



## The right to health in Nigeria

'Right to health in the Middle East' project, Law School, University of Aberdeen,  
<http://www.abdn.ac.uk/law/hhr.shtml>

***Draft Report December 2007- for questions or comments please contact the author***

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### Introduction

Nigeria recognizes the right to health and has committed itself to its protection by assuming obligations under international treaties and domestic legislations mandating specific conduct with respect to the health of individuals within its jurisdiction. Prior to the economic travails of the mid-1980s, the health sector witnessed robust growth, principally as a result of unfettered support by the government, coupled with assistance from international donor agencies. Except in rural areas, access to health care was readily available at public hospitals and clinics at no charge. However, by 1985, this positive development had screeched to a grinding halt, owing to a plurality of factors, two of which clearly stood out: precipitous economic decline and military usurpation of power, the latter marking the genesis of many of the intractable challenges besetting the health system.<sup>1</sup>

The current state of health in Nigeria is intertwined with its history of political governance. In its forty seven years (1960 – 2007) as an independent nation, the military has held the reins of power for twenty nine years.<sup>2</sup> But it was the last phase of military dictatorship (1983 –1998)<sup>3</sup> that altered the socio-political and economic landscape of Nigeria. As noted in a recent article, the deterioration currently experienced in the health sector is directly attributable to long years of

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<sup>1</sup> Though not the first military administration in Nigeria, the regimes of Ibrahim Babangida (1985 – 1993) and Sanni Abacha (1993 – 1998) were, by all accounts, of a different genre. As more forcefully argued elsewhere, the dismal state of the health system in Nigeria is inextricably linked to the flagitious and venal governance of that momentous historical period. See Obiajulu Nnamuchi, "Kleptocracy and its Many Faces: The Challenges of Justiciability of the Right to Health Care in Nigeria" (2008) 52 (1) *Journal of African Law* 12 –18.

<sup>2</sup> No country has been under military dictatorship longer than Nigeria. See the United Nations (UN) Economic Commission for Africa, "Country Report: Nigeria," available at [http://www.uneca.org/aisi/NICI/country\\_profiles/Nigeria/nigeriab.htm](http://www.uneca.org/aisi/NICI/country_profiles/Nigeria/nigeriab.htm), accessed 9 July 2007. Control of the country's vast natural resources, particularly oil, which translates to enormous personal wealth for whoever succeeds in gaining effective control of the reins of government, was at the root of coups and counter-coups to which the country had been subjected: Thomas Pogge, "Severe Poverty as a Human Rights Violation" in Thomas Pogge, ed., *Freedom From Poverty as a Human Right: Who Owes What to the Very Poor* (New York: Oxford University Press, 2007) 49. For an analysis of these resources, see Energy Information Administration (EIA), "Nigeria," available at [eia.doe.gov/emeu/cabs/nigeria.html](http://eia.doe.gov/emeu/cabs/nigeria.html), accessed 8 December 2007.

<sup>3</sup> The regime of Abdusalam Abubakar (1998 – 1999) is purposefully exempted. Though not by any means blameless, his was merely a "caretaker" administration, left with no choice but to lay the foundational for transition to democratic governance. He had neither the time nor, as most observers would agree, the temperament for the type of brutality and corruption associated with his predecessors.

kleptocratic repressive military dictatorship and widespread corruption and mismanagement of that era.<sup>4</sup> A report released by the United Nations (UN) shortly before democracy was restored came to the same conclusion, implicating the military as being non-responsive to the deficiencies and continued rot of the health system.<sup>5</sup> This rot is evident in a patchwork of decrepit public health infrastructure strewn across the country, most of which are severely understaffed and suffer extreme shortages of even the most basic equipment and medicine. Even in spotty instances where medical treatment and consultation are available, escalated cost means that millions are effectively shut out of the system.<sup>6</sup> Bleak picture, indeed, but to a large extent, these observations are fairly accurate depictions of the conditions in Nigeria.

With the demise of military dictatorship in 1999 came new expectations and rekindled hope for a change in status quo. In response, or so it seems, the democratically-elected administration introduced several innovative policy initiatives, some of which are presently being pursued at different tiers of government. These initiatives aim to restructure and revamp the health system and, concomitantly, realize the goals of the recently revised National Health Policy and other health programmes, including the health-related benchmarks of the Millennium Development Goals (MDGs). Although the process has been far from perfect, the development and implementation of these programmes represent a significant departure from the errors and deficiencies of the past, at least in terms of openness and greater public participation.

This report seeks to present a reliable account of important issues impacting upon public health in Nigeria and use same, first, as a tool for evaluating the state of health in Nigeria and, second, as a guide to future development of the health system. While accuracy was a prime concern, limited availability and low reliability of data were constraining factors. But given the overall goal of the project, the impact is relatively insignificant and scarcely worthy of concern. Key sources of information have been data and reports published by the Federal Ministry of Health (FMH), World Health Organization (WHO) and the United Nations Development Fund (UNDP).

### **Legal Commitment to the Right to Health**

International treaties which recognize the right to health are legionary. And Nigeria is a party to most of them. The most important of these treaties are the International Covenant on Economic, Social and Cultural Rights (ICESCR), Convention on the Elimination of all Forms of Discrimination (CERD), the Convention on the Elimination of all Forms of Discrimination

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<sup>4</sup> Sally Hargreaves, "Time to Right the Wrongs: Improving Basic Health Care in Nigeria" (2002) 359 *Lancet* 2030; Adora Okonkwo, "Nigeria Set to Launch Health Insurance Scheme" (2001) 358 (9276) *Lancet* 131; Sofu Ali-Akpajiak and Toni Pyke, *Measuring Poverty in Nigeria* (Abuja, Nigeria: Oxfam, 2003) 9.

<sup>5</sup> UN Commission on Human Rights (UNCHR), "Questions of the Violation of Human Rights and Fundamental Freedoms in Any Part of the World: Situation of Human Rights in Nigeria," Report Submitted by the Special Rapporteur of the Commission on Human Rights, Soli Jehangir Sorabjee, E/CN/4/1999/36, 14 January 1999, at para(s) 61 & 62; Human Right Watch, "Chop Fine: The Human Rights Impact of Local Government Corruption and Mismanagement in Rivers State," *Nigeria*, vol. 19, No. 2(A) (January 2007) at 41, available at <http://hrw.org/reports/2007/nigeria0107/>, accessed 15 September 2007, quoting World Bank, "Health Country Status Report," at para. 10.

<sup>6</sup> Sally Hargreaves, *supra*, note 4; Hannah Roberts, "Reproductive Health Struggles in Nigeria" (2003) 361 (9373) *Lancet* 1966. Basic medical supplies such as hand gloves and disinfectants are not available in many of the nation's hospitals: Transparency International, *The National Integrity Systems TI Country Study Report Nigeria 2004* (Berlin: Transparency International, 2004) 13. Patients are required to purchase these items prior to receiving treatment in such hospitals.

against Women (CEDAW) and the Convention on the Rights of the Child (CRC). Nigeria is also a party to two health-related treaties on civil and political rights, namely, the International Covenant on Civil and Political Rights (ICCPR) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. In addition, the country is a party to several Conventions of the international Labour Organization, some of which contain provisions on the health of workers. Nigeria is also a party to the Geneva Conventions and Additional Protocols that prescribe rules for conduct of warfare, including health-related obligations.

Further, the country adheres to several non-binding instruments/standards that address health issues: the 1993 Vienna Declaration and Programme of Action, the Programme of Action of the 1993 UN International Conference on Population and Development and the 1995 Beijing Declaration and Platform for Action (UN Fourth World Conference on Women). At a regional level, Nigeria is a party to the African Charter on Human and Peoples' Rights (African Charter), the African Charter on the Rights and Welfare of the Child and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

With respect to the applicability of these treaties within domestic framework, it is significant to note that with the exception of the African Charter, which has been incorporated into domestic legal order, no other treaty bearing on the right to health has direct application in Nigeria.<sup>7</sup> Nigeria, like most common law countries, adopts a dualist approach in receiving international law; meaning that notwithstanding ratification, treaties acquire legal force only upon enactment by the National Assembly. Though the Constitution denies legal recognition to the right to health as well as other social and economic (socio-economic) rights, the domestication of the African Charter in 1983 has introduced monumental changes to the legal status of these rights in Nigeria. More specifically, article 16 (1) guarantees the right to health: "Every individual shall have the right to enjoy the best attainable state of physical and mental health." Regrettably, as far as this author knows, only one case implicating substantive aspects of the right to health has made it to the court in Nigeria since the domestication of the Charter.<sup>8</sup> There was also a communication brought in 1996 before the African Commission on Human and People's Rights (African Commission), challenging the obligation of Nigeria in regard to the right to health.<sup>9</sup> And a landmark case, with far-reaching implications for the right to health in Nigeria, is pending before a federal court in the United States.<sup>10</sup>

### **Health Policy and Financing**

The current health policy of Nigeria is embodied in the *National Health Policy and Strategy to Achieve Health for All Nigerians*, introduced in 1988 and subsequently revised in 2004.<sup>11</sup> Founded on egalitarian principles, the policy seeks to improve the health of all Nigerians by devising a sustainable health system based on primary health care (PHC), that is promotive, protective, preventive, restorative and rehabilitative and which will ensure a socially and economic productive and fulfilling life to every individual. The policy adopts WHO's strategy

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<sup>7</sup> See S. 12 (1) & (2) of the Constitution; African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, Chapter 10, Laws of the Federation of Nigeria 1990.

<sup>8</sup> See *infra*, note 158.

<sup>9</sup> See *infra*, note 155.

<sup>10</sup> See *infra*, note 157.

<sup>11</sup> Federal Ministry of Health (FMH), *National Health Policy and Strategy to Achieve Health for all Nigerians* (Lagos, Nigeria: FMH, 1988); *Revised National Health Policy* (Abuja, Nigeria: FMH, 2004).

for realizing PHC as elaborated in the Declaration of Alma Ata.<sup>12</sup> The main focus of the National Health Policy is on the National Health System and its Management; National Health Care Resources; National Health Interventions and Services Delivery; National Health Information Systems; Partnership for Health Development; and Health Research and Health Care Laws. Though they are still in embryonic stages, each of these areas represents important components of an effective health system and would, if fully developed and implemented, go a long way in plugging the gaps and inadequacies of the current system.

### Health Expenditure

According to UNDP, government expenditure on health as a percentage of GDP was 1.3% in 2003,<sup>13</sup> a decline from 2.2% in 2000.<sup>14</sup> In regard to government expenditure as a percentage of total expenditure on health, the Nigerian government share declined from 29.1% in 1999 to 25.5% in 2003,<sup>15</sup> lagging behind many other African countries, even those similarly classified by the World Bank as low income economies.<sup>16</sup> In per capita terms, public spending on health stands at less than \$5, and in some parts of the country can be as low as \$2, far short of the \$34 recommended by WHO for low income countries within the Macroeconomics Commission Report.<sup>17</sup> Apparently, this level of spending will make it extremely difficult to provide even the most basic of services. In addition, there is a concern that the budgeted figures may not be representative of the actual amount spent on health as there continues to be a gap between the two figures.<sup>18</sup> Moreover, it is not even clear whether the budgetary allocations were actually spent on health services or wound up in private hands.<sup>19</sup>

### Public and Private Health Care Expenditure and Provision

The public and private sectors are partners in delivering health care throughout the country. While public health expenditure in Nigeria is 1.3% of GDP, private health expenditure is 3.7%.<sup>20</sup> The decline in quality of services provided at public health facilities which, as noted earlier, began in mid-1980s precipitated the emergence and continued growth of private hospitals and clinics in virtually all parts of the country. The surge in number of these facilities has been so rapid that it is estimated that more people receive medical treatment from them than from public facilities. According to WHO, private expenditure on health as a percentage of total expenditure

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<sup>12</sup> Declaration of Alma-Ata, adopted by the International Conference on Primary Health Care, jointly sponsored by WHO and UNICEF in 1978, Principle VII, available at <http://www.righttohealthcare.org/Docs/DocumentsC.htm>, accessed 5 June 2007.

<sup>13</sup> UNDP, *Human Development Report 2006* (Geneva: Palgrave Macmillan/UNDP, 2006) 303.

<sup>14</sup> WHO, "Nigeria: Malaria Country Profiles," available at <http://www.afro.who.int/malaria/country-profile/nigeria.pdf>, accessed 27 September 2007.

<sup>15</sup> WHO, *The World Health Report 2006: Working Together for Health* (Geneva: WHO, 2006) 182.

<sup>16</sup> During the same period, the shares of governments of Senegal, Ethiopia and Sierra Leone improved to 41.8 %, 58.4% and 58.3% respectively. *Idem* at 180, 182.

<sup>17</sup> WHO, "WHO Country Cooperation Strategy: Federal Republic of Nigeria, 2002-2007" at 6, available at [http://www.who.int/countries/nga/about/ccs\\_strategy02\\_07.pdf](http://www.who.int/countries/nga/about/ccs_strategy02_07.pdf), accessed 20 August 2007.

<sup>18</sup> WHO, "Health Financing and Social Protection," available at [http://www.who.int/countries/nga/areas/health\\_financing/en/index.html](http://www.who.int/countries/nga/areas/health_financing/en/index.html), accessed 20 August 2007.

<sup>19</sup> This is a serious problem given that, as the FMH conceded, no reliable data exists on either the aggregate health expenditure by the federal, state and local governments or on private spending. FMH, *Health Sector Reform Programme: Strategic Thrusts with a Logical Framework and a Plan of Action 2004 – 2007* (Abuja: FMH, 2004) 12, 20.

<sup>20</sup> UNDP, *supra*, note 13.

on health was 69.6% in 2004,<sup>21</sup> and this figure is bound to rise unless there is an urgent and significant infusion of resources to the public sector. Because no such changes have been made, the growth in the proportion of care provided at private facilities continues to surge, resulting in escalation of cost of treatment and, consequently, diminished access as the cost is unaffordable by most people. There is no social security programme<sup>22</sup> and, until recently, there was no health insurance system in the country. As a result, payment for health care is directly made out-of-pocket in most instances. There are private companies underwriting health insurance but their services are grossly under utilized due to high premiums.

The National Health Insurance Scheme (NHIS) Act, promulgated in 1999, seeks to bring changes to this system of health care financing by reducing the cost burden on individuals and improving the quality, availability and affordability of services.<sup>23</sup> The Act provides for the creation of health maintenance organizations (HMOs) which, in turn, are authorized to contract with health care providers for services to insured individuals. Each insured person is entitled to choose a health center with which he wishes to register, with payment made to the health center on monthly capitation basis. While universal coverage is intended by the NHIS, beneficiaries have been limited to employees of the Federal Government and large corporations. Given this limitation, most people continue to pay for health care directly out of pocket, and this has significant access implications.

A whopping 70.8% of Nigerians live below the poverty line, on less than \$1/day,<sup>24</sup> and are therefore not in a position to afford the high cost of health care, meaning that millions are left without any form of coverage. As a result, concern has arisen that continued growth in the number of people without coverage would further add to the downward spiral of key health indicators and, in addition to the scourge of HIV/AIDS, contribute to exacerbating an already appalling life expectancy rate. However, the recent launching of the US \$131 million Insurance Health Fund (IHF) by the Dutch Ministry of Foreign Affairs would expand coverage to a significant portion of the population.<sup>25</sup> The appeal of the fund lies on its impact on the major factor militating against utilization of health insurance: cost. The fund would subsidize the cost of premium by as much as 95% in some cases,<sup>26</sup> thereby making it possible for more people to purchase coverage.

### Emphasis on Primary Care

The National Health Policy prioritizes PHC as the cornerstone of the Nigeria health system. This prioritization mirrors the approach adopted at the UN for realizing the right to health, namely, according primacy to PHC over secondary and tertiary care and making its provision and availability a core obligation.<sup>27</sup> Although the National Health Policy contains guidelines for

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<sup>21</sup> WHO, *World Health Statistics 2007* (Geneva: WHO, 2007) 68

<sup>22</sup> WHO, *supra*, note 15 at 183.

<sup>23</sup> Act 35 of 1999, Laws of the Federation of Nigeria, Part II, S. 5.

<sup>24</sup> UNDP, *supra*, note 13 at 294.

<sup>25</sup> See IRIN, "Nigeria: New Insurance Scheme for Poor," available at <http://www.irinnews.org/Report.aspx?ReportId=62764>, accessed 20 August 2007.

<sup>26</sup> *Idem*.

<sup>27</sup> General Comment No 14, The Right to the Highest Attainable Standard of Health (Art. 12, ICESCR), UN COMM. ESCR, 22<sup>nd</sup> Session, UN Doc. E/C.12/2000/4 (2000), para(s) 43 & 47; General Comment No. 3, The Nature of States Parties Obligations (Art. 2, par.1 ICESCR, ), UN COMM. ESCR, 5th Session, UN Doc. E/1991/23

investment of resources in the area of secondary and tertiary care, it recognizes that given prevailing conditions, PHC provides the most rewarding vehicle for dealing with the numerous health sector challenges and therefore deserves greater resource allocation. According to government sources, there were 18,258 registered PHC, 3,275 secondary and 29 tertiary facilities across the country in 1999.<sup>28</sup>

In order to operationalize the PHC component of the National Health policy, the National Primary Health Care Development Agency (NPHCDA) was established in 1992 and charged with the following responsibilities: translating policies into feasible strategies, developing health care facilities at the local government level, providing technical knowledge and expertise on the provision of PHC and monitoring its delivery on behalf of the FMH.<sup>29</sup> These functions involve guiding various stakeholders on cost-effective and efficient means of reaching identified goals. To this end, the agency has been credited with conducting training programmes for upgrading the skills of PHC personnel and training of village health workers, including traditional birth attendants (TBAs) to assist in reducing the rate of maternal mortality.<sup>30</sup> The agency was also among a consortium of organizations and institutions whose initiatives led to the development of policy guidelines on anti-malaria strategies. However, the effectiveness of the agency has been constrained by insufficient government support.<sup>31</sup> As well, inadequate funding has severely curtailed the capacity of PHC facilities to deliver critical services, currently serving only about 5–10% of the potential case load.<sup>32</sup>

#### Other Health Policy Issues

One of the major criticisms against health system governance in Nigeria is lack of coordinated response to critical health sector needs.<sup>33</sup> Needless duplication of efforts in the past has led to redundancy and waste of resources that could have yielded greater dividend had they been employed elsewhere. As a response to this criticism, the Federal Government is in the process of developing a system to guide and coordinate investments and actions by the three tiers of

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(1990), para. 10; Declaration of Alma-Ata, *supra* note 12, Principle VII; Report of the International Conference on Population and Development, Cairo, 1978 (UN Publication, Sales No. E.95.XIII.18) Chaps. VII & VIII, particularly Items 7.6 & 8.4, available at <http://www.iisd.ca/Cairo/programme/p00000.html>, accessed 5 June 2007.

<sup>28</sup> WHO, *supra*, note 17 at 5.

<sup>29</sup> The National Primary Health Care Development Agency Decree (No. 29) 1992, S. 3.

<sup>30</sup> UNDP, *Millennium Development Goals Report 2004: Nigeria* (Abuja, Nigeria: UNDP, 2006) at 36. Private organizations have begun offering training to TBAs on various aspects of reproductive health: Hannah Roberts, *supra*, note 6. For an overview of the role of village health workers and TBAs in the delivery of PHC in the country, see S. Apantaku, “Relevance to Primary Health Care of Village Health Workers and Traditional Birth Attendants in Rural Areas of Oyo State, Nigeria” (2005) 12 (3) *International Journal of Sustainable Development and World Ecology* 256–265.

<sup>31</sup> Inadequate funding has been the bane of many important health projects in Nigeria. For instance, the reason an ambitious antiretroviral therapy programme began in 2002, with a target of enrolling 10,000 adults and 5,000 children within one year, is yet to reach its goal, after more than five years in operation is nothing other than funds. See A. Odotola, “ARV Drug Treatment in Africa,” available at <http://academic.udayton.edu/health/06world/africa04.htm>, in Jane Pennington, “HIV & AIDS in Nigeria”, available at <http://www.avert.org/aids-nigeria.htm>, accessed 30 June 2007.

<sup>32</sup> FMH, *supra*, note 19 at 11.

<sup>33</sup> Perhaps the enormity of the challenges was the impetus for the surge in the number of health-related agencies and programmes but rather than quality output, the result was overlapping functions and stagnation. See Nkolika Aniekwu, “Health Sector Reform in Nigeria: A Perspective on Human Rights and Gender Issues” (2006) 11 (1) *Local Environment* 130–131.

government, the private sector, donors and other stakeholders.<sup>34</sup> Known as the “Health Sector Reform (HSR) Plan of Action,” the plan targets seven strategic areas, namely, PHC, diseases control, sexual and reproductive health including STIs/HIV/AIDS, secondary and tertiary care, drug production and management, coordination of development partners, organization and management.<sup>35</sup>

### International Aid

A major reason for the deplorable state of health in Nigeria was the decline in international contributions to the development of the health sector which began in mid-1980s and continued until a few years ago. Following the military government’s recalcitrance to acquiesce to relentless demands for restoration of democracy and its subsequent ostracization by the international community, most donor countries and international agencies ceased funding projects in Nigeria, including those that were health-related. But since re-establishment of democracy, the situation has steadily improved, with many of the foreign partners resuming cooperation with the government and significantly contributing to addressing priority areas of concern. The percentage of total foreign aid to the health sector, a miserly 3.0% in 1998, surged to 19.8% in 1999, the year civilians regained control of government.<sup>36</sup>

According to WHO, there are six UN agencies providing support to the health sector: World Bank, UNDP, United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United Nations Office for Drug Control and Crime Prevention (UNODCCP) and WHO.<sup>37</sup> The list is not exhaustive. Recently, the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria<sup>38</sup> approved a \$68 million grant to strengthen TB and TB-HIV/AIDS programmes in Nigeria.<sup>39</sup> The main focus of the fund is on enhancing TB case detection and outcomes and TB-HIV/AIDS collaboration.<sup>40</sup> Nigeria is also one of the fifteen countries identified by the United States Government as a key target in its HIV/AIDS prevention, treatment and care programme. Under the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), Nigeria received more than \$70.9 million in 2004, \$110.2 million in 2005, \$163.1 million in 2006 and an additional commitment of \$270 million in 2007, making the Plan the largest contributor to the country’s HIV/AIDS programme.<sup>41</sup>

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<sup>34</sup> WHO, *supra*, note 17 at 7.

<sup>35</sup> *Idem*.

<sup>36</sup> *Idem*, at 8.

<sup>37</sup> *Idem*.

<sup>38</sup> The Global Fund is an international funding agency created in 2002 with a mandate to attract, manage and disburse resources to fight AIDS, TB and malaria in countries of greatest need. Since becoming operational, the Global has committed US\$7.6 billion to support more than 450 grants in 136 countries. See The Global Fund, *The Global Fund: Who We Are, What We Do* (Geneva: Global Fund, 2007) at 9; report also available at: [http://www.theglobalfund.org/en/files/publications/brochure/gf\\_brochure\\_07\\_full\\_high\\_en.pdf](http://www.theglobalfund.org/en/files/publications/brochure/gf_brochure_07_full_high_en.pdf), accessed 18 August 2007.

<sup>39</sup> USAID, “Nigeria: Tuberculosis Profile,” available at [www.usaid.gov](http://www.usaid.gov), accessed 17 July 2007.

<sup>40</sup> *Idem*.

<sup>41</sup> U. S. Mission to Nigeria, “President’s Emergency Plan for Aid relief,” available at [http://abuja.usembassy.gov/uploads/images/Rt\\_ywZxStF\\_LTXSNXZORCQ/pepfar\\_nigeria\\_ovc\\_fact\\_sheet.pdf](http://abuja.usembassy.gov/uploads/images/Rt_ywZxStF_LTXSNXZORCQ/pepfar_nigeria_ovc_fact_sheet.pdf), accessed 24 August 2007. One of the several projects funded by PEPFAR in Nigeria is the Global HIV/AIDS Initiative Nigeria (GHAIN), a five year project aimed at providing anti-retroviral treatment to more than 68,000 people, HIV care to more than 1,500,000 persons including orphans and vulnerable children and preventing 800,000 new infections by 2009. See Family Health International, “FHI 'GHAINS' New Funds for HIV/AIDS, TB Services in Nigeria,” available at <http://www.fhi.org/en/HIVAIDS/country/Nigeria/nigernews.htm>, accessed 18 July 2007.

Nigeria's HIV/AIDS initiative also received a huge boost from the World Bank. In 2002, the country received a loan of \$90.3 million under the World Bank Multi-Country HIV/AIDS Programme (MAP) in support of its domestic initiatives.<sup>42</sup> Another major donor is the European Union. A donation of €3.3 million (approximately \$41.4 million) from the European Commission in support of UNICEF- assisted water and sanitation projects in Nigeria represents the largest contribution ever by the Union to a development project undertaken by the agency in any part of the world.<sup>43</sup> Other major contributors include the U.K. Department of International Development (DFID), United States Agency for International Development (USAID), Canadian International Development Agency (CIDA) and Japan International Cooperation Agency (JICA).<sup>44</sup>

### **Health-Related Information**

Health data, survey and related information in Nigeria are published by the FMH and the National Bureau of Statistics (NBS). However, as a result of growing concern about the quality of the information generated, a new agency, the National Health Management Information System (NHMIS), was created in 1997 with a mission to gather, collate and disseminate accurate, timely and reliable health information. But the ability of the System to respond to these challenges is being hampered by several factors, including low return rates and incomplete/inaccurate reports by health facilities.<sup>45</sup>

### **Participation of the Public in the Decision-Making Process over Important Health-Related Decisions**

A key strategy for realizing the goals of PHC is bringing health care closer to the people by involving local communities in its implementation.<sup>46</sup> To this end, the National Health Policy requires the establishment of "Ward Health Committees" and "Village Health Committees" at ward and village levels in order to strengthen grass root participation. Committee members are required to actively participate in planning, organizing and managing the primary health system in the villages.<sup>47</sup> With regard to the operation of secondary and tertiary care, the input of the public in terms of organization and management is quite limited.

### **General Health of the Population**

Measured by life expectancy, the general health of the population has taken a nosedive. In 1991, the life expectancy at birth was 53.8 and 52.6 years for females and males respectively<sup>48</sup> but dropped to 48 years for females and 47 years for males in 2005, six years after re-establishing democratic governance.<sup>49</sup> These figures are slightly higher than Niger but lower than Cameroun,

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<sup>42</sup> ThisDay Newspaper, "Nigeria May Lose N11.2956 World Bank Grant," 28 June 2004, available at [www.naijapost.com/news/publish/article\\_980.shtml](http://www.naijapost.com/news/publish/article_980.shtml), accessed 18 July 2007.

<sup>43</sup> UNICEF, "At a Glance: Nigeria – New EU Donation will Help Provide Safe Water for 2.1 Million People," available at [http://www.unicef.org/infobycountry/nigeria\\_28236.html](http://www.unicef.org/infobycountry/nigeria_28236.html), accessed 18 July 2007.

<sup>44</sup> WHO, *supra*, note 17 at 8.

<sup>45</sup> FMH, *supra*, note 19 at 9.

<sup>46</sup> General Comment No 14, *supra*, note 27 at para(s) 19 & 43.

<sup>47</sup> D.O. Adeyemo, "Local Government and Health Care Delivery in Nigeria: A Case Study" (2005) 18(2) Journal of Human Ecology 152.

<sup>48</sup> WHO, "HIV/AIDS," available at <http://www.who.int/countries/nga/areas/hiv/en/index.html>, accessed 29 September 2007.

<sup>49</sup> WHO, *supra*, note 21 at 26.

neighboring countries to the North and East.<sup>50</sup> The decline in life expectancy could be attributed to a sharp rise in mortality among people infected with HIV/AIDS. For while only 50,000 persons died of AIDS in Nigeria in 1995, by 2000, the figure had risen to 209,000 and is expected to reach 700,000 by 2010.<sup>51</sup>

## **Women's Health**

As a party to CEDAW, Nigeria committed itself to take a series of measures, in line with Article 12, for realizing the right of access to health care for women, including sexual and reproductive care.<sup>52</sup> As stipulated in paragraph 21 of the General Comment on the Right to Health, one of the major goals of securing women's right to health care is reducing women's health risks, particularly lowering the rate of maternal mortality.<sup>53</sup>

### Access to Health Care during Pregnancy and Delivery/Maternal Mortality

The maternal mortality rate (MMR) as a key index for assessing the survival of women in Nigeria is abysmal. Noted by WHO as "one of the highest in the world," the country recorded 800 deaths per 100,000 live births in 2000.<sup>54</sup> Disaggregated figures show that there are wide urban-rural and inter regional disparities. Urban areas recorded lower MMR of 351 per 100,000 live births compared to 828 in rural areas.<sup>55</sup> As for regional disparities, the MMR for South West and South East regions were 165 and 286 while regions of North West and North East recorded 1,025 and 1,549 respectively.<sup>56</sup> Factors contributing to MMR include poor health status, illiteracy, poor access to antenatal care, poor nutrition and HIV infection. Most importantly, complications arising from illegal abortions account for a significant proportion of these deaths.<sup>57</sup>

In general, access to antenatal care is very low, particularly for younger women. According to a report submitted to the UN Committee on Elimination of Discrimination against Women, 45% of

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<sup>50</sup> In 2005, life expectancy in Niger was 41 and 42 years for females and males; 51 years and 50 years for females and males in Cameroun. *Idem* at 22, 26.

<sup>51</sup> FMH, *HIV/AIDS: What it Means for Nigeria(Background, Projections, Impact, Interventions and Policy)*, (Abuja, Nigeria: FMH, 2002) 31

<sup>52</sup> CEDAW, Art. 12, United Nations, *Treaty Series*, vol. 1249, p. 13; text available at <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>, accessed 18 July 2007.

<sup>53</sup> General Comment No 14, *supra*, note 27 at para. 21.

<sup>54</sup> WHO, *supra*, note 17 at 4. The high mortality is consistent with the finding in a recent study that the number of women in Nigeria that obtain antenatal care during pregnancy is generally low, approximately 60%. H. Galadanci, C. Ejembi, Z. Iliyasu, B. Alagh and U. Umar, "Maternal Health in Northern Nigeria – A Far Cry from Ideal" (2007) 114 (4) *BJOG: An International Journal of Obstetrics and Gynaecology* 448.

<sup>55</sup> UNDP, *supra*, note 30 at 39.

<sup>56</sup> *Idem*.

<sup>57</sup> The true figure is not known but claims ranging from as high as nearly 50% to as low as less than 11% have been made. In their article, "Why Nigerian Adolescents Seek Abortion Rather than Contraception: Evidence from Focus-Group Discussions," Valentine Otoide, Frank Oronsaye and Friday Okonofua suggested that 20,000 of the estimated 50,000 maternal mortality in Nigeria are abortion-related: (2001) 27 (2) *International Family Planning Perspective* 77– 81, available at <http://www.guttmacher.org/pubs/journals/2707701.html#2>, accessed 26 September 2007, citing Akingba J.B., "Abortion Mortality and other Health Problems in Nigeria" (1977) 7(4) *Nigeria Medical Journal* 4465-4471; Boniface Oye-Adeniran, Carolyn Long and Isaac Adewole, "Africa: Advocacy for Reform of the Abortion Law in Nigeria" (2004) *Reproductive Health Matters* 12(24) at 210. On the other hand, a government report maintained that 11% of MMR in Nigeria was the result of abortion, malaria, anemia and Toxemia. See Nigeria's Combined Fourth and Fifth Periodic Report of State Parties (Nigeria's Report), CEDAW/C/NGA/4-5, 28 April 2003, at 43.

women of less than 20 years of age lacked access whereas for those aged 20-34 and 35 plus, the rates were 26.1% and 28.4% respectively.<sup>58</sup> Though the proportion of births attended by qualified medical personnel rose from 31% in 1998 to 42% in 2000,<sup>59</sup> the number is still less than half of all births recorded during that period. Even at that, the improved figure masks a disturbing disparity between urban and rural dwellers. While 58.8% of births in urban areas are attended by skilled health personnel, for rural women the rate is only 27.1%,<sup>60</sup> fueling concern about increasing reliance on TBAs. This is because most of the TBAs are not sufficiently skilled to handle pregnancy-related complications and might resort to harmful traditional practices, thus endangering the life of the mother and child.

#### Access to Reproductive Health Services and Information

On the basis of paragraph 34 of the General Comment on the Right to Health, States are required to refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, including sexual education and information.<sup>61</sup> In Nigeria, access to reproductive health services and information is addressed in two important respects. First, the National Policy on Reproductive Health defines its objective as, *inter alia*, to increase knowledge of reproductive health and promote responsible behavior of adolescents regarding prevention of unwanted pregnancies and sexual transmitted infections (STIs).<sup>62</sup> Second, an important area of concern of the PHC component of the National Health Policy is maternal/child health and family planning services. Along these lines, the government has adopted several strategies in order to create awareness and increase knowledge about reproductive health services. Some of the strategies include the recent approval of Family Life and HIV Education (FLHE) Curriculum (formerly National Sexuality Education Curriculum) which is to be implemented at the state and local government levels and employed in teaching reproductive sex education at secondary schools,<sup>63</sup> and a national campaign promoting the use of contraceptives.

Promoting the sale, distribution and use of contraceptives is one thing, actual utilization by women is quite a different matter. A FMH study in 1999 found that only 15.7% of women make use of reproductive health services in Nigeria.<sup>64</sup> This is within the same statistical range as the figure reported by WHO: 12.6%.<sup>65</sup> The 1999 study also found that utilization of reproductive health services is far greater for sexually active unmarried women than for married women, at 58.6% and 15.7% respectively.<sup>66</sup> Among the factors constraining access include widespread poverty among women; illiteracy and ignorance, which perpetuate myths about the adverse consequences of contraceptives; traditional misconceptions about family planning; tendency to equate contraceptive use with promiscuity; inadequate commitment of resources by the government; and, shortage of skilled personnel.

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<sup>58</sup> Nigeria's Report, *idem* at 45.

<sup>59</sup> UNDP, *supra*, note 30 at 39.

<sup>60</sup> WHO, *supra*, note 21 at 75.

<sup>61</sup> General Comment No. 14, *supra*, note 27.

<sup>62</sup> FMH (1988), *supra*, note 11 at Chap. 6.9 (2) (viii).

<sup>63</sup> The Guardian Newspaper, "Sexuality Education in Nigerian Schools," 29 February 2004, available at <http://odili.net/news/source/2004/feb/29/16.html>, accessed 20 August 2007.

<sup>64</sup> Nigeria's Report, *supra*, note 57 at 46; Stanley Henshaw, Isaac Adewole, Susheela Singh, Akinrinade Bankole, Boniface Oye-Adeniran and Rubina Hussain, "Severity and Cost of Unsafe Abortion Complications Treated in Nigerian Hospitals" (2008) 34 (1) International Family Planning Perspectives 41.

<sup>65</sup> WHO, *supra*, note 21 at 40.

<sup>66</sup> Nigeria's Report, *supra*, note 57 at 46.

Non-governmental organizations (NGOs) are crucial partners in raising awareness about, and providing, reproductive health services in Nigeria. The two most important of these NGOs are the Planned Parenthood Federation of Nigeria (PPFN), considered to be the largest NGO providing reproductive health services in the country, and the Population Services International which, through its Society for Family Health programme, distributes emergency contraceptives and condoms.<sup>67</sup>

### Abortion

Nigeria operates a bifurcated criminal justice system based on the Criminal Code and Penal Code. The Criminal Code applies in the mainly Christian Southern States whereas the operation of the Penal Code is restricted to the Muslim-dominated Northern States. Both Codes prohibit abortion,<sup>68</sup> except where continuation of the pregnancy would endanger the life of the woman.<sup>69</sup> Any person who procures abortion (physician or anyone else, including the pregnant woman) for any other reason is subject to a prison term not exceeding fourteen years and/or payment of a fine. The Criminal Code prescribes similar punishment except that, unlike the Penal Code, a woman is liable to seven years imprisonment if she self-procures abortion.

As a result of these highly restrictive abortion laws, women often resort to risky abortion methods, employing the services of clandestine abortion providers, most of whom lack requisite medical expertise for performing the procedure. Complications arising from such abortions are rampant, accounting for a large number of maternal deaths in Nigeria.<sup>70</sup> A study conducted between 1995 and 1997 found that there were approximately 610,000 abortions annually, at a rate of 25 abortions per 1000 women aged 15 – 44.<sup>71</sup>

Attempts to liberalize abortion laws in Nigeria have stalled due to lack of popular support. A Bill, sponsored by the Society of Gynecologists and Obstetricians of Nigeria, that would have expanded the permissible grounds for abortions, was roundly defeated in the House of Representatives in 1982. The proposed law would have created new exceptions, for instance, where two physicians certify that continued pregnancy would involve risk of injury to the physical and mental health of the woman or in circumstances where there was a substantial risk that the child, if born alive, would suffer serious disability.<sup>72</sup> The controversial Bill was opposed by overwhelming majority of the population, including the National Council of Women's Societies of Nigeria, an influential women group. Opponents argue that such liberalization is immoral, would increase the rate of sexually transmitted diseases and encourage promiscuity.

### Female Genital Mutilation (FGM)

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<sup>67</sup> Population Services International (PSI), "Nigeria: Society for Family Health," available at [http://www.psi.org/where\\_we\\_work/nigeria.html](http://www.psi.org/where_we_work/nigeria.html), accessed 23 September 2007.

<sup>68</sup> SS. 228 – 230 of the Criminal Code Act Chapter 77 Laws of the Federation of Nigeria 1990; SS. 232 and 234 of the Penal Code (Northern States), Federal Provisions Act Chapter 345 Laws of the Federation of Nigeria, 1990.

<sup>69</sup> S. 297 of the Criminal Code and S. 235 of the Penal Code.

<sup>70</sup> *Supra*, note 57.

<sup>71</sup> Boniface Oye-Adeniran, *et al*, *supra*, note 57 at 212.

<sup>72</sup> It is not clear why Nigeria ratified, without reservations, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa which allowed abortion under similar circumstances. See Art. 14(2) (c). Adopted at the 2nd Ordinary Session of the Assembly of the Union, Maputo, CAB/LEG/66.6, reprinted in 1 African Human Rights Law Journal 40.

FGM is common in Nigeria. The practice is deeply embedded in the culture of many of the ethnic groups in the country and this has assured its survival through Christianization, Islamization and colonization. In communities where it is practiced, FGM is thought of as an ageless ancestral edict that pre-qualifies women for marriage; non-compliance significantly impairs marital prospects and subjects the woman and her family to shame, ridicule and condemnation. There are four variations of the procedure: Type I or clitoridectomy is the excision of clitoral hood, with or without removal of part or all of the clitoris; Type II or excision refers to the removal of the clitoris, with partial or total excision of the labia minora; Type III, also called infibulations or pharaonic circumcision, involves excising part or all of the external genitalia and stitching/narrowing of the vaginal opening; and Type IV (unclassified) includes pricking, piercing or incising of the clitoris and/or labia.<sup>73</sup> Of the four types, the most prevalent in Nigeria are Types I and II, particularly in the Southern states.

Although FGM is practiced in one form or another in different parts of the country, there are regional as well as ethnic differences. The highest prevalence rate, nearly 60%, is found among women of Yoruba ethnic group, compared to less than 1% for Hausa and Fulani women.<sup>74</sup> As for regional differences, the rate is highest in the South West (57%) and the South East (41%) compared to the North East (1.3%) or the North West (0.4%).<sup>75</sup> Advocates of FGM argue that removal of female external genitalia, particularly the clitoris, decreases promiscuity, promotes cleanliness and aesthetic quality of the external genitalia, increases fertility and reduces parturition-related difficulties.

Beginning in mid-1990s, opposition to FGM has steadily garnered support from the government, the general population and the international community. Drawing on the link between HIV/AIDS and non-sanitary/unhygienic nature of the procedure (notably multiple use of non-sterilized equipments), in addition to other health and psychological consequences, local NGOs and an array of foreign partners have been successful in galvanizing popular support for legislations outlawing the practice. Such laws have now been enacted in six states.<sup>76</sup> However, the extent to which these laws are being enforced, if at all, is not clear.

## **HIV/AIDS**

The most common form of HIV infection in Nigeria is through heterosexual contact. It is estimated that this form of transmission accounts for 84% of all infections, with other modes such as mother-to-child transmission accounting for 14%, and 2% for the remainder.<sup>77</sup> At 3.9%, the adult prevalence rate of HIV infection in Nigeria<sup>78</sup> pales in comparison to other African countries such as Zimbabwe,<sup>79</sup> Lesotho<sup>80</sup> and South Africa,<sup>81</sup> but the impact in terms of raw

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<sup>73</sup> WHO, "Female Genital Mutilation," available at <http://www.who.int/mediacentre/factsheets/fs241/en/>, accessed 30 September 2007.

<sup>74</sup> UNICEF, "Nigeria FGM/C Country Profile," available at <http://www.childinfo.org/areas/fgmc/profiles/Nigeria%20FGM%20profile.pdf>, accessed 30 September 2007.

<sup>75</sup> *Idem*.

<sup>76</sup> Abiodun Raufu, "Nigeria Recommends Jail Terms to Eradicate Female Genital Mutilation" (2002) 324 (7345) *British Medical Journal* 1056.

<sup>77</sup> FMH, *supra*, note 51 at 9.

<sup>78</sup> See the Joint UN Programme on HIV/AIDS (UNAIDS), "Uniting the World against AIDS: Nigeria," available at [http://www.unaids.org/en/Regions\\_Countries/Countries/nigeria.asp](http://www.unaids.org/en/Regions_Countries/Countries/nigeria.asp), accessed 18 September 2007.

<sup>79</sup> The prevalence rate is 20.1%. See UNAIDS, "Uniting the World against AIDS: Zimbabwe," available at [http://www.unaids.org/en/Regions\\_Countries/Countries/zimbabwe.asp](http://www.unaids.org/en/Regions_Countries/Countries/zimbabwe.asp), accessed 17 September 2007.

numbers is staggering. A 2006 report estimated that 2,900,000 Nigerians were HIV positive, the third largest number after South Africa and India.<sup>82</sup> It has also been estimated that 930,000 children under age 17 have been orphaned in Nigeria as a result of HIV/AIDS.<sup>83</sup> There is no significant difference in prevalence rate between rural and urban areas, though there are striking regional differences. A national sero-prevalence sentinel survey conducted in 2003 found that North Central region has the highest rate, 7.4%, while states in the South West region have the lowest rate, 2.3%.<sup>84</sup>

Since restoration of democracy, the government has elevated the fight against the spread of HIV/AIDS to a priority public health concern. Buoyed by support from foreign donor partners, the government has made significant strides toward its prevention, treatment, care and other support activities. Agencies and programmes constituted to aid in this effort include the National AIDS Control and Prevention Programme (NASCP), the National Action Committee on AIDS (NACA) based in the office of the Presidency and charged with coordinating the various prevention, treatment and care activities in the country, and the HIV/AIDS Emergency Action Plan (HEAP). HEAP concerns itself mainly with eliminating barriers to prevention and supporting community based responses as well as providing direct preventive, curative and support interventions.<sup>85</sup> A new initiative known as the National HIV/AIDS Strategic Framework has now replaced HEAP and will be operational until 2009.<sup>86</sup>

The government introduced antiretroviral treatment (ART) for people living with HIV/AIDS (PLWHA) in 2001. Since then, only about 30,000 – 40,000 of the then estimated 520,000 PLWHA have actually benefited from the programme.<sup>87</sup> Many factors account for this: limited capacity of the health system (insufficient manpower and institutional inefficiency), cost of provision of medicines and lack of effective monitoring and evaluation system.<sup>88</sup> It is not clear whether a Presidential directive in 2005 to increase the number of PLWHA with access to ART to 250,000 by June 2006<sup>89</sup> has been met. But even if the target was reached, the number still represents a small percentage of those in need of coverage. Responsibility for the slow progress is placed on foreign pharmaceutical companies as exorbitant prices limits the quantity of ART drugs that the government can purchase. However, with the recent announcement of domestic

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<sup>80</sup> The current adult prevalence rate stands at 23.2 %. See UNAIDS, “Uniting the World against AIDS: Lesotho,” available at <http://www.unaids.org/en/Regions/Countries/Countries/lesotho.asp>, accessed 17 September 2007.

<sup>81</sup> The prevalence rate is 18.8%. See UNAIDS, “Uniting the World against AIDS: South Africa,” available at [http://www.unaids.org/en/Regions/Countries/Countries/south\\_africa.asp](http://www.unaids.org/en/Regions/Countries/Countries/south_africa.asp), accessed 17 September 2007.

<sup>82</sup> South Africa’s and India’s HIV populations were reported to be 5,500,000 and 5,700,000 respectively. See UNAIDS, *Report on the Global AIDS Epidemic 2006* (Geneva: UNAIDS, 2006) 374, 421, 455, also available at [http://www.unaids.org/en/HIV\\_data/2006GlobalReport/default.asp](http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp), accessed 18 September 2007.

<sup>83</sup> UNAIDS, *idem* at 421.

<sup>84</sup> For a breakdown of all the regions, see UNDP, *supra*, note 30 at 45.

<sup>85</sup> U.S. Center for Disease Control and Prevention (CDC), “The Emergency Plan in Nigeria,” available at <http://www.cdc.gov/nchstp/od/gap/countries/Nigeria.htm>, accessed 23 July 2007; Avert, “HIV & AIDS in Nigeria”, available at <http://www.avert.org/aids-nigeria.htm>, accessed 21 August 2007.

<sup>86</sup> Avert, *idem*.

<sup>87</sup> WHO, *supra*, note 48.

<sup>88</sup> *Idem*.

<sup>89</sup> *Idem*.

production of ART, it is expected that resulting lower prices would translate to greater access for more PLWHA.<sup>90</sup>

In addition to governmental and inter-governmental response, an important role is also being played by NGOs in caring, treating and supporting PLWHA. Organizations such as the Center for the Right to Health (CRH) and The Living Hope Organization (Livhorg), among others, are involved in health-related research, training, advocacy and delivery of services. A network of these organizations, launched on 11 May 2005, was instrumental to mapping and facility readiness assessment exercises conducted of health facilities involved in provision of ART and related services in all the 36 states and the federal capital territory.<sup>91</sup>

### **Tuberculosis**

TB is another deadly disease reportedly ravaging Nigeria. Declared a national health emergency by the FMH in 2006, cases of TB infection has risen sharply in recent years.<sup>92</sup> According to WHO, one-third of the world's population is currently suffering from TB<sup>93</sup> and Nigeria has the fourth largest number, with approximately 373,682 estimated new cases annually.<sup>94</sup>

Rising cases of HIV infection is complicating efforts at combating the TB burden. This is because prior infection with other diseases, particularly those that affect the immune system such as HIV/AIDS renders one more susceptible to developing an active TB disease.<sup>95</sup> The rate of HIV infection among TB patients is greater than among the general population, skyrocketing from 2.2% in 1991 to 19.1 % in 2001 and an estimated 27% in 2003.<sup>96</sup> It is reported that about 1 million adults between the ages of 15 and 49 living in Nigeria are infected with both HIV and TB.<sup>97</sup> Thus, given the growing number of HIV/AIDS patients in Nigeria, there is a real danger of continued growth in the number of TB infections and resulting mortality.

### **Malaria**

In addition to the scourge of HIV/AIDS and TB, malaria is another serious epidemic that is yet to be brought under control. It is the number one public health issue in Nigeria, accounting for 25% of under-5 mortality, 30% of total childhood mortality and 11% maternal mortality.<sup>98</sup> According to recent reports, 20% of the global malaria cases occur in Nigeria, with approximately 110

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<sup>90</sup> A local pharmaceutical company, Archy Pharmaceuticals Ltd, commissioned a plant in Lagos for the manufacture of generic ART drugs in 2004. Shortly afterward, another company, a Nigerian subsidiary of Indian's largest pharmaceutical company, Ranbaxy, began production of pediatric ART. See Reuters NewsMedia, "Nigerian to Begin Making HIV/AIDS Generic Drug," available at <http://www.aegis.com/news/re/2004/RE040783.html>, accessed 19 July 2007.

<sup>91</sup> WHO, *supra*, note 48. In addition to assisting HIV/AIDS patients, NGOs are also actively involved in several programmes designed to combat the spread of the disease. Davidson Umeh and Florence Ejike, "The Role of NGOs in HIV/AIDS Prevention in Nigeria" (2004) 28 (3-4) *Dialectical Anthropology* 339 – 352.

<sup>92</sup> USAID, *supra*, note 39.

<sup>93</sup> WHO, "Tuberculosis," available at <http://www.who.int/countries/nga/areas/tuberculosis/en/index.html>, accessed 17 July 2007.

<sup>94</sup> USAID, *supra*, note 39.

<sup>95</sup> WHO, *supra*, note 93.

<sup>96</sup> *Idem*.

<sup>97</sup> *Idem*.

<sup>98</sup> WHO, "Malaria," available at <http://www.who.int/countries/nga/areas/malaria/en/index.html>, accessed 19 July 2007.

million people affected annually<sup>99</sup> and majority of outpatient visits being malaria-related.<sup>100</sup> Most Nigerians are likely to suffer at least one episode of malaria in their lifetime but the vast majority experience multiple bouts. The economic impact of the mosquito-borne disease is not insignificant. It is estimated that the cost of treatment and loss of productivity and earnings as a result of sick days may be as high as 1.3% of annual economic growth.<sup>101</sup>

With the support of WHO, the World Bank and other partners, the government has adopted various strategies as part of its National Malaria Control Programme. These strategies include the provision of affordable anti-malaria drugs and promotion of preventive methods such as use of mosquito nets and indoor residual spraying. But the efforts are being frustrated by increasing resistance of malaria parasites to existing drugs.<sup>102</sup> The obstacle is being tackled by importation and distribution of artemisinin-based anti-malaria combination drugs that are proving to be effective. This, coupled with the recent effort to scale up the number and availability of insecticide-treated bed nets, is expected to reduce the incidence of the epidemic.

### **Child Health**

One of the greatest challenges facing the health system in Nigeria is in the area of child health. Despite ratifications of the major international treaties on the rights of the child<sup>103</sup> and the enactment of a child-centered domestic legislation in 2003 – the Child Rights Act – available data paints a depressing picture. According to WHO, Nigeria is among five countries that contribute 50% of the annual global mortality among infants and children under five years of age.<sup>104</sup> Poverty, poor health status of mothers, high prevalence of malaria, pneumonia, measles, diarrhea, HIV/AIDS, malnutrition and inadequate immunization coverage in the country are blamed for most of these deaths.<sup>105</sup>

The revitalized National Health Policy promises to address these problems by its emphasis on PHC. In furtherance of this goal, the agency responsible for implementing the PHC component of the policy, NPHCDA, has trained and deployed village health workers and TBAs in order to assist in curtailing mortality among infants and children.<sup>106</sup>

### **Infant Mortality Rate**

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<sup>99</sup> World Bank, “Big Boost for Malaria Fight: World Bank Approves \$180 Million for Nigeria,” available at <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/NIGERIAEXTN/0,,contentMDK:21159796~menuPK:368918~pagePK:2865066~piPK:2865079~theSitePK:368896,00.html>, accessed 7 June 2007.

<sup>100</sup> UNDP, *supra*, note 30 at 46; T. Okeke, H. Okafor and B. UzoChukwu, “Traditional Healers in Nigeria: Perception of Cause, Treatment and Referral Practices for Severe Malaria” (2006) 38 (4) *Journal of Biosocial Science* 492.

<sup>101</sup> WHO, *supra*, note 98.

<sup>102</sup> *Idem*.

<sup>103</sup> UN Convention on the Rights of the Child, 20 Nov. 1989, GA Res. 44/25 (XLIV), UN GAOR, 44<sup>th</sup> Sess., Supp. No. 49 at 167, UN Doc. A/44/49. The African Charter on the Rights and Welfare of the Child, OAU Doc. CAB/LEG/24.9/49 (1990).

<sup>104</sup> WHO, “Child and Adolescent Health,” available at <http://www.who.int/countries/nga/areas/cah/en/index.html>, accessed 18 August 2007.

<sup>105</sup> *Idem*. See also the Concluding Observations of the UN Committee on the Rights of the Child, Nigeria, U.N. Doc. CRC/C/15/Add.257 (2005) at para. 48, available at <http://www1.umn.edu/humanrts/crc/nigeria2005.html>, accessed 22 August 2007; UNDP, *supra*, note 30 at 35.

<sup>106</sup> UNDP, *idem*, at 36.

Nigeria has an abysmal infant mortality rate (IMR), reported to be 85 and 195 deaths per 1000 live births in 1990 and 1995 respectively.<sup>107</sup> In 2005, the figure stood at 101<sup>108</sup> but slightly declined to 97 the following year.<sup>109</sup> Worse still, Nigeria was among twelve countries identified in a recent report by the African Development Bank (ADB) as regressing from, and in danger of not, meeting the 2015 MDG of reducing infant mortality by two-thirds.<sup>110</sup> IMR was found to be higher in rural communities than in urban areas, and this was attributed to disparity in access to health care, as health facilities are more readily available to urban residents than rural dwellers.<sup>111</sup> Current efforts at combating morbidity and mortality among children center on expanded immunization programmes.

### Immunization

Immunization of children against vaccine-preventable diseases is recognized by the government as key to reducing child morbidity and mortality in the country. More prevalent among these diseases are measles and polio. It is reported that between January and August 2004, at least 35,856 children were affected by measles in Nigeria.<sup>112</sup> And in 2004, 1266 children globally were paralyzed by polio, out of which 792 or more than half were Nigerians.<sup>113</sup>

With assistance from international agencies, particularly WHO and UNICEF, the government has significantly boosted the reach of its programme on immunization, with the goal of ensuring that every child in Nigeria receives comprehensive immunization against these diseases. The National Programme on Immunization (NPI) was established as a vehicle for achieving this goal. NPI provides support to the implementation of state and local government immunization programmes. It is reported that immunization coverage against measles increased from 45% in 1990 to 90.4% in 2002 for one year old children, a 100% increase,<sup>114</sup> and thus, drastically lowered the prevalence of the disease in Nigeria. Similarly, renewed immunization campaign against polio has brought significant results, with the number of cases and states in which they are concentrated steadily declining. Between January and May 2005, 78 cases of polio were reported in 18 states compared to 125 cases in 25 states during the same period in 2004.<sup>115</sup>

### **Prison Health**

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<sup>107</sup> *Idem*, at 32.

<sup>108</sup> WHO, *supra*, note 21 at 26.

<sup>109</sup> CIA, "The World Factbook – Nigeria," available at <https://www.cia.gov/cia/publications/factbook/geos/ni.html>, accessed 18 August 2007.

<sup>110</sup> "The ADB Report on MDGs," available at [http://www.afdb.org/portal/page?\\_pageid=293,158705&\\_dad=portal&\\_schema=PORTAL&focus\\_item=7148219&focus\\_lang=us](http://www.afdb.org/portal/page?_pageid=293,158705&_dad=portal&_schema=PORTAL&focus_item=7148219&focus_lang=us), accessed 22 August 2007.

<sup>111</sup> UNDP, *supra*, note 30 at 32–33.

<sup>112</sup> WHO, "Expanded Programme on Immunization," available at <http://www.who.int/countries/nga/areas/epi/en/index.html>, accessed 22 August 2007.

<sup>113</sup> WHO, "Polio Eradication in Nigeria: Backgrounder," available at [http://www.who.int/countries/nga/mediacentre/backgrounders/2005/polio\\_backgrounder\\_270405.pdf](http://www.who.int/countries/nga/mediacentre/backgrounders/2005/polio_backgrounder_270405.pdf), assessed 19 August 2007.

<sup>114</sup> UNDP, *supra*, note 30 at 32.

<sup>115</sup> WHO, "Nigeria Making Progress towards Polio Eradication Goal," available at <http://www.who.int/countries/nga/mediacentre/releases/2005/05/en/index.html>, accessed 21 August 2007.

Prisons throughout the country are severely congested, some holding 200 – 300% beyond capacity.<sup>116</sup> This is blamed on an inefficient criminal justice system. About 64% of those detained in Nigerian prisons and needlessly contributing to overcrowding are yet to be convicted of crimes.<sup>117</sup> Inmates are housed in dilapidated and poorly ventilated structures dating back to the colonial era and lacking basic facilities.<sup>118</sup> They are poorly fed, with most of them relying on outside sources – family and friends – for sustenance.<sup>119</sup> Improper nutrition, in addition to lack of potable water, poor sanitary conditions and severe congestion contribute to unhealthy conditions in the prison system. Studies indicate that the health status of the prisoners is disproportionately worse than the general population. For instance, while the national HIV prevalence rate is 5.4%, for inmates, the rate is 9%.<sup>120</sup>

There is a chronic shortage of medical supplies and equipment in prisons throughout the country. The little that is available is quite often misappropriated by corrupt prison officials and treatment is frequently withheld from sick inmates as a form of punishment or graft solicitation technique.<sup>121</sup> Consequently, there is an alarmingly high rate of morbidity and mortality among inmates.<sup>122</sup> According to estimates released in 1999, at least one inmate died per day at Kirikiri, a maximum security prison located in Lagos.<sup>123</sup> There is no nationwide estimate of deaths in the prison system.

### **Mental Health**

Although mental health is a formidable public health challenge in Nigeria, it suffers from serious institutional and normative neglect. Despite a steady growth in the number of mentally ill patients roaming the streets and the resulting danger to the public, the government is yet to develop any plans that might mitigate the problem. There are no social programmes specifically targeting the needs of mental patients, with the result that except for the few who are able to afford the cost of treatment and provide for themselves, the vast majority are left to their fate. Many die on the streets.

Access to orthodox psychiatric facilities is beset with a number of difficulties. There are few psychiatric hospitals in the country, all of which are located in big cities, far removed from rural areas where a significantly larger proportion of mental health patients reside. According to a recent WHO report, there is 1 psychiatric bed per 10,000, 2 psychiatric nurses and 1 psychiatrist

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<sup>116</sup> U.S. Department of State, “Nigeria: Country Reports on Human Rights Practices 2005,” available at <http://www.state.gov/g/drl/rls/hrrpt/2005/61586.htm>, accessed 24 August 2007. According to a 1999 UN report, quoting the Controller-General of Prisons, the prison system has an overall capacity of 36,375 but is populated by about 47,387 inmates. See UNHCR, *supra*, note 5 at para. 21.

<sup>117</sup> U.S. Department of State, *idem*; BBC, “Nigeria to Free Half of its Inmates,” available at <http://news.bbc.co.uk/2/hi/africa/4583282.stm>, accessed 22 August 2007.

<sup>118</sup> U.S. Department of State, *idem*.

<sup>119</sup> *Idem*.

<sup>120</sup> O. O. Taiwo and A. Bukar, “Knowledge and Attitude of Prisoners towards HIV/AIDS Infection” (2006) 1(1) Nigerian Journal of Clinical and Biomedical Research 32.

<sup>121</sup> U.S. Department of State, *supra*, note 116.

<sup>122</sup> Human rights group point to overcrowding and unsanitary conditions as the reason for the high number. See BBC, *supra*, note 117.

<sup>123</sup> U.S. Department of State, *supra*, note 116.

per 100,000 of the population.<sup>124</sup> Another study suggests that the number of psychiatrists in the country may even be lower than reported by WHO: less than 100;<sup>125</sup> that is, in a country of 140 - 150 million people.<sup>126</sup> To make matters worse, budgetary allocation to mental health is grossly inadequate to meet ever increasing need (estimated at less than 1% of total health budget).<sup>127</sup> In addition, there is a concern that given widespread belief that mental illness is caused by supernatural forces, most people, regardless of social status, rely on traditional and spiritual healers and seek orthodox treatment only as a last resort, when the patient's condition might have deteriorated and, consequently, more difficult to treat.<sup>128</sup>

### **Persons with Disabilities**

In a report submitted to the UN in 1996, the government averred that it has adequate legal framework for protection of the rights of people with disability within its jurisdiction.<sup>129</sup> The Nigerians with Disability Decree 1993, the purpose of which is to “provide a clear and comprehensive legal protection and security for Nigerians with disability,”<sup>130</sup> guarantees equality to, and confers special benefits on, the disabled. For our purposes, the most important provision is Section 4(1) (a) which entitles disabled persons to free health care in all public health facilities. Other benefits conferred by the Decree include free education, employment quota, subsidized housing and free transportation (excluding air travel).

There are facilities both at the federal and state levels to assist the disabled in becoming self-sufficient but owing to resource constraints, the number of these facilities has remained relatively small and grossly insufficient to meet increasing demand. As a result, it is not uncommon to find physically and mentally incapacitated individuals soliciting alms in public places, living in abandoned buildings or scavenging for food in dumpsters. Except for the few with financial resources or those participating in government programmes, disability in Nigeria virtually guarantees a life of destitution. But this is more a reflection of the prevailing socio-economic conditions than institutionalized discrimination against a vulnerable segment of society. Free health services, for instance, cannot be provided to any particular group, regardless of their vulnerability, unless there is a functioning health system capable of responding to the needs of the general population. Regrettably, the health system is in the process of being revamped and, owing to present deficiencies, can meet neither general nor specific group needs.

Nigeria was among eighty original signatories to the recently adopted UN Convention on the Rights of Persons with Disabilities.<sup>131</sup> At the signing ceremony, the Nigerian Minister for

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<sup>124</sup> WHO, *Atlas: Mental Health Resources in the World 2001* (Geneva: WHO, 2001) 44 – 45, also available at [http://www.who.int/mental\\_health/media/en/244.pdf](http://www.who.int/mental_health/media/en/244.pdf), accessed 16 August 2007.

<sup>125</sup> Olabisi Odejide and Jide Morankinyo, “Mental Health and Primary Care in Nigeria” (2003) 2 (3) *World Psychiatry* 165.

<sup>126</sup> U.S. Department of State, *supra*, note 116.

<sup>127</sup> Oye Gureje, Dan Chisholm, Lola Kola, Victor Lasebikan and Shekhar Saxena, “Cost-effectiveness of an Essential Mental Health Intervention Package in Nigeria”, (2007) 6(1) *World Psychiatry* 42–48, available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1805717#B8>, accessed 24 August 2007.

<sup>128</sup> Olabisi Odejide and Jide Morankinyo, *supra*, note 125.

<sup>129</sup> See Independent Living Institute, “Government Action on Disability Policy: A Global Survey,” available at [http://www.independentliving.org/standardrules/UN\\_Answers/UN.pdf](http://www.independentliving.org/standardrules/UN_Answers/UN.pdf), accessed 2 October 2007.

<sup>130</sup> S.1 (a), text available at <http://www.dredf.org/international/nig1.html>, accessed 22 August 2007.

<sup>131</sup> Adopted 13 December 2006, GA Res. A/RES/61/106, UN GAOR, 66<sup>th</sup> Sess. Opened for signature 30 March 2007, available at <http://www.un.org/disabilities/convention/signature.shtml>, accessed 24 August 2007. Nigeria

Foreign Affairs announced that a Bill that would outlaw all forms of discrimination against persons with disabilities is pending before the legislature.<sup>132</sup> It is not clear what purpose such law, assuming the Bill is passed, would serve given that the present conditions of disabled persons, as noted above, result from finitude of resources rather than a vacuum of legislative protection.

### **Occupational Health**

Though Nigeria is a party to 34 ILO Conventions, some of which are health-related, none has been domesticated.<sup>133</sup> Nonetheless, there are local legislations which incorporate, and therefore can be said to give effect to, some of the concerns of the conventions. The first, the Factories Act,<sup>134</sup> deals with enforcement of safety and health standards in the workplace. To protect workers from occupational hazards, the Act requires employers of labor to adopt several measures relating to workplace conditions such as sanitation, overcrowding and ventilation.<sup>135</sup> The second, the Labour Act,<sup>136</sup> repealed the previous labour code and consolidated labour laws hitherto in force in the country. The Act, considered progressive by many, contains important safeguards regarding the health of workers. All new hires are required to undergo an employer-paid medical examination prior to commencement of employment;<sup>137</sup> female employees who become pregnant in the course of employment are entitled to maternal leave, paid for by the employer in some cases;<sup>138</sup> and, employment of women and children in dangerous sites and facilities such as underground mines is prohibited.<sup>139</sup>

In spite of this seemingly robust legislative protection, problems still persist. But this is mainly the result of a weak enforcement mechanism. The sanction for violating the law is not stringent, limited to paltry fines and/or imprisonment ranging from one to twenty four months, in most cases.<sup>140</sup> Insufficient capacity is another serious obstacle. There are 5,888 registered factories but only 39 inspectors.<sup>141</sup> In 2006, there were less than 1000 inspections carried out and 57

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signed but did not ratify the Convention. List of Signatory States and Regional Integration Organizations, available at <http://www.un.org/esa/socdev/enable/conventionsign.htm>, accessed 25 August 2007.

<sup>132</sup> Angola Press, "Nigeria Enacts Law on Disability," available at <http://www.angolapress-angop.ao/noticia-e.asp?ID=521375>, accessed 20 August 2007.

<sup>133</sup> For a list of these Conventions, see <http://www.ilo.org/ilolex/english/newratframeE.htm>, accessed 24 August 2007.

<sup>134</sup> Chapter 126, Laws of the Federation of Nigeria, 1990, available at <http://www.ilo.org/dyn/natlex/docs/WEBTEXT/47979/65089/E87NGA01.htm>, accessed 11 December 2007.

<sup>135</sup> See Part II.

<sup>136</sup> Chapter 198, Laws of the Federation of Nigeria 1990, available at <http://www.nigeria-law.org/LabourAct.htm>, accessed 24 August 2007.

<sup>137</sup> SS. 8 & 28.

<sup>138</sup> S. 54.

<sup>139</sup> SS. 56 & 59 (5) (a).

<sup>140</sup> See, for instance, SS. 70 & 71 of the Factories Act, *supra*, note 134 and SS. 21, 46 & 47 of the Labour Act, *supra*, note 136. The only provision with tough sanction is S. 47(1) (g) of the Labour Act which prescribes a fine and/or a prison term not exceeding five years for illegal recruitment of workers or violation of any of the rules relating to transportation of workers to places of employment.

<sup>141</sup> See Nigeria, "Report of the National Occupational Safety and Health Information Centre" (CIS) Geneva, Switzerland, 4<sup>th</sup> –15<sup>th</sup> September 2006, available at [http://www.ilo.org/public/english/protection/safework/cis/about/mtg2006/pnga\\_mlpid.pdf](http://www.ilo.org/public/english/protection/safework/cis/about/mtg2006/pnga_mlpid.pdf), accessed 25 August 2007.

workplace accident reported.<sup>142</sup> There is no data on occupational-related morbidity and mortality in the country.

### **Access to Safe Water and to Adequate Excreta Disposal Facilities**

Access to safe drinking water and adequate excreta disposal facilities in Nigeria is problematic. More than half of the population have neither access to safe water nor to excreta facilities. Recent data indicates that only 48% of households in Nigeria have access to improved drinking water sources, with access twice greater in urban than rural areas.<sup>143</sup> While safe drinking water is available to 67% of urban dwellers, the figure for rural inhabitants is only 31%.<sup>144</sup> An even lower number, 44%, have access to adequate sanitation coverage.<sup>145</sup> Disaggregated figures show that 36% of rural dwellers have access, compared to 53% of urban residents.<sup>146</sup>

Shortage of safe drinking water sources and adequate excreta facilities contribute to high morbidity and mortality in Nigeria, particularly among children. For instance, schistosomiasis or snail fever, which typically afflicts people without access to safe water and sanitation and whose daily activities bring them into direct contact with infected water sources, is common in some parts of the country. The disease ranks second to malaria as a source of human morbidity and mortality in tropical countries.<sup>147</sup> Reports indicate that there is an estimated 200 million people infected with the disease globally, out of which 100 million reside in Africa, 22 million of them in Nigeria, making Nigeria the worst affected country in Africa.<sup>148</sup>

The Carter Center's Schistosomiasis Control Programme partners with the government in providing praziquantel treatments of the disease. Though the disease is easy and cheap to treat (requires only a single annual dose of the drug praziquantel which costs US\$0.07 to manufacture) it falls within the "neglected diseases" category despite its toll on human lives. Only a handful of agencies have shown any interest in committing resources to combating the disease.

### **Environmental Health**

Given that many of the serious diseases affecting its people such as malaria, TB and schistosomiasis originate from unsafe and unhealthy environments, environmental health is of particular significance to Nigeria. Tackling the environmental factors that create or exacerbate the conditions responsible for these diseases is thus a necessary prelude to combating them. Nigeria is cognizant of this relationship and is a party to a number of international environmental treaties which address health-related concerns: the Biodiversity Convention, the Climate Change Convention, Climate Change Kyoto Protocol, Vienna Convention for the Protection of the Ozone

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<sup>142</sup> *Idem.*

<sup>143</sup> UNICEF, *supra*, note 43; UNDP, *supra*, note 13 at 307.

<sup>144</sup> UNICEF, *idem*; WHO, *supra*, note 21 at 51.

<sup>145</sup> UNICEF, *idem*; UNDP, *supra*, note 13 at 307.

<sup>146</sup> UNICEF, *idem*; WHO, *supra*, note 21 at 51.

<sup>147</sup> The Carter Center, "The Carter Center Schistosomiasis Control Programme," available at <http://www.cartercenter.org/health/schistosomiasis/index.html>, accessed 8 December 2007

<sup>148</sup> *Idem*; The Carter Center, "The Carter Center Celebrates 1 Million Treatments for Schistosomiasis in Nigeria," available at <http://www.cartercenter.org/news/documents/doc2459.html>, accessed 8 December 2007; Colleen Mastony, "River Parasite Eats at Children," Chicago Tribune 14 March 2007, <http://www.chicagotribune.com/news/nationworld/chi-070314parasite,0,6242204.story>, accessed 8 December 2007.

Layer, Desertification Convention, Hazardous Wastes Convention, the Convention on the Law of the Sea, Marine Dumping, Marine Life Conservation and Oil Pollution Preparedness, Response and Co-Operation Conventions, among others.<sup>149</sup>

More important, Nigeria is also a party to the African Charter which guarantees the right to a satisfactory environment. Unlike the other treaties to which Nigeria is a party, the African Charter has been incorporated into municipal law.<sup>150</sup> On the domestic front, the Federal Environmental Protection Agency Act (amended by Decree 59 of 1992)<sup>151</sup> was enacted in order to create a normative and institutional framework for addressing environmental challenges in the country.<sup>152</sup> To operationalize the provision of the Act, the Federal Environmental Protection Agency (FEPA) launched the National Policy on the Environment in 1989 (subsequently revised in 1999) with the goal of achieving sustainable development, particularly securing a quality environment that is adequate for and promotive of the health and well-being of Nigerians.<sup>153</sup> Despite these institutional and policy arrangements, no significant success has been recorded in actualizing the health benefits of environmental protection in the country. To the contrary, recent years have witnessed an increase in violations of existing environmental regimes.

Among the numerous environmental challenges facing the country are soil degradation, deforestation, air and water pollution, desertification, oil pollution, loss of arable land and rapid urbanization.<sup>154</sup> The most significant of these problems is pollution arising from oil exploration and production, particularly in the oil-rich Niger Delta region. Residents of communities in close proximity to the source of pollution have suffered greatly as a result of exposure to oil spills, gas flaring, contamination of food and water sources, and loss of arable land and livestock.

With regard to oil pollution, it is widely believed that the government deliberately ignores the activities of oil companies simply on account of the significance of oil to the economy. This concern was the basis for a petition before the African Commission on Human and Peoples' Rights in *Social and Economic Rights Action Centre v Nigeria (SERAC)*.<sup>155</sup> Nigeria was found to have violated the right to health and the right to clean environment as recognized under Articles 16 and 24 of the African Charter in that it failed to take reasonable measures to (a) prevent pollution and ecological degradation, and (b) promote conservation and secure an ecologically

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<sup>149</sup> CIA, "The World Factbook – Field Listing – Environment- International Agreement," available at <https://www.cia.gov/library/publications/the-world-factbook/fields/2033.html>, accessed 8 December 2007; Center for International Environmental Law, "CBPR Database – Nigeria," available at [http://www.ciel.org/Publications/CBPR\\_Nigeria\\_9-18-06.pdf](http://www.ciel.org/Publications/CBPR_Nigeria_9-18-06.pdf), accessed 8 December 2007. Note that though Nigeria signed these conventions, it is yet to ratify any of them.

<sup>150</sup> *Supra*, note 7.

<sup>151</sup> For text, see <http://www.nigeria-law.org/LFN-1992.htm>, accessed 9 December 2007.

<sup>152</sup> UNDP, *supra*, note 30 at 50.

<sup>153</sup> Nerry Echefu and E. Akpofure, "Environmental Impact Assessment in Nigeria: Regulatory Background and Procedural Framework" at 65, available at <http://www.unep.ch/etu/publications/14%2063%20to%2074.pdf>, accessed 24 August 2007; Lawrence Anuka, "Case Study 4: Nigeria," in Richard Helmer and Ivanildo Hespanhol, eds., *Water Pollution Control: A Guide to the Use of Water Quality Management Principles* (London: E & FN Spon, 1997) at para. IV.2.2.

<sup>154</sup> CIA, *supra*, note 109.

<sup>155</sup> Communication 55 of 1996, available at <http://www1.umn.edu/humanrts/africa/comcases/allcases.html>, accessed 18 November 2007.

sustainable development and use of natural resources.<sup>156</sup> The communication alleged that a joint venture between the government of Nigeria and Shell Petroleum for the production of oil was responsible for environmental degradation in the Niger delta area of Southeastern Nigeria. It further alleged that the resulting contamination of water, soil and air has had serious short and long-term health impacts, including skin infections, gastrointestinal and respiratory ailments, increased risk of cancers and neurological and reproductive problems.

In a case with similar facts as *SERAC, Wiwa v Royal Dutch Petroleum Co.*,<sup>157</sup> the U.S. Court of Appeals for the Second Circuit held, reversing the District Court, that under the 1789 Alien Tort Claims Act (ATCA), the plaintiff can sue the defendant in U.S. federal courts for human rights violation committed in a foreign country (in this case, Nigeria). The original suit had been dismissed on *forum non conveniens* ground, that New York was not the most suitable forum for hearing the matter. This is an important development not only in the realm of environmental rights but also for the broader human rights corpus. For it means that victims of human rights violations, hitherto unable to obtain justice within domestic legal systems, can legitimately petition courts in the U. S. for redress in appropriate cases.

Recently, a Federal High Court in Nigeria heard a case that centered on environmental health. In that case, *Jonah Gbemre & Ors v Shell Petroleum Development Company of Nigeria LTD & Ors*,<sup>158</sup> the applicants sought and were granted a declaration that gas flaring by oil companies operating in the plaintiffs' community is illegal, harmful to their health and environment and therefore constitutes a violation of their rights to life and human dignity as guaranteed by the Constitution.

### **Availability of Health Care Professionals**

Among the many challenges facing the health system in Nigeria, as in several sub-Saharan African countries, is acute shortage of competent health care providers.<sup>159</sup> As a result of inadequate infrastructure and poor compensation packages, a sizeable number of physicians, nurses and other medical professionals are lured away to developed countries in search of better fulfilling and lucrative positions. In fact, some of these countries have established recruiting agencies and examination protocols targeting the best and brightest medical minds in the country, prompting the government to require that these agencies register with the FMH and operate within an established framework.<sup>160</sup> There is no evidence of compliance with the federal government mandate. This is hardly surprising as there is no incentive for these countries to toe

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<sup>156</sup> Para. 52.

<sup>157</sup> 226 F.3d 88; 2000 U.S. App. LEXIS 23274; Aaron Fellmeth, "Wiwa v. Royal Dutch Petroleum Co.: A New Standard for the Enforcement of International Law in U.S. Courts?" (2002) 5 Yale Human Rights and Development Law Journal 241.

<sup>158</sup> Suit FHC/CS/B/153/2005, Federal High Court, Benin City, Judgment of 14 November 2005 (unreported); copy of judgment available at <http://www.climatelaw.org/>, accessed 6 December 2007.

<sup>159</sup> See World Health Assembly, "International Migration of Health Personnel: A Challenge for Health Systems in Developing Countries," WHA58.17 (25 May 2005), also available at [http://www.who.int/gb/ebwha/pdf\\_files/WHA58/WHA58\\_17-en.pdf](http://www.who.int/gb/ebwha/pdf_files/WHA58/WHA58_17-en.pdf), accessed 8 June 2007. While Africa is burdened with 24% of global diseases, its share of world medical workforce is only 3%. See Physicians for Human Rights, "Health Action AIDS: Strengthening Africa's Health Workforce," available at <http://physiciansforhumanrights.org/hiv-aids/issues/health-workforce/>, accessed 8 June 2007.

<sup>160</sup> FMH (1988), *supra*, note 11, Chapter 5.9; FMH (2004) *supra*, note 11 at 25.

the government line. There has been no interruption in the flow of health care workers to these countries, all of which have been privately arranged.<sup>161</sup>

Nigeria is a major health-staff-exporting nation, accounting for 347 (recently revised upward to 432) out of a total of 2000 nurses that emigrated out of Africa between April 2000 and March 2001.<sup>162</sup> This figure appears to be underreported as it fails to take into account the vast number of nurses who migrate abroad under different pretexts. A recent study found that the number of Nigerian physicians employed in the United States far exceeds that of any other country in Africa,<sup>163</sup> estimated at more than 21,000.<sup>164</sup> The efflux has resulted to acute shortages in local health facilities and drastically impacted access. In 2003, there were only 34,923 and 127,580 physicians and nurses in Nigeria compared to 133, 641 physicians and 704,332 nurses in the United Kingdom (U.K.) in 1997.<sup>165</sup> The population of Nigeria in 2003 was 122,790,463 whereas 58,808,266 people lived in the United Kingdom in 1997,<sup>166</sup> meaning that U.K., with less than half the population of Nigeria at the relevant period, had nearly four times the number of physicians and five and half times the number of nurses in Nigeria. In 2003, 1,510 U.K. work permits were approved for health and medical personnel from Nigeria.<sup>167</sup>

Related to brain drain is the problem of geographical distribution of health care professionals. There is a disproportionate concentration of medical professionals in urban areas. While access to medical personnel is readily available in cities, rural dwellers often have to travel considerable distance in order to get treatment. This has significant consequences on the health of inhabitants of rural areas as unavailability of physicians and nurses within close proximity often leads to delaying and postponing visits to health care facilities until the condition becomes unbearable. Transporting the patient on treacherous roads to urban facilities may take several hours and this may mean the difference between life or death.

Orthodox medicine is complemented by traditional medicine in Nigeria. Traditional healers provide low-cost care and are usually the first point of contact for many residents of rural areas. Historically, there are certain conditions for which the skills of traditional healers have been

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<sup>161</sup> Democracy has had little effect on the working conditions of health care professionals. With public hospitals shutting down on regular basis due to strikes, it is unlikely that wholesale migration to Western countries will end any time soon.

<sup>162</sup> WHO, "Managing Brain Drain and Brain Waste of Health Workers in Nigeria," citing B. Stillwell, *et al*, "Migration of Health Care Workers from Developing Countries: Strategic Approaches to its Management," Bulletin of the World Health Organization 2004, 82:595–600, also available at [http://www.who.int/bulletin/bulletin\\_board/82/stilwell1/en/](http://www.who.int/bulletin/bulletin_board/82/stilwell1/en/), accessed 24 August 2007; Abiodun Raufu, "Nigerian Health Authorities Worry Over Exodus of Doctors and Nurses" (2002) 325 (7355) British Medical Journal 65.

<sup>163</sup> Avraham Astor, Tasleem Akhtar, María Matallana, Vasantha Muthuswamy, Folarin Olowu, Veronica Tallo and Reidar Lie, "Physician Migration: Views from Professionals in Colombia, Nigeria, India, Pakistan and the Philippines" (2005) 61 (12) Social Science and Medicine 2493.

<sup>164</sup> Virginia Gidley-Kitchin, "UN Tackles African Brain Drain," BBC News, available at <http://news.bbc.co.uk/2/hi/africa/652801.stm>, accessed 25 October 2007; Economic Commission for Africa (ECA), *Transforming Africa's Economies: Overview* (Addis Ababa, Ethiopia: ECA, 2001) 32, quoting UNDP Human Development Report 1998.

<sup>165</sup> WHO, *supra*, note 21 at 60, 62.

<sup>166</sup> United States Census Bureau, "IDB – Rank Countries by Population," available at <http://www.census.gov/cgi-bin/ipc/idbrank.pl>, accessed 23 June 2007.

<sup>167</sup> BBC News, "UK 'Crippling Africa Healthcare'," available at <http://news.bbc.co.uk/1/hi/health/4582283.stm>, accessed 15 July 2007.

customarily sought and for which their expertise is widely recognized. Snakebites, severe malaria, bone fracture and dislocation are common examples. But as a result of escalating cost of orthodox care, many people are forced to seek care from traditional healers, even for conditions that appropriately belong to the domain of modern medicine.<sup>168</sup> This has given rise to a concern about over-dependence, as some of the traditional healers, because they lack necessary medical skills, might resort to methods that worsen rather than improve the condition. At present, there is no coordination of activities of traditional and modern medical practitioners, but efforts are underway to standardize the practice of traditional medicine and integrate it into the formal health system.<sup>169</sup>

## Conclusion

In many ways, Nigeria has not been compliant with its obligation regarding the right to health. As evident in this report, accessibility remains problematic, with most of the health facilities concentrated in urban areas, far removed from rural areas where majority of the population lives and where the need is more urgent. Many of these facilities are understaffed and lack basic essentials such as syringes and bandages. These factors, in addition to high cost of services and lack of insurance coverage, mean that, except for the wealthy, quality health care eludes a vast majority of Nigerians. This is evident in the galloping rate of morbidity and mortality among the population. However, in spite of all these challenges, the fact that Nigeria has bound itself to a great number of health-related treaties and domestic legislations is undeniably an important step, even if rudimentary, in the right direction. Concededly, legal commitment *per se* does not necessarily translate to practical implementation of associated duties and obligations, but it does provide a solid foundation for achieving the targeted goals. In this regard, the re-emergence of democratic polity in the country has meant a re-evaluation of the various factors stifling the development of the health system and adoption of far-reaching remedial measures, some of which are already proving successful, albeit at a lethargic pace. These measures, in order to be successful, require a significant infusion of funds to the health sector – an ineluctable prerequisite for the implementation of the National Health Policy, the new health insurance scheme and other health-related programmes projected in this report as essential to an effective, efficient and sustainable health system.

Further, given that many of the negative health indicators in Nigeria such as maternal and infant deaths are directly linked to poverty – poor nutrition, exorbitant cost of reproductive care and illiteracy – a multi-sectoral approach focusing on eliminating the various factors adversely impacting upon the underlying or social determinants of health in the country seems to be the only response capable of improving the health of the population. This notion of the right to health, as not limited to health care but encapsulating other socio-economic rights (underlying

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<sup>168</sup> An estimated 70 – 80% of the population reportedly rely on the services of traditional healers for most common illnesses: T. Okeke, H. Okafor and B. UzoChukwu, *supra*, note 100 at 498.

<sup>169</sup> WHO, “Essential Medicine,” available at [https://www.who.int/countries/nga/areas/essential\\_medicines/en/index.html](https://www.who.int/countries/nga/areas/essential_medicines/en/index.html), accessed 15 July 2007. For difficulties involved in this process, see Daniel A. Offiong, “Traditional Healers in the Nigerian Health Care Delivery System and the Debate over Integrating Traditional and Scientific Medicine” (1999) 72 (3) *Anthropological Quarterly* 126–129. In 2000, at a conference by African heads of states to adopt a common approach to combating AIDS epidemic in the continent, the Minister for Health announced that “traditional medicine and practitioners henceforth will be accorded formal status in the health system.” *African Times*, “Why Nigeria Okayed Traditional Cure for HIV/AIDS” 15 December 2000 at 3.

determinants of health),<sup>170</sup> profoundly demonstrating the indivisibility and interdependence of human rights, should occupy center stage in all health sector deliberations and inform decisions based thereon. What I mean is that due regard must be paid to the availability of food, shelter, potable water, adequate sanitation, schools and other goods that are intimately related to health and without which pursuit of health will decidedly amount to an exercise in futility. Improving the health of Nigerians is not an exclusive task of the health sector; it requires multi-sectoral collaboration, the collective support of other sectors of the economy.<sup>171</sup>

Above all, adequate safeguards must be entrenched in the system in order to assure total transparency and accountability on the part of individuals, agencies and institutions entrusted with the task of implementing the programmes, thus insuring against experiences of past decades in terms of historical tendencies to misappropriate public resources.<sup>172</sup> Such measures would serve to restore the confidence of a skeptical public on the ability of its government to execute public health programmes and translate goals to reality for the benefit of everyone. For a country with endemic levels of corruption, such as Nigeria, the importance of these cautionary measures cannot be glossed over but must be internalized by all stakeholders, foreign and domestic in the struggle for advancement of the state of health of the population and actualization of the right to health.

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<sup>170</sup> General Comment No 14, *supra*, note 27 at para(s) 4 and 11; Judyth Twigg, “Obligatory Medical Insurance in Russia: The Participant’s Perspective” (1999) 49 (3) *Social Science and Medicine* 381.

<sup>171</sup> FMH, *supra*, note 19 at 14, available at

[http://www.herfon.org/docs/Nigeria\\_HealthSectorReformProgramme\\_2004\\_2007.pdf](http://www.herfon.org/docs/Nigeria_HealthSectorReformProgramme_2004_2007.pdf), accessed 11 December 2007.

<sup>172</sup> Transparency and accountability are critical to actualization of all human rights, including the right to health. General Comment No 14, *supra*, note 27 at para. 55; UNCHR, *supra*, note 5 at para. 64.