

# Access to anti-retroviral drugs as a component of the right to health in international law: Examining the application of the right in Nigerian jurisprudence

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## Summary

*Nigeria has a significant number of people living with HIV/AIDS. Access to anti-retroviral drugs is important to enable such persons to live a healthy life. This paper examines access to anti-retroviral drugs as part of the right to health under international law. It locates the right of health, its scope and content in international human rights instruments and attempts to draw the connection between access to anti-retroviral drugs and the right to health. It examines the interpretation of the right to health in the broader context of socio-economic rights in Nigerian jurisprudence. It concludes that the jurisprudence leaves much to be desired with respect to the protection of the right to health and specifically to access to anti-retroviral drugs.*

## 1 Introduction

Nigeria is a low-income developing country whose economy is mainly dependent on its oil exports. It is the most populous country in Africa with a population of about 133 million people.<sup>1</sup> It is estimated that

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<sup>1</sup> See United Nations Development Programme *Human Development Report 2003* (2003) 85.

about three million of these people are living with HIV/AIDS.<sup>2</sup> In 2001, Nigeria, alongside India, China, and Ethiopia, was described by a Central Intelligence Agency (CIA) report as one of the 'next wave countries', that is, countries where the HIV/AIDS crisis may reach frightening levels in a very short time, whose governments have been slow to respond to the disease and 'have not yet given the issue the sustained high priority that has been key to stemming the tide of the disease in other countries'.<sup>3</sup> Under military governments in Nigeria, and prior to the coming into power of a civilian administration in 1999, HIV/AIDS was not actively engaged with.<sup>4</sup> Nigeria had no policy for dealing with HIV/AIDS until 1997.<sup>5</sup>

More recently, the federal government has undertaken a rigorous campaign to combat the disease, both from a prevention perspective and a treatment standpoint. Through the National Agency for the Control of AIDS, established in 2000, the government is currently co-ordinating efforts to provide anti-retroviral drugs (ARVs) at the national level.<sup>6</sup> ARVs do not provide an ultimate cure, but are very effective in managing the disease by suppressing the effects of the virus, thus deferring the onset of AIDS. ARVs have changed the disease to a chronic but manageable medical condition, enabling people living with HIV/AIDS (PLWHA) to live healthy lives.<sup>7</sup> Nigeria commenced the provision of ARVs in January 2002 at subsidised rates, becoming one of the first African countries to take this step.<sup>8</sup>

Nigeria has received support from international initiatives aimed at increasing the number of persons accessing treatment, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Bank and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Recently, the National Agency for the Control of AIDS Act<sup>9</sup> was passed, establishing the co-ordinating body as a statutory

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<sup>2</sup> UNAIDS, AIDS Epidemic Update 2006 (Geneva UNAIDS 2006) [http://data.unaids.org/pub/EpiReport/2006/2006\\_EpiUpdate\\_en.pdf](http://data.unaids.org/pub/EpiReport/2006/2006_EpiUpdate_en.pdf) (accessed 2 July 2007).

<sup>3</sup> National Intelligence Council *The next wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India and China* (2002) 3 ICA 2002-04D (Next Wave Report) [http://img.thebody.com/whatis/pdfs/aids\\_wave.pdf](http://img.thebody.com/whatis/pdfs/aids_wave.pdf) (accessed 5 July 2007).

<sup>4</sup> G Kombe *et al* *Scaling up anti-retroviral treatment in the public sector in Nigeria: A comprehensive analysis of resource requirements* (2004) 3. 'Partners for health' [http://www.synergyaids.com/documents/PHRPlus\\_NigeriaARVFeb2004.pdf](http://www.synergyaids.com/documents/PHRPlus_NigeriaARVFeb2004.pdf) (accessed 22 June 2007).

<sup>5</sup> Next Wave Report (n 3 above).

<sup>6</sup> There is also co-ordination at the state and local governments. See *The National HIV/AIDS Strategic Framework 2005-2009* 3-4, online: [siteresources.worldbank.org/.../2693181-1155742859198/NigerianNationalStrategicFrameworkonHIVAIDS.pdf](http://siteresources.worldbank.org/.../2693181-1155742859198/NigerianNationalStrategicFrameworkonHIVAIDS.pdf) (accessed 11 October 2007).

<sup>7</sup> See World Health Organisation 'Anti-retroviral therapy' <http://www.who.int/hiv/topics/arv/en/print.html> (accessed 3 November 2003).

<sup>8</sup> Kombe *et al* (n 4 above) 4.

<sup>9</sup> National Agency for the Control of AIDS Act 2006 <http://www.naca.gov.ng/aboutus/naca-agency-act.pdf> (accessed 12 October 2007).

body, thus creating room for more effective and sustainable functioning. Currently, a significant number of people who require anti-retroviral treatment are still unable to access the drugs in Nigeria, even though the number of people on the drugs has increased substantially since the inception of the anti-retroviral programme.

From a human rights perspective, access to anti-retroviral drugs is most closely linked with the right to health, even though indirectly it may be linked to other rights, including the right to life. Human rights norms set broad standards for the obligations of countries with regard to realising the human rights to which their citizens are entitled.<sup>10</sup> Further, human rights are an instrument for compelling governments of countries to fulfil certain basic entitlements and expectations that people have, either through enforcement procedures where they exist, or through the exertion of public pressure on governments.<sup>11</sup> With specific regard to the health sector, Braveman and Gruskin point out that<sup>12</sup>

[t]he internationally recognised human rights mechanisms for legal accountability could be used by the health sector to provide processes and forums for engagement and to suggest concrete approaches to reducing poverty and health inequity. International human rights instruments thus provide not only a framework but also a legal obligation for policies towards achieving equal opportunity to be healthy, an obligation that necessarily requires consideration of poverty and social disadvantage.

Yamin also notes with specific regard to access to medicines that<sup>13</sup>

[h]uman rights law not only offers an alternative paradigm for understanding issues relating to the availability and distribution of medications, it also provides a workable framework for influencing the way in which adjudicative and legislative bodies, as well as other actors, make decisions that affect access to medications.

The aim of this article is to examine the legal foundations of access to anti-retroviral drugs within the context of the right to health in Nigeria. For this purpose, the meaning of the right to health is examined in international law, as well as its constitutional basis in Nigeria. The article consists of five sections. The first section of the paper is this introduc-

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<sup>10</sup> Z Lazarinni 'Access to HIV drugs: Are we changing the two world paradigm?' (2002) 17 *Connecticut Journal of International Law* 281 288.

<sup>11</sup> R Macklin *Against relativism: cultural diversity and the search for ethical universals in medicine* (1999) 221 where she notes: 'When a moral claim is cast in terms of human rights, it commands the attention of governments and citizens throughout the world. It also compels the need for a response on the part of those accused of violating human rights.'

<sup>12</sup> P Braveman & S Gruskin 'Poverty, equity, human rights and health' (2003) 81 *Bulletin of the World Health Organisation* 539 539.

<sup>13</sup> AE Yamin 'Not just a tragedy: Access to medications as a right under international law' (2003) 21 *Boston University International Law Journal* 325 327. See also H Watchirs 'A human rights approach to HIV/AIDS: Transforming international obligations into national laws' (2002) 22 *Australian Yearbook of International Law* 77 79-80.

tion. The second section puts the issues relating to access to anti-retroviral drugs in context and discusses briefly Nigeria's policy on access to anti-retroviral drugs. The third section examines the right to health in international law within the context of the health and human rights debate, specifically looking at the provisions of some international instruments, including the International Covenant on Economic, Social and Cultural Rights (CESCR) and the African Charter on Human and Peoples' Rights (African Charter). It also attempts to draw the link between the right to health and access to anti-retroviral drugs, and briefly identifies the need to situate the application of the international right to health in domestic legal systems. The fourth section examines the right to health under the Nigerian Constitution. The fifth section concludes the article.

## 2 The need for access to anti-retroviral drugs in Nigeria and Nigeria's policy on access

As mentioned above, Nigeria has about three million people living with HIV/AIDS. Nigeria has shown a commitment in recent years to combat HIV/AIDS and, in particular, to increase access to anti-retroviral treatment. In 2001, the government announced a programme to provide anti-retroviral treatment at subsidised rates in 25 treatment centres to 10 000 adults and 5 000 children living with HIV/AIDS.<sup>14</sup>

The National HIV/AIDS Policy drawn up in 2003 contains the stated policy of the Nigerian government to provide access to anti-retroviral drugs for PLWHA. It states:<sup>15</sup>

The government will work towards ensuring that all persons in the country shall have access to the quality of health care that can adequately treat or manage their conditions, *including the provision of anti-retroviral medication.*

Nigeria has committed to provide universal access in line with regional commitments and plans to provide, by 2010, at no cost in the public sector, anti-retroviral treatment to 80% of adults and children who require it, and to HIV-positive pregnant women. The more recent National HIV/AIDS Strategic Framework 2005-2009 builds further on Nigeria's policy on, and plan for, access to anti-retroviral treatment. It states that one of the objectives of the government is to: increase equitable access to ART and ensure an uninterrupted supply of good quality ARV drugs; strengthen capacity of health sector institutions, systems and personnel to plan and manage a well co-ordinated and adequately resourced health sector response to HIV and AIDS at all levels and enhance an efficient and sustainable logistics system for

<sup>14</sup> National HIV/AIDS Strategic Framework 2005-2009 (n 6 above).

<sup>15</sup> National HIV/AIDS Policy 2003 20 <http://www.nigeria-aids.org/documents/National-HIVPolicy.pdf> (accessed 12 October 2007) (my emphasis).

improved access to health commodities for HIV and AIDS-related services.<sup>16</sup> Amongst other things, it also contains several key findings from conferences and studies on the issue of access to anti-retroviral drugs and other related issues. These findings include an inadequate human, technical and institutional capacity, including inadequate infrastructure, staff, equipment and supplies to provide anti-retroviral services; the predominance of treatment centres in urban centres within tertiary institutions, thus limiting access in rural areas and that anti-retroviral treatment for children had not commenced.<sup>17</sup>

Many of these limitations remain. In the past, the programme faced some problems, including inadequate and irregular funding, inefficient planning, allegations of corruption and disruptions in supplies.<sup>18</sup> Currently, although significant steps are being taken, only about 81 000 people, 15% of those requiring anti-retroviral treatment, currently have access to it.<sup>19</sup> Only about 3% of children requiring anti-retroviral drugs are able to access treatment.<sup>20</sup> The major shortcomings of the Nigerian programme for access to anti-retroviral drugs have been summarised by a recent World Health Organisation (WHO) report, which notes that treatment sites are mainly located in urban areas, leaving rural areas with inequitable access to treatment centres. Also, many health facilities lack trained personnel. Further, although treatment is provided at no

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<sup>16</sup> See Objective 3 of the National HIV/AIDS Strategic Framework 2005-2009 (n 6 above).

<sup>17</sup> n 6 above, 11.

<sup>18</sup> Eg, from about June 2003 until about March 2004, many of the pilot sites established to supply the drugs did not have any supplies of drugs. Some of the sites also gave out expired ARVs to PLWHA, urging them to take the drugs since there were no other alternatives. See 'Nigeria: Over 14 000 on subsidised AIDS drugs run out of medication' *IRIN News* 3 February 2004 [http://www.plusnews.org/AIDSreport.asp?ReportID=2986&SelectRegion=West\\_Africa&SelectCountry=NIGERIA](http://www.plusnews.org/AIDSreport.asp?ReportID=2986&SelectRegion=West_Africa&SelectCountry=NIGERIA) (accessed 22 June 2007); O Akanni 'Saving the ARVs programme' (6 January 2004) Nigeria-AIDS <http://www.nigeria-aids.org/MsgRead.cfm?ID=2196> (accessed 23 June 2004); 'Nigeria: AIDS treatment resumes as depleted drug stocks replaced' *IRIN News* 12 March 2004 [http://www.irinnews.org/report.asp?ReportID=40035&SelectRegion=West\\_Africa&SelectCountry=NIGERIA](http://www.irinnews.org/report.asp?ReportID=40035&SelectRegion=West_Africa&SelectCountry=NIGERIA) (accessed 23 June 2007).

<sup>19</sup> WHO, UNAIDS & UNICEF 'Towards universal access: Scaling up priority HIV/AIDS interventions in the health sector: Progress report' (April 2007) 58 [http://www.who.int/hiv/mediacentre/universal\\_access\\_progress\\_report\\_en.pdf](http://www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf) (accessed 5 July 2007). Recently, in September 2007, however, NACA reported progress in the goal of creating increased access to anti-retroviral drugs. The treatment centres had been tripled, thereby helping to ensure access to anti-retroviral drugs for approximately 135 000 persons requiring the drugs. While this is laudable, Nigeria has been unable to meet the goal of providing treatment access for 250 000 people set by the government in 2006. See 'Nigeria triples number of HIV treatment centres, fails to meet target of providing anti-retrovirals to 250 000 HIV-positive people' *Kaiser Daily HIV/AIDS Report* September 20, 2007 [http://www.kaisernetwork.org/daily\\_reports/rep\\_index.cfm?DR\\_ID=47628](http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=47628) (accessed 11 October 2007).

<sup>20</sup> WHO, UNAIDS and UNICEF (n 19 above).

cost at public sector sites, the cost of diagnostic tests remains high and unaffordable for many patients.<sup>21</sup> The report concludes that<sup>22</sup>

[d]espite political commitment at the highest levels and efforts in recent years to scale up the national response, the coverage of basic health services for HIV prevention, care and treatment remains limited. A large country with a complex administrative structure, Nigeria faces the challenge of scaling up a co-ordinated response at the federal, state and local levels. The infrastructure and the skills for providing services are inadequate, especially in rural areas. Another problem is that the large private health sector is not linked to the state health system.

It is obvious that, while steps are being taken to expand access to anti-retroviral treatment in Nigeria, several impediments remain.

### 3 The right to health in international law

#### 3.1 Context and scope of the right

WHO defines 'health' as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.<sup>23</sup> The widely used definition of WHO has been criticised by many commentators as overly wide, too aspirational and somewhat devoid of actual meaning.<sup>24</sup> It has also been criticised as unrealistic and therefore an unsuitable foundation for determining the scope of the right to health.<sup>25</sup> Others are of the opinion that the definition of 'health' adds little or nothing to an understanding of the right.<sup>26</sup> While there may perhaps be problems with the WHO definition in relation to defining the scope of the right (such as the possible difficulty in explaining exactly what the right to health may contain and what specific steps may need to be taken in regard to protecting the right), it is a comprehensive definition which recognises that health is a concept that is dependent not only on therapeutic interventions and medical services, but also on psychological and social determinants. Such social determinants may include such factors as poverty and gender, which may

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<sup>21</sup> As above.

<sup>22</sup> As above.

<sup>23</sup> Preamble to the Constitution of the World Health Organisation as adopted by the International Health Conference, New York, 19-22 June 1946; signed on 22 July 1946 by the representatives of 61 states (Official Records of the World Health Organisation 2, 100) and entered into force on 7 April 1948.

<sup>24</sup> See BCA Toebes *The right to health in international law* (1999) 22-24. It is now accepted that the right to health does not mean a right to be healthy, since no one can guarantee good health to anyone. See DP Fidler *International law and public health: Materials on and analysis of global health and jurisprudence* (2000) 302. See a criticism of a 'right to health' as opposed to a 'right to health care' in R Macklin *Against relativism: cultural diversity and the search for ethical universals in medicine* (1999) 235.

<sup>25</sup> As above.

<sup>26</sup> Toebes (n 24 above) 24. In Toebes's opinion, the right to health can be defined by its content without necessarily having recourse to a definition of 'health'.

increase vulnerability to illness as well as preclude access to health-improving facilities. The definition has a special significance in light of the vulnerability of certain categories of persons to HIV/AIDS, (for example, women) and the increased likelihood of inability to have access to essential medicines like ARVs. Further, the definition represents an ideal that ought to be aspired to by all countries which should aim to promote health in all possible ways, including attending to the underlying preconditions for health.

In recent years, HIV/AIDS has brought into focus the relationship between health and human rights.<sup>27</sup> In particular, the right to health has been invoked more frequently in the context of the HIV/AIDS epidemic and access to ARVs in developing countries than it has perhaps been in the past. The link between health and human rights has been articulated elsewhere.<sup>28</sup> As has been argued in detail elsewhere, these links include the fact that health policies and programmes, such as policies to provide anti-retroviral drugs (or not to do so) impact on the human rights of citizens and that human rights violations, such as the use of torture in interrogations, may have an impact on health. Thus, as has been argued in detail elsewhere, the 'promotion and protection of human rights and promotion and protection of health are fundamentally linked'.<sup>29</sup> Below, I consider the ways in which health has been provided for in human rights instruments.

The Universal Declaration of Human Rights (Universal Declaration)<sup>30</sup> provides for the right to health in article 25: 'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family . . .' The WHO definition is reflected in article 12 of CESCR, which provides for the right to health, stating: 'The States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' This socio-economic right (sometimes referred to as a second-generation right<sup>31</sup>), is couched in similar terms in the African Charter,<sup>32</sup> which

<sup>27</sup> DP Fidler *International law and infectious diseases* (1998) 197.

<sup>28</sup> JM Mann *et al* 'Health and human rights' 1:1 *Health and Human Rights: An International Journal* <http://www.hsph.harvard.edu/fxbcenter/V1N1mannetal.htm> (accessed 11 October 2007).

<sup>29</sup> As above.

<sup>30</sup> Universal Declaration of Human Rights GA Res 217A (III), UN Doc A/810 71 (10 December 1948).

<sup>31</sup> C Archibold 'The incorporation of civic and social rights in domestic law' in J-M Copicud *et al* (eds) *The globalisation of human rights* (2003). See also M Craven *The International Covenant on Economic, Social and Cultural Rights: A perspective on its development* (1995) 8.

<sup>32</sup> African Charter on Human and Peoples' Rights 21 June 1981 OAU Doc CAB/LEG/67/3Rev 5, (1982) 21 *International Legal Materials* 58 (entered into force 21 October 1986), reprinted in C Heyns & M Killander (eds) *Compendium of key human rights documents of the African Union* (2006) 23.

provides that: '[e]very individual shall have the right to enjoy the best attainable state of physical and mental health'.<sup>33</sup>

Having noted that these international instruments provide for the right to health, the question that arises is: What is the content and scope of the right to health? This can be determined by examining the provisions of some international instruments. In addition to providing for the right to health, article 12 of CESCRC contains steps to be taken by countries which are parties to CESCRC in order to fully achieve the right to health. It provides that in order to realise the right to health, countries should take steps necessary for the prevention, treatment and control of epidemic, endemic occupational and other diseases.<sup>34</sup> It provides also that countries have to take measures towards the creation of conditions which would assure medical service and medical attention to everyone in the event of sickness.<sup>35</sup> Similarly, article 16(2) of the African Charter also provides that

[s]tate parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

These measures, required by both instruments, would appear to cover the need for countries not only to engage in prevention measures in relation to the HIV/AIDS epidemic, but also to assure treatment to persons infected with the disease. Such treatment (which should include anti-retroviral treatment) is conceivably therefore a component of the right to health of such persons under CESCRC. In addition, it also covers the need for countries to ensure that there are adequate facilities to deliver the treatment in an appropriate manner which, as explained previously, is necessary to ensure increased access to ARVs.

The United Nations (UN) Economic, Social and Cultural Rights Committee (ESCR Committee), which is responsible for implementing, monitoring and enforcing CESCRC, has further clarified the normative content and scope of the right as provided in CESCRC in a General Comment.<sup>36</sup> The General Comment sheds light on the obligations of countries which have ratified CESCRC to respect, protect and fulfil the right to health.<sup>37</sup> The General Comment on the right to health is the

<sup>33</sup> Art 16.

<sup>34</sup> Art 12(2)(c) CESCRC.

<sup>35</sup> Art 12(2)(d) CESCRC.

<sup>36</sup> ESCR Committee General Comment No 14: The right to the highest attainable standard of health (art 12 of the Covenant), 22nd session, 25 April to 12 May 2000 E/C.12/2000/4.

<sup>37</sup> Given the differences of opinion which may exist as a result of the different interpretations which countries could give to the provisions of CESCRC and their obligations under it, there is a need for an authoritative interpretation of the provisions and the obligations incurred thereunder. As Craven rightly states: '[I]n the absence of any authoritative procedure for settling the divergences of opinion over the interpretation of the Covenant, it is for states parties to construe the Covenant for



only UN document in which the content and the scope of the right to health are explained. Thus, although the General Comment is not binding, it is at least a primary point of reference which clarifies the scope of the right and provides countries with guidance as to the requirements of complying with the obligations they incur with respect to the right to health. The General Comment reiterates that<sup>38</sup>

[h]ealth is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.

In defining the normative content of the right, the General Comment states that the right takes into account the biological conditions of an individual, socio-economic conditions and the resources available to a country, and recognises that countries cannot guarantee good health or protect against all possible causes of ill-health.<sup>39</sup> As such, the right to health must be seen to connote a right to 'the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health'.<sup>40</sup> It also interprets the right to health to include not only early and proper health care, but also the underlying determinants of health, such as access to clean water and proper sanitation, a sufficient supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including information relating to sexual and reproductive health.<sup>41</sup>

Like all other human rights, the right to health imposes on countries the obligations to respect, protect and fulfil the right.<sup>42</sup> The precise application of the right according to the General Comment relates to

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themselves. Individual states may put forward their own interpretations of the Covenant's provisions but such interpretations are by no means authoritative and may be rejected by other states. In fact, states have rarely made direct statements regarding the meaning of Covenant provisions.' See A Rosas & M Scheinin 'Implementation mechanisms and remedies' in A Eide *et al* (eds) *Economic, social and cultural rights: A textbook* (1995) 379.

<sup>38</sup> Para 1 of the General Comment.

<sup>39</sup> Para 9. It also acknowledges that the right to health does not mean the right to be healthy.

<sup>40</sup> n 24 above.

<sup>41</sup> Para 11.

<sup>42</sup> Para 33. The General Comment, however, recognises also the application of the concept of progressive realisation as provided in CESCR and the resource constraints to which state parties may be subject, but states that some of the obligations under the right to health are of immediate effect, in particular the obligation to ensure non-discrimination in guaranteeing the right to health. It also states that the concept of progressive realisation should not be interpreted to mean a complete denial of the obligations which countries have under CESCR. See paras 30 & 31.

several elements namely, availability,<sup>43</sup> accessibility,<sup>44</sup> acceptability<sup>45</sup> and quality.<sup>46</sup> The General Comment also elucidates the obligations of countries with regard to implementing the right to health. It interprets the obligations as involving the obligation to respect, to protect and to fulfil. Countries are under a duty to respect the right to health, among other things, by refraining from denying or limiting the equal access for all persons to preventive, curative and palliative health services and abstaining from enforcing discriminatory practices as state policy.<sup>47</sup> The negative nature of this obligation requires governments, for example, not to deny health services to any specific group of people.

The obligation to protect involves, among other things, the duty to adopt legislation or take other steps in order to ensure equal access to health care and health-related services provided by third parties, including ensuring that medical practitioners have adequate training and that privatisation of the health sector does not jeopardise availability, accessibility, acceptability and quality of health facilities, goods and services

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<sup>43</sup> 'Availability' involves the presence of sufficient functioning public health and health-care facilities, goods and services, as well as programmes. These facilities must include the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs (para 12(a)).

<sup>44</sup> 'Accessibility' implies that health facilities, goods and services have to be accessible to everyone within a country's jurisdiction without discrimination. There are four dimensions to the requirement for 'accessibility', including non-discrimination, which means that health facilities, goods and services must be accessible to everyone, particularly to vulnerable and marginalised groups without discrimination. The second dimension is physical accessibility, which means that the health facilities, goods and services must be within easy reach for all sections of the population, particularly for vulnerable and marginalised groups, including ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. They must also be accessible to persons in rural areas. Economic accessibility or affordability is another dimension of 'accessibility' and requires that health facilities, services and goods must be affordable for all including socially disadvantaged groups. The General Comment further states that payment must be made on the principle of equity and poorer households should not be disproportionately burdened with health expenses as compared to richer households. The fourth dimension is information accessibility, which requires that persons shall be able to seek, receive and impart information (para 12(b)).

<sup>45</sup> 'Acceptability' requires that all medical services must be respectful of medical ethics as well as culture (para (c)).

<sup>46</sup> 'Quality' requires that health facilities, goods and services must be scientifically, medically and appropriate and of good quality. Among other things, this would necessitate the presence of skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. As is discussed in the next subsection, these requirements have implications for access to ARVs (para (d)).

<sup>47</sup> Para 34.

and to control the marketing of medical equipment and medicines by third parties.<sup>48</sup>

The obligation to fulfil requires countries to take positive steps to promote the right to health. These steps include recognition through legislation of the right to health in the national legal system and establish a national policy with a detailed plan to ensure the right to health.<sup>49</sup> Countries must ensure the provision of health care, including immunisation against infectious diseases, public health services, including reproductive health services, particularly in rural areas, the underlying determinants of health. Countries are also required to ensure appropriate training of doctors, the provision of a sufficient number of hospitals, clinics and other health-related facilities, as well as the promotion of and support for the establishment of institutions providing counselling and mental health services. These must be provided with due regard to equitable distribution throughout the country. Further, countries are under an obligation to take positive measures to enable and assist individuals and communities to enjoy the right to health. In particular, countries are under an obligation to fulfil the right to health for individuals and groups who are unable for reasons beyond their control to realise the right to health for themselves by providing them with the requirements for realising the right.<sup>50</sup> The obligation to fulfil or promote the right to health requires countries to undertake actions that create, maintain and restore the health of the population.<sup>51</sup>

The General Comment further states that countries have a core obligation to satisfy '*at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care*'.<sup>52</sup> As such, it identifies the core obligations of countries with regard to the right to health as including, at least, ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups, minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone, access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water. The core obligations also include providing essential drugs, 'as from time to time defined under the WHO Action Programme on Essential Drugs and ensuring equitable distribution of all health facilities, goods and services'.<sup>53</sup> The minimum core obligations of countries are especially important because they are non-derogable and countries cannot

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<sup>48</sup> Para 35.

<sup>49</sup> Para 3.

<sup>50</sup> Para 36.

<sup>51</sup> Para 37.

<sup>52</sup> Para 43 (my emphasis).

<sup>53</sup> Para 43.

'under any circumstances' justify non-compliance with these obligations.<sup>54</sup>

### 3.2 Access to anti-retroviral drugs as a component of the right to health: Examining the links

The right to health, as contained in CESCRC and the African Charter, is applicable to all human beings and imposes obligations on countries that are parties to these instruments. What would the right to health mean for people living with HIV/AIDS? For one thing, it could mean the availability of treatment for opportunistic infections to which they are subject because of the failure of their immune system as a result of HIV infection. It could also mean availability of health facilities which are necessary to receive care for HIV/AIDS-related illnesses. However, the need for ARVs may be more necessary, especially for those who can no longer benefit substantially from the sole treatment of opportunistic infections.

With respect particularly to children, the Convention on the Rights to the Child (CRC)<sup>55</sup> provides for the right of children to the highest attainable standard of health and to facilities for the treatment of children. The CRC Committee has in a recent General Comment on HIV/AIDS and the Right of the Child clarified that the right to health of children specifically requires countries to provide anti-retroviral treatment, amongst other things, stating that<sup>56</sup>

[t]he obligations of states parties under the Convention extend to ensuring that children have sustained and equal access to comprehensive treatment and care, including necessary HIV-related drugs . . . It is now widely recognised that comprehensive treatment and care includes anti-retroviral and other drugs, diagnostics and related technologies for the care of HIV/AIDS, related opportunistic infections and other conditions.

In recent resolutions, the Commission on Human Rights has also recognised that access to medications in the context of the pandemic such as HIV/AIDS is a fundamental element to realising the right to health and calls upon countries to pursue policies which ensure the availability, accessibility and affordability of pharmaceutical products and medical technologies necessary for the treatment of HIV/AIDS.<sup>57</sup> It further calls

<sup>54</sup> Para 47 (my emphasis).

<sup>55</sup> Art 28 of the Convention on the Rights of the Child, GA Res 44/25, annex, 44 UN GAOR Supp (49) 167, UN Doc A/44/49 (1989) (entered into force 2 September 1990).

<sup>56</sup> General Comment No 3: HIV/AIDS and the Rights of the Child, Committee on the Rights of the Child, 32nd session, UN Doc CRC/GC/2003/1 (2003) para 25.

<sup>57</sup> See Commission on Human Rights 'Access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria' 56th session of the Commission on Human Rights E/CN.4/2003/L.33. See also Commission on Human Rights Resolution 2001/33 'Access to medication in the context of pandemics such as HIV/AIDS' adopted 20 April 2001, (E/CN.4/RES.2001.33) and art 15 of the Declaration of Commitment on HIV/AIDS UNGA Res.A/Res/S-26/2.

upon countries to adopt and implement legislations and positive measures in accordance with international law and international agreements acceded to in order to safeguard access to pharmaceutical and medical technologies from any limitations by third parties.<sup>58</sup> With specific regard to the problems posed by pharmaceutical patents which have been discussed extensively elsewhere,<sup>59</sup> this would refer to the need for countries to take legislative steps to ensure that developing countries benefit from agreements in international trade organisations, such as the World Trade Organisation, which allow for public health exceptions to intellectual property rules, thus allowing for the manufacture, exportation and importation of cheaper generic versions of ARVs.<sup>60</sup> On the international level, the Commission on Human Rights calls upon developed countries to assist resource-poor developing countries in ensuring access to pharmaceutical and medical technologies and ensure that their actions as members of international organisations take into consideration the right to health.<sup>61</sup>

The Declaration of Commitment on HIV/AIDS, adopted by the General Assembly, also recognises that access to ARVs is fundamental to realising the right to health of PLWHA and is an essential part of the efforts by countries to combat the epidemic.<sup>62</sup> The Declaration shows that countries recognise, at least in principle, the danger that HIV/AIDS poses to societies in developing countries and the role that anti-retroviral treatment can play in mitigating such danger. Like most soft law instruments which are not intended to be legally binding, the Declaration reflects a good faith commitment and a desire to influence the actual practice of countries,<sup>63</sup> and as such can be used not only as reflecting the desire of countries to provide access to ARVs (amongst

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<sup>58</sup> Art 5.

<sup>59</sup> See, eg, P Cullett 'Patents and medicines: The relationship between patents and the human right to health' (2003) 79 *International Affairs* 139; B Loff & M Heywood 'Patents on drugs: Manufacturing capacity or advancing health?' (2002) 30 *Journal of Law, Medicine and Ethics* 621. See also M Berger 'Tripping over patents: AIDS, access to treatment and the manufacturing of scarcity' (2002) 17 *Connecticut Journal of International Law* 157.

<sup>60</sup> Decision on implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and public health, Decision of 30 August 2003 WTO Doc WT/L/540 (2003) WTO [http://www.wto.org/english/tratop\\_e/trips\\_e/implement\\_para6\\_e.htm](http://www.wto.org/english/tratop_e/trips_e/implement_para6_e.htm) (28 October 2003) which allows developing countries which lack the capacity for manufacturing to import generic drugs and amends the Agreement on Trade-Related Aspects of Intellectual Property, 15 April 1994 Agreement Establishing the World Trade Organisation Annex 1C, Results of the Uruguay Round of Multilateral Trade Negotiations: The Legal Texts 6 ILM 119.

<sup>61</sup> Art 8. See also art 15 of the Declaration of Commitment on HIV/AIDS UNGA ResA/Res/S-26/2.

<sup>62</sup> See art 15 of the Declaration.

<sup>63</sup> See AE Boyle 'Some reflections on the relationship of treaties and soft law' (1999) 48 *International and Comparative Law Quarterly* 902, where the author describes here how soft instruments may become non-binding law.

other things), but as a tool to encourage governments to act in response to the need for wide access to ARVs in developing countries.<sup>64</sup>

In line with the General Comment's interpretation of the right to health, which includes access to essential drugs like ARVs, and the resolution of the Commission on Human Rights, the office of the UN High Commissioner for Human Rights and UNAIDS have formulated guidelines on human rights in the context of HIV/AIDS, the International Guidelines on HIV/AIDS and Human Rights (Guidelines).<sup>65</sup> The Guidelines, which are non-binding, are designed to help countries prepare adequate policies and to respect human rights.<sup>66</sup> The Guidelines have been argued to form a 'soft law' bridge between 'hard law' international obligations and the practice of countries.<sup>67</sup> The Guidelines were issued first in 1998. Guideline 6, which deals expressly with access to medicines, was, however, revised in 2002 to take into account the obligation of countries to provide ARVs as part of the right to health as interpreted by the ESCR Committee in the General Comment in 2000, as well as other developments in the area of access to HIV/AIDS treatment.<sup>68</sup> It states that<sup>69</sup>

[u]niversal access to HIV/AIDS prevention, treatment, care and support is necessary to respect, protect and fulfill human rights related to health, including the right to enjoy the highest attainable standard of health. Universal access will be achieved progressively over time.

Although the Guidelines recognise that the right to health must be achieved progressively over time, it nevertheless states that countries have an immediate obligation to take steps as quickly as possible to ensure, among other things, access to treatment.<sup>70</sup> Guideline 6, which is expressed in very similar terms as found in the General Comment but which refers specifically to HIV/AIDS treatment, recommends the enactment of legislation by countries to provide for HIV-related goods, services and information so as to ensure, among other things, safe and effective medication. Countries are required under the guideline to ensure access to essential medications at affordable prices, and on a non-discriminatory, sustainable basis. It further requires countries to

<sup>64</sup> D Patterson & L London 'International law, human rights and HIV/AIDS' (2002) 80 *Bulletin of the World Health Organisation* 964 966.

<sup>65</sup> UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights* (1997). See also UNAIDS & OHCHR *International guidelines on HIV/AIDS and human rights: Revised Guideline 6* (2002) <http://www.unhchr.ch/hiv/g6.pdf> (3 August 2004). The guidelines were developed by the Second International Consultation on HIV/AIDS and Human Rights. The Guidelines were drawn up after the Secretary-General of the UN recommended to Commission Human Rights that guidelines were needed to clearly outline the application of human rights in the context of HIV/AIDS.

<sup>66</sup> See Preface to the Revised Guideline 6.

<sup>67</sup> Watchirs (n 13 above) 98.

<sup>68</sup> n 65 above.

<sup>69</sup> Para (b) of Guideline 6.

<sup>70</sup> See n 66 above.

take measures to ensure for all persons, on a sustained and equal basis, the availability and accessibility of HIV-related goods, including anti-retroviral and other safe and effective medicines. Countries are also to pay particular attention to vulnerable individuals and populations.

Apart from the express link between access to ARVs and the right to health, eliminating the obstacles which may impede access to and the delivery of ARVs in developing countries is also necessary for the full enjoyment of the right to health. The interpretation of the right to health to include the underlying determinants of health would mean that countries have obligations under the right to health to deal with the political, economic and health structure obstacles which may prevent access to ARVs, including the inadequacy of a health infrastructure, the non-availability of trained medical professionals, particularly in rural areas, and inequitable resource distribution.<sup>71</sup> Dealing with these obstacles is very clearly a part of fulfilling the right to health as revealed by the General Comment with regard to the application of the right by countries under the criteria of availability, accessibility, acceptability and quality provided under the General Comment.<sup>72</sup> For instance, the availability criterion requires that the presence of sufficient functioning public health and health-care facilities, goods and services, trained medical professionals as well as programmes are necessary. Countries are therefore required as part of their obligations under the right to health to take steps within their available resources as required under article 2(1) of CESCR to deal with inadequacy of health structures as part of progressively fulfilling the right to health of PLWHA as well as the entire populace.

The accessibility principle involves affordability and thus requires countries to provide what may be necessary for the enjoyment of the right to health for people who cannot afford to provide it for themselves. It is thus obligatory for countries to put in place health insurance schemes to enable their citizens to pay for health services. This is particularly important in developing countries like Nigeria, where many people cannot afford to pay for health services or make out of pocket spending. It is necessary to take steps to the extent possible to provide free ARVs for those who cannot afford to pay for them and to subsidise other costs associated with anti-retroviral treatment. It also requires that health facilities should be accessible to all parts of the country. This would involve ensuring that rural areas have health facilities which

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<sup>71</sup> MC Hosseinipour *et al* *Challenges in delivering anti-retroviral treatment in resource-poor countries* (2002) 16 (Suppl. 4) *AIDS* S178; SS Abdool Karim *et al* *Implementing anti-retroviral therapy in resource-constrained settings: Opportunities and challenges in integrating HIV and tuberculosis care* (2004) 18 *AIDS* 975; UNAIDS 2004 *Report on the Global AIDS Epidemic* (Geneva: UNAIDS, 2004); C Webb 'AIDS: The real problem is getting the medicine out' *International Herald Tribune* 14 July 2004.

<sup>72</sup> Paras 12(a)-(d); T Barnett & A Whiteside *AIDS in the twenty-first century: Disease and globalisation* (2002).

PLWHA living in rural areas can easily access. The quality principle states amongst other things that the right to health includes the provision of unexpired drugs as well as trained health personnel. Countries would therefore have to monitor the proper administration and utilisation of ARVs provided to PLWHA. For instance, it must be ensured that the drugs provided are safe and that they are not expired. The provision of expired ARVs has already occurred in Nigeria.<sup>73</sup> Ensuring good quality ARVs would also involve a provision of monitoring equipment to ensure that the risks of drug resistance are reduced substantially. The Guidelines also expressly recognise the various obstacles which may impede access to ARVs and require countries to take measures to deal with these obstacles. Accordingly, it states that<sup>74</sup>

[a]ccess to HIV/AIDS-related information, goods and services is affected by a range of social, economic, cultural, political and legal factors. States should review and, where necessary, amend or adopt laws, policies, programmes and plans to realise universal and equal access to medicines, diagnostics and related technologies, taking these factors into account.

The Guidelines also recommend that countries increase their budgetary allocation in order to provide sustainable access to ARVs and other HIV/AIDS related goods.<sup>75</sup>

It seems fairly obvious that to respect, protect and fulfil the right to health of PLWHA, countries may be argued to have legal obligations not only to provide ARVs, but also to take steps to eliminate the obstacles which may impede access to ARVs for PLWHA.

### **3.3 The need to examine the application of the international right to health in domestic legal systems**

As shown above, the right to health is entrenched in international law, and gives rise to international legal obligations to ensure that PLWHA have access to ARVs. It is, however, important to examine the application of the right to health under the domestic laws of developing countries for various reasons. International human right obligations contained in international human rights instruments are primarily meant to apply domestically within countries and the obligations therein are required to be discharged in the domestic setting.<sup>76</sup> However, although many countries have ratified or signed international human rights treaties, including CESC (currently 145 states have

<sup>73</sup> See n 18 above.

<sup>74</sup> Para (d) of Guideline 6.

<sup>75</sup> Para (c) of Guideline 6.

<sup>76</sup> Countries are required to give effect to their obligations under international human rights treaties, including CESC, within their domestic legal systems. See ESCR Committee General Comment No 9: The domestic application of the Covenant (1998) UN Doc E/1999/22, Annex IV, (19th session, 1998), UN Doc E/C.12/1998/24 (1998).



ratified CESCER),<sup>77</sup> such ratification may simply be a ceremonial and empty gesture<sup>78</sup> unless brought into the domestic legal system. Thus, domestic legal systems may offer more effective protection of human rights to citizens because, where human rights norms are established in legislation or jurisprudence, they acquire a special status which is not easily changed.<sup>79</sup> Where they are recognised as justiciable in domestic law, (either in the constitution or other legislation), human rights norms can be enforced in domestic courts by interested parties. Further, the orders of domestic courts may have a stronger effect than the recommendations and concluding observations made by human rights monitoring committees, the execution of which frequently depends on good faith on the part of countries. Government accountability with respect to the protection and promotion of human rights may therefore be better guaranteed within domestic legal systems than in international law where adequate enforcement mechanisms may present difficulties.<sup>80</sup> Domestic jurisprudence may also influence the interpretation of rights and obligations in international law.<sup>81</sup> With particular regard to the right to health, the interpretation by domestic courts of the obligations of countries under the right to health may provide evidence of state practice, thus strengthening the effect of the right in international law, as well as provide further resources for legal analysis of the right in international law.<sup>82</sup>

There are, of course, debates about the justiciability of socio-economic rights such as the right to health.<sup>83</sup> Such debates frequently revolve around the legitimacy of socio-economic rights and how they are incorporated in the domestic legal system, whether as enforceable

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<sup>77</sup> Office of the United Nations High Commissioner for Human Rights Status of Ratifications of the International Human Rights Instrument Treaties (as of June 2004) <http://www.unhchr.ch/pdf/report.pdf> (accessed 6 July 2007).

<sup>78</sup> See C Heyns & F Viljoen 'The impact of the United Nations treaties on the domestic level' (2001) 23 *Human Rights Quarterly* 483.

<sup>79</sup> C Archibold 'The incorporation of civic and social rights in domestic law' in Copicud *et al* (n 31 above) 57; Heyns & Viljoen (n 78 above) 483.

<sup>80</sup> Heyns and Viljoen note that internalising treaty norms into the constitution as justiciable norms into the domestic legal system represents one of the most powerful ways in which treaty norms could be enforced on the domestic level. See Heyns & Viljoen (n 78 above) 500.

<sup>81</sup> See art 38(1)(d) of the Statute of the International Court of Justice, which states that the sources of international law provide that the decisions of national courts can be a subsidiary means for interpreting rules of international law. Statute of the International Court of Justice <http://www.icj-cij.org/icjwww/ibasicdocuments/ibasictext/ibasicstatute.htm> (accessed 24 August 2004). See Heyns & Viljoen (n 78 above).

<sup>82</sup> Fidler (n 24 above) 309. See Watchirs (n 13 above) 108. See also MA Torres 'The human right to health, national courts, and access to HIV/AIDS treatment: A case study from Venezuela' (2002) 3 *Chicago Journal of International Law* 107-108.

<sup>83</sup> See M Pieterse 'Coming to terms with judicial enforcement of social rights' (2004) Paper presented at the *South African Journal on Human Rights Conference*, 5-7 July 2004 [http://wwwserver.law.wits.ac.za/sajhr/conference\\_papers/pietersepaper.pdf](http://wwwserver.law.wits.ac.za/sajhr/conference_papers/pietersepaper.pdf) (accessed 6 July 2007).

rights or merely as directive principles of state policy.<sup>84</sup> These issues can be resolved more effectively within the domestic legal system of countries. It is therefore necessary to investigate the domestic legal systems of countries to determine how the right to health is incorporated and the limits of the obligations of governments, particularly as regards access to ARVs. For the purpose of the analysis carried out here, the next section of this article will examine the protection of the right to health in the Nigerian Constitution. It will look at the application of international law in Nigeria, with particular regard to the right to health, as well as judicial decisions which have implications for the right to health and for access to ARVs.

#### 4 The right to health in Nigeria

As discussed above, the right to health as provided for in international human rights law requires, among other things, that national legislation and policy be established with a detailed plan to ensure the right to health as well as the provision of health care and public health services, particularly in rural areas, the appropriate training of doctors, and the provision of a sufficient number of hospitals, clinics and other health-related facilities. Further, as discussed above, countries have obligations under the right to health to deal with the political, economic and health structure obstacles which may prevent access to ARVs, including the inadequacy of health infrastructure, the non-availability of trained medical professionals, particularly in rural areas, and inequitable resource distribution.<sup>85</sup>

Nigeria has developed a policy to provide access. However, as pointed out in section 2, several problems remain, particularly in relation to the adequacy of coverage, sufficiency of trained health personnel, inequitable access of the drugs and other facilities between urban and rural areas, with rural areas suffering a disadvantage. Below, I examine the effectiveness with which the right to health as described above is applied in Nigerian jurisprudence and the possibility of compelling government to take further steps to increase access in the courts. I consider the provision and application of the right by the courts under the constitution and international human rights instruments to which Nigeria is a party. I finally consider very briefly the application of the right in other developing world jurisdictions in comparison with Nigeria.

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<sup>84</sup> Pieterse (n 83 above) 8.

<sup>85</sup> See n 72 above.

#### 4.1 The Constitution

The Constitution of the Federal Republic of Nigeria, adopted in 1999,<sup>86</sup> provides for the protection of the rights of individuals and obligations of government. Like the Indian Constitution, the Nigerian Constitution contains fundamental rights,<sup>87</sup> consisting of civil and political rights and fundamental objectives and directive principles of state policy containing socio-economic rights.<sup>88</sup> Fundamental rights are enforceable by citizens against the government in Nigerian courts.<sup>89</sup> By contrast, fundamental objectives and directive principles of state policy do not entitle citizens to any actionable claims and are non-justiciable under the Nigerian Constitution.<sup>90</sup> In this regard, section 6 of the Constitution ousts the jurisdiction of the courts with regard to fundamental objectives, stating that<sup>91</sup>

[t]his section shall not, except as other wise 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 judicial decision is in conformity with the Fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution.

In cases such as *Archbishop Olubunmi Okogie and Others v Attorney-General of Lagos State* and *Adeyinka Badejo v Federal Minister of Education and Others*, Nigerian courts have held severally that the fundamental objectives and directive principles of state policy are non-justiciable and therefore the courts lack jurisdiction to deal with them.<sup>92</sup> They held that section 6(6)(c) of the Nigerian Constitution, which declares the fundamental objectives and directive principles of state to be non-justiciable, takes precedence over section 13, which provides that all the organs of government have the duty and responsibility to conform to, observe and apply the fundamental objectives and directive principles.<sup>93</sup> Nigerian courts have not read the fundamental objectives as part of the fundamental rights in order to ensure a greater level of accountability on the part of government with regard to the realisation of the

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<sup>86</sup> Constitution of the Federal Republic of Nigeria 1999 <http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.htm> (accessed 6 July 2007).

<sup>87</sup> Ch IV of the Constitution of Nigeria.

<sup>88</sup> Ch II.

<sup>89</sup> Sec 46 of the Constitution.

<sup>90</sup> Sec 6(6)(c) of the Constitution.

<sup>91</sup> See n 76 above.

<sup>92</sup> See *Archbishop Olubunmi Okogie & Others v Attorney-General of Lagos State* (1981) 1 NCLR 218; *Adeyinka Badejo v Federal Minister of Education & Others* Suit No M/500/88 of High Court of Lagos State (ruling delivered on 4 November 1988).

<sup>93</sup> See n 92 above.

fundamental objectives and directive principles.<sup>94</sup> Nigerian courts seem to be shy of going beyond the literal letter of the law. Indeed, there has been little protection of human rights in Nigeria, particularly, under the military, when court orders constituting redress against human rights violations were routinely ignored by the executive.<sup>95</sup> It is therefore perhaps not very surprising (although not necessarily excusable) that Nigerian courts are reluctant to enforce socio-economic rights as contained in the directive principles, such as the right to health. It would therefore seem that the enforceability of the right to health and the accompanying obligations in Nigerian courts are in doubt.

In Nigeria, although fundamental objectives and directive principles are not enforceable in the courts, the executive, legislative and judicial arms of government are under a constitutional obligation to observe and apply them.<sup>96</sup> The fundamental objectives and directive principles, although not justiciable, were entrenched in the Constitution in order to promote the welfare and the advancement of society.<sup>97</sup> Thus, as some authors have argued, the fundamental objectives and directive principles are a serious mandate as well as a benchmark for measuring the performance of the government.<sup>98</sup>

Like other socio-economic rights, the right to health is contained in the Nigerian Constitution as a directive principle. The right as provided for in the Nigerian Constitution is very narrowly defined. Section 17 provides as follows:<sup>99</sup>

The State shall direct its policy towards ensuring that:

...

- (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused;
- (d) there are adequate medical and health facilities for all persons.

What may be construed as the right to health in Nigeria is therefore couched less broadly than in international human rights instruments,

<sup>94</sup> This is unlike the Indian courts and other courts such as the Ghanaian and Ugandan courts operating under similar constitutions. See C Obiagwu & CA Odinkalu 'Nigeria: Combating legacies of colonialism and militarism' in AA An-N'aim (ed) *Human rights under African constitutions: Realising the promise for ourselves* (2003) 226. See GW Kanyeihamba 'Constitutional obligation in developing countries' in ML Marasinghe & WE Conklin (eds) *Essays on third world perspectives in jurisprudence* (1984) 55; J Krishnan 'The rights of the new untouchables: A constitutional analysis of HIV jurisprudence in India' (2003) 25 *Human Rights Quarterly* 791.

<sup>95</sup> Obiagwu & Odinkalu (n 94 above) 227-228.

<sup>96</sup> Sec 13 of the Constitution. See BO Nwabueze *The Presidential Constitution of Nigeria* (1982) 456. See also BO Okere 'Fundamental objectives and directive principles of state policy under the Nigerian Constitution' (1978-1988) 3 *Nigerian Juridical Review* 74.

<sup>97</sup> BO Okere 'Fundamental objectives and directive principles of state policy under the Nigerian Constitution' (1983) 32 *International and Comparative Law Quarterly* 214-215.

<sup>98</sup> Okere (n 97 above) 228.

<sup>99</sup> Secs 17(c) & (d) of the Nigerian Constitution.

with obligations in regard only to ensuring occupational safety and the provision of adequate medical and health facilities. The right to health as contained in the Nigerian Constitution does not create obligations on the government in respect of the underlying determinants of health. However, establishing and implementing policies with regard to access to ARVs and the provision of adequate delivery systems undoubtedly comes within the scope of the government's obligation to provide adequate medical and health facilities for all persons as required by the Constitution. The government's policy of making ARVs available to a small number of PLWHA can therefore be seen as a step towards complying with the fundamental objectives and directive principles of state policy.

The non-justiciability of the right to health under the Nigerian Constitution, however, makes it difficult (if not impossible) to hold the government accountable for taking adequate steps to ensure access to ARVs and for Nigerian courts to question the reasonableness of the government's policy as courts in other jurisdictions have done.<sup>100</sup> The obligations of the government to ensure access to ARVs would therefore appear to be largely discretionary. Given that irregularities have previously occurred and may occur in the future in the current anti-retroviral programme run by the government, it may be difficult to compel the government to discharge its 'obligations' to ensure access to ARVs and to deal with any obstacles to access.

Despite these difficulties, however, it may be argued, as Okere has, that mere non-justiciability of the fundamental objectives does not completely divest them of any legal value. In his view, '[e]ven though disregard of these [p]rinciples cannot affect the validity of the legislation, a bold judiciary may yet vest them with legal significance'.<sup>101</sup> This view can, however, be extended to the interpretation of fundamental rights. In this regard, Nigerian courts can investigate whether or not fundamental rights have been violated by making reference to fundamental objectives and directive principles which may be connected to such fundamental rights.<sup>102</sup> However, as discussed above, Nigerian courts appear to stop at simply stating that fundamental objectives are not justiciable and do not seem to have interpreted the fundamental objectives and directive principles broadly and purposively to vest them with much legal significance. It may therefore be questioned

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<sup>100</sup> South Africa is one example. See *Minister of Health & Others v Treatment Action Campaign* 2002 10 BCLR 1033 (CC); *Government of the Republic of South Africa v Grootboom* 2000 (11) BCLR 1169 (CC).

<sup>101</sup> Okere (n 97 above) 223.

<sup>102</sup> This has been the approach of the Indian courts towards similar provisions in the Indian Constitution which provides socio-economic rights as fundamental objectives and directive principles. See *Paschim Banga Khet Mazdoor Samity & Others v State of West Bengal & Another* [1996] ICHRL 31 (6 May 1996) (AIR) 1996 SCC 246 (Supreme Court of India), in which the Supreme Court linked the right to health to the right to life which is justiciable under the Indian Constitution.

whether relying on international law may not be a better option than placing reliance on the non-justiciable right to health in the Nigerian Constitution.

#### 4.2 International law: CESCER and the African Charter

Nigeria is a party to CESCER and therefore has obligations under it. However, Nigeria operates a dualist system. The Nigerian Constitution therefore stipulates that international treaties between Nigeria and other countries must be enacted as domestic laws in order to have effect as enforceable laws in Nigeria.<sup>103</sup> CESCER has not been domesticated in Nigeria and therefore will not be enforceable in the courts as law, although it may be of persuasive authority.<sup>104</sup> But, as is the case with state parties of any treaty, Nigeria is obliged to ensure that it takes no steps which would defeat the purpose of the treaty.<sup>105</sup> It can also be argued that Nigeria is obliged to take positive steps towards ensuring that it discharges its obligations under CESCER, having voluntarily ratified CESCER, thereby accepting the obligations imposed thereunder. Nigeria is also a party to the African Charter. The African Charter has been enacted as a domestic law in Nigeria.<sup>106</sup> It requires among other things that all organs of government give full recognition to the Act.<sup>107</sup>

As stated above, the right to health as provided for in the African Charter is couched in similar terms as the right to health in CESCER. The two instruments may therefore be subject to the same interpretation. In any event, it is apparent from the wording of the provision in the African Charter (which clearly requires parties to it to take measures towards providing medical treatment for people who need them)<sup>108</sup> that access to treatment is a basic component of the right to health. It follows that access to ARVs and the elimination of obstacles with respect thereto are components of the right to health for people living with HIV/AIDS in Nigeria. Nigeria, as a party to the African Charter, which is also domestic law in Nigeria, is thus under an obligation to ensure that people living with HIV/AIDS have access to treatment, including anti-retroviral treatment and treatment for opportunistic infections. It is also worth noting that, unlike CESCER, which requires the progressive realisation of the rights contained therein, the African Charter, which recog-

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<sup>103</sup> Sec 12(1) of the Nigerian Constitution provides that '[n]o treaty between the Federation and any other country shall have the force of law to the extent to which any such treaty has been enacted into law by the National Assembly'.

<sup>104</sup> See *Ogugu v State* (1994) 6 NWLR 316 (Supreme Court of Nigeria).

<sup>105</sup> See *MS Shaw International law* (2003) 818.

<sup>106</sup> African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act Cap 10 Laws of the Federation of Nigeria 1990.

<sup>107</sup> Sec 1.

<sup>108</sup> Art 16(2).

nises civil and political rights as well as socio-economic rights without any distinction, requires immediate implementation by parties.<sup>109</sup>

Since the African Charter is domestic law in Nigeria, people living with HIV/AIDS in Nigeria are entitled to access ARVs and can enforce their right to health with respect to such access in Nigerian courts. This argument may, however, present some difficulty when it is recalled that the obligation of the government to ensure that medical facilities are provided, is merely a part of the fundamental objectives and directive principles of state policy which are not enforceable.

A recent decision of the Supreme Court, which ruled on the position of the African Charter in Nigeria's legal system, strengthens this argument. In *General Sani Abacha and Others v Gani Fawehinmi*, the Supreme Court held that, while the African Charter is a municipal law enforceable in Nigerian courts and is on a higher pedestal than other municipal law because of its international origins, it is, however, inferior to and cannot override the provisions of the Constitution from which it takes its authority.<sup>110</sup> The Supreme Court held that '[t]he African Charter is not superior to and does not override the Constitution of the Federal Republic of Nigeria'.<sup>111</sup> It further emphasised that:<sup>112</sup>

The Constitution is the supreme law of the land; it is the *grundnorm*. Its supremacy has never been called to question in ordinary circumstances. Thus any treaty enacted into law in Nigeria by virtue of section 12(1) of the Constitution is circumscribed in its operational scope and extent as may be prescribed by the legislature.

The Supreme Court thus acknowledged a difference between the African Charter and other domestic laws on the basis of its origin in international law and its binding nature, but asserted the supremacy of the Constitution over the African Charter. It did not, however, interpret the African Charter as being useful in giving meaning to the fundamental rights and the directive principles and fundamental objectives in the Constitution. This is in sharp contrast with the position of legal systems of countries such as Venezuela which allows the courts to employ international human rights treaties over the Constitution where the treaties offer greater protection of human rights than constitutional provisions.<sup>113</sup> The stance of the Supreme Court in this case seems to suggest that international human rights treaties, even when domesticated, do not offer any more protection of human rights than the Constitution provides. The decision in this case has therefore been criticised as con-

<sup>109</sup> Art 1 of the African Charter. See CA Odinkalu 'Analysis of paralysis or paralysis of analysis? Implementing economic, social and cultural rights under the African Charter on Human and Peoples' Rights' (2001) 23 *Human Rights Quarterly* 327-349.

<sup>110</sup> *General Sani Abacha & Others v Gani Fawehinmi* (2000) 6 *Nigerian Weekly Law Reports* 228 (Supreme Court of Nigeria).

<sup>111</sup> n 110 above, 255.

<sup>112</sup> n 110 above, 258.

<sup>113</sup> See art 19 of the Constitution of Venezuela.

servative and retrogressive with regard to the protection of human rights.<sup>114</sup>

While this was a case dealing with fundamental rights which are justiciable under the Nigerian Constitution,<sup>115</sup> it would seem that on the basis of this decision, economic and social rights provided for in the Constitution as fundamental objectives and directive principles cannot be enforced in Nigerian courts, since the Constitution specifically states that they are non-justiciable. Although the African Charter makes them justiciable, the African Charter, according to the Supreme Court's decision, is subject to the Constitution and as such cannot give rise to justiciable rights where the Constitution expressly denies the justiciability of such rights. This superficial interpretation is somewhat problematic in that it denies the African Charter, as incorporated in the Nigerian legal system, the full force which it should have as a domestic law as well as an international treaty which imposes obligations on Nigeria. Some have therefore contended that the rights in the African Charter (including socio-economic rights such as the right to health) can be enforced in Nigerian courts since the African Charter is a statute of its own and 'stands on its own legs'.<sup>116</sup> In this regard, it may be argued that the right to health as provided for in the African Charter being much broader in scope, as earlier discussed, cannot be taken to be the exact equivalent of the obligation of the government to provide adequate medical facilities under the Constitution, even though the right to health, as provided for in both the African Charter and the Constitution, has been argued to engender obligations to provide access to ARVs to persons living with HIV/AIDS in Nigeria. As such, the right to health under the African Charter, as distinguished from the duty of the government to provide medical services as required under the non-justiciable directive principles of state policy in the Constitution, can be enforced as a right in Nigerian courts.

Further, it can also be argued that any acceptance of the non-justiciability of economic and social rights as contained in the African Charter amounts to a contracting out of international obligations which Nigeria had voluntarily accepted by ratifying and domesticating the African Charter which is unacceptable in international law.<sup>117</sup> It is thus appro-

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<sup>114</sup> See SC Agbakwa 'Retrieving the rejected stone: Rethinking the marginalisation of economic, social and cultural rights under the African Charter on Human and Peoples' Rights' unpublished LLM thesis, Dalhousie Law School, 2000 159.

<sup>115</sup> The respondent brought an action for unlawful detention by the military government in power at the time.

<sup>116</sup> See Obiagwu & Odinkalu (n 94 above) 227.

<sup>117</sup> It is well established in international law that countries cannot avoid their international obligations by internal legislative arrangements. See the *Norwegian Loans* case (1957) ICJ Reports 37. Indeed, Musdapher JCA had held in the Court of Appeal in the case of *Fawehinmi v Abacha* that the government cannot contract out of its obligations under the African Charter by means of local legislation. See *Gani Fawehinmi v Sani Abacha* (1996) 9 *Nigerian Weekly Law Reports* 747. The Supreme Court overturned the decision of the Court of Appeal.



priate and necessary for the Nigerian courts to take a bolder stance in interpreting the provisions of the African Charter to secure greater accountability from the government with respect to socio-economic rights. To approach the matter differently will be to deny the Nigerian people, including persons living with HIV/AIDS, the rights which are guaranteed to them by the African Charter and to make the African Charter, which is now domestic law, superfluous and unnecessary, which cannot have been the intention in domesticating it.

### 4.3 The right to health in other jurisdictions

The Nigerian model<sup>118</sup> differs from that of some developing countries, such as South Africa<sup>119</sup> and Venezuela,<sup>120</sup> in terms of the manner in which the right to health is incorporated into the legal system. In these two countries, the right to health is a justiciable constitutional right. But the Nigerian model is similar to the model in India,<sup>121</sup> Namibia,<sup>122</sup>

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<sup>118</sup> It has been noted that the Nigerian model of incorporating socio-economic rights as fundamental objectives and directive principles is no longer the norm in Africa and that many African constitutions are beginning to recognise these rights as fundamental rights. See DM Chirwa 'A full loaf is better than half: The constitutional protection of economic, social and cultural rights in Malawi' (2005) 49 *African Journal of Law* 207.

<sup>119</sup> Sec 27(1) of the Constitution of the Republic of South Africa Act 108 of 1996 states that '[e]veryone has the right to have access to health care services, including reproductive health care'. However, the Constitution recognises that resources may not be sufficient and therefore provides in sec 27(2) that '[t]he state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights'. Sec 27(3) also provides that no one may be refused emergency medical treatment.

<sup>120</sup> Venezuela is a monist state. As such, the Constitution also provides that the government is bound to protect all the human rights in the human rights treaties it ratifies. More importantly, it provides that human rights treaties which have been ratified by Venezuela have a constitutional effect and are superior to other domestic legislation where such treaties provide for rights which are wider or more protective than the rights in domestic legislation. Such treaties can be applied directly by the courts. The import of this is that CDESCR and all the rights contained therein, including the right to health, apply with the same force as constitutional provisions in Venezuela. Where the right to health as provided by CDESCR is wider in scope than the right to health provided in the Constitution, the courts will apply CDESCR. See arts 19 and 23 of the Constitution of the Bolivarian Republic of Venezuela, 1999 (English translation online).

<sup>121</sup> Art 47 of the Constitution of India, 1950 <http://www.constitution.org/cons/india/const.html> (accessed 6 July 2007).

<sup>122</sup> JC Mubangizi 'The constitutional protection of socio-economic rights in selected African countries: A comparative evaluation' (2006) 2 *African Journal of Legal Studies* 7-9.

Uganda,<sup>123</sup> Ghana<sup>124</sup> and Malawi,<sup>125</sup> where the right to health is part of the fundamental objectives and directive principles of state policy. Typically, the right to health is most secure and compels more binding obligations where incorporated as a constitutional and an enforceable right. The courts in Venezuela and in South Africa have therefore been better able to deal with issues relating to the obligations of government with respect to the right to health and in particular to access to ARVs.<sup>126</sup> The incorporation of the right as an enforceable right under the constitutions of countries depends frequently on several factors, the most important being perhaps their history and ideologies. Given the apartheid history of South Africa and the need to remedy the injustices of the past by addressing social and economic inequalities, the inclusion of the right to health as an enforceable right along with other socio-economic rights is hardly surprising.<sup>127</sup> Thus, the incorporation of the right to health in the South African Constitution has its basis in the history and accompanying ideology of the country. The same can be said of Venezuela in that there appears to be some form of socialist ideology in its Constitution which provides a wide range of welfare rights and requires the government to provide social security and a public health care system.<sup>128</sup>

India and Nigeria do not appear to recognise (at least not in the same clear manner as South Africa and Venezuela) strong welfare rights. Where incorporated as a fundamental objective and directive principle of state policy, the right to health is not justiciable. Courts therefore have to develop innovative ways and boldness to ensure that the right has some force and effectiveness. The courts in India appear to have been more successful at this than the courts in Nigeria, and have interpreted fundamental rights widely as including fundamental objectives and directive principles where necessary, thereby giving the fundamental objectives and directive principles some legal force.<sup>129</sup> The Indian

<sup>123</sup> Art XIV(b) of the Constitution of Uganda 1995 [http://www.parliament.go.ug/index.php?option=com\\_wrapper&Itemid=78](http://www.parliament.go.ug/index.php?option=com_wrapper&Itemid=78) (accessed 6 July 2007). See Mubangizi (n 122 above).

<sup>124</sup> Art 34(2) of the Constitution of Ghana [http://www.parliament.gh/const\\_constitution.php#Chapter%206](http://www.parliament.gh/const_constitution.php#Chapter%206) (accessed 6 July 2007); Mubangizi (n 122 above) 16-17.

<sup>125</sup> Sec 30(2) of the Constitution of Malawi. See Chirwa (n 118 above).

<sup>126</sup> See *NA et al v Ministerio de Sanida y Asistencia Social*, Sala Politico Administrativa, Corte Suprema de Justicia, Republica de Venezuela, Expediente numero 14.625 (1998). For Venezuela, see *Cruz Bermudez et al v Ministerio de Sanidad y Asistencia Social* Sala Politico Administrativa, Corte Suprema de Justicia, Republica de Venezuela, Expediente Numero 15.789 (1999), where the Venezuelan courts interpreted the right to health to include the right to access to anti-retroviral drugs. See also Torres (n 82 above) 105. For South Africa, see the *Treatment Action Campaign* case (n 100 above).

<sup>127</sup> See K Pillay 'Tracking South Africa's progress on health care rights: Are we any closer to achieving the goal?' (2003) 7 *Law, Democracy and Development* 1; Pieterse (n 83 above) 1. See also Archibold (n 81 above) 67-73.

<sup>128</sup> See arts 81-85 of the Constitution of Venezuela.

<sup>129</sup> See n 102 above.

Supreme Court, which is regarded as 'probably the only Third World court that continues to show boldness in upholding the Constitution against an over-zealous executive and a timid legislature'<sup>130</sup> and a champion of the poor and oppressed,<sup>131</sup> has taken a progressive stance regarding making orders regarding the obligations of governments and actions to be taken to improve the health care system. This stance is likely to have a positive impact on the right to health, including the right to essential medicines of people living with HIV/AIDS in that country. Nigerian courts, on the other hand, seem to be shy of going beyond the literal letter of the law. The Indian Supreme Court, operating within a similar legal system, has taken a different and more progressive approach to the interpretation of fundamental objectives and directive principles by linking them to fundamental rights, as well as employing international human rights standards in interpreting the fundamental objectives in the Indian Constitution, thereby making them largely justiciable. Nigerian courts seem to have taken a different direction. Indeed, there has been little protection of human rights in Nigeria, particularly under the military, when court orders constituting redress against human rights violations were routinely ignored by the executive.<sup>132</sup> It is therefore perhaps not very surprising that Nigerian courts are reluctant to enforce socio-economic rights as contained in the directive principles such as the right to health.

Given the enforceability of the right to health under the South African and Venezuelan Constitutions, the right to health, including the right to essential medicines such as ARVs, provides the courts with greater powers of enforcement. India, on the other hand, with similar provisions to those found in the Nigerian Constitution which provides socio-economic rights as fundamental objectives and directive principles, has adopted the approach of linking fundamental objectives to fundamental rights, thereby giving them more recognition than would otherwise be possible.<sup>133</sup>

## 5 Conclusion

Recently, Nigeria has taken steps to engage more effectively with the HIV/AIDS scourge, including efforts to provide anti-retroviral drugs to people living with HIV/AIDS in Nigeria. This article has sought to link access to treatment to the right to health. It is clear from the international instruments examined that access to effective medication, including anti-retroviral drugs, is a component of the right to health, a socio-

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<sup>130</sup> Kanyeihamba (n 94 above) 55.

<sup>131</sup> Krishnan (n 94 above) 791.

<sup>132</sup> Obiagwu & Odinkalu (n 94 above) 227-228.

<sup>133</sup> See n 102 above.

economic right. This article has also examined the jurisprudence surrounding the right to health in Nigeria. The specific issue of access to treatment for people living with HIV/AIDS or the broader issue of the right to health has not been adjudicated in Nigerian courts. It is therefore not clear what the decision of the courts would be in regard to such a case, given the complexities surrounding the enforceability of socio-economic rights and the effect of international human rights treaties in Nigerian jurisprudence discussed above.

However, the provisions of the Nigerian Constitution and the strict interpretation given to the issue of justiciability of fundamental objectives and directive principles of state under which the right to health falls in the Constitution indicate that any matter relating to access to anti-retroviral drugs in Nigeria is likely to present difficulties for the complainant. For instance, a complainant who brings an action to compel the government to deal with issues relating to his or her right to health, such as the inadequacy of health infrastructure or the lack of health facilities in rural areas for efficient and equitable delivery of the anti-retroviral drugs, faces seemingly insurmountable difficulties and may have little chance of success. The approach of courts in Nigeria to the enforceability of socio-economic rights has so far been less than positive, thus creating doubts about the applicability of the right to health and the protection of other socio-economic rights in Nigeria.

A reliance on international law and the domestic application of the right to health in international law present similar problems in light of the Supreme Court's decision in *Fawehinmi v Abacha*, discussed above. It is arguable that, in view of the fact that Nigeria is a party to CESC, and has domesticated the African Charter, one could reasonably contend that the government is under an obligation to discharge its obligations under these human rights treaties. However, the success of such an argument is debatable because, in effect, the Supreme Court has interpreted the usefulness of the African Charter rather narrowly and thus appears to leave little room for creative and purposive domestic application of the human rights treaties in Nigeria. The situation in Nigeria thus illustrates the difficulty in applying international human rights at the domestic level.

It would appear that the jurisprudence in Nigeria, as it currently stands, if applied to the right of access to anti-retroviral drugs specifically, and the right to health generally, would be trailing behind even government recognition for the need for, and efforts at, providing access to anti-retroviral drugs. At the very least, the courts should be able to inquire into the rationality of the policy which the government is currently implementing with regard to its anti-retroviral programme. A creative approach which takes into consideration the right to health of people living with HIV/AIDS, including the right of access to anti-retroviral drugs and other treatment, is required from the courts, particularly since such an approach will have positive implications, not only for

people living with HIV/AIDS, but also more broadly for government prioritising social services such as the improvement of the failing health sector,<sup>134</sup> thus benefiting many people who require other health services.

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<sup>134</sup> See S Agbakwa 'Reclaiming humanity: Economic, social, and cultural rights as the cornerstone of African human rights' (2002) 5 *Yale Human Rights and Development Journal* 190, noting that if socio-economic rights are enforceable in Nigeria, it would be possible to question the priorities of government.