by the above examples, it is suggested that 'in theory',[23] constitutional rights provisions on health in Nigeria and the comparators express norms that these states have accepted as binding in their domestic legal systems.[24] However, there are implications–

---

21 *Constitution of India*, art 47.

22 *Constitution of South Africa 1996*, art 196.

23 The qualification introduced here is because, as the discussion further along the chapter will show, not every normative statement in the constitution expresses a norm which is being observed, respected, and/or given effect in states.

24 Alexy makes the point that 'constitutional rights are norms' and they 'share all the problems associated with the concept of a norm. See Alexy, above n 1, 20.

relating to enforcement–that flow from this suggestion for the legal system of Nigeria and the comparators, which are explored below.

5.1.2 Criteria for Identifying Constitutional Rights Norms

If constitutional rights provisions are normative statements that express constitutional rights norms whose meaning is borne by the norms that they have expressed; and if, as Alexy and suggests, such norms can sometimes be expressed without the use of words;[25] then one can argue, as do Alexy and Wright, that 'the concept of a norm is prior to that of a normative statement'.[26] There are two important consequences that follow from this argument for the discussion in this chapter and for the problem statement of this thesis. First, it means that a constitutional rights norm on health can emerge or be in place long before it is expressed as a normative statement in the constitutions of Nigeria and the comparators. Second, and as a corollary, it means that it is possible to have a normative statement that has been expressed in these constitutions that does not reflect the meaning of the norm that it has supposedly expressed. A further scrutiny of these two claims is embarked upon below. As a caveat it is important to note that the point to this analysis is not to suggest that the constitutional text does not matter for the framing of right to health in Nigeria and the comparators. Rather, it is to avoid being too beholden to constitutional provisions, ignoring that constitutions do not enforce themselves but depend on state and non-state actors for their enforcement.

5.1.3 Constitutional Rights Norms as Prior

Alexy argues against the identification of a norm at the level of the normative statement. He suggests that this should be done at the level of the norm itself.[27] He further suggests that deontic modes such as command, prohibition and permission can assist in the process of identifying a constitutional rights norm.[28] Thus, a normative statement that expresses a prohibition, such as the statement in art 16(2) of the *German Basic Law*—which says 'Germans will not be extradited to a foreign country'—expresses a norm, and is a normative statement because it prohibits the extradition of Germans to a foreign country.[29]

---

[25] Ibid; see also Wright, above n 6, 102
[26] Ibid.
[27] See Alexy, above n 1, 22.
[28] Ibid.
[29] Ibid.

In the context of Nigeria and the comparators, the four examples of constitutional rights provisions on health discussed in Section 5.1.1 are identified as norms because they all command the state to act in a particular manner to ensure the fulfilment of the right to health. Although Example 4, involving the *Constitution of South Africa*, does not employ the language of duty as the other constitutions have done—rather it employs the language of rights, that is, the 'right of access of everyone to health care services, including reproductive health'—one can still infer a command arising from this provision and directed at the state to ensure access to health services for all South Africans. It is therefore suggested that even though the *Constitution of South Africa* has guaranteed a right of access to health services, it has indirectly commanded the state to provide the conditions for enabling that access, and therefore it is a constitutional rights norm.

However, it is not entirely satisfactory that one has to refer to the normative statements of the *Constitution of Nigeria* and the comparators to establish whether a constitutional rights norm on health is in place on the basis of whether there is found a command, prohibition or permission. This is because instances abound where even though a norm has been expressed in the constitutional text, the expression of that norm and its treatment does not clarify whether it has commanded, prohibited or permitted a course of conduct. This is the point that was made in Section 1.1 about the framing of responsibility for health in the *Constitution of* Nigeria–although by all accounts a normative statement, yet it is unclear to whom the deontic modes in that norm has been addressed to. This gives rise to the need for a criteria for ascertaining the presence of a constitutional rights norm that does not soley depend on the written expression of such a norm in the constitution.

In this regard, it is suggested in this thesis that in seeking to establish whether a norm guaranteeing the right to health is a constitutional rights norm, the proper determination to be made is how state organs and other actors[30] in Nigeria and the comparators behave with respect to that norm. If state organs and other actors *observe*, *respect* and/or *give effect* to the norm as a matter of course, then it is a constitutional rights norm, regardless of whether or not the normative statement in the constitution of these states has framed it a manner that clarifies its status as such.[31]

---

[30] State organs, as stated in Chapter 1, refers to the legislature, executive and judiciary. Other actors, on the other hand, refers to individuals and entities that are not connected to the state such as private individuals, civil society organisations, for-profit and non-profit entities (essentially everyone else that is not the state).

[31] It is suggested that this criterion can be used to establish the presence of just about any constitutional norm. However, it is only engaged with in this thesis in the context of constitutional rights norms on the right to health.

In other words, this claim suggests that we should consider the context and, based on what we observe from the context, we can draw our conclusions as to whether or not a constitutional rights norm on health is in place in Nigeria and the comparators. Alexy makes a similar point when he argues that 'one can tell that a statement … expresses a norm … from the context'.[32] As to the meaning of context, Alexy says '"[c]ontext" includes both the statement that is connected with the one in question and its use, that is, the circumstances and rules concerning its application'.[33] When applied to the right to health, the circumstances and rules concerning its application in Nigeria and the comparators implicates the way the right has been given further expression in policy and legislation; and by the courts when dealing with cases involving the right. To put it in another sense, one is concerned with the 'radiating effect' that the constitutional right norm has on the legal system (this issue is further treated in Section 5.3 below).

The import of the 'context argument' for the discourse in this chapter is that while it may be relevant to refer to constitutional provisions expressing the right to health in Nigeria and the comparators, it is more appropriate to consider the context to ascertain how state organs and other actors in these countries are behaving in relation to the constitutional rights norm in question: if state organs and other actors in Nigeria and the comparators are observing, respecting and/or giving effect to the norm, then it is a constitutional rights norm on health. If otherwise, then it is not a constitutional rights norm, regardless of whether normative statements in the constitutions of these states have expressed it to be so. Again it is pertinent to clarify that the context argument does not suggest that the constitutional text does not matter in the architecture of the right to health in Nigeria and the comparators. As clarified in Section 5.1.2, the point to this analysis is to allow a clear distinction to be made between the *textual* and *living* law.

As regards the import of the 'context argument' for the problem statement of this thesis, it is suggested that it relates to the claim made in Chapter 1 to the effect that *the root cause of the challenges bedevilling the health system of Nigeria is the perception that health is not an entitlement of the people*.[34] The point here is that despite the constitutional guarantee of the right to health in s 17(3)(d) of the *Constitution of Nigeria,* the norm that appears to have taken hold in the country is one that suggests that such a right does not in fact exist. The argument here is that—based on the context, evaluated from the behaviour of state organs and other actors in Nigeria—a constitutional right to health does not in

[32] Alexy, above n 1, 23.
[33] Ibid.
[34] See Section 1.1.

fact exist in the country. This argument leads to the discussion of the second aspect of the claim made in Section 5.1.2 on normative expressions of constitutional rights norms on health in the *Constitution of Nigeria* and that of the comparators that are devoid of meaning.

5.1.4 Constitutional Normative Statements Devoid of Meaning

It is contended that it is possible to have a normative statement on the right to health in a constitution that is devoid of meaning because it does not express a norm that is being observed, respected and/or given effect in a state. If, as earlier argued by Alexy, 'a norm is the meaning of a normative statement'[35] this means that a normative statement has no meaning if the norm it purports to express is not observed, respected and/or given effect by state organs and other actors in a country. There is a flip side to this argument dealing with instances where the normative statement in the constitution of a state declares that a norm on the right to health does not exist, but in practice, the norm is being observed, respected and/or given effect by state organs and other actors. Nigeria and India illustrate each of these situations, as follows.

(a) *Nigeria*. As earlier noted, s 17(3)(d) of the *Constitution of Nigeria,* which is part of the Fundamental Objectives and Directive Principles of State Policy in Chapter II of the constitution, mandates the state to:

> direct its policy towards ensuring that there are adequate medical and health facilities for all persons.[36]

However, s 6(6)(c) of the constitution restrains the courts from considering any claim arising from the Fundamental Objectives and Directive Principles of State Policy in Chapter II. According to this constitutional provision:

> The judicial powers vested in accordance with the foregoing provisions of this section—shall not except as otherwise provided by this Constitution, extend to any issue or question as to whether any act 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.[37]

It is argued that by derogating from the constitutional guarantee of the right to health in s 17(3)(d) of the *Constitution of Nigeria*, s 6(6)(c) renders the normative expression of the right to health in the constitution devoid of practical meaning. Beyond a textual

---

35 Alexy, above n 1, 22.
36 *Constitution of Nigeria 1999*, s 17(3)(d).
37 Ibid s 6(6)(c).

interpretation of these constitutional provisions, there are other bases for the view that the normative expression of the right to health in the constitution lacks meaning. The first involves the way non-state actors in Nigeria are resigned to the interpretation that economic and social rights norms contained in Chapter II of Nigeria's constitution (which includes the right to health) are not part of the enforceable norms of Nigeria's constitutional rights framework.[38]

The second basis of support derives from the attitude of Nigerian courts towards the enforceability of economic and social rights norms contained in Chapter II of the constitution. In *Okogie v Attorney General of Lagos State,*[39] the Nigerian Court of Appeal held that s 6(6)(c) of the constitution denied it jurisdiction over the rights contained in Chapter II of the constitution. In a similar vein, the Supreme Court of Nigeria has shown its reluctance to accept the argument that the rights guaranteed in the African Charter[40] (which include the right to health)[41] are constitutional rights norms in Nigeria. Thus in *Abacha v Fawehinmi*,[42] the Supreme Court, in pronouncing on the status of the African Charter incorporated into Nigerian domestic law by the African Charter Act,[43] held that although the African Charter Act 'possesses a "greater vigour and strength" than any other domestic statute', it ranks below the *Constitution of Nigeria* and thus conflicts between the constitution and the African Charter must be resolved in favour of the constitution.[44] This suggests that the African Charter 'even though it has been incorporated into Nigerian domestic law, cannot introduce justiciable rights that the Constitution has declared non-justiciable'.[45]

On the basis of the foregoing, it is argued that state organs and other actors in Nigeria have not observed, respected and/or given effect to the constitutional rights norm on health contained in s 17(3)(d) of the *Constitution of Nigeria*. It is further argued that

---

38 See for eg: Femi Falana, 'Nigeria: Socio-Economic Rights in Court', *THISDAY* 3 Febraury 2016; Solomon T Ebobrah, 'The Future of Economic, Social and Cultural Rights Litigation in Nigeria' (2007) 1(2) *Review of Nigerian Law and Practice* 109; and Ajepe Taiwo Shehu, 'The Enforcement of Social and Economic Rights in Africa: The Nigerian Experience' (2013) 2(1) *Journal of Sustainable Development Law and Policy* 101.

39 *Okogie v Attorney General of Lagos State* (1981) 2 Nigeria Constitutional Law Report 350 (Court of Appeal of Nigeria).

40 *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986).

41 Ibid art 16.

42 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

43 *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria).

44 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

45 Chinonye Obiagwu and Chdi Anslem Odinkalu, 'Combating Legacies of Colonialisam and Militarism' in Abdullahi Ahmed An-Na'im (ed), *Human Rights Under African Constitutions: Realizing the Promise for Ourselves* (University of Pennsylvannia Press, 2002) 227.

among state organs and other actors, the widely held belief is that s 6(6)(c) of the constitution renders the constitutional rights norm on health unenforceable in Nigeria. In other words, although Nigeria's constitutional rights framework contains a normative expression of the right to health, that expression is meaningless because the norm it purports to express is not observed, respected and/or given effect by state organs and other actors in the country.

(b) *India*. A different dynamic plays out in the case of India. Like Nigeria's constitution, the *Constitution of India* recognises the right to health in a number of provisions. These include art 39(e), which provides that:

> The State shall, in particular, direct its policy towards securing that the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength.[46]

With respect to the health of children, art 39(f) provides that:

> children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment.[47]

Finally, with regard to the improvement of public health, art 47 provides that:

> The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.[48]

However, as is the case in Nigeria, art 37 of the *Constitution of India* provides that the rights stated above—which are in Part IV, Directive Principles of State Policy of the *Constitution of India*—are non-justiciable. Article 37 provides that:

> The provisions contained in this Part shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.[49]

India's response through its courts to the above derogatory provision runs contrary to that of Nigeria. The courts in India have ignored this derogatory provision and opted for an interpretation of the constitution that recognises an enforceable constitutional rights norm

---

46 *Constitution of India*, art 39(e).
47 Ibid art 39(f).
48 Ibid art 47.
49 Ibid art 37.

on health. Beginning with a decision in 1981, in a case dealing with deplorable prison conditions, the Indian Supreme Court interpreted the right to life to include the right to live with human dignity and all that goes along with it, such as adequate nutrition, clothing and shelter.[50] In subsequent cases, the court expanded the recognition of the right to health to other areas of social life and wellbeing.[51] Today, the right to health is routinely cited as one of the fundamental human rights guaranteed by the *Constitution of India.*[52] Thus, despite the normative statement in art 37 declaring the right to health to be non-justiciable, state organs (such as the Indian Supreme Court) have succeeded in bringing about the observance and respect of a constitutional rights norm on health. Brazil and South Africa have not been examined in this section because neither country has constitutional provisions that derogate from the right to health.

5.2 Constitutional Rights Norms and Rights

The fact that constitutional rights norms influence the legal system of Nigeria and the comparators by creating rights on behalf of the population against the legislature, executive and judiciary is hardly debatable. Alexy points to the fundamentality of constitutional rights norms because of 'their location at the top of the hierarchy of the legal system as law directly binding on the legislature, executive, and judiciary'.[53] This section examines how constitutional rights norms create rights that individuals can enforce against the legislature, executive and judiciary of Nigeria and the comparators.

5.2.1 Rights against the Legislature

Rights against the legislature, in the sense used in this section, refer to those rights that entitle citizens to expect certain actions to be taken (or not taken) by legislative organs of state. In the event of failure to give effect to those rights, the expectation is that citizens

---

50 *Mullin v Delhi* (1981) 2 Supreme Court Report 516 (Supreme Court of India).

51 See *CESC Ltd v Bose* AIR 1992 SC 573, 585 (Supreme Court of India) (case dealing with the provision of for state workers' health and medical care); *Katara v Union of India* (1989) 4 SCC 286 (Supreme Court of India) (case involving access to medical treatment for prisoners); *Consumer Education and Research Centre v Union of India* (1995) 3 SCC 42 (Supreme Court of India) (case about better standard of life, hygienic conditions in work place and leisure); *Samity v State of West Bengal* (1996) 4 SCC 37; AIR 1996 SC 2426 (Supreme Court of India) (case where the government was directed to compensate the petitioner for being denied emergency medical treatment by seven hospitals); *State of Punjab v Chawla* (1997) 2 SCC 83 (Supreme Court of India) (case dealing with the constitutional obligation to provide health facilities to government workers).

52 See *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India) where the right to health was referenced as part of the fundamental rights recognised in India in a case about adverse possession of property.

53 Alexy, above n 1, 349.

are able to approach the courts to seek the enforcement of the rights. In a manner of speaking, these rights create legal positions.

The deontic modes of command, prohibition and permission discussed in Section 5.1.2 as integral to the identification of constitutional rights norms on health also have the consequence of creating obligations against the legislature of Nigeria and the comparators, namely, to enact legislation that would lead to the fulfilment of constitutional rights norms on health. Hans Kelsen is one scholar who has sought to map out the obligations that arise from deontic modes such as commands and permissions against the legislature. Kelsen points out that norms that command bear an 'ought' imperative that casts upon the legislator a sense of duty to issue further commands in accordance with the historical first constitution.[54] On the other hand, norms that permit do not carry such imperative.[55] The argument here is that constitutional rights norms on health in Nigeria and the comparators create further obligations on the legislature of these states to take legislative action that would bring about the fulfilment of the rights guaranteed by such norms. To the extent that these obligations arise against the legislature of Nigeria and the comparators, it is argued that they create rights that the population can enforce against the legislature.

There are two aspects to this discussion. The first deals with the availability of specific constitutional rights norms on health that give rise to a corresponding obligation on the part of the legislature to enact legislation to fulfil the right to health. The second relates to the constitutional scheme on the division of legislative responsibilities, enabling the identification of the specific legislative body with the responsibility to legislate on the right to health. These two considerations are argued to be essential to the enforcement of the rights of individuals to appropriate legislative action on health.

5.2.1.1 Availability of Constitutional Rights Norms for Legislation

There are a number of specific provisions in the constitutions of Nigeria and the comparators that give rise to a right right of individuals to legislative action on the right to health.

(a) *Nigeria*. Section 17(3)(d) of the *Constitution of Nigeria*, requiring the state to ensure by its policy that there are adequate medical and health facilities for all persons, implies a command to the legislature to take appropriate legislative action in this area.

---

[54] Guastini, above n 4, 63.
[55] Ibid.

Following the discussion in Section 5.1.4 (on the non-justiciability of s 17(3)(d) of the constitution), there is a need to clarify why this right against the legislature still arises.

In the Exclusive Legislative List contained in the Second Schedule, Part I of the *Constitution of Nigeria,* Item 60(a) provides:

> To promote and enforce the observance of the Fundamental Objective and Directive Principles contained in this Constitution.

Thus, while the right to health is not justiciable under the constitution, Item 60(a) suggests that the National Assembly has a duty to enact laws that 'promote and enforce' the guarantees in Chapter II of the constitution, including the right to health. One can therefore contextualise the decade-long advocacy for a national health law that culminated in the promulgation of the *National Health Law 2014*[56] as the fulfilment of this right to legislative action. The clear import of this argument is that there is a right right to legislative action on health in Nigeria. Whether this norm is being respected, observed and given effect is an altogether different consideration.

(b) *Brazil*. In the context of Brazil, the following provisions of the *Constitution of Brazil* are noteworthy: (i) art 194, which makes the right to health one of the social welfare actions to be initiated by government; (ii) art 196, which provides that health is a right of all and the duty of the state to guarantee through social and economic policies; (iii) art 197, which makes it incumbent upon the government to regulate and supervise the provision of health services; (iv) art 198, which provides for the organisation of the health system of Brazil into a regionalised and hierarchical network constituted into a single system; and (v) art 200, which sets forth duties for the unified health system of Brazil. These are all identified as provisions that support a framework of rights to legislative action on behalf of the population of Brazil, against the Brazilian legislative body.[57]

(c) *India*. The relevant provisions in the *Constitution of India* giving rise to a right right to legislative action include art 39(e) obligating the state to secure the health and strength of workers and prevent the economic abuse of men, women and children; art 39(f) requiring the state to ensure that children are given the opportunity and facility to

---

[56] See Wole Oyebade, 'A National Health Bill to Rescue, Save All', *The Guardian* Thursday, 12 June 2014 <http://www.ngrguardiannews.com/features/science/165535-a-national-health-bill-to-rescue-save-all>; Lagun Akinloye, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', *Think Africa Press* 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>; Alexander Chiejina, 'Jonathan Finally Signs National Health Bill into Law', *BusinessDay* 9 December 2014 <businessdayonline.com/2014/12/president-jonathan-finally-signs-national-health-bill/#.VMH4AUeUd8H>.

[57] See *Constitution of Brazil, 1988*.

develop in a healthy manner in conditions of freedom and dignity; and art 47 that makes it the primary duty of the state to raise the level of nutrition and standard of living of its people, and improve the state of public health.[58]

(d) *South Africa*. The relevant provisions of the *Constitution of South Africa* on the right to legislative action include (i) s 27(1)(a), which provides for the right of access of everyone to healthcare services, including reproductive health services; (ii) s 27(1)(b), which provides for the right of access to sufficient food and water; (iii) s 27(2), which mandates the state to take reasonable legislative and other measures within available resources to achieve the progressive realisation of the rights guaranteed by the constitution; (iv) s 27(3), which prohibits the refusal of medical emergency treatment for anyone; (v) s 28(1)(c), which guarantees for every child the right to basic nutrition, shelter, basic healthcare services and social services; and (vi) s 28(1)(f)(ii), which guarantees for every child the right not to be required or permitted to perform work or provide services that place such child's wellbeing or mental health at risk.[59]

5.2.1.2 Legislative Responsibility for Constitutional Rights Norms

(a) *Nigeria*. The constitutional framework on legislative responsibility for health in Nigeria is confusing and ineffective. First, primary responsibility for health is vested in local government councils;[60] second, local government councils are under the legislative authority of state governments;[61] and third, as the discussion in Section 5.2.1.1 illustrates, the National Assembly has exclusive powers to legislate for the enforcement of the Directive Principles in Chapter II (which also includes health).

Following the above constitutional scheme of legislative responsibility, direct powers for health are vested in local government councils through the states.[62] Indirect legislative powers for health can be inferred for the federal government. It is difficult to understand how the exclusive legislative powers of the federal government over Chapter II rights can

---

58 See *Constitution of India*.

59 See *Constitution of South Africa 1996*.

60 In this regard, the Fourth Schedule to the *Constitution of Nigeria* provides for the functions of local government councils as including '…participation of such councils in the Government of a State as respects… the provision and maintenance of health services…' See *Constitution of Nigeria 1999*, Fourth Schedule, s 2(c).

61 Section 7(1) of the *Constitution* provides that: '[t]he system of local government by democratically elected local government councils is under this Constitution guaranteed; and accordingly, the Government of every State shall, subject to section 8 of this Constitution, ensure their existence under a Law which provides for the establishment, structure, composition, finance and *functions* of such councils' [italics supplied].

62 *Constitution of Nigeria 1999*, s 4(2); see Remigius Nwabueze, 'The Legal Protection and Enforcement of Health Rights in Nigeria' in Colleen Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press, 2014) 380.

be reconciled with the residual legislative powers of the states to legislate for the health functions of local government councils under Chapter II. This is the basis of the confusion and untidiness in the specification of legislative responsibility for health in Nigeria.

What this framework suggests is that although both the federal and state governments can have a hand in legislating for health, only local government councils have direct constitutional responsibility to provide and maintain health services. The practical implication of this constitutional arrangement for the Nigerian population is that any expectations for the provision of health services has remained within the financial means of local government councils, which happens to be the least funded tier of government in the country (based on allocations from the Federation Account).[63]

(b) *Brazil*. In Brazil, a complex federal system exists, comprising the Union, the states, the Federal District and the municipalities, all of which are autonomous entities under the constitution.[64] The power to legislate 'in common' over the provision of health and public assistance is conferred on the Union, the states, the Federal District and the municipalities.[65] On the other hand, the Union, states and Federal District 'have the power to legislate concurrently on social security, protection and defence of health'.[66] There are pros and cons to this complex diffusion of powers across the governance hierarchy in the state. On the positive side, it allows full participation of all governance entities in the provision of health services. On the negative side, it can lead to loopholes in the system where one government entity can abdicate its health responsibility because there are other responsible participants in the national health system.

(c) *India*. Like Brazil, India has a complex federal system comprising the Union, the states and the territories.[67] Other levels of administration include the panchayats[68] and municipalities.[69] The specification of legislative powers is contained in three lists: the

---

63 *Allocation of Revenue (Federation Account, Etc.) Act 1982* (Nigeria), s 1 specifies the following formula for the distribution of revenue accruing to the federation account: the Federal Government (56%); State Governments (24%); and Local Government Councils (20%). In practice, some state governments hijack the allocation due to local governments and give them only paltry sums to cover administrative costs.

64 *Constitution of Brazil, 1988*, art 18.

65 Ibid art 23(II).

66 Ibid art 24(XI).

67 *Constitution of India*, art 1.

68 The Panchayat is 'an institution (by whatever name called) of self-government constituted under article 243B, for rural areas.' See Ibid art 243(d).

69 The Municipality is 'an institution of self-government constituted under article 243Q' for urban areas. See Ibid art 243P(e).

Union List,[70] the State List[71] and the Concurrent List.[72] Article 246(1) of the *Constitution of India* confers on the Parliament of the Union exclusive powers to legislate on matters enumerated in the Union List;[73] art 246(2) confers on parliament and the Legislature of States powers to legislate over matters enumerated in the Concurrent List; and art 246(3) confers exclusive legislative powers on the Legislature of States over matters enumerated in the State List. In this regard, public health, sanitation, hospital and dispensaries are matters enumerated in the State List.[74] However, in instances of public health emergencies, the Union and states share concurrent legislative powers for the '[p]revention of the extension from one State to another of infectious or contagious diseases or pests affecting men, animals or plants'.[75] While the Indian setup is more specific than that of Brazil in its allocation of primary responsibility for health, it lacks the advantage of collective responsibility for health by all hierarchies of government enjoyed under the Brazilian arrangement.

(d) *South Africa*. Governance in South Africa is organised into the national, provincial and local spheres. At the national sphere, legislative power is vested in the parliament;[76] at the provincial sphere it is vested in the provincial legislatures;[77] and at the local sphere of government, it is vested in the municipal councils.[78] Parliament and provincial legislatures share concurrent legislative competence for the functional areas listed in Part A of Schedule 4 to the *Constitution of South Africa*; health services is one of the matters listed therein.[79] The functional areas enumerated in Part B of Schedule 4 are the responsibility of the local government; municipal health services are captured therein.[80] Under the South African system, therefore, all spheres of government are responsible for health.[81] The pros and cons highlighted in the case of Brazil equally apply here.

The breadth of constitutional rights norms on health in the constitutions of Brazil and South Africa, giving rise to the rights of the population to legislative action on health,

---

70 Ibid art 246(1).
71 Ibid art 246(3).
72 Ibid art 246(2).
73 The matters contained in the Union, State and Concurrent Lists are captured in the Seventh Schedule of the Constitution.
74 *Constitution of India*, Seventh Schedule, List II, s 6.
75 Ibid Seventh Schedule, List III, s 29.
76 *Constitution of South Africa 1996*, s 43(a).
77 Ibid s 43(b).
78 Ibid s 43(c).
79 Ibid ss 44(1)(ii) and 104(4).
80 Ibid s 155(6)(a) and (7).
81 This is similar to the situation in Brazil and completely different to the situation in Nigeria and India.

stands in sharp contrast to the paucity of such provisions in the constitutions of Nigeria and India. What is more, when account is also taken of the discussion in Section 5.1.4 about the presence of constitutional norms that derogate from the right to health in the constitutions of Nigeria and India, it becomes clear that the Nigerian and Indian constitutions have expressed poorly their norms on health.

With respect to legislative responsibility for health, the foregoing discussion shows that Nigeria has a confusing setup compared to these countries. It is difficult to envisage progress towards securing legal positions on the right to health and achieving better health outcomes in Nigeria's health system, on the basis of the current setup of legislative responsibility for health in the *Constitution of Nigeria*. The Indian approach, where only the state governments have responsibility for health, while an improvement on the Nigerian approach, has the disadvantage of excluding the federal government from the health governance framework of India. The approach of Brazil and South Africa, where the responsibility for health services is shared by all governing entities in the country, is suggested to be the most meaningful for strengthening legal positions on the right to health.

5.2.2 Rights against the Executive

As the branch of government responsible for implementing the constitution through the various ministries, agencies and departments of government, the executive branches are often the main respondents to judicial proceedings alleging violations of the right to health by individuals. Unlike in Nigeria where the right to health is not justiciable (see Section 5.1.4), the populations of Brazil, India[82] and South Africa have frequently enforced breaches of the right to health against the executive branches.

In the case of Brazil and South Africa, apart from general constitutional guarantees to fair hearing (see Section 5.2.3) there are a number of special rights available to individuals against the executive branch. In Brazil, the *Mandado de Segurança* (writ of mandamus) under art 5(LXIX) of the *Constitution of Brazil* allows individuals to seek judicial protection whenever a party responsible for an illegal action or abuse of power is a public official or agent of a corporate legal entity exercising the duties of government. In South Africa, with respect to the right to just administrative action, the *Bill of Rights* guarantees

[82] As Section 5.1.4 shows, the right to health is justiciable in India because of the activism of the Indian Supreme Court that has interpreted the justiciable rights in Part III of the *Constitution of India* to include the non-justiciable rights in Part IV of the Constitution.

the right of everyone to administrative action that is just, lawful and procedurally fair. This includes the right to be given written reasons for any adverse administrative action.[83]

5.2.3 Rights against the Judiciary

The right to fair hearing for the determination of civil rights and obligations is a right guaranteed by the constitutions of Nigeria and the comparators. The relevant provision is found in s 36(1) of the *Constitution of Nigeria* under Chapter IV Fundamental Rights provisions. The provision does not extend to economic and social rights contained in Chapter II of the constitution.

In the case of Brazil, art 5(XXXV) of the *Constitution of Brazil* says no law should exclude any injury or threat from the consideration of the judiciary. This is a right against the judiciary to the extent that expectations arise that the courts will always ensure that laws excluding any injury or threat from its consideration are struck down.

The right to fair hearing in the *Bill of Rights* of South Africa's constitution is contained in s 34 of the *Constitution of South Africa* and guarantees to everyone the right to have any dispute resolved in a fair public hearing before a court or an independent tribunal. This right has supported South Africa's robust jurisprudence on the right to health.[84]

In India, the right to constitutional remedies in art 32 of the *Constitution of India* is a right that entitles the Indian population to approach the Supreme Court for the enforcement of the fundamental rights contained in Part III of the Indian constitution. Although s 37 declares the right to health and other economic, social and cultural rights in Part IV of the *Constitution of India* to be non-justiciable, the discussion in Section 5.1.4 shows that this has not hindered the Indian Supreme Court from finding these rights justiciable by interpreting Part III Fundamental rights provisions in a way that incorporates Part IV socio-economic rights provisions.

5.3 The 'Radiating Effect' of Constitutional Rights Norms

The 'radiating effect' theory owes to the work of the Federal Constitutional Court of Germany. Alexy cites that court in developing this theory as follows:

> according to the long-standing case-law of the Federal Constitutional Court, constitutional rights norms do not simply contain defensive rights of the individual against the state, but at the same time they embody an objective order of values, which

[83] *Constitution of South Africa 1996*, s 33(1) and (2).
[84] Further discussion on this issue is offered in Chapter 7.

> applies to all areas of law as a basic constitutional decision, and which provides guidelines and impulses for the legislature, administration and judiciary.[85]

As Alexy observes, the reference to 'values' by the German court is problematic for the theory given the 'large objections to the theory of values'.[86] This thesis is therefore in agreement with Alexy that the use of 'values' in the quotation above should be substituted by 'principles'. The main benefit of the radiating effect theory for this thesis lies in the idea that constitutional rights norms provide 'guidelines and impulses for the legislature, administration and judiciary'.[87] This thesis adds domestic social actors to these categories. Although domestic social actors are not state organs like the bodies listed by the German court, constitutional rights norms still provide impulses that galvanise the activism of these actors as they push for the fulfilment of health rights. The specific ways in which constitutional rights norms on health provide guidelines and impulses to the legislature, executive, judiciary and domestic social actors in Nigeria and comparators are examined below.

5.3.1 The Radiating Effect on the Legislature

The presence or absence of robust constitutional rights norms guaranteeing the right to health in Nigeria and the comparators is critical in determining how the legislature responds to issues that affect legal positions on the right to health. Using Brazil and South Africa as examples, the discussion in this chapter shows that consistently, across the different dimensions requiring constitutional provisions for the protection and enforcement of the right to health,[88] the constitutions of these states have offered robust protection for the right to health. In assessing how these robust constitutional rights guarantees of health in Brazil and South Africa have provided guidelines and impulses to the legislature of these countries, one only needs to consider the discussion in Chapter 6 of this thesis showing that in Brazil, 11 pieces of legislation that positively influence legal positions on the right to health are identifiable;[89] while nine are identifiable for South Africa.[90] In contrast, Nigeria and India, whose constitutional rights norms on health are not as robust as those of Brazil and South Africa, have performed poorly in this indicator:

---

85 Alexy, above n 1, 352, quoting BVerfGE 39, 1 (41).
86 Alexy, above n 1, 352.
87 Ibid.
88 In this regard, reference is being made to the availability of constitutional rights norms on health, the allocation of legislative responsibility for health in the Constitution, and the constitutional provisions for enforcement measures against violations of the right to health and other rights guaranteed by the Constitution.
89 See Table 6.2.
90 See Table 6.4.

in the case of Nigeria only four pieces of legislation are identifiable;[91] while just two are identifiable for India.[92]

5.3.2 The Radiating Effect on the Executive

It is hardly a matter for debate that robust constitutional rights guarantees of the right to health are likely to serve as guidelines and impulses for the executive branch to perform better in securing legal positions on the right to health. What may be open for debate are the specific ways in which this has happened in these countries. Once again, reference is made to the discussion in Chapter 6 where the findings show that in terms of the adoption of policies, programmes and strategies to strengthen the health system, Brazil and South Africa have adopted far more policies and other measures than have Nigeria and India.[93]

5.3.3 The Radiating Effect on the Judiciary

The degree of willingness of courts to offer remedies for violations of the right to health depends on whether they can refer to any constitutional rights norm on health to ground their decisions. The courts, as the primary interpreters of the constitution, play a very significant role in ensuring that the imperatives of the constitution are always given effect. The discussion in Chapter 7 shows that the courts of Brazil and South Africa have been far more willing than those of Nigeria to pronounce against violations of the right to health. It is argued that the basis for these differing judicial attitudes is principally because the constitutions of Brazil and South Africa have provided the right guidelines and impulses for the courts in these countries. In contrast, the courts in Nigeria have not had the right impulses and guidelines from the constitution; hence the reluctance of Nigerian courts to enforce the right to health. India, however, presents a totally different example that defies the logic of this argument. Despite the absence of a robust framing of the right to health in the *Constitution of India,* the Indian Supreme Court has still succeeded in interpreting the constitution in a way that supports the enforcement of the right to health. To explain the contrary position of India, it is argued that the Indian Supreme Court demonstrates that if a proactive judicial branch is determined to ensure that human rights norms on health are given effect in a country, it can identify the right set of impulses and guidelines from a weak constitutional rights normative framework on health.

---

91 See Table 6.1.
92 See Table 6.3.
93 See Tables 6.1–4.

5.3.4 The Radiating Effect on Domestic Social Actors

The availability of a robust range of constitutional rights norms on health is argued to be a powerful weapon in the repertoire of domestic social actors. Although domestic social actors can also act in spaces where there are no norms, and push for new norms to emerge,[94] their work is made easier when all they are seeking is the enforcement of constitutionally guaranteed norms. It is in this light that one can understand the robust human rights activism on the right to health taking place in Brazil and South Africa, which sharply contrasts with the near absence of such activism in Nigeria. India's example is also differentiated by the fact that, due to the very conducive environment offered by the Indian Supreme Court, activism for the right to health by domestic social actors in India has found a foothold and has flourished.

5.4 Conclusion

This chapter has argued that on account of two significant effects of constitutional rights norms on health on the legal system, they influence legal positions on the right to health in Nigeria and the comparators. The effects were identified as the way constitutional rights norms influence the legal system of Nigeria and the comparators by affecting the legal relationships between the state and individuals in the form of rights against the legislature, executive and judiciary; and the radiating effect that constitutional rights norms have on the entire legal system of these states by appealing to the concept of an objective order of values applying to all areas of law, and providing guidelines and impulses for the legislature, executive and judiciary.

In developing these arguments, the chapter began by deconstructing the concept of constitutional rights norms to deepen the theoretical framework of this argument. The semantic model of norms was engaged to draw out the distinction between a norm and a normative statement. The main point that emerged from this analysis was that while the various normative statements on the right to health found in the constitutions of Nigeria and the comparators are important as expressions of the right to health in these countries, the meaning of those normative statements are only to be found in the norm they have embodied. This was the premise for the search for criteria for identifying constitutional rights norms on health without depending on the normative statement expressing the norm. The deontic modes of commands, permissions and prohibitions were found to be a

---

[94] See Neil Stammers, 'Social Movements and the Social Construction of Human Rights' (1999) 21(4) *Human Rights Quarterly* 980; Balakrishnan Rajagopal, *International Law From Below: Developments, Social Movements and Third World Resistance* (Cambridge University Press, 2003).

useful basis for establishing the presence of a norm on the right to health in the constitutional instruments of Nigeria and the comparators.

However, difficulties arose with respect to the need to identify the presence of a constitutional rights norm on health without recourse to what has been written in the constitutions of Nigeria and the comparators. In seeking to meet this need, the chapter proposed that the appropriate test was whether the norm guaranteeing the right to health was being observed, respected and given effect by state organs and other actors in these countries. When this test was applied to Nigeria and the comparators, it was found that while the comparators where observing, respecting and giving effect to constitutional rights norms on health, Nigeria was not doing so.

In the examination of the first effect of constitutional rights norms on the legal system of Nigeria and the comparators, consideration was given to the availability of normative expressions of the right to health in the constitutions of Nigeria and the comparators; as well as the manner of allocation of legislative responsibility for health in these constitutions. The findings showed that Brazil and South Africa have robust constitutional rights norms on health, and have conferred joint responsibility for health on all entities involved in governance at the various hierarchies of government. India has less robust constitutional rights norms on health, which have been declared non-justiciable. However, the Indian Supreme Court has been proactive in interpreting the *Constitution of India* in a way that makes health and other economic, social and cultural rights justiciable in India. In the allocation of legislative responsibility for health, the *Constitution of India* has made the provision of health services a matter for the states. Nigeria's constitution, like that of India, states that the right to health and other economic, social and cultural rights is not justiciable. However, unlike India, the Supreme Court of Nigeria has been unwilling to interpret the constitution in a way that recognises health rights among the enforceable rights of Nigeria's constitutional rights framework. With respect to the allocation of legislative responsibility for health, a confusing setup of this responsibility was identified. Under the current arrangement, only local government councils are directly responsible for health. It is not really clear how to determine who has legislative responsibility for health as the constitution provides for exclusive federal powers for Chapter II rights and residual powers for states to legislate for the functions of local government councils, which also covers health.

In examining the second effect of constitutional rights norms on the legal system of Nigeria and the comparators, it was argued that these norms provided guidelines and

impulses to the legislature, executive, judiciary and domestic social actors of these countries to respond to the right to health in a manner that either led to the strengthening, or weakening, of legal positions on the right to health. In the context of Brazil and South Africa, it was found that on account of the robustness of the constitutional rights normative framework on health in these countries, the legislature, executive, judiciary and domestic social actors have had the right set of impulses to strengthen legal positions on the right to health. In the context of India, while the guidelines and impulses from the *Constitution of India* were identified to be in need of further improvements, the finding was that India's Supreme Court had nonetheless created the right set of guidelines and impulses for the right to health to flourish in India. On this basis, it was argued that the Indian example demonstrated that a proactive and determined judicial branch could still find the right set of impulses and guidelines from a weak constitutional rights normative framework on health if it was determined to ensure that human rights norms on health are given effect in the country. In the case of Nigeria, it was found that the weak guidelines and impulses offered by the *Constitution of Nigeria* have led to the weakening of legal positions on the right to health in the country.

CHAPTER 6: THE POLICY AND LEGISLATIVE CONTEXT

6.0 Introduction

This chapter argues that the commitment of Nigeria and the comparators to advancing legal positions on the right to health in their domestic legal systems can be gauged by considering their preferences when promulgating policies and legislation that affect the right to health. Three considerations are essential to this evaluation: (a) whether a preference has been shown for hard law instruments such as legislation, as opposed to soft law instruments such as policy, in adopting measures that affect the right to health; (b) whether the protection of the right to health in policy and/or legislation gives further expression to constitutional rights norms on health or fails to do so; and (c) whether clear arrangements, preferably by legislation, have been made for financing the health system.

Although the chapter makes reference to policy and legislation as if they are distinct concepts, it does not challenge the settled understanding in legal discourse that policy and legislation share an inextricable link and are often considered to mean the same thing.[1] The distinction drawn between policy and legislation is to highlight the different legal effects that arise when health rights norms are characterised as policy and given legislative backing; and when they are characterised as policy without legislative backing.

The chapter finds that Brazil and South Africa have promulgated more legislation that strengthens underlying determinants of the right to health than have Nigeria and India. In addition, Brazil and South Africa have promulgated more policies on various issues affecting the right to health than have Nigeria and India. On the basis of these findings, the chapter concludes that Brazil and South Africa have done more than Nigeria and India to advance legal positions on the right to health in their domestic legal systems. In reaching this conclusion, the chapter acknowledges that the number of policies and/or legislation promulgated by states is not always reflective of their commitment to fulfilling the right to health in their domestic legal system. States may adopt different legislative practices, one of which may be a preference for an 'omnibus legislation or policy' to deal with issues. Nonetheless, the chapter argues that in the context of its analysis, Nigeria and India do not fall into the category of states that have shown such a preference.

[1] A widely accepted view in public policy discourse is that in the governance of society, policy and legislation are components of the same process. See Thomas Birkland, *An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making* (Routledge, 3rd ed, 2011) 25-26.

Section 6.1 examines the preferences that Nigeria and the comparators have shown in their choice of legal instruments for giving expression to the right to health in their domestic legal systems. Section 6.2 analyses how the instruments adopted by these countries enable or hinder them in giving further expression and fulfilling the right to health in their domestic legal system. Section 6.3 examines the funding mechanisms that Nigeria and the comparators have established for their health systems, and how this strengthens their ability to attain the objectives of the right to health. Section 6.4 concludes the chapter, highlighting the relevance of the policy and legislative context for legal positions on the right to health in Nigeria and the comparators.

6.1 Policy and Legislation on the Right to Health

This section examines existing policies and legislation on the right to health that Nigeria and the comparators have promulgated in their domestic legal systems with the aim of understanding their preferences in the choice of legal instruments for giving expression to the right to health. It provides a backdrop for the analysis that follows in the rest of the chapter. As observed in Section 6.0, the categorisation 'policy and legislation' employed by this thesis is mainly to draw attention to different levels of legal obligations that arise for states.[2] This does not take away from the established fact that in the governance process, in the legislative, executive and judicial spheres, policy considerations play a key role in determining decisional outcomes.[3] While taking this into account, the section isolates for special consideration policies that have and have not attained binding status through the process of promulgation as statutes.[4] This allows room for analysis of the variety of legal processes which Nigeria and the comparators have engaged to strengthen legal positions on the right to health in their domestic legal systems.

Another important reason for the distinction between policy and legislation is that legal norms arising from policy decisions are very often the outcome of complex political

---

2 Odethie Kamugundu, 'Prioritising Legislation in the Policy Process' (2013) 39(3) *Commonwealth Law Bulletin* 471.

3 Guy Peters, 'State Failure, Governance Failure and Policy Failure: Exploring the Linkages' (2015) 30(3-4) *Public Policy and Administration* 261; Glendon Schubert, *Judicial Policy Making: The Political Role of the Courts* (Glenview, III: Scott, Foresman, Rev. ed, 1974); Charles Nutting, 'Legislative Policy and Civil Rights' (1962) 48(4) *American Bar Association Journal* 385.

4 There are other ways of creating binding policies apart from statutes. In the genre of statutes are regulations, bye-laws, administrative decisions etc. However, another important way is through the judicial process where decisions of superior courts become binding precedents to be followed by courts in lower levels of judicial hierarchy. This latter category falls outside the purview of this chapter and will not be treated here. It will however be taken up in chapter 7 of the thesis.

negotiations and compromises.[5] To a large extent, they depend on the will of political actors for enforcement. They are not as settled as legal norms promulgated in statutes. As such, one must continuously monitor the situation of domestic politics to be assured of how policies that have not been embodied in statutes will fare either in the present or the future. This argument suggests the existence of a kind of 'sliding scale'[6] of enforceability of legal norms in which those promulgated as *law,* in statutes, are more binding than those that have not been so promulgated.

This argument emphasises the need for legislative measures for important norms of the right to health to give them an attribute of enforceability by the courts; thereby strengthening legal positions on the right to health. However, this does not suggest that other forms of policy on the right to health do not matter. The point here is that in the sliding scale of bindingness of legal norms, those that have been embodied in statutes are more consequential than those that have not been so embodied. This becomes relevant when the politics of the day is hostile towards the implementation of such norms.

A final preliminary point is the scope covered in the consideration of policy and legislation on the right to health. The discussion in Sections 2.1.1.1 and 2.1.1.2 shows that the definition and content of the right to health remain contested categories in international and scholarly discourse. At the domestic level, public health law has not emerged as an established category of law like criminal law and constitutional law; rather it has emerged from the 'application of other legal categories to purposes that serve to protect human health'.[7] As such, it is possible for one to have a broad outlook[8] or narrow

---

5 For a general discussion of how politics affect policies see Geoffrey Hawker, R.F.I. Smith and Patrick Weller, *Politics and Policy in Australia* (University of Queensland Press, 1979); Theodore Marmor and Claus Wendt, 'Conceptual Frameworks for Comparing Healthcare Politics and Policy' (2012) 107 *Health Policy* 11; Frederico Toth, 'Healthcare Policies Over the Last 20 Years: Reforms and Counter-Reforms' (2010) 95 *Health Policy* 82.

6 On the idea of a sliding scale of human rights norms, see Danie Brand, 'Socio-economic Rights and Courts in South Africa: Justiciability on a Sliding Scale' in Fons Coomans (ed), *Justiciability of Economic and Social Rights: Experiences From Domestic Systems* (Intersentia, 2006) 227; Obiora Okafor and Basil Ugochukwu, 'Have the Norms and Jurisprudence of the African Human Rights System Been Pro-Poor?' (2011) 11(2) *African Human Rights Law Journal* 396.

7 Christopher Reynolds, *Public Health Law and Regulation* (The Federation Press, 2004) 6.

8 On this view, public health law may be said to cover statutory laws that establish health programs; regulate food safety, water quality, hazardous waste disposal, and occupational safety; establish ordinances/laws relating to land use and transportation; and regulate public health agencies and managed care organisation etc., Christopher Reynolds, *Public Health Law and Regulation* (The Federation Press, 2004); a broad definition, which is commonly cited, is that offered by the Institute of Medicine to the effect that '[p]ublic health is what we, as a society, do collectively to assure the conditions for people to be healthy.' Committee for the Study of the Future of Public Health, *The Future of Public Health* (National Academy Press, 1988) 19; see also Micah Berman, 'Defining the Field of Public Health Law' (2013) 15(2) *DePaul Journal of Health Care Law* 45, 61.

focus[9] of the scope of public health. These approaches suffer the shortcoming of being either too broad or too narrow.[10]

The approach of this thesis, as explained in Section 2.1.2.3, is a focus on the attainment of universal health coverage and better health outcomes in the health system. As such, this section is restricted to policy and legislative instruments that enable Nigeria and the comparators to achieve universal health coverage and better health outcomes in their health systems. Such policies and legislation include those dealing with both underlying determinants of health (such as clean water, nutritious food, adequate sanitation and a healthy environment) and the delivery of healthcare services (such as access to health goods and services, maternal health, child health, immunisation, health control measures with respect to communicable and non-communicable diseases, health education and related health actions). The policy instruments excluded from consideration include those on the health workforce, labour issues affecting health, pharmaceuticals, medical negligence and others not part of the categories mapped out in this section.

6.1.1 Health Policies and Legislation in Nigeria

In Section 5.1.4, it was observed that although the right to health is recognised in the *Constitution of Nigeria*,[11] it is not a justiciable right because it forms part of Chapter II rights of the constitution, which are non-justiciable.[12] Further, in Section 5.2.1.2, it was observed that primary responsibility for health is vested by the constitution in local government councils,[13] and state governments are expected to exercise legislative authority over them, providing for their financing and function, among other things.[14] In analysing the situation of health policy and legislation in Nigeria, the aim is to establish whether the right to health has featured prominently in the promulgation of these instruments. In chronological order, according to their date of promulgation, the following policy and legislative instruments on health are worthy of note:

- *National Primary Health Care Development Agency Act 1992.* This Act establishes the National Primary Health Care Development Agency. A number of its functions

---

9 A narrow focus to public health law will only focus on actions directly connected with the delivery of health care services without considering factors outside that setting that impact on health.

10 A broad conception of public health law opens it up to the charge that it is encroaching into areas traditionally reserved for other disciplines such as environmental law, labour law, land law, water resources etc. A narrow conception, on the other hand, prevents it from taking account of the important factors, outside clinical care, that impact on health.

11 *Constitution of Nigeria 1999*, s 17(3)(d).

12 Ibid s 6(6)(c).

13 Ibid s 7(5).

14 Ibid s 7(1).

affect the right to health: for example, providing support to the national health policy by reviewing existing health policies with respect to their relevance to the development of primary healthcare; and mobilising resources, nationally and internationally, for the development of primary healthcare.[15]

- *National Agency for Food and Drug Administration and Control Act 1992*. This Act establishes the National Agency for Food and Drug Administration and Control and vests it with regulatory oversight over the food and drug industry. Its mandate is to ensure the safety of food and drugs, medical devices and related products that are manufactured, imported, exported, advertised or in any way used by the public. The agency's powers include conducting appropriate tests on any of the above to ensure compliance with required standards.[16] To the extent that its work affects an important underlying determinant of health, it is useful for securing the right to health.
- *National Health Insurance Scheme Act 1999*. As its name suggests, this Act establishes a health insurance scheme for the country.[17] However, the Act suffers from two main criticisms: first, rights do not form the basis of its provisions, thus an opportunity for it to secure a national mandate for health insurance coverage has not been provided; second, it is overloaded with items that exceed the purview of health insurance and are best suited for a national health legislation.[18] As such, after a legislative passage that has spanned more than 15 years, the critique of Obiajulu Nnamuchi that the Act is a 'white elephant' and is not an 'antidote' to the challenges of access to healthcare in Nigeria still rings true.[19]
- *Revised National Health Policy 2004.* This revised policy replaced the *National Health Policy and Strategy to Achieve Health for All Nigerians 1988*.[20] In 2004, when the policy was promulgated, there was 'no Health Act describing the national health system and defining the health functions of each of the three tiers of government (federal, state and local government)'.[21] This task was taken up by the revised policy.

---

15 *National Primary Health Care Development Agency Act 1992* (Nigeria), s 3.

16 *National Agency for Food and Drug Administration and Control Act 1992* (Nigeria), s 5.

17 *National Health Insurance Scheme Act 1999* (Nigeria), s 5.

18 For example, the provisions about ensuring adequate health facilities in the federation, and ensuring equitable patronage of all levels of health care are objectives best suited for a national health legislation.

19 Obiajulu Nnamuchi, 'The Nigerian Social Health Insurance System and the Challenges of Access to Health Care: An Antidote or a White Elephant?' (2009) 28 *Medicine and Law* 125; see also Obiajulu Nnamuchi and Steve Metiboba, 'Healthcare Organization and Financing' in Irehobhude O Iyioha and Remigius N Nwabueze (eds), *Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law* (Ashgate, 2015) 11-45.

20 The 1988 health policy was the first comprehensive health policy to be promulgated by Nigeria since attaining independence in 1960. Federal Ministry of Health (Nigeria), *Revised National Health Policy,* September 2004, 1.

21 Ibid 3.

Although the policy made commitments to advancing the right to health, it lacked the legislative backing necessary to make those commitments obligatory for government. The policy is currently being reviewed to bring it in line with recent developments in the country since the passage of the *National Health Act 2014*.[22]

- *National Health Financing Policy 2006*. As a policy describing the goals, structure and policy directions of health financing in Nigeria, this one draws heavily upon right to health principles to frame its objectives.[23] However, without legislative backing to give it the force of law, it is merely an indication of the intentions of government and cannot be used to obligate the government. This policy is also being reviewed to bring it in line with the *National Health Act 2014*.[24]
- *National Policy on the Health & Development of Adolescents & Young People in Nigeria 2007*. This policy revises the *National Adolescent Health Policy 1995* to bring it in line with national and international development policies and frameworks. Its objective is to provide a framework for generating the required political will to ensure the optimal health and development of adolescents and young people in Nigeria by mobilising resources, creating a safe and supportive environment, fostering collaborations and developing programmes.[25] Without legislative backing, the policy does not offer any enforceable rights to the people.
- *National Policy on HIV/AIDS 2009*. The main objective of this policy is to provide a framework for advancing the national multi-sectoral response to the HIV/AIDS epidemic in Nigeria. The expectations are that this response will lead to reductions in the rate of new infections, provide equitable care and support to infected persons, mitigate the impact of the disease, and enable infected persons to achieve socially and economically productive lives free of the effects of the disease.[26] The policy advances very important strategies in the fight against the HIV/AIDS pandemic in Nigeria.
- *National Policy on Malaria Diagnosis and Treatment 2011*. Section 3.3.1.10 shows that the incidence rate of malaria is a very problematic area for the health system of Nigeria. As such, this policy aiming to roll back the disease is highly relevant to the health system.[27] The policy institutionalises evidence-based diagnosis and treatment

---

22 L. N. Awute, *One Year Anniversary of the National Health Act, 2014* (<http://www.health.gov.ng/index.php/news-media/9-uncategorised/228-one-year-anniversary-of-the-national-health-act-2014>.

23 Federal Republic of Nigeria, *National Health Financing Policy, 2006*, 2.

24 Awute, above n 22.

25 Federal Ministry of Health, *National Policy on the Health & Development of Adolescents & Young People in Nigeria,* First Revision, 2007, 12.

26 Federal Republic of Nigeria, *National Policy on HIV/AIDS,* October 2009, 10.

27 Federal Republic of Nigeria, *National Policy on Malaria Diagnosis and Treatment*, June 2011, 9.

in the management of malaria in Nigeria, and prioritises access to appropriate and adequate treatment for persons with symptoms of malaria. However, it is without legislative backing to create an enforceable mandate against the government.[28]

- *National Oral Health Policy 2012*. This policy sets out to improve the oral health status of all Nigerians. It aims to do so by developing and promoting an accessible, effective, efficient and sustainable oral health system based on prevention, early detection and prompt treatment of oral diseases, using evidence-based interventions.[29] Although it draws upon human rights consideration, it lacks legislative backing for its mandate.[30]
- *National Strategic Health Development Plan 2010–2015*. Until it expired in 2015, this policy represented the major strategic framework for interventions in the health system of Nigeria. It is being considered here because a revision is currently underway for the period 2016–2020.[31] The policy re-affirms 'the principles of health as a basic human right and the leadership role of government in the health of its people'.[32] The strength of the policy is that it infuses human rights considerations into its objectives; its weakness, on the other hand, is absence of legislative backing securing its mandate.
- *National Strategic Plan of Action for Nutrition 2014–2019.* The main objective of this policy is to improve the nutritional status of Nigerians throughout their lives with a particular focus on vulnerable groups such as women of reproductive age and children under five years of age.[33] It is thus a highly significant policy for advancing a key underlying determinant of health for the most vulnerable segment of the Nigerian population. Unfortunately, it has no legislative backing to secure its mandate.
- *National Policy on Food Safety and its Implementation Strategy 2014*. The purpose of this policy is to provide a framework for identifying national food safety objectives, and to formulate suitable laws, regulations and guidelines for achieving international best practices in all sectors of the food supply chain. The policy also seeks to establish an effective early warning system for detecting, tracing and preventing outbreaks of food-borne diseases.[34] It is vital for securing the right to health of the population, as

---

28 Ibid 10.
29 Federal Ministry of Health (Nigeria), *National Oral Policy*, November 2012, 5.
30 Ibid.
31 Awute, above n 22.
32 Federal Ministry of Health (Nigeria), *National Strategic Health Development Plan 2010-2015*, November 2010, 10.
33 Federal Ministry of Health (Nigeria), *National Strategic Plan of Action for Nutrition 2014-2019,* May 2014, 11.
34 Federal Ministry of Health (Nigeria), *National Policy on Food Safety and its Implementation Strategy,* 2014, 25-7.

food safety is indispensable to population health. The absence of legislative backing for this policy is argued to be detrimental to the right to health in the country.

- *National Guideline for the Control and Management of Sickle Cell Disease 2014*. This disease-specific policy develops guidelines for facilitating uniformity and standardisation of care for patients with sickle cell disease, across different disciplines. It also aims to keep clinical practice abreast of findings from scientific research about the disease.[35]
- *National Nutritional Guideline 2014*. The purpose of this guideline is to provide information and knowledge on good nutrition that is essential to the prevention and management of non-communicable diseases. The target audience of the guideline is individuals, households, health workers, health institutions, educational institutions, corporate organisations, the food industry and any other interested entity.[36]
- *Minimum Standards for Primary Health Care in Nigeria*. The overall objective of this policy is to uniformly define for Nigeria the various levels of fixed primary health facilities and minimum standards for primary healthcare structures, staffing, equipment and service delivery (at the local government level), to improve access and quality of services. It also aims to guide the continuous development of primary healthcare in the country.[37] It has legislative backing from the *National Primary Health Care Development Agency Act 1992.*
- *National Health Act, 2014.* This is the first national health legislation promulgated to set standards for the health system of Nigeria.[38] The Act establishes a national health system and provides 'a framework for standards and regulation of health services'.[39] The Act affects the right to health in a number of ways: it contains provisions that persons living in Nigeria should have the best possible health service within available resources;[40] it specifies the rights and obligations of healthcare providers, health

---

35 Federal Ministry of Health (Nigeria), *National Guideline for the Control and Management of Sickle Cell Disease,* 2014, 1.

36 Federal Ministry of Health (Nigeria), *National Nutritional Guideline on Non-Communicable Disease Prevention, Control and Management 2014,* October 2014, 2.

37 National Primary Health Care Development Agency (Nigeria), *Minimum Standards for Primary Health Care in Nigeria*, 12.

38 See Wole Oyebade, 'A National Health Bill to Rescue, Save All', *The Guardian* Thursday, 12 June 2014 <http://www.ngrguardiannews.com/features/science/165535-a-national-health-bill-to-rescue-save-all>; Lagun Akinloye, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', *Think Africa Press* 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>; Alexander Chiejina, 'Jonathan Finally Signs National Health Bill into Law', *BusinessDay* 9 December 2014 <businessdayonline.com/2014/12/president-jonathan-finally-signs-national-health-bill/#.VMH4AUeUd8H>.

39 *National Health Act 2014* (Nigeria), s 1.

40 Ibid s 1(1)(c).

workers, health establishments and users;[41] and commits to 'protect, promote and fulfil the rights of the people of Nigeria to have access to health care services'.[42]

The Act establishes a *Basic Health Care Provision Fund* ('Basic Health Fund' or 'the Fund') to be financed from federal government annual grants of not less than 1% of the Consolidated Revenue Fund; grants by international donor partners; and funds from any other source.[43] It provides that 50% of the Basic Health Fund is to finance a basic minimum package of health services for citizens in eligible primary or secondary healthcare facilities through the *National Health Insurance Scheme*;[44] 20% of the Fund is for essential drugs, vaccines and consumables to eligible primary healthcare facilities;[45] 15% is for the provision and maintenance of facilities and equipment, and transport for eligible primary healthcare facilities;[46] 10% is for developing human resources for primary healthcare;[47] and 5% is for emergency medical treatment to be administered by a committee appointed by the National Council on Health.[48]

States and local governments seeking to access the Fund are expected to provide counterpart funding for the project in which the Fund will be utilised and their contribution must not be less than 25% of the total cost of the project.[49] The Fund will not be disbursed if the states and local government fail to contribute their counterpart funding;[50] if the supervisory agency of government is not satisfied that earlier disbursements of the Fund were applied in accordance with the provisions of the Act;[51] or if the states and local governments fail to implement the national health policy, norms, standards and guidelines prescribed by the National Council on Health as empowered by the Act.[52]

The passage of the *National Health Act 2014* has ushered in a new era for the right to health in Nigeria.[53] Before the passage of the Act, Nigeria relied heavily on policies that did not create binding obligations on government in the health system (see Table 6.1).

---

41 Ibid s 1(1)(d).
42 Ibid s 1(1)(e).
43 Ibid s 11(2).
44 Ibid s 11(3)(a).
45 Ibid s 11(3)(b).
46 Ibid s 11(3)(c).
47 Ibid s 11(3)(d).
48 Ibid s 11(3)(e).
49 Ibid s 11(5)(a) & (b).
50 Ibid s 11(6)(b).
51 Ibid s 11(6)(a).
52 Ibid s 11(6)(b).
53 Awute, above n 22.

Compounding this problem is the constitutional provision that says the right to health is not justiciable. Further, as shown in Section 5.2.1.2, the primary responsibility for health services is vested in local governments. This allows the federal and state governments to relegate the health system to the margin of policy and legislation. It is for this reason that the *National Health Act 2014* is argued to be a significant piece of legislation for Nigeria as it specifies roles for all players in the national health system. The main critique of the Act however is that without the constitutional backing of a justiciable right to health its impact on the situation of the right to health in the country may be limited. As discussed in Section 5.1.3, this is the case because the behaviour of state organs and domestic actors is likely to continue to reflect the fact that the right to health is not justiciable.

Table 6.1: Summary of health policies and legislation protecting the right to health in Nigeria

Nigeria			
Policy		Legislation	
1.	*Revised National Health Policy 2004*	1.	*National Primary Health Care Development Agency Act 1992*
2.	*Health Financing Policy 2006*	2.	*National Agency for Food and Drugs Administration and Control Act 1992*
3.	*National Policy on the Health & Development of Adolescents & Young People in Nigeria 2007*	3.	*National Health Insurance Scheme Act 1999*
4.	*National Policy on HIV/AIDS 2009*	4.	*National Health Act 2014*
5.	*National Policy on Malaria Diagnosis and Treatment 2011*		
6.	*National Oral Health Policy 2012*		
7.	*National Strategic Health Development Plan 2010–2015*		
8.	*National Strategic Plan of Action for Nutrition 2014–2019*		
9.	*National Policy on Food Safety and Its Implementation Strategy 2014*		
10.	*National Guideline for the Control and Management of Sickle Cell Disease 2014*		
11.	*National Nutritional Guideline 2014*		
12.	*Minimum Standards for Primary Health Care in Nigeria*		

6.1.2 Health Policies and Legislation in Brazil

In 1988, at a time when 'neo-liberal health reforms elsewhere in the world were driving the marketisation of health', Brazil's SUS was established.[54] The health sector reform that occurred in Brazil 'was ideologically at odds with the post-welfare health sector reforms happening worldwide at that time'.[55] Activism for health reform in Brazil commenced in the mid-1970s during the struggle for the restoration of democratic governance in the country. Out of this activism arose a widespread social movement bringing together 'initiatives in different sections of society—from grassroots sectors to middle-class populations and trade unions—and in some cases in conjunction with the then-illegal left-wing political parties'.[56] The key political and ideological viewpoint of this reform movement 'was of health not as an exclusively biological issue to be resolved by medical services, but as a social and political issue to be addressed in public'.[57] A successful alliance was struck among progressive public health professors, researchers from the Brazilian Society for the Advancement of Science and health professionals engaged with grassroots and trade union struggles.[58] From this alliance emerged an institutional platform for pushing for health reform in Brazil.[59]

Health was adopted as a human right at the 8th National Health Conference of 1986, laying the foundation for the SUS.[60] At the National Constituent Assembly (1987–1988) the health reform movement and its allies secured approval for reform despite strong opposition 'from a powerful and mobilised private health sector'.[61] The 1988 *Constitution of Brazil* was thus 'proclaimed at a time of economic instability, with social movements on the retreat, neoliberal ideology spreading, and workers losing purchasing power'.[62]

As discussed in Section 5.2.1.1, the *Constitution of Brazil* guarantees health as a right of all and its provision as the duty of the state.[63] Further, Section 5.2.1.2 shows that the power to legislate in common for health is conferred by the *Constitution of Brazil* on the Union, states, Federal District and the municipalities;[64] while the Union, states and

---

54 Andrea Cornwall and Alex Shankland, 'Engaging Citizens: Lessons From Building Brazil's National Health System' (2008) 66 *Social Science & Medicine* 2173.
55 Jairnilson Paim et al, 'The Brazilian Health System: History, Advances, and Challenges' (2011) 377 *Lancet* 1778, 1784.
56 Ibid.
57 Ibid.
58 Ibid.
59 Ibid 1785.
60 Ibid.
61 Ibid.
62 Ibid.
63 *Constitution of Brazil, 1988*, art 196.
64 Ibid art 23(II).

Federal District are empowered to legislate concurrently on social security, protection and defence of health.[65] A defining characteristic of the health system of Brazil is its three subsectors: the public subsector (SUS), where services are funded by the state at the federal, state and municipal levels; the private (for-profit and not-for-profit) subsector, where services are financed in various ways with public or private funds; and the private health insurance subsector, where 'different forms of health plans, varying insurance premiums, and tax subsidies'[66] exist. Although distinct, the public and private components of Brazil's health system are interconnected and 'people can use services in all three subsectors, depending on ease of access or their ability to pay'.[67]

The overarching principles of the SUS (as enunciated in the *Constitution of Brazil* and in policy and legislation) include universal access to health services, with health defined as a citizen's right and an obligation of the state; equality of access to healthcare; integrality;[68] and continuity of care.[69] Underpinning these principles are a number of other ideals, such as the decentralisation of most responsibilities to municipalities and putting in place joint financing responsibilities; increased community participation; reorganising the system to enhance integration, improve coordination and reduce duplication; assured patient autonomy and right to information; and enhanced effectiveness through the use of epidemiology to define priorities and allocate resources.[70] The process of transforming these principles into reality in Brazil remains ongoing. The following section summarises this transformative process in four waves to identify the key legislative and policy instruments that Brazil has employed in fulfilling the mandate of the right to health guaranteed by its constitution.

6.1.2.1 The First Wave

The first wave of implementation of the SUS covers the period 1988–1990 and 'focused on establishing the basic legislation and regulations', including the transfer of responsibilities from the National Institute for Social Medical Assistance (the body in charge of curative care under the social security system that preceded SUS) to the

---

65 Ibid art 24(XI).
66 Paim, above n 55, 1785.
67 Ibid.
68 This refers to an important feature of the Brazilian health system which comprises many components (public/private, state/federal/municipal, private health insurance etc.) aligning to form one unified system.
69 Michele Gragnolati, Magnus Lindelow and Bernard Couttolenc, *Twenty Years of Health System Reform in Brazil: An Assessment of the Sistema Único de Saúde* (The World Bank, 2013) 17.
70 Ibid.

Ministry of Health.[71] It was also a time of implementing the policy of decentralisation to the state level and establishing mechanisms for social participation.[72] The key legislative instruments promulgated during this period include *Law No 8.080 of 1990* (Brazil) (regulating the conditions for the promotion, protection and recovery of health as well as the organisation and operation of corresponding services)[73] and *Law No 8.142 of 1990* (Brazil) (providing for community participation in the management of the SUS and for intergovernmental transfers of financial resources in health).[74] *Law 8.080* reiterates in its art 2 that health is a fundamental right and it is the duty of the state to provide necessary conditions for its enjoyment. It goes on to provide the conditions for the promotion, protection and provision of health as well as the organisation and functioning of the components of the health system. *Law 8.142*, on the other hand, provides for the decentralisation of the governance framework of the health system. For instance it provides in art 1 that the SUS, in each sphere of government (subject to legislative oversight), is to be managed by the Health Conference and the Board of Health.

6.1.2.2 The Second Wave

The second wave covers the period 1991–1995. The focus of this period was detailing the norms and rules of the organisation of the SUS, its financing and operation, the 'municipalisation' of 'service delivery, and the implementation of financial mechanisms for allocating federal funds'.[75] A key policy instrument of this period is the *Family Health Strategy* (formerly called the *Family Health Programme*) set up in 1994.[76] This policy 'expanded primary health care using geographic targeting to reach the poorest areas of the country, particularly the rural northeast and north, small cities, and periurban neighbourhoods in metropolitan areas'.[77] A second policy of note established in this period is the *Bolsa Familia* (family allowance) based on the conditional cash transfer

---

71 Ibid

72 Ibid.

73 *Law No 8.080 of 19 September 1990* (Brazil).

74 *Law No 8.142 of 28 December 1990* (Brazil).

75 Gragnolati, Lindelow and Couttolenc, above n 69, 17.

76 Anya Spector et al, 'Implementation of Brazil's "Family Health Strategy": Factors Associated With Community Health Workers', Nurses', and Physicians' Delivery of Drug Use Services' (2015) 26 *International Journal of Drug Policy* 509; Paim et al, above n 55, 1784; Rogério Pinto, Sueli Bulhões da Silva and Rafaela Soriano, 'Community Health Workers in Brazil's Unified Health System: A Framework of their Praxis and Contributions to Patient Health Behaviors' (2012) 74 *Social Science & Medicine* 940.

77 Cesar Victora et al, 'Health Conditions and Health-Policy Innovations in Brazil: The Way Forward' (2011) 377 *Lancet* 2042, 2043.

programme. The *Bolsa Familia* was designed as a social protection system and has benefitted a quarter of Brazil's population.[78]

6.1.2.3 The Third Wave

The third wave commenced in the mid-1990s and extended to the early 2000s. This period addressed issues in the 'organisation and provision of health care by emphasising primary care'.[79] Notable policies during this period include the national HIV/AIDS prevention and control programme;[80] the *Tobacco Control Policy*;[81] the consolidation of the *Comprehensive Programme for Woman's Health*;[82] the implementation of the *Humanization of Prenatal Care and Childbirth Program*;[83] the establishment of the National Supplementary Health Agency;[84] the creation of a model of care for Indigenous health;[85] the establishment of the Mobile Emergency Care Service;[86] the adoption of *Health Care Operational Guidelines*;[87] and the launch of the *National Oral Health Policy*.[88] The key legislative instruments promulgated during this period include:

- *Decree No 2203*[89] *of 1996* (Brazil), which promotes and consolidates the full exercise of healthcare managerial functions of the municipal government and the Federal

---

78 Ibid; Paim, above n 55, 1779.

79 Gragnolati, Lindelow and Couttolenc, above n 69, 17-18.

80 Alan Berkman et al, 'A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries' (2005) 95(7) *American Journal of Public Health* 1162.

81 Luiz Teixeira and Tiago Jaques, 'Legislation and Tobacco Control in Brazil Between the Late 20th and Early 21st Centuries' (2011) 57(3) *Brazilian Journal of Cancerology* 295; Stella Bialous et al, 'The Political Economy of Tobacco Control in Brazil: Protecting Public Health in a Complex Policy Environment' (2014).

82 Sonia Correa et al, 'The Population and Reproductive Health Programme in Brazil 1990-2002: Lessons Learned' (2005) 13(25) *Reproductive Health Matters* 72, 75-76.

83 The aim of this policy is to integrate prenatal, intrapartum, and postpartum care in cooperation with the national obstetrician/gynecologist association, the nurse-midwifery association and the Pan-American Health Organization. The goal is to strengthen 'evidence-based practice through the translated WHO's *Care in Normal Birth: A Practical Guide* and production and distribution of educational manuals to all relevant hospitals and clinics.' See Marylou Carr and Maria Riesco, 'Rekindling of Nurse-Midwifery in Brazil: Public Policy and Childbirth Trends' (2007) 52(4) *Journal of Midwifery & Women's Health* 406, 408.

84 This Agency was created in 2000 to provide legal and administrative regulation of the private health insurance market. See Paim et al, above n 55, 1787.

85 Vera Coelho and Alex Shankland, 'Making the Right to Health a Reality for Brazil's Indigenous Peoples: Innovation, Decentralization and Equity' (2011) 13(3) *MEDICC Review* 50.

86 Cristiani Machado, Fernanda Salvador and Gisele O'Dwyer, 'Mobile Emergency Care Service: Analysis of Brazilian Policy' (2011) 45(3) *Rev Saúde Pública* 1.

87 Michele Gragnolati (et al) note that the idea for this policy dates back to the 1980s, but became an official policy in early 2000, when the SUS Health Care Operational Guidelines (Regulations 01/2001 and 01/2002) identified implementation of a 'hierarchical and regionalised health system' as a key objective. See Gragnolati, Lindelow and Couttolenc, above n 69, 51.

88 'Brasil Sorridente' (smiling Brazil) was launched in 2004. See G.A Pucca Jr et al, 'Ten Years of a National Oral Health Policy in Brazil: Innovation, Boldness, and Numerous Challenges' (2015) 94(10) *Journal of Dental Research* 1333.

89 Brazil uses a variety of appellations such as Law, Decree or Ordinance to classify legislation in its legal system. Decrees are commonly used to refer to legislation passed by a military junta in systems that

District. It also redefines the responsibilities of the states, the Federal District and the Union in advancing the SUS principles;[90]

- *Law No 9.836 of 1999* (Brazil), which amends *Law 8.080* to include provisions instituting a subsystem for Indigenous health—in the process extending the implementation of the right to health in the SUS to Indigenous peoples;[91]
- *The Psychiatric Reform Law 2001* (Brazil), which deinstitutionalises and reinforces the rights of individuals with mental illness. It also introduces outpatient services, such as psychosocial care centres and psychosocial support and rehabilitation for those leaving psychiatric hospitals;[92]
- *Ordinance No 373 of 2002* (Brazil), which approves the *Health Care Operational Norm* (NOAS-SUS 01/2002) expanding the responsibilities of municipalities in primary care; establishes the regionalisation process as a tiering strategy of health services and the search for greater equity; and creates mechanisms for strengthening the management capacity of the SUS and updating the capability criteria for states and municipalities;[93] and
- *Law No 10.424 of 2002* (Brazil), which adds a chapter and an article to *Law No 8.080 of 1990* (Brazil) setting forth provisions for the regulation of home care in the SUS.[94]

6.1.2.4 The Fourth Wave

The fourth and most recent wave of implementation, starting in the mid-2000s, has addressed, among other things, efficiency and quality issues by reforming governance of the system, contracting and payment mechanisms, and establishing regional healthcare networks.[95] Notable policies in this period include:

- the *Pact for Health 2006*, creating commitments for managers at each level of government to certain health goals and responsibilities;[96]
- the *National Policy of Primary Care 2006*, amplifying the concept and scope of primary healthcare in the country;[97]

---

have experienced military rule at some point in their history (e.g. Nigeria). However this may not be the case with Brazil as some of the Decrees enacted by it were enacted during its democratic dispensation.

90 *Decree No 2203 of 5 November 1996* (Brazil).

91 *Law No 9.836 of 23 September 1999* (Brazil).

92 *Law No 10216 of 6 April 2001* (Brazil); see Paim et al, above n 55, 1790; World Health Organization, 'WHO-AIMS Report on Mental Health System in Brazil ' (2007).

93 *Ordinance No 373 of 27 February 2002* (Brazil).

94 *Law No 10.424 of 15 April 2002* (Brazil).

95 Gragnolati, Lindelow and Couttolenc, above n 69.

96 *Operational Guidelines for the Pact for Health 2006* (Brazil); Paim et al, above n 55, 1786.

97 Luis Sampaio, 'The Brazilian Health System: Highlighting the Primary Health Care Reform' (2010) 7(4) *Italian Journal of Public Health* 359, 364.

- the *National Policy for Strategic and Participatory Management 2007*;[98]
- the *Regional-based Integrated Healthcare Network Policy*;[99] and
- the *National Policy on Comprehensive Care for People with Rare Diseases 2014*.[100]

Another notable development of this period is the adoption of policies and frameworks aimed at monitoring the system-wide performance of the health sector of Brazil. Examples of such policies include:

- the *Health Sector Assessment Policy 2006*;
- the *Primary Health Care Assessment Tool* of the Ministry of Health;
- the *Quality Improvement Program for Private Health Plans* of the National Regulatory Agency for Private Health Insurance and Plans;
- the *Program for Evaluation of Health System Performance*; and
- the *SUS Performance Indicator*.[101]

The legislative instruments promulgated during this period include:

- *Law No 11.108 of 2005* (Brazil), which amends *Law No 8.080 of 1990* (Brazil) to ensure the right of pregnant women to the presence of a companion during labour, delivery and the immediate postpartum period under the SUS;[102]
- *Decree No 399 of 2006* (Brazil), which gives disclosure and approves the *Operational Guidelines of the Pact for Health 2006*;[103] and
- *Ordinance No 4,279 of 2010* (Brazil)[104] and *Decree No 7,508 of 2011* (Brazil),[105] which establish 'new guidelines for healthcare network organisation as well as instruments for their development at the macro and micro levels'.[106]

In conclusion, the policy and legislative framework of Brazil is saturated with measures aimed at giving effect to the right to health (see Table 6.2). The challenges that have

---

98 This policy was approved in 2007 'with the clear objective to integrate actions related to social participation, ombudsmanhip, auditing, monitoring, and evaluation.' See Victora et al, above n 77, 2044.

99 This policy consolidates on earlier regional-based integrated health networks policies through rules contained in the *Health Pact 2006* and in legislation. See Ingrid Vargas et al, 'Regional-based Integrated Healthcare Network Policy in Brazil: From Formulation to Practice' (2015) 30 *Health Policy and Planning* 705, 707; Lenir Santos and Gastão de Sousa Campos, 'SUS Brazil: The Health Region as a Way Forward' (2015) 24(2) *Saúde Soc. São Paulo* 438.

100 Débora Gusmão Melo et al, 'Genetics in Primary Care and the National Policy on Comprehensive Care for People with Rare Diseases in Brazil: Opportunities and Challenges for Professional Education ' (2015) 6 *Journal of Community Genetics* 231.

101 Gragnolati, Lindelow and Couttolenc, above n 69, 19.

102 *Law No 11.108 of 7 April 2005* (Brazil).

103 *Decree No 399 of 22 February 2006* (Brazil).

104 *Ordinance No 4,279 of 30 December 2010* (Brazil).

105 *Decree No 7,508 of 28 July 2011* (Brazil).

106 Vargas et al, above n 99, 707.

confronted Brazil (and in some cases continue to do so) are well documented.[107] Many of the policies and legislation adopted by Brazil throughout the course of its four waves of implementing the SUS have been in response to these challenges. This level of commitment makes it possible for some observers to concede that 'despite the various financing issues, there have been significant improvements in health-care outcomes in Brazil',[108] and although Brazil's health system continues to experience some challenges, it is a fair system as it 'reaches out to the poor'.[109]

---

[107] For example, see Paim et al, above n 55; Gragnolati, Lindelow and Couttolenc, above n 69.

[108] World Health Organization, 'Brazil's March Towards Universal Coverage' (2010) 88(9) *Bulletin of the World Health Organization* 646, 647; see Section 3.3 for further details on health outcomes in Brazil.

[109] World Health Organization, 'Flawed but Fair: Brazil's Health System Reaches out to the Poor' (2008) 86(4) *Bulletin of the World Health Organization,* 248.

Table 6.2: Summary of health policies and legislation protecting the right to health in Brazil

Brazil			
Policy		Legislation	
1.	*Family Health Strategy 1994*	1.	*Law 8.080 of 1990* (regulates the conditions for health promotion and the organisation of the health system)
2.	*Bolsa Familia* (family allowance)	2.	*Law 8.142 of 1990* (establishes community participation in the management of SUS and the transfer of financial resources)
3.	*HIV/AIDS prevention and control programme*	3.	*Decree No. 2203 of 1996* (redefines the responsibilities of the states, Federal District and Union in advancing the SUS)
4.	*Tobacco control policy*	4.	*Law 9.836 of 1999* (amending law instituting a subsystem for Indigenous health)
5.	*Comprehensive Programme for Woman's Health*	5.	*Psychiatric Reform Law 2001*
6.	*Humanization of Prenatal Care and Childbirth Program*	6.	*Ordinance No. 373 of 2002* (approves the Health Care Operational Norm)
7.	*Model of Care for Indigenous Health*	7.	*Law 10.424 of 2002* (amending law providing for the regulation of home care in the SUS)
8.	*Mobile Emergency Care Service*	8.	*Law No. 11.108 of 2005* (amending law creating rights for pregnant women)
9.	*Health Care Operational Guidelines*	9.	*Decree No. 399 of 2006* (approves Pact for Health 2006 Operational Guidelines)
10.	*National Oral Health Policy*	10.	*Ordinance No. 4.279 of 2010* (establish new guidelines for healthcare network organisations)
11.	*Pact for Health 2006*	11.	*Decree No. 7508 of 2011* (establishes new guidelines for healthcare network organisations).
12.	*National Policy of Primary Care 2006*		
13.	*National Policy for Strategic and Participatory Management 2007*		
14.	*Regional-based Integrated Healthcare Network Policy*		
15.	*National Policy on Comprehensive Care for People with Rare Diseases 2014*		
16.	*Health Sector Assessment Policy 2006*		
17.	*Primary Health Care Assessment Tool*		
18.	*Quality Improvement Program for Private Health Plans*		
19.	*Program for Evaluation of Health System Performance*		
20.	*SUS Performance Indicator*		

6.1.3 Health Policies and Legislation in India

In India, an important preoccupation of the health policy landscape is how to move the health system towards universal health coverage. This preoccupation is salient in policy proposals[110] and scholarly discourse focusing on ways to transform the health system of India.[111] However, universal health coverage is not the only issue to have engaged policy makers and stakeholders in India in recent times. A number of other important health concerns have also featured prominently in scholarly discourse, such as the situation of mental healthcare delivery,[112] childhood immunisation,[113] malaria planning,[114] the gap in health and nutrition,[115] maternal and child health services,[116] HIV/AIDS policy implementation,[117] barriers to healthcare delivery[118] and human resource inequalities.[119]

---

110 See for instance K Srinath Reddy et al, 'High Level Expert Group Report on Universal Health Coverage for India' (Planning Commission of India, 2011); although in the draft National Health Policy of India released in 2015, universal health coverage has not featured prominently in the strategies outlined for the health system. See Ministry of Health and Family Welfare (India), *National Health Policy 2015 Draft,* December 2014.

111 A K Shiva Kumar et al, 'Financing Health Care for All: Challenges and Opportunities' (2011) 377 *Lancet* 668; Ravi Narayan, 'Universal Health Care in India: Missing Core Determinants' (2011) 377 *Lancet* 883; Amit Sengupta and Vandana Prasad, 'Towards a Truly Universal Indian Health System' (2011) 377 *Lancet* 702; Vikram Patel et al, 'Universal Health Care in India: The Time is Right' (2011) 377 *Lancet* 448; Richard Horton and Pam Das, 'Indian Health: The Path from Crisis to Progress ' (2011) 377 *Lancet* 181; K Srinath Reddy et al, 'Towards Achievement of Universal Health Care in India by 2020: A Call to Action ' (2011) 377 *Lancet* 760; Devaki Nambiar, 'India's "Tryst" with Universal Health Coverage: Reflections on Ethnography in Indian Health Policymaking' (2013) 99 *Social Science & Medicine* 135; Antonio Duran, Joseph Kutzin and Nata Menabde, 'Universal Coverage Challenges Require Health System Approaches: The Case of India' (2014) 114 *Health Policy* 269; A.K. Virk and R. Atun, 'Towards Universal Health Coverage in India: A Historical Examination of the Genesis of Rashtriya Swasthya Bima Yojana - The Health Insurance Scheme for Low-Income Groups' (2015) 129 *Public Health* 810.

112 Anindya Das, 'The Context of Formulation of India's Mental Health Program: Implications for Global Mental Health' (2014) 7 *Asian Journal of Psychiatry* 10; Dinesh Sharma, 'India's New Policy Aims to Close Gaps in Mental Health Care' (2014) 384 *Lancet* 1564;

113 Anu Rammohan and Niyi Awofeso, 'District-Level Variations in Childhood Immunizations in India: The Role of Socio-economic Factors and Health Infrastructure ' (2015) 145 *Social Science & Medicine* 163.

114 Constantine Boussalis, Hal Nelson and Siddharth Swaminathan, 'Towards Comprehensive Malaria Planning: The Effect of Government Capacity, Health Policy, and Land Use Variables on Malaria Incidence in India' (2012) 75 *Social Science & Medicine* 1213.

115 Deborah Thomas et al, 'Closing the Health and Nutrition Gap in Odisha, India: A Case Study of How Transforming the Health System is Achieving Greater Equity ' (2015) 145 *Social Science & Medicine* 154.

116 William Story, 'Social Capital and the Utilization of Maternal and Child Health Services in India: A Multilevel Analysis' (2014) 28 *Health & Place* 73; Stephanie Smith, 'Political Contexts and Maternal Health Policy: Insights From a Comparison of South Indian States' (2014) 100 *Social Science & Medicine* 46; Shyama Nagarajan et al, 'The National Rural Health Mission in India: Its impact on Maternal, Neonatal, and Infant Mortality ' (2015) 20 *Seminars in Fetal & Neonatal Medicine* 315.

117 Kabir Sheikh and John Porter, 'Discursive Gaps in the Implementation of Public Health Policy Guidelines in India: The Case of HIV Testing' (2010) 71 *Social Science & Medicine* 2005.

118 Umang Gupta and A. Ramesh, 'Analyzing the Barriers of Health Care Supply Chain in India: The Contribution and Interaction of Factors' (2015) 189 *Procedia - Social and Behavioral Sciences* 217.

119 Saseendran Pallikadavath et al, 'Human Resource Inequalities at the Base of India's Public Health Care System' (2013) 23 *Health & Place* 26.

It is perhaps for these reasons that the 'key message' put forth by the authors of *The Lancet Series* on the Indian health system was the need to create an 'integrated National Health System with three overarching goals':[120] 'ensuring the reach and quality of health services to all in India; reducing the financial burden of health care on individuals; and empowering people to take care of their health and hold the healthcare system accountable'.[121] These priority areas are still being debated and are yet to find their way into health policy or legislation in India.[122] A major reason for this delay is that under the *Constitution of India* health is a subject-matter within the legislative competence of states.[123] The central government cannot effect changes in the health system without the cooperation of states.[124] This difficulty has been acknowledged in India's Draft National Health Policy 2015 in the context of the desirability of a national legislation on the right to health.[125]

Two conclusions are drawn from India's policy dilemma: first, unlike Brazil, where the right to health is the cornerstone of domestic health policy and legislation, in India this is not the case; second, even where the desirability of policy and legislation on the right to health is appreciated by stakeholders in India, it will require more than promulgating such a policy or legislation at the national level to bring about its uptake in the country because legislative competence for health is vested in states. The existing policy and legislative instruments affecting the right to health at the national level in India are considered chronologically as follows:

- *National Health Policy 2002*. This policy replaced the earlier *National Health Policy 1983*.[126] It identifies its main objective as achieving 'an acceptable standard of good

---

120 Reddy et al, above n 110.

121 Ibid.

122 Vikram Patel (et al) point out that India's health system continues to face seven key challenges, many of which are part of the priority areas outlined above by the authors of *The Lancet* Series: a weak primary health care sector; unequally distributed skilled human resources; a large, unregulated private sector; low public spending on health; fragmented health information systems; irrational use and spiraling costs of drugs and technology; and weak governance and accountability. See Vikram Patel et al, 'Assuring Health Coverage for All in India' (2015) 386 *Lancet* 2422, 2425-2430.

123 See Section 5.2.1.2 for this discussion.

124 An illustration of the difficulty in introducing health policy or legislation with national application in India is provided by Antonio Duran (et al) who write that: 'In October 2012…the National Commission for Human Resources for Health Bill aimed at reforming the regulatory framework and improving skilled personnel supply was returned by the Parliamentary Standing Committee on Health and Family Welfare. The recommendation to the Ministry to "bring forward a fresh bill after sufficiently addressing the views, suggestions and concerns expressed by discussions with all stakeholders including the State Governments" was a clear expression of the existing debate in the country.' Duran, Kutzin and Menabde, above n 111, 273.

125 Ministry of Health and Family Welfare (India), *National Health Policy 2015 Draft,* December 2014, 56.

126 Ministry of Health and Family Welfare (India), *National Health Policy 2002*, 1.

health in the general population'.[127] This is to be accomplished by increasing access to 'the decentralised public health system by establishing new infrastructure in deficient areas' and 'upgrading the infrastructure in … existing institutions'.[128] The policy lacks legislative backing and thus creates no enforceable rights for the Indian population.

- *National Rural Health Mission*. Although this programme ended in 2012, it was launched in 2005 as an interventionist programme providing 'effective healthcare to rural population throughout the country with special focus on 18 states' with 'weak public health indicators and/or weak infrastructure'.[129]
- *Unorganised Workers Social Security Act 2008*. This Act provides for the social security and welfare of unorganised workers. The Act recommends that the Central Government of India provide social security schemes to mitigate risks due to disability, health shocks, maternity and old age, to which all unorganised workers are exposed and are likely to suffer from. The Act provided the basis for the launch of the *National Health Insurance Scheme* in 2008.[130]
- *Rashtriya Swasthya Bima Yojna* (National Health Insurance Scheme). This programme was launched in 2008 as a hospitalisation costs insurance scheme protecting households below the poverty line. This vulnerable group is usually populated by 'the vast majority of people in the unorganised sector, including agriculture'.[131] Although managed by the Labour Ministry nationally, at the state level where implementation takes place, 'the Health and Labour Ministries each manages the program in about half the states'.[132] Legislative backing for this policy is derived from the *Unorganised Workers Social Security Act 2008.*
- *Janant Shishu Suraksha Karyakram* (Child Protection Program). This is a cashless service provided for normal deliveries and caesarean operations as well as to care for sick newborns in government health institutions in the country.[133] As a policy directly influencing access to health services, it would have been further strengthened by legislative backing.

---

127 Ibid 20.
128 Ibid.
129 Ministry of Health and Family Welfare (India), *National Rural Health Mission: Framework for Implementation 2005-2012*, 8; Duran, Kutzin and Menabde, above n 111, 270.
130 *Unorganised Workers Social Security Act 2008* (India).
131 Duran, Kutzin and Menabde, above n 111, 270.
132 Ibid.
133 Ibid.

- *Clinical Establishments (Registration and Regulation) Act 2010*. This legislation sets minimum standards of facilities and services in all clinical establishments and systems of medicine, whether public or private.[134]
- *National Vaccine Policy*. This policy was launched in 2011 and sets out to guide decision making and develop a long-term plan to strengthen the vaccine programme of India. It provides broad policy guidelines for the creation of evidence base to justify the need for research and development, production, procurement and quality assessment of vaccines for the Universal Immunization Program in India.[135]
- *National Policy for Containment of Antimicrobial Resistance*. This policy was launched in 2011. It aims, among other things, to understand the emergence and spread of antimicrobial resistance and factors influencing it, while establishing a nationwide well-coordinated response programme. It achieves its objectives by establishing government commitment and support for the programme and promoting a national alliance for the prevention and control of antimicrobial resistance.[136]
- *National Mental Health Policy of India.* This policy was launched in 2014 to 'promote mental health, prevent mental illness, enable recovery from mental illness, promote destigmatisation and desegregation, and ensure socio-economic inclusion of persons affected by mental illness'.[137] These objectives are to be accomplished through the provision of 'accessible, affordable and quality health and social care to all persons through their life-span, within a rights-based framework'.[138] It is another important policy for the right to health in India that has no legislative backing.

In conclusion, in India (like Nigeria, but unlike Brazil) the right to health is not the cornerstone of health policy making. As such, little has been done to protect the right through policy and legislation. Table 6.3 shows that India has the smallest number of policies and laws on health. This is clearly an area where the country can improve its record. India's situation contrasts sharply with that of Brazil, as seen in Table 6.2, where a plethora of policy and legislative measures directed at giving effect to the right to health have been promulgated. Moreover, the desire for universal health coverage in India is a recognition of the need to infuse 'rights' considerations into health policy making. Until

---

134 *The Clinical Establishments (Registration and Regulation) Act, 2010* (India); Duran, Kutzin and Menabde, above n 111, 274.

135 Ministry of Health and Family Welfare (India), *National Vaccine Policy,* 2011.

136 Ministry of Health and Family Welfare (India), *National Policy for Containment of Antimicrobial Resistance,* 2011.

137 Ministry of Health and Family Welfare, *New Pathways New Hope: National Mental Health Policy of India*, October 2014 3.

138 Ibid.

that happens, the findings show that there is a current preference for *policy* as opposed to *legislation* as the instrument for giving effect to underlying determinants of health in India.

Table 6.3: Summary of health policies and legislation protecting the right to health in India

India			
Policy		Legislation	
1.	*National Health Policy 2002*	1.	*Clinical Establishments (Registration and Regulation) Act 2010*
2.	*National Mental Health Policy of India*	2.	*Unorganised Workers Social Security Act 2008*
3.	*National Rural Health Mission*		
4.	*Rashtriya Swasthya Bima Yojna* (National Health Insurance Scheme)		
5.	*Janant Shishu Suraksha Karyakram* (Child Protection Program)		
6.	*National Vaccine Policy*		
7.	*National Policy for Containment of Antimicrobial Resistance*		

6.1.4 Health Policies and Legislation in South Africa

The right of access to healthcare services is guaranteed by the *Constitution of South* Africa and the state is mandated to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation' of the right.[139] As the discussion in Section 5.2.1.2 illustrates, legislative responsibility for health in South Africa is shared jointly by the national, provincial and municipal governments in South Africa's federal system.

A number of salient issues have dominated health policy discourse in South Africa. Bongani Mayosi et al. note that 15 years after South Africa's first democratic election and its liberation from apartheid, the country is faced with 'four colliding epidemics: HIV and TB; a high burden of chronic illness and mental health disorders; deaths related to injury and violence; and a silent epidemic of maternal, neonatal, and child mortality'.[140] It is not

[139] *Constitution of South Africa 1996*, s 27.
[140] Bongani Mayosi et al, 'Health in South Africa: Changes and Challenges Since 2009' (2012) 380 *Lancet* 2029, 2030.

surprising therefore that substantial attention has focused on these concerns in scholarly discourse about health in South Africa.[141]

Health policy in South Africa has been responsive to these and other challenges facing the health system. For instance, the 1997 White Paper published by the Department of Health identified had as a priority, 'the task of developing a unified health system capable of delivering quality health care to all … citizens efficiently and in a caring environment'.[142] Like Brazil, South Africa identifies primary healthcare as a key strategy for driving health reforms. Hence, the White Paper declared its main objective as presenting to 'the people of South Africa a set of policy objectives and principles upon which the Unified Health System of South Africa will be based'.[143] The strategic approach guiding this process is 'Comprehensive Primary Health Care'.[144] The specifics of this approach involve the decentralisation of management of health services, with emphasis on the district health system; the increase of access to services by making primary healthcare available to all citizens; ensuring the availability of safe, good quality essential drugs in health facilities; rationalising health financing through budget reprioritisation; developing a national health information system that facilitates health planning and management; strengthening disease prevention and health promotion in areas such as HIV/AIDS, STDs and maternal, child and women's health; and putting in place the *Integrated Nutrition Programme* focused on sustainable food security for the needy.[145]

South Africa's position as an upper middle income country[146] with major disparities and inequalities along racial, gender and provincial lines arising from the period of apartheid

---

141 See for instance: Diane Cooper et al, 'Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status' (2004) 12(24) *Reproductive Health Matters* 70; Sisa Ngabaza and Tamara Shefer, 'Policy Commitment vs. Lived Realities of Young Pregnant Women and Mothers in School, Western Cape, South Africa' (2013) 21(41) *Reproductive Health Matters* 106; Marnie Vujovic et al, 'Addressing the Sexual and Reproductive Health Needs of Young Adolescents Living with HIV in South Africa' (2014) 45 *Children and Youth Services Review* 122; Nicola Foster et al, 'The Economic Burden of TB Diagnosis and Treatment in South Africa' (2015) 130 *Social Science & Medicine* 42; Linda Waldman and Marion Stevens, 'Sexual and Reproductive Health and Rights and mHealth in Policy and Practice in South Africa' (2015) 23(45) *Reproductive Health Matters* 93; Andrea Hoopes et al, 'An Analysis of Adolescent Content in South Africa's Contraception Policy Using a Human Rights Framework' (2015) 57 *Journal of Adolescent Health* 617; Diane Haddad et al, 'Barriers to Early Prenatal Care in South Africa' (2016) 132 *International Journal of Gynecology and Obstetrics* 64; Alexandra Müller et al, '"You Have to Make a Judgment Call". - Morals, Judgments and the Provision of Quality Sexual and Reproductive Health Services for Adolescents in South Africa' (2016) 148 *Social Science & Medicine* 71.

142 South Africa, *White Paper for the Transformation of the Health System in South Africa,* Government Gazette No 39506, 11 December 2015.

143 Ibid.

144 Ibid.

145 Ibid.

146 The World Bank, *South Africa* (<http://data.worldbank.org/country/south-africa>.

rule has created the serious need for policy that is responsive to challenges facing its health system. It is for this reason that the 1997 White Paper, as one of South Africa's early policy responses to the health needs of the country, was a step in the right direction. Although its health system continues to grapple with many of the health challenges identified in that policy, it is not debatable that important accomplishments have been recorded in the health system of South Africa in terms of improvements to health outcomes.[147] Recent policy initiatives indicate a push towards consolidating the gains recorded in the health system. A clear example is the Department of Health's White Paper of 11 December 2015,[148] introducing for public comment and representation the *National Health Insurance* scheme, aimed at achieving universal health coverage.[149] Building on the foregoing, the key policies and legislation that have defined South Africa's approach to the fulfilment of the right to health are considered chronologically as follows:

- *Medicines and Related Substances Act 1965*. This Act provides for the registration of medicines and other medicinal products to ensure their safety, quality and efficiency. It also provides for transparency in the pricing of medicines.[150]
- *Foodstuffs, Cosmetics and Disinfectants Act 1972 (as amended)*. This legislation provides for the regulation of foodstuffs, cosmetics and disinfectants, in particular it stipulates quality standards that must be complied with by manufacturers, as well as in the importation and exportation of these items.[151]
- *Hazardous Substances Act 1973*. This legislation, which is under the portfolio of the Minister of Health, provides for the control of hazardous substances, in particular those emitting radiation.[152]
- *Occupational Diseases in Mines and Works Act 1973*. This legislation provides for the conduct of medical examinations on persons suspected of having contracted occupational diseases, especially in mines and for compensation in respect of those diseases.[153]

---

147 This is evident in the discussion in Section 5.3, where data sets are presented on the performance of the health system of Nigeria and the comparators on a number of key health indicators.

148 White Paper on National Health Insurance (Government Gazette No. 39506) 11 December 2015.

149 Republic of South Africa, *National Health Insurance for South Africa: Towards Universal Health Coverage* (Department of Health, 2015); Rebecca Surender et al, 'The Drive for Universal Healthcare in South Africa: Views From Private General Practitioners ' (2015) 30 *Health Policy and Planning* 759.

150 *Medicines and Related Substances Act 1965* (South Africa).

151 *Foodstuffs, Cosmetics and Disinfectants Act 1972 (as amended)* (South Africa).

152 *Hazardous Substances Act 1973* (South Africa).

153 *Occupational Diseases in Mines and Works Act 1973* (South Africa).

- *National Policy for Health Act 1990*. This legislation provides for the determination of national policy to guide the legislative and operational programmes of the health portfolio.[154]
- *Integrated Nutrition Programme*. This policy, launched in 1994, establishes a set of nutritional objectives for South Africa by mobilising governance structures at the national, provincial, regional, district and community levels to work towards a number of principles. One such principle states that 'good nutrition for all South Africans should be promoted as a basic human right and as an integral component and outcome measure of social and economic development'.[155]
- *White Paper for Transformation of the Health System 1997*. This White paper, as discussed above, was responsible for mapping out the direction for future developments in the health system of South Africa.[156]
- *The Health Promoting Schools Initiative* (HPS). This WHO-recommended programme has been established in South Africa. It is informed by a health promotion philosophy that, among other things, encourages the development of healthy school policies that will assist the school community in addressing its health needs, and improve access to appropriate services to address the health needs of the community.[157]
- *Integrated National Disability Strategy 1998*. The White Paper on this policy was introduced in 1997 after an extensive consultative process in which persons with disabilities participated. The policy came about as a result of the post-apartheid paradigm shift in policy making, which focused on empowering population groups that were disadvantaged in the past, including persons with disabilities. The policy seeks to achieve disability coherence throughout all government processes, particularly in an attempt to address the social, economic and political inequalities that persons with disabilities experience due to disability.[158]
- *Tobacco Products Control Amendment Act 1999 (as amended)*. This legislation provides for the control of tobacco products and the prohibition of smoking in public

---

154 *National Policy for Health Act 1990* (South Africa).

155 South Africa, *Integrated Nutrition Programme*, 1994, 3.

156 South Africa, *White Paper for the Transformation of the Health System in South Africa,* Government Gazette No 39506, 11 December 2015.

157 Department of Health (South Africa), *Health Promoting Schools: Report on Provincial Health Promoting Schools Networks,* 1997.

158 Office on the Status of Disabled Persons (South Africa), *Integrated National Disability Strategy,* 1998.

places; advertisements for tobacco products; and sponsoring of events by the tobacco industry.[159]

- *Child and Adolescent Mental Health Policy Guidelines 2001*. This policy adopts a rounded approach to addressing the various risk factors that may affect the mental health of children and adolescents. It recognises schools as an important setting for the provision of interventions addressing mental health because they have the potential to reach large numbers of children and adolescents in a cost-effective manner.[160]
- *Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities*. This policy identifies its objectives as reducing the burden of genetic disorders and birth defects on the individual, the family and society; empowering individuals with genetic disorders and birth defects, and their families, to live and reproduce as normally and responsibly as possible; and creating awareness of the psychosocial and fiscal impact of genetic disorders and birth defects.[161]
- *Mental Health Care Act 2002*. Among other things, this Act provides for the care, treatment and rehabilitation of persons who are mentally ill. One of the objectives of the Act is to regulate mental healthcare in a manner that 'makes the best possible mental health care, treatment and rehabilitation services available to the population equitably, efficiently and in the best interest of mental health care users within the limits of available resources'.[162]
- *South African National Oral Health Strategy*. This policy sets out to improve the oral health of the South African population by promoting good oral health practices and appropriately addressing oral diseases through prevention, screening and treatment. The policy also sets out to reduce dental caries and gum diseases among children by instituting school oral health preventive services that focus on providing health education (including tooth-brushing campaigns) and applying tooth fissure sealants where resources permit.[163]
- *National Health Act 2003*. This Act lays down the framework for the uniform health system of South Africa, taking into account obligations imposed on national,

---

159 *Tobacco Products Control Amendment Act 1999 (as amended)* (South Africa).

160 Department of Health (South Africa), *Child and Adolescent Mental Health Policy Guidelines,* 2002.

161 Department of Health (South Africa), *Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities,* 2001; Valerie Ehlers, 'Republic of South Africa: Policies and Politics Guide Nurses' Application of Genetic Technology in Public Health Settings ' (2002) 3(2) *Policy, Politics & Nursing Practice* 149.

162 *Mental Health Care Act 2002* (South Africa), s 3.

163 Department of Health (South Africa), *South African National Oral Health Strategy,* 2002.

provincial and local governments with regard to health services by the *Constitution of South Africa* and other laws.[164] Section 2 of the Act, in outlining the objectives of the Act, codifies the constitutional guarantees of the right to health.[165]

- *Household and Community Component of Integrated Management of Childhood Illness Strategy*. This integrated child care approach aims at improving household practices likely to have the greatest effects on child survival, growth and development. The child-to-child or child family approach is based on the idea that learners will share child knowledge and practices with other family and household members.[166]
- *Traditional Health Practitioners Act 2007*. Among other things, this Act establishes the Interim Traditional Health Practitioners Council of South Africa and provides a regulatory framework for ensuring efficacy, safety and quality of traditional healthcare services.[167]
- *Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines*. This policy provides a technical basis for the introduction of helminth (parasitic worm) control programmes that include regular treatment of children for soil-transmitted helminth infections and bilharzia.[168]
- *Expanded Programme on Immunisation in South Africa* (EPI-SA). This 2010 policy revision aims to prevent death and reduce suffering from infections that can be prevented by immunisation of women and children. The target audience of the policy is health professionals in public health facilities (provincial, district and municipalities); private health facilities; South African National Defence Force; correctional services; and academics.[169]
- *Regulations Relating to Communicable Diseases 2010*. This regulation puts in place a framework for policy and guidelines formulation on matters relating to the

---

164 *National Health Act 2003* (South Africa), Preamble.

165 Ibid s 2(c) provides as follows: the objects of this Act are to regulate the national health system and to provide uniformity in respect of health services across the nation by – protecting, respecting, promoting and fulfilling the rights of – (i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care; (ii) the people of South Africa to an environment that is not harmful to their health or well-being; (iii) children to basic nutrition and health care services contemplated in section 28(1)(c) of the Constitution; and vulnerable groups such as women, children, older persons and persons with disabilities.

166 Department of Health (South Africa), *The Household and Community Component of Integrated Management of Childhood Strategy,* 2005.

167 *Traditional Health Practitioners Act (Act No. 22) 2007*, s 2.

168 Department of Health (South Africa), *Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia. Policy and Implementation Guidelines,* 2008.

169 Department of Health (South Africa), *Expanded Programme on Immunisation,* 2010.

prevention and control of communicable diseases, and the sharing and management of communicable diseases data/information, and so on.[170]

- *National Environmental Health Policy 2011*. This policy 'sets out the vision for environmental health and outlines the principles that underpin the policy. It also specifies government's strategic goals for environmental health in South Africa'.[171]
- *Integrated School Health Policy*. This policy is inspired by the commitment made by the President of South Africa in 2010 to reinstate health programmes in public schools. It aims to contribute to improving the general health of school-going children and the environmental conditions in schools. This is to be achieved by addressing health barriers to learning, to improve education outcomes of access to school, retention within school and achievement at school.[172]
- *Adolescent and Youth Health Policy 2012*. This policy provides guidance to departments and organisations working with the Department of Health on how to respond to the health needs of young people. It develops an integrated approach that is not just problem-oriented but provides for the mitigation of risk factors and puts in place 'safety nets' for early detection and prevention of diseases.[173]
- *National Strategic Plan on HIV, STIs and TB 2012–2016*. This policy aims to reduce the incidence of new HIV infections by 50% and minimise the impact of HIV and AIDS as well as TB on individuals, families, communities and society. It proposes to accomplish its objectives by improving access to suitable treatment, care and support. Four key strategies underpin its plan: focusing on social and structural approaches to HIV and TB prevention, care and impact; preventing HIV and TB infections; sustaining health and wellness; and protecting human rights while promoting access to justice.[174]
- *Strategic Plan (2014/15–2018/19)*. This policy aims to improve the health status of South Africans through the prevention of disease, the promotion of healthy lifestyles and making improvements to the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.[175]
- *National HIV Counselling and Testing Policy Guidelines*. This policy, launched in 2015, mobilises civil society organisations and development partners to ensure that

---

170 *Regulations Relating to Communicable Diseases 2010* (South Africa) reg 5.
171 South Africa, *National Environmental Health Policy,* No 34499, 3 August 2011, s 2.
172 South Africa, *Integrated School Health Policy*.
173 Department of Health Republic of South Africa, *Adolescent and Youth Health Policy 2012*.
174 South African National AIDS Council, *National Strategic Plan for HIV, STIs and TB 2012-2016*.
175 Department of Health Republic of South Africa, *Strategic Plan 2014/15 - 2018/19* (2014) 5.

the HIV testing goals of the *National Strategic Plan* are implemented. The policy also establishes a number of core principles for HIV counselling and testing in South Africa.[176]

- *Roadmap for Nutrition in South Africa 2013–2017*. This five-year plan seeks to direct nutrition-related activities in the health sector to achieve the sector's focus areas. It draws on recommendations of reviews of the implementation of the *Integrated Nutrition Programme*. It provides a framework for repositioning nutrition and nutrition-related issues and actions in the healthcare system with particular reference to the *Strategic Plan for Maternal, Neonatal, Child and Women's Health and Nutrition in South Africa*.[177]
- *Implementation Guidelines of Health Workforce Normative Guides and Standards for Fixed Primary Health Care Facilities 2015*. These guidelines were developed to fulfil the dictate of s 48(1) of the *National Health Act 2003*, which requires the National Health Council to 'develop policy and guidelines for, and monitor the provision, distribution, management and utilisation of human resources within the national health system'.[178] It also contemplates s 48(2), which dwells on the need for an adequate distribution of human resources for health; provision for appropriately trained human resources for health at all levels of the national health system to meet the population's healthcare needs; and ensure the effective and efficient utilisation, functioning, management and support of human resources within the national health system.[179]
- *Traditional Health Practitioners Regulations 2015*. This regulation is made pursuant to the *Traditional Health Practitioners Act 2007*. It regulates a number of important aspects of traditional health practice in South Africa such as who can be registered; categories of traditional health practitioners that must undergo training; the registration of students; minimums standards of education; and duration of educational programme etc.[180]

---

176 Department of Health (South Africa) *National HIV Counselling and Testing Policy Guidelines,* 2010.
177 Department of Health (South Africa), *Roadmap for Nutrition in South Africa 2013-2017,* 2013.
178 Republic of South Africa, *Implementation Guideline of Health Workforce Normative Guides and Standards for Fixed Primary Health Care Facilities* (National Department of Health, 2015) 14.
179 Ibid.
180 South Africa, *Traditional Health Practitioners Regulations*, No 39358, 3 November 2015.

- *White Paper on National Health Insurance 2015*. This White Paper is in the process of introducing a *National Health Insurance* policy for South Africa as a stepping stone towards the attainment of universal health coverage in the country.[181]

In summary, the fulfilment of the right to health is an important consideration in health policy making in South Africa. This is because of the constitutional mandate to realise the right to health.[182] In the process of giving effect to this constitutional mandate, South Africa has adopted a substantial number of policies and laws that advance the operationalisation of the right to health in the country (see Table 6.4). Compared to Brazil (see Table 6.2), South Africa's record matches that of Brazil in the number of health policies promulgated to give effect to the right to health (20 health policies have been promulgated by both countries). In the area of legislation, South Africa's record is also very close to that of Brazil (with nine statutes as compared to 11 in Brazil). Overall, both countries outperform Nigeria and India in their preference for hard law instruments such as legislation to give effect to the right to health. They also perform better than Nigeria and India in their use of policy instruments to advance the underlying determinants of the right to health.

[181] South Africa, *White Paper for the Transformation of the Health System in South Africa,* Government Gazette No 39506, 11 December 2015; Republic of South Africa, above n 149.

[182] *Constitution of South Africa 1996*, s 27.

Table 6.4: Summary of health policies and legislation protecting the right to health in South Africa

South Africa			
Policy		Legislation	
1.	*Integrated Nutrition Programme 1994*	1.	*Medicines and Related Substances Act 1965*
2.	*White Paper for Transformation of the Health System 1997*	2.	*Foodstuffs, Cosmetics and Disinfectants Act 1972 (as amended)*
3.	*The Health Promoting Schools Initiative 1997*	3.	*Hazardous Substances Act 1973*
4.	*Integrated National Disability Strategy 1998*	4.	*Occupational Diseases in Mines and Works Act 1973*
5.	*Child and Adolescent Mental Health Policy Guidelines 2001*	5.	*National Policy for Health Act 1990*
6.	*Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities*	6.	*Tobacco Products Control Amendment Act 1999 (as amended)*
7.	*South African National Oral Health Strategy*	7.	*Mental Health Care Act 2002*
8.	*Household and Community Component of Integrated Management of Childhood Illness Strategy*	8.	*National Health Act 2003*
9.	Expanded Programme on *Immunisation in South Africa*	9.	*Traditional Health Practitioners Act 2007*
10.	*Regulations Relating to Communicable Diseases 2010*		
11.	*National Environmental Health Policy 2011*		
12.	*Integrated School Health Policy*		
13.	*Adolescent and Youth Health Policy 2012*		
14.	*National Strategic Plan on HIV, STIs and TB (2012–2016)*		
15.	*Strategic Plan (2014/15–2018/19)*		
16.	*National HIV Counselling and Testing Policy Guidelines*		
17.	*Roadmap for Nutrition in South Africa (2013–2017)*		
18.	*Implementation Guidelines of Health Workforce Normative Guides and Standards for Fixed Primary Health Care Facilities 2015*		
19.	*Traditional Health Practitioners Regulations 2015*		
20.	*White Paper on National Health Insurance 2015*		

6.2 Implications for Legal positions on the right to health

Based on the discussion in Section 6.1, three observations are made in this section about the preferences that Nigeria and the comparators have shown towards the adoption of appropriate policy and/or legislation for advancing the objectives of the right to health in their health systems. First, Brazil and South Africa, whose constitutional rights framework firmly guarantee the right to health,[183] have shown greater willingness to use legislative instruments to give further expression to norms that protect the right in their domestic system. In contrast, Nigeria and India, whose constitutional rights framework contain weak guarantees of the right to health,[184] have been less inclined to use legislation to promulgate norms that influence the right in their health system. On the basis of this observation, it is argued that this shows that the impetus to adopt legislation to give effect to norms that advance the right to health is stronger where the constitutional foundation of the right is also strong.

Second, it is observed that the specification of who has legislative responsibility for health in a constitution also determines whether a state will be inclined to legislate for health nationally, or rely more on soft law instruments like policy for the health system. Nigeria and India, whose constitutions provide that state governments are to exercise legislative authority for health, have relied more on policy instruments than legislative instruments to govern the national health system. In the case of India, the situation has resulted in only two pieces of legislation at the national level that influence the right to health, although seven policies have been promulgated. This suggests that India is more willing to use policy to respond to national health issues than legislation. India's preference for policy over legislation can be explained by the limitation placed on it under the *Constitution of India* (where health is a matter in the state list).[185] In the case of Nigeria, only four pieces of legislation that influence the right to health have been promulgated at the national level. While this is better than India's record, it does not measure up with what Brazil and South Africa have done. At the same time, Nigeria has promulgated 12 policies for the health system. As with the case of India, it is suggested that Nigeria is more willing to rely on policy instruments than on legislation when adopting measures for the national health

[183] See Section 5.2.1.1.
[184] Ibid.
[185] This was the main reason given by India in the draft National Health Policy 2015, for the inability to promulgate a national legislation on the right to health. See the discussion in Section 6.1.3; see also Ministry of Health and Family Welfare (India), *National Health Policy 2015 Draft,* December 2014, 56.

system, and this cannot be divorced from the way the *Constitution of Nigeria* has allocated responsibility for health.

On the other hand, Brazil and South Africa, whose constitutions provide for joint legislative responsibility for health,[186] have been able to freely promulgate a variety of laws that advance the right to health in their domestic systems. Many of these touch on important subject-matters that have great consequence for the right to health. In addition, these countries have also adopted a wide range of policy measures (around 20 policies for each country), surpassing what Nigeria and India have adopted in their health systems. This suggests a higher level of commitment by both countries to bring about the fulfilment of the right to health in their domestic system.

The final observation relates to the subject-matter covered by the policies and legislation promulgated by Nigeria and the comparators. In Section 6.1, the point was made that states might have different legislative practices that may determine whether they adopt one or more laws to deal with issues in a particular subject area. Thus one should not be overly focused on the numerical exercise of counting how many statutes or policies a country has promulgated to assess its level of commitment to fulfilling the imperatives of the right to health. However, even taking account of this caveat, none of these countries fit the description of one whose legislative drafting practice favours omnibus legislation on health.

With specific regard to the subject-matter of coverage, Tables 6.1 – 6.4 show that Brazil and South Africa have covered a wider range of subject-matters affecting the right to health than Nigeria and India. An area like mental health, for which India has adopted a policy instrument, has been dealt with by Brazil and South Africa using legislation. On the other hand, an area like Traditional health practice, where Nigeria, does not have a statute or policy, has been dealt with by South Africa using legislation. Overall, when one evaluates the range of legislative and policy measures that Nigeria and the comparators have adopted in their health systems, the compelling conclusion is that Brazil and South Africa have been more committed to advancing right to health norms in their health systems, while Nigeria and India have not. This is a consequential finding when one also considers the discussion in Section 3.3, showing that Brazil and South Africa have better health outcomes in their health system than Nigeria and India.

[186] See the discussion in Section 5.2.1.2.

6.3 Implications for Health Financing

Policies and legislation on health are not self-executing; they require states to devote resources to finance the health system. How states go about doing so is another important way of evaluating their commitment to advancing the imperatives of the right to health in their health systems. There are two aspects to health financing: how individuals pay for health goods and services; and how states fund the provision of health goods and services. This section considers whether provisions for either or both of these aspects are contained in constitutions, legislation and policy.

The *National Health Insurance Scheme Act 1999,*[187] *the National Health Financing Policy 2006*[188] and the *National Health Act 2014*[189] are the relevant instruments on health financing in Nigeria. While the *National Health Act 2014* sets up the Basic Health Fund to finance the priority areas of that Act,[190] it is difficult at this stage to judge the success of the Act due to the recency of its promulgation. On the other hand, the health insurance scheme, which is relevant to how individuals pay for health goods and services, has not fulfilled its objective of guaranteeing access without financial hardship for the majority of Nigerians.[191]

Brazil's financing of the provision of health goods and services is contained in the *Constitution of* Brazil, which provides that the unified health system is to be financed with funds from the social welfare budget of the Union, the states, the Federal Districts and the municipalities, as well as from other sources.[192] With respect to how individuals pay for health, the discussion in Section 6.1.2 shows that the unified health system of Brazil comprises three subsectors: public, private and private health insurance. Each of these is relevant to how individuals finance health. However, Brazil's financing system is underpinned by emphasis on securing universal health coverage.

In India, the financing of health is not specified in the *Constitution of India.* In addition, legislation and policy in this area was not identified. It is more likely the case that individual states have made provisions in this area. However, the Draft National Policy

---

187 *National Health Insurance Scheme Act 1999* (Nigeria).
188 Federal Republic of Nigeria, *National Health Financing Policy, 2006*.
189 *National Health Act 2014* (Nigeria).
190 See the discussion in Section 6.1.1.
191 *National Health Insurance Scheme Act 1999* (Nigeria), s 5; see also the critique by Nnanuchi that the Act is a White Elephant: Nnamuchi, above n 19; for a reading on current challenges to health financing in Nigeria, see Nnamuchi and Metiboba, above n 19.
192 *Constitution of Brazil, 1988*, art 198.

2015 shows that India is seeking ways to legislate nationally in this area to achieve universal health coverage.[193]

In South Africa, in line with the joint responsibility for health under its constitution,[194] health is financed through a combination of mechanisms involving general tax (accounting for ~40%); private medical schemes (accounting for ~45%) and out-of-pocket payments (accounting for ~14%) of total healthcare financing.[195] In addition, it is pushing for the attainment of universal health coverage with its recent *White Paper on National Health Insurance* tabling a proposed legislation in that regard for public scrutiny.[196]

In summary, this discussion reveals that Brazil and South Africa have made robust provisions, through constitutional guarantees and a mix of funding arrangements involving the public and private spheres, for financing their health system. They have either emphasised (e.g. Brazil), or are beginning to emphasise (e.g. South Africa) universal health coverage in their funding priorities. With respect to Nigeria, although legislation and policy has been promulgated, these are either unenforceable (e.g. *Health Financing Policy 2006*), have failed to achieve their mandate (e.g. the *Health Insurance Scheme Act 1999*), or have only just come into operation and cannot be evaluated at this time (e.g. *Health Act 2014*). India has no legislation or policy for health financing at the national level, but it is currently pushing for the promulgation of a legislation in this area.

6.4 Conclusion

This chapter has identified that Brazil and South Africa have done more to give effect to the objectives of the right to health in their health systems than Nigeria and India and that this is largely due to the constitutional rights norms on health that have been guaranteed by both countries. The chapter also found that when account is taken of the health outcomes being recorded by these countries (see Section 3.3) the evidence strongly suggests that the measures being adopted by these states in giving effect to the right to health in their domestic system are quite consequential for health outcomes.

The chapter emphasised the need for more hard law instruments (such as legislation) to be adopted to give effect to important underlying determinants of the right to health, in

---

[193] Ministry of Health and Family Welfare (India), *National Health Policy 2015 Draft,* December 2014, 56.

[194] See the discussion in Section 5.2.1.2.

[195] See Di McIntyre et al, 'A Critical Analysis of the Current South African Health System' (University of Cape Town, 2007) 2.

[196] White Paper on National Health Insurance (Government Gazette No. 39506) 11 December 2015.

preference to soft law instruments (such as policy). The chapter also acknowledges that soft law instruments have their uses, but only so long as they are not used to replace the need for legislation in important areas where rights need to be secured.

By emphasising the need for legislation to strengthen health actions in the domestic system, the chapter does suggest it is necessary to pass several laws on health to show commitment to fulfilling the objectives of the right to health. In cases where a state's legislative practice favours the passage of a single omnibus legislation on an issue, this would suffice as long as the major issues have been dealt with under such legislation.

The chapter also found that Brazil and South Africa have performed better than Nigeria and India by putting in place robust financing mechanisms for their health systems. Both countries have been inspired by the constitutional provision on joint responsibility for health to adopt a financing scheme that involves the public and private domain, and emphasises the attainment of universal health coverage. Recommendations for Nigeria's improvement in this area are offered in Chapter 8.

CHAPTER 7: THE JUDICIAL CONTEXT

7.0 Introduction

As the primary site for the resolution of claims about violations of the right to health, the courts play a very significant role in securing legal positions on the right to health. This chapter argues that one of four possible outcomes may result from the involvement of the courts with the right to health through the 'judicialisation' process (i.e., the recourse to litigation to advance claims about the right to health).[1] These outcomes include *enabling* the right, *amplifying* the right, *impeding* the right and being *ambivalent* towards the right. The chapter argues that use of this taxonomy makes it is possible to assess the influence of the courts in the resolution of disputes involving violations of the right to health in Nigeria and the comparators. The value of this taxonomy to the campaign for public health is that it creates a framework for ascertaining how best to engage with the courts to advance the right to health, and highlights the potential limitations arising from this engagement.

This framework, while examining the same thematic issue examined by Katharine Young's 'typology of economic and social rights adjudication',[2] differs from Young's framework in two important respects: firstly, it is broadly conceived to depict the experiences with health rights litigation in a variety of judicial settings (Nigeria, the comparators and potentially other judicial settings), while Young's framework is based on the South African Constitutional Court's experience with justiciable economic and social rights.[3] Secondly, the framework sets out to understand the impact of the judicialisation of the right to health for the attainment of health justice in Nigeria and the comparators, while Young's framework aims to contribute towards lowering the tension that exists between courts and elected branches in order to achieve rights-protective outcome.[4]

The chapter finds that the courts in Nigeria have been ambivalent in their engagement with the right to health in the judicialisation process, largely because of their reticence in clarifying the status of economic and social rights in the country. In Brazil, the courts have impeded the right to health by failing to strike a balance between the competing

---

1 'Judicialisation' is used interchangeably with 'litigation' of the right to health in this chapter.

2 Katharine G Young, 'A Typology of Economic and Social Rights Adjudication: Exploring the Catalytic Function of Judicial Review' (2010) *International Journal of Constitutional Law* 385.

3 Ibid.

4 Ibid.

needs of the public health system and individual claimants who make demands on it for scarce resources to fund expensive medical treatments. In India, the courts have enabled the right to health through activism that has elevated the right from a status of non-justiciability to one where it is widely regarded as one of the fundamental rights guaranteed by the *Constitution of India.* In South Africa, the courts have amplified the right to health through decisions that have illuminated the constitutional guarantees of the right. The chapter also finds that very often, more than one of these outcomes may manifest in these countries, thereby complicate our understanding of the judicialisation process.

Section 7.1 examines the literature on the judicialisation of the right to health in Nigeria and the comparators. Scholarly works devoted to understanding the phenomenon of health rights litigation have in recent times captured the imagination of many in the health and human rights discipline.[5] Some of these works raise a number of important questions about the *equity impact* of health rights litigation across different jurisdictions and systems of law.[6] In the process, they reveal complex and significant issues that affect the praxis of health rights litigation. More importantly, they compel us to confront the realities of a complicated field where no easy answers can be found to the troubling

---

[5] For edited volumes and books, see Roberto Gargarella, Pilar Domingo and Theunis Roux (eds), *Courts and Social Transformation in New Democracies: An Instituional Voice for the Poor?* (Aldershot: Ashgate, 2006) – this work identifies two coinciding trends, namely, an increase in democratically elected governments and new rights-rich constitutions after 1990, and an increase in social rights litigation (which includes the right to health); Malcolm Langford (ed), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge University Press, 2008) – this book provides a descriptive and detailed compendium of court cases that recognise the justiciability and enforceability of social and economic rights at the national, regional and international levels; Christian Courtis, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (International Commission of Jurists, 2008) – this comparative work draws attention to economic, social, and cultural rights cases, focusing attention on the circumstances under which litigation in this area is likely to succeed in terms of implementation; Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008) – this work is one of a few that analyses the impact of health rights litigation. It engages in a comparative study of litigation on health and education in Brazil, India, Indonesia, Nigeria, and South Africa; and Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) – this work studies whether the trend towards judicialisation is positive or negative for the advancement of the right to health and whether it can bring more justice to health care. It features cases studies from Argentina, Brazil, Colombia, Costa Rica, India, and South Africa. For examples of scholarly articles dealing with the issue of health rights litigation, see Siri Gloppen, 'Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health' (2008) 10(2) *Health and Human Rights* 21; Jennifer Sellin, 'Justiciability of the Right to Health - Access to Medicines: The South African and Indian Experience ' (2009) 2(4) *Erasmus Law Review* 445; and Siri Gloppen, 'Legal Enforcement of Social Rights: Enabling Conditions and Impact Assessment ' (2009) 2(4) *Erasmus Law Review* 465.

[6] See for instance Yamin and Gloppen, above n 2; and Gauri and Brinks, above n 5.

questions that have been asked.[7] As such, the purpose of the discussion in this section is to engage broadly with the key issues in the discourse about health rights litigation—issues that have defined, and continue to define, developments in this area. The section also seeks to examine how these issues play out in the domestic legal systems of Nigeria and the comparators.

Section 7.2 examines the jurisprudence on the judicialisation of the right to health in Nigeria and the comparators. The objective of the section is to identify how the courts in these countries have engaged with the right to health, and the effects generated by this engagement.

Section 7.3 develops a taxonomy on the effects of judicialisation of the right to health. In doing so, it draws upon the literature and jurisprudence on health rights litigation examined in Section 7.1 to respond to two important questions: first, whether it is possible to classify the effects of the judicialisation of the right to health in the manner suggested by the chapter; and second, whether this method of classification potentially simplifies (or further complicates) an already complex discourse, thereby allowing Nigeria and the comparators to engage more meaningfully with health rights litigation in their domestic legal systems.

Section 7.4 reiterates the overarching claim that the judicialisation of the right to health is a complex phenomenon requiring careful study because of the divergent outcomes capable of manifesting as by-products of its praxis. As such, states desirous of engaging judicial mechanisms in transforming their health system ought to be aware of these possible outcomes to guard against potential pitfalls.

7.1 The Literature

This section examines the literature on the litigation of the right to health in Nigeria and the comparators. It engages broadly with the key issues in scholarly discourse on health rights litigation and examines how these issues interpret themselves or play out in the domestic legal context of Nigeria and the comparators.

Of the multitude of works to have emerged in recent times on the litigation of the right to health,[8] the most relevant for this thesis—owing to its thematic focus and choice of

---

7 See Siri Gloppen and Mindy Jane Roseman, 'Introduction: Can Litigation Bring Justice to Health?' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) 2.

8 An extensive catalogue of some of these works has been provided in footnote 5 above.

countries in the case studies[9]—is the edited volume by Yamin and Gloppen (hereafter *Litigating health rights*).[10] Equally relevant, but to a lesser degree—because of its broad focus on social and economic rights (and not specifically the right to health)—is the edited volume by Gauri and Brinks (hereafter *Courting social justice*).[11] In examining the litigation of the right to health in Nigeria and the comparators, this section and the next (on the jurisprudence of health rights litigation) focus on the findings of *Litigating health rights*. Occasionally, as the need arises, reference is made to the findings of *Courting social justice*.

7.1.1 Litigating Health Rights

Litigating health rights claims that 'the dynamics of health rights litigation, both in terms of its driving forces and effects, vary according to the nature of a country's health and legal systems'.[12] With regard to the health system, it assumes that the 'nature' of the litigation, and 'volume' of cases litigated are 'influenced by how the health system is organised, particularly whether there is a well-functioning universal public health-care system … or a more fragmented and competitive system of predominantly privately financed and/or provided health care'.[13] In other words, litigation patterns are influenced by the way health systems are designed to function, and the health reforms being put in place for the system.[14] For a diagrammatic representation of this claim, see Figure 7.1.

---

9 In the work by Yamin and Gloppen, above n 5, the countries examined in the case studies include Argentina, Brazil, Colombia, Costa Rica, India and South Africa. Three of these countries (Brazil, India and South Africa) are the comparators of this thesis.

10 Ibid.

11 Gauri and Brinks, above n 5.

12 Siri Gloppen, 'Litigating Health Rights: Framing the Analysis' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) 19.

13 Ibid.

14 Ibid.

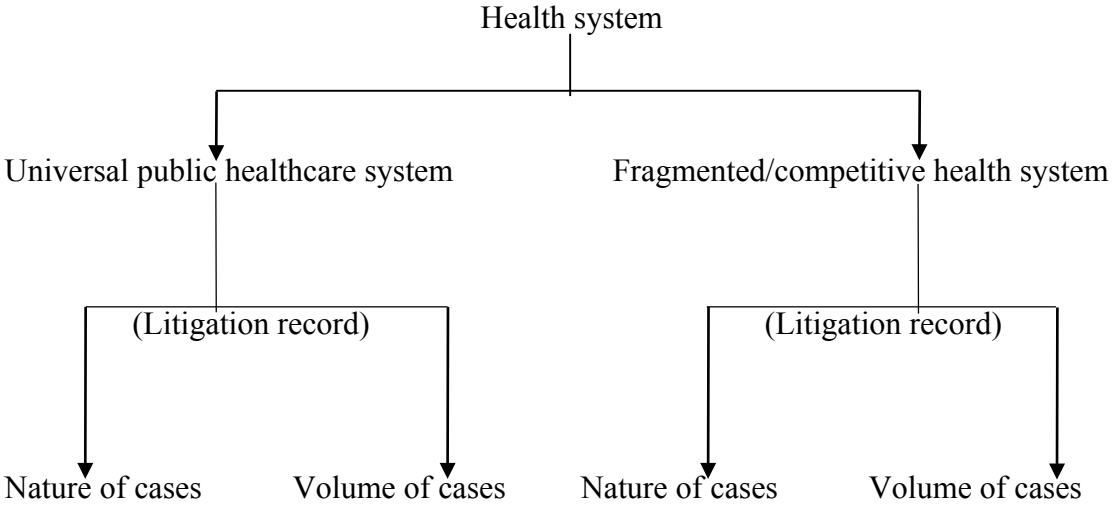

Figure 7.1: First assumption of *Litigating health rights* on the dynamics of health rights litigation

With regard to the legal system, *Litigating health rights* identifies a divergence between legal systems where cases have 'an *erga omnes* effect (in the sense that individual cases set precedent for others similarly situated)'[15] and legal systems where 'each individual claim in principle is settled on its own terms without creating precedent'.[16] It makes two assumptions about this observation: first, 'these differences' in the precedent value of cases 'influence the volume and nature of cases'[17] that are litigated; second, 'the threshold of access to the courts for different types of litigants is important'. Figure 7.2 illustrates this second aspect of the hypothesis.

[15] Ibid.
[16] Ibid.
[17] Ibid.

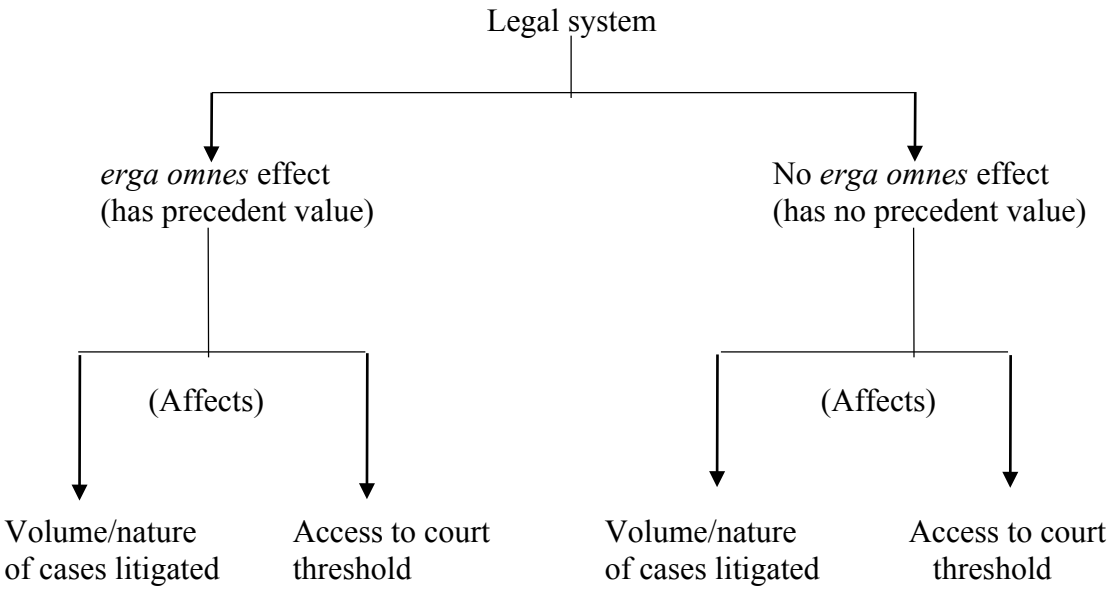

Figure 7.2: Second assumption of *Litigating health rights* on the dynamics of health rights litigation

7.1.2 First Assumption on the Health System

Different dynamics play out when the first assumption of *Litigating health rights* about the health system (the *nature* and *volume* of health rights cases litigated) is applied to the comparators.[18] In the first place, Brazil and South Africa are noted to have unified healthcare systems 'that in principle are open to the whole population' but in practice are heavily relied upon by the lower class while 'the middle and upper classes rely overwhelmingly on private health insurance'.[19] India's health system by contrast is not unified.[20] In addition, it is 'overwhelmingly privatised both in financing and provision'.[21] Nigeria's health system is not one of the case studies of *Litigating health rights*. However the discussion in Section 5.2.1.2 shows that Nigeria's health system, like that of India, is not unified; Section 6.1.1 also shows that Nigeria has no universal coverage system in place. Given these patterns of organisation of the health systems of Nigeria and the comparators, *Litigating health rights* implies the following about the nature and volume of health rights cases litigated upon in these countries:

(a) *Nigeria*. Here, the discussion proceeds by way of an extrapolation,[22] and there are difficulties with that endeavour. As noted in Section 5.1.4, the right to health is not a

---

18 The comparators of this thesis have been earlier noted to have also formed part of the country case studies of *Litigating Health Rights.*

19 Gloppen, above n 12.

20 See the discussion in Sections 5.2.1.2 and 6.1.3. These discussions show that health is a subject-matter for the states alone in India.

21 Gloppen, above n 12.

22 This is because, as earlier noted, Nigeria is not one of the case studies of *Litigating Health Rights.*

justiciable right in Nigeria. In this respect, Nigeria is similar to India. However, unlike India, where the Supreme Court has been proactive in enabling the right to health, the attitude of Nigeria's Supreme Court can best be described as 'ambivalence' towards socio-economic rights enforcement. This claim stems from the court's treatment of the African Charter,[23] which guarantees the right to health[24] and has been incorporated into Nigerian law by the African Charter Act.[25] While the Court has clarified that African Charter rights are enforceable in Nigeria through court processes deploying rules of procedure of Nigerian courts,[26] it has equally maintained that charter rights do not rise to the status of a constitutional norm.[27] The court was willing to concede that the African Charter 'possesses "a greater vigour and strength" than any other domestic statute',[28] however, it was of the view that it ranked below the constitution and thus conflicts between the constitution and the African Charter must be resolved in favour of the constitution.[29] By adopting this stance, it is argued that the court failed to clarify in what sense socio-economic rights provisions in the African Charter can be justiciable if they are constitutionally non-justiciable. This is the premise for the claim of ambivalence by the court.[30]

With respect to the standing to sue, Nigeria's Supreme Court has been known to vacillate from a restrictive[31] to a liberal interpretation of the rules of standing.[32] Nonetheless, it is noteworthy that the *Fundamental Rights (Enforcement Procedure) Rules 2009* (Nigeria) made pursuant to s 46(3) of the *Constitution of Nigeria* (in respect of Chapter IV Fundamental Rights provisions), puts in place generous rules on the standing to sue to

---

23 *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986).

24 Ibid art 16.

25 *Constitution of Nigeria 1999*, s 12(1) says no treaty between Nigeria and any other country should have the force of law except it has been enacted into law by the National Assembly; the domestication of the African Charter was accomplished through the *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria).

26 *Ogugu v State* [1996] 6 Nigerian Weekly Law Report (Pt. 316) 1, 30-31 (Supreme Court of Nigeria); *Nemi v State* [1996] Nigerian Weekly Law Report (Pt. 452) 42 (Supreme Court of Nigeria).

27 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

28 Ibid.

29 Ibid.

30 Chinonye Obiagwu and Chdi Anslem Odinkalu, 'Combating Legacies of Colonialisam and Militarism' in Abdullahi Ahmed An-Na'im (ed), *Human Rights Under African Constitutions: Realizing the Promise for Ourselves* (University of Pennsylvannia Press, 2002) 227.

31 For a restrictive interpretation, see *Adesanya v President* (1981) 2 Nigeria Constitutional Law Report 358 (Supreme Court of Nigeria); and *Thomas v Olufosoye* (1986) 1 Nigerian Weekly Law Report (Pt 18) 669 (Supreme Court of Nigeria).

32 For a liberal interpretation, see *Fawehinmi v Akilu* (1987) 4 Nigerian Weekly Law Report 797 (Supreme Court of Nigeria).

enforce fundamental rights.[33] However, these rules do not apply to Chapter II dealing with economic and social rights such as the right to health.

In summary, the extrapolation to the Nigerian context of the first assumption of *Litigating health rights* yields little fruit. This is not to suggest that there are no cases in Nigeria that have decided issues involving the right to health.[34] The point is that it is unusual to encounter cases where the main issue for determination is the violation of the right to health of the Nigerian populace by the state.[35]

(b) *Brazil*. Thousands of lawsuits are filed every year in Brazil by individuals—and to a lesser extent groups—claiming 'some kind of health good (medication, surgery, medical equipment, and even food and diapers) based on the right to health'[36] guaranteed in the *Constitution of Brazil*. Largely as a result of the 'expansive interpretation of the right to health … adopted at all levels of the Brazilian judiciary' most of these 'lawsuits have been successful for claimants'.[37] The approach of the courts in Brazil is one that considers the right to health to be 'an individual entitlement to *any* health procedure, equipment, or product that a person can prove he/she needs, irrespective of its costs'.[38] This liberal posture of the courts towards the right to health has given rise to an exponential growth in health rights litigation in Brazil.[39]

---

33 See *Fundamental Rights (Enforcement Procedure) Rules 2009* (Nigeria) Preamble, which extends standing to sue to 'anyone acting in the public interest' amongst others'.

34 Litigation involving the right to health in Nigeria has tended to occur in criminal cases where accused persons seek bail on health grounds. See for example *Fawehinmi v State* [1990] 1 Nigerian Weekly Law Report (Pt. 127) 486, 496-497 (Court of Appeal of Nigeria); the prevailing judicial position in Nigeria is that, although the courts are not precluded from doing so, it is unusual to grant bail in capital cases such as murder – see for instance *Abacha v The State* [2002] 5 Nigerian Weekly Law Report (Pt. 761) 638 (Supreme Court of Ngeria); *Bamaiyi v State* (2001) 8 Nigerian Weekly Law Report (Pt. 715) 270 (Supreme Court of Nigeria). As such the basis for the litigation in these cases is not to compel the government to secure the right to health of the accused persons by providing them health care facilities, but rather for accused persons to be allowed to go on bail to attend to their medical emergencies due to the poor state of the facilities available to incarcerated persons. While this is no doubt an important aspect of the right to health, it is not the main sense in which the litigation of the right is being considered in this chapter.

35 As such in 2010, it was considered news-worthy by Sahara Reporters (an online news outlet popular in Nigeria) that Femi Falana (a Senior Lawyer based in Lagos State of Nigeria) sued the federal government over conditions of public hospitals. See Sahara Reporters, 'Falana Sues FG Over Conditions of Public Hospitals ', *Sahara Reporters* 29 July 2010 <http://saharareporters.com/2010/07/29/falana-sues-fg-over-conditions-public-hospitals>.

36 Octavio L. Motta Ferraz, 'Brazil: Health Inequalities, Rights, and Courts: The Social Impact of the Judicialization of Health' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health* (Harvard University Press, 2011) 76.

37 Ibid.

38 Ibid.

39 This development has stirred mixed feelings about the benefits (equity impact) of health rights litigation in Brazil. While there are no doubt positive impacts to be derived from this development, especially for health seeking members of the public, the more dominant perception (especially among health administrators) is that the judicialisation of the right to health is an epidemic that needs to be

Available data on the volume and cost of litigation for the government of Brazil show that between 2003 and 2009, the Ministry of Health responded to 5,323 lawsuits 'claiming some kind of health benefit based on the right to health' and this resulted in an expenditure of 159.03 million Brazilian Real (BRL) (US$50.5 million).[40] The data also show that in 2009 alone, when the highest cost was incurred, 'the expenditure reached BRL83.16 million (US$27.3 million), more than the expenditure for the previous six years combined'.[41] Situating these data in a broader context, Ferraz observes that 'this cost represents 0.4% of the ministry's total health budget (US$20 billion) and 4% of its budget for medicines (US$2 billion)'.[42] The high resort to litigation in Brazil needs to be viewed in the light of liberal standing rules such the *Mandado de Segurança* (writ of mandamus) under art 5(LXIX) of the *Constitution of Brazil* allowing easy access to courts by individuals seeking protection against public or private entities that have not acted in accordance with the law.[43]

With respect to the nature of cases litigated, available data show that the vast majority of cases dealing with the right to health have been in the areas of access to medication and claims for surgical and diagnostic procedures abroad or in the private health system (that the public health system is not equipped to carry out or prepared to fund); medical equipment (e.g. wheelchairs, prosthetics and insulin infusion pumps); special dietary products (e.g. special milk for people with allergies); and hygiene products (e.g. geriatric diapers).[44] In many of these claims, the focus is on the individual and the remedies sought are individualised and not collective—'that is, they seek the *provision of a health benefit* for an individual litigant rather than a change in policy to benefit a whole group or the population as a whole'.[45]

(c) *India*. A different dynamic plays out in India because its constitution does not guarantee a justiciable right to health.[46] Moreover, legislative responsibility for health is a matter for the states.[47] Parmar and Wahi identify other limitations to India's health system as lack of political commitment to realising universal healthcare; emphasis of budgetary priorities on vertical disease-eradication programmes and family planning;

---

curbed. See Ibid; Octavio L. Motta Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' (2009) 11(2) *Health and Human Rights* 33.

40 Ferraz, aboved n 36, 81.

41 Ibid.

42 Ibid.

43 See the discussion in Section 5.2.2.

44 Ferraz, aboved n 36, 94.

45 Ibid.

46 See Section 5.1.4.

47 See Section 5.2.1.2.

failure to develop an integrated health infrastructure; and implementation of ill-conceived and non-cost-effective health programmes at the expense of universal care.[48] Despite this bleak narrative, an activist Indian Supreme Court has enabled the development of social rights litigation in the country through a liberal interpretation of its power of review[49] and substantive rights guaranteed in the *Constitution of India*.[50] Health rights litigation, in this context, has focused primarily on responding to the inadequacies of public health policies and infrastructure that is 'clearly inadequate' to meet the health needs of the population.[51]

The progress towards recognising an enforceable right to health in India has been measured, deliberate and incremental. This began in 1981 with a decision dealing with deplorable prison conditions where the Supreme Court interpreted the right to life to 'include the right to live with human dignity and all that goes along with it, including the bare necessities of adequate nutrition, clothing and shelter'.[52] In 1992, in a case about the provision for state workers' health and medical care, a minority opinion by the Supreme Court recognised the right to health as falling within the right to life, paving the way for further development of the law in this area.[53] Between 1989 and 1995, decisions from the court included health-related issues within the right to life (such as access to medical treatment for prisoners[54] and 'better standard of life, hygienic conditions in work place and leisure'[55]). It was however in 1996 that the right to health fully emerged as an independently justiciable right in India when the government was directed to compensate a petitioner with a medical emergency who was denied treatment by seven hospitals.[56] Further affirming this position in 1997, the court declared that 'it is now settled law that

---

48 Sharanjeet Parmar and Namita Wahi, 'India: Citizens, Courts and the Right to Health: Between Promise and Progress?' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011) 160.

49 *Constitution of India* vests the Supreme Court with original (art 131), appellate (art 132-6) and advisory jurisdiction (art 143). The *Constitution* makes a law declared by the Supreme Court to be binding on 'all courts within the territory of India' (art 141); the Supreme Court is also empowered to issue any orders 'to do complete justice' between parties (art 142); and 'all authorities, civil and judicial, in the territory of India' are expected to 'act in aid of the Supreme Court of India' (art 144).

50 Parmar and Wahi, above n 45, 163; see also Upendra Baxi, 'Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India' (1985) 4(6) *Third World Legal Studies* 107; Jayna Kothari, 'Social Rights Litigation in India: Developments of the Last Decade' in Daphne Barak-Ere and Aeyal Gross (eds), *Exploring Social Rights* (Hart Oxford, 2011) 171-192.

51 Parmar and Wahi, above n 48, 164.

52 *Mullin v Delhi* (1981) 2 Supreme Court Report 516 (Supreme Court of India) (rights of prisoners and conditions of detention).

53 *CESC Ltd v Bose* AIR 1992 SC 573, 585 (Supreme Court of India).

54 *Katara v Union of India* (1989) 4 SCC 286 (Supreme Court of India) (this was a Public Interest Litigation seeking provision of emergency medical care for injury following newspaper report of doctors' refusal to treat injured motorists).

55 *Consumer Education and Research Centre v Union of India* (1995) 3 SCC 42 (Supreme Court of India) (regarding issuing extensive occupational health and safety guidelines for asbestos workers).

56 *Samity v State of West Bengal* (1996) 4 SCC 37; AIR 1996 SC 2426 (Supreme Court of India) (extending the right to speedy medical assistance to workers).

right to health is integral to right to life'.[57] Since then, health has been routinely cited among the fundamental rights protected under the constitution.[58]

(d) *South Africa*. Health rights litigation in South Africa derives its context from 'the country's political transition from a parliamentary sovereignty run by a white minority regime (the apartheid era) to a constitutional democracy based on majority representation'.[59] The legacies of the apartheid era include profound systemic inequalities affecting millions; poverty-linked diseases; lack of critical amenities essential for health; and imbalance in health system resourcing (between well-resourced private health facilities and under-resourced public health facilities).[60] Added to these are four colliding epidemics with far-reaching consequences for the right to health, such as HIV/AIDS and TB, chronic and mental illness, deaths from injury and violence, and maternal, neonatal and child mortality.[61]

Major progress has been made in addressing inequalities in the health sector of South Africa (see Section 6.1.4) and these have yielded fruit in the form of improvements to health outcomes (see Section 3.3). However, there are still areas of severe policy failings where judicial intervention is required, for instance, the HIV/AIDS epidemic:[62] '[w]ith an estimated 5.6 million people living with HIV (a 2014 estimate shows the figure to be around 6.8 million[63]) the epidemic has placed enormous pressure on an already overburdened health-care system'.[64] It is against this backdrop that the protection of the right to health in the *Constitution of South Africa* is quite consequential.[65]

As Chapter 5, Section 5.2.1.1 shows, the *Constitution of South Africa* guarantees a number of health rights. This has made it possible for litigation to address three main

---

57 *State of Punjab v Chawla* (1997) 2 SCC 83 (Supreme Court of India) (dealing with the constitutional obligation to provide health facilities to government workers under art 21 when read with Directive Principles of State Policy arts 39(c), 41 and 43).

58 *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India) (considering the right to property in a case of adverse possession).

59 Carole Cooper, 'South Africa: Health Rights Litigation: Cautious Constitutionalism' in Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health* (Harvard University Press, 2011) 190.

60 Ibid 190-191; Sampie Terreblanche, *A History of Inequality in South Africa* (University of KwaZulu-Natal Press, 2002); Jeremy Seekings and Nicoli Nattrass, *Class, Race, and Inequality in South Africa* (Yale University Press, 2005).

61 Bongani Mayosi et al, 'Health in South Africa: Changes and Challenges Since 2009' (2012) 380 *Lancet* 2029, 2030.

62 The Thabo Mbeki government (1999-2008) denied any causal connection between HIV and AIDS and refused to provide antiretroviral medicines to treat it. See Cooper, above n 56, 191-192.

63 UNAIDS, *HIV and AIDS Estimates (2014)* (<http://www.unaids.org/en/regionscountries/countries/southafrica>.

64 Cooper, above n 59, 192.

65 Ibid.

issues: challenges to health policies and laws considered to hinder or undermine access to health rights (policy gaps);[66] challenges to practices considered inimical to the health needs of poor and vulnerable groups (regulatory gaps);[67] and challenges to failure by government to enforce laws and policies, thereby undermining health rights (implementation gaps).[68] A particular difficulty with health rights litigation in South Africa is the cost and technical difficulty, which limit individuals' access to the courts.[69] As such, many health rights cases in South Africa are prosecuted by public interest bodies having the financial resources and technical expertise required for such cases.[70] This is not to suggest that individuals are hindered from equally maintaining actions challenging violations of their right to health.[71] The point here is that generous standing rules have facilitated public interest litigation on health and other rights.[72]

Non-parties, under a new *amicus curiae* provision, can also seek permission to intervene in litigation to advance their own argument, 'with entry depending, inter alia, on whether the argument will be of use to the Court'.[73] In summary, South Africa shares nothing of the 'open-flood-gates' concerns characterising health rights litigation in Brazil. It is more robust than the Indian context because of the constitutional and legislative support available to litigants—who do not have to rely on the innovativeness/activism of the courts to be assured of remedies for violations of their right to health. It also does not mirror the ambivalence of the Nigerian context where the courts have not clearly clarified the status of economic, social and cultural rights in view of its guarantee under the African Charter Act.

---

66 See for eg *Biljoen v Minister of Correctional Services* [1997] 4 SA 441 (High Court).

67 See for eg *Tau v GlaxoSmithKline* Case No. 2002Sep226 (Competition Commission).

68 See for eg *Minister of Health and Welfare v Woodcarb Pty Ltd* [1996] 3 SA 155 (Provincial Division); Cooper, above n 59, 194.

69 Cooper, above n 59, 193.

70 Ibid.

71 *Soobramoney's* case for instance, is an example of an individual maintaining an action seeking redress for violation of his right to health. Indeed s 167(6) *Constitution of South Africa 1996* allows individuals to bring a matter directly to the Constitutional Court; or to appeal directly to the Court 'when it is in the interests of justice and with leave of the Constitutional Court. However, in reality, the Court has shown reluctantance to act as a court of first instance and last resort, and has generally required applicants to exhaust all other remedies or procedures before approaching it. As such, most constitutional cases reach the Court only on appeal. See Cooper, above n 56, 193; Matthew Chaskalson, Gilbert Marcus and Michael Bishop, 'Constitutional Litigation' in Stu Woolman and Michael Bishop (eds), *Constitutional Law of South Africa* (Juta Law, 2008) 3.1-31; and only the 'most persistent and well supported litigants are able to access the court' Jackie Dugard and Theunis Roux, 'The Record of the South African Constitutional Court in Providing an Institutional Voice for the Poor: 1995-2004' in Roberto Gargarella, Pilar Domingo and Theunis Roux (eds), *Courts and Social Transformation in New Democracies: An Institutional Voice for the Poor?* (Ashgate Publishing Limited, 2006) 112-113.

72 Cooper, above n 59, 194; see *Ferreira v Levin NO; Vryenhoek v Powell NO* 1996 (1) SA 984 (CC).

73 *Constitutional Court Rules 2003* (South Africa) r 10.

7.1.3 Second Assumption on the Legal System

The second assumption of *Litigating health rights* states is a divergence between legal systems where cases have an *erga omnes* effect (in that individual cases set precedent for others similarly situated) and legal systems where each individual claim in principle is settled on its own terms without creating 'precedent'.[74] *Litigating health rights* claims that these distinct patterns of organising legal systems also affect the *nature* and *volume* of health rights cases litigated. In addition, they affect the threshold question of who can access the court to seek judicial interventions for violations or threatened violations of the right to health.[75]

Nigeria and the comparators are used once again to verify this claim. These countries are associated with either the common law or civil law traditions.[76] Brazil, for instance, is associated with the civil law tradition, whereas Nigeria and India are categorised as common law countries. South Africa is also often regarded as a common law country in public law discourse;[77] however, this categorisation is one that can be tenuous given South Africa's legal pluralism involving the amalgam of Roman–Dutch civil law, English common law and African customary law.[78] However, for the purpose of the public law questions identified in this chapter, South Africa is also categorised as a common law country.[79]

An attribute of the civil law tradition that manifests in the Brazilian legal system is the absence of a system of precedent.[80] Although this point is not fully explored in *Litigating health rights,* it is acknowledged that Brazilian courts are quite receptive to health rights

---

74 See Gloppen, above n 9, 19; Vincy Fon and Francesco Parisi, 'Judicial Precedent in Civil Law Systems: A Dynamic Analysis' (2006) 26 *International Review of Law and Economics* 519, 520-523.

75 Gloppen, above n 12, 19.

76 Merryman and Perez-Perdomo draw an important distinction between the terms 'legal tradition' and 'legal systems' and this distinction is maintained here. In their view, a legal system 'is an operating set of legal institutions, procedures, and rules.' In this sense, every country in the world has a different legal system from the other because the operating set of legal institutions, procedures and rules differ. On the other hand, there are good reasons to classify national legal systems as either 'civil law' or 'common law', based on a shared tradition. The point to note here is the important distinction between what constitutes a legal system and what constitutes a legal. See John Henry Merryman and Rogelio Perez-Perdomo, *The Civil Law Tradition: An Introduction to the Legal Systems of Europe and Latin America* (Standford University Press, 3rd ed, 2007) 9.

77 See John Andrew Faris, 'African Customary Law and Common Law in South Africa: Reconciling Contending Legal Systems' (2015) 10(2) *International Journal of African Renaissance Studies* 171.

78 See Cheryl Saunders and Anna Dziedzic, 'Parliamentary Sovereignty and Written Constitutions in Comparative Perspective' in A Welikala (ed), *The Sri Lankan Republic at 40: Reflections on Constitutional History, Theory and Practice* (Centre for Policy Alternatives, 2012) [5].

79 Constitutional support is found for this categorisation in s 173 *Constitution of South Africa 1996* which vests power on the Constitutional Court, Supreme Court of Appeal and High Court to 'develop the common law'.

80 Anna Silva Bruno, 'Bringing Uniformity to Brazilian Court Decisions: Looking at the American Precedent and at Italian Living Law' (2007) 11(4) *Electronic Journal of Comparative Law* 1.

litigation and adopt an expansive interpretation of the constitutional right to health.[81] This in turn has encouraged litigation by individuals challenging the violation of their right to health. Such individuals are enabled by the constitutional writ of mandamus allowing them to seek the intervention of the courts against violations, or threatened violations, of their right. The vast majority of cases in Brazil—around 97%—were brought by individual claimants demanding individualised health benefits; less than 3% involved collective claimants seeking protection of their right to health.[82]

In contrast, India and South Africa, whose legal systems are influenced by the common law tradition and its system of judicial precedent reflect a different experience. Although litigation in these systems serves the primary purpose of deciding individual claims brought before a court, an important secondary purpose is also served. This occurs when judicial decisions become the basis for plugging policy or legislative gaps in line with existing constitutional mandates on the right to health (as in the case of South Africa); and in the absence of such mandate, using the opportunity of health rights litigation to create new understandings of what the right to health means vis-à-vis other constitutionally recognised rights such as the right to life (as in the case of India). In both instances, the litigation process is complex and driven by entities with the requisite resources and expertise to manage the complexities inherent in these cases.[83]

What emerges from the foregoing discussion is the sense, as claimed by *Litigating health rights*, that the way a legal system is structured is critical to the nature and volume of health rights cases that are litigated. An important dimension to this issue is the ease or difficulty with which cases can be instituted before the courts. In this regard, Brazil has easier access to the court regime (for health rights litigants) than does India and South Africa. Ordinarily this is a positive trait desired of any legal system. However, given the inevitable demands placed on the redistribution of scarce resources in the health system to meet the outcome of the litigation process, it is difficult not to view the frequent and easy recourse to litigation—resulting in individualised remedies—as a weakness of the Brazilian system. Thus, what is regarded as its strength is also its weakness.

No parallels can be drawn with Nigeria on the basis of this second assumption of *Litigating health rights.* This is because as the discussion in the first assumption shows, health rights litigation is virtually non-existent in Nigeria: if it is present at all, it is

---

81 Ferraz, above n 36, 96.
82 Ibid 87.
83 Parmar and Wahi, above n 48; Cooper, above n 56.

happening on a scale that cannot support the hypothesis of *Litigating health rights.* Notwithstanding, it is argued that the hypothesis of *Litigating health rights* may still be relevant for Nigeria to the extent that it can explain how patterns of the organisation of Nigeria's legal system, as a common law system with a strong tradition of precedent, affect its willingness to recognise a justiciable right to health. Thus, the influence of the common law tradition on Nigeria's legal system may account for why the courts are reluctant to be seen to be opening the floodgates for litigation.[84] What is more, because the Supreme Court of Nigeria has pronounced on the status of the African Charter, courts below the Supreme Court must maintain that status quo in line with the doctrine of precedent.

7.2 The Jurisprudence

This section highlights broadly the trajectory of the jurisprudence of Nigeria and the comparators in the area of health rights litigation. The aim is to deepen understanding of the sense in which the judicialisation of the right to health has occurred in each of these systems.

7.2.1 Nigeria's Jurisprudence

Nigeria's jurisprudence on the right to health is shaped by its broader approach to social and economic rights. This approach can be understood in four ways: the unwavering adherence to the constitutional provision that social and economic rights are not justiciable;[85] the acknowledgement that the incorporation of the African Charter into Nigerian law makes enforceable all the social and economic rights contained in it through the normal processes of Nigerian courts;[86] the recognition that the rights contained in the African Charter (now part of Nigeria's domestic law)[87] 'possess "a greater vigour and strength" than any other domestic statute';[88] and the refusal to regard African Charter rights as equal to, or above constitutional rights, or as a yardstick for judging the validity of other domestic statutes.[89]

---

84 Thus by refusing to recognise that the *African Charter*, in its incorporated form as a statute, is clothed with constitutional flavour (despite recognising its pre-eminence over other local legislation) the Supreme Court of Nigeria, arguably, has closed a potential floodgate of litigation of Charter rights not previously guaranteed by the *Constitution* (for eg the right to health).

85 *Constitution of Nigeria 1999*, s 6(6)(c).

86 *Ogugu v State* [1996] 6 Nigerian Weekly Law Report (Pt. 316) 1, 30-31 (Supreme Court of Nigeria); *Nemi v State* [1996] Nigerian Weekly Law Report (Pt. 452) 42 (Supreme Court of Nigeria).

87 *African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983* (Nigeria).

88 *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

89 Ibid.

Mainly as a result of the foregoing ambivalent judicial posture, little has happened in the area of health rights litigation in Nigeria. The context in which health rights jurisprudence has emerged in Nigeria is in criminal cases where medical grounds have been accepted by the courts as a condition for the grant of bail to accused persons.[90] Even then, the argument is not whether accused persons have a right to medical treatment; rather it is whether they should be granted bail to seek medical treatment.[91]

7.2.2 Brazil's Jurisprudence

In *Courting social justice*, Hoffman and Bentes survey health rights litigation across 5 of the 26 states and two apex tribunals of Brazil in the period 1994–2004. Their findings reveal a number of interesting trends that are examined in this section.[92] Of the 7,400 health-related cases captured by the survey, only 2% involved collective claims; 98% involved individual claims.[93] The predominant type of actions were direct provision claims by individuals against the state. These cases accounted for 85% of all cases.[94] Obligation claims, mostly by individuals against private health insurance companies, accounted for another 13% of the cases,[95] and less than 1% of the cases involved issues of regulation.[96]

In a further survey by Hoffman and Bentes of the success rate of cases considered by three levels of higher courts in Brazil (the trial, intermediate appellate and apex courts), the findings reveal a number of interesting trends as well: plaintiffs recorded a success rate of around 70% (including partial wins) at the trial level;[97] at the appellate level, the courts of appeals reversed the decision in 24% of the cases that favoured the plaintiffs. However, they also reversed 32% of the decisions favouring the defendants and gave the defendants three of the partial wins by plaintiffs from the trial level (i.e., cases where plaintiffs only won part of the claim). Thus, the overall plaintiff success rate dropped and

---

90 *Dokubo-Asari v Federal Republic of Nigeria* SC 208/2006 (Supreme Court of Nigeria); *Bamaiyi v State* (2001) 8 Nigerian Weekly Law Report (Pt. 715) 270 (Supreme Court of Nigeria); *Ani v State* (2002) 1 Nigerian Weekly Law Report (Pt 747) 217 (Court of Appeal of Nigeria).

91 *Bamaiyi v State* (2001) 8 Nigerian Weekly Law Report (Pt. 715) 270 (Supreme Court of Nigeria).

92 This survey was carried out by Hoffmann and Bentes and forms part of their chapter in *Courting Social Justice.* See Florian F. Hoffmann and Fernando R. N. M. Bentes, 'Accountability for Social and Economic Rights in Brazil' in Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008) 115-20.

93 Ibid 116.

94 Ibid 117.

95 Ibid.

96 Ibid.

97 Ibid 119.

was slightly above 60%;[98] and the apex court reversed this trend. Of the 25 cases initially favouring defendants, 16 were reversed in favour of plaintiffs, and all the partial wins were handed to the plaintiffs. In 12 of the 13 cases in which the appellate court reversed a pro-plaintiff decision, the apex court returned a verdict in favour of the plaintiffs. In the final analysis, the plaintiffs ended up with an 82% success rate in respect of cases brought before the apex court—a much higher success rate than at the initial trials.[99]

7.2.3 India's Jurisprudence

As noted in Section 7.1.2, health rights in India have emerged from a position of non-justiciability to a position where they are now routinely cited among the fundamental rights protected by the *Constitution of India*.[100] This dramatic shift in the treatment of health rights has occurred because of activists' stance towards India's courts—particularly its Supreme Court—which has enabled the recognition of the right to health as a justiciable right. The jurisprudence that has emerged in this area has focused on responding to the inadequacies of public health policies and infrastructure.[101] However, this has not been the sole focus of health rights litigation. A sampling of 218 health rights cases reviewed by Parmar and Wahi, show that 24% of the cases involved medical negligence claims; 18% dealt with medical malpractice regulation; 13% concerned drugs regulation and provision; 11.5% dealt with environmental health; 10% concerned workers' reimbursements; 10% involved the delivery of public health services; 7.4% placed into the category 'others' dealt mostly with cases on assisted suicide; 6.5% focused on HIV/AIDS; 5% involved mental health; and 4.6% involved issues of reproductive rights.[102] This broad spectrum covered by India's jurisprudence gives a sense of the extent of health rights litigation in India.

Many of these cases have been used to influence policy changes at various levels. In one case, the Medical Council of India was directed by the Supreme Court to set up a formalised mechanism for hearing patient complaints concerning medical negligence.[103] After this decision, the council initiated the process of formulating guidelines for

---

98 Ibid.
99 Ibid.
100 *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India).
101 Parmar and Wahi, above n 48, 164.
102 Ibid 169.
103 *Ganguly v Medical Council of India* W. P. (C) No. 317 of 2000 (Supreme Court of India); see also *Mathew v State of Punjab*(2005) 6 SCC 1 (Supreme Court of India) – a case involving guidelines for medical professionals regarding criminal negligence.

investigating cases of medical negligence.[104] In another case affirming the right to food under the right to life, the Supreme Court empowered village administration bodies (called *gram sabhas*) to monitor the distribution of food supplies under a public distribution scheme, and set up a grievance redress mechanism.[105]

7.2.4 South Africa's Jurisprudence

In Section 7.1.2, it emerged that three main areas have been the focus of South Africa's health rights jurisprudence: policy gap claims; regulatory gap claims; and implementation gap claims. Because of the complexity and financial resources required to litigate these cases, the majority of these claims are prosecuted by public interest bodies with the financial resources and technical expertise required to prosecute them to their logical conclusion.[106] Thus, in a sampling of 19 health rights cases reviewed by Cooper, most were said to have been brought by public interest bodies; only three were brought by individuals.[107] A brief review of some of these cases provides a sense of South Africa's jurisprudence on the right to health.

(a) *Policy gap claims*. An early policy gap claim was the case *Biljoen v Minister of Correctional Services.*[108] This claim sought the provision of HIV anti-retroviral vaccines (ARV) to four prisoners (two of whom had already been prescribed treatment) pursuant to the constitutional right of detained persons to the provision of adequate medical treatment at state's expense.[109] The Cape High Court ordered the state to provide ARV treatment to the two prisoners for whom treatment had already been prescribed, noting that 'adequate medical treatment' in this case was not defined by availability in the public health system, and the state had not proved that the treatment was unaffordable. This decision was able to address a gap in policy on whether the constitutional right to adequate medical treatment extended to prisoners. The court held that it did.

In *Soobramoney v Minister of Health, KwaZulu-Natal*,[110] the claim concerned the refusal to provide medical treatment (namely renal dialysis), which was being contested as infringing the constitutional right to emergency medical treatment.[111] The Constitutional

---

[104] From the Press, 'Guidelines on Investigating Medical Negligence' (2003) 11(4) *Indian Journal of Medical Ethics* 106.
[105] *People's Union for Civil Liberties (PUCL) v Union of India and Others,* W. P. (C) No. 196 of 2001.
[106] Cooper, above n 59, 193.
[107] Ibid.
[108] *Biljoen v Minister of Correctional Services* [1997] 4 SA 441 (High Court).
[109] *Constitution of South Africa 1996*, s 35(2)(e).
[110] *Soobramoney v Minister of Health KwaZulu-Natal* [1998] 1 SA 765 (Constitutional Court).
[111] *Constitution of South Africa 1996*, ss 27(3) and 11.

Court found the policy rationale denying treatment to be fair given resource constraints; granting the claim could undermine the general provision of health services. The decision was important in clarifying the policy around the right to healthcare services when public interest is in competition with individual need. The court clarified that public interest may trump individual need.

(b) *Regulatory gap claims*. *Tau v GlaxoSmithKline*[112] was a claim for lowering ARV prices on the grounds that existing prices led to premature, predictable and avoidable deaths. The complaint was brought under the *Competition Act*[113] but was withdrawn when companies acceded to the demand in December 2003. Afterwards, the market became open to generic ARV medicines, reducing prices in public and private sectors. Although the case did not achieve final determination by the courts, the litigation process was able to provide an impetus for the resolution of the policy issues surrounding the availability of generic ARV medicines to the public.

Affordable Medicines Trust v Minister of Health[114] concerned an action for a declaration that regulations regarding licensing requirements for doctors and nurses to prescribe medicines were ultra vires the *Medicines and Related Substances Control Act 1965* (South Africa).[115] It was brought pursuant to the constitutional right to choose one's profession,[116] freedom of movement[117] and dignity.[118] Although most of the claims were struck down, the regulation hampering health care providers' ability to dispense medicines was also struck down, thereby creating greater access to medicines by facilitating dispensing by doctors and nurses. This decision was important for reshaping the policy surrounding access to medicine.

(c) *Implementation gap claims*. In *Minister of Health and Welfare v Woodcarb Pty Ltd*[119] an order was sought prohibiting the respondent from continuing with polluting activities without a certificate. The action was brought pursuant to the *Atmospheric Pollution Prevention Act 1965* (South Africa)[120] and the constitutional right to an environment not harmful to health.[121] The Natal Provincial Division Court granted an

---

112 *Tau v GlaxoSmithKline* Case No. 2002Sep226 (Competition Commission).
113 *Competition Act 89 of 1998*, ss 49B(2)(b) and 8(a).
114 *Affordable Medicines Trust v Minister of Health* [2005] 6 BCLR 529 (Constitutional Court).
115 *Medicines and Related Substances Control Act 1965* (South Africa).
116 *Constitution of South Africa 1996*, s 22.
117 Ibid s 21.
118 Ibid s 10.
119 *Minister of Health and Welfare v Woodcarb Pty Ltd* [1996] 3 SA 155 (Provincial Division).
120 *Atmospheric Pollution Prevention Act 1965* (South Africa).
121 *Constitution of South Africa 1996*, s 24(a).

interdict prohibiting respondents from continuing with the pollution activities. The decision gave impetus to the enforcement of an existing constitutional right and legislative policy on the environment.

In summary, the literature and jurisprudence on health rights litigation in Nigeria and the comparators reveal that the courts in Nigeria have not been actively engaged with the litigation of the right to health, and this can principally be explained with reference to the constitutional prohibition on the justiciability of economic and social rights provisions in Chapter II of the *Constitution of Nigeria.* Brazil, on the other hand, is noted to have a thriving and energetic experience with the litigation of the right to health in view of very liberal standing rules that allow individualised remedies to be sought and obtained against violations and/or threatened violations of the right to health. In India, the discussion shows that an activist Indian Supreme Court has brought about the litigation of the right to health through the interpretation of non-justiciable economic and social rights provisions in line with the fundamental rights guarantee of the constitution.

7.3 Taxonomy on the Effect of Judicialisation of the Right to Health

The discussion in Section 7.1 is the basis for the hypothesis that when courts engage with the right to health through the judicial process, they are either *enabling* the right, *amplifying* the right, *impeding* the right or being *ambivalent* towards the right. Because judicial involvement with the right to health may sometimes produce more than one of these outcomes in a particular state, our understanding of the judicialisation process can be complicated. Nonetheless, it is argued that the discussion in Section 7.2 demonstrates that the effect of the judicialisation of the right to health in Nigeria and the comparators can be organised on the basis of the above taxonomy. It is further argued that this taxonomy simplifies some of the complexities surrounding the discourse in this area, thereby providing a basis for Nigeria and the comparators to engage more meaningfully with the judicialisation of the right to health.

7.3.1 The Courts as Enabling the Right to Health

Courts enable the right to health within the meaning of our taxonomy when their decisions serve as a basis for the recognition of an enforceable right to health in the absence of adequate constitutional, policy and/or legislative guarantees of the right. Courts that can potentially act as enablers of the right to health require a favourable predisposition to judicial activism and the ability to withstand the inevitable criticisms that attend such predisposition. The value of a court that *enables* the right to health is best appreciated in

political settings where other branches of government have taken a backseat in initiating and/or implementing policies and legislation that recognise and protect the right to health. The Supreme Court of India is an example of a court that has enabled the right to health. This conclusion is informed by the discussion in Section 7.2.3. This is because despite the non-recognition of a justiciable right to health by the *Constitution of India*,[122] the Supreme Court of India has gradually advanced the recognition of that right through a series of decisions that have moved the right to health from a position of non-justiciability to one where it is now routinely cited among the fundamental rights protected under the *Constitution of India*.[123]

7.3.2 The Courts as Amplifying the Right to Health

Courts amplify the right to health according to our taxonomy when their decisions serve as a basis for strengthening and giving effect to existing constitutional and/or legislative guarantees of this right. The amplifying process requires courts to be actively involved in strengthening the enforcement regime of the right to health by balancing competing interests in society and establishing the best way to bring about the fulfilment of the right in the light of these competing interests. Ideally, the context where this occurs is one in which there is no dispute about the justiciability of the right to health; and where the focus of the court is on how best to mediate competing demands on scarce state resources. This is not to suggest that the amplifying process cannot also occur in other settings: for instance, India's formal acceptance of the right to health—although without constitutional or legislative guarantees of the right to health; rather via the judicialisation process—has saddled the courts with the responsibility of balancing competing interests in strengthening its uptake in India. South Africa, on the other hand, is a prime example of where courts are amplifying the right to health. As the discussion in Section 7.2.4 shows, the courts in South Africa have done a lot in addressing policy, regulatory and implementation gap claims. This has gone a long way in strengthening the jurisprudence of the right to health in South Africa.

7.3.3 The Courts as Impeding the Right to Health

According to our taxonomy, courts impede the right to health when their decisions do not take account of the best way to balance competing interests of other stakeholders in society. Admittedly, value judgments are involved in assessing whether an approach

[122] *Constitution of India*, art 37.
[123] *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India).

taken by a court in a particular case is the best way to resolve the dispute. However, because of the complexities involved in litigating claims about the right to health, such value judgments inevitably arise as a consequence of the *means–ends* debate about the allocation of scarce resources to address public health needs. There is thus a pressing need for courts to avoid deontological forms of reasoning and valuation, under which the only considerations taken into account by the courts are those of the applicants before them, relevant laws and constitutional texts, and their own predispositions.[124] Courts ought rather to embrace aggregative/utilitarian logic where judicial decisions take into account infrastructural limitations, anticipate legislative and executive priorities, and engage other stakeholders in an ongoing dialogue on how best to respect, protect and fulfil the right to health.[125] Brazil is an example of a state where the courts are argued to be impeding the right to health. Although the Brazilian courts are no doubt doing a fine job of interpreting and enforcing the constitutional guarantees of the right to health and a plethora of legislative instruments protecting that right, they are yet to elevate a judicial policy where individualism does not frequently trump the interests of the collective. This has opened up the Brazilian courts to many criticisms[126] and left behind an unconvincing account of their efforts to promote health equity in Brazil. To be clear, although this thesis does not claim that giving effect to individual claims on the right to health is wrong, such claims have to be weighed against the larger collective interests of ensuring equity in the health system. The South African example in a case like *Soobramoney v Minister of Health KwaZulu-Natal*[127] is a salient one of how courts can weigh up competing interests to ensure that individual interests do not always trump the interest of the collective.

Another dimension to this issue arises in the context of the view advanced by some scholars that many of those who use the courts to secure claims about their right to health are not necessarily the most disadvantaged in society.[128] It is fair to assume that if a person has the means to access the courts despite the expense of the litigation process, this places them above a certain level of desperation that urgent public health interventions are required to address. As such, many of those who explore the option of litigation to secure

---

[124] See Varun Gauri and Daniel M. Brinks, 'Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights' in Varun Gauri and Daniel M. Brinks (eds), *Court Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008) 5.

[125] Ibid.

[126] See Ferraz, above n 36.

[127] *Soobramoney v Minister of Health KwaZulu-Natal* [1998] 1 SA 765 (Constitutional Court).

[128] This is a thematic concern that is evident in the edited volume by Gauri and Brinks, above n 5.

their right to health may appropriately be regarded as belonging to the class of elites in society.

7.3.4 The Courts as Ambivalent Towards the Right to Health

Courts demonstrate ambivalence towards the right to health, within the meaning of our taxonomy, when their decisions avoid firm commitments that protect the right to health. An ambivalent court may not directly declare that it will not enforce the right to health; on the other hand, its decision will not demonstrate a commitment to clarifying what that right means and how it can be respected, protected and fulfilled. Courts inclined to ambivalence towards the right to health are usually aided by constitutional provisions that declare economic and social rights to be non-justiciable; the absence of legislation that protects the right to health; and the unwillingness of other branches of government to take responsible actions to protect the right. The difficulty with the ambivalent court is that it does not declare outright that it will not protect the right to health; rather through the adoption of tenuous distinctions and all manner of exclusionary rules (including rules as to standing),[129] it creates a situation where the right to health has no practical meaning in the sense that it is able to be the basis for demands to be made of state institutions to observe, respect and give effect to the right.[130] In extreme cases, the ambivalent court may refuse to act even when there are legitimate bases for it to do so, such as where a treaty that protects the right to health has been incorporated into the domestic legal system by the other branches of government. Nigeria is a prime example of where the courts are ambivalent towards the right to health. This position is informed by the discussion in Section 7.2.1. A further diagnosis suggests that Nigeria is an extreme case of ambivalence towards the right to health (and other social and economic rights). This is because despite the incorporation of the African Charter into Nigeria's domestic law, the Supreme Court of Nigeria has quarantined that treaty by declaring that the incorporating statute stands on its own, subordinate to the constitutional regime, which treats social and economic rights as non-justiciable.[131]

In Section 7.1, the objective of this chapter was stated as substantiating the hypothesis that when courts engage with the right to health in the judicialisation process, they are

---

[129] Chidi Anselm Odinkalu, 'The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights' in Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008) 218.

[130] See the discussion in Sections 5.1.3 and 5.1.4 on the meaningfulness of the right to health arising only when it is being observed, respected and given effect in a state.

[131] *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

either enabling, amplifying, impeding or being ambivalent towards the right. In this section, the contours of this taxonomy were mapped out and examined in relation to Nigeria and the comparators, contextualised by discussion in Sections 7.1 (on the literature) and 7.2 (on the jurisprudence) of the right to health in these states. In the process of substantiating this taxonomy, only one state was used to illustrate each of the four categories in the taxonomy. What is noteworthy about this discussion is that the examples provided merely suggest that the state in question is an ideal descriptor of the elements of the category in question; it does not suggest that other categories in the taxonomy may not also manifest in these states. As such, although India's higher courts were identified as enabling the right to health, it is also possible that in some cases the courts in India have impeded or been ambivalent towards the right to health; the same principle applies to the discussion about the other countries.

7.4 Conclusion

In conclusion, the findings of this chapter are that when courts engage with the right to health through the litigation process, they end up either enabling the right, amplifying the right, impeding the right or being ambivalent towards the right. On the basis of this taxonomy, this chapter has found that it is possible to better understand the outcomes that are being experienced in the domestic system of Nigeria and the comparators as a result of the judicialisation of the right to health. Nigeria, Brazil, India and South Africa were found to illustrate each of these possible outcomes in their encounter with health rights litigation.

It was also observed that the categories of this taxonomy are not mutually exclusive: it is possible for a state that is amplifying the right to health in one breath to also be impeding the right in another. By the same token, it is possible for a state that is ambivalent towards the right to health, to also be enabling the right. The chapter has found that when this overlapping occurs, it complicates our understanding of the effect of the judicialisation process. Nonetheless, the chapter has argued that awareness of this likely outcome is necessary for engaging meaningfully with health rights litigation to advance the campaign for public health.

In the specific context of how Nigeria and the comparators have engaged with the judicialisation of the right to health, the chapter has found that in varying ways, India and South Africa have achieved better outcomes than Brazil and Nigeria. In the case of Brazil, the findings show that although individuals are easily securing remedies for violations (or

threatened violations) of their right to health, the inability of the courts to balance these remedies against the needs of the public to achieve an equitable distribution of scarce health resources has proven to be an impediment to the attainments of the broad objectives of the right to health—namely, securing better health outcomes for everyone where practicable. With respect to Nigeria, the reluctance of the courts to give effect to the right to health on the basis of restrictive constitutional provisions is argued to be a drawback for Nigeria's jurisprudence on the right to health.

In suggesting areas for improvement by Nigeria to achieve better outcomes in the judicialisation of the right to health, recommendations are made in Chapter 8 for a liberal interpretation of rules of standing and extending them to the enforcement of economic and social rights under the constitution*;* giving more robust effect to the African Charter Act that incorporates the right to health into Nigerian law; interpreting fundamental rights provisions in the constitution to give effect to economic and social rights; paying special attention to the effect of health right litigation on the health and legal systems to ensure they are only enabling and amplifying the right to health, not impeding or being ambivalent towards the right; and considering the equity effects of the judicialisation of the right to health when handing down decisions that influence that right.

CHAPTER 8: CONCLUSION

8.0 Introduction

This thesis has examined how the peripheral position of health in Nigeria and the poor engagement with the right to health—at the international, constitutional, policy and legislative, and judicial levels—might explain why the health system of Nigeria is experiencing poor health outcomes. Across seven chapters, the thesis has examined how the right to health, viewed as a set of legal positions to universal health coverage, can serve as the framework for transforming the health system of Nigeria to achieve better health outcomes. In developing this hypothesis, the thesis engaged with three comparators—Brazil, India and South Africa—the choice of which was explained in Section 3.1 as involving considerations of demographic, political, geo-political, economic, legal and institutional factors. In concluding the thesis, this chapter sets out to achieve two objectives: first, to summarise the key findings, highlighting the contribution to knowledge; and second, to recommend what can be done to transform the health system of Nigeria, through the right to health, to achieve better health outcomes.

8.1 Summary

The claim that health generally, and the right to health in particular, lies at the fringe of the domestic legal system of Nigeria is the central idea that informs the work undertaken in this thesis. A further dimension to this claim is that the poor health outcomes being experienced in Nigeria can be traced back to the poor treatment of health and the right to health in the legal system. The scholarly literature, data sets, international treaties, constitutions, legislation and policies, and other documents analysed in the thesis were used to substantiate this claim. The choice of Brazil, India and South Africa as the comparators of Nigeria (in addition to the rationale provided in Section 3.1) aimed to offer a range of perspectives for evaluating this claim.

The international, constitutional, policy and legislative, and judicial contexts were identified as the main legal sites that were consequential to the health system of Nigeria and the comparators. Consequently, the discussion following the first three foundational chapters examined how the actions and inactions of Nigeria and the comparators in these four contexts contributed to the health outcomes experienced in their health systems. To enable this assessment, Chapter 3 presented data derived from the WHO and other relevant international institutions on 17 health indicators widely used for making broad

country comparisons of health systems.[1] The outcomes experienced by Nigeria and the comparators across these indicators served as a reference point for the discussion that followed in Chapters 4–7 dealing respectively with the international, constitutional, policy and legislative, and judicial contexts of the right to health. In keeping with this thematic organisation, the findings presented in this section are organised in line with these four thematic areas and chapters.

8.1.1 Findings from the International Context

Chapter 4 advanced the claim of a strong correlation between the domestic commitment of Nigeria and the comparators to the right to health and their engagement and response to obligations they have assumed in respect of that right in the international treaty framework.[2] In substantiating this claim, the chapter examined the engagement and compliance of Nigeria and the comparators with the UPR mechanism of the Human Rights Council; treaty-based bodies on health; and regional human rights mechanisms of the AU System and the Inter-American System.

Chapter 4 found that Brazil and South Africa were more engaged with the UPR mechanism than Nigeria and India.[3] The relative strength of Brazil and South Africa's engagement lay in their:

- maintaining a standing invitation for special procedures, whereas Nigeria and India had failed to do so;
- responding to more communications than Nigeria and India. These communications comprised letters of communications and urgent appeals sent to the Human Rights Council by individuals and groups with respect to violations of human rights by organs of state; and

---

1 See Section 3.3.

2 In Chapter 1, this was identified as referring to *Constitution of the World Health Organization* Preamble, 62 Stat. 2697, 14 U.N.T.S. 185 (22 July 1946); *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) art 25; *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976) (ICESCR) art 12; *Convention on the Elimination of All Forms of Discrimination Against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) (CEDAW) art 12; *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) (CRC) art 24; *African (Banjul) Charter on Human and Peoples' Rights,* opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986) (African Charter) art 16; *American Declaration of the Rights and Duties of Man, (*adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948) art XI; and *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador',* opened for signature 17 November 1988, 69 OASTS (entered into force 16 November 1999) art 10.

3 See details of this finding in Section 4.1.9.1.

- responding to questionnaires on thematic issues, whereas Nigeria and India had failed to respond to any.[4]

A further dimension to the findings in Chapter 4 involved the performance of Nigeria and the comparators at the two Universal Periodic Review (UPR) cycles of the Human Rights Council in which they have so far participated. Section 4.1.9.2 showed that during the UPR cycles:

- right to health concerns were raised with respect to Nigeria, India and South Africa—only Brazil did not have such concerns raised during its UPR cycles;
- although health disparities were found in all four countries, those of Nigeria and India were more marked than those of Brazil and South Africa;
- although all countries had institutionally induced barriers to achieving the right to health, only Nigeria faced widespread corruption and mismanagement of the annual budget of the federal, state and local governments as an institutional barrier;
- while Brazil and South Africa were found to have robust laws in their domestic systems for promoting the right to health, the same could not be said of Nigeria and India; and
- there were more shortcomings to achieving the right to health in Nigeria and India than in Brazil and South Africa.[5]

With respect to the engagement with treaty bodies responsible for the relevant international treaties on the right to health,[6] it was found that the reporting behaviour of Nigeria and the comparators was not informative about their commitment to the right to health because all four countries were either behind in the submission of their periodic reports to the treaty bodies; or had developed the habit of submitting a single report titled the 'combined periodic report', to cover for missing years when no report was submitted.[7]

In the consideration of the engagement with regional human rights systems that promoted the right to health, only Nigeria and South Africa (with respect to the AU System); and Brazil (with respect to the Inter-American System) were discussed. India was omitted because it is not part of any regional human rights system. The findings in this regard were that:

---

4 See Table 4.1.
5 See Table 4.2.
6 The treaty bodies considered in this regard are the Committee on Economic Social and Cultural Rights (CESCR); the CEDAW Committee; and the Child Rights Convention Committee (CRC Committee).
7 See Section 4.1.9.

- in terms of robustness and sophistication of the instruments and mechanisms for monitoring the human rights behaviour of states, the Inter-America System is better positioned than the AU System;
- Brazil was found to be more engaged with the Inter-American System than were Nigeria and South Africa with the AU System; and
- to the extent that these states were engaged with regional mechanisms for the protection of human rights norms, it was found that these mechanisms provided an additional layer of support for the advancement of the objectives of the right to health.[8]

Overall, Chapter 4 found that Brazil and South Africa had better records than Nigeria and India in demonstrating domestic commitment to the right to health. By the same measure, Brazil and South Africa had better records of engagement and compliance with the right to health obligations they had assumed in the treaty framework than Nigeria and India.[9]

8.1.2 Findings from the Constitutional Context

Chapter 5 advanced the claim that on account of two significant effects of constitutional rights norms, they define the corresponding situation of legal positions on the right to health in the legal system of Nigeria and the comparators. These effects were identified as (a) the way constitutional rights norms influence the legal system by affecting the legal relationships between the state and individuals in the form of rights against the legislature, executive and judiciary; and (b) the radiating effect that constitutional rights norms have on the entire legal system of these states by appealing to the concept of an objective order of values that applies to all areas of law and provides guidelines and impulses for the legislature, executive, judiciary and domestic social actors.

In accordance with the scholarly literature, Chapter 5 found that the deontic modes of *commands*, *permissions* and *prohibitions* were useful categories for establishing the presence of constitutional rights norms on health.[10] Thus, if a constitution has commanded, permitted or prohibited an act involving the right to health, this could be construed as a constitutional rights norm on health. However, Chapter 5 identified difficulties in the use of this criterion to identify the presence of a constitutional rights norm on health in the *Constitution of Nigeria* and the comparators without referring to

---

8 See Section 4.4.3.

9 See Section 4.4.

10 See Section 5.1.3; see also Robert Alexy, *A Theory of Constitutional Rights* (Julian Rivers trans, Oxford University Press, 2002) 22; Georg Henrik Von Wright, *Norm and Action: A Logical Enquiry* (Routledge and Kegan Paul, 1963) 102.

the written provisions in the constitution of these states. In resolving this difficulty, Chapter 5 developed a test to the effect that consideration should be given to whether state organs and other actors in the state are *observing*, *respecting* and *giving effect* to the supposed norm on the right to health;[11] if that is the case, then the norm in question is a constitutional rights norm on health; if the opposite is the case, then it was not a constitutional rights norm on health, notwithstanding a contrary assertion in the constitution.[12] Chapter 5 argued that the usefulness of these criteria was to provide a way for distinguishing constitutional rights norms on health that were *meaningful* because they were being observed, respected and given effect by state organs and other actors; or were *meaningless* because these responses were not being accorded to the norm.[13] Chapter 5 found that:

- Brazil, India and South Africa have meaningful constitutional rights norms on health because state organs and other actors were observing, respecting and giving effect to constitutional provisions guaranteeing the right to health;
- in the case of India, despite the provision in the *Constitution of India* declaring economic and social rights to be non-justiciable,[14] the Supreme Court of India has given meaning to the right through its interpretation of the *Constitution of India*;[15] and
- state organs and other actors in Nigeria were not observing, respecting and giving effect to constitutional rights norms on health due to the provision in the *Constitution of Nigeria* that economic and social rights are non-justiciable.[16]

With respect to the rights that constitutional rights norms have created against the legislature, Chapter 5 found two considerations to be determinative: the availability of normative expressions of the right to health in the constitutions of Nigeria and the comparators; and the manner in which legislative responsibility for health has been allocated in these constitutions. Chapter 5 found that:

- Brazil and South Africa have more robust constitutional rights norms on health than India and Nigeria;
- in Brazil and South Africa, health is the joint responsibility of all tiers of government, whereas in India, it is the responsibility of the states alone and this is problematic because it excludes the Union government of India from the national health system;

---

11 Scholarly support for this test was found in the argument by Robert Alexy that 'one can tell that a statement…expresses a norm…from the context.' See Alexy, above n 10, 23.
12 See Section 5.1.4.
13 Ibid.
14 *Constitution of India*, s 37.
15 See the discussion in Section 7.1.2.
16 See Section 5.1.4.

- Nigeria has a confusing constitutional setup on health responsibility. First, local government councils are the only tier of government with direct constitutional responsibility to provide and maintain health services;[17] second, the federal government has exclusive legislative power to promote and enforce Chapter II rights of the *Constitution of Nigeria*;[18] and third, state governments have residual legislative authority to provide for the functions of local government councils (including health functions).[19]
- the setup in Brazil and South Africa is more beneficial for the right to health than the setup in Nigeria and India; and
- the setup in Nigeria was ineffective as it conferred primary responsibility for health on the local government (the least funded tier of government),[20] while vesting legislative responsibility for health in state governments.[21]

Chapter 5 identified the *Mandado de Segurança* (writ of mandamus) under art 5(LXIX) of the *Constitution of Brazil* as a right right against the executive. The right entitles individuals to seek judicial protection against the executive or its agents. With respect to South Africa, the right to just administrative action in the *Bill of Rights* of South Africa's constitution was identified as a right right against the executive.[22] No similar right was identified in the Nigerian or Indian constitutions.

Chapter 5 also identified a number of rights against the judiciary in the constitutions of the comparators, but found no such right in *Constitution of Nigeria*.[23] These rights include:

- the provision in art 5(XXXV) of the *Constitution of* Brazil that no law should exclude any injury from the consideration of the judiciary;
- with respect to South Africa, the right to fair hearing in s 34 of the *Constitution of South Africa*; and
- the right to constitutional remedies in art 32 of the *Constitution of India*.

---

17 See *Constitution of Nigeria 1999*, Fourth Schedule, s 2(c).

18 Ibid Second Schedule, Part I, Item 60(a).

19 Ibid Fourth Schedule, s 2(c) and s 7(1); and Second Schedule, Part I, item 60(a).

20 The funding in question is based on what the local governments are by law entitled to from the Federation Account of Nigeria. See *Allocation of Revenue (Federation Account, Etc.) Act 1982* (Nigeria) s 1.

21 See Section 5.2.1.2.

22 *Constitution of South Africa 1996*, s 33(1) and (2); see also David Bilchitz et al, *Assessing the Performance of the South African Constitution* (International Institute for Democracy and Electoral Assistance, 2016).

23 The right to fair hearing in s 36(1) *Constitution of Nigeria 1999* was found to be excluded from the economic and social rights provisions in Chapter II of the *Constitution* by s 6(6)(c).

Finally, Chapter 5 found that the argument that constitutional rights norms have a *radiating effect* that provides *guidelines* and *impulses* that influence the actions of the three branches of government was particularly true for Brazil and South Africa. In those states such impulses have been provided:

- to the legislative branch to enact robust laws that give further expression to constitutional guarantees on the right to health;[24]
- to the executive branch to adopt a plethora of policies that give further effect to the right to health;[25] and
- to the courts to pronounce more willingly against violations of the right to health.[26]

The context of India was, however, identified as defying the logic of this argument. This is because despite the absence of the right impulse from the *Constitution of India,* the Indian Supreme Court still gives effect to the right to health. It was thus argued that the Indian context stands as an example of how a proactive and determined judicial branch can still find the right set of impulses and guidelines from a weak constitutional rights normative framework on health, if it is determined to ensure that human rights norms on health are given effect in the country.

Chapter 5 also found that domestic social actors can leverage these impulses and guidelines from the constitution to ground their activism for the fulfilment of the right to health. However, they are not constrained by the absence of such impulses and guidelines because they can push for new constitutional rights norms to emerge in the absence of one. Overall, Chapter 5 showed that Brazil, South Africa and to some extent India, were better situated than Nigeria in the constitutional context in giving effect to the right to health as a set of legal positions to universal health coverage.

8.1.3 Findings from the Policy and Legislative Context

Chapter 6 argued that we can assess the commitment of Nigeria and the comparators to advancing legal positions on the right to health by considering their preferences when promulgating policies and legislation that affect the right to health. Three considerations where identified as relevant to this assessment: (a) whether a preference has been shown for hard law instruments such as legislation, as opposed to soft law instruments such as policy, when adopting measures that affect the right to health; (b) whether the protection of the right to health in policy and/or legislation gives further expression to constitutional

---

24 See Tables 6.2 and 6.4.
25 See Section 6.1.2 and 6.1.4.
26 See Chapter 7.

rights norms on health; and (c) whether clear arrangements, preferably by legislation, have been made for financing the health system. The chapter found that:

- Brazil and South Africa have shown a greater preference for legislation to guarantee a number of important underlying determinants of health, whereas Nigeria and India have relied on policy instruments that lack legislative backing;[27]
- Brazil and South Africa have done more than Nigeria and India to give effect to the right to health in their domestic legal systems by promulgating a robust range of legislative instruments that give further expression to constitutional rights norms on health;[28] and
- Brazil and South Africa have performed better than Nigeria and India by putting in place robust financing mechanisms for the health system.[29]

The policy and legislative context thus confirmed that Brazil and South Africa were performing better than Nigeria and India in advancing legal positions on the right to health by giving legislative backing to measures that affected underlying determinants of health.

8.1.4 Findings from the Judicial Context

Chapter 7 examined the *equity impact* of health rights litigation. In response to the difficulty arising from the assessment of the equity impact of health rights litigation (highlighted by the literature[30]and jurisprudence[31]), Chapter 7 developed a taxonomy that could help in understanding this impact. According to this taxonomy, when courts engage with the right to health through the litigation process, one of four outcomes are likely to result: the courts may enable, amplify, impede or remain ambivalent towards the right to health.

The chapter argued that more than one of these outcomes may manifest in a state and thereby complicate our understanding of the judicialisation process. The chapter found that:

- in Nigeria, the courts have been ambivalent in their engagement with the right to health in the litigation process because of their reluctance to clarify the status of economic and social rights in the country;[32]

---

27 See Section 6.1.
28 See Tables 6.2 and 6.4, respectively.
29 See Section 6.3.
30 See for example Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011).
31 See Section 7.2.
32 See Section 7.2.1.

- in Brazil, the courts have impeded the right to health by failing to strike a balance between the competing needs of the public health system and the multitude of individual claimants who make demands on it for scarce resources to fund expensive medical treatments;[33]
- in India, the courts have enabled the right to health through activism that has elevated the right from a status of non-justiciability to one where it is widely regarded as one of the fundamental rights guaranteed by the *Constitution of India*;[34] and
- in South Africa, the courts have amplified the right to health through decisions that have illuminated the constitutional guarantees of the right.[35]

The chapter argued that the outcomes of India and South Africa were more positive than those of Brazil and Nigeria. The chapter also acknowledged that to the extent that the courts in Brazil were giving individualised remedies for violations of the right to health, the Brazilian outcome was preferable to that of Nigeria.[36]

* * *

In summary, across all four thematic areas covered by this thesis, Brazil and South Africa were found to have performed better than Nigeria; while with respect to India, they had performed better only in the first three (the international, constitutional, and policy and legislative contexts). When this finding is contextualised by the health outcomes discussed in Section 3.3, showing that across 17 health indicators Brazil and South Africa also perform better than Nigeria and India, there is a firm basis to believe that this is more than coincidence. Regard has to be given to how the differing treatments of the right to health in each country has had significant effects on their health outcomes.

It is for this reason that this thesis claims that if the right to health, understood as a set of legal positions to universal health coverage, is implemented in Nigeria—by means of compliance and engagement with the relevant international treaty framework, constitutional entrenchment, legislation and policy, and judicial enforcement, driven by domestic social activism—then better health outcomes are likely to result.

---

33 See Section 7.2.2.
34 See Section 7.2.3; see also *Reddy v Revamma* AIR 2007 SC 1753 (Supreme Court of India).
35 See Section 7.2.4.
36 See Section 7.3.3.

8.2 Recommendations: a Blue Print for Transforming the Health System of Nigeria through the Right to Health

In line with the hypothesis and the findings summarised in Section 8.1, the following recommendations are offered as a *blueprint* for the transformation of the health system of Nigeria to achieve better health outcomes.

8.2.1 Recommendations for the International Context

In the international context, the following recommendations are made to Nigeria on how it can become better engaged with the institutions and human rights monitoring processes. The recommendations also highlight possible benefits for Nigeria in the bid to strengthen legal positions on the right to health in the country.

Nigeria should become more engaged with the instruments and mechanisms of the UPR system. The benefits of this engagement are likely to flow down to the domestic system where state organs in Nigeria will be able to draw from Nigeria's involvement at the international level to advance the protection of the right to health in the domestic system. Another potential benefit is that domestic social actors are able to become involved (both at the international level and in the domestic system) in pushing for the advancement of legal positions on the right to health in Nigeria.

Through its involvement with the instruments and mechanisms of the UPR system, Nigeria can draw attention to the most critical areas of health needs in its domestic system, and push for more global action, involving financial and technical assistance, to enable it to meet these health needs.

Nigeria should step up its involvement with the treaty-based system. The country is already doing this in the context of the CEDAW Committee, to which it has not only submitted all outstanding periodic reports but whose proceedings it has consistently attended with a high-powered government delegation to defend its reports and activities in promoting the rights of women in the country. In addition, domestic social actors have actively engaged with this process by submitting 'shadow reports' that offer alternative critical accounts of what is happening on the ground in terms of issues affecting the rights of women in Nigeria. Unfortunately, this kind of engagement is lacking in the context of the Committee on Economic, Social and Cultural Rights (CESCR) where Nigeria has submitted only its initial report (in 1996) since it ratified the *International Covenenat on Economic, Social and Cultural Rights* (ICESCR) on 29 July 1993. Nigeria currently has four periodic reports to submit to the CESCR. This is not a good development for legal

positions on the right to health because the ICESCR is the leading treaty protecting the right to health in international law.

Finally, while there may be limitations to what the AU System can offer Nigeria on account of shortcomings in that regional human rights system, it is suggested that benefits can still flow to Nigeria from the jurisprudence of the African Court. As such, Nigeria should accept the contentious jurisdiction of the African Court as this will open up another avenue for strengthening legal positions on the right to health in the country.

8.2.2 Recommendations for the Constitutional Context

The following recommendations are made for the constitutional context, where Nigeria has been identified to be poorly situated.

Bearing in mind that the normative framework on health offered by the *Constitution of Nigeria* significantly affects other domains in the legal system of Nigeria, the normative expression of the right to health in the constitution needs to be seriously strengthened in a manner that results in the robust expression of the right to health. In strengthening this framework, more areas of health need to be captured as rights in the constitution; and responsibility for the provision and maintenance of health services should be jointly shared by the federal, state and local governments in the country.

While it is important to amend the *Constitution of Nigeria,* more attention should also be paid to whether the right to health is being observed, respected and/or given effect by state organs and other actors in Nigeria.

Keeping in mind difficulties with bringing about amendments to Nigeria's federal constitution, there is an important role to be played by Nigeria's Supreme Court in strengthening legal positions on the right to health in the country. The court can utilise extant normative expressions of the right to health in Nigeria's constitutional rights framework, emulating the Indian Supreme Court, to find Chapter II rights enforceable through Chapter IV rights. The court can also reverse its position in *Abacha v Fawehinmi*[37] by finding that the rights contained in the African Charter, which are part of Nigeria's domestic law, have the same 'force and vigour', as constitutional rights.

Finally, domestic social actors in Nigeria need to realise that constitutional rights norms do not need expression in the *Constitution of Nigeria* before they can emerge. The

[37] *Abacha v Fawehinmi* [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria).

emergence of these norms can be the result of the activism of domestic social actors. As such, these actors should actively push for state organs (in the legislative, executive and judicial spheres of government) to observe, respect and/or give effect to norms that advance the right to health in Nigeria.

8.2.3 Recommendations for the Policy and Legislative Context

In the policy and legislative context, where Nigeria has not been inclined to adopt legislative measures that codify the policy of the country on important underlying determinants of health, it is recommended that Nigeria should begin to do so. It is also recommended that Nigeria should consider setting up a more robust system for the financing of the health system by the state and the Nigerian population. One way of doing this is to clearly spell out how the health system is to be funded, either through appropriate constitutional amendment or by promulgating legislation to that effect. In addition, the existing framework of health insurance needs to be strengthened to ensure it brings about universal health coverage in the country.

8.2.4 Recommendations for the Judicial Context

The following recommendations are advanced for the judicial context, where the courts in Nigeria have been identified as ambivalent towards the right to health.

The courts need to adopt a more principled stand in their interpretation of rules of standing to sue. Although the *Fundamental Rights (Enforcement Procedure) Rules 2009* (Nigeria) has now made generous provisions on the standing to sue for the enforcement of fundamental rights under Chapter IV of the *Constitution of Nigeria*, its provisions do not extend to the economic and social rights under Chapter II. The courts should consider making similar rules for economic and social rights in view of the African Charter Rights which make those rights part of Nigeria's domestic law.

The Supreme Court of Nigeria should adopt a more robust attitude towards the African Charter Act than it has currently done in *Abacha v Fawehinmi*.[38] This is because the Act offers the court a unique opportunity to bypass the wait for constitutional amendment, to give effect to the right to health. By willingly ratifying the African Charter and complying with the incorporation requirement of the constitution,[39] Nigeria has signified its willingness to be bound by all the principles in that treaty. As such, it cannot raise an

---

[38] Ibid.

[39] *Constitution of Nigeria 1999*, s 12(1).

obstacle in its domestic law, such as the non-justiciability of economic and social rights under the constitution to justify its unwillingness to observe the treaty.[40]

The courts should shed their judicial timidity and other self-imposed constraints, which have been suggested to be responsible for the inability to bring about the uptake of the right to health in the country.[41] The Supreme Court of Nigeria should emulate the approach of its Indian counterpart in interpreting Chapter IV Fundamental Rights in a way that gives effect to Chapter II Economic and Social Rights in the *Constitution of Nigeria*.

In bringing about the judicialisation of the right to health, the courts in Nigeria should be mindful of whether their decisions serve to enable, amplify, impede or promote ambivalence towards the right to health. To this extent, they should strive to enable and amplify the right and avoid impeding or being ambivalent towards the right. In practical terms, the courts should avoid opening the floodgates in health rights litigation (as in the case of Brazil) and aim for a deliberate decision making policy where judicial pronouncements can help shape system-wide policy on the right to health (as in the case of South Africa and India); thereby ensuring an equitable distribution of the positive outcomes of health rights litigation.

Finally, although the litigation process by its very nature involves the resolution of specific issues that are brought before the court for adjudication, and although courts are loathe to engage in 'academic exercises' where they are called upon to adjudicate on issues that have no immediate consequence for parties, Nigerian courts have to recognise the unique position of health rights litigation. Keeping in mind how decisions in individual cases can redefine the trajectory of public health policy, the courts need to strive constantly to balance the competing rights of individuals and the public when deciding health rights cases.

* * *

In closing, one is reminded of Alicia Ely Yamin's argument on why human rights frameworks for health matter:

---

40 *Vienna Convention on the Law of Treaties* opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980) arts 26 and 27.

41 Chidi Anselm Odinkalu, 'The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights' in Varun Gauri and Daniel M. Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008).

> applying a human rights framework to health forces us to think about how we understand our own suffering and that of others, and the fundamental causes of suffering. What is our agency—our power to act—as human subjects? What is the agency of other humans in decisions that affect our health, and how is the line drawn between what are mutable human policies and decisions and what we may see as 'natural'?[42]

By framing the transformation of the health system of Nigeria in terms of the right to health as a set of legal positions to universal health coverage, this thesis has sought to emphasise that ultimately, better health outcomes will result in Nigeria when the population is equipped to take ownership of the health system and its outcomes. Nigeria's place as a regional power house (politically and economically) and as a respected member of the international community sits in stark contrast to the poor health outcomes being experienced to date in its health system. Improvements cannot be brought to the health system without making necessary legal changes to ensure a strengthening of its framework. Brazil and South Africa stand as good examples of how Nigeria can use the human rights framework to transform its health system. Although development scholars have predicted a great economic future for Nigeria as the country with one of the fastest growing populations in the world,[43] there is no doubt that this bright future is contingent on Nigeria's capacity to bring about improvements to its health system to achieve better health outcomes.

---

[42] Alicia Ely Yamin, *Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter* (University of Pennsylvannia Press, 2016) 4.

[43] See United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision, Key Findings and Advance Tables.* ESA/P/WP.241, 4.

BIBLIOGRAPHY

A *Articles/Books/Reports*

Adedini, Sunday et al, 'Barriers to Accessing Health Care in Nigeria: Implications for Child Survival ' (2014) 7 *Global Health Action* 1

Alexy, Robert, *A Theory of Constitutional Rights* (Julian Rivers trans, Oxford University Press, 2002)

Allen, Heather and Rebecca Katz, 'Demography and Public Health Emergency Preparedness: Making the Connection' (2010) 29(4) Population Research and Policy Review 527

Alubo, Ogoh, 'Power and Privileges in Medical Care: An Analysis of Medical Services in Post-Colonial Nigeria' (1987) 24(5) Social Science & Medicine 453

Anaeto, Emeka, '22.45m Nigerians Unemployed, as Job Loss Hits 710,693', Vanguard 22 March 2016 <http://www.vanguardngr.com/2016/03/22-45m-nigerians-unemployed-job-loss-hits-710693/>

Aristotle, Nicomachean Ethics (Terence Irwin trans, Hackett Publishing Co., 2nd ed, 1999)

Asuzu, Mike, 'The necessity for a health systems reform in Nigeria' (2004) 16(1) Journal of Community Medicine & Primary Health Care 1

Atubi, A O, 'Effects of Oil Spillage on Human Health in Producing Communities of Delta State, Nigeria' (2015) 4(8) European Journal of Business and Social Sciences 14

Austin, John, Lectures on Jurisprudence (The Law Book Exchange, 5th ed, 1873)

Ayuba, Kadafa Adati, 'Environmental Impacts of Oil Exploration and Expliotation in the Niger Delta of Nigeria' (2012) 12(3) Global Journal of Science Frontier Research 1

Aziken, Emmanuel, Clifford Ndujihe and Charles Kumolu, 'How Corruption Hit Civil Service - Asiodu', Vanguard 10 August 2015 <http://www.vanguardngr.com/2015/08/how-corruption-hit-civil-service-asiodu/>

Baxi, Upendra, 'Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India' (1985) 4(6) Third World Legal Studies 107

BBC, 'Nigeria Becomes Africa's Biggest Economy', BBC NEWS Business 2014 <http://www.bbc.com/news/business-26913497>

Beauchamp, Tom and Ruth Faden, 'The Right to Health and the Right to Health Care' (1979) 4(2) The Journal of Medicine and Philosophy 118

Bee, Cristiano and Dimitra Pachi, 'Active Citizenship in the UK: Assessing Institutional Political Strategies and Mechanisms of Civic Engagement' (2014) 10(1) Journal of Civil Society 100

Bee, Cristiano and Roberta Guerrina, 'Participation, Dialogue, and Civic Engagement: Understanding the Role of Organized Civil Society in Promoting Active Citizenship in the European Union ' (2014) 10(1) Journal of Civil Society 29

Bell, David C., Constructing Social Theory (Rowman & Littlefield Publishers, 2009)

Bentham, Jeremy, Of Laws in General (Athlone Press, 1970)

Berkman, Alan et al, 'A Critical Analysis of the Brazilian Response to HIV/AIDS: Lessons Learned for Controlling and Mitigating the Epidemic in Developing Countries' (2005) 95(7) American Journal of Public Health 1162

Berman, Micah, 'Defining the Field of Public Health Law' (2013) 15(2) DePaul Journal of Health Care Law 45

Bialous, Stella et al, 'The Political Economy of Tobacco Control in Brazil: Protecting Public Health in a Complex Policy Environment' (2014)

Bilchitz, David et al, Assessing the Performance of the South African Constitution (International Institute for Democracy and Electoral Assistance, 2016)

Bilchitz, David, 'Giving Socio-Economic Rights Teeth: The Minimum Core Content and its Importance' (2002) 119 The South African Law Journal 484

Bilchitz, David, Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights (Oxford University Press, 2007)

Bilchitz, David, 'Towards a Reasonable Approach to the Minimum Core: Laying the Foundation for Future Socio-Economic Rights Jurisprudence' (2003) 19 South Africa Journal on Human Rights 1

Birkland, Thomas, An Introduction to the Policy Process: Theories, Concepts, and Models of Public Policy Making (Routledge, 3rd ed, 2011)

Bok, Sissela, 'WHO Definition of Health, Rethinking the' in Kris Heggenhougen and Stella Quah (eds), International Encyclopedia of Public Health (Academic Press, 2008) vol 6, 590

Bole, Thomas and William Bonderson (eds), Right to Health Care (Kluwer, 1991)

Boussalis, Constantine, Hal Nelson and Siddharth Swaminathan, 'Towards Comprehensive Malaria Planning: The Effect of Government Capacity, Health Policy, and Land Use Variables on Malaria Incidence in India' (2012) 75 Social Science & Medicine 1213

Brand, Danie, 'Socio-economic Rights and Courts in South Africa: Justiciability on a Sliding Scale' in Fons Coomans (ed), Justiciability of Economic and Social Rights: Experiences From Domestic Systems (Intersentia, 2006)

Bras, Hervé Le, The Nature of Demography (Princeton University Press, 2008)

Brolan, Claire E., Peter S. Hill and Gorik Ooms, '"Everywhere but not Specifically Somewhere": A Qualitative Study on Why the Right to Health is not Explicit in the Post-2015 Negotiations' (2015) 15(22) *BMC International Health & Human Rights* 1

Bruno, Anna Silva, 'Bringing Uniformity to Brazilian Court Decisions: Looking at the American Precedent and at Italian Living Law' (2007) 11(4) Electronic Journal of Comparative Law 1

Buchanan, Allen, 'Justice: A Philosophical Review ' in Earl Shelp (ed), Justice and Health Care (D Reidel Publishing Co, 1981)

Buchanan, Allen, 'The Right to a Decent Minimum of Health Care' (1984) 13(1) Philosophy & Public Affairs 55

Busse, R, J Schreyögg, and C Gericke, *Analyzing Changes in Health Financing Arrangements in High-Income Countries: A Comprehensive Framework Approach* (World Bank, 2007)

Callahan, Daniel, 'The WHO Definition of 'Health'' (1973) 1(3) The Hastings Center Studies 77

Campos, Thana Cristina de, 'Health as a Basic Human Need: Would This Be Enough?' (2012) 40 Journal of Law, Medicine & Ethics 251

Carozza, Paolo G, 'From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights' (2003) 25 Human Rights Quarterly 281

Carr, Marylou and Maria Riesco, 'Rekindling of Nurse-Midwifery in Brazil: Public Policy and Childbirth Trends' (2007) 52(4) Journal of Midwifery & Women's Health 406

Charlesworth, Hilary and Emma Larking (eds), Human Rights and the Universal Periodic Review: Rituals and Ritualism (Cambridge University Press, 2014)

Charlesworth, Hilary and Emma Larking, 'Introduction: The Regulatory Power of the Universal Periodic Review' in Hilary Charlesworth and Emma Larking (eds), Human Rights and the Universal Periodic Review: Rituals and Ritualism (Cambridge University Press, 2014)

Chaskalson, Matthew, Gilbert Marcus and Michael Bishop, 'Constitutional Litigation' in Stu Woolman and Michael Bishop (eds), Constitutional Law of South Africa (Juta Law, 2008)

Clapham, Andrew, Mary Robinson and Scott Jerbi (eds), Realizing the Right to Health, Swiss Human Rights Book (ruffer & rub, 2009)

Coelho, Vera and Alex Shankland, 'Making the Right to Health a Reality for Brazil's Indigenous Peoples: Innovation, Decentralization and Equity' (2011) 13(3) MEDICC Review 50

Coleman, James S. (ed), Foundations of Social Theory (Harvard University Press, 1990)

Coleman, James S., 'The Demand for Effective Norms' in James S. Coleman (ed), Foundations of Social Theory (Harvard University Press, 1990)

Coleman, James S., 'The Realization of Effective Norms' in James S. Coleman (ed), Foundations of Social Theory (Harvard University Press, 1990)

Committee for the Study of the Future of Public Health, The Future of Public Health (National Academy Press, 1988)

Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil, UN Doc E/C.12/1/Add.87 (26 June 2003)

Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Brazil, UN Doc E/C.12/BRA/CO/2 (12 June 2009)

Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights: India, UN Doc E/C.12/IND/CO/5 (8 August 2008)

Committee on Economic, Social and Cultural Rights, Concluding Observations of the Committee on Economic, Social and Cultural Rights: Nigeria, UN Doc E/C.12/1/Add.23 (16 June 1998)

Committee on Economic, Social and Cultural Rights, Consideration of Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant Concerning Rights Covered by Articles 6 to 12, UN Doc E/1984/WG.1/SR.8 (19 April 1984)

Committee on Economic, Social and Cultural Rights, Consideration of Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant Concerning Rights Covered by Articles 10 to 12, UN Doc E/1984/WG.1/SR.6 (18 April 1984)

Committee on Economic, Social and Cultural Rights, Initial Reports Submitted by State Parties Under Articles 16 and 17 of the Covenant: Brazil, UN Doc E/1990/5/Add.53 (20 November 2001)

Committee on Economic, Social and Cultural Rights, Periodic Reports Submittted by States Parties Under Articles 16 and 17 of the Covenant: Combined Second, Third, Fourth and Fifth Report of India, UN Doc E/C.12/IND/5 (1 March 2007)

Committee on Economic, Social and Cultural Rights, Replies by the Government of Brazil to the list of Issues (E/C.12/BRA/Q/2) to be taken up in Connection with the Consideration of the Second Periodic Report of Brazil (E/C.12/BRA/2), UN Doc E/C.12/BRA/Q/2/Add.1 (16 March 2009)

Committee on Economic, Social and Cultural Rights, Replies by the Government of India to the List of Issues (E/C.12/Q/5) to be Taken Up in Connection with the Consideration of the Fifth Periodic Report of India (E/C.12/IND/5) UN Doc E/C.12/IND/Q/5/Add.1 (18 March 2008)

Committee on Economic, Social and Cultural Rights, Reports Submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant, Concerning Rights Covered by Articles 10 to 12: India, UN Doc E/1980/6/Add.34 (30 May 1983)

Committee on Economic, Social and Cultural Rights, Second Periodic Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Brazil, UN Doc E/C.12/BRA/2 (6 August 2007)

Committee on the Elimination of All Forms of Discrimination Against Women, Response to the List of Issues and Questions with regard to the Consideration of the Sixth Periodic Report: Brazil, UN Doc CEDAW/C/BRA/Q/6/Add.1 (4 May 2007)

Committee on the Elimination of Discrimination Against Women, Combined Fourth and Fifth Periodic Reports of States Parties, Addendum: India, UN Doc CEDAW/C/IND/4-5/Add.1 (4 November 2013)

Committee on the Elimination of Discrimination Against Women, Combined Fourth and Fifth Periodic Reports of States Parties: India, UN Doc CEDAW/C/IND/4-5 (30 October 2012)

Committee on the Elimination of Discrimination Against Women, Combined Fourth and Fifth Periodic Reports of States Parties: Nigeria, UN Doc CEDAW/C/NGA/4-5 (28 April 2003)

Committee on the Elimination of Discrimination Against Women, Combined Initial, Second, Third, Fourth and Fifth Reports of State Parties: Brazil, UN Doc CEDAW/C/BRA/1-5 (7 November 2002)

Committee on the Elimination of Discrimination Against Women, Combined Second and Third Periodic Reports of States Parties: India, UN Doc CEDAW/C/IND/2-3 (19 October 2005)

Committee on the Elimination of Discrimination Against Women, Combined Second, Third and Fourth Periodic Report of States Parties: South Africa, UN Doc CEDAW/C/ZAF/2-4 (24 March 2010)

Committee on the Elimination of Discrimination Against Women, Concluding Comments of the Committee on the Elimination of Discrimination Against Women: Brazil, UN Doc CEDAW/C/BRA/CO/6 (10 August 2007)

Committee on the Elimination of Discrimination Against Women, Concluding Comments of the Committee on the Elimination of Discrimination Against Women: India, UN Doc CEDAW/C/IND/CO/3 (2 February 2007)

Committee on the Elimination of Discrimination Against Women, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Brazil, UN Doc CEDAW/C/BRA/CO/7 (23 March 2012)

Committee on the Elimination of Discrimination Against Women, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: India, UN Doc CEDAW/C/IND/CO/SP.1 (3 November 2010)

Committee on the Elimination of Discrimination Against Women, Concluding Observations of the Committee on the Elimination of Discrimination Against Women: Nigeria, 41st sess, UN Doc CEDAW/C/NGA/CO/6 (8 July 2008)

Committee on the Elimination of Discrimination Against Women, Concluding Observations of the Committtee on the Elimination of Discrimination Against Women: South Africa, UN Doc CEDAW/C/ZAF/CO/4 (5 April 2011)

Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Combined Fourth and Fifth Periodic Reports of India, UN Doc CEDAW/C/IND/CO/4-5 (24 July 2014)

Committee on the Elimination of Discrimination Against Women, Initial Report of States Parties: South Africa, UN Doc CEDAW/C/ZAF/1 (25 February 1998)

Committee on the Elimination of Discrimination Against Women, Initial Reports of States Parties: India, UN Doc CEDAW/C/IND/1 (10 March 1999)

Committee on the Elimination of Discrimination Against Women, Second and Third Periodic Reports of States Parties: Nigeria, UN Doc CEDAW/C/NGA/2-3 (26 February 1997)

Committee on the Elimination of Discrimination Against Women, Seventh and Eight Periodic Reports of States Parties Due in 2014: Nigeria UN Doc CEDAW/C/NGA/7-8 (7 October 2015)

Committee on the Elimination of Discrimination Against Women, Seventh Periodic Reports of States Parties: Brazil, UN Doc CEDAW/C/BRA/7 (31 August 2010)

Committee on the Elimination of Discrimination Against Women, Sixth Periodic Report of State Parties: Nigeria, UN Doc CEDAW/C/NGA/6 (5 October 2006)

Committee on the Elimination of Discrimination Against Women, Sixth Periodic Report of States Parties: Brazil, UN Doc CEDAW/C/BRA/6 (29 August 2005)

Committee on the Rights of the Child, Combined Second to Fourth Periodic Reports of States Parties Due in 2007: Brazil, UN Doc CRC/C/BRA/2-4 (8 December 2014)

Committee on the Rights of the Child, Concluding Observations of the Committee on the Rights of the Child: India, UN Doc CRC/C/15/Add.115 (23 February 2000)

Committee on the Rights of the Child, Concluding Observations of the Committee on the Rights of the Child: Nigeria, UN Doc CRC/C/15/Add.61 (30 October 1996)

Committee on the Rights of the Child, Concluding Observations of the Committee on the Rights of the Child: South Africa, UN Doc CRC/C/15/Add.122 (22 February 2000)

Committee on the Rights of the Child, Concluding Observations on the Combined Second to Fourth Periodic Reports of Brazil, UN Doc CRC/C/BRA/CO/2-4 (30 October 2015)

Committee on the Rights of the Child, Concluding Observations on the Combined Third and Fourth Periodic Reports of India, UN Doc CRC/C/IND/CO/3-4 (7 July 2014)

Committee on the Rights of the Child, Concluding Observations on the Second Periodic Report of South Africa, UN Doc CRC/C/ZAFCO/2 (27 October 2016)

Committee on the Rights of the Child, Concluding Observations: India, UN Doc CRC/C/15/Add.228 (26 February 2004)

Committee on the Rights of the Child, Concluding Observations: Nigeria, UN Doc CRC/C/15/Add.257 (13 April 2005)

Committee on the Rights of the Child, Concluding Observations: Nigeria, UN Doc CRC/C/NGA/CO/3-4 (21 June 2010)

Committee on the Rights of the Child, Concludinging Observations: Brazil, UN Doc CRC/C/15/Add.241 (3 November 2004)

Committee on the Rights of the Child, Initial Reports of States Parties Due in 1992: Brazil, UN Doc CRC/C/3/Add.65 (17 December 2003)

Committee on the Rights of the Child, Initial Reports of States Parties Due in 1993: Nigeria, UN Docs CRC/C/8/Add.26 (21 August 1995)

Committee on the Rights of the Child, Initial Reports of States Parties Due in 1995: India, UN Doc CRC/C/28/Add.10 (7 July 1997)

Committee on the Rights of the Child, Initial Reports of States Parties Dues in 1997: South Africa, UN Doc CRC/C/51/Add.2 (22 May 1998)

Committee on the Rights of the Child, List of Issues in relation to the Combined Third and Fourth Periodic Reports of India, UN Doc CRC/C/IND/Q/3-4 (25 November 2013)

Committee on the Rights of the Child, List of Issues to the Combined Third and Fourth Periodic Reports of India, Replies of India to the List of Issues, UN Doc CRC/C/IND/Q/3-4/Add.1 (1 May 2014)

Committee on the Rights of the Child, Second Periodic Reports of States Parties Due in 1998: Nigeria, UN Doc CRC/C/70/Add.24 (17 September 2004)

Committee on the Rights of the Child, Second Periodic Reports of States Parties Due in 2000: India, UN Doc CRC/C/93/Add.5 (16 July 2003)

Committee on the Rights of the Child, Second Periodic Reports of States Parties Due in 2002: South Africa, UN Doc CRC/C/ZAF/2 (17 March 2015)

Committee on the Rights of the Child, Third and Fourth Periodic Report of States Parties Due in 2008: Nigera, UN Doc CRC/C/NGA/3-4 (5 January 2009)

Cooper, Carole, 'South Africa: Health Rights Litigation: Cautious Constitutionalism' in Alicia Ely Yamin and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health (Harvard University Press, 2011)

Cooper, Diane et al, 'Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status' (2004) 12(24) Reproductive Health Matters 70

Cornwall, Andrea and Alex Shankland, 'Engaging Citizens: Lessons From Building Brazil's National Health System' (2008) 66 Social Science & Medicine 2173

Correa, Sonia et al, 'The Population and Reproductive Health Programme in Brazil 1990-2002: Lessons Learned' (2005) 13(25) Reproductive Health Matters 72

Cotterrell, Roger, 'Ehrlich at the Edge of Empire: Centres and Peripheries in Legal Studies' in Marc Hertogh (ed), Living Law: Reconsidering Eugen Ehrlich (Hart Publishing 2008)

Courtis, Christian, Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability (International Commission of Jurists, 2008)

Daniels, Norman, Just Health: Meeting Health Needs Fairly (Cambridge University Press, 2008)

Das, Anindya, 'The Context of Formulation of India's Mental Health Program: Implications for Global Mental Health' (2014) 7 Asian Journal of Psychiatry 10

Davis, D M, 'The Case Against the Inclusion of Socio-Economic Demands in a Bill of Rights Except as Directive Principles' (1992) 8 South Africa Journal on Human Rights 475

Department of Health Republic of South Africa, Strategic Plan 2014/15 - 2018/19 (2014)

Development, Ministry of Women and Child, 'India: Third and Fourth Combined Periodic Report on the Convention on the Rights of the Child' (2011)

Dixon, Rosalind, 'Creating Dialogue About Socioeconomic Rights: Strong-Form Versus Weak-Form Judicial Review ' (2007) 5(3) International Journal of Constitutional Law 391

Doyle, Michael W, 'Kant, Liberal Legacies, and Foreign Affairs' (1983) 12(3) *Philosophy & Public Affairs* 205

Duffy, Benedict J. and H. Behm, 'Demography and Public Health' (1964) 42(2) The Milbank Memorial Fund Quarterly 276

Dugard, Jackie and Theunis Roux, 'The Record of the South African Constitutional Court in Providing an Institutional Voice for the Poor: 1995-2004' in Roberto Gargarella, Pilar Domingo and Theunis Roux (eds), Courts and Social Transformation in New

Democracies: An Institutional Voice for the Poor? (Ashgate Publishing Limited, 2006)

Dugard, John, 'International Law and the South African Constitution ' (1997) 8(1) European Journal of International Law 77

Duran, Antonio, Joseph Kutzin and Nata Menabde, 'Universal Coverage Challenges Require Health System Approaches: The Case of India' (2014) 114 Health Policy 269

Ebenstein, William, The Pure Theory of Law (Augustus M. Kelley, 1969)

Ebobrah, Solomon T, 'The Future of Economic, Social and Cultural Rights Litigation in Nigeria' (2007) 1(2) Review of Nigerian Law and Practice 109

Ehlers, Valerie, 'Republic of South Africa: Policies and Politics Guide Nurses' Application of Genetic Technology in Public Health Settings ' (2002) 3(2) Policy, Politics & Nursing Practice 149

Elliott, Anthony, Contemporary Social Theory: An Introduction (Routledge, 2014)

Faris, John Andrew, 'African Customary Law and Common Law in South Africa: Reconciling Contending Legal Systems' (2015) 10(2) International Journal of African Renaissance Studies 171

Farmer, Paul, Pathologies of Power: Health, Human Rights, and the New War on the Poor (University of California Press, 2005)

Faulks, Keith, Citizenship (Routledge, 2000)

Ferraz, Octavio L. Motta, 'Brazil: Health Inequalities, Rights, and Courts: The Social Impact of the Judicialization of Health' in Alicia Ely Yamin and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health (Harvard University Press, 2011)

Ferraz, Octavio L. Motta, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities?' (2009) 11(2) Health and Human Rights 33

Filiu, Jean-Pierre, The Arab Revolution: Ten Lessons From the Democratic Uprising (Oxford University Press, 2011)

Flood, Colleen and Aeyal Gross (eds), The Right to Health at the Public/Private Divide (Cambridge University Press, 2014)

Fon, Vincy and Francesco Parisi, 'Judicial Precedent in Civil Law Systems: A Dynamic Analysis' (2006) 26 International Review of Law and Economics 519

Forman, Lisa et al, 'What Do Core Obligations Under the Right to Health Bring to Universal Health Coverage?' (2016) 18(2) *Health and Human Rights Journal* 23

Forman, Lisa, Gorik Ooms, Claire E. Brolan, 'Rights Language in the Sustainable Development Agenda: Has Right to Health Discourse and Norms Shaped Health Goals?' (2015) 4(12) *International Journal of Health Policy and Management* 799

Foster, Nicola et al, 'The Economic Burden of TB Diagnosis and Treatment in South Africa' (2015) 130 Social Science & Medicine 42

Frieden, Jeff, 'Sectoral Conflict and Foreign Economic Policy, 1914-1940' (1988) 42 *International Organization* 59

From the Press, 'Guidelines on Investigating Medical Negligence' (2003) 11(4) Indian Journal of Medical Ethics 106

Gargarella, Roberto, Pilar Domingo and Theunis Roux (eds), Courts and Social Transformation in New Democracies: An Instituional Voice for the Poor? (Aldershot: Ashgate, 2006)

Gauri, Varun and Daniel M. Brinks (eds), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (Cambridge University Press, 2008)

Gauri, Varun and Daniel M. Brinks, 'Introduction: The Elements of Legalization and the Triangular Shape of Social and Economic Rights' in Varun Gauri and Daniel M. Brinks (eds), Court Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (Cambridge University Press, 2008)

Geiger, Theodor, Vorstudien zu einer Soziologie des Rechts (Duncker & Humblot 2nd ed, 1964)

Glendon, Mary Ann, 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea' (2003) 16 Harvard Human Rights Journal 27

Gloppen, Siri and Mindy Jane Roseman, 'Introduction: Can Litigation Bring Justice to Health?' in Alicia Ely Yamin and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health? (Harvard University Press, 2011)

Gloppen, Siri, 'Legal Enforcement of Social Rights: Enabling Conditions and Impact Assessment ' (2009) 2(4) Erasmus Law Review 465

Gloppen, Siri, 'Litigating Health Rights: Framing the Analysis' in Alicia Ely Yamin and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health? (Harvard University Press, 2011)

Gloppen, Siri, 'Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health' (2008) 10(2) Health and Human Rights 21

Golding, Martin, 'Justice and Rights: A Study in Relationship' in Earl Shelp (ed), Justice and Health Care (D Reidel Publishing Co, 1981)

Gostin, Lawrence O, 'The Human Right to Health: A Right to the "Highest Attainable Standard of Health"' (Hastings Center Report, March-April 2001 2001)

Gostin, Lawrence O. et al, 'The Joint Action and Learning Initiative: Towards a Global Agreement on National and Global Responsibilities for Health' (2011) 8(5) PLoS Medicine 1

Gostin, Lawrence O., Global Health Law (Harvard University Press, 2014)

Gragnolati, Michele, Magnus Lindelow and Bernard Couttolenc, Twenty Years of Health System Reform in Brazil: An Assessment of the Sistema Único de Saúde (The World Bank, 2013)

Greene, Jennifer C., Holly Kreider and Ellen Mayer, 'Combining Qualitative and Quantitative Methods in Social Inquiry' in Bridget Somekh and Cathy Lewin (eds), Research Methods in the Social Sciences (SAGE Publications, 2005)

Griffin, James, On Human Rights (Oxford University Press, 2008)

Grundy, Emily, 'Demography and Public Health' in Roger Detels et al (eds), Oxford Textbook of Public Health (Oxford University Press, 5th ed, 2009) vol 2,

Guastini, Riccardo, 'The Basic Norm Revisited' in Luis Duarte d'Almeida, John Gardner and Leslie Green (eds), Kelsen Revisited: New Essays on the Pure Theory of Law (Hart Publishing, 2013)

Gupta, Umang and A. Ramesh, 'Analyzing the Barriers of Health Care Supply Chain in India: The Contribution and Interaction of Factors' (2015) 189 Procedia - Social and Behavioral Sciences 217

Haddad, Diane et al, 'Barriers to Early Prenatal Care in South Africa' (2016) 132 International Journal of Gynecology and Obstetrics 64

Halperin, Jean-Louise, 'Law in the Books and Law in Action: The Problem of Legal Change' (2011) 64(1) *Maine Law Review* 45

Hargreaves, Sally, 'Time to Right the Wrongs: Improving Basic Health Care in Nigeria' (2002) 359 The Lancet 2030

Hart, H L A, The Concept of Law (Oxford University Press, 3rd ed, 2012)

Hathaway, Oona A, 'Do Human Rights Treaties Make a Difference?' (2002) 111(8) *The Yale Law Journal* 1935

Hawker, Geoffrey, R.F.I. Smith and Patrick Weller, Politics and Policy in Australia (University of Queensland Press, 1979)

Haysom, Nicholas, 'Constitutionalism, Majoritarian Democracy and Socio-Economic Rights' (1992) 8 South Africa Journal on Human Rights 451

Hendriks, Aart, 'The Right to Health in National and International Jurisprudence ' (1998) 5 European Journal of Health Law 389

Hessler, Kristen and Allen Buchanan, 'Specifying the Content of the Human Right to Health Care' in Allen Buchanan (ed), Justice and Health Care: Selected Essays (Oxford University Press, 2009)

Heuberger, Peter and Thomas de Hoog, 'Transformation Theory' in Peter S.C. Heuberger, Paul M.J. Van Den Hof and Bo Wahlberg (eds), Modelling and Identification with Rational Orthogonal Basis Functions (Springer 2005)

Hirschl, Ran, 'Case Selection and Research Design in Comparative Constitutional Studies ' in Comparative Matters: The Renaissance of Comparative Constitutional Law (Oxford University Press, 2014)

Hoffmann, Florian F. and Fernando R. N. M. Bentes, 'Accountability for Social and Economic Rights in Brazil' in Varun Gauri and Daniel M. Brinks (eds), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (Cambridge University Press, 2008)

Hoopes, Andrea et al, 'An Analysis of Adolescent Content in South Africa's Contraception Policy Using a Human Rights Framework' (2015) 57 Journal of Adolescent Health 617

Horton, Richard and Pam Das, 'Indian Health: The Path from Crisis to Progress ' (2011) 377 Lancet 181

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa, 13th sess, UN Doc A/HRC/WG.6/13/ZAF/2 (23 March 2012)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: Brazil, 13th sess, UN Doc A/HRC/WG.6/13/BRA/2 (22 March 2012)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: India, 13th sess, UN Doc A/HRC/WG.6/13/IND/2 (11 April 2012)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1 and Paragraph 5 of the Annex to Council Resolution 16/21: Nigeria, 17th sess, UN Doc. A/HRC/WG.6/17/NGA/2 (9 August 2013)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Nigeria, 4th sess, UN Doc A/HRC/WG.6/4/NGA/2 (5 January 2009)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: India, 1st sess, UN Doc A/HRC/WG.6/1/IND/2 (27 March 2008)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1: South Africa, 1st sess, UN Doc A/HRC/WG.6/1/ZAF/2 (11 April 2008)

Human Rights Council, Institution-building of the United Nations Human Rights Council, HRC Res 5/1, 5th sess, UN Doc A/HRC/RES/5/1 (18 June 2007) Annex

Human Rights Council, National Report Submitted in Accordance with Paragrapgh 15(a) of the Annex to the Human Rights Council Resolution 5/1: Nigeria, 4th sess, UN Doc A/HRC/WG.6/4/NGA/1 (5 January 2009)

Human Rights Council, National Report Submitted in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: India, 13th sess, UN Doc A/HRC/WG.6/13/IND/1 (8 March 2012)

Human Rights Council, National Report Submitted in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa, 13th sess, UN Doc A/HRC/WG.6/13/ZAF/1 (7 March 2012)

Human Rights Council, National Report Submitted in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: Brazil, 13th sess, UN Doc A/HRC/WG.6/13/BRA/1 (7 March 2012)

Human Rights Council, National Report Submitted in Accordance with Paragraph 15(a) of the Annex to Human Rights Council Resolution 5/1: Brazil, 1st sess, UN Doc A/HRC/WG.6/1/BRA/1 (7 March 2008)

Human Rights Council, National Report Submitted in Accordance with Paragraph 15(a) of the Annex to the Human Rights Council Resolution 5/1: India, 1st sess, UN Doc A/HRC/WG.6/1/IND/1 (6 March 2008)

Human Rights Council, National Report Submitted in Accordance with Pragrapgh 5 of the Annex to Human Rights Council Resolution 16/21: Nigeria, 17th sess, UN Doc A/HRC/WG.6/17/NGA/1 (30 July 2013)

Human Rights Council, Report of the Human Rights Council on its Seventh Organizational Meeting, 7th org mtg, UN Doc A/HRC/OM/7/1 (4 April 2013)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: Brazil, 8th sess, UN Doc A/HRC/8/27 (22 May 2008)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: Brazil, 21st sess, UN Doc A/HRC/21/11 (9 July 2012)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: India, 8th sess, UN Doc A/HRC/8/26 (23 May 2008)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: India, 21st sess, UN Doc A/HRC/21/10 (9 July 2012)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: Nigeria, 11th sess, UN Doc A/HRC/11/26 (5 October 2009)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: Nigeria, 25th sess, UN Doc. A/HRC/25/6 (16 December 2013)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: South Africa, 8th sess, UN Doc A/HRC/8/32 (23 May 2008)

Human Rights Council, Report of the Working Group on the Universal Periodic Review: South Africa, 21st sess, UN Doc A/HRC/21/16 (9 July 2012)

Human Rights Council, Review of the Work and Functioning of the Human Rights Council, HRC Res 16/21, 16th sess, UN Doc A/HRC/RES/16/21 (12 April 2011)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Brazil, 13th sess, UN Doc A/HRC/WG.6/13/BRA/3 (14 March 2012)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: South Africa, 13th sess, UN Doc A/HRC/WG.6/13/ZAF/3 (12 March 2012)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 5 of the Annex to the Human Rights Council Resolution 16/21: India, 13th sess, UN Doc A/HRC/WG.6/13/IND/3 (12 March 2012)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1 and Paragraph 5 of the Annex to Human Rights Council Resolution 16/21: Nigeria, 17th sess, UN Doc. A/HRC/WG.6/17/NGA/3 (31 July 2013)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights in Accordance with Paragraph 15(c) of the Annex to the Human Rights Council Resolution 5/1: Nigeria, 4th sess, UN Doc A/HRC/WG.6/4/NGA/3 (27 November 2008)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(c) of the Annex to Human Rights Council Resolution 5/1: South Africa, 1st sess, UN Doc A/HRC/WG.6/1/ZAF/3 (11 March 2008)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraphs 15(c) of the Annex to the Human Rights Council Resolution 5/1: India, 1st sess, UN Doc A/HRC/WG.6/1/IND/3 (6 March 2008)

Inter-American Commission on Human Rights, Petition and Case System: Informational Brochure (Organization of American States, 2010)

Isola, Omoleke, 'The "Relevance" of the African Traditional Medcine (Alternative Medicine) to Health Care Delivery System in Nigeria' (2013) 47(1) The Journal of Developing Areas 319

Ityavyar, Dennis, 'Health Services Inequalities in Nigeria' (1988) 27(11) Social Science & Medicine 1223

Jellinek, Georg, System der subjektiven öffentlichen Rechte (Mohr Siebeck, 1905)

Joseph, Jonathan, Marxism and Social Theory (Palgrave Macmillan, 2006)

Jr, G.A Pucca et al, 'Ten Years of a National Oral Health Policy in Brazil: Innovation, Boldness, and Numerous Challenges' (2015) 94(10) Journal of Dental Research 1333

Kamugundu, Odethie, 'Prioritising Legislation in the Policy Process' (2013) 39(3) Commonwealth Law Bulletin 471

Kant, Immanuel, ‘Perpetual Peace’ in Ted Humphrey (trans) *Perpetual Peace and Other Essays on Politics, History, and Morals* (1795) (Hackett Publishing Co)

Kasner, Edward, 'The General Transformation Theory of Differential Elements' (1910) 32(4) American Journal of Mathematics 391

Kawabata, Kei, Ke Xu and Guy Carrin, 'Preventing Improverishment Through Protection Against Catastrophic Health Expenditure' (2002) 80(8) Bulletin of the World Health Organization 612

Kelsen, Hans, The Pure Theory of Law (BL Paulson and SL Paulson trans, University of California Press, 2nd ed, 1967)

Kende, Mark S, 'The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics' (2004) 19 Connecticut Journal of International Law 617

Kende, Mark S, 'The South African Constitutional Court's Embrace of Socio-Economic Rights: A Comparative Perspective' (2003) 6 Chapman Law Review 137

Keohane, Robert O, *After Hegemony: Cooperation and Discord in the World Political Economy* (Princeton University Press, 1984)

Keohane, Robert O, 'Institutional Theory and the Realist Challenge After the Cold War' in David A Baldwin (ed) *Neorealism and Neoliberalism* (Columbia University Press, 1993)

Keohane, Robert O, *International Institutions and State Power: Essays in International Relations Theory* (Westview Press, 1989)

Kingsbury, Benedict, 'The Concept of Compliance as a Function of Competing Conceptions of International Law' (1998) 19 *Michigan Journal of International Law* 345

Kinney, Eleanor D. and Brian Alexander Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) 37 Cornell International Law Journal 285

Kirkup, Alex and Tony Evans, 'The Myth of Western Opposition to Econmic, Social, and Cultural Rights?: A Reply to Whelan and Donnelly' (2009) 31(1) Human Rights Quarterly 221

Kothari, Jayna, 'Social Rights Litigation in India: Developments of the Last Decade' in Daphne Barak-Ere and Aeyal Gross (eds), Exploring Social Rights (Hart Oxford, 2011)

Kumar, A K Shiva et al, 'Financing Health Care for All: Challenges and Opportunities' (2011) 377 Lancet 668

Kumar, Rajendra, Research Methodology (APH Publishing Corporation 2012)

Kumm, Mattias, 'Democracy is not Enough: Rights, Proportionality and the Point of Judicial Review' (2009) New York University Public Law and Legal Theory Working Papers 118

Langford, Malcolm (ed), Social Rights Jurisprudence: Emerging Trends in International and Comparative Law (Cambridge University Press, 2008)

Lindahl, Lars, Position and Change: A Study in Law and Logic (D Reidel Publishing, 1977)

Litsios, Socrates, 'The Long and Difficult Road to Alma-Ata: A Personal Reflection' (2002) 32(4) International Journal of Health Services 709

Luhmann, Niklas, A Sociological Theory of Law (Elizabeth King-Utz and Martin Albrow trans, Routledge, 2nd ed, 2014)

Luhmann, Niklas, Grundrechte als Institution (Duncker & Htjmblot, 2nd ed, 1974)

Machado, Cristiani, Fernanda Salvador and Gisele O'Dwyer, 'Mobile Emergency Care Service: Analysis of Brazilian Policy' (2011) 45(3) Rev Saúde Pública 1

MacRalid, Donald M., Social Theory and Social History (Palgrave Macmillan, 2004)

Marmor, Theodore and Claus Wendt, 'Conceptual Frameworks for Comparing Healthcare Politics and Policy' (2012) 107 Health Policy 11

Mayosi, Bongani et al, 'Health in South Africa: Changes and Challenges Since 2009' (2012) 380 Lancet 2029

Meier, Benjamin Mason, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health For Public Health Advancement' (2010) 46(1) Standford Journal of International Law 1

Melo, Débora Gusmão et al, 'Genetics in Primary Care and the National Policy on Comprehensive Care for People with Rare Diseases in Brazil: Opportunities and Challenges for Professional Education ' (2015) 6 Journal of Community Genetics 231

Merryman, John Henry and Rogelio Perez-Perdomo, The Civil Law Tradition: An Introduction to the Legal Systems of Europe and Latin America (Standford University Press, 3rd ed, 2007)

Mezirow, Jack, 'Understanding Transformation Theory' (1994) 44(4) Adult Education Quarterly 222

Moravcsik, Andrew, 'Taking Preferences Seriously: A Liberal Theory of International Politics' (1997) 51 *International Organization* 513

Müller, Alexandra et al, '"You Have to Make a Judgment Call". - Morals, Judgments and the Provision of Quality Sexual and Reproductive Health Services for Adolescents in South Africa' (2016) 148 Social Science & Medicine 71

Nagarajan, Shyama et al, 'The National Rural Health Mission in India: Its impact on Maternal, Neonatal, and Infant Mortality ' (2015) 20 Seminars in Fetal & Neonatal Medicine 315

Nambiar, Devaki, 'India's "Tryst" with Universal Health Coverage: Reflections on Ethnography in Indian Health Policymaking' (2013) 99 Social Science & Medicine 135

Narayan, Ravi, 'Universal Health Care in India: Missing Core Determinants' (2011) 377 Lancet 883

Nelken, David, 'Eugen Ehrlich, Living Law, and Plural Legalities' (2008) 9(2) Theoretical Inquiries in Law 443

Neuman, Gerald L, 'Human Rights and Constitutional Rights: Harmony and Dissonance' (2003) 55(5) Standford Law Review 1863

Ngabaza, Sisa and Tamara Shefer, 'Policy Commitment vs. Lived Realities of Young Pregnant Women and Mothers in School, Western Cape, South Africa' (2013) 21(41) Reproductive Health Matters 106

Ngowu, Rufus, James Larson and Min Su Kim, 'Reducing Child Mortality in Nigeria: A Case Study of Immunization and Systemic Factors' (2008) 67 Social Science & Medicine 161

Nnamuchi, Obiajulu and Steve Metiboba, 'Healthcare Organization and Financing' in Irehobhude O Iyioha and Remigius N Nwabueze (eds), Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law (Ashgate, 2015)

Nnamuchi, Obiajulu, 'The Nigerian Social Health Insurance System and the Challenges of Access to Health Care: An Antidote or a White Elephant?' (2009) 28 Medicine and Law 125

Nozick, Robert, Anarchy, State, and Utopia (Basic Books 1974)

Nutting, Charles, 'Legislative Policy and Civil Rights' (1962) 48(4) American Bar Association Journal 385

Nwabueze, Remigius, 'The Legal Protection and Enforcement of Health Rights in Nigeria' in Colleen Flood and Aeyal Gross (eds), The Right to Health at the Public/Private Divide: A Global Comparative Study (Cambridge University Press, 2014)

Obiagwu, Chinonye and Chdi Anslem Odinkalu, 'Combating Legacies of Colonialisam and Militarism' in Abdullahi Ahmed An-Na'im (ed), Human Rights Under African Constitutions: Realizing the Promise for Ourselves (University of Pennsylvannia Press, 2002)

Odinkalu, Chidi Anselm, 'The Impact of Economic and Social Rights in Nigeria: An Assessment of the Legal Framework for Implementing Education and Health as Human Rights' in Varun Gauri and Daniel M. Brinks (eds), Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World (Cambridge University Press, 2008)

Office of the High Commissioner for Human Rights, The United Nations Human Rights System (United Nations, 2012)

Okafor, Obiora and Basil Ugochukwu, 'Have the Norms and Jurisprudence of the African Human Rights System Been Pro-Poor?' (2011) 11(2) African Human Rights Law Journal 396

Okafor, Obiora Chinedu and Uchechukwu Ngwaba, 'The International Criminal Court as a 'Transitional Justice' Mechanism in Africa: Some Critical Reflections ' (2014) 9(1) International Journal of Transitional Justice 90

Okafor, Obiora Chinedu, 'Irrigating the Famished Fields: The Impact of Labour-led Struggles on Policy and Action in Nigeria (1999-2007)' (2009) 27(2) Journal of Contemporary African Studies 159

Okafor, Obiora Chinedu, 'Newness, Imperialism, and International Legal Reform in Our Time: A Twail Perspective ' (2005) 43(1/2) Osgoode Hall Law Journal 171

Okonji, Emma and Obinna Chima, 'Udoma: Lack of Policy Implementation Forced Nigeria into Recession ', THISDAY 24 September 2016 <http://www.thisdaylive.com/index.php/2016/09/24/udoma-lack-of-policy-implementation-forced-nigeria-into-recession/>

O'Neill, Onora, 'The Dark Side of Human Rights' (2005) 81(2) International Affairs 427

Ooms, Gorik et al, 'Great Expectations for the World Health Organization: A Framework Convention on Global Health to Achieve Universal Health Coverage' (2014) 128 Public Health 173

Ooms, Gorik et al, 'Universal Health Coverage Anchored in the Right to Health' (2013) 91(2-2A) Bulletin of the World Health Organization 1

Oyebade, Wole, 'A National Health Bill to Rescue, Save All', The Guardian Thursday, 12 June 2014 <http://www.ngrguardiannews.com/features/science/165535-a-national-health-bill-to-rescue-save-all>

Paim, Jairnilson et al, 'The Brazilian Health System: History, Advances, and Challenges' (2011) 377 Lancet 1778

Pallikadavath, Saseendran et al, 'Human Resource Inequalities at the Base of India's Public Health Care System' (2013) 23 Health & Place 26

Pantami, Isa Ali, 'Nigeria's Civil Service: An Engine of Corruption', Premium Times March 23 2012 <http://www.premiumtimesng.com/opinion/4355-nigeria_s_civil_service_an_engine_of_corruption_by_isa_ali_panta.html>

Parmar, Sharanjeet and Namita Wahi, 'India: Citizens, Courts and the Right to Health: Between Promise and Progress?' in Alicia Ely Yamin and Siri Gloppen (eds),

Litigating Health Rights: Can Courts Bring More Justice to Health? (Harvard University Press, 2011)

Patel, Vikram et al, 'Assuring Health Coverage for All in India' (2015) 386 Lancet 2422

Patel, Vikram et al, 'Universal Health Care in India: The Time is Right' (2011) 377 Lancet 448

Pellegrino, Edmund, 'The Social Ethics of Primary Care: The Relationship between a Human Need and an Obligation of Society ' (1978) 45 Mount Sinai Journal of Medicine 593

People's Health Movement et al, *Global Health Watch 4: An Alternative World Health Report* (Zed Books, 2014) 82

Peters, Guy, 'State Failure, Governance Failure and Policy Failure: Exploring the Linkages' (2015) 30(3-4) Public Policy and Administration 261

Pickel, Andreas, 'Bewteen Social Science and Social Technology: Towards a Philosophical Foundation for Post-Communist Transformation Studies' (2001) 31(4) Philosophy of the Social Sciences 459

Pickel, Andreas, 'Transformation Theory: Scientific or Political?' (2002) 35 Communist and Post-Communist Studies 105

Pickles, John and Adrian Smith (eds), Theorising Transition: The Political Economy of Post-Communists Transformations (Routledge, 1998)

Pieterse, Marius, 'Coming to Terms with Judicial Enforcement of Socio-Economic Rights' (2004) 20 South Africa Journal on Human Rights 383

Pinto, Rogério, Sueli Bulhões da Silva and Rafaela Soriano, 'Community Health Workers in Brazil's Unified Health System: A Framework of their Praxis and Contributions to Patient Health Behaviors' (2012) 74 Social Science & Medicine 940

Pound, Roscoe, 'Law in the Books and Law in Action' (1910) 44 *American Law Review* 12

Premium Times, 'Governor Dickson Suspends Nine Bayelsa Teachers for Dereliction of Duty', Premium Times 14 December 2013 <http://www.premiumtimesng.com/regional/ssouth-east/151478-governor-dickson-suspends-nine-bayelsa-teachers-dereliction-duty.html>

Rajagopal, Balakrishnan, International Law From Below: Developments, Social Movements and Third World Resistance (Cambridge University Press, 2003)

Rajagopal, Balakrishnan, 'Locating the Third World in Cultural Geography ' (1999) 15(2) Third World Legal Studies 1

Rammohan, Anu and Niyi Awofeso, 'District-Level Variations in Childhood Immunizations in India: The Role of Socio-economic Factors and Health Infrastructure ' (2015) 145 Social Science & Medicine 163

Rawls, John, A Theory of Justice (Oxford University Press, 1971)

Reddy, K Srinath et al, 'High Level Expert Group Report on Universal Health Coverage for India' (Planning Commission of India, 2011)

Reddy, K Srinath et al, 'Towards Achievement of Universal Health Care in India by 2020: A Call to Action ' (2011) 377 Lancet 760

Report of the Committee on the Elimination of Discrimination Against Women, UN GAOR, 53rd sess, Supp No 38, UN Doc A/53/38/Rev.1 (14 May 1998)

Report of the Committee on the Elimination of Discrimination Against Women, UN GAOR, 53rd sess, Supp No 38, UN Doc A/53/38/Rev.1 (21 August 1998)

Report of the Committee on the Elimination of Discrimination Against Women, UN GAOR, 55th sess, Supp No 38, UN Doc A/55/38 (4 February 2000)

Report of the Committee on the Elimination of Discrimination Against Women, UN GAOR, 58th sess, Supp No 38, UN Doc A/58/38 (18 July 2003)

Report of the Committee on the Elimination of Discrimination Against Women, UN GAOR, 59th sess, UN Doc A/59/38 (18 March 2004)

Republic of South Africa, Implementation Guideline of Health Workforce Normative Guides and Standards for Fixed Primary Health Care Facilities (National Department of Health, 2015)

Republic of South Africa, National Health Insurance for South Africa: Towards Universal Health Coverage (Department of Health, 2015)

Reynolds, Christopher, Public Health Law and Regulation (The Federation Press, 2004)

Ross, Alf, Directives and Norms (Routledge & Kegan Paul 1968)

Rózsa, Erzsébet N, 'Arab Awakening, or a New Regional Order Emerging in the Middle East?' (2011) 20(2) International Issues & Slovak Foreign Policy Affairs 3

Ruddick, William, 'Why Not a General Right to Health Care' (1989) 56(3) Mount Sinai Journal of Medicine 161

Ruger, Jennifer Prah, 'Towards a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18(2) Yale Law Journal of Law & the Humanities 273

Runciman, Walter Garrison, The Methodology of Social Theory (Cambridge University Press, 1983)

Sahara Reporters, 'Falana Sues FG Over Conditions of Public Hospitals ', Sahara Reporters 29 July 2010 <http://saharareporters.com/2010/07/29/falana-sues-fg-over-conditions-public-hospitals>

Sampaio, Luis, 'The Brazilian Health System: Highlighting the Primary Health Care Reform' (2010) 7(4) Italian Journal of Public Health 359

Santos, Lenir and Gastão de Sousa Campos, 'SUS Brazil: The Health Region as a Way Forward' (2015) 24(2) Saúde Soc. São Paulo 438

Saunders, Cheryl and Anna Dziedzic, 'Parliamentary Sovereignty and Written Constitutions in Comparative Perspective' in A Welikala (ed), The Sri Lankan Republic at 40: Reflections on Constitutional History, Theory and Practice (Centre for Policy Alternatives, 2012)

Schubert, Glendon, Judicial Policy Making: The Political Role of the Courts (Glenview, III: Scott, Foresman, Rev. ed, 1974)

Seekings, Jeremy and Nicoli Nattrass, Class, Race, and Inequality in South Africa (Yale University Press, 2005)

Sellin, Jennifer, 'Justiciability of the Right to Health - Access to Medicines: The South African and Indian Experience ' (2009) 2(4) Erasmus Law Review 445

Sengupta, Amit and Vandana Prasad, 'Towards a Truly Universal Indian Health System' (2011) 377 Lancet 702

Sharma, Dinesh, 'India's New Policy Aims to Close Gaps in Mental Health Care' (2014) 384 Lancet 1564

Shehu, Ajepe Taiwo, 'The Enforcement of Social and Economic Rights in Africa: The Nigerian Experience' (2013) 2(1) Journal of Sustainable Development Law and Policy 101

Sheikh, Kabir and John Porter, 'Discursive Gaps in the Implementation of Public Health Policy Guidelines in India: The Case of HIV Testing' (2010) 71 Social Science & Medicine 2005

Simmons, Beth A, *Mobilizing for Human Rights: International Law in Domestic Politics* (Cambrdige University Press, 2009)

Smith, Stephanie, 'Political Contexts and Maternal Health Policy: Insights From a Comparison of South Indian States' (2014) 100 Social Science & Medicine 46

Spector, Anya et al, 'Implementation of Brazil's "Family Health Strategy": Factors Associated With Community Health Workers', Nurses', and Physicians' Delivery of Drug Use Services' (2015) 26 International Journal of Drug Policy 509

Stammers, Neil, 'Social Movements and the Social Construction of Human Rights' (1999) 21(4) Human Rights Quarterly 980

Stark, David, 'From System Identity to Organizational Diversity: Analyzing Social Change in Eastern Europe' (1992) 21(3) Contemporary Sociology 299

Story, William, 'Social Capital and the Utilization of Maternal and Child Health Services in India: A Multilevel Analysis' (2014) 28 Health & Place 73

Surender, Rebecca et al, 'The Drive for Universal Healthcare in South Africa: Views From Private General Practitioners ' (2015) 30 Health Policy and Planning 759

Tang, Yi Shin, 'International Justice Through Domestic Courts: Challenges in Brazil's Judicial Review of the Amnesty Law' (2015) 9 International Journal of Transitional Justice 259

Teixeira, Luiz and Tiago Jaques, 'Legislation and Tobacco Control in Brazil Between the Late 20th and Early 21st Centuries' (2011) 57(3) Brazilian Journal of Cancerology 295

Terreblanche, Sampie, A History of Inequality in South Africa (University of KwaZulu-Natal Press, 2002)

Thomas, Deborah et al, 'Closing the Health and Nutrition Gap in Odisha, India: A Case Study of How Transforming the Health System is Achieving Greater Equity ' (2015) 145 Social Science & Medicine 154

Tobin, John, The Right to Health in International Law (Oxford University Press, 2012)

Toebes, Brigit, The Right to Health as a Human Right in International Law (Intersentia - Hart, 1998)

Toth, Frederico, 'Healthcare Policies Over the Last 20 Years: Reforms and Counter-Reforms' (2010) 95 Health Policy 82

Tushnet, Mark, Weak Courts, Strong Rights: Judicial Review and Social Welfare Rights in Comparative Constitutional Law (Princeton University Press, 2007)

Udo, Bassey, '19,000 Nigerians Suffer Public Sector Job Losses in 6 Months', Premium Times 13 September 2016 <http://www.premiumtimesng.com/news/headlines/210329-19000-nigerians-suffer-public-sector-job-losses-6-months.html>

Unger, Roberto Mangabeira, Social Theory, its Situation and its Task (Cambridge University Press, 1987)

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, Key Findings and Advance Tables. ESA/P/WP.241

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, Volume I: Comprehensive Tables. ST/ESA/SER.A/379

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, Volume II: Demographic Profiles. ST/ESA/SER.A/380

United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospects: The 2015 Revision, World Population Wallchart. ST/ESA/SER.A/378

Vargas, Ingrid et al, 'Regional-based Integrated Healthcare Network Policy in Brazil: From Formulation to Practice' (2015) 30 Health Policy and Planning 705

Victora, Cesar et al, 'Health Conditions and Health-Policy Innovations in Brazil: The Way Forward' (2011) 377 Lancet 2042

Virk, A.K. and R. Atun, 'Towards Universal Health Coverage in India: A Historical Examination of the Genesis of Rashtriya Swasthya Bima Yojana - The Health Insurance Scheme for Low-Income Groups' (2015) 129 Public Health 810

Vujovic, Marnie et al, 'Addressing the Sexual and Reproductive Health Needs of Young Adolescents Living with HIV in South Africa' (2014) 45 Children and Youth Services Review 122

Waldman, Linda and Marion Stevens, 'Sexual and Reproductive Health and Rights and mHealth in Policy and Practice in South Africa' (2015) 23(45) Reproductive Health Matters 93

Waltz, Kenneth N, *Theory of International Politics* (Waveland Press, 1979)

Weinberger, Christiane and Ota Weinberger, Logic, Semantics, Hermeneutics (Wolfgang G. Stock, 1979)

Weston, Burns H, 'Human Rights: Concepts and Content' in Burns H Weston and Anna Grear (eds), Human Rights in the World Community: Issues and Action (University of Pennsylvania Press, 4th ed, 2016)

Whelan, Daniel J and Jack Donnelly, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight ' (2007) 29(4) Human Rights Quarterly 908

Whelan, Daniel J and Jack Donnelly, 'Yes, a Myth: A Reply to Kirkup and Evans' (2009) 31(1) Human Rights Quarterly 239

World Health Organization, 'Brazil's March Towards Universal Coverage' (2010) 88(9) Bulletin of the World Health Organization 646

World Health Organization, 'Flawed but Fair: Brazil's Health System Reaches out to the Poor' (2008) 86(4) Bulletin of the World Health Organization, 248

World Health Organization, Health in 2015: From MDGs, Millennium Development Goals to SDGs, Sustainable Development Goals (World Health Organization, 2015)

World Health Organization, 'Millennium Development Goals (MDGs)' (2014) <http://www.who.int/topics/millennium_development_goals/en/>

World Health Organization, The First Ten Years of the World Health Organization (1958)

World Health Organization, The World Health Report: Health Systems Financing: The Path to Universal Coverage (2010)

World Health Organization, 'WHO-AIMS Report on Mental Health System in Brazil ' (2007)

World Health Organization, World Health Statistics 2012 (2012)

World Health Organization, World Health Statistics 2014 (2014)

World Health Organization, World Health Statistics 2015 (2015)

Wright, Georg Henrik Von, Norm and Action: A Logical Enquiry (Routledge and Kegan Paul, 1963)

Wróblewski, Jerzy, 'The Problem of the Meaning of the Legal Norm' in Aulis Aarnio (ed), Meaning and Truth in Judicial Decision (Juridica, 1979)

Yamin, Alicia Ely and Siri Gloppen (eds), Litigating Health Rights: Can Courts Bring More Justice to Health? (Harvard University Press, 2011)

Yamin, Alicia Ely, 'Defining Questions: Situating Issues of Power in the Formulation of a Right to Health Under International Law' (1996) 18 Human Rights Quarterly 398

Yamin, Alicia Ely, Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why they Matter (University of Pennsylvannia Press, 2016)

Young, Katharine G, 'A Typology of Economic and Social Rights Adjudication: Exploring the Catalytic Function of Judicial Review' (2010) 8(3) International Journal of Constitutional Law 385

Young, Katharine G, 'Securing Health Through Rights' in Thomas Pogge, Matthew Rimmer and Kim Rubenstein (eds), Incentives for Global Public Health: Patent Law and Access to Essential Medicines (Cambridge University Press, 2010)

Young, Katharine G, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 The Yale Journal of International Law 113

B *Cases*

Abacha v Fawehinmi [2000] 6 Nigerian Weekly Law Report (Pt 660) 228 (Supreme Court of Nigeria)

Abacha v The State [2002] 5 Nigerian Weekly Law Report (Pt. 761) 638 (Supreme Court of Ngeria)

Adesanya v President (1981) 2 Nigeria Constitutional Law Report 358 (Supreme Court of Nigeria)

Affordable Medicines Trust v Minister of Health [2005] 6 BCLR 529 (Constitutional Court)

Ani v State (2002) 1 Nigerian Weekly Law Report (Pt 747) 217 (Court of Appeal of Nigeria)

Bamaiyi v State (2001) 8 Nigerian Weekly Law Report (Pt. 715) 270 (Supreme Court of Nigeria)

Biljoen v Minister of Correctional Services [1997] 4 SA 441 (High Court)

Case of Ximenes-Lopes v Brazil (Merits, Reparations and Costs) (Judgment of 4 July 2006) (Inter-American Court of Human Rights)

Case of Ximenes-Lopes v Brazil (Preliminary Objection) (Judgment of 30 November 2005) (Inter-American Court of Human Rights)

CESC Ltd v Bose AIR 1992 SC 573, 585 (Supreme Court of India)

Consumer Education and Research Centre v Union of India (1995) 3 SCC 42 (Supreme Court of India)

Damiao Ximenes Lopes, Case 12.237 (Brazil) (1 October 2004)

Dokubo-Asari v Federal Republic of Nigeria SC 208/2006 (Supreme Court of Nigeria)

Fawehinmi v Akilu (1987) 4 Nigerian Weekly Law Report 797 (Supreme Court of Nigeria)

Fawehinmi v State [1990] 1 Nigerian Weekly Law Report (Pt. 127) 486, 496-497 (Court of Appeal of Nigeria)

Femi Falana v. African Union (Application No. 001/2011) Judgment

Ferreira v Levin NO; Vryenhoek v Powell NO 1996 (1) SA 984 (CC)

Ganguly v Medical Council of India W. P. (C) No. 317 of 2000 (Supreme Court of India)

Government of the Republic of South Africa v Grootboom [2001] 1 SA 46 (Constitutional Court)

Indigenous Communities of the Xingu River Basin, Pará, (Brazil) (PM 382/10)

Katara v Union of India (1989) 4 SCC 286 (Supreme Court of India)

Mathew v State of Punjab(2005) 6 SCC 1 (Supreme Court of India)

Matter of of the Penitentiary Complex of Pedrinhas regarding Brazil, (Order of the Inter-American Court of Human Rights) (14 November 2014)

Matter of the Penitentiary Complex of Curado regarding Brazil, (Order of the Inter-American Court of Human Rights) (7 October 2015)

Minister of Health and Welfare v Woodcarb Pty Ltd [1996] 3 SA 155 (Provincial Division)

Minister of Health v Treatment Action Campaign (No. 2) [2002] 5 SA 721 (Constitutional Court)

Mullin v Delhi (1981) 2 Supreme Court Report 516 (Supreme Court of India)

Nemi v State [1996] Nigerian Weekly Law Report (Pt. 452) 42 (Supreme Court of Nigeria)

Ogugu v State [1996] 6 Nigerian Weekly Law Report (Pt. 316) 1, 30-31 (Supreme Court of Nigeria)

Okogie v Attorney General of Lagos State (1981) 2 Nigeria Constitutional Law Report 350 (Court of Appeal of Nigeria)

People deprived of their freedom at Professor Aníbal Bruno Prison, (Brazil) (PM 199/11)

People's Union for Civil Liberties (PUCL) v Union of India and Others, W. P. (C) No. 196 of 2001

Persons Deprived of Liberty at the Pedrinhas Prison Complex, (Brazil) (PM 367/13)

Persons Deprived of Liberty at the Porto Alegre Central Prison, (Brazil) (PM 8/13)

Persons Deprived of Liberty in the Judicial Police Department (DPJ) of Vila Velha, (Brazil) (PM 114-10)

Persons Deprived of Liberty in the Polinter-Neves Penitentiary, (Brazil) (PC 236/08)

Reddy v Revamma AIR 2007 SC 1753 (Supreme Court of India)

Samity v State of West Bengal (1996) 4 SCC 37; AIR 1996 SC 2426 (Supreme Court of India)

Soobramoney v Minister of Health KwaZulu-Natal [1998] 1 SA 765 (Constitutional Court)

State of Punjab v Chawla (1997) 2 SCC 83 (Supreme Court of India)

Tau v GlaxoSmithKline Case No. 2002Sep226 (Competition Commission)

Thomas v Olufosoye (1986) 1 Nigerian Weekly Law Report (Pt 18) 669 (Supreme Court of Nigeria)

C *Legislation*

African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act 1983 (Nigeria)

Allocation of Revenue (Federation Account, Etc.) Act 1982 (Nigeria)

Atmospheric Pollution Prevention Act 1965 (South Africa)

Basic Law for the Federal Republic of Germany

BVerfGE 39, 1 (41)

Competition Act 89 of 1998

Constitution of Brazil, 1988

Constitution of India

Constitution of Nigeria 1999

Constitution of South Africa 1996

Constitutional Court Rules 2003 (South Africa)

Decree No 2203 of 5 November 1996 (Brazil)

Decree No 399 of 22 February 2006 (Brazil)

Decree No 7,508 of 28 July 2011 (Brazil)

Foodstuffs, Cosmetics and Disinfectants Act 1972 (as amended) (South Africa)

Fundamental Rights (Enforcement Procedure) Rules 2009 (Nigeria)

Hazardous Substances Act 1973 (South Africa)

Law No 10.424 of 15 April 2002 (Brazil)

Law No 10216 of 6 April 2001 (Brazil)

Law No 11.108 of 7 April 2005 (Brazil)

Law No 8.080 of 19 September 1990 (Brazil)

Law No 8.142 of 28 December 1990 (Brazil)

Law No 9.836 of 23 September 1999 (Brazil)

Medicines and Related Substances Act 1965 (South Africa)

Medicines and Related Substances Control Act 1965 (South Africa)

Mental Health Care Act 2002 (South Africa)

National Agency for Food and Drug Administration and Control Act 1992 (Nigeria)

National Health Act 2003 (South Africa)

National Health Act 2014 (Nigeria)

National Health Insurance Scheme Act 1999 (Nigeria)

National Policy for Health Act 1990 (South Africa)

National Primary Health Care Development Agency Act 1992 (Nigeria)

Occupational Diseases in Mines and Works Act 1973 (South Africa)

Ordinance No 373 of 27 February 2002 (Brazil)

Ordinance No 4,279 of 30 December 2010 (Brazil)

Rules of Procedure of the Inter-American Court of Human Rights

The Clinical Establishments (Registration and Regulation) Act, 2010 (India)

Tobacco Products Control Amendment Act 1999 (as amended) (South Africa)

Traditional Health Practitioners Act (Act No. 22) 2007

Unorganised Workers Social Security Act 2008 (India)

D *Treaties*

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 'Protocol of San Salvador', opened for signature 17 November 1988, 69 OASTS (entered into force 16 November 1999)

African (Banjul) Charter on Human and Peoples' Rights, opened for signature 27 June 1981, OAU Doc CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (entered into force 21 October 1986)

African Charter on the Rights and Welfare of the Child, OAU Doc CAB/LEG/24.9/49 (1990) (entered into force 29 November 1999)

American Convention on Human Rights, (Adopted at San Jose, Costa Rica, 22 November 1969 at the Inter-American Specialized Conference on Human Rights) 36 OASTS (entered into force 18 July 1978)

American Declaration of the Rights and Duties of Man, (adopted by the Ninth International Conference of American States, Bogota, Colombia, 2 May 1948)

Constitution of the World Health Organization Preamble, 62 Stat. 2697, 14 U.N.T.S. 185 (22 July 1946)

Convention on the Elimination of All Forms of Discrimination Against Women, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981)

Convention on the Rights of the Child, opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990)

International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976)

International Covenant on Economic, Social and Cultural Rights, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 Janaury 1976)

Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women, opened for signature 6 October 1999, 2131 UNTS 83 (entered into force 22 December 2000)

Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, opened for signature 10 December 2008, UNTC 14531 (entered into force 5 May 2013)

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, Adopted by the 2nd Ordinary Session of the Assembly of the Union, Maputo, 1 July 2003 (entered into force 25 November 2005)

Universal Declaration of Human Rights, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948)

Vienna Convention on the Law of Treaties opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980)

E *Others*

Advanced Renal Education Program, Incidence and Prevalence <http://advancedrenaleducation.com/content/incidence-and-prevalence>

African Commission on Human and Peoples' Rights, Rules of Procedure of the African Commission on Human and Peoples' Rights <http://www.achpr.org/files/instruments/rules-of-procedure-2010/rules_of_procedure_2010_en.pdf>

African Commission on Human and Peoples' Rights, State Reporting Procedure <http://www.achpr.org/states/reporting-procedure/>

African Commission on Human and Peopls' Rights, Binding Instruments Ratification <www.achpr.org/instruments/>

African Commission on Human and Peopls' Rights, States Reporting Map <www.achpr.org/states/>

African Union, List of Countries Which Have Signed, Ratfied/Acceded to the Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights <http://en.african-court.org/images/Basic%20Documents/Statuts_of_the_Ratification_Process_of_the_Protocol_Establishing_the_African_Court.pdf>

African Union, Member States <www.au.int/en/member_states/countryprofiles>

Akinloye, Lagun, 'Nigeria's National Health Bill: Delayed, Disputed and Desperately Needed', Think Africa Press 3 April 2013 <http://thinkafricapress.com/nigeria/nigerias-national-health-bill-brave-new-world>

Awute, L. N., One Year Anniversary of the National Health Act, 2014 <http://www.health.gov.ng/index.php/news-media/9-uncategorised/228-one-year-anniversary-of-the-national-health-act-2014>

Brazil, Brazil Geography Introduction <http://www.brazil.org.za/brazil-geography-into.html>

Center for Reproductive Rights, Supplementary Information on Nigeria Scheduled for Review During the 41st Session of the CEDAW Committee, (30 June 2008)

Chiejina, Alexander, 'Jonathan Finally Signs National Health Bill into Law', BusinessDay 9 December 2014 <businessdayonline.com/2014/12/president-jonathan-finally-signs-national-health-bill/#.VMH4AUeUd8H>

Chima, Obinna, 'S'Africa Overtakes Nigeria as Africa's Biggest Economy', THISDAY 11 August 2016 <http://www.thisdaylive.com/index.php/2016/08/11/safrica-overtakes-nigeria-as-africas-biggest-economy/>

Comisión Interamericana de Derechos Humanos, Reports on Cases <http://www.oas.org/en/iachr/decisions/cases_reports.asp>

Committee on Economic Social and Cultural Rights, General Comment No 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant), 5th sess, UN Doc E/1991/23 (14 December 1990)

Committee on Economic Social and Cultural Rights, General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12), 22nd sess, UN Doc E/C.12/2000/4 (11 August 2000)

Committee on Economic, Social and Cultural Rights, List of Issues to be taken up in Connection with the Consideration of the Combined Second, Third, Fourth, and Fifth Periodic Report of India Concerning the Rights Covered by Articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/IND/5), UN Doc E/C.12/IND/Q/5 (14 September 2007)

Committee on Economic, Social and Cultural Rights, List of Issues to be Taken Up in Connection with the Consideration of the Initial Report of Brazil Concerning the Rights Referred to in Articles 1-15 of the International Covenant on Economic, Social and Cultural Rights (E/1990/5/Add.53), UN Doc E/C.12/Q/BRA/1 (5 June 2002)

Committee on Economic, Social and Cultural Rights, List of Issues to be taken up in Connection with the Consideration of the Second Periodic Reports of Brazil Concerning the Rights Covered by Articles 1 to 15 of the International Covenant on Economic, Social and Cultural Rights (E/C.12/BRA/2), UN Doc E/C.12/BRA/Q/2 (11 June 2008)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions in relation to the Combined Fourth and Fifth Periodic Reports of India, UN Doc CEDAW/C/IND/Q/4-5 (28 October 2013)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions in Relation to the Combined Fourth and Fifth Periodic Reports of India: Replies of India, UN Doc CEDAW/C/IND/Q/4-5/Add.1 (23 January 2014)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions with Regard to the Consideration of Periodic Reports: Brazil, Replies of Brazil to the List of Issues to be taken up in Connection with the Consideration of its Seventh Periodic Report (CEDAW/C/BRA/7) UN Doc CEDAW/C/BRA/Q/7/Add.1 (20 February 2012)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions with regard to the Consideration of Periodic Reports: Brazil, UN Doc CEDAW/C/BRA/Q/6 (26 February 2007)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions with regard to the Consideration of Periodic Reports: Brazil, UN Doc CEDAW/C/BRA/Q/7 (1 September 2011)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions with regard to the Consideration of Periodic Reports: India, UN Doc CEDAW/C/IND/Q/3 (8 August 2006)

Committee on the Elimination of Discrimination Against Women, List of Issues and Questions with regard to the Consideration of Periodic Reports: South Africa, UN Doc CEDAW/C/ZAF/Q/4 (2 September 2010)

Committee on the Elimination of Discrimination Against Women, Responses to the List of Issues and Questions with regard to the Consideration of the Combined Second, Third and Fourth Periodic Reports: South Africa, UN Doc CEDAW/C/ZAF/Q/4/Add.1 (10 January 2011)

David Bilchitz, 'Can Fundamental Rights Bridge the Divide Between Ideal Justice and the South African Reality' (Paper Presented at Legal Processes and Human Rights Workshop, Macquarie University Research Centre for Agency, Values and Ethics, 26 April, 2016)

Department of Health (South Africa) National HIV Counselling and Testing Policy Guidelines, 2010

Department of Health (South Africa), Child and Adolescent Mental Health Policy Guidelines, 2002

Department of Health (South Africa), Expanded Programme on Immunisation, 2010

Department of Health (South Africa), Health Promoting Schools: Report on Provincial Health Promoting Schools Networks, 1997

Department of Health (South Africa), Policy Guidelines for the Management and Prevention of Genetic Disorders, Birth Defects and Disabilities, 2001

Department of Health (South Africa), Regular Treatment of School Going Children for Soil Transmitted Helminth Infections and Bilharzia. Policy and Implementation Guidelines, 2008

Department of Health (South Africa), Roadmap for Nutrition in South Africa 2013-2017, 2013

Department of Health (South Africa), South African National Oral Health Strategy, 2002

Department of Health (South Africa), The Household and Community Component of Integrated Management of Childhood Strategy, 2005

Department of Health Republic of South Africa, Adolescent and Youth Health Policy 2012

Department of International Law: Organization of American States Washington DC, General Information of the Treaty: B-32 <www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights_sign.htm>

Eboh, Michael, 'Nigeria in Recession as Economy Shrinks by 2.06%', Vanguard 31 August 2016 <http://www.vanguardngr.com/2016/08/nigeria-recession-economy-shrinks-2-06/>

Economic and Social Council, Initial Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Nigeria, UN Doc E/1990/5/Add.31 (7 February 1996)

Facts About India.com, Geography Facts About India <http://www.facts-about-india.com/Geography-facts-about-india.php>

Falana, Femi, 'Nigeria: Socio-Economic Rights in Court', THISDAY 3 Febraury 2016

Federal Ministry of Health (Nigeria), National Guideline for the Control and Management of Sickle Cell Disease, 2014

Federal Ministry of Health (Nigeria), National Nutritional Guideline on Non-Communicable Disease Prevention, Control and Management 2014, October 2014

Federal Ministry of Health (Nigeria), National Oral Policy, November 2012

Federal Ministry of Health (Nigeria), National Policy on Food Safety and its Implementation Strategy, 2014

Federal Ministry of Health (Nigeria), National Strategic Health Development Plan 2010-2015, November 2010

Federal Ministry of Health (Nigeria), National Strategic Plan of Action for Nutrition 2014-2019, May 2014

Federal Ministry of Health (Nigeria), Revised National Health Policy, September 2004

Federal Ministry of Health, National Policy on the Health & Development of Adolescents & Young People in Nigeria, First Revision, 2007

Federal Republic of Nigeria, National Health Financing Policy, 2006

Federal Republic of Nigeria, National Policy on HIV/AIDS, October 2009

Federal Republic of Nigeria, National Policy on Malaria Diagnosis and Treatment, June 2011

Government of Canada, Project Profile: Accelerating the Reduction of Maternal and Newborn Mortality (on file with Author)

Government of Canada, Project Profile: Enhancing the Prevention of Mother-To-Child Transmission of HIV (on file with Author)

Human Rights Council, Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to the Human Rights Council Resolution 5/1: Brazil, 1st sess, UN Doc A/HRC/WG.6/1/BRA/2 (31 March 2008)

Human Rights Council, Summary Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraphs 15(c) of the Annex to Human Rights Council Resolution 5/1: Brazil, 1st sess, UN Doc A/HRC/WG.6/1/BRA/3 (6 March 2008)

Index Mundi, Brazil Age Structure (30 June 2015) <http://www.indexmundi.com/brazil/age_structure.html>

Index Mundi, India Age Structure (30 June 2015) <http://www.indexmundi.com/india/age_structure.html>

Index Mundi, Nigeria Age Structure (30 June 2015) <http://www.indexmundi.com/nigeria/age_structure.html>

Index Mundi, South Africa Age Structure (30 June 2015) <http://www.indexmundi.com/south_africa/age_structure.html>

Infoplease, India <http://www.infoplease.com/country/india.html>

Inter-American Commission on Human Rights, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights "Protocol of San Salvador" <www.cidh.oas.org/Basicos/English/Basic6.Prot.Sn%20Salv%20Ratif.htm>

Inter-American Commission on Human Rights, American Convention on Human Rights "Pact of San Jose, Costa Rica" <www.cidh.oas.org/Basicos/English/Basic4.Amer.Conv.Ratif.htm>

Inter-American Commission on Human Rights, Annual Reports <http://www.oas.org/en/iachr/reports/annual.asp>

Inter-American Commission on Human Rights, Cases in the Court <http://www.oas.org/en/iachr/decisions/cases.asp>

Inter-American Commission on Human Rights, Country Reports <http://www.oas.org/en/iachr/reports/country.asp>

Inter-American Commission on Human Rights, Individual Petition System Portal <http://www.oas.org/en/iachr/portal/>

Inter-American Commission on Human Rights, Precautionary Measures <http://www.oas.org/en/iachr/decisions/precautionary.asp>

Inter-American Commission on Human Rights, Precautionary Measures 1996 <http://www.cidh.org/medidas/1996.eng.htm>

Inter-American Commission on Human Rights, Precautionary Measures 2004 <http://www.cidh.org/medidas/2004.eng.htm>

Inter-American Commission on Human Rights, Precautionary Measures 2005 <http://www.cidh.org/medidas/2005.eng.htm>

Inter-American Commission on Human Rights, Precautionary Measures 2006 <http://www.cidh.org/medidas/2006.eng.htm>

Inter-American Commission on Human Rights, Precautionary Measures 2007 <http://www.cidh.org/medidas/2007.eng.htm>

Inter-American Commission on Human Rights, Questionnaires <http://www.oas.org/en/iachr/reports/questionnaires.asp>

Inter-American Commission on Human Rights, Rules of Procedure of the Inter-American Commission on Human Rights <http://www.oas.org/en/iachr/mandate/Basics/rulesiachr.asp>

Inter-American Commission on Human Rights, Statute of the Inter-American Commission on Human Rights <http://www.oas.org/en/iachr/mandate/Basics/statuteiachr.asp>

Inter-American Commission on Human Rights, Thematic Rapporteurships and Units <http://www.oas.org/en/iachr/mandate/rapporteurships.asp>

Inter-American Commission on Human Rights, Thematic Reports <http://www.oas.org/en/iachr/reports/thematic.asp>

Inter-American Court of Human Rights, I/A Court History <http://www.corteidh.or.cr/index.php/en/about-us/historia-de-la-corteidh>

International Justice Research Center, Inter-American Human Rights System <www.ijrcenter.org/regional/inter-american-system/#Inter-American_Instruments>

International Justice Research Center, Unit on Economic, Social and Cultural Rights <www.ijrcenter.org/regional/inter-american-system/unit-on-economic-social-and-cultural-rights/>

InvestingAnswers, Bull Market <http://www.investinganswers.com/node/922>

InvestingAnswers, Per Capita GDP <http://www.investinganswers.com/financial-dictionary/economics/capita-gdp-5096>

InvestingAnswers, Recession <http://www.investinganswers.com/node/2562>

Investopedia, Morbidity Rate <http://www.investopedia.com/terms/m/morbidity-rate.asp>

Iyatse, Geoff and Odusina Olutola, 'Nigerians Proffer Solutions to Economic Recession', PUNCH 21 September 2016 <http://punchng.com/nigerians-proffer-solutions-economic-recession/>

Khan, Mehreen, 'What Does GDP Really Tell Us About Economic Growth?', The Telegraph 15 October 2014 <http://www.telegraph.co.uk/finance/economics/11159277/What-does-GDP-really-tell-us-about-economic-growth.html>

McIntyre, Di et al, 'A Critical Analysis of the Current South African Health System' (University of Cape Town, 2007)

Millennium Project, Goals, Targets and Indicators (2006) <http://www.unmillenniumproject.org/goals/gti.htm>

Ministry of Health and Family Welfare (India), National Health Policy 2002

Ministry of Health and Family Welfare (India), National Health Policy 2015 Draft, December 2014

Ministry of Health and Family Welfare (India), National Policy for Containment of Antimicrobial Resistance, 2011

Ministry of Health and Family Welfare (India), National Rural Health Mission: Framework for Implementation 2005-2012

Ministry of Health and Family Welfare (India), National Vaccine Policy, 2011

Ministry of Health and Family Welfare, New Pathways New Hope: National Mental Health Policy of India, October 2014

Mohita, Negi, Indo-Gangetic Plain: 3 Divisions of the Ganga Plain in India <http://www.yourarticlelibrary.com/geography/indo-gangetic-plain-3-divisions-of-the-ganga-plain-in-india/13796/>

National Primary Health Care Development Agency (Nigeria), Minimum Standards for Primary Health Care in Nigeria

Nwabughiogu, Levinus, 'Poverty of Ideas, Corruption, Inefficiency Killing Civil Service, Says Buhari', Vanguard 8 September 2015 <http://www.vanguardngr.com/2015/09/poverty-of-ideas-corruption-inefficiency-killing-civil-service-says-buhari/>

Office of the High Commissioner for Human Rights, Advance Questions to Brazil <lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to Brazil - Addendum 1

<lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL-ADD1.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to Brazil - Addendum 2 <lib.ohchr.org/HRBodies/UPR/Documents/Session1/BR/QUESTIONSBRAZIL-ADD2.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to India <lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to India - Addendum 1 <lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA-ADD1.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to India - Addendum 2 <lib.ohchr.org/HRBodies/UPR/Documents/Session1/IN/QUESTIONSINDIA-ADD2.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to South Africa <lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/QUESTIONSSOUTHAFRICA.pdf>

Office of the High Commissioner for Human Rights, Advance Questions to South Africa - Addendum 1 <lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/QUESTIONSSOUTHAFRICA-ADD1.pdf>

Office of the High Commissioner for Human Rights, Basic Facts About the UPR <www.ohchr.org/EN/HRBodies/UPR/Pages/BasicFacts.aspx>

Office of the High Commissioner for Human Rights, Human Rights Council Universal Periodic Review <www.ohchr.org/EN/HRBodies/UPR/Documents/uprlist.pdf>

Office of the High Commissioner for Human Rights, Questions Submitted in Advance - Nigeria <http://lib.ohchr.org/HRBodies/UPR/Documents/Session4/NG/NIGERIAAdd1.pdf>

Office of the High Commissioner for Human Rights, South Africa's Country Report to the Human Rights Council's Universal Periodic Review Mechanism: 15 April 2008 <lib.ohchr.org/HRBodies/UPR/Documents/Session1/ZA/A_HRC_WG6_ZAF_1_E.pdf>

Office of the High Commissioner for Human Rights, Special Procedures of the Human Rights Council <http://www.ohchr.org/EN/HRBodies/SP/Pages/Welcomepage.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review <http://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review - Brazil <http://www.ohchr.org/EN/HRBodies/UPR/Pages/BRSession1.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review - India <www.ohchr.org/EN/HRBodies/UPR/Pages/INSession1.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review - Nigeria <http://www.ohchr.org/EN/HRBodies/UPR/Pages/NGSession4.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review -South Africa <www.ohchr.org/EN/HRBodies/UPR/Pages/ZASession1.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review Second Cycle - Brazil <www.ohchr.org/EN/HRBodies/UPR/Pages/BRSession13.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review Second Cycle - India <www.ohchr.org/EN/HRBodies/UPR/Pages/INSession13.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review Second Cycle - Nigeria <www.ohchr.org/EN/HRBodies/UPR/Pages/NGSession17.aspx>

Office of the High Commissioner for Human Rights, Universal Periodic Review Second Cycle - South Africa <www.ohchr.org/EN/HRBodies/UPR/Pages/ZASession13.aspx>

Office on the Status of Disabled Persons (South Africa), Integrated National Disability Strategy, 1998

Ogunmade, Omololu and Obinna Chima, 'IMF Warns Nigeria Heading Towards Recession', THISDAY 20 July 2016 <http://www.thisdaylive.com/index.php/2016/07/20/imf-warns-nigeria-heading-towards-recession/>

Operational Guidelines for the Pact for Health 2006 (Brazil)

Organization of American States, Member States <www.oas.org/en/member_states/default.asp>

Regulations Relating to Communicable Diseases 2010 (South Africa)

South Africa, Integrated Nutrition Programme, 1994

South Africa, Integrated School Health Policy

South Africa, National Environmental Health Policy, No 34499, 3 August 2011

South Africa, Traditional Health Practitioners Regulations, No 39358, 3 November 2015

South Africa, White Paper for the Transformation of the Health System in South Africa, Government Gazette No 39506, 11 December 2015

South African Government, Geography and Climate <http://www.gov.za/about-sa/geography-and-climate>

South African National AIDS Council, National Strategic Plan for HIV, STIs and TB 2012-2016

Strengthening and Enhancing the Effective Functioning of the Human Rights Treaty Body System, GA Res 68/268, UN GAOR, 68th sess, 81st plen mtg, Agenda Item 125, UN Doc A/RES/68/268 (9 April 2014)

Sustainable Health Financing, Universal Coverage and Social Health Insurance, WHA Res 58.33, 9th plen mtg, Doc A58/20 (25 May 2005)

The Nigeria CEDAW NGO Coalition Shadow Report, For Consideration by the CEDAW Committee in its Review of the Government of Nigeria 6th Periodic Country Report (2004-2008) on the Implementation of the CEDAW in Nigeria (30 June 2008)

The World Bank, Health Expenditure, Total (% of GDP) <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>

The World Bank, Land Area (Sq. km): Overview Per Country <http://data.worldbank.org/indicator/AG.LND.TOTL.K2>

The World Bank, South Africa <http://data.worldbank.org/country/south-africa>

Umoru, Henry, 'Recession: The Future is Bright for Nigeria - Adeosun', Vanguard 24 July 2016 <http://www.vanguardngr.com/2016/07/recession-worst-adeosun/>

UN General Assembly, Human Rights Council, GA Res 60/251, 60th sess, UN Doc A/RES/60/251 (15 March 2006)

UNAIDS, HIV and AIDS Estimates (2014) <http://www.unaids.org/en/regionscountries/countries/southafrica>

United Nations Department of Economic and Social Affairs, Gross Domestic Product Per Capita <http://www.un.org/esa/sustdev/natlinfo/indicators/methodology_sheets/econ_development/gdp_percapita.pdf>

White Paper on National Health Insurance (Government Gazette No. 39506) 11 December 2015

World By Map, Land Area of All Countries of the World <http://world.bymap.org/LandArea.html>

World Health Organization and United Nations Children's Fund, Alma Ata 1978 Primary Health Care http://www.unicef.org/about/history/files/Alma_Ata_conference_1978_report.pdf

World health Organization, General Government Expenditure on Health as a Percentage of Total Government Expenditure <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=93>

World health Organization, Global Health Observatory Data Repository: Health Financing (2016) <http://apps.who.int/gho/data/node.main.484>

World Health Organization, Health Accounts and Universal Health Coverage <http://www.who.int/health-accounts/universal_health_coverage/en/>

World Health Organization, Out-of-pocket Expenditure as a Percentage of Private Expenditure on Health <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=107>

World Health Organization, Per Capita Government Expenditure on Health at Average Exchange Rate (US$) (2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=109>

World Health Organization, Per Capita Total Expenditure on Health at Average Exchange Rate (US$) (2011) <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=111>

World Health Organization, Private Expenditure on Health as a Percentage of Total Expenditure on Health (2011)

<http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=119>

World Health Organization, Total Expenditure on Health as a Percentage of Gross Domestic Product <http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=122>