



The Global Initiative
for Economic, Social and Cultural Rights



The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic

*Discrimination and inequality in the
enjoyment of the right to health*

A report by the **Global Initiative for Economic, Social and Cultural Rights**, in partnership with the **Justice & Empowerment Initiatives** and with the support of **Corporate Accountability and Public Participation Africa**.

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Executive Summary

Nigeria has the obligation to respect, protect and fulfil the right to health, which is guaranteed under both its constitution and the international human rights treaties which it has signed and ratified. While the right to health does not require States to ensure that everyone is healthy, it demands that they establish the best possible health system, within their capacities, to reach the highest attainable standard of health – and of pandemic prevention and response.



However, since the first COVID-19 case was confirmed on 27 February 2020,¹ the West African country has been struggling to guarantee the right to health of all, amidst shortages of accessible health facilities, medical staff and drugs.² Unfortunately, this was to be expected, as the flaws of Nigeria's healthcare system predate the pandemic. Healthcare services are severely underfunded: health spending as a share of general government expenditure decreased from 7.3% in 2006 to as little as 4.4% in 2018.³ Access to these limited resources is also extremely unequal, with the most marginalised facing multiple and interconnected socio-economic, geographical, information and technological barriers in accessing healthcare services, including during the pandemic.

This report analyses the impacts of COVID-19 on the right to health in Nigeria, one of the largest economies in Africa,⁴ in the context of the privatised healthcare system in the country, with a focus on people living in urban informal settlements in Lagos and Port Harcourt. Through a systematic review of academic literature and reliable news as well as interviews with individuals living in poverty, the report explains how Nigeria's healthcare

¹ Reuters COVID-19 Tracker, 'Nigeria: The Latest Coronavirus Counts, Charts and Maps' *Reuters* (2021) <<https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/nigeria/>> accessed 26 October 2021.

² Siddharth Dixit, Kofoworola Ogundeji Yewande and Obinna Onwujekwe, 'How Well Has Nigeria Responded to COVID-19?' *Brookings* (2 July 2020) <<https://www.brookings.edu/blog/future-development/2020/07/02/how-well-has-nigeria-responded-to-covid-19/>> accessed 26 October 2021.

³ WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)* (2022) <<https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS>> accessed 29 January 2022; see also: BudgIT, 'Nigeria: Health Budget Analysis' (2021) <<https://yourbudget.com/wp-content/uploads/2018/04/Nigeria-Health-Budget-Analysis.pdf>> accessed 25 October 2021.

⁴ World Bank national accounts data and OECD National Accounts data files, *GDP (current USD) Sub-Saharan Africa (2022)* <https://data.worldbank.org/indicator/NY.GDPMKTP.CD?locations=ZG&most_recent_value_desc=true> accessed 19 January 2022.

system was largely unprepared to respond adequately to the current pandemic, with harmful impacts for several elements of the right to health. The report has four main findings:

1. Nigeria lacks universal, public healthcare services to respond to public health emergencies. The country is critically short of health facilities, staff and medical equipment necessary to deliver COVID-19 treatment, testing and vaccination to its population of more than 206 million in 2020.
2. Several barriers impede access to healthcare services amidst the pandemic, as such access is largely shaped by socioeconomic inequalities. The most marginalised groups not only face disproportionate hurdles in obtaining timely COVID-19 medical services but are also more exposed to the collateral damages of the pandemic on access to all medical services, as the healthcare system struggles to respond to the emergency.
3. Regulation and monitoring of private health providers by authorities are insufficient. There have been numerous cases of private clinics and hospitals not complying with scientifically appropriate medical standards and practices during the pandemic. The report documents how private facilities were initially not allowed to admit COVID-19 cases for treatment because authorities had concerns over their quality, and how this has translated into empty beds and untapped capacity when it was most needed. For example, based on a range of quantitative indicators, a study found that the private healthcare sector in Edo State was not adequately equipped to provide screening services for COVID-19.⁵
4. Several private health providers offer substandard healthcare services and fail to comply with appropriate medical protocols and standards, including by using expired drugs or employing unqualified staff, especially in urban informal settlements. Well before the pandemic, academic literature documented ineffective malaria therapies in the private health sector.⁶ During COVID-19, there have been cases of private health facilities using expired reagents for COVID-19 testing.⁷

⁵ Darlington Ewaen Obaseki and others, 'Mainstreaming the Private Health Sector in the Response to COVID-19: Facility Readiness assessment for Screening Services in Edo State, Nigeria' (2020) 35 *The Pan African Medical Journal* 93.

⁶ Roger Bate and others, 'Antimalarial Drug Quality in the Most Severely Malarious Parts of Africa – A Six Country Study' (2008) 3 *PLoS ONE* e2132; Benjamin SC Uzochukwu and others, 'Examining Appropriate Diagnosis and Treatment of Malaria: Availability and Use of Rapid Diagnostic Tests and Artemisinin-Based Combination Therapy in Public and Private Health Facilities in Southeast Nigeria' (2010) 10 *BMC Public Health* 486; Grace O Gbotosho and others, 'Potential Contribution of Prescription Practices to the Emergence and Spread of Chloroquine Resistance in South-West Nigeria: Caution in the Use of Artemisinin Combination Therapy' (2009) 8 *Malaria Journal* 313.

⁷ National, 'COVID-19: Enugu lab shut for sharp practices' *The Sun* (29 October 2021) <<https://www.sunnewsonline.com/covid-19-enugu-lab-shut-for-sharp-practices/>> accessed 31 October 2021.



While multiple factors contribute to this difficult situation, the report argues that the commercialisation of Nigeria's healthcare system is amongst the main drivers of the right to health challenges described above. In Nigeria, the commercialisation of the healthcare system, marked by the growth of market mechanisms and private actors in health, began in the 1980s, partly as a result of structural adjustment programmes backed by international financial institutions,⁸ and has continued until today. This is visible, for instance, through the rapidly expanding share of private spending for healthcare, which increased from 64.7% in 2000 to 77.27% in 2018. Policy decisions have propelled this trend. For example, the 2004 Revised National Health Policy dedicates an entire chapter to supporting the increase of partnerships with the private sector for health development,⁹ and, in 2005, the Federal Ministry of Health developed the National Policy on public-private partnerships, which aims at strengthening and expanding public-private partnerships in health.¹⁰

After decades of privatisation in healthcare, a fragmented and varied private sector, made up of commercial actors as well as faith-based and civil society providers, covers an estimated 60% of health services.¹¹ In this system, the upper-income groups can obtain medical care of relatively higher perceived standards in expensive-looking facilities across major cities, such as Lagos. By contrast,



those living in poverty in areas where public medical care might be absent or too far away, and with expensive private services beyond reach, are often forced to seek assistance at low-fee commercial healthcare facilities providing low-quality services.¹² In the worst cases, these services might be unlicensed, unsafe and unregulated, employing untrained and unqualified staff, selling expired drugs and operating without adhering to scientifically appropriate medical standards and ethics. Such low-quality commercial services can severely threaten the health and lives of those who use them, while also entailing severe epidemiological risks. For instance, a study shows that pub-

⁸ U Onwudiegwu, 'The Effect of a Depressed Economy on the Utilisation of Maternal Health Services: The Nigerian Experience' (2009) *Journal of Obstetrics and Gynaecology* <<https://www.tandfonline.com/doi/abs/10.3109/01443619309151701>> accessed 3 December 2021.

⁹ Federal Republic of Nigeria, *Revised National Health Policy (2004)* <<https://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf>> accessed 3 November 2021, 50.

¹⁰ Federal Ministry of Health, *National Policy on Public-Private Partnership for Health in Nigeria (2005)* <<https://goonk.com/WXzjbG/>> accessed 3 November 2021.

¹¹ Federal Government of Nigeria, *National Strategic Health Development Plan (2018 – 2022) (2018)* <<https://www.health.gov.ng/doc/NSHDP-II-Final.pdf>> accessed 26 October 2021, p. 6.

¹² Anna Marriott, 'Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries' *Oxfam* (1 February 2009) <<https://policy-practice.oxfam.org/resources/blind-optimism-challenging-the-myths-about-private-health-care-in-poor-countries-114093/>> accessed 28 October 2021.

lic health providers are significantly more likely to use rapid malaria diagnostics and the recommended combination of therapies than private providers in South-East Nigeria.¹³ Poor adherence to guidelines in prescription practices in the private sector has also been associated with a rise in drug-resistant malaria in the country.¹⁴ While genuine high-quality, non-commercial private actors, such as some of the faith-based or civil society providers, also exist and can play a positive role in enhancing access to medical care, they are the exception rather than the rule.

Health inequalities and socioeconomic barriers in Nigeria are thus inherent to the overall marketised healthcare system, where access to medical care, and thereby survival and dignified life, is highly dependent on one's social and economic status.

It does not have to be this way. The answer is to build a strong, well-coordinated public healthcare system for all. Commercial healthcare will not fulfil the rights of everyone in Nigeria, let alone address public health priorities as well as present and future pandemics. Expanding the availability of public healthcare services for everyone is urgent, including inverting the current national and international development policies intended to encourage higher private sector engagement in healthcare. At the same time, Nigeria should ensure that all healthcare providers are strictly monitored and regulated at the federal, state and local levels.

From the analysis presented in this report, we make the following recommendations for the federal and state governments, within their respective areas of competencies:

- **Increase governmental funding to health to at least 15% of the budget to meet the Abuja commitment and expand the availability of quality, well-coordinated public healthcare services**

Nigeria is among the African Union States that pledged to raise the proportion of government funding for health to at least 15% of the overall national budget in the 2001 Abuja Declaration.¹⁵ However, Nigeria is still far behind on that target. Authorities should thus consider increasing general government expenditure on health from the current 4.4% share of general government expenditure (as of 2018)¹⁶ to at least 15%, in line with the Abuja Declaration

¹³ Benjamin SC Uzochukwu and others, 'Examining Appropriate Diagnosis and Treatment of Malaria: Availability and Use of Rapid Diagnostic Tests and Artemisinin-Based Combination Therapy in Public and Private Health Facilities in South-East Nigeria' (2010) 10 BMC Public Health 486.

¹⁴ Grace O Gbotosho and others, 'Potential Contribution of Prescription Practices to the Emergence and Spread of Chloroquine Resistance in South-West Nigeria: Caution in the Use of Artemisinin Combination Therapy' (2009) 8 Malaria Journal 313.

¹⁵ WHO, *The Abuja Declaration: Ten Years On (2011)* <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

¹⁶ WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)* <<https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=NG>> accessed 17 January 2022; see also: BudgIT, 'Nigeria: Health Budget Analysis' (2021) <<https://yourbudgetit.com/wp-content/uploads/2018/04/Nigeria-Health-Budget-Analysis.pdf>> accessed 25 October 2021.



commitment. Committing more public finances in health would be in line with Nigeria's obligation to invest the maximum of its available resources to ensure that everyone has access to universal, public healthcare services, which is set out in the African Charter on Human and Peoples' Rights and the other international human rights treaties to which Nigeria is a party.

- **Reverse the current policies intended to encourage higher private sector engagement in healthcare**

The 2016 National Health Policy and the National Health Development Plan (2018-2022) set out as a goal the promotion of public-private partnerships in healthcare. As shown in this report, market mechanisms involving competition, that are typically at play in public-private partnerships, fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions in healthcare, which have dangerous impacts on the realisation of the right to health, Nigeria should invest in a strong public healthcare system, that is democratically managed, funded, and delivered by non-commercial actors, and reinforce the public healthcare sector's capacity.

- **Ensure that all healthcare providers are strictly monitored and regulated at the federal, state and local levels**

This report has shown that in practice the quality of private healthcare provision is sometimes very low and not in line with medical standards. Stronger regulatory and monitoring efforts are needed. In particular, the federal, state and local governments should coordinate efforts to ensure that all providers in the country operate under a Certificate of Standards, as provided in the National Health Act (2014), with harmonised eligibility criteria and meaningful follow-up quality monitoring and enforcement.

- **Take concrete steps to ensure universal access to social health insurance or another pre-pooled financing scheme**

This report has highlighted once again that participation in the National Health Insurance Scheme is extremely low, covering mostly some workers in the formal sector. While the existence of programmes targeting the informal sector, individuals living in poverty, and marginalised groups is a positive step, in practice these programmes are poorly implemented, as data on enrolment rates show.



1. Introduction

‘When the oxygen was removed, we moved her to the house until she breathed her last. It was a terrible experience. The family is poor. We don’t have money’: this is how Simon Okonye recalls losing his mother-in-law.¹⁷ The woman was battling for her life in a private hospital in Aba, Nigeria, but the oxygen therapy was interrupted as her family could not afford to pay the daily fee of 2,500 nairas (6 USD).¹⁸ This is not an isolated story: with 40% of the 206 million Nigerians living below the international poverty line (1.9 USD),¹⁹ many in the country are unable to cover the cost of one of the few available tanks of oxygen.²⁰ At public hospitals, shortages of oxygen leave many gasping for air in COVID-19 wings, as recalled by a 47-year-old businesswoman interviewed by the media: *‘There was a shortage. It was discussed all around. It felt like that was the main issue – oxygen, oxygen, oxygen.’*²¹

Since the first case of COVID-19 was confirmed on 27 February 2020,²² Nigeria has been struggling to cope with the pandemic. In addition to oxygen shortages, the country lacks emergency services, healthcare facilities, as well as ventilators, therapeutics, acute care beds, physicians and testing kits.²³ Furthermore, as the interviews conducted for this report show, Nigerians living in most deprived areas, such as informal settlements, face several barriers in accessing even the most basic medical care, let alone specialised care for COVID-19. This difficult situation was to be expected: in 2017, the World Health Organisation (WHO), while praising the existence of the national public health institute (the Nigeria Centre for Disease Control), evaluated the country’s overall preparedness to control epidemics as being very low.²⁴ Inaccurate official statistics further complicate efforts to contain new waves: COVID-19 cases are underreported and tracking is poor, as is the case for most countries in the region, due to the limited resources allocated to monitoring the spread of the infection.²⁵

¹⁷ Daily Trust, ‘How High Cost Of Medical Oxygen ‘Kills’ Patients in Nigerian Hospitals’ *Daily Trust* (19 June 2021) <<https://dailytrust.com/how-high-cost-of-medical-oxygen-kills-patients-in-nigerian-hospitals/>> accessed 26 October 2021.

¹⁸ Ibid.

¹⁹ World Bank, Global Poverty Working Group, *Poverty Headcount at National Poverty Line (% of the Population) (2022)* <<https://data.worldbank.org/indicator/SL.POV.NAHC?locations=NG>> accessed 21 January 2021; see also: Alexis Akwagyiram, ‘Forty Percent of Nigerians Live in Poverty: Stats Office’ Reuters (4 May 2020) <<https://www.reuters.com/article/us-nigeria-economy-poverty-idUSKBN-22G19A>> accessed 26 October 2021.

²⁰ Libby George and Alexis Akwagyiram, ‘“Oxygen, Oxygen, Oxygen”: Nigeria Battles Shortages amid COVID-19 Surge’ *Reuters* (2 February 2021) <<https://www.reuters.com/business/healthcare-pharmaceuticals/oxygen-oxygen-oxygen-nigeria-battles-shortages-amid-covid-19-surge-2021-02-02/>> accessed 26 October 2021.

²¹ Ibid.

²² Reuters, ‘Nigeria: The Latest Coronavirus Counts, Charts and Maps’ *Reuters* (2021) <<https://graphics.reuters.com/world-coronavirus-tracker-and-maps/countries-and-territories/nigeria/>> accessed 26 October 2021.

²³ Siddarth Dixit, Yewande Kofoworola Ogundeji and Obinna Onwujekwe, ‘How Well Has Nigeria Responded to COVID-19?’ *Brookings* (2 July 2020) <<https://www.brookings.edu/blog/future-development/2020/07/02/how-well-has-nigeria-responded-to-covid-19/>> accessed 26 October 2021.

²⁴ WHO, ‘Joint External Evaluation of the IHR Core Capacities of the Federal Republic of Nigeria’ (2017) <https://apps.who.int/iris/bitstream/handle/10665/259382/WHO-WHE-CPI-REP-2017_46-eng.pdf?sequence=1> accessed 26 October 2021.

²⁵ Annalisa Merelli, ‘Why you are not hearing about COVID-19 outbreaks in Africa’ *Quartz Africa* (26 October 2021) <<https://qz.com/africa/2079064/only-one-in-seven-cases-of-covid-19-in-africa-is-reported/>> accessed 2 November 2021.





Writing in November 2021, the more contagious and deadly Delta variant²⁶ was rapidly spreading in Nigeria,²⁷ and only 1% of the population had been fully vaccinated against COVID-19.²⁸ Adding to this situation, since January 2020, Nigeria had also been battling an outbreak of Lassa fever, an acute haemorrhagic disease with a remarkably high fatality ratio (19.5% for the period January-April 2020), meaning that Nigeria is fighting two epidemics at once.²⁹

This situation has several human rights impacts. The right to health is well protected in Nigeria's legal framework in both its constitution and the regional³⁰ and international human rights treaties to which it is a party, including the International Covenant on Economic, Social and Cultural Rights (ICESCR, ratified in 1993). While the right to health does not require States to ensure that everyone is healthy, it demands that they establish the best possible health system, within their capacities, to try to reach the highest attainable standard of health – and pandemic prevention and response. At the same time, Nigeria's system is highly commercialised, which goes hand in hand with a lack of investment in public healthcare services for all. The commercialisation of healthcare – which can be defined as the growth of market mechanisms in healthcare – is a common feature of many healthcare systems in the region. A question that arises is thus whether such a commercialised system can adequately respond to a crisis, such as the COVID-19 pandemic, and thus meet Nigeria's human rights obligations.

This report investigates how the pandemic has impacted the right to health in the country. Then, it reflects on the root causes of these impacts, finding that the growing commercialisation of healthcare in Nigeria since the late 1980s has been a key factor in undermining the country's ability to respond to COVID-19 and has led to severe impacts in terms of the right to health and potential human rights violations.

²⁶ PunchNG, 'COVID-19: Nigeria records 10 cases of Delta variant – NCDC' (27 July 2021) <https://punchng.com/covid-19-nigeria-records-10-cases-of-delta-variant-ncdc/?utm_source=auto-read-also&utm_medium=web> accessed 26 October 2021.

²⁷ Doyin Odubanjo, 'Nigeria isn't ready to deal with rising COVID-19 cases' *The Conversation* (1 August 2021) <<https://theconversation.com/nigeria-isnt-ready-to-deal-with-rising-covid-19-cases-165201>> accessed 2 August 2021.

²⁸ Our World in Data, Share of the population fully vaccinated against COVID-19, Nigeria (2021) <<https://ourworldindata.org/coronavirus/country/nigeria>> accessed 14 October 2021.

²⁹ Sanjeet Bagcchi, 'Lassa Fever Outbreak Continues across Nigeria' (2020) 20 *The Lancet Infectious Diseases* 543.

³⁰ African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, 1990.



What is privatisation and commercialisation in healthcare?

In this report, we define privatisation in healthcare as the growth of the share of private sector involvement in healthcare, or the adoption of private-sector practices in the health sector. This might take several forms. Higher private sector involvement in the ownership, financing, management, governance or provision of healthcare services can all be deemed as privatisation in healthcare. Examples of privatisation are the selling of public assets to private actors as well as shifts in governance or administration of healthcare services from the public onto the private sphere. Privatisation is thus an umbrella term that might cause or encompass one or more of the following:

- Commercialisation: the progressive spread of market mechanisms in health to gain private benefits.
- Marketisation: enabling State enterprises to operate as market-oriented firms.
- Financialisation: the increasing role of financial motives and financial markets in health, such as private investment in health-related bonds.

Privatisation in healthcare has been growing in the last decades everywhere in the world. This causes several challenges for the realisation of the right to health, as United Nations Human Rights Treaty bodies,³¹ as well as human rights organisations³² and scholars,³³ are increasingly recognising. Likewise, several empirical academic studies have raised concerns about the impact of the commercialisation of healthcare. For instance, a systematic review has shown how private healthcare providers in low- and middle-income countries are associated with poorer health outcomes and less efficiency, and they are less likely to comply with medical standards and protocols in comparison to public providers.³⁴ Another systematic news review found widespread episodes of malpractice, business closure and a general liquidity crisis in the private health sector as a consequence of COVID-19.³⁵ Reflecting on this evidence, the study points out that market models in healthcare might be not sufficiently resilient to external shocks, such as epidemics.³⁶ This led some experts to talk about ‘the collapse of private healthcare’ amidst the pandemic.³⁷

³¹ GI-ESCR, ‘Compendium on United Nations Human Rights Treaty Bodies’ Statements on Private Actors in Healthcare’ (June 2021) <<https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 8 November 2021.

³² GI-ESCR, ‘Italy’s experience during COVID-19 and the limits of privatisation in healthcare’ (2 June 2021) <<https://www.gi-escr.org/publications/policy-brief-italys-experience-during-covid-19-and-the-limits-of-privatisation-in-healthcare>> accessed 3 December 2021.

³³ Audrey Chapman, ‘The Impact of Reliance on Private Sector Health Services on the Right to Health’ (2014) 16 Health Hum Rights 122; Antenor Hallo de Wolf and Brigit Toebes, ‘Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health’ (2016) 18 Health and Human Rights 79.

³⁴ Sanjay Basu and others, ‘Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review’ (2012) 9 PLoS Medicine e1001244.

³⁵ Owain David Williams, Ka Chun Yung and Karen A Grépin, ‘The Failure of Private Health Services: COVID-19 Induced Crises in Low- and Middle-Income Country (LMIC) Health Systems’ (2021) 16 Global Public Health 1320.

³⁶ Ibid.; See also: Owain David Williams, ‘COVID-19 and Private Health: Market and Governance Failure’ (2020) 63 Development 181.

³⁷ Mark Hellowell and others, ‘COVID-19 and the Collapse of the Private Health Sector: A Threat to Countries’ Response Efforts and the Future of Health Systems Strengthening’ (27 May 2020) *Health Systems Collaborative* <<https://hsgovcollab.org/en/blog/covid-19-and-collapse-private-health-sector-threat-countries-response-efforts-and-future>> accessed 26 October 2021.



Methodology

This report is based on primary data and secondary data from official statistics, household surveys, academic literature, news, as well as normative and policy documents.

Primary data

The Justice & Empowerment Initiatives (JEI), a Nigerian human rights organisation, conducted 24 open-ended, narrative, individual interviews with individuals living in poverty in urban informal settlements in Lagos and Port Harcourt regarding their experience in accessing healthcare services amidst the pandemic. Such interviews add a larger project including more than 100 interviews with individuals living in poverty during the COVID-19 pandemic.³⁸ Interviews were conducted by skilled professionals trained from JEI, were audio-recorded, transcribed and complemented with pictures. The interviews were all used as primary data for this report. Some direct quotes from these interviews are also used throughout the text. In-text quotes from interviews have been slightly edited to make the testimonies clearer.

Secondary data

- Statistics were retrieved from the following public databases: the Nigeria Health Facility Registry (HFR); the Nigeria Demographic Health Survey (2003, 2013); the World Bank; the WHO Global Health Observatory; the World Federation of Societies of Anaesthesiologists.
- Academic literature on the evolution of the private healthcare system in Nigeria was retrieved by searching PubMed, Scopus and Google Scholar with the following keywords, including synonyms and different spelling: 'healthcare', 'health services', 'medical services', 'medicine', 'commodification', 'privatisation', 'privatising'. The search was restricted to Nigeria and no time restriction was applied.
- News on Nigeria's healthcare system response to COVID-19, with a focus on privatisation and the impact on the right to health, was retrieved searching Google News between February 2021 and November 2021 with the following keywords (including different spelling): COVID-19, coronavirus, test*, kit*, mask*, ventilator*, oxygen, virus, protective equipment, pandemic. Once articles related to COVID-19 were identified, they were manually searched for the following keywords: 'privat*', 'commercial*', 'for-profit'. Google news alerts were also set with the same keywords to monitor a constantly evolving situation: this resulted in many articles being included in the analysis routinely, after the first search was implemented. Twitter and YouTube were also manually searched with the same keywords over the same period. Only articles related to Nigeria were included.
- Document analysis of national acts, bills and administrative sources.

All searches were conducted in English.

³⁸ Justice & Empowerment Initiative, *Coronadiaries of the Urban Poor* (2022) <<https://www.justempower.org/coronadiaries>> accessed 19 January 2022.



2. Context: the right to health and healthcare services in Nigeria

The right to health is well protected in Nigeria's legal system. Its implementation is however dependent on a complex healthcare system with several layers of responsibility. This section introduces Nigeria's legal obligation on respecting, protecting and fulfilling the right to health, as well as a human rights framework to assess private sector involvement in healthcare. Then, the section provides a historical overview of the introduction of private actors in healthcare in Nigeria, reflecting on privatisation and commercialisation trends in the healthcare system from independence until today.

1. The right to health

Several domestic, regional and international legal norms entitle everyone in Nigeria to the highest attainable standard of physical and mental health through adequate public health services.

At the domestic level, the 1999 Constitution guarantees a right to 'adequate medical and health facilities for all persons'.³⁹ Although this provision is contained in a section of the Constitution that is non-justiciable, the right to health in Nigeria can be indirectly brought in courts through the right to life.⁴⁰ In 2014, 50 years after its independence, Nigeria also enacted the National Health Act, which is a comprehensive legal framework for the regulation, development and management of all health services.⁴¹ The Act establishes a National Health System which is intended to 'protect, promote and fulfil the rights of the people of Nigeria to have access to health services'.⁴² The National Health Act also entitles all Nigerians to a 'basic minimum package of health services and allows the Federal Ministry of Health to prescribe conditions under which certain categories of persons might be exempted from payment for healthcare services at 'public health establishments'.⁴³ Finally, the 2016 Revised National Health Policy recognises that 'health and access to quality and affordable health care is a human right'.⁴⁴



³⁹ Constitution of Nigeria (1999 amended in 2011) section 17(3)(d).

⁴⁰ Remigius Nwabueze, 'The Legal Protection and Enforcement of Health Rights in Nigeria' in Colleen M Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).

⁴¹ National Health Act 2014 (Act. 8 of 2014) <<https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/104157/126947/F-693610255/NGA104157.pdf>> accessed 26 October 2021.

⁴² *Ibid.*, 1(1)(e).

⁴³ *Ibid.* section I, 3(1, 2).

⁴⁴ Federal Ministry of Health, *Revised National Health Policy* (2016) <https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf> accessed 26 October 2021.

At the regional level, Nigeria is a party to the African Charter on Human and People's Rights (ratified in 1983).⁴⁵ Article 16 of the African Charter, which has been domesticated into Nigerian law,⁴⁶ prescribes that 'States Parties shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick'.⁴⁷ In 2019 and 2020, the African Commission on Human and Peoples' Rights, which monitors the implementation of the African Charter, issued two landmark resolutions that address the role of private actors in health and education.⁴⁸ The 2019 resolution reaffirms that the African States are 'the duty bearers for the protection and fulfilment of economic, social and cultural rights, in particular the rights to health and education without discrimination, for which quality public services are essential'⁴⁹ and expresses concerns over the current trend of multilateral donors and international institutions putting 'pressure on States Parties to privatise or facilitate access to private actors in their health and education sectors' in disregard of these obligations.⁵⁰ The Commission also calls on governments to 'consider carefully the risks for the realisation of economic, social and cultural rights of public-private partnerships and ensure that any potential arrangements for public-private partnerships are by their substantive, procedural and operational human rights obligations'.⁵¹ The 2020 resolution sets the ground for the development of norms on States' obligations to regulate private actors involved in the provision of social services.⁵² In 2001, Nigeria also ratified the African Charter on the Rights and Welfare of the Child, whose Article 14 obliges States 'to ensure the provision of necessary medical assistance and healthcare to all children, emphasising the development of primary healthcare.'⁵³

At the international level, Nigeria is a party to several human rights treaties recognising the right to health,⁵⁴ including the International Covenant on Economic, Social and Cultural Rights (ICESCR, ratified in 1993).⁵⁵ Article 12 of this Covenant enshrines 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'⁵⁶ Nigeria has also ratified all other major treaties including health provisions, such as the International Covenant on Civil and Political Rights, the Convention

⁴⁵ African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter).

⁴⁶ African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act, 1990.

⁴⁷ *Ibid.*, Art. 16.

⁴⁸ African Commission on Human and Peoples' Rights, 'Resolution on States' Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services' (2019) Res. 420 (LXIV) <<https://bit.ly/31u1VSu>> accessed 26 October 2021.

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² African Commission on Human and Peoples' Rights, 'Resolution on the Need to Develop Norms on States' Obligations to Regulate Private Actors Involved in the Provision of Social Services' (2020) Res. 434 (EXT.OS/XXVI1) <<https://www.achpr.org/sessions/resolutions?id=465>> accessed 31 January 2022.

⁵³ African Charter on the Rights and Welfare of the Child (adopted 11 July 1990, entered into force 29 November 1999) OAU Doc. CAB/LEG/24.9/49 (1990).

⁵⁴ Obiajulu Nnamuchi, 'The Right to Health in Nigeria' (2010) SSRN Electronic Journal <<http://www.ssrn.com/abstract=1622874>> accessed 26 October 2021.

⁵⁵ International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12.

⁵⁶ *Ibid.*



on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of Persons with Disabilities.

Nigeria also has an obligation under global health law. Under WHO's international health regulations, a legally-binding treaty that Nigeria ratified in 2007, the country must develop, strengthen and maintain the capacity to respond to public health emergencies promptly and effectively (Article 13.1).⁵⁷ and detect, assess and report on public health risks (Article 5.1).⁵⁸ This mirrors obligations under Article 12 of the ICESCR, which requires States to progressively build coordinated universal public health systems for 'the prevention, treatment and control of epidemic, endemic, occupational and other diseases.'⁵⁹

This legal framework on pandemic preparedness applies to all instances, including when private actors are involved in healthcare delivery, and to situations involving



commercialisation in healthcare. Although still limited, further guidance can be sought from the practice of the United Nations Committee on Economic, Social and Cultural Rights, the body in charge of monitoring and interpreting the ICESCR. The Committee recently affirmed, in response to the COVID-19 pandemic, that States must adopt appropriate regulatory measures to ensure that healthcare resources in

'both the public and the private sectors are mobilised and shared among the whole population to ensure a comprehensive, coordinated healthcare response to the crisis'.⁶⁰ More broadly, United Nations human rights treaty bodies have in the last years increasingly reflected on the human rights implications of private sector involvement in healthcare, calling on States to assess the impact of any plan to privatise healthcare on the right to health, prevent any impact on marginalised groups as well as to monitor and regulate private healthcare providers.⁶¹

To clarify the applicable human rights framework, the University of Essex, the Global Initiative for Economic, Social and Cultural Rights, and the Initiative for Social and Economic Rights published in 2019 a scoping of existing standards, in the report '*Private*

⁵⁷ WHO, International Health Regulations (adopted in 2005, entered into force in 2007) Edition (Internet version, 2016) <<https://apps.who.int/iris/bitstream/handle/10665/246107/9789241580496-eng.pdf;jsessionid=571A416D79BA24BE767C1B1A23389728?sequence=1>> accessed 11 November 2021.

⁵⁸ Ibid.

⁵⁹ International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR).

⁶⁰ CESCR 'Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social, and Cultural Rights' (17 April 2020) E/C.12/2020/1.

⁶¹ GI-ESCR, 'Compendium on United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <<https://www.gi-esecr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare>> accessed 8 November 2021.

actors in health services: towards a human rights impact assessment framework'.⁶² Building on an analysis of the jurisprudence, it recalls some of the main human rights obligations regarding the right to health, including the obligations of States,⁶³ in the context of private sector involvement, to:

- protect the right to health when a third party is involved.
- ensure that any private involvement in healthcare does not undermine healthcare accessibility, availability, acceptability and quality.
- assess any privatisation plans so that they don't interfere with the fulfilment of the right to health at the maximum of their available resources.
- ensure that healthcare privatisation does not reduce the level of the enjoyment of the right previously granted.
- strictly regulate and monitor private healthcare actors. In particular, when private actors provide services in areas where the public sector has traditionally been strong, they should be 'subject to strict regulations that impose on them so-called 'public services obligations': (...) private healthcare providers should be prohibited from denying access to affordable and adequate services, treatments or information.'

It is against this background that the present analysis is conducted.

2. The healthcare system

Nigeria has a complex healthcare system that includes public and private sectors as well as modern and traditional systems.⁶⁴ For over 50 years, since Nigeria's independence, the country had lacked a comprehensive legal and policy framework setting rules on healthcare services across its wide territory. Its current organisation is thus the result of a relatively recent development over the last ten years.⁶⁵

The key pillar of such framework is the aforementioned 2014 National Health Act, which establishes a National Health System⁶⁶ and 'sets standards for rendering health

⁶² GI-ESCR, ISER, University of Essex, *Private Actors in Healthcare: Towards a Human Rights Impact Assessment Framework* (2019) <<https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/5dfb832f7894511787b02d52/1576764300874/Private+Actors+and+the+Right+to+Health+Report+-+December+2019.pdf>> accessed 3 December 2021.

⁶³ See, for example: Human Rights Council (HRC) 'Human rights and transnational corporations and other business enterprises' (2001) A/HRC/RES/17/4; CESCR, 'General Comment No. 14, The right to the highest attainable standard of health (Article 12 of the Covenant)' (11 August 2000) E/C.12/2000/4; CESCR, 'General Comment No. 24: State obligations under the ICESCR in the context of business activities' (10 August 2017) 21.

⁶⁴ Suellen Li and others, 'Traditional Medicine Usage among Adult Women in Ibadan, Nigeria: A Cross-Sectional Study' (2020) 20 BMC Complementary Medicine and Therapies, p. 93.

⁶⁵ Osahon Enabulele, 'Nigeria's National Health Act 2014: A Review of Some of Its Implications and Challenges' (2017) 16 Annals of Biomedical Sciences 243.

⁶⁶ National Health Act 2014 (Act. 8 of 2014) Section I.





services in the federation'.⁶⁷ The National Health Act states that the National Health System is composed of the Federal Ministry of Health, the Ministry of Health in every federated state and local governments as well as private, traditional and alternative healthcare providers.⁶⁸ According to the National Health Act, the responsibility to organise the health sector is shared by the federal, state and local tiers of government. The local governments are responsible for primary care within districts called 'wards'. However, in practice, the local government level is very weak in Nigeria, with funding for local healthcare being managed at the state level by the Primary Healthcare Boards and the Ministry of Health. Even if the goal is to have a primary health centre in every ward, this is yet not the reality on the ground. The state governments run secondary care, while the Federal Government is in charge of tertiary care.⁶⁹ The Federal Ministry of Health also runs the implementation and development of specific public health programmes, such as the National Malaria Elimination Programme or the National Tuberculosis and Leprosy Control Programme. The Federal Ministry of Health has prioritised primary care provision as a policy objective, including the commitment to operationalise one Primary Health Clinic per ward.⁷⁰ The Act also establishes a National Health Council, a Technical Committee for the National Health Council, and a National Tertiary Health Institutions Standards Committee. Importantly, healthcare in Nigeria is often referred to as organised in four levels: primary healthcare (health centres at local government, ward and community level offering immunizations, ante-natal services, and similar general care); secondary healthcare (general and specialist care in hospitals); tertiary care (highly specialised care offered in federal teaching and specialist hospitals, health promotion and preventive care); and emergency care, usually taking place at hospitals.⁷¹ These distinctions might differ from those of other countries.

⁶⁷ Osahon Enabulele and Joan Emien Enabulele, 'Nigeria's National Health Act: An Assessment of Health Professionals' Knowledge and Perception' (2016) 57 *Nigerian Medical Journal* 260.

⁶⁸ National Health Act 2014 (Act. 8 of 2014) Section 1, 1.2 (a-i).

⁶⁹ Federal Government of Nigeria, *National Strategic Health Development Plan (2018 – 2022)* <<https://www.health.gov.ng/doc/NSHDP-II.Final.pdf>> accessed 26 October 2021, p. 6.

⁷⁰ *Ibid.*

⁷¹ Francis Koce, Gurch Randhawa and Bertha Ochieng, 'Understanding Healthcare Self-Referral in Nigeria from the Service Users' Perspective: A Qualitative Study of Niger State' (2019) 19 *BMC Health Services Research* 209.

Since 2005, Nigeria introduced a national health insurance scheme to pre-pool resources to finance the cost of healthcare services. This system has features similar to the traditional social health insurance schemes, a concept introduced in Germany and adopted by France, Belgium and other European countries, and it is the main alternative to financing the healthcare system through general taxation. In Africa, the most developed examples of social health insurance schemes are found in Ghana, South Africa, Rwanda and Kenya.⁷² In Nigeria, the governmental National Health Insurance Scheme (NHIS) entered into force in 2005 with the Federal Government NHIS Act, under Article 35 of the Nigerian constitution. Importantly, enrolment in the NHIS is voluntary, not mandatory as in Germany, for instance. However, enrolment in the NHIF is extremely low, with only 5% of Nigerians registered, and it is also skewed, covering mostly workers in the formal sector.⁷³ This has effects on the capacity of Nigerians of accessing both private and public health provision, as public facilities also require a fee for some treatments. A recent study found that obstacles to the implementation of the NHIS include weak regulation and governance, its voluntary nature, superstitious beliefs, mistrust or lack of interest in the system and lack of knowledge of its benefits.⁷⁴ These findings are consistent with a broader trend in health insurance schemes leaving those living in poverty behind in low- and middle-income countries.⁷⁵ Furthermore, although the scheme can be accessed by informal workers, in practice most of those in the informal sector with unstable incomes either lack the financial means to enrol in it or they are excluded due to the form of payment (i.e. deducting a premium from a fixed source of income).⁷⁶ This likely explains the high rate of out-of-pocket payments for health care in Nigeria, which constitute 76% of all health expenditure (Figure 1), compared to 23.6% in Kenya or the 33% average statistics in Sub-Saharan Africa.⁷⁷ This figure is amongst the highest in the world, with only Armenia, Yemen and Afghanistan presenting higher rates of user fees as a share of all health spending.⁷⁸ Out-of-pocket payments, in these statistics, are defined as spending on health directly paid at the point of use by households living in Nigeria. In this context, paying fees for healthcare is pushing many below the poverty line,⁷⁹ fuelling socioeconomic health inequalities and inequalities in accessing health services.⁸⁰

⁷² Ama Pokuaa Fenny, Robert Yates and Rachel Thompson, 'Social health insurance schemes in Africa leave out the poor' (2018) 10 *International Health* 1. Top of Form Bottom of Form

⁷³ Gbadegehin O Alawode and David A Adewole, 'Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers' (2021) 21 *BMC Public Health* 124.

⁷⁴ *Ibid.*

⁷⁵ Ceri Averill and Anna Marriott, 'Universal Health Coverage: Why Health Insurance Schemes are Leaving the Poor Behind' Oxfam International (09 October 2013) <<https://policy-practice.oxfam.org/resources/universal-health-coverage-why-health-insurance-schemes-are-leaving-the-poor-beh-302973/>> accessed 13 January 2022.

⁷⁶ *Ibid.*

⁷⁷ WHO, Global Health Expenditure database (2021) <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=ZA&most_recent_value_desc=true> accessed 26 November 2021.

⁷⁸ *Ibid.*

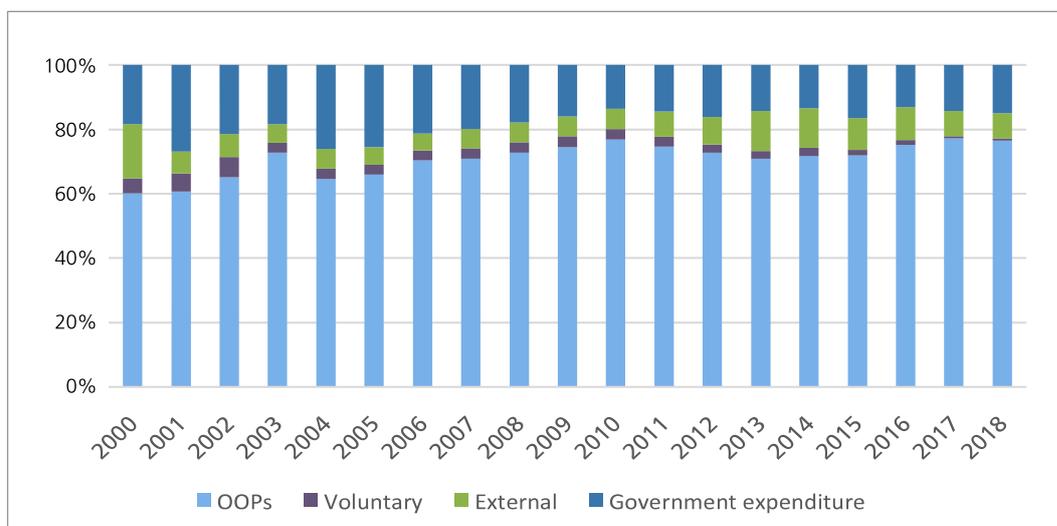
⁷⁹ Bolaji Samson Aregbeshola, 'Out-of-Pocket Payments in Nigeria' (2016) 387 *The Lancet* 2506.

⁸⁰ Bolaji Samson Aregbeshola and Samina Mohsin Khan, 'Out-of-Pocket Payments, Catastrophic Health Expenditure and Poverty among Households in Nigeria 2010' (2018) 7 *International journal of health policy and management* 798.



By contrast, government spending on health, which includes social health insurance contributions, subsidies and domestic revenue, is extremely low. Another component of health spending is represented by external sources, which are all financial inflows injected into the domestic health system from outside the country, such as international cooperation and aid.⁸¹ Finally, a minimal part of domestic private healthcare spending is from voluntary health insurance, (in some countries, like Germany or Kenya, there are mandatory requirements to purchase health insurance).

Figure 1: Health Financing in Nigeria (%), by source (2000 - 2018)



Source: World Bank Data, <https://data.worldbank.org>.

⁸¹ Ibid.



3. Privatisation and commercialisation in healthcare

Privatisation and commercialisation in healthcare have been growing in Nigeria since the 1980s. As a result, a large and diverse private healthcare sector emerged, including for-profit, faith-based and non-governmental organisations, as well as a large informal sector. This fragmented private healthcare sector has different levels of quality, ranging from very high perceived quality levels in expensive hospitals within rich urban areas to sub-standard, low-fee healthcare services. Beyond this modern health sector, traditional healing, as in the case of traditional birth attendants or herbal treatments, are still widespread, especially in communities where these might be the only options.

1. The privatisation and commercialisation of the healthcare system since independence

Before 1984, healthcare services in Nigeria were predominantly financed, delivered and governed by the public sector.⁸² After Nigeria's independence, declared in 1960 and ratified in 1963, public healthcare services expanded rapidly, sustained by the oil boom (1971 – 1980), with growing numbers of medical practitioners and hospital beds.⁸³ Until 1984, medical treatment was free for those under 18 as well as for government workers and their families.⁸⁴ This system was however not without challenges, such as the concentration of medical services in urban areas and neglect of rural ones.⁸⁵ From 1984, this public health sector experienced a crisis, due to the financial crises happening in the country; Nigeria started experiencing shortages of drugs, reagents, and personnel.⁸⁶ Amidst the financial crisis, the government introduced social cuts, including to the health budget, which was compensated for by the introduction of user fees at government-run facilities,⁸⁷ including as part of structural adjustment programmes required by the World Bank and the International Monetary Fund.⁸⁸

⁸²Akinyinka Akinyoade and Bukola Adeyemi Oyeniyi, 'Milking the Sick: Medical Pluralism and the Commoditization of Healthcare in Contemporary Nigeris' in *Markets of well-being* (Brill 2010).

⁸³Ogoh Alubo, 'The Promise and Limits of Private Medicine: Health Policy Dilemmas in Nigeria' (2001) 16 *Health Policy and Planning* 313.

⁸⁴Ibid.

⁸⁵Irehobhude Iyioha and Remigius Nwabueze, *Comparative health law and policy: critical perspectives on Nigerian and global health law* (2016) Routledge, p. 13.

⁸⁶Ogoh Alubo, 'The Promise and Limits of Private Medicine: Health Policy Dilemmas in Nigeria' (2001) 16 *Health Policy and Planning* 313.

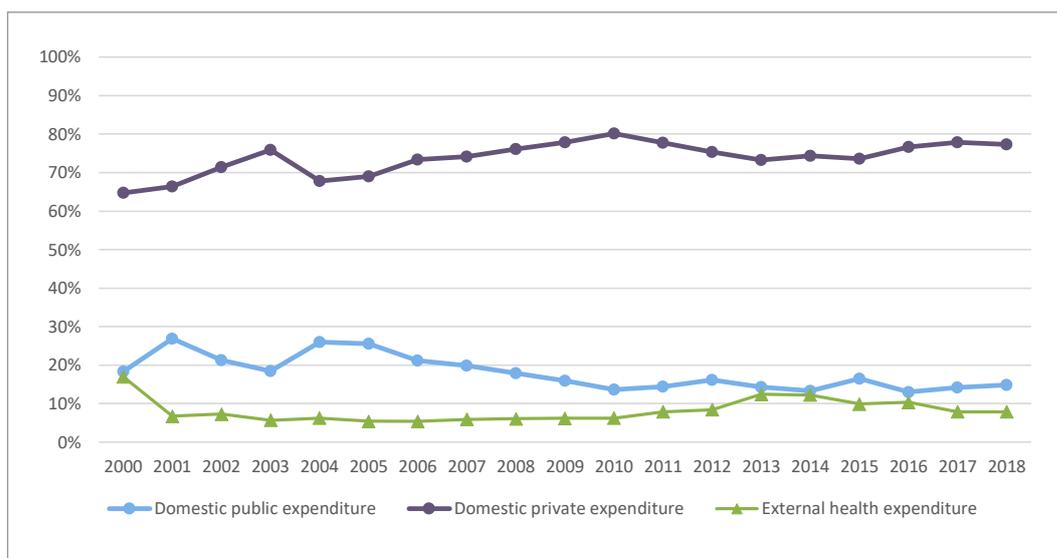
⁸⁷Ahamefule Amaghionyeodiwe L, 'The Effect of User Charges on the Pattern of Health Care Demand in Nigeria' (2020) 10 *American Journal of Biomedical Science & Research* 181.

⁸⁸U Onwudiegwu, 'The effect of a depressed economy on the utilization of maternal health services: The Nigerian experience' (1997) *Journal of Obstetrics and Gynaecology* 17(2): 143-148.



The crisis of the public healthcare system was further exacerbated by the government's efforts to encourage private initiatives and self-employment in health. For instance, the mandatory limit of 5 years before going into private practice was removed.⁸⁹ Some argued that this also provided gains in terms of efficiency and quality,⁹⁰ while, others responded that the benefits of private medicine in Nigeria have been rather limited in public health terms due to its 'for-profit *raison d'être*'.⁹¹ The withdrawal of the State from healthcare provision and financing has steadily continued over time until today. This is illustrated by the evolution of the sources of financing of healthcare. As can be seen in Figure 2, the share of private healthcare financing has continuously grown from 64% in 2000 to 78% in 2018. In the meantime, the already limited share of public spending fell from 18% in 2000 to 14% in 2018. General disinvestment in health can also be seen through general government health spending as a share of GDP dropping from the already low 1.2% in 2004 to 0.57% in 2018.⁹²

Figure 2. Public and private spending on healthcare in Nigeria, share of total spending on health (%), (2000-2018)



Source: WHO Global Health Expenditure Database, <https://www.who.int/data/gho>.

In the last two decades, successive Nigerian governments have further encouraged private sector engagement in healthcare. Nigeria 2004 Revised National Health Policy dedicates an entire chapter to fostering partnership with the private sector for health

⁸⁹ Ogoh Alubo, 'Doctoring as Business: A Study of Entrepreneurial Medicine in Nigeria' (1990) 12 *Medical Anthropology* 305.

⁹⁰ Ibukun Ogunbekun, Adenike Ogunbekun and Nosa Orobato, 'Private Health Care in Nigeria: Walking the Tightrope' (1999) 14 *Health Policy and Planning* 174.

⁹¹ Ogoh Alubo, 'The Promise and Limits of Private Medicine: Health Policy Dilemmas in Nigeria' (2001) 16 *Health Policy and Planning* 313.

⁹² World Bank, *Domestic General Government Health Expenditure (% of GDP)* (2021) <<https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=NG>> accessed 26 October 2021.

development, claiming that public-private partnerships in health are of crucial importance and that the government would be actively promoting them.⁹³ Following up on these commitments, in 2005, the Federal Ministry of Health developed the National Policy on public-private partnerships in Nigeria, intending to strengthen and expand the practice in the healthcare system.⁹⁴ The 2016 National Health Policy further lists 'to promote effective partnerships among the public and private sectors and other stakeholders for optimum resource mobilisation' in particular by 'promoting public-private partnerships'.⁹⁵

Another factor that might be accelerating healthcare provision privatisation lies in the establishment of the National Health Insurance Scheme (NHIS) in 2005. The NHIS guidelines define the scheme as social health insurance, specifying that such model is non-profit and that contributions are based on the ability to pay rather than health risk, as would be the case in private health insurance.⁹⁶ Amongst its objectives, the act establishing the NHIS lists improving and harnessing 'private sector participation in the provision of healthcare services'.⁹⁷ The NHIS operates as a private-public partnership⁹⁸ between three stakeholders: the NHIS, the health maintenance organisations (companies registered by the NHIS to manage the purchasing of services through health care providers accredited by the scheme, a model also present in the USA)⁹⁹, and all health care providers (public and private). Some studies¹⁰⁰ argue that private and commercial interests, embedded in the governance of the NHIS, might be creating inefficiencies in how the scheme works and delaying success in expanding coverage. According to these studies, this happens in Nigeria because of the health maintenance organisations' industry growing as a lobby and influencing policy-making, combined with weak state capacity to regulate their activities.¹⁰¹

The first health maintenance organisations in Nigeria were established in the late 1990s as privately-owned companies supplying private health insurance to private firms.¹⁰² The role of these private health companies grew over time to the point that policy-

⁹³ Federal Republic of Nigeria, *Revised National Health Policy* (2004) <<https://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf>> accessed 3 November 2021, 50.

⁹⁴ Federal Ministry of Health, *National Policy on Public-Private Partnership for Health in Nigeria* (2005) <<https://goonk.com/WXzjbG>> accessed 3 November 2021.

⁹⁵ Federal Ministry of Health, 'National Health Policy 2016' (2016) <https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf> accessed 3 December 2021, pp. 56-7.

⁹⁶ National Health Insurance Scheme, 'National Health Insurance Scheme, Operational Guidelines' (revised in 2012, reprinted in 2020) <https://www.nhis.gov.ng/?media_dl=2714> accessed 11 November 2021.

⁹⁷ National Health Insurance Scheme, Decree no. 35 (10 May 1999) (Nigeria) Art. 5 (e) <<https://www.health.gov.ng/doc/NATIONAL%20HEALTH%20INSURANCE%20SCHEME%20ACT.pdf>> accessed 11 November 2021.

⁹⁸ *Ibid.*

⁹⁹ *Ibid.*, p. 7.

¹⁰⁰ Chima A Onoka, Kara Hanson and Johanna Hanefeld, 'Towards Universal Coverage: A Policy Analysis of the Development of the National Health Insurance Scheme in Nigeria' (2015) 30 *Health Policy and Planning* 1105; Chima A Onoka, Kara Hanson and Anne Mills, 'Growth of Health Maintenance Organisations in Nigeria and the Potential for a Role in Promoting Universal Coverage Efforts' (2016) 162 *Social Science & Medicine* 11.

¹⁰¹ *Ibid.*

¹⁰² Chima A Onoka, Kara Hanson and Anne Mills, 'Growth of Health Maintenance Organisations in Nigeria and the Potential for a Role in Promoting Universal Coverage Efforts' (2016) 162 *Social Science & Medicine* 11, p. 12.



makers actively included them in the organisation of the NHIS.¹⁰³ At time of writing, of all the 58 health insurance maintenance organisations accredited with the NHIS, only 2 are publicly owned (by the defence and police departments), while the rest are privately owned.¹⁰⁴ They also offer their own private health insurance plans, and some of them are multi-product companies owning health facilities. One of the largest is Hygeia Nigeria Limited,¹⁰⁵ a health maintenance organisation that also owns three hospitals in Lagos. These corporate health maintenance organisations are often backed by international financial institutions: the International Finance Corporation, the World Bank's private-sector focused arm, issued a 390 million Nigerian naira (3 million USD) loan to Hygeia Nigeria Limited.¹⁰⁶ The private interests that might be at play within the structure of the NHIF deserve further exploration by future research.

Governmental support for private sector engagement also continued during the COVID-19 pandemic. During the outbreak, the Central Bank of Nigeria contributed with a 100-billion-naira (263.16 million USD) credit specifically targeted to the pharmaceutical and healthcare industry.¹⁰⁷ At the same time, in March 2020, a group of corporate actors launched the private-sector coalition against COVID-19 aimed at supporting the federal government's COVID-19 response.¹⁰⁸

Patients turned into customers: the commodification of healthcare in practice

Profit-seeking behaviours are common across both the public and private health sectors in Nigeria. This is so widespread that academics have noted that a private-in-public system exists in the Nigerian healthcare system: patients entering public facilities are often redirected to private healthcare hospitals and clinics, often run by staff employed by the public, where they can seek the needed treatment at high prices. Patients are also often asked to pay for medical goods needed for their treatment, such as diagnostics, drugs and other medical equipment or screening needed even in government-run facilities. Some parts of medical services, such as pharmacies, diagnostics, emergency services and any or all medical goods (gloves, sterilised water, gauze, oxygen, blood, etc.) are fully outsourced to private providers businesses located outside or within the government-run health facilities.¹⁰⁹

¹⁰³ Ibid.

¹⁰⁴ We manually searched all the websites of the HMOs listed on the official NHIS website as of 2 December 2021: National Health Insurance Scheme, *HMOs Contacts* <<https://www.nhis.gov.ng/hmo-contacts/>> accessed 2 December 2021.

¹⁰⁵ International Finance Corporation, World Bank Group, *IFC and Hygeia Partner to Deliver High-Quality, Affordable Health Care in Nigeria* (2020) <<https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=21041>> accessed 3 November 2021.

¹⁰⁶ Investment Funds for Health in Africa (IFHA), *Hygeia Nigeria Limited* <<https://www.ifhafund.com/portfolio/hygeia-nigeria-limited-2/>> accessed 1 December 2021.

¹⁰⁷ Bolaji Samson Aregbeshola and Morenike Oluwatoyin Folayan, 'Nigeria's financing of health care during the COVID-19 pandemic: challenges and recommendations' *MPRA Paper* (25 January 2021) <https://mpra.ub.uni-muenchen.de/105293/1/MPRA_paper_105293.pdf> accessed 15 September 2021.

¹⁰⁸ Ibid.

¹⁰⁹ Boniface Ayanbekongshie Ushie, David Betelwhobel Ugal and Justin Agorye Ingwu, 'Overdependence on For-Profit Pharmacies: A Descriptive Survey of User Evaluation of Medicines Availability in Public Hospitals in Selected Nigerian States' (2016) 11 PLOS ONE



A story shared in the news perfectly illustrates this situation.¹¹⁰ A woman described the hurdles of accessing emergency care for severe diseases. When her family had to rush to take his father to the public hospital, it took over three hours to find an ambulance, and when it arrived, they had to pay 81,969 nairas (approximately 200 USD). At the hospital, there was no oxygen for her father, and they paid the ambulance driver an additional 200 USD to keep his oxygen tank for more hours: *'we were taken advantage of, partly due to our vulnerability and visible fear'*. The family realised soon they could not leave the father alone at the hospital because *'payment was demanded constantly – for drugs, emergency care, gloves, and basic supplies as well as food. We had to fight for every bit of care, and almost always had to pay for it. In addition, we became responsible for running hospital errands such as going to collect blood from the blood bank for his transfusions.'* This story, which happened during the pandemic and echoes the others in this report, is an example of how market logic and private interest and profit-seeking behaviours undermine healthcare provision even within the public system.

2. The private healthcare sector

As a result of commercialisation trends, there is currently a large and growing private healthcare sector in Nigeria. On the one hand, there are formally registered private providers that can be found in the official health facility ministerial facilities list. Such a formal private sector is made of for-profit, faith-based and non-governmental providers.¹¹¹ On the other hand, there are a plethora of informal private health actors, including unlicensed healthcare facilities, sometimes employing quack personnel or offering sub-standard services. To complicate matters even further, the distinction between licensed and unlicensed private providers is blurred in many contexts, such as informal livelihood, where informality is the norm rather than the exception. Many communities also still rely on traditional and religious healing, such as the use of herbs, traditional remedies and or delivering with the assistance of traditional birth attendants, in contexts where access to modern medicine might be completely absent or out of reach due to multiple barriers.

The formally registered private sector encompasses health facilities providing medical services or retailers, with the main types being:

- **Hospitals or medical centres:** facilities with at least one doctor offering inpatient services.
- **Clinics:** facilities offering outpatient services.

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¹¹⁰ Oyeronke Oyebanji, 'Amid Hospital Chaos, a Daughter's Grief' *The Nation* (22 October 2021) <<https://thenationonline.net/amid-hospital-chaos-a-daughters-grief/>> accessed 1 November 2021.

¹¹¹ Jeff Barnes, Taara Chandani, and Rich Feeley, *Nigeria Private Sector Health Assessment* (2008) <https://www.shopsplusproject.org/sites/default/files/resources/5137_file_FINAL_Nigeria_Private_Sector_Health_Assessment_rev.pdf> accessed 26 October 2021, p. 15



- **Nursing homes:** facilities owned and operated by a nurse or midwife offering residential care, mostly for the elderly.
- **Community pharmacies:** stand-alone retail pharmacies where a trained pharmacist is employed and are licensed by the Pharmacy Council of Nigeria.
- **Patent medicine vendors:** stand-alone medicine shops licensed by the Pharmacy Council of Nigeria selling only certain medications.¹¹²

Official statistics on the extent of the private sector is not easily available. The National Strategic Health Development Plan (2018 – 2022) specifies: ‘Nigeria has a growing private health sector which provides 60% of the health care services through 30% of the country’s conventional health facilities.’¹¹³ According to a 2021 WHO survey, 52% of the population in Nigeria uses the private sector for outpatient care, which is the highest proportion in Africa.¹¹⁴ Looking at the relative shares of private and public sector provision, the Ministry of Health data on hospitals and clinics show that private actors are particularly present in secondary care, where they account for 78.8% of all hospitals and clinics, whereas they account for only 18% of primary care and 36% of tertiary care facilities.¹¹⁵ It is important to note, however, that official statistics might not be accurate, including because it does not account for the informal sector, that could be potentially very large. A report found that official registration lists are not updated systematically and there is no mechanism or incentive for verifying that registered providers are practicing.¹¹⁶ The same study found that, in 6 Nigerian federated states, 32% of private healthcare facilities surveyed were not included in official governmental lists. Conversely, 53% of facilities registered in official governmental lists could not be found by surveyors.¹¹⁷ To make the situation even more complex, many health practitioners who operate in the public sector also operate in the private sector formally or informally.¹¹⁸



¹¹² Johnson Douglas and others, *A Census of Private Health Facilities in Six States of Nigeria* (2014) <https://www.shopsplusproject.org/sites/default/files/resources/SHOPS%20Nigeria%20Private%20Sector%20Health%20Census_6.15.2014%20FINAL.pdf> accessed 26 October 2021.

¹¹³ Federal Government of Nigeria, *National Strategic Health Development Plan* (2018 – 2022) (2018) <https://www.health.gov.ng/doc/NSHDP_II_Final.pdf> accessed 26 October 2021, p. 6.

¹¹⁴ WHO, Advisory Group on the Governance of the Private Sector for UHC, ‘Engaging the private health service delivery sector through governance in mixed health systems’ <<https://www.who.int/publications-detail-redirect/strategy-report-engaging-the-private-health-service-delivery-sector-through-governance-in-mixed-health-systems>> (2020) accessed 11 August 2021.

¹¹⁵ Federal Ministry of Health, *Nigeria Health Facility Registry (HFR)* (2021) <<https://hfr.health.gov.ng/statistics/charts>> accessed 2 August 2021.

¹¹⁶ Johnson Douglas and others, *A Census of Private Health Facilities in Six States of Nigeria* (2014) <https://www.shopsplusproject.org/sites/default/files/resources/SHOPS%20Nigeria%20Private%20Sector%20Health%20Census_6.15.2014%20FINAL.pdf> accessed 26 October 2021.

¹¹⁷ *Ibid.* p. 41.

¹¹⁸ *Ibid.*

3. Regulatory framework on private actors in healthcare

In Nigeria, the regulatory framework on private actors in healthcare has been recently clarified, yet it is poorly implemented. The National Health Act (2014)¹¹⁹ states that a health institution must have a Certificate of Standards before it can offer health services.¹²⁰ The Certificate of Standards may be obtained with ‘the appropriate body of government where the facility is located’ and a fee has to be paid if the facility operates without such certificate.¹²¹ Nigeria’s National Health Council is responsible for the coordination between public healthcare services and private providers.¹²² According to commentaries of experts in newspapers, the implementation of these norms at the federal level is however poor, in practice.¹²³ Some states have developed detailed monitoring and regulation mechanisms. In Lagos, for instance, where most of this report’s interviews have been undertaken, the regulatory framework is well developed on paper: the Lagos State Health Facility Monitoring and Accreditation Agency,¹²⁴ established by the Health Reform Law in 2006, is tasked to register, monitor and inspect all healthcare facilities. The Agency provides a clear and detailed set of minimum quality requirements to obtain a license or its renewal for all typologies of private facilities. The agency has the power of enforcing compliance with the law, including by closing healthcare facilities that do not adhere to criteria.¹²⁵ However, more comparative research would be needed to assess whether the regulatory and monitoring institutional framework is in line with human rights law.

The regulation framework for healthcare workers is more developed. For instance, the Medical and Dental Practitioners Act (1963, revised in 2004)¹²⁶ regulates medical and dental care practice. It sets the Medical and Dental Council of Nigeria as the responsible body for preparing and maintaining registers of persons entitled to practice in healthcare. Under the Medical and Dental Practitioners Act, a person must hold proof of completion of relevant training, in line with requirements specified by the Council.¹²⁷ Beyond doctors and dentists, other health professions have their own regulatory statutes, such as the Nursing and Midwifery Act¹²⁸ or the Pharmacists Council of Nigeria Act.¹²⁹ These measures are complemented by the prohibition of reckless and negligent medical treatment as well as unsafe abortion under relevant criminal law.¹³⁰

¹¹⁹ National Health Act 2014 (Act No. 8 of 2014).

¹²⁰ *Ibid.*, Section XIII, paras 1-2.

¹²¹ *Ibid.*, section XIII, paras. 1-2.

¹²² *Ibid.*, section I, para 5(j).

¹²³ Angela Onwuzoo, ‘Six years after enacting National Health Act, many provisions not implemented’ *Punch HealthWise* (16 February 2020) <<https://healthwise.punchng.com/six-years-after-enacting-national-health-act-many-provisions-not-implemented/>> accessed 3 November 2021.

¹²⁴ Health Facility Monitoring and Accreditation Agency, *Official Website - Home* (2021) <<https://hefamaa.lagosstate.gov.ng/>> accessed 3 December 2021.

¹²⁵ Chidi Emenike, ‘Lagos shuts 16 health facilities for non-compliance with regulatory standards’ *Business News* (18 November 2020) <<https://nairametrics.com/2020/11/17/lagos-shuts-16-health-facilities-for-non-compliance-with-regulatory-standards/>> accessed 3 December 2021.

¹²⁶ Medical and Dental Practitioners Act, Cap. M8, Vol. 8, Laws of the Federation of Nigeria [LFN], 2004, § 1(1).

¹²⁷ *Ibid.*, § 8 and 9.

¹²⁸ Nursing and Midwifery (Registration, etc.) Act, Cap N 143, vol 12, LFN 2004.

¹²⁹ Pharmacists Council of Nigeria Acts, Cap P 17, vol 13, LFN 2004.

¹³⁰ Penal Code (Northern States) Federal Provisions Act, Cap P 3, vol 13, LFN 2004 and Criminal Code Act, Cap C 38, vol 4, LFN 2004.



4. A human rights analysis of commercialisation in healthcare during COVID-19

Drawing on the data collected in this research, four interconnected ways in which the commercialisation of healthcare impacts the right to health in Nigeria arise. These challenges were present before the pandemic, while also being further exacerbated by the pandemic. First, there are not enough public medical services for all. Second, this lack of availability of public healthcare services is combined with strong inequalities in accessing these limited resources. In this context, the private sector, to which people are redirected when public services are weak or absent, is fragmented, including low-fee or substandard, unsafe facilities that can be accessed by disadvantaged individuals, and high-quality services targeting the richest with very high fees. Third, the regulation and monitoring of the private health sector are weak, which leads to several cases of medical malpractice. Fourth, private healthcare providers often offer sub-standard and low-quality medical services, ranging from suggesting unnecessary treatments and misdiagnosis to the use of expired drugs and reagents as well as employing unqualified and untrained medical staff.

1. Not enough public medical services for all

States must make available a range of health services in adequate quantity to meet public health targets appropriately and realise the right to health. United Nations human rights monitoring bodies have growingly reiterated that States are required, as a matter of human rights law, to directly provide public services or ensure their provision by a public body.¹³¹ The United Nations Committee on Economic, Social and Cultural Rights and Committee on the Rights of the Child have both called on specific States to provide public services and public healthcare.¹³²

Nigeria's healthcare system is not equipped to provide adequately even the most basic medical services. It is severely underfunded: in 2018, general government spending on health was as low as 0.57% of GDP.¹³³ This is below the governmental spending on

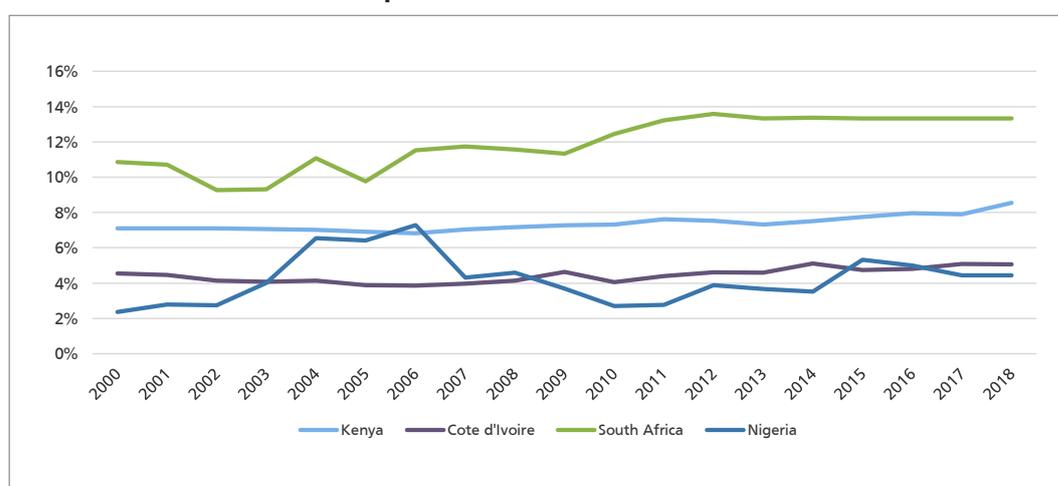
¹³¹ GI-ESCR, 'States' Human Rights Obligations regarding Public Services: The United Nations' Framework' (19 October 2020) <<https://www.gi-escr.org/publications/states-human-rights-obligations-regarding-public-services-the-united-nations-normative-framework>> accessed 1 December 2021.

¹³² CESCR, 'Concluding observations on the third periodic report of the Bolivarian Republic of Venezuela' (7 July 2015) UN Doc E/C.12/VEN/CO/3, para 27.

¹³³ WHO Global Health Expenditure Database, *Domestic General Government Health Expenditure (% of GDP) (2021)* <<https://data.who.int>>

health of comparable African economies, such as Kenya (2.17% of GDP) or Cote d'Ivoire (1.2%), and also below Sub-Saharan Africa's average more broadly (1.9% of GDP),¹³⁴ despite Nigeria having the largest GDP in Sub-Saharan Africa's average as of 2018.¹³⁵ Likewise, healthcare spending as a share of total government spending decreased from 7.2% in 2006 to as little as 4.4% in 2018 (figure 3),¹³⁶ below similar African states such as South Africa and Kenya, and far below the 15% of their annual national budget to which the African Union States committed to in the Abuja Declaration.¹³⁷

Figure 3. Healthcare spending as a share of total government spending (%), 2000-2018, in selected comparable African countries



Source: WHO Global Health Expenditure Database, <https://www.who.int/data/gho>.

In practice, there is a significant shortage of healthcare providers across the country. According to the latest WHO data available, the number of medical staff in Nigeria is far too low for the population, with only 0.38 physicians, 1.179 nurses and midwives and 0.128 community healthcare workers per 1,000 people.¹³⁸ While there is no golden rule for the ideal density of healthcare workers, the WHO recommends at least 2.3 health workers per 1,000 to adequately respond to public health needs.¹³⁹ Likewise, Nigeria has only 0.99 hospital beds per 1,000 people, against 1.4 in Kenya or 2.9 in South Africa.¹⁴⁰

[worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=NG-KE-ZA-CI](https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=NG-KE-ZA-CI) accessed 26 October 2021.

¹³⁴ Ibid.

¹³⁵ World Bank national accounts data and OECD National Accounts data files, *GDP (current USD) Sub-Saharan Africa* (2022) https://data.worldbank.org/indicator/NY.GDP.MKTP.CD?locations=ZG&most_recent_value_desc=true accessed 19 January 2022.

¹³⁶ WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)*

<<https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=NG>> accessed 17 January 2022.

¹³⁷ WHO, *The Abuja Declaration: Ten Years On* (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

¹³⁸ WHO, *The Global Health Observatory* (2021) <<https://www.who.int/data/gho/data/indicators/indicator-details/GHO/hospital-beds-per-10-000-population>> accessed 25 October 2021.

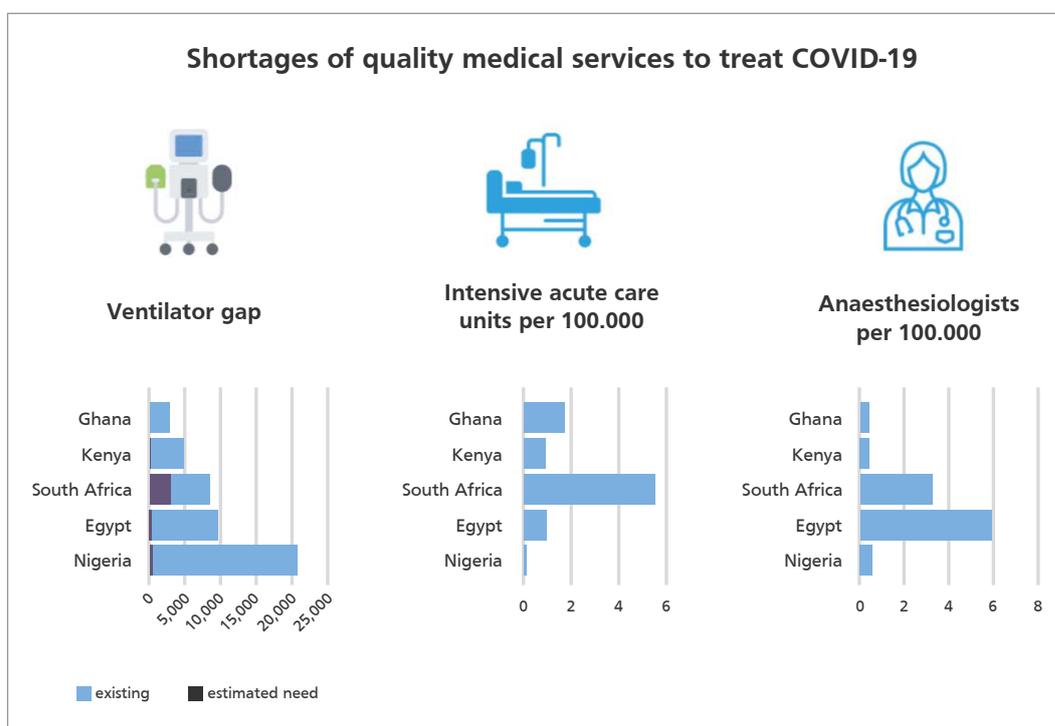
¹³⁹ WHO, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals* (2006) <<https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf>> accessed 11 November 2021.

¹⁴⁰ Ibid.



During the pandemic, the inadequate supply of available medical services was even more evident. The country displayed a critical shortage of lifesaving equipment to treat acute cases of COVID-19, such as ventilators, oxygen and qualified specialists. According to a Reuters’ survey,¹⁴¹ the country had only 500 ventilators in May 2020, against the 20,325 that would be needed to address the epidemic, as estimated by an academic study.¹⁴² The same survey also found that Nigeria has only 0.17 intensive care unit (ICU) beds per 100.000 inhabitants.¹⁴³

Figure 4. Availability of medical services in Nigeria at the time of the COVID-19 pandemic



Source: Own elaboration of data from Reuters and World Federation of Societies of Anaesthesiologists (WFSA).

These shortages are further aggravated by the fact that electricity is extremely unreliable, and hospitals depend on diesel-powered generators. In marginalised and rural areas, several health facilities are unable to guarantee constant fuel and maintenance.¹⁴⁴

Likewise, Nigeria does not have enough public facilities to provide adequate testing for

¹⁴¹ Katharine Houreld and others 'Understanding COVID-19: Virus exposes gaping holes in Africa's health system' *Reuters Graphics* (7 May 2021) <<https://graphics.reuters.com/HEALTH-CORONAVIRUS/AFRICA/yzdpxoqbvdx/>> accessed 10 September 2021.

¹⁴² Lara Adejoro, 'Lagos spends N.1m daily on each mild-to-moderate COVID-19 patient - Commissioner' *Punch Healthwise* (23 July 2020) <<https://healthwise.punchng.com/lagos-spends-n-1m-daily-on-each-mild-to-moderate-covid-19-patient-commissioner/>> accessed 15 September 2021.

¹⁴³ Katharine Houreld and others 'Understanding COVID-19: Virus exposes gaping holes in Africa's health system' *Reuters Graphics* (7 May 2021) <<https://graphics.reuters.com/HEALTH-CORONAVIRUS/AFRICA/yzdpxoqbvdx/>> accessed 10 September 2021.

¹⁴⁴ Ibid.



'My name is Chinuso Harry. I am six years old. I have a brother, Emeka Harry who is six years old. We live in the Soku community. It has been very difficult for my family, especially my brother and me, since the start of the COVID-19 pandemic. We were both attending St Andrew's government primary school, but we had to stop schooling because it is hard for us to feed. Both of our parents are old. Sometimes Dad will return home with nothing because the job is not constant. My brother and I can't watch our parents starve to death, we needed a solution not minding our age. So, we started fishing and catching crabs.'

Chinuso Harry, Port Harcourt

(Credit: photo and narrative by Henry Dickson)

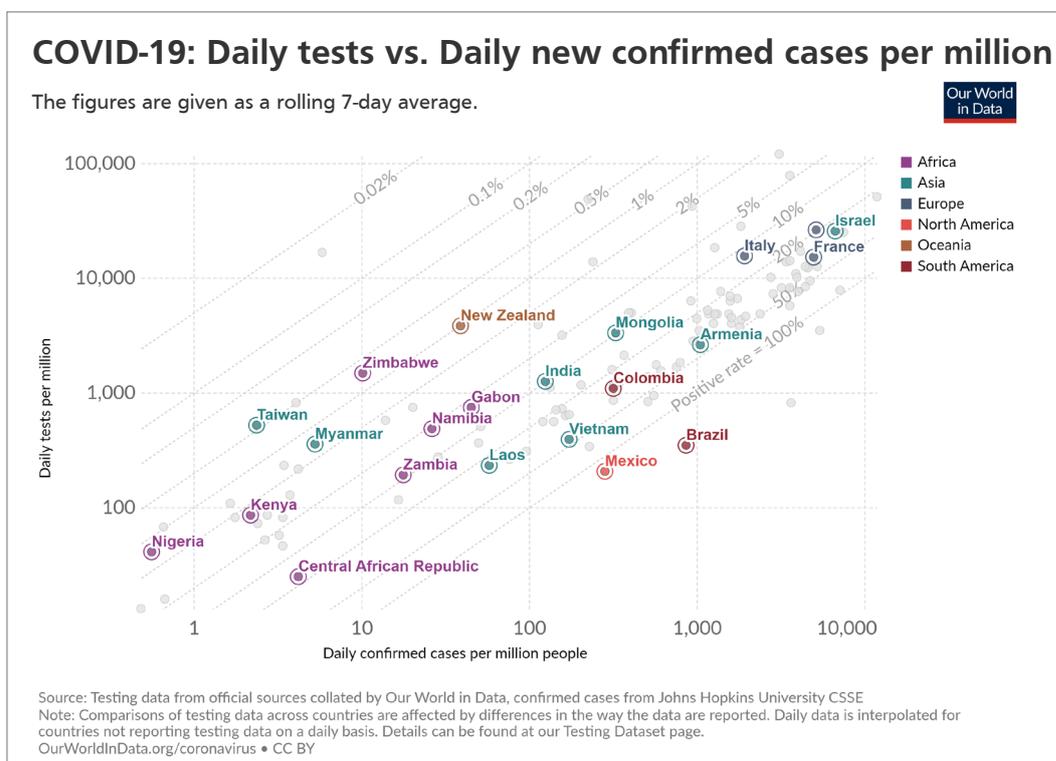
Read more at: [Corona Diaries of the Urban Poor, Justice & Empowerment Initiatives](#)

COVID-19. As of November 2021, the official website of the Ministry of Health in Nigeria lists only 84 public laboratories in 32 out of 34 Nigerian states, to which the private sector only adds 59 fee-paying private laboratories and 9 corporate laboratories for the whole country.¹⁴⁵ The lack of available testing facilities has resulted in extremely low rates of testing for COVID-19, undermining a key tool in efforts to combat the virus. As of October 2021, Nigeria had conducted only 0.04 COVID-19 tests per 1000 people, compared to 0.08 in Kenya, 0.12 in Ghana and 0.51 in South Africa, and far below 4.57 in Italy or 3.88 in the USA.¹⁴⁶ As of October 2021, Nigeria was amongst the countries in Africa and the world doing the least tests compared to the spread of the COVID-19 outbreak (figure 5). This also shows that the true extent of the pandemic might be largely underestimated in Nigeria, as discussed above.

¹⁴⁵ The Nigeria Centre for Disease Control, COVID-19 *Microsite* (2021) <<https://covid19.ncdc.gov.ng/laboratory/>> accessed 03 December 2021.

¹⁴⁶ Our World in Data, *Daily COVID-19 tests per thousand people* (2021) <<https://ourworldindata.org/coronavirus/country/nigeria>> accessed 14 October 2021.

Figure 5: Daily COVID-19 tests per thousand people, selected countries (as of October 2021)



Source: Image customised and downloaded from Our World in Data, Our World in Data, 'Daily COVID-19 tests per thousand people' <https://ourworldindata.org/grapher/positive-rate-daily-smoothed>

2. Discrimination and inequality in a marketised healthcare system.

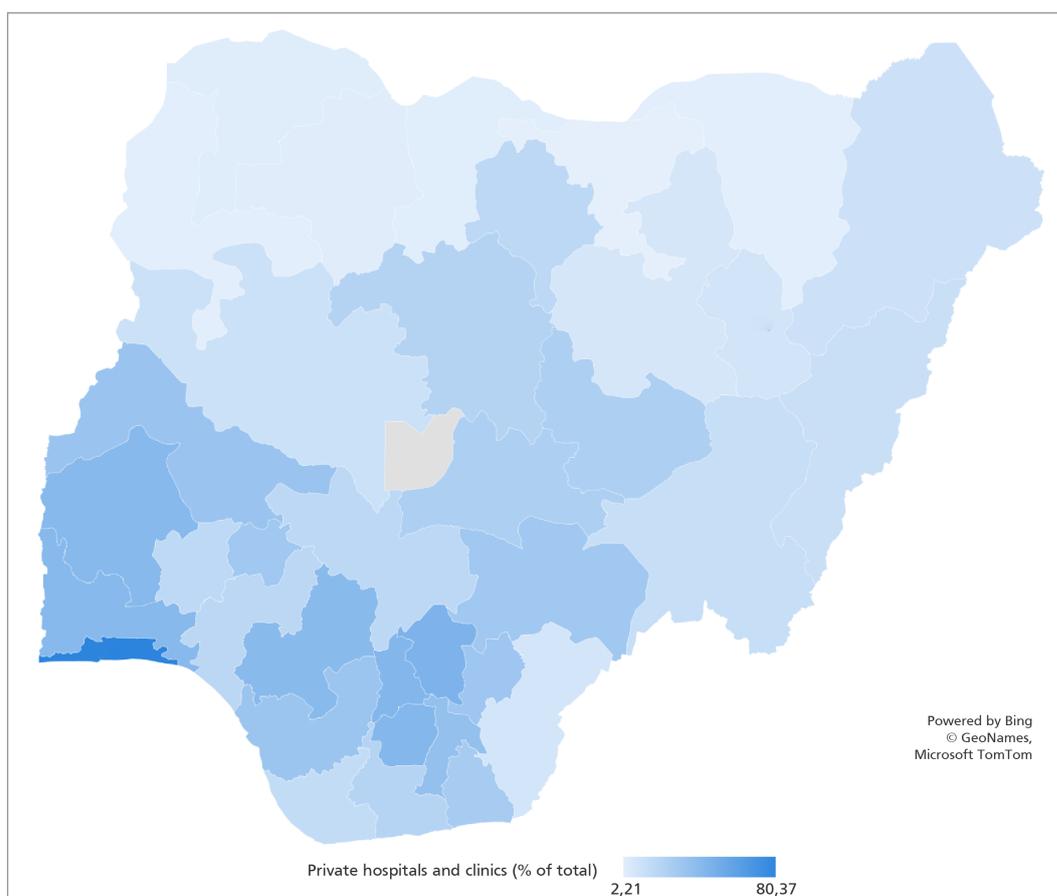
Everyone has a right to access healthcare without discrimination. Under human rights law, States have the obligation to ensure everyone can access similar quality of healthcare regardless of their socioeconomic status, disability, gender, age or any other status. Equality has to be guaranteed in form and substance by eliminating *de jure* and *de facto* barriers to enjoy the right to health.

The lack of availability of public healthcare services is combined with a widespread inequality in accessing medical services, whether public or private. This inequality is inherent to the overall marketised healthcare system as it has grown in the country, which has turned into a two-tier approach, where access to care, and thus survival and dignified life, is highly dependent on one's social and economic status.

The private healthcare sector, which provides an estimated 60% of health services in the country, offers both the best and the worst healthcare. Some private hospitals and

clinics in major cities, such as Lagos, serve the upper-income groups by delivering relatively higher standards of medical care with well-trained staff.¹⁴⁷ However, most private healthcare actors appear to be at the lowest end of the quality spectrum, employing unqualified and untrained staff in informal, often unregistered, facilities.¹⁴⁸ The latter are the services most likely used by those living in poverty in low- and middle-income countries, as it has been documented by Oxfam in 2009.¹⁴⁹

Figure 6. Distribution of private healthcare provision in Nigeria, (private clinics and hospitals, % of total)



Source: Own elaboration on data from the Nigeria Health Facility Registry (HFR), <https://hfr.health.gov.ng/statistics/tables>. Data for this map can be downloaded [here](#).

The relatively better quality, formally registered private healthcare providers are also unequally distributed across the country. This inequality mirrors the long-standing

¹⁴⁷ Jeff Barnes, Taara Chandani, and Rich Feeley, *Nigeria Private Sector Health Assessment* (2008) <https://www.shopsplusproject.org/sites/default/files/resources/5137_file_FINAL_Nigeria_Private_Sector_Health_Assessment_rev.pdf> accessed 26 October 2021, p. 15.

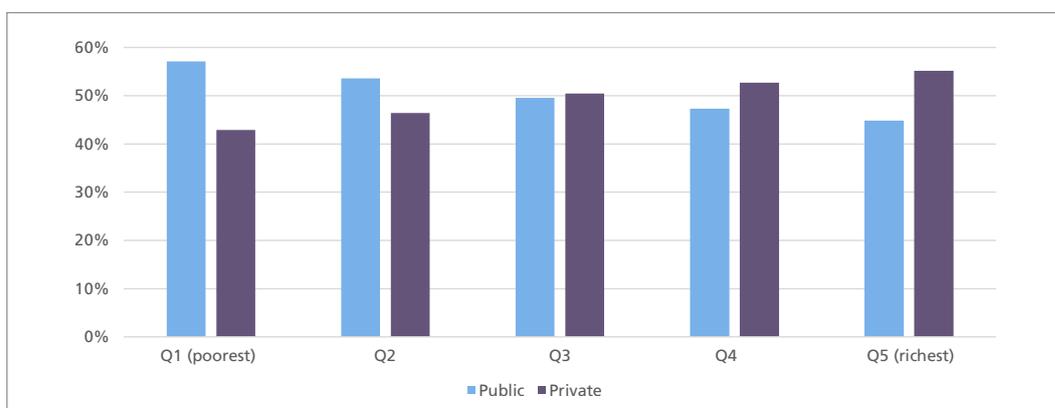
¹⁴⁸ Ibid.

¹⁴⁹ Anna Marriott, 'Blind Optimism: Challenging the Myths about Private Health Care in Poor Countries' *Oxfam* (February 2009) <<https://policy-practice.oxfam.org/resources/blind-optimism-challenging-the-myths-about-private-health-care-in-poor-countries-114093/>> accessed 28 October 2021.

North-South socio-economic gap. The wealthier Southern regions¹⁵⁰ have considerably higher concentrations of private healthcare providers – of those that can be found on the official list of Nigeria’s Ministry of Health (Figure 6). The highest peaks are in Lagos (80%) and Imo (43%). By contrast, private health actors are far less present in the North, with percentages as low as 3% in Yobe. This suggests that formally registered private health providers, which might also be of higher quality, tend to concentrate their operations where profit chances are higher - which is a dynamic that is expected and that has been observed in other sectors and countries, such as education in Morocco¹⁵¹ and Ghana.¹⁵²

The two-tier unequal health system in Nigeria is not only visible in the unequal access to formal private facilities, but also through the differential access to the public system. As shown in Figure 6, people from disadvantaged socioeconomic groups look for medical assistance in public facilities relatively more than the well-off. An explanation for this dynamic might be the difference in healthcare costs: the National Health Policy (2016) mentions the ‘unaffordability of services provided by the private sector to the poor’¹⁵³ as one of the main challenges within Nigeria’s healthcare system.

Figure 7. Where individuals look for medical care (%), by wealth quintile



Source: WHO Global Health Observatory data, <https://www.who.int/data/gho>. Data are available [here](#).

Finally, less than 10% of Nigeria’s population is subscribed to any form of healthcare insurance,¹⁵⁴ meaning that almost all Nigerians pay out-of-pocket at the point of use

¹⁵⁰ Zuhuman Dapel, ‘Poverty in Nigeria: Understanding and Bridging the Divide between North and South’ *Center for Global Development* (6 April 2018) <<https://www.cgdev.org/blog/poverty-nigeria-understanding-and-bridging-divide-between-north-and-south>> accessed 23 August 2021.

¹⁵¹ GI-ESCR, *Private actors in Education and Morocco* (2021) <<https://www.gi-escr.org/private-actors-social-services/morocco>> accessed 12 November 2021.

¹⁵² GI-ESCR, *The UN asks Ghana to explain itself on privatisation* (24 October 2021), <<https://www.gi-escr.org/latest-news/the-un-asks-ghana-to-explain-itself-on-privatisation-in-education>> accessed 12 November 2021.

¹⁵³ Federal Ministry of Health, *Revised National Health Policy* (2016) <https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/nigeria/draft_nigeria_national_health_policy_final_december_fmoh_edited.pdf> accessed 26 October 2021.

¹⁵⁴ WHO, ‘WHO supports Government to monitor health inequities amidst COVID-19 response’ (2021) *WHO Nigeria* <<https://www.who.int/nigeria>>



for the medical services that are not free (i.e. fee-charging medical treatments at either public or private facilities) resulting in access barriers, medical debt, unexpected health-care costs and higher socioeconomic health inequalities.

Inequalities in accessing healthcare have been evident during COVID-19 as well. First, access to testing for COVID-19 is largely dependent on a persons' socioeconomic background. Even if testing for suspected COVID-19 cases is provided for free at NCDC-accredited testing centres, there were only 83 public testing laboratories as of November 2021, in 32 out of 36 federated states, for a population of over 200 million inhabitants.¹⁵⁵ This is clearly not enough as it evidenced by reports in the media that several public health facilities redirect suspected COVID-19 cases, including with visible symptoms, to fee-paying laboratories due to lack of capacity and corruption.¹⁵⁶ As a result, delays in testing and release of results of up to two weeks have been very common.¹⁵⁷ The alternative is fee-charging laboratories, which charge as high as 50,400 naira (132 USD) per test. Some private providers also add extra-fees for 'logistics',¹⁵⁸ up to between 60,400 and 100,400 naira (159 – 264 USD) for a COVID-19 test, which is approximately two to three times more than the monthly minimum wage in Nigeria.

Second, inequalities are also rampant in access to COVID-19 treatment. Patients can obtain COVID-19 medical care either in designated public isolation centres or in private hospitals. Nevertheless, public facilities are relatively few and are accessible only holding a valid COVID-19 test, which is very difficult to obtain due to the challenges discussed above. Therefore, many Nigerians seek private healthcare for even severe COVID-19 infections at very high costs.¹⁵⁹ One patient shared how he spent 6-million-naira (approximately 14631,29 USD) while being treated for COVID-19 at a private facility.¹⁶⁰ These costs are especially concerning considering the widespread practice of illegally detaining patients, including women and their new-borns, over unpaid medical bills in Nigeria's healthcare facilities.¹⁶¹

[afro.who.int/news/who-supports-government-monitor-health-inequities-amidst-covid-19-response](https://www.afro.who.int/news/who-supports-government-monitor-health-inequities-amidst-covid-19-response) accessed 27 October 2021.

¹⁵⁵ The Nigeria Centre for Disease Control, *COVID-19 Microsite* (2021) <<https://covid19.ncdc.gov.ng/laboratory/>> accessed 3 December 2021.

¹⁵⁶ Kehinde Ogunyale, 'Updated - Investigation: How public laboratories redirect suspected COVID-19 patients to fee-charging private labs' <<https://www.premiumtimesng.com/news/top-news/453307-updated-investigation-how-public-laboratories-redirect-suspected-covid-19-patients-to-fee-charging-private-labs.html>> *Premium Times Ng* (5 April 2021) accessed 25 October 2021.

¹⁵⁷ Ibid.

¹⁵⁸ Punch, 'Lagos' laboratories accredited for COVID-19 testing charge extra fees ranging from N10,000 to 50,000' *Punch.ng* (12 July 2020) <https://punchng.com/lagos-laboratories-accredited-for-covid-19-testing-charge-extra-fees-ranging-from-n10000-to-n50000/> accessed 26 October 2021.

¹⁵⁹ Gbadegesin O Alawode and David A Adewole, 'Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers' (2021) 21 *BMC Public Health* 124.

¹⁶⁰ Premium Times NG, 'How I spent over N6 million treating COVID-19 – Pete Edochie's son' *Premium Times NG* <<https://www.premiumtimesng.com/entertainment/naija-fashion/485711-how-i-spent-over-n6million-treating-covid-19-pete-edochies-son.html>> (19 September 2021) accessed 7 October 2021.

¹⁶¹ BBC Africa, 'The Nigerian Patients being held over unpaid bills (22 November 2018) <https://www.bbc.com/news/av/world-africa-46291289> accessed November 2021.





'My name is Babundo Ndubuisi and I live in the Igboese community. When I am sick, I usually go to the hospital. But since the COVID-19 pandemic, I am not going to hospitals as I don't have the money and the hospital that is nearby is a private hospital, so I can't afford to pay the bill. That is why whenever I am sick, I take herbs at the bush and find relief and cook it and drink, and I'll be okay. To get the vaccine they say we have to go to the general hospital in the district of Apapa, Lagos. The transportation to get there is very expensive. Whenever I can afford it, I would go and take the vaccine. If they can be able to bring it here, it would be better, we need it.'

Ms Babundo Ndubuisi, Lagos

(Credit: photo by the media team at Justice & Empowerment Initiatives, narrative by GI-ESCR)

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Third, the most marginalised people are most at risk of being left behind in accessing COVID-19 vaccinations.¹⁶² The Lagos government for instance announced on October 2021 that it has included 400 private health providers in COVID-19 vaccination delivery.¹⁶³ While the COVID-19 vaccine is freely available at public health facilities, in private facilities it is available at an administrative cost of 6,000 naira (15 USD) per dose.¹⁶⁴ Other Lagos residents, however, are experiencing difficulties in accessing vaccines at public health centres. Olubunmi Adeyanju, a petty trader who tried to get vaccinated at several public health facilities, declared: *'We were told that vaccines were not available. I went back the next day and the day after, it was the same experience. Some people I met there suggested that we should go to the private hospital to get the vaccine, but how do I raise the administrative fee from the little profit I make from my petty trade?'*¹⁶⁵ The situation is even worse for those living in poverty in Lagos' urban informal settlements, who might not afford to travel or face difficulties navigating the health system. This is confirmed by the interviews we conducted in Lagos urban informal settlements.

Fourth, the pandemic is prompting collateral damage on access to healthcare services in general. For instance, barriers in accessing COVID-19 testing also indirectly affects

¹⁶² Updated information on vaccination sites in Nigeria can be found here: National Primary Healthcare Development Agency, *Vaccination Portal* (2021) <https://nphcda.vaccination.gov.ng/vaccination-sites> accessed 1 November 2021.

¹⁶³ Moojed Alabi, 'COVID-19: Vaccination to cost N6,000 in Lagos as state-owned centre charges N350,000 per day for treatment' *Premium Times Ng* (28 October 2021) <<https://www.premiumtimesng.com/news/headlines/492149-covid-19-vaccination-to-cost-n6000-in-lagos-as-state-owned-centre-charges-n350000-per-day-for-treatment.html>> accessed 29 October 2021.

¹⁶⁴ Ibid.

¹⁶⁵ Agency Report, 'COVID-19: Lagos residents complain of challenge accessing vaccination' *Premium Times Ng* (3 November 2021) <<https://www.premiumtimesng.com/regional/south-west/493237-covid-19-lagos-residents-complain-of-challenge-accessing-vaccination.html>> accessed 4 November 2021.

access to inpatient medical care. This is because most hospitals in Nigeria are requiring proof of a negative COVID-19 test to accept patients for life-saving treatments such as surgery, obstetrical care,¹⁶⁶ and paediatric surgical practice.¹⁶⁷ Academic research has warned that this might lead to additional forms of inequalities in access to medical care.¹⁶⁸ The story of Napoleon, one of the individuals interviewed in Port Harcourt for this report, is a glaring example of how information and technology barriers make access to healthcare services troublesome for those who live in poverty in urban informal settlements amidst the pandemic.



'During the Covid-19 pandemic, people had many health challenges, (...), especially the older ones. One elderly man named Ibori who was 60 years old collapsed in the community. He was rushed to Braith Waith Memorial Specialist Hospital at Forces Avenue, Old GRA, Port Harcourt. However, there was no quick attention, and he died. Another elderly man named Hosiery (aka Abacha) who was 70 years old and ran a small business in the community had a partial stroke due to high blood pressure. He later died due to insufficient medical attention because he lacked money.'

No hospital or health centre attended to patients at that time because they were instructed not to attend to patients due to the lack of equipment to verify patients' Covid-19 status, as they were cautious of their own safety. This included both hospitals and primary health care clinics, such as BMSH, as well as Ken Harrison Hospital at Abakiliki near Emenike, Rumowoji Primary Health Care, and New Mile 1 Hospital at Emenike by Ojoto, all in Mile 1 Diobu area of Port Harcourt.

Yes, the Government did well by putting up an isolation centre for Covid-19 patients. The Government gave palliative based onwards in the local government areas. But what about those who are not participating in politics? They were not beneficiaries of the government palliatives. I urge the government to ensure that people are given more palliatives as some persons have lost their livelihoods, some are beginning life again from the scratch, as their savings are exhausted.'

Mr Napoleon Amoni, Port Harcourt

(Credit: photo and narrative by Henry Dickson)

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¹⁶⁶ AbdulHafiz Oladapo Adesunkanmi and others, 'Impact of COVID-19 on the Cost of Surgical and Obstetric Care: Experience from a Nigerian Teaching Hospital and a Review of the Nigerian Situation' (2020) 37 The Pan African Medical Journal 15.

¹⁶⁷ Ibukunolu Olufemi Ogundele and others, 'Early Impact of COVID-19 Pandemic on Paediatric Surgical Practice in Nigeria: A National Survey of Paediatric Surgeons' (2020) 4 BMJ paediatrics open e000732.

¹⁶⁸ Ibid.



'During the COVID-19 pandemic, my only source of income was shut down and, because of it, I went into fishing to just survive. I felt sick during that stressful period, but I was not able to go to the health clinic because I did not have money to deposit before a doctor could attend to me.'

Mr Soso Braide, Port Harcourt

(Credit: photo and interview by John Wellington Miller)

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Finally, as resources are diverted to COVID-19 services, other medical treatments are disrupted or downsized. This disproportionality impacts the marginalised groups, such as the chronically ill. A vivid example of this are some stories collected by the news amidst the pandemic, such as the testimony of an HIV-positive 35-year-old woman from Abuja, who recalls skipping her medication due to the lockdowns: *'During this COVID-19 pandemic, I had serious challenges getting access to health care, especially my daily medication. Due to the lockdown, moving around was difficult as well as getting to the hospital.'*¹⁶⁹

Private healthcare did not solve her situation: *'I go to a private clinic. At some point, I could not see a doctor at all, the nurses and the doctors have gone to isolation centres or are doing some COVID-19 related engagements.'*¹⁷⁰ Likewise, a diabetic woman from Abuja also laments how she struggled financially during the pandemic to afford medical services: *'I missed my routine blood sugar testing during the pandemic as I was not able to go to work, I couldn't make money to afford the tests.'*¹⁷¹

The widespread impact of the pandemic on access to healthcare services, with the most disadvantaged being left behind, is once again shown by the testimonies collected in Lagos and Port Harcourt for this report, such as the story shown in the box.

The COVID-19 pandemic impacted other medical services also through lockdowns, restriction of movement and fear of police harassment, especially for those living in urban informal settlements. Women have suffered disproportionately, as it emerged from the interview collected in Lagos and Port Harcourt, including severe barriers in obtaining general as well as sexual, reproductive and maternal care, as exemplified by the words of Mrs Victor, a woman living in an informal settlement in Port Harcourt.

¹⁶⁹ WHO, 'WHO supports Government to monitor health inequities amidst COVID-19 response' (15 April 2020) <<https://www.afro.who.int/pt/node/14394>> accessed 20 January 2022.

¹⁷⁰ Ibid.

¹⁷¹ Ibid.



'I am Mrs Victor. I live in Nanka community, Port Harcourt. During last year outbreak Covid-19, many people really fell sick. Their experience was too bad, and most people did not go to any health clinic because they were afraid of being quarantined. Also, there was not enough money to go to the hospital. Therefore, many people only went to the medicine shop to get some drugs.'

My neighbour, Ms Ifeoma, wanted to go to a health centre, but due to restriction of movement, she could not. Even some pregnant women on my street found it difficult to go for their normal check-ups because of police harassment. My younger sister had a miscarriage, and it was very difficult rushing her to the health clinic due to roadblocks and police everywhere.'

Mrs Victor, Port Harcourt

(Credit: photo and interview by Ruth Samuel, narrative by GI-ESCR)

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Other people that have been particularly hit during the pandemic are those with disabilities as well as those that face technology barriers when seeking medical attention. Mr Mohammed Zanna's story, collected in Lagos, illustrates the impacts of these multiple healthcare access barriers.

'I have been sick for around two or three weeks now. A couple of days ago, one of our colleagues tested positive for COVID-19. So, I tried to get tested for COVID-19 and I went to Melan hospital yesterday, in Lagos. They said I have to register online, but I don't have access to any facility where I can log in and register online. I am disabled. There are many other people who have no access to facilities where they can go online.'

Being computer illiterate should not hinder access to COVID-19 testing because, at the end of the day, it's about protecting the larger society and getting everybody protected. It's not an individual issue, it's a societal issue. It's important that the government provides facilities that can assist the urban poor to assess COVID-19 cases in settlements.'

Mr Mohammed Zanna, Lagos

(Credit: photo and interview by the media team at Justice & Empowerment Initiatives, narrative by GI-ESCR)

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**PUBLIC NOTICE:
COVID-19 OFFICE USE PROC**
Issued: 27 December 2020
To assist in curbing the risk of transmission of the following protocols for our Lagos State:
1. Everyone must wear a face mask and use hand sanitiser frequently, especially in public settings.
2. Everyone must wash their hands at the facilities around the office and any time.
3. Everyone must have their temperature taken at a temperature of 37.3°C or higher.
4. Everyone must maintain social distance (at least 1 metre) at all times.
5. Everyone must avoid close contact with anyone displaying any signs or symptoms of COVID-19.
6. All windows must be kept open.
7. Everyone who has COVID-19 symptoms or has tested positive for COVID-19 must self-isolate and avoid public places.
8. Everyone who is unable to self-isolate and who needs medical attention, can register for a COVID-19 test.
9. Everyone is urged to continue to follow the above protocols.
For helping to need

3. Weak regulation and quality monitoring of private health-care providers

Under human rights law, States have an obligation to protect everyone's right to health when non-State actors provide medical services or are involved in other forms of activities related to healthcare. This means that States have to enact clear regulation and monitoring frameworks and implement them ensuring their realisation in practice, such as through quality assurance.

Even if the legal framework on regulating private health providers has been recently clarified in Nigeria, implementation is still weak.¹⁷² Furthermore, some federated states implement regulation better than others, with huge differences across the country.¹⁷³ Episodes of medical malpractice amidst the COVID-19 pandemic provide yet another example of the need for stricter regulation and monitoring. A report by an investigative journalist revealed that several private laboratories are issuing fake positive COVID-19 tests by paying 3,000 naira (7.30 USD).¹⁷⁴ The students interviewed by the investigative journalist declared: *'I don't even know the actual person who did the result, I just paid to a friend who works in a laboratory and then I got the result.'*¹⁷⁵

Private hospitals treating COVID-19 cases while unlicensed to do so is another example of insufficient regulation. At the beginning of the pandemic, the Nigerian Medical Association advised against using private hospitals to treat COVID-19 patients over concerns of limited capacities for infection control,¹⁷⁶ including because this might lead to uncontrolled community spread of the virus as well as endangering the lives of healthcare workers.¹⁷⁷ Consistently, the federal government did not allow private healthcare providers to treat COVID-19 cases.¹⁷⁸ Nevertheless, in Lagos State, six hospitals were found to treat COVID-19 patients without government approval.¹⁷⁹ Likewise,

¹⁷² Angela Onwuzoo, 'Six years after enacting National Health Act, many provisions not implemented' *Punch HealthWise* (16 February 2020) <<https://healthwise.punchng.com/six-years-after-enacting-national-health-act-many-provisions-not-implemented/>> accessed 15 November 2021.

¹⁷³ Atsumi Hirose and others, 'Technical Quality of Delivery Care in Private- and Public-Sector Health Facilities in Enugu and Lagos States, Nigeria' (2018) 33 *Health Policy and Planning* 666.

¹⁷⁴ Ope Adetayo, 'Why are Nigerians paying for fake COVID-19 tests results?' *Al Jazeera* (1 October 2021) <<https://www.aljazeera.com/economy/2021/10/1/why-are-nigerians-paying-for-fake-covid-test-results>> accessed 12 October 2021.

¹⁷⁵ Ibid.

¹⁷⁶ News Agency of Nigeria, 'NMA advises Lagos govt against treating coronavirus patients in private hospitals' *Pulse.ng* (17 April 2020) <<https://www.pulse.ng/news/local/nma-advises-lagos-govt-against-treating-coronavirus-patients-in-private-hospitals/r5nx3zw>> accessed 26 October 2021.

¹⁷⁷ Sahara reporters, 'Six Private Hospitals in Lagos Secretly Treating COVID-19 Patients Revealed' *Sahara Reporters* (2 April 2020) <<http://saharareporters.com/2020/04/20/six-private-hospitals-lagos-secretly-treating-covid-19-patients-revealed>> accessed 11 August 2021.

¹⁷⁸ Jimoh Amzat and others 'Coronavirus outbreak in Nigeria: burden and socio-medical response during the first 100 days' (2020) *Int J Infect Dis.* 2020;98: 218-224.

¹⁷⁹ Akinola Ajibola, 'About 40 Health Workers Tested Positive for COVID-19, Says Ehanire' *ChannelsTV.com* (23 April 2020) <<https://www.channelstv.com/2020/04/23/breaking-about-40-health-workers-tested-positive-for-covid-19-says-ehaniire/>> accessed 11 August 2021.



in Delta State, the Government closed an unlicensed private hospital for treating two COVID-19 cases while being unauthorised to do so.¹⁸⁰

4. Lack of quality of private health providers

Human rights law guarantees everyone the right to the highest possible physical and mental health standard. This includes access to healthcare, which is scientifically and medically appropriate, as well as of good quality. Good quality means, *inter alia*, that healthcare services must be provided through skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.¹⁸¹

Nigerian private health providers are often far from international human rights standards. Well before the pandemic, a systematic review found that diagnostic accuracy and adherence to medical standards were worse in private rather than public sector providers across a range of developing countries, including Nigeria.¹⁸² By the same token, a study conducted in South-Western Nigeria found that public health providers were significantly more likely to use rapid malaria diagnostics and the recommended combination therapies than private providers.¹⁸³ Further academic research yields that poor adherence to guidelines in prescription practices in the private sector has been associated with a rise in drug-resistant malaria in Nigeria.¹⁸⁴ Another scientific article also reported the widespread use of ineffective therapies for malaria in the country's private health sector.¹⁸⁵

Beyond malaria, similar evidence has been found in the field of sexual and reproductive care. Data by the Nigeria Demographic Health Survey (from 2003 and 2013)¹⁸⁶ show that users are twice as likely to receive information about side-effects of contraceptive methods in public rather than private facilities (Table 1).

¹⁸⁰ Paul Olayemi, 'Delta state government seals hospital for admitting two COVID-19 patients' *Vanguard* (8 June 2023) <https://www.vanguardngr.com/2020/06/delta-state-govt-seals-hospital-for-admitting-two-covid-19-patients/> accessed 11 August 2021.

¹⁸¹ CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health' (adopted on 11 August 2020) E/C.12/2000/4.

¹⁸² Sanjay Basu and others, 'Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review' (2012) 9 *PLoS Medicine* e1001244.

¹⁸³ Benjamin SC Uzochukwu and others, 'Examining Appropriate Diagnosis and Treatment of Malaria: Availability and Use of Rapid Diagnostic Tests and Artemisinin-Based Combination Therapy in Public and Private Health Facilities in Southeast Nigeria' (2010) 10 *BMC Public Health* 486.

¹⁸⁴ Grace O Gbotosho and others, 'Potential Contribution of Prescription Practices to the Emergence and Spread of Chloroquine Resistance in South-West Nigeria: Caution in the Use of Artemisinin Combination Therapy' (2009) 8 *Malaria Journal* 313.

¹⁸⁵ Roger Bate and others, 'Antimalarial Drug Quality in the Most Severely Malarious Parts of Africa – A Six Country Study' (2008) 3 *PLoS ONE* e2132.

¹⁸⁶ National Population Commission (NPC) and ORC Macro, *Nigeria Demographic and Health Survey 2003* (2004) <<https://www.dhsprogram.com/pubs/pdf/FR148/FR148.pdf>> accessed 29 October 2021; National Population Commission (NPC) and ORC Macro, *Nigeria Demographic and Health Survey 2014* (2015) 102 <<https://dhsprogram.com/pubs/pdf/fr293/fr293.pdf>> accessed 29 October 2021.



Table No. 1: Informed choice on contraception in public and private sectors.

	Informed about side effects		Informed what to do in case of side effect		Informed about other methods	
	2003	2013	2003	2013	2003	2013
Public sector	64.5%	75.5%	60.3%	72.1%	69.5%	80.1%
Private sector	36.1%	47.1%	34.8%	39.6%	46.6%	51.9%

Data source: cross-sectional Nigeria DHS surveys (2003, 2013).

The lack of quality in a large part of private sector provision also complicated the response to the pandemic. It has been already discussed that private providers were initially not allowed to treat COVID-19 cases because authorities were concerned of their quality, and that this translated in empty beds and unused capacity when it was most needed. Likewise, an academic study found that the private healthcare sector in Edo State was poorly equipped to provide screening services for COVID-19 based on a range of quantitative indicators.¹⁸⁷

In Enugu State, the Medical Laboratory Science Council of Nigeria has sealed down three private laboratories over quality problems during the pandemic, including one molecular laboratory providing COVID-19 test.¹⁸⁸ These private labs were closed due to expired products usage, quack personnel, deceitful practices and because they were operating without required certificates, which, in turn, raised concerns over the reliability of test results.¹⁸⁹

The story of a 16-year-old boy interviewed in Port Harcourt best exemplifies the issue of the lack of quality of private healthcare providers used by those living in poverty.

¹⁸⁷ Darlington Ewaen Obaseki and others, 'Mainstreaming the Private Health Sector in the Response to COVID-19: Facility Readiness assessment for Screening Services in Edo State, Nigeria' (2020) 35 *The Pan African Medical Journal* 93.

¹⁸⁸ National, 'COVID-19: Enugu lab shut for sharp practices' *National* (29 October 2021) accessed 31 October 2021 <<https://www.sunnewsonline.com/covid-19-enugu-lab-shut-for-sharp-practices/>> accessed 20 December 2021.

¹⁸⁹ *Ibid.*



'My name is Precious Daniel. I am 16 years old. We are nine in the family. My dad died when I was 11 years old, so it's just mom taking care of the family by selling fish. After school, I assist my mom in selling at the market.'

Last year during the COVID-19 outbreak, the lockdown was so sudden and unexpected. Things became so difficult. We barely had what to feed on since our survival was based on selling fish. There was no one to seek assistance from, since it was a general pandemic that affected everyone. Because of depression, my mom got sick in May last year and couldn't move her feet or speak loudly.

During the early stage of her depression, she always cried and lamented on how to take care of our feeding, house rental and other essential needs without selling fish in the market. Due to lack of finance, medication was given to her by various local traditional attendants but there was no improvement. We took her to a nearby private hospital, but she was not given proper medication.

If there's money, we will take her to the Universal of Port Harcourt Teaching Hospital in Port Harcourt for medical tests and intensive treatments. Her health condition has made me drop out of school since I have to take over the family business for our survival.

I'm afraid of COVID-19. It's real and has been killing many lives. Although I have not seen any person infected or sick person with it. But I do see it on television and listen to it on the radio too. I'll love to be vaccinated if opportune.'

Precious Daniel, Port Harcourt

(Credit: photo and narrative by Jonah Sunday. Narrative slightly edited by GI-ESCR.)

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5. Concluding observations

This report shows that the commercialisation of healthcare services is widespread in Nigeria. However, the long-standing public health challenges in the country are being exacerbated, rather than eased, by reliance on the private sector's commercial solutions for healthcare delivery. Corroborating previous findings on other Sub-Saharan African countries,¹⁹⁰ this report documents that the private healthcare charges fees that are prohibitively expensive for many, even for essential and everyday care. Likewise, the report shows that the private health private sector is of vastly varying quality, with most facilities, especially those that are the only private choices for people living in poverty, being substandard. This fragmented health system, which is organised as a quasi-free market, is difficult to navigate and encourages competition rather than solidarity. As a result, access to quality healthcare is largely dependent on socioeconomic status, which influences both the capacity to pay for healthcare costs and access to information. The national insurance scheme does not redress these inequalities: enrolment in the voluntary national insurance scheme is extremely low, with only 5% of Nigerians registered, and it is also skewed, covering mostly workers in the formal sector.¹⁹¹ In other words, healthcare resembles much more a commodity rather than a fundamental human right in the country.

This health system is facing several difficulties in delivering on the right to health in the context of the COVID-19 pandemic. First, Nigeria lacks universal, public healthcare services to respond to public health emergencies such as epidemics, with critical shortages of health facilities, staff and medical equipment necessary to provide COVID-19 treatments, testing and vaccination to its population of 206 million. Second, the report identifies numerous types of barriers in accessing healthcare at times of COVID-19, including financial, technology, transportation and information barriers. The most marginalised groups not only face disproportionate obstacles in obtaining timely COVID-19 medical services but are also more exposed to the collateral damage of the pandemic on access to all medical services, as the healthcare system struggles to respond to the emergency.

Third, the report finds that regulation and monitoring of private health providers by authorities are insufficient. It lays out several cases of private clinics and hospitals not complying with scientifically appropriate medical standards and practices during the

¹⁹⁰ Sanjay Basu and others 'Comparative performance of private and public healthcare systems in low-and middle-income countries: a systematic review' (2012) *PLoS medicine* 9, no. 6 e1001244.

¹⁹¹ Gbadegehin O Alawode and David A Adewole, 'Assessment of the Design and Implementation Challenges of the National Health Insurance Scheme in Nigeria: A Qualitative Study among Sub-National Level Actors, Healthcare and Insurance Providers' (2021) 21 *BMC Public Health* 124.



pandemic. It also describes how private facilities were initially not allowed to admit COVID-19 cases for treatment because authorities had concerns over their quality, translating in empty beds and untapped capacity when it was most needed. Fourth, a substantial share of private healthcare providers delivers substandard medical care. Especially in urban informal settlements, low-cost private health facilities are often involved in cases of misdiagnosis, unnecessary treatment, usage of expired drugs and reagents, or employment of untrained and unqualified staff.

Several issues would deserve further research. It would be useful to analyse differences across and within Nigerian federated states. Additional investigation on the conformity of private facilities operation with human rights law and medical ethics would be required to assess the extent of the lack of compliance with regulations. Lastly, the potential role of the NHIF in favouring private interests in healthcare would be an important area of inquiry.

Policy decisions of the last decades have led to a healthcare system in which Nigerians have to rely on expensive, low-quality and fragmented commercialised health provision, where high private-sector participation exacerbates existing health inequalities and challenges. The absence of strong public healthcare services thus leads to an overreliance on the low-quality, inaccessible and unregulated private healthcare sector. While there is no one solution for all contexts, public financing and provision of free, quality healthcare services can be an effective way to realise the right to health for all. This is far from being the case in Nigeria at the moment, as the federal and state governments have not devoted enough resources to build a universal public healthcare system. It is urgent to re-think the current development strategies that encourage, directly or indirectly, the development of healthcare as a market and to change the approach by focusing, instead, on strengthening public healthcare services for all. Only resilient public healthcare can help Nigeria face future pandemics and other shocks such as those that are highly likely to happen in the near future, in the face of the climate crisis.



6. Policy recommendations

From the analysis presented in this report, we make the following recommendations for the federal and state governments, within their respective areas of competencies:

- **Increase governmental funding to health to at least 15% of the budget to meet the Abuja commitment and expand the availability of quality, well-coordinated public healthcare services**

Nigeria is among the African Union States that pledged to raise the proportion of government funding for health to at least 15% of the overall national budget in the 2001 Abuja Declaration.¹⁹² However, Nigeria is still far behind on that target. Authorities should thus consider increasing general government expenditure on health from the current 4.4% share of general government expenditure (as of 2018)¹⁹³ to at least 15%, in line with the Abuja Declaration commitment. Committing more public finances in health would be in line with Nigeria's obligation to invest the maximum of its available resources to ensure that everyone has access to universal, public healthcare services, which is set out in the African Charter on Human and Peoples' Rights and the other international human rights treaties to which Nigeria is a party.

- **Reverse the current policies intended to encourage higher private sector engagement in healthcare**

The 2016 National Health Policy and the National Health Development Plan (2018-2022) set out as a goal the promotion of public-private partnerships in healthcare. As shown in this report, market mechanisms involving competition, that are typically at play in public-private partnerships, fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions in healthcare, which have dangerous impacts on the realisation of the right to health, Nigeria should invest in a strong public healthcare system, that is democratically managed, funded, and delivered by non-commercial actors, and reinforce the public healthcare sector's capacity.

- **Ensure that all healthcare providers are strictly monitored and regulated at the federal, state and local levels**

¹⁹² WHO, *The Abuja Declaration: Ten Years On* (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.

¹⁹³ WHO Global Health Expenditure Database, *Domestic general government health expenditure (% of general government expenditure)* <<https://data.worldbank.org/indicator/SH.XPD.GHED.GE.ZS?locations=NG>> accessed 17 January 2022; see also: BudgIT, 'Nigeria: Health Budget Analysis' (2021) <<https://yourbudget.com/wp-content/uploads/2018/04/Nigeria-Health-Budget-Analysis.pdf>> accessed 25 October 2021.

This report has shown that in practice the quality of private healthcare provision is sometimes very low and not in line with medical standards. Stronger regulatory and monitoring efforts are needed. In particular, the federal, state and local governments should coordinate efforts to ensure that all providers in the country operate under a Certificate of Standards, as provided in the National Health Act (2014), with harmonised eligibility criteria and meaningful follow-up quality monitoring and enforcement.

- **Take concrete steps to ensure universal access to social healthcare insurance or another pre-pooled financing scheme**

This report has highlighted once again that participation in the National Health Insurance Scheme is extremely low, covering mostly some workers in the formal sector. While the existence of programmes targeting the informal sector, individuals living in poverty, and marginalised groups is a positive step, in practice these programmes are poorly implemented, as data on enrolment rates show.



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