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The prospects of litigation to secure maternal health in Nigeria: Does *SERAP v Attorney-General Lagos* have any value?

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Summary: *Blood transfusions play a crucial role in addressing obstetric complications such as post-partum haemorrhage and anaemia that contribute to maternal deaths. The right to health guaranteed by numerous international human rights instruments, national constitutions and legislation obligates governments to ensure that women have access to interventions to prevent maternal mortality. In 2020 a health policy in Lagos State, Nigeria, providing that, in the event that patients are likely to need a blood transfusion, such as pregnant women, spouses and relatives are required to donate blood as a condition for accessing maternity and health services in government-run health facilities, was the subject of a High Court ruling. The judgment declared the policy to be a breach of some human rights guaranteed by the Nigerian Constitution, legislation and international instruments that the country had ratified. Additionally, the judge noted that the policy contributed to maternal deaths. Consequent to the above, this article explores the contribution of human rights litigation and the ensuing verdicts to the protection of maternal health globally, and in light of these evaluates the value of the judgment in particular. A few national and international cases involving other countries that depict the strides that have been made*

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in the use of human rights litigation to protect maternal health are presented to enable an appreciation of the extent to which human rights litigation has been used to support maternal mortality reduction efforts. A critical appraisal of the Lagos State court's decision with a view to determining its potential to contribute to maternal mortality reduction efforts in Nigeria and elsewhere is then embarked upon. The finding is that despite certain flaws identified in the judgment, it makes a valuable contribution to the protection of maternal health and, by extension, the reduction of maternal mortality in Nigeria.

Key words: *maternal health; Nigeria; compulsory blood donation; human rights litigation*

1 Introduction

The description of maternal mortality as a challenge for the twenty-first century[1] is not due to its novelty but is based on the consensus that the problem has lasted for too long. Despite significant progress having been made in the last decade,[2] the present figures nonetheless are daunting. In 2017 the maternal death figure was estimated as being between 279 000 and 340 000, besides thousands of unrecorded maternal deaths.[3] Eighty-six per cent of those deaths occurred in Southern Asia and sub-Saharan Africa. In the countries' lead is Nigeria, the focus of this article, which contributed 23 per cent of the global maternal death numbers.[4] The fact that an estimated 67 000 of these deaths took place in only one country[5] at a time when insignificant numbers are being recorded in developed countries is perplexing. This also means that hundreds of women are being lost daily due to an ostensibly avoidable cause.

1 WHO 'Reducing maternal mortality: A challenge for the 21st century' 9 March 2000, Microsoft Word - RC50.TD1E Reducing maternal mortality.doc (who.int) (accessed 15 August 2022).

2 There was a 44% reduction between 1992 and 2015. See WHO 'Trends in maternal mortality 1990 – 2015' Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 9789241565141_eng (1).pdf (who.int) (accessed 15 August 2022).

3 It is common knowledge that MM ratios are far from accurate. Reasons for this include countries with inefficient record taking, deliberate measures by families and communities to hide deaths occurring due to certain causes, and so forth. See JR Bale, BJ Stoll & AO Lucas 'Introduction' in JR Bale, BJ Stoll & AO Lucas (eds) *Improving birth outcomes: Meeting the challenge in the developing world* (2003) 27, https://www.nap.edu/download/10841 (accessed 15 August 2022).

4 UNFPA 'Trends in maternal mortality: 2000 to 2017 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division' 32, Trends in Maternal Mortality: 2000 to 2017 | UNFPA - United Nations Population Fund (accessed 15 August 2022).

5 As above.

Maternal mortality[6] refers to 'the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes'.[7] Alongside this definition provided by the World Health Organisation (WHO), two categories of causes – direct and indirect – were also identified. The direct causes are medical complications whilst non-direct causes predispose or increase the chances of a woman dying from a maternal cause.[8] An obvious understanding of the definition indicates that pregnancy must be a direct or contributing cause of death. However, it also states that the cause must be intentional and non-secondary. While what is meant by 'unintentional' is not clear, the idea of excluding secondary causes may be contentious and the classification fuels that contention by only providing for medical complications as both direct and indirect causes. It is argued that socio-economic factors and other determinants such as illiteracy, inadequate nutrition, child marriage, teenage pregnancy, and a lack of access to safe abortion services are indirect causes.[9] These lead to death by placing a woman in a position where she can develop complications or by actively preventing her from receiving the necessary maternal health care to prevent death arising from complications.[10] Indirect causes are demonstrated by evidence that establishes that the woman would not have died (or would not have had the medical complication) 'but for' those factors. In criminal law 'but for' is a principle used to determine culpability in homicide cases and it asks the following

6 In respect of maternal health, another problem, more common and often discussed alongside MM, is maternal morbidity that refers to varying degrees of ill-health ranging from anaemia to debilitating conditions such as fistulas that result from complications of pregnancy or childbirth. WHO 'Maternal mortality' 19 September 2019, https://www.who.int/news-room/fact-sheets/detail/maternal-mortality (accessed 15 August 2022).

7 UNFPA (n 4) 8.

8 As above.

9 See also V Fillipi and others 'Levels and causes of maternal mortality and morbidity' in RE Black and others (eds) *Reproductive maternal, newborn and child health: Disease control priorities* (2016), Levels and Causes of Maternal Mortality and Morbidity - Reproductive, Maternal, Newborn, and Child Health - NCBI Bookshelf (nih.gov) (accessed 15 August 2022). Policies that prevent access to health facilities such as the Lagos State government's policy (discussed below), which is the subject of the decision discussed in this article, can also be described as some of the indirect factors.

10 According to Ronsmans and Graham, emerging evidence is leading to considerations to class the deaths of pregnant women or women within 42 days of delivery that were due to accidents, murders or suicides, and usually categorised as incidental to the pregnancy state, as maternal deaths. The evidence is that murders, for instance, through domestic violence may be a consequence of the pregnancy. C Ronsmans & WJ Graham 'Maternal mortality: Who, when, where and how?' (2006) 368 *The Lancet* 1195.

question: 'But for the defendant's action, would the death have occurred?'[11]

Post-partum haemorrhage, eclampsia and pre-eclampsia, obstructed labour, sepsis and unsafe abortion are the five leading medical causes of maternal mortality globally[12] and in Nigeria as well.[13] In Nigeria, however, the level of contribution of each factor varies from one geopolitical region to another. Nevertheless, haemorrhage or excessive loss of blood has been identified as a major cause of maternal mortality in all parts of the country.[14] According to the WHO, access to timely and high-quality health care during pregnancy, in childbirth and after childbirth, which is the right to health, is vital to reducing maternal mortality.[15] It also recommends delivery by skilled birth attendants and both essential and comprehensive emergency obstetric care that can address all five causes of maternal mortality above.[16] Comprehensive emergency obstetric care includes two additional services, namely, surgery (including administering anaesthetic) and blood transfusion.[17] The availability of safe blood and access to blood transfusions to save women from death arising from excessive blood loss, however, can be hampered by non-medical factors such as inadequate knowledge of blood donation.[18] Therefore, the WHO tasks countries with high maternal mortality ratios to embark on enlightenment campaigns to encourage voluntary donation of safe blood and blood products.[19] Adhering to strict rules with respect to choosing donors and better donor care are some strategies recommended to ensure the availability of safe blood.[20]

11 In support of this argument, it is trite that to determine culpability in homicide cases, a cause of death need not be direct. *R v Mitchell* (1983) 76 Cr App R 293 CA. The principle is also employed in the law of torts.
12 L Say 'Global causes of maternal deaths: A WHO systematic analysis' (2014) 2 *The Lancet* e323.
13 C Meh and others 'Levels and causes of maternal mortality in Northern and Southern Nigeria' (2019) 19 *BioMedCentral Pregnancy and Childbirth* 417, Levels and determinants of maternal mortality in northern and southern Nigeria (biomedcentral.com) (accessed 15 August 2022).
14 As above.
15 WHO (n 6).
16 AM Gulmezouglu and others 'Interventions to reduce maternal and child morbidity and mortality' in Black and others (n 9) 20, http://www.dcp-3.org/sites/default/files/chapters/V2C7Gulmezoglu_01.13.15.pdf (accessed 15 August 2022).
17 As above.
18 Y Dei Adomakoh and others 'Safe blood supply in sub-Saharan Africa: Challenges and opportunities' (2021) 8) *The Lancet Haematology* e770-776.
19 See WHO Media Centre 'Safe blood can save the lives of 800 mothers everyday' where the WHO regional director decried the practice of relying on families, https://www.who.int/mediacentre/news/releases/2014/world-blood-donor-day/en/ (accessed 15 August 2022).
20 Dei Adomakoh and others (n 18).

Many of the interventions to prevent maternal mortality resonate with maternal health obligations that governments either enshrined in national laws or constitutions or that are in ratified international instruments. Additionally, it has been observed that all countries have agreed to obligations on the right to health in one form or another.[21] This article focuses on the right to health because it includes the guarantee of sexual and reproductive health and rights (SRHR). Other relevant rights, such as the rights to equality and non-discrimination, are discussed in the context of, and as integral parts of the right to health.[22]

The right to health comprises entitlements and freedoms.[23] It also encompasses health care and the underlying determinants of health such as sanitation, nutrition, health information, and so forth.[24] The availability of functional facilities and personnel, financial and physical accessibility, acceptable care to ensure culture and medical ethics, and good quality health care and the underlying determinants are elements present in the guarantee of the right to health in all its forms.[25] As a component of the right to health, SRHR necessarily possesses the features of the right to health.[26] As a result, giving effect to SRHR in the context of maternal health[27] may be interpreted as the enjoyment of sexual and reproductive health freedoms and entitlements essential for women to have a safe pregnancy and/or childbirth. These entitlements that states have an obligation to provide include access to maternal health goods, services, facilities, information, adequate health facilities, skilled birth attendants, antenatal, birthing and post-birth services, access to essential drugs and blood products that are acceptable and of good quality.[28]

21 P Hunt 'Interpreting the international right to health in a rights-based approach to health' (2016) 18 *Health and Human Rights Journal* 109-130.

22 UN Committee on Economic, Social and Cultural Rights (ESCR Committee) General Comment 14, The Right to Highest Attainable Standard of Physical and Mental Health (article 12) of the Covenant 11 August 2000 E/C.12/2000/4 paras 18 & 19.

23 General Comment 14 (n 22) para 8.

24 General Comment 14 para 11.

25 General Comment 14 para 12. The realisation of the right to health is also dependent on other rights such as the right to equality, non-discrimination, education, access to information, food, privacy, life, human dignity, and so forth. General Comment 14 para 3.

26 See ESCR Committee General Comment 22 on the Right to Sexual and Reproductive Health (2016) E/C.12/GC/22 paras 5, 7, 12-21 (elements), 9, 10.

27 Maternal health, that is, the health of women during pregnancy, childbirth and post-childbirth, is a subset of sexual and reproductive health. WHO 'Maternal health overview', Maternal Health | WHO | Regional Office for Africa (accessed 15 August 2022).

28 See generally Committee on the Elimination of Discrimination Against Women General Recommendation 24 of the Convention (Women and Health), 1999 A/54/38/Rev.1 ch 1.

In 2020 a judgment was given by a High Court in Lagos State, Nigeria in respect of *SERAP v Attorney-General Lagos State,* a case that bordered largely on maternal health. The assessment of the value of that case to the protection of maternal health and or prevention of maternal mortality in Nigeria and possibly elsewhere is the objective of this article. This first part lays a foundation for the significance of the right to health in the prevention of maternal mortality. The second part discusses the legal basis for the enforcement of the right to health in Nigeria and cites some examples of attempts to enforce the right against the Nigerian government through litigation. The potential of litigation for the enforcement of the right to maternal health and its challenges as a human rights enforcement mechanism are discussed in the third part. This is followed by a discussion of the facts and the court's decision in the Lagos case. Against the background of the potential of litigation to protect the right to maternal health, the fifth part attempts a critical analysis of the judgment highlighting its strengths with respect to the realisation of the right to maternal health. The article concludes that the contribution of the decision to the protection of maternal health and, by extension, the reduction of maternal mortality in Nigeria, albeit affected by some shortcomings, nonetheless are of great value.

2 Basis for the enforcement of the right to health in Nigeria

In Nigeria, socio-economic rights do not enjoy a justiciable status in the Constitution.[29] These rights were enshrined as aspirational objectives, and issues related to their non-implementation are also precluded from being entertained by the courts.[30] However, it has been argued that this no longer is fatal to enforcing the obligation of the nation to provide adequate medical and healthcare facilities,[31] and that the enactment of the 2014 National Health Act[32] could make the full spectrum of the right to health available to Nigerians.[33] This is premised on the decision of the Supreme Court in *Attorney-General Ondo v Attorney-General Federation* where the application

29 The Constitution of the Federal Republic of Nigeria 1999, Cap C38, LFN 2004.

30 They are precluded by sec 6(6)(c) which provides that 'the judicial powers … 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 judicial decision is in conformity with fundamental Objectives and Directive Principles of State Policy set out in Chapter II of this Constitution'.

31 As above. Sec 17(3)(d) provides for the provision of adequate medical and health facilities.

32 National Health Act 18 of 2014.

33 O Nnamuchi 'Securing the right to health in Nigeria under the framework of the National Health Act' (2018) 37 *Medicine and Law* 47.

of the Corrupt Practices and Other Related Offences Act in Ondo State was contested on the basis that it related to abolishing corrupt practices, an objective situated in the non-justiciable portion of the Constitution.[34] The Supreme Court held in that case that the otherwise non-justiciable parts of the Constitution could become justiciable if legislated upon by the National Assembly.

It, therefore, stands to reason that on the same basis, the right to the best attainable standard of physical and mental health guaranteed in the African Charter (Ratification and Enforcement) Act, Nigeria's domesticated version of the African Charter on Human and Peoples' Rights (African Charter) is justiciable.[35] This is so especially as the African Charter Act has been held by the Supreme Court as occupying a higher position than federal legislation being a domestic legislation with international flavour.[36] The African Charter Act makes it an obligation of the Nigerian government to take necessary measures to safeguard the health of its people and guarantee access to medical services when they are sick.[37] Article 14 of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol),[38] which has been ratified without reservations by Nigeria,[39] although not yet domesticated, deepens the African Charter's intention with respect to the protection of the health, and particularly the sexual and reproductive health, of women and girls. On the continental level, obligations in respect of the right to health in the Charter have been argued in various cases, including against Nigeria, before the African Commission on Human and Peoples' Rights (African Commission) and the African Court on Human and Peoples' Rights (African Court). In these instances, the African Commission had always taken a broad approach, which has also been followed by the African Court.[40] The Commission recognised violations of the right to health through the denial of other human

34 *Attorney-General Ondo State v Attorney-General Federation* (2002) 9 NWLR (Pt 772) 222.
35 African Charter on Human and Peoples' Rights, OAU Doc CAB/LEG/67/3 rev. 5; 1520 UNTS 217; 21 ILM 58 (1982); African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act Cap LFN 2004, sec 16.
36 *Fawehinmi v Abacha* (2001) 51 WRN 59.
37 Arts 16(1) & (2).
38 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa adopted by the African Union General Assembly in 2003 in Maputo CAB/LEG/66.6 (2003), entered into force 25 November 2005.
39 Ratified by Nigeria in December 2004.
40 Eg, the African Court took a broad approach in *Kwoyelo v Uganda*, by referring to the Commission's decisions in *International Pen & Others (on behalf of Saro Wiwa) v Nigeria* (2000) AHRLR 212 (ACHPR 1998) and *Media Rights Agenda & Others v Nigeria* (2000) AHRLR 200 (ACHPR 1998), both cases wherein the rights to medical care of prisoners were in contention but distinguishing these from *Kwoyelo*. See *Kwoyelo v Uganda* Communication 431/12, African Commission on Human and Peoples Rights 129 (2018).

rights upon which its realisation is dependent, and also confirmed violations that related to the denial of the right to access healthcare facilities and violations relating to the underlying determinants of health.[41] The African Commission has also adopted guidelines on the implementation of the economic, social and cultural rights in the African Charter,[42] and the interpretation of article 16 on the right to health in the guidelines is largely modelled after General Comment 14 of the UN Committee on Economic, Social and Cultural Rights (ESCR Committee).

Litigation in relation to government's obligation in respect of the right to health in Nigeria has been a mixed bag. In 2011 *Femi Falana v Attorney-General Fed & Others,*[43] a suit conceived on the basis of the provisions of the African Charter Act, was instituted by the applicant at the Federal High Court Lagos. It sought to enforce the right of the Nigerian populace to equal access to government resources in relation to receiving medical attention and a declaration that the government was in breach of its right to health obligations by not providing all Nigerians with adequate healthcare facilities and medical attention when sick, and also that the government breached the right to equality by covering the expenses of public officers who travel abroad for medical treatment.

The suit was thrown out on the basis of the earlier-mentioned section 6(6)(c) of the Constitution. Meanwhile, earlier in 2004, in *Festus Odafe & Others v Attorney-General Federation,*[44] the case of four awaiting trial prison inmates, who had tested HIV positive and were not provided with medical treatment, was brought before the Federal High Court sitting in Port Harcourt. It was argued by the applicants that the state's action was in breach of article 16 of the African Charter Act. Here the Court upheld the applicant's argument and ordered that the applicants, though in prison custody, be provided with the proper medical treatment commensurate to their illness. As must have been noticed, the two cases were heard by courts of equal jurisdiction, thus eliciting little effect as to precedence.

41 Durojaye describes the Commission's decisions as constituting two approaches, namely, the indivisibility approach and the underlying determinants approach. See E Durojaye 'The approaches of the African Commission to the right to health under the African Charter' (2013) 17 *Law, Democracy and Development* 393. See, eg, *Social and Economic Rights Action Centre (SERAC) & Another v Nigeria* (2001) AHRLR 60 (ACHPR 2001); *Free Legal Assistance Group & Others v Zaire* (2000) AHRLR 74 (ACHPR 1995); *Purohit & Another v The Gambia* (2003) AHRLR 96 (ACHPR 2003.

42 African Commission Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the Charter, 2011 (Nairobi Principles).

43 Unreported Suit FHC/IKJ/CS/M59/10.

44 Unreported Suit FHC/PH/CS/680/2003.

In relation to maternal illnesses or death, apart from medical negligence cases, litigation to protect maternal health is not common in Nigeria. At the level of the regional African Court also, there has not been cases on maternal health, although a case alleging the violation of some reproductive rights by Mali has been brought before it.[45] However, in states around the world and at the international level, there has been litigation in respect of the right to maternal health. Some of these cases form part of the discussion below.

3 Evaluating the role of human rights litigation in the protection of maternal health

In the words of Dunn and others, human rights litigation is a specific form of litigation centred on promoting structural and systemic changes in order to bring about social transformation.[46] Herskoll's opinion that human rights litigation is a means by which the socially-disadvantaged and those who lack the forum to influence public policy can have their own say[47] corroborates that of Dunn and others. Human rights litigation also facilitates the interpretation or elaboration of the substantive content of the rights. Then, the government's actions or inactions are measured against the clarified standards of the right. This is because human rights are recognised at the international level in order to be enforced at the national level. Consequent to this, even international bodies look to states for guidance on how rights are to be interpreted because the national courts apply it to concrete cases.[48] Domestic court orders are also weightier than recommendations in the Concluding Observations issued by treaty-monitoring bodies that in their role do not pronounce

45 In the case, the African Court held that the Malian Persons and Family Code was in violation of the Protocol concerning the age of marriage of girls, forced marriage and some other traditional practices inimical to the rights of girls and women. See A*PDF & IHRDA V Rep of Mali* (046/2016) AfCHPR 15 (2018).

46 JT Dunn, K Lesyna & A Zaret 'The role of human rights litigation in improving access to reproductive health care and achieving reductions in maternal mortality' (2017) 17 *BioMedCentral Pregnancy and Childbirth.*

47 H Hershkoff 'Public interest litigation: Selected issues and examples', http://siteresources.worldbank.org/INTLAWJUSTINST/Resources/PublicInterest Litigation per cent5B1 per cent5D.pdf cited in CC Ngang 'Socio-economic rights litigation: A potential strategy in the struggle for social justice in South Africa' LLM dissertation, University of the Free State, 2013 24 (on file with author).

48 V Leary 'The right to health in international human rights law' (1994) 1 *Health and Human Rights* 34. See also C Onyemelukwe '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' (2007) 7 *African Human Rights Law Journal* 461. Eg, Durojaye recommended the reasonableness approach on economic, social and cultural rights, adopted by the South African Court, to the African Commission. E Durojaye 'Litigating the right to health in Africa', Litigating the Right to Health in Africa (southernafricalitigationcentre.org) (accessed 15 August 2022).

on or find state parties in violation of their obligations.[49] In summation, human rights litigation represents an opportunity for the state to be assessed in respect of the performance of the obligations they owe to their subjects, by an impartial arbiter and, where necessary, to be told what to do in order to fulfil those obligations. Achieving these objectives is made possible by a comprehensive consideration of the issues raised in the case and a recourse to the existing jurisprudence available on the issues derived from courts in the same country, other national courts, and even international human rights bodies.

These features of human rights litigation are the reasons why they are often used to secure government accountability in respect of socio-economic rights that which are not often guaranteed in legislation or constitutions or, when featured, are made non-justiciable. For these socio-economic rights issues, human rights litigation enables the creative use of civil and political rights (that almost always are justiciable) to achieve the vindication of socio-economic rights.[50] This is possible by virtue of the indivisibility, interconnectedness and interrelatedness of human rights.

In pursuing the realisation of the right to maternal health and reproductive health, litigation has proved fortuitous for attaining maternal health objectives, including the goal to protect women from preventable maternal mortality. In the human rights approach to maternal mortality, litigation can ensure the right to a remedy and is a tool for fostering accountability on duty bearers. According to Cook, it is a useful strategy for accelerating state action to reduce maternal mortality.[51] Before both national courts and international human rights bodies, litigation has been employed to hold nations liable for non-fulfilment of the right to maternal health and for preventable maternal deaths. The cases of *Josephine Majani v Attorney-General of Kenya & Others*[52] and *Laxmi Mandal Deen Dayal Harinagar Hospital & Others, Jaitun v Maternal Home MCD Jaypura & Others* (*Laxmi Mandal's* case)[53] will be briefly discussed as illustrations

49 CMV Lougarre 'Right to health using legal content through supranational monitoring' PhD thesis, University College London, 2016 100 (on file with author).

50 In *Paschim Banag,* justiciability of the right to health was derived from the right to life, and in *Mohini Jain* the Supreme Court held that the right to education flowed from the right to life; *Mohini Jain v State of Kanarkata* (1992) AIR 1858.

51 RJ Cook 'Human rights and maternal health: Exploring the effectiveness of the *Alyne* decision' (2013) 41 *Journal of Law, Medicine and Ethics* 103.

52 Petition 5 of 2014 of the High Court of Kenya sitting at Bungoma, http://kenyalaw.org/caselaw/cases/view/150953/ (accessed 15 August 2022). See also B Odallo, E Opondo & M Onyago 'Litigating to ensure access to quality maternal health care for women and girls in Kenya' (2018) 53 *Reproductive Health Matters* 123.

53 WP(C) 8853 of 2008.

of national cases. *Alyne Pimental v Brazil*[54] brought before the Committee of the Convention on Elimination of Discrimination Against Women (CEDAW Committee) will also be discussed in relation to international cases.

Although the focus is on the content and implication of the decisions, it is pertinent to give a brief background of the legal status of the right to health in the three countries in comparison to Nigeria. Brazil and Kenya have express constitutional provisions guaranteeing enforceable rights to health.[55] In contrast, but similar to Nigeria, India does not have a justiciable right to health in its Constitution, but the Indian Supreme Court blazed the trail by enforcing it through the constitutionally-justiciable right to life.[56] India is a common law jurisdiction and, therefore, relies on judicial precedent as a major source of law. Nigeria's situation is as explained above – the right is guaranteed by laws that derive their authority from the Constitution. The pivotal role of a constitution if the right to health is to be enjoyed has been emphasised by scholars[57] and the WHO,[58] but the present objective is to show that in all four countries, the right to health is legally guaranteed, although the means vary. It is also worth highlighting that the CEDAW decision involved a country where CEDAW is not domesticated. However, Brazil had ratified the Optional Protocol and did not object to the jurisdiction of the CEDAW Committee to receive communications against it.[59]

In *Josephine Majani* a pregnant woman was left to have her baby on the floor of a labour ward and was afterwards slapped and verbally abused for messing the floor up as a result of the childbirth. Her case was made available to the public via a video recording of the incident and was taken up by the Centre for Reproductive Rights, an international non-governmental organisation (NGO).[60] Through the case, the state of maternal health facilities in Kenya was revealed as

54 CEDAW/C/49/D/17/2008 (*Alyne* case).
55 Art 196 Constitution of Brazil 1988 and art 43 Constitution of the Republic of Kenya 2010 respectively.
56 *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37) (*Paschim Banag* case). Other countries have since followed. See the Bangladeshi case of *Dr Mohiuddin Farooque v Bangladesh & Others (No 1)* 48 DLR (1996).
57 R Roemer 'Right to healthcare' in HL Fuenzalida-Puelma & SS Connor (eds) *The right to health in the Americas* (1989) cited in V Leary 'The right to health in international human rights law' (1994) 1 *Health and Human Rights Journal* 34.
58 WHO *Right to health in the constitutions of member states of the World Health Organisation South East Asia regions* (2011), Right to health in the constitutions of member states.indd (who.int) (accessed 6 September 2023).
59 The situation is the same with Nigeria. Nigeria ratified CEDAW on 13 June 1985. It ratified the Protocol without a declaration on 22 November 2004. United Nations *United Nations treaty collection* 7 September 2023, UNTC (accessed 7 September 2023).
60 Centre for Reproductive Rights 'Kenya's High Court rules in favour of woman physically abused during delivery' 22 March 2018, https://reproductiverights.

there had been no spare bed in the labour room for the woman and the staff was overstretched. The abusive treatment usually meted out to maternity patients was also put on display. According to the Centre for Reproductive Rights, these lapses were not temporary failures of the system but evidence of a systemic culture of unethical practices and the government's non-fulfilment of SRHR of women and other health rights.[61] Giving judgment in favour of the woman, the judge found that the hospital, the county government and the health secretary had violated her right to health and dignity.

The consolidated Indian cases collectively referred to as *Laxmi Mandal* has reportedly encouraged the institution of many similar cases in the country. The case elicited a similar judgment as the *Majani* case, and the facts resonate with the experiences of Josephine Majani. Abusive care and denial of maternal health care and other SRHR facilities led to the death of Shanti Devi who had a pregnancy for which she received no help to prevent, and she later died following a complicated childbirth at home unattended by a skilled birth attendant. Fatema, the victim in the second case, was a sick and homeless pregnant woman who, upon being denied access to government-provided medical care, put to bed under a tree. While the unavailability of medical facilities may not be the crux of the matter here, access to the facilities was a problem. Notably, the guarantee of universal access to (maternal) healthcare facilities must not be prejudiced by any form of discrimination.[62] The Court found that the state's failure to properly implement its healthcare policies was a breach of its right to health obligations. This indicated that the right to health obligated the government to not only put health schemes and implementation mechanisms in place but to ensure that the implementation is monitored for effectiveness.

Alyne Pimental's case, also brought on behalf of the victim and her family by the Centre for Reproductive Rights and Advocacia Cidada Pelos Direitos Humanos, a Brazilian NGO, is celebrated as the first case in which a country was held to be in breach of their maternal health obligations by a treaty-monitoring body. The treaty-monitoring body, in this case, was the CEDAW Committee. In this case, a Brazilian woman of African descent, who was six months pregnant, had the delivery of her foetus induced as the baby had died in her womb. A dilation and curettage procedure was also performed. However, she

org/kenyas-high-court-rules-in-favor-of-woman-physically-abused-during-delivery/ (accessed 15 August 2022). See also Odallo and others (n 52).

61 Centre for Reproductive Rights (n 60).

62 General Recommendation 24 (n 28) para 11; General Comment 14 (n 22) paras 12(b), 18, 19, 21.

suffered complications, including haemorrhage, and needed to be transferred to a better-equipped hospital. The state hospital refused to allow the use of their ambulance. When she eventually arrived at the hospital eight hours later, she was not attended to for 21 hours, after which time she died. The CEDAW Committee found a violation of CEDAW based on the discrimination (based on her ethnicity) she suffered in accessing health facilities and health care and a violation of the right to life under the International Covenant on Civil and Political Rights (ICCPR).

The consequence of the *Majani* ruling was that she was issued a formal apology from the County Cabinet Secretary for Health, the hospital, and the nurses who perpetrated the abuse.[63] Monetary compensation of KSh 2,5 million was also awarded.[64] In the Indian cases, financial compensation was also awarded and red cards were given to the family of one of the victims to enable them to access health and nutrition services.[65] A reformation[66] of the health schemes was ordered and directions were given to stop access to health services being tied to states, to pay more attention to the volume of home child deliveries in order to inform the need for better services at the hospitals, plug gaps and clarify the provision of the schemes, to extend primary breadwinner status to include women who were responsible for family finances. *Alyne*'s case also led to the payment of reparations to her mother. A new maternal and reproductive health programme was developed in Brazil with the assistance of the technical follow-up team created to follow the implementation of the CEDAW decision. They monitored the implementation of the Country's Pact on the Reduction of Maternal Mortality and Morbidity and embarked on providing training and workshops for healthcare professionals in order to improve maternal health care service delivery.[67] As a result of the *Alyne* case, the maternal mortality ratio of Brazil was reported to have decreased (though not evenly spread

63 *Josephine Majani* case (n 52).
64 As above.
65 *Laxmi Mandal v Deen Dayal Harinagar Hospital & Others* WP(C) 8853 of 2008, ESCR-Net (accessed 15 August 2022).
66 It is instructive to note that India has the second-highest MM ratio in the world. A maternal death occurs every five minutes. The society itself is characterised by discrimination among social groups perpetuated by the caste system which, though outlawed, has continued to fuel discriminatory practices including, as in this case, access to social and economic infrastructure. *Laxmi Mandal* (n 65). Economically, India is a lower-middle-income country, meaning that it is not on the lowest rung of the ladder. There exists a vast amount of literature that describes the various efforts or initiatives the country develops to combat health inequalities and maternal mortality even in the rural areas. See Dunn and others (n 46).
67 A Yamin, B Galliz & S Valongueiro 'Implementing international human rights recommendations to improve obstetric care in Brazil' (2018) 143 *International Journal of Gynecology and Obstetrics* 114.

throughout the country) to 60 per 100 000 live births between 2010 and 2015 and by 43 per cent between 1990 and 2013.[68]

3.1 Challenges of human rights litigation

What is expected following the success of cases such as those highlighted above, especially with respect to the cases at the national courts, is compliance. However, it is alleged that in most cases, it is the persistent follow-up and agitations of civil society that bring about any positive actions from the government toward compliance with the courts' decisions. Two years after the *Laxmi Mandal* case and despite the Court going further to insist on affidavits of compliance from the state, nothing was done to comply. Also, in the *Alyne* case it took five years after that historic decision for a technical follow-up commission to be created[69] and some years after that before compliance was achieved.[70]

The reasons for non-compliance with both international and national decisions are not much different. The lack of dedicated enforcement mechanisms is a common criticism in respect of implementing international human rights law. On the domestic level,[71] there often are enforcement mechanisms attached to judicial authorities. However, as can be seen from the *Alyne* case, where external experts were needed to develop the mechanisms necessary for meeting the dictates of the CEDAW Committee's decision, it is possible for a state not to have such specialised or expert enforcement mechanisms. It may then fall on the usual policy makers and administrators who may treat such tasks as 'business as usual'. That makes enforcement a problem that is common to both. Another shared problem is political will, especially in respect of socio-economic rights. Consequently, when cases, even if decided based on civil and political rights, involve the provision of social goods and services, governments could be unwilling to comply with such decisions.[72] They often cite unavailable or limited resources that possibility were recognised by the international human rights system by providing for progressive realisation. The reality, however, is that

68 As above. See also Dunn and others (n 46).
69 Yamin and others (n 67).
70 This situation is not restricted to Africa, Asia or South America as even Europe is facing a similar situation. As of March 2018, 7 500 judgments of the European Court of Human Rights were reported as having been unenforced. See V Fikfak 'Changing state behaviour: Damages before European Court of Human Rights (2018) 29 *European Journal of International Law* 1091 1092.
71 Dunn and others (n 46).
72 See Dunn and others (n 46) generally, for an in-depth discussion of other limitations of human rights litigation.

this often-cited reason sometimes is not the case. Irresponsible, wasteful and high-handed despots parading as democratic leaders often also lack the political will to make changes. Closely related to the limited resources excuse of states is the danger posed by monetary compensation to victims. It is noted that in all the cases highlighted, monetary compensation was awarded. Pecuniary damages are a *bona fide* remedy and may need to be awarded as a matter of expediency, but it should be kept to a minimum. This is because, for countries that already claim financial incapability, complying can impact the few resources available. Another drawback of awarding compensation is that it risks commercialising the real goal of accountability or litigating human rights violations, which is not to punish states for non-fulfilment but to get them to respect and fulfil the rights.[73] Even the language of the instruments and the means of enforcement are not designed to be punitive. As Chayes argued, which was repeated by Kent Roach, 'public law litigation relief is not conceived as compensation for a past wrong … instead it is forward-looking, fashioned *ad hoc* on flexible and broadly remedial lines important for people other than the plaintiff'.[74] This underscores the importance of auditing the role of judgments in public interest or human rights cases or, even more specifically, ensuring that in social and economic rights cases, advocates do not lose sight of the goal which is to bring about structural and systemic changes and to tip the power balance more to the side of the disadvantaged.[75] In relation to litigating the right to health in Africa, some other challenges have been identified by Durojaye.[76] According to this scholar, recognition of the right to health as a legally-enforceable right in Africa remains very poor, skilled lawyers that are versed in issues relating to the right to health are not readily available, and judges are also unwilling to ruffle the feathers of the executive. Disadvantaged people often are ignorant and illiterate and the unaffordable cost of litigation makes right to health litigation difficult.

73 See B Fontana 'Damage awards for human rights violations in the European and Inter-American Court of Human Rights' (1991) 31 *Santa Clara Law Review* 1127 1158.

74 A Chayes 'The role of the judge in public law litigation' (1976) 89 *Harvard Law Review* 1281-1316 cited in Kent Roach 'The challenges of crafting remedies for violations in socio-economic rights' in M Langford (ed) *Socio-economic rights jurisprudence: Emerging trends in international and comparative law* (2008) 46-58.

75 Socio-economic rights often are the most visible evidence of the quality of life (often dealing with issues bordering on social inequality such as poverty, illiteracy, hunger, homelessness, sickness and deprivation). Yet, in many countries socio-economic rights are often unprotected by law.

76 Durojaye (n 48).

4 SERAP v Attorney-General Lagos State

On 3 August 2018 the registered trustees of Socio-Economic Rights and Accountability Project (SERAP), a human rights NGO, brought a court action against Lagos State naming the Attorney-General, the Ministry of Health and Lagos Commissioner for Health as the defendants. Their grievance was in relation to one of the health policies of Lagos State[77] that compulsorily required spouses/relatives of all patients seeking services that potentially required blood transfusions to make a blood donation before their spouse or relative could access medical services.[78] It was alleged that women seeking pre-natal and maternity services were most affected by this policy since blood transfusion is one of the emergency medical interventions in the case of obstetric complications. Attempts by the state to deny that they implemented the policy in the manner stated by the claimants were unsuccessful.[79]

The claimants formulated three issues for determination by the court: (i) whether by this policy the constitutional right of Nigerians to freedom of thought, conscience, and religion (as a result of conscientious objection) guaranteed in section 42 of the 1999 Nigerian Constitution was not being violated; (ii) whether by this policy the right to health that afforded equality of access to health facilities and to maternal, child and reproductive health services guaranteed by articles 3 and 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) was not being violated; (iii) whether the policy violated the right to life guaranteed by section 33 of the Constitution and right to equal protection of the law and equality before the law guaranteed by article 3 of the African Charter, and the right to dignity of the person guaranteed under section 34(1)(a) of the Constitution. The application was supported by, among other prescribed documents, a 19-page affidavit and a written address to which the present author has no access.

The Court was implored to make declarations that all the above was the case. A consequential order restraining the defendants from continuing with the policy or requesting patients or relatives to instead pay for such blood was also requested. Lastly, the Court was requested to make any other order it saw fit to make in the

77 In Nigeria, the federal government and component states' governments concurrently provide health care in the country.
78 A similar policy is in use in all other component states of the federation.
79 The applicants provided witnesses that testified to having been subjected to that policy. In fact, two culprit major government hospitals, the Lagos State University Teaching Hospital (LASUTH) and Ifako Ijaiye General Hospital, were named in order to strengthen the credibility of the claimant's allegations.

circumstances. The judge granted all the claimant's reliefs but made no further order.

4.1 The ruling

To facilitate an objective evaluation of the ruling, the highlights are provided in this part while an analysis of the case against the background of the Brazilian, Kenyan and Indian cases discussed above follows below. In respect of the first issue for determination as to whether the rights to freedom of thought, conscience, religion and discrimination were violated by the policy, the Court had recourse to the Medical Code of Ethics and cases cited by the parties, including the Supreme Court judgment in *Okonkwo v Medical and Dental Practitioners Disciplinary Council*.[80] While the applicants relied on the case to buttress their point that the state (and their agents) had a duty to respect the right of a patient not to donate blood if his or her religion, practice or belief so forbids, the defendants relied on the same case to convince the Court that it was a medical practitioner's duty to always take measures to preserve life irrespective of his or the patient's religious views. The defendants proceeded to argue that based on the above and the code of ethics, doctors faced with the refusal of consent to life-saving measures should either terminate the contract or refer the patient to another hospital where necessary measures may be taken to preserve such life. Consequently, according to them, to consider or grant the applicant's request (and invariably force hospitals to treat objectors) would affect established standards put in place in healthcare services,[81] presumably for the purpose of preserving lives. Reacting to the above, the judge analysed *Okonkwo*'s case and distinguished the facts from the instant case. Apart from noting that the argument made with reference to the application of the Code of Ethics was not a good summary of that case, the judge also noted that, unlike the *Okonkwo* case, the instant case was not based on the act of a single doctor. She also stated clearly that the circumstances mentioned in the *Okonkwo* case, which may justify a suspension of the liberty rights of the individual, did not arise in this case. Not only was this related to access to the facilities, but it also was not a given that all the patients that potentially needed a transfusion would eventually need it.

80 (2001) 6 NWLR (Pt 711) 206 235.

81 They also contended that their actions were based on international best practices. The defendants' argument was that if doctors had the right to terminate the medical contracts of objectors, they had the right to deny them access in the first place, as well. See Certified True Copy of the Judgment 4, CTC Judgment on Health.pdf (dropbox.com) (accessed 15 August 2022).

With respect to issues 2 and 3, on which she jointly ruled, the judge noted that the compulsory demand for blood donations in order to access maternal services will be a violation of the constitutionally-guaranteed right to life, the right to equality and equal protection of the law, and the right to health guaranteed by international instruments ratified by Nigeria, namely, the Universal Declaration of Human Rights, ICESCR and the African Charter.

5 Critical comments

With due respect to the judge, a few comments will arise as to her pronouncements in respect of issues 2 and 3. The comments pertain, first, to the legal basis of the declarations granted on those issues and, second, to the adequacy of the ruling in addressing the issues. While the first ground could affect the strength of the judgment, the consequence of the second ground is the possibility that the issues have not been fully dealt with. Both undoubtedly impact the value of the decision. We next turn to the specific comments although the comments are not necessarily arranged according to either ground.

First, it is observed that in the course of preparing the judgment, the judge left too much to the imagination of the public. This is because no explanation was given for arriving at the conclusion that the defendant's policy would violate the right to life,[82] nor how it would constitute inequality before the law.[83] The omitted explanations on these rights were necessary as they would have contributed to the existing body of legal guidance on the application of these rights. For example, the right to life is a civil and political right, and until quite recently civil and political rights were considered to engender mainly the obligation to respect and protect[84] and, thus, the right to life was primarily considered a protection against arbitrary loss of life. Therefore, although the right to life is constitutionally protected in Nigeria, the extant body of knowledge on it could have benefited from a comprehensive analysis of how the effect of the compulsory blood donation on maternal mortality qualified as arbitrary loss of life associated with the right to life.[85] Such an analysis would facilitate

82 Given that the jurisprudence available in Nigerian cases on the right to life was mostly interpreted to prevent arbitrary loss of life. See *Musa v State* (1993) 2 NWLR 550; *Kalu v State* (1998) 13 NWLR 531 SC.

83 Presumably it will breed inequality since persons seeking treatment will no longer be treated in the same way, because those who agree to donate blood will be granted access while those who do not agree will be denied access.

84 General Comment 36 of ICCPR which explains that not preventing foreseeable causes of death such as maternal mortality is a breach of the right to life was adopted recently, in 2019. See Human Rights Committee (HRC) General Comment 36 on Article 6, Right to life, 3 September 2019, CCPR/C/GC/35.

85 General Comment 36 (n 84) paras 18, 21, 22.

a greater understanding of the normative standards of the right to (maternal) health and the obligations of the Nigerian state to ensure its enjoyment. This was the case in the *Laxmi Mandal* case where it was declared that the government's duty to protect the right to life and health was beyond merely making relevant policies.[86] It is notable that the right to health provision in the Indian Constitution, like that of Nigeria, is not justiciable, but has been made enforceable through its interpretation by the Supreme Court as an aspect of the constitutionally-guaranteed right to life.[87]

Second, the Universal Declaration of Human Rights (Universal Declaration), the provisions of which formed part of the basis of the finding, although a considerably influential international instrument, is non-binding and, therefore, viewed as aspirational.[88] ICESCR is a binding instrument, but Nigeria's dualist system of receiving international law requires it to be domesticated for the provisions to be available for invocation before the courts,[89] and ICESCR has not been domesticated. On the other hand, the African Charter has been domesticated by Nigeria's National Assembly with the result that its provisions on the right to health form part of Nigeria's laws. Therefore, the judge rightly posited that the defendant's policy violated that right. She also accepted the applicant's assertion that the defendant's policy contributed to child and maternal deaths, although she confirmed that no data on the maternal death rate to establish the link between the policy and maternal mortality was placed before the Court. It is also worth noting that in arriving at her decision, there was no reference to any arguments or reasoning or interpretations on the rights canvassed in issues 2 and 3 from Nigerian courts of higher jurisdiction or even international human rights bodies such as the monitoring body of ICESCR, or even the African Commission.[90] The present author has found only one human rights case in respect of violations of maternal health that had been

86 See paras 37, 40, 44 of judgment (*SERAP* case).
87 *Paschim Banga* case (n 50).
88 Some scholars opine that that the Universal Declaration has attained the status of *jus cogens* and, therefore, forms part of international customary law. See, eg, Leary (n 48). However, this remains debatable as the Law Commission's latest report on the formation of customary international law made no mention of human rights as a field that has produced customary international law. See First Report on formation and evidence of customary international law, M Wood, Special Rapporteur International Law Commission, (2013), UN Doc. A/CN.4/663 (2013).
89 Constitution of Nigeria (n 29) sec 12.
90 In the *Mandal Laxmi* case (n 65) the Court referred to the *Paschim Banga* case (n 50) in order to justify their decision.

brought before any court in Nigeria, which was *WARDC & Another v Attorney General-Nigeria*.[91] It was brought by the Women Advocate Research and Documentation Centre (WARDC), a Nigerian-based NGO, in 2015, on behalf of Folake Oduyoye, who after the birth of her child in 2014 was illegally and inhumanely detained for not paying her hospital bills. She developed complications while being detained and was denied medical treatment until she died.[92] However, the case was thrown out by the Federal High Court for procedural irregularities.[93]

Therefore, since in this instant case the judge was minded to go beyond the issue of discrimination that was canvassed in issue 1, but declared in addition that the policy violated maternal health, it is expected that she would have expatiated on the state's obligations in respect of the right to maternal health which had been breached. The judge should have set out the expected standards based on the relevant legal instruments and determined whether or not the defendant's action fell below the expected standards. It is expected that as a ground-breaking case, it ought to have been decided in a manner that would enable references to be made to it by future cases even if it would only have persuasive influence (being a High Court judgment) as was the case in *Festus Odafe*.[94] This article is emphatic of the danger such non-elucidation of human rights provisions canvassed in support of an applicant's rights portends. To say the least, it gives the impression that all litigants need to do is to wave human rights before the judges, mention sober words such as 'maternal and child mortality',[95] and the courts would give judgment in their favour. Such perceived weaknesses could also make the

91 Unreported. The assumption is made on the basis that the writer is oblivious to the existence of other cases and on the fact that if other cases exist, they would have been brought forward by either of the parties or the judge.

92 Centre for Reproductive Rights 'Supplementary information on Nigeria scheduled for review by the Committee on the Elimination of Discrimination against Women during its 67th session' (CRP, 30 May 2017), INT_CEDAW_NGO_NGA_27559_E.pdf (ohchr.org) (accessed 15 August 2022).

93 By this time, the Kenyan case of *Millicent Awuor* with facts similar to *Folake's* case had been decided. In *Millicent's* case the women were detained for having failed to pay their maternity care bills, and besides being denied further medical treatment were subjected to all kinds of ill-treatment. The Court held that the defendants' actions were discriminatory, violated the women's rights to dignity and were a breach of the Kenyan government's maternal health obligations guaranteed under the Kenyan Constitution and relevant international human rights instruments that the country had signed. See *Millicent Awuor Omuya alias Maimuna Awuor & Another v The Attorney-General & 4 Others* [2015] Petition 562 of 2012 (High Court of Kenya at Nairobi (Constitutional and Human Rights Division) (*Millicent Awuor* case).

94 *Odafe* (n 44).

95 This statement is only made to emphasise the necessity of substantiating claims or assertions made before the courts and is without prejudice to Nigeria's notorious maternal and child death ratios.

case a candidate for appeal, although in this case the Lagos state government had expressed its unwillingness to appeal the decision.

To further analyse: While the case vindicated the aspect of the right that requires the state to respect the right to health of people by not putting stumbling blocks in their way to access, it leaves unaddressed the duty of the state to 'fulfil'. Social rights, like all other human rights, cannot be realised by addressing only one aspect of their guarantee. In this case the right to health/maternal health, a socio-economic right, was in issue and, as noted by Ngwena, granting negative aspects of a right without granting the positive aspects of it will bring about little development.[96] The judgment has satisfactorily addressed the issue of 'respect' in that it declares that making mandatory donation a condition for accessing the relevant services such as maternity services, prevents patients from enjoying their right to health. However, it leaves aside the question as to who should be responsible for making the blood available. The essence of the blood donation or transfusion was not focused on by any of the parties (based on the text of the judgment) although the defendants did make averments in relation to conforming to 'international best practices'. In the judge's words, 'they submitted no evidence on what that means', but the judge's knowledge of the importance of protecting the full spectrum of the right to health ought to have necessitated the judge to ask them what 'international best practices' meant, especially in terms of how the blood ought to be made available. This would have eliminated any allegations against the judge if she had gone beyond the applicant's claims.[97] Asking that question would also have drawn attention to the fact that not only was the policy violating the right to health by denying access to patients, but it was also evidence of the government shirking its right to health responsibilities. This may have also allowed a pronouncement on the positive duties of the government in respect of human rights realisation.[98]

Therefore, rather than request the judge to make further orders as she saw fit, the applicants could have specifically applied for positive orders. The cases of *Alyne Pimental* and *Majani* both drew attention to the breach of government's positive obligations to ensure that all women had access to necessary lifesaving maternity care, going ahead to make orders that would facilitate their fulfilment. In the

96 C Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 790.
97 See *Nkwocha v Ofurum* (2002) 5 NWLR (Pt 761) 506.
98 It is reminiscent of *Roe v Wade*, where a negative right was founded but no positive right to make the abortion services available. *Roe v Wade* 410 US 113 (1973).

instant case, the government the next day made a statement that the judgment would lead to higher maternal mortality ratios.[99] This is evidence that there was a *lacuna* in the judgment. Statements were also made by the commissioner for health and the chief medical director of the state's teaching hospital to the effect that Lagos state would take steps to increase their voluntary blood donation drive in order to ensure the availability of blood for transfusions, but would also still appeal to spouses and relatives to donate blood. Notably, the Lagos state blood transfusion service has since embarked on making good on that promise.[100] While these appear to be an acceptance of an obligation on the part of the government, clarification by the judge that it is the government's obligation to make safe and voluntarily-donated blood available in order to fulfil the right to health would have erased all doubt and strengthened the understanding of that right by both the populace and the government.

Further analysis may also be adduced by considering this ruling in light of the factors usually considered to be determinants of the outcome of a judicial exercise.[101] The principal determinants of the decision in a case are the issues formulated for determination by the claimants and the petitions of the aggrieved party. As the saying goes, 'the law court is not Father Christmas' and cannot give you what you have not asked for. This is to mean that the judge must remain an impartial arbiter and allow the parties to determine the parameters of their case. In this case, the applicants alleged a breach of the right to health and also referred the judge to Nigeria's obligations under the Universal Declaration and ICESCR upon which the judge based her judgment. Therefore, the judge did not *suo motu* consider both points which, had she done so, might have connoted partiality. Additionally, in line with the issues formulated for determination, the judge refrained from pronouncing on the positive duties of the government. Nevertheless, as argued above, proper elucidation of the right was wanting and the binding influence of both instruments on Nigeria is debatable. The quality of arguments canvassed and the quality of evidence adduced, which includes legal materials consulted and referred to by the counsel in order to convince the judge of the

99 A Onwuzoo 'Court order banning compulsory blood donation will lead to acute shortage in Lagos – LASUTH CMD' *Punch Newspaper* Lagos, 4 March 2020, Court order banning compulsory blood donation'll lead to acute shortage in Lagos —LASUTH CMD - Healthwise (punchng.com) (accessed 15 August 2022).

100 See D Ojerinde 'LSBTS seeks innovative strategies on voluntary blood donation' *Punch Newspaper* Lagos 14 October 2020, LSBTS seeks innovative strategies on voluntary blood donation – Punch Newspapers (punchng.com) (accessed 15 August 2022).

101 S Danziger, J Levav & L Avnaim-Pesso 'Extraneous factors in judicial decisions' (2011) *PNAS, Princeton University*, pnas201018033 6889..6892 (accessed 15 August 2022).

rightness of his party's position in a case, are also determining factors of the quality of the judgment. However, as we do not have access to the pleadings of both parties beyond the summaries contained in the decision, this will be impossible to assess. The nature of the case may also play a determining role in the holding. As the instant case borders on socio-economic rights, the conundrum of the justification of socio-economic rights may have played a role.[102] Judicial incursion in the realisation of socio-economic rights has been trailed by misgivings and is unsupported for various reasons, including the arguments that courts are unable to make decisions on issues bordering on government resources and the budget that the executive is more empowered and in a better position to make.[103] While this issue may not directly involve budgetary allocation,[104] it nonetheless requires a positive duty, which it is common knowledge that the government has been unable to fulfil.[105] As a result, to conclude that the judge may have been influenced by anti-socio-economic rights justification arguments is not far-fetched. The novelty of the case or otherwise is another important factor as this may determine the availability of jurisprudence from courts or other adjudicatory bodies on the issue(s). The earlier explanations offered in this article with respect to the antecedents of this case show a mixture of Nigerian judges' willingness and reluctance to hold the government accountable for rights to health violations. Additionally, there is no record that cases in respect of the right to maternal health have ever been decided in the country.

The last factor of which there also is no means of assessing, in this case, relates to the judge himself or herself. That is, that a judge's level of exposure, education, experience, training, access to relevant research, personal ideologies, and psychological, political and social influences also determine the nature and quality of their judgments.[106] None of these aspects of the judge's constitution is public knowledge and, therefore, are not open to discussion in this article.

102 See N Christopher 'Challenges to the judicial enforcement of socio-economic rights in Ghana and South Africa' in M Addaney & G Nyarko (eds) *Ghana @60: Governance and human rights in 21st century Africa* (2017) 151.

103 See *Soobramooney v Minister of Health KwaZulu-Natal* 1998 (1) SA 765 CC.

104 It may indirectly involve budgetary decisions, however, because the government may have to solve the problem of shortage of blood and blood products by buying them.

105 Editorial 'Safe blood: Nigeria fails to meet WHO requirements' *The Guardian* (Lagos) 13 June 2017, Safe blood: Nigeria fails to meet WHO requirements | The Guardian Nigeria News – Nigeria and World News – Opinion – The Guardian Nigeria News – Nigeria and World News (accessed 15 August 2022).

106 Danziger and others (n 101).

5.1 Value of the decision

According to Cook, the value of a judgment in a human rights case should not be compliance with the judgment, but the contribution of that case to the sphere of justice, for instance, by expatiating on the norms of the field in question.[107] It also includes its contribution to the current knowledge on the right and as it applies to the issue in question.[108]

This article concludes that this decision is valuable. This is because, as mentioned earlier, before the institution of this case and the ruling under discussion, there had been unsuccessful attempts to hold the Nigerian government accountable for infringements of the right to health based on its obligations under the African Charter Ratification Act. However, the government's duty to give effect to the right to health on the basis of this Act was argued for and upheld in this case. Thus, in spite of its imperfections this decision has not only confirmed that the human right to health is a justiciable right of the Nigerian populace but has declared its realisation necessary for reducing preventable maternal mortality in Nigeria. The enthusiastic manner in which the judge, despite not being furnished with statistics on maternal mortality caused by a denial of access to maternity services due to the compulsory blood donation policy, was willing to imagine the inevitable link also has a positive connotation. The action could be interpreted as showing the judge's willingness to overlook non-compliance with legal technicalities if it would make it possible to hold the state accountable for glaring injustices being suffered by the vulnerable in society, which the government's ineptitude or irresponsibility has encouraged.

6 Conclusion

Getting the courts to stand by the decision that Nigeria legally is unable to avoid being held in breach of its right to health obligations is long overdue. Due to this delay, the non-recognition of Nigeria's liability in right to health cases by domestic courts has been a subject of discussion in numerous legal and other scholarly works and fora. The delay has also negatively impacted the amount of jurisprudence Nigerian courts would have developed in the course of interpreting the content of the right and clarifying obligations with respect to several aspects of the right, including maternal health. The

107 Cook (n 51).
108 See the *Majani* case (n 49) where the judge elaborated on the minimum expected standard of healthcare delivery.

availability of quality jurisprudence generated on the right by courts in the country may also have meant that the circumstances that led to the instant case may have been pre-empted by the authorities and thus avoided. We also reiterate that, if the ruling in this case had been contrasted against the achievements of the featured right to health cases such as that of *Majani*, where maternal health was in issue, or the *Laxmi Mandal* cases, where maternal death was in issue, and national courts elaborated on government's obligations in respect of the right to health of these women and ordered them to take positive steps to right those wrongs, the extant judgment may not match up in value. However, if one were to consider the fact that, unlike the mentioned cases that had precedents upon which to draw,[109] this judgment to a large extent is a first of its kind in the hitherto restrictive socio-economic rights judicial climate in Nigeria, it would lead to a conclusion that the contribution of this case is of immense value.

109 In Kenya, the *Millicent Awuor* case had already been decided before the *Majani* case. In India's *Laxmi Mandal* case the Court specifically referred to the *Paschim Banga* case.