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THE DEPRIVATION OF SOCIAL SERVICES TO CITIZENS OF A STATE AS A VIOLATION OF HUMAN RIGHTS

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ABSTRACT
Provision of social services such as food, housing, healthy environment such as water, electricity and sanitation, health services, education and employment, that can ensure a standard of living adequate for the health and well-being of citizens in a country, is a universal human right. They are economic and social rights on their own, and they are also social determinants of the right to health and can be viewed collectively as a right to health. Right to health it is guaranteed in the International Covenant on Economic, and Cultural Rights, and other international instruments. This right is being violated by states, particularly in the West African region. Minimal attention is paid to this violation because globally, people do not realize that this right is a universal right, and they thereby view it as a prerogative of a state, more so as privileges that accrue to citizens of a state. The interesting part of this research is that it links socioeconomic rights to the right to health. The deprivation of social services by a state may have a negative impact on the health of its citizens, thereby making it a violation of the right to health, as well as a violation of socioeconomic rights. Using case studies of three countries in West Africa, this research seeks to find that provision of social services is a major responsibility of states. Therefore, where a state deprives its citizens of such it can be said to be in violation of a universal human right.

Keywords: Human Rights, Health, Economic and Social Rights, Deprivation, Social Services, Poverty, Violation.

INTRODUCTION

The right to social services or economic and social rights is linked with health and can be understood as a right to health. These rights are guaranteed in international laws and treaties such as the International Covenant on Economic, Social and Cultural Rights 1966 and its Optional Protocol 2008, and the Committee on Economic, Social and Cultural Rights, General Comment 14 2000. It is also guaranteed in Regional and Sub-Regional Charters such as the African Charter on Human and Peoples Rights 1981 and the Economic Community of West African States Revised Treaty 1993. It is surprising to note that people are not cognizant of the fact that provision of social services is a human right, being a social and economic right, and a right to health. This could be because these social and economic rights lie solely within the prerogative of the state concerned therefore, the means of enforcing them may seem problematic. It is worthy to note that the provision of social services such as food, housing, healthy environment which includes water, electricity and sanitation, health services, and security, employment, that can ensure a standard of living adequate for the health and well-being of citizens in a country, is a universal human right. They are economic and social rights on their own, and they are also social determinants of the right to health and are therefore intertwined with the right to health, and can be viewed as a right to health. These are rights that should not be neglected but enforced. This

study will focus on the deprivation of social services by states in West Africa, as a violation of human rights. The study will enable us to understand why deprivation of social services is a violation of human rights. The main question this research paper addresses is: "can the deprivation of social services to citizens of a state in the West African region be viewed as a human right violation?

Part I of this study will explore the definition of the key terms used in this paper. I will also review the literature on social services, to create a better understanding of what aspects of social services this study cuts across. This study will further review literature on health and human rights, which will be focused primarily on social and economic rights, and the social determinants of health in relation to the right to health. I will further review the literature on the International, Regional and Sub-Regional laws and institutions that are sources for the right to health and human rights.

Part II of this study will measure the extent of deprivation of social services so that one can know the extent to which you can say that there is a deprivation and therefore, a violation of human right. This study will show the current data on social services in the three countries from West Africa, which I will use for my cross-country comparison. I will compare Gambia, Ghana and Nigeria, from the Western Region of Africa, of which two countries have the largest GDP per capita in the sub-region and one with the lowest GDP per capita. I chose to use West Africa as my area of focus, using Gambia, Ghana and Nigeria as my countries for cross-country comparison, because the African region is known for its devastating social and economic and health conditions.

I further employ a theoretical approach that sees achievement of human rights as the main objective towards the development of a state. In this section I will consider how

compliance with socio-economic rights and right to health can be enforced on violating states. The results of my findings will also be discussed in this sections.

The last part of this study will look at suggestions and/or policy recommendations for how there can be improvement in ensuring that states cease to violate this important right. And then, this study will conclude based on its findings as highlighted above.

CONTEXT

Human rights can be exercised to advance a range of claims, which includes but are not limited to political, social, economic, and cultural claims. However, these claims will be considered from the context of their provision in the international instruments accepted and binding on states. Human rights are inclusive of economic, social and cultural rights and the right to health. These socio-economic rights and the right to health are enshrined in international law, treaties and declarations. All these human rights mechanisms emphasize the importance and protection of human rights as a condition precedent to attaining health and well-being. Social, economic and cultural rights consist of the right to education, right to work and earn a living, right to basic medical services, right to social security, right to fair housing, and right to cultural life (Ocran 2007:2). Economic and social rights are just as important as civil and political rights but more attention is usually given to civil and political rights than to economic and social rights (Agbakwa 2002:178). This is revealed in the number of Human Rights Organizations and Activists, who usually tend to devote much of their resources to civil and political activism,

leaving out right to health challenges which are numerous and pose a threat to humanity (Para.30 Special Rapporteur 2007). A sentence captured in the New African editorial (2009:72) emphasized this line of reasoning when it stated thus: “Economic rights are human rights too but don’t mention it to the human rights NGOs”. It is very intriguing to see that the government as well as human rights organizations now pick and choose which aspect of human right is more important and the rest less important. Another take home caption in the editorial said that “if the Africans were not cheated or denied their economic rights, the continent would have been a better place to live in”. It is important to acknowledge these economic and social right being intertwined with the right to health (Gruskin et al 2007:450).

The ‘right to the highest attainable standard of health’ (or right to health) is firmly enshrined in international law. Article 12 of the International Covenant on Economic, Social, and Cultural Rights (ICESCR) 1966 provides for the right to health and further creates a legal backing for creating a positive impact on the health and well-being of people globally. The Article recognizes that “State Parties to the covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. The ICESCR also contains provisions for social and economic rights. The United Nations Committee on Economic, Social and Cultural Rights (CESCR) provides a candid explanation and a form of implementation of the right to health as contained in the ICESCR by stating in Paras 4 & 11 of the General Comment 14 2000 that the right to health is an “inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health”.

The right to the highest attainable standard of health, just like the economic, social and cultural rights, is dependent on two factors which will be used in this research, progressive realization and resource availability (Hunt and Backman 2008:84). Progressive realization requires states to take measures that would enable them to work progressively towards an effective health system (which includes the underlying determinants) and ensure there is equal access for all. Progressive realization means there should be a progressive movement, and states must at least maintain the present level of enjoyment of the right to health, and not retrogress (Hunt and Backman P.84). Resource availability looks at the resources of the state, therefore, the right to health is viewed as being realistic, demanding more from high income states than low income states. This framework provides a measure for assessing the level of implementation at the state level. Prior to the adoption of the international covenant, states did not feel obligated to fulfill their obligations, as they saw economic, social and cultural rights to represent mere policy goals, giving states the leverage to decide whether to fulfill such obligations (Riedel 2009:29). Notwithstanding the provision for socio-economic right and the right to health in the international covenants, few states still do not recognize them as fundamental rights in their constitutions. These rights are still listed as state policy directives, while some states do not recognize the right in whatever form, in their constitution (Kinney 2001:1465). To measure whether a state is moving progressively towards an effective health system, indicators such as the Human Development Index and benchmarks to access states' compliance with the international instruments are used, which will be used in this paper. Resource availability is measured considering the Gross Domestic Product (GDP) of the state, whether the amount allocated towards the realization of this right corresponds with its GDP. This is provided in Article 2 of the ICESCR. Furthermore, Para.3 of the CESCR General Comment 3 1990 states

that the means that would be used satisfy the obligations in Article 2 of the ICESCR will be to take "all appropriate means, including particularly the adoption of legislative measures". Para.5 states further that "among the measures which might be considered appropriate, in addition to legislation, is the provision of judicial remedies with respect to rights which may, in accordance with the national legal system, be considered justiciable". It therefore signifies that states ought to go beyond the ratification of the treaties to including it in national laws and providing ways that violations can be addressed nationally. Para. 2 of CESCR General Comment 9 states that "the Covenant norms must be recognized in appropriate ways within the domestic legal order".

The continuous lack of access to health care and health systems for people living in developing countries constitutes a violation of human rights (Gruskin et al 2007:449). In Africa, the deprivation of basic social services to citizens by states is very common, and this deprivation amounts to a violation of their socio-economic rights. These violations also affect the right to health, having a direct impact on their health. The deprivation of social services and/or socio-economic rights is often a consequence of poverty, which affects the right to health. The impact of poverty on health is not just based on the lack of access to health services but due to the lack of other factors known as the social/underlying determinants of health, which consists of the conditions of daily life. These conditions impact on health as well as the lack of access to health care does. (Toebes et al 2014:27). In African regions, it is common to find dilapidated infrastructure, poorly staffed hospitals, and inadequate Medical care (Toebes et al 2014:9). Toebes et al (2014:23) further assert that "poverty is evident in homelessness, inadequate housing, unsafe environment, social discrimination and other vices which contribute to poor health". Article 25 of Universal Declaration on Human Rights (UDHR) 1948 asserts that "everyone has the right to a standard of living adequate for the health and well-being of himself

and of his family, including food, clothing, housing and medical care and social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control". It therefore means that if poverty or outright deprivation of these services deprive a person of enjoying this right, then poverty and such deprivation is a denial of human rights, which further affects health and well-being. Ill health is often caused by poor living conditions, which includes unhealthy environment, unsafe water, inadequate food, housing, poor work conditions and unemployment.

This research seeks to show that the deprivation of social services does occur in states despite the availability of resources. Though this research does not seek to explore the various reasons why states with available resources deprive citizens of their rights, I would, however want to state that where a state fails to use its resources effectively towards the realization of the right to health and human rights it is in violation of these said rights.

Social/underlying determinants of health used in the context of this research include the following: food, housing, healthy environment such as water, electricity and sanitation, health services, education and employment. I will add poverty and discrimination to this list both being basic social determinants for the realization of the right to health. These are the two basic social determinants that affect health negatively as addressed by Paul Hunt, a former UN Special Rapporteur on the right to health, in his 2003 report to the United Nations Committee on Human Rights, titled "Economic and Social Rights"; they are poverty and discrimination (Hunt 2009:38). While poverty and discrimination are the social determinants of health, food, water, education, housing, healthy environment, health services, and employment are the underlying determinants of health. Some scholars lump all these determinants together (Wilson 2009:62-72,

lumps them all together as social determinants). Progressive realization and equal distribution of access to all these factors improves an individual's health and quality of life.

The reason behind connecting socioeconomic rights to the right to health is to advance well-being, which ordinarily may not be achieved through socioeconomic rights or health approach alone. Furthermore, the purpose of this connection seeks to establish the nature of obligation a state owes its citizens. Understanding the relationship between the individual and the state is important to have knowledge about the practicability of the enjoyment of human rights. Likewise, understanding the ambit of state obligations is important to know how human rights can in practice be advanced (Tarantola et al 2013:156). States have an obligation to respect, protect and fulfill the right to health. Respecting the right to health means that a state violates the right to health when it refuses to respect it, by withholding the means to provide access to the right to certain populations. Protecting right to health means that the state ought to provide a means of seeking redress to people whose rights have been violated. Fulfilling the right to health means that the state must use every available resource towards the fulfillment and promotion of the right to health (Gruskin and Tarantola 2005:14). Fulfilling the obligations to the right to health does not depend on whether there is a provision for the fulfillment of these obligations in the domestic laws. The right to health like every other human right, is recognized by its provision in an international instrument recognized by a state and legally binding on that state. This research paper will proceed further to review literature on the key issues I raised in the paper.

LITERATURE REVIEW

i. Definition of Key Concepts

Human Rights are "legal claims that persons have on governments simply on the basis of their being human" (Tarantola and Gruskin 2013:44). "Human rights refer to a fundamental set

of protections and entitlements that are due to all human beings irrespective of their race, class, gender, sexual orientation, age, religion, cultural background, national origin, or place of residence" (Voigt and Thornton 2015:1296). Human rights are "universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements and human dignity" (OHCHR 2012). Harman and Williams (2013:160) define human rights as "those rights which all people in every region in the world share under international law". I will adopt their definition since it very much fits into the context of my paper. Furthermore, human rights include positive rights such as food, housing, education, health care, work, healthy environment amongst others.

Fundamental human rights possess certain characteristics. They are universal, that is applicable to every individual by being human. They are inalienable, that is individuals cannot lose such right by any circumstance other than ceasing to be human beings. They are indivisible, no one can be denied a right because it is less important compared to some other rights. They are independent, that is primarily the right of every individual and establishes the relationship between the individual and the state. They are interdependent, all rights complement each other, and enjoyment of one right leads to the enjoyment of another. Finally, the promotion and protection of human rights is not limited to the boundaries of a state (Mann et al 1999:23).

Health is defined in the preamble to the constitution of the World Health Organization (WHO) 1946 as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity". However, this definition seems to be ambiguous because it does not explain what it means by complete physical, mental and social well-being. Furthermore, a state of complete physical, mental and social well-being seems to be a very high benchmark which might seem impossible to attain. It is on the bases of this ambiguity that the UN General

Assembly did not adopt the definition by the WHO but rather chose the term "highest attainable standard of physical and mental health" in Article 12.1 of the ICESCR. General Comment 14 2000 explains the right to health does not necessarily mean a right to be healthy but the need to create the necessary underlying conditions that can facilitate the attainment of the right to health.

Health as a concept is derived from two broad categories. These categories are: Medicine and Public health. Medicine focuses on the health of an individual, which is associated with health care. Public health focuses on the health of the entire population, dealing with issues such as the conditions in which people can be healthy (Mann et al 1999:8). The concept of health has been stretched beyond what it used to be which was mainly health care and now embraces other social conditions in relation to the well-being of individuals and the population. This expanded scope is what links health to human rights.

Agbakwa (2002:182) asserts that a sense of deprivation occurs when there is a disparity between what the people expect as of right and what is given to them. Deprivation has been viewed to depict a socio-political condition induced by poverty (Sanusi 2008:385). It has been defined to mean lack of basic goods and services within a given community (UN Habitat 1995). Fu et al (2014:224) define deprivation in terms of relative deprivation, which they divided into broad groups that is, social psychology and social economic. The first they say relates to the feelings of deprivation held by the people concerned while the second, which is mostly used relates to health and social science, and is subject to measurement. Deprivation further tends to describe health inequality using socio-economic inequality (Fu et al 2014:229). The Human Development 2016 report asserts that deprivations are still lingering worldwide. About 45 percent of deaths among children under the age of 5 is caused by poor nutrition. 114 million people still lack basic reading and writing skills. About 880 million people live in slums and

about 700 million of urban slum dwellers lack adequate sanitation, which includes lack of clean drinking water. 73.3 million young people are out of work, and 40 percent of young people in the global force are either unemployed or poorly paid (HDR 2016:29-34).

Social Services was defined by Ndikumana and Pickbourne (2016:102) to include education, health care, potable water and sanitation. Article 25 of the UDHR 1948 does not specifically define social services but it lists it among the basic requirements of food, clothing, housing and medical care. One can therefore conclude that social services fall within the said category of basic needs, which are also components of the underlying determinants of health.

Violation has been defined by the Civil Liberties Organization (2006) to be what occurs "when a law, policy or practice deliberately contravenes or ignores obligations held by the State concerned or when the State fails to achieve a required standard of conduct or result". Furthermore, human rights violation is defined to include "governmental transgressions of the rights guaranteed by national, regional and international human rights laws and acts and omissions directly attributable to the State involving the failure to implement legal obligations derived from human rights standard" (CLO 2006).

Poverty is defined by the UN Committee on Economic, Social, and Cultural Rights as "a deprivation of resources … necessary for enjoyment of adequate standard of living and other civil, cultural, economic, political and social rights". Hunt (2009:36) acknowledges poverty as a human rights problem. Poverty is mostly viewed or associated with low or lack of income (Chandola and Conibere 2015:285). Sanusi (2008:385) views poverty as a type of deprivation, that is poverty is embedded in deprivation. The United Nations Development Report (2000:73) views the scope of poverty to go beyond the unavailability of income but one that includes deprivation that transcends many aspects. Therefore, the UNDP report defined poverty as "a

deprivation of the valuable things that a person can do or be". A multi-dimensional view of the concept of poverty has been incorporated in the definition of poverty by certain scholars. The multi-dimensional definition of poverty has been defined to include "the accumulation of several deprivations" (Alkire 2007); and socio-economic deprivations (Naveed and Islam 2010). Though poverty and deprivation tend to be grouped together, some believe that the concepts are distinct. Deprivation refers to conditions of life that are below the normal expectation of life, while poverty is lack of income or resources preventing one from living a standard quality of life (Fu et al 2014:225). Furthermore, measuring deprivation enables one to determine whether a human right violation has occurred, and to encourage the use of a rights-based approach to ensure an equal distribution of goods and services (Fu et al 2014:226).

Having reviewed literature on my key concepts in this paper, I would proceed further to review literature on social services, so that readers would have a deeper grasp of the meaning of what I mean by social services.

ii. Literature on Social Services

General Comment 14 of the CESCR 2000, lists the rights to food, housing, work, education as integral components of the right to health, which are, in other words, considered as the underlying determinants of health. Ocran (2007:1) views the neglect of the provision of social services as a violation of socio-economic rights of the citizens (See also Popovic 1996:528). Ocran (2007:1) asserts that in African countries, citizens are denied access to social services and other important functions of government.

The right to adequate food signifies the right to be free from hunger. Article 11 of the ICESCR explains the importance of the right to food. It states that "state parties to the present covenant recognize the right of everyone to an adequate standard of living for himself and his

family, including adequate food …; … recognizing the fundamental right of everyone to be free from hunger ….” Para.6 of General Comment 12 asserts that the right to food must be progressively realized. Para.8 recognizes that the core concept of the right to food shall imply “the availability of food in a quantity and quality sufficient to satisfy the dietary needs of individuals, free from adverse substances, and acceptable within a given culture; and the accessibility of such food in ways that are sustainable and that do not interfere with the enjoyment of other human rights”. Para.17 states that violation of the right to food occurs when “state fails to ensure the satisfaction of, at the very least, the minimum essential level required to be free from hunger”.

Housing is considered a central necessity to health, because the features of any housing can likely affect health, as studies have shown an interrelationship between the features of housing and public health (Wan and Su 2016:12). Poor health outcomes have been associated with deprivation of adequate housing (Wan and Su 2016:19). Housing should be made available to those who reside in rural areas, and should not be left out for any reason whatsoever. Another issue is the condition in which low income families live, whether it is healthy or not. Do these housing structures lack basic infrastructure and amenities such as clean water, electricity, gas and adequate sewage disposal? Are a certain percentage of the population homeless? Is homelessness caused by unemployment, poverty, and lack of affordable housing? It has been estimated that about 800 million people in Africa, Asia and Latin America live in weak and overcrowded houses (known as slums) lacking water and sanitation (Fox 2013:191). Article 11 of the ICESCR recognizes the right of everyone to adequate housing and to continuous improvement of living conditions. Paras. 4 and 7 of the General Comment 14 state that the right to health embraces underlying determinants such as adequate housing. Para. 7 of General Comment 4 1992 states

that the right to housing is the right to "live somewhere is security, peace and dignity". The dignity employed in the definition implies that it must be ensured to all irrespective of income or access to economic resources. Para. 7 further defined adequate shelter as "adequate privacy, adequate space, adequate security, adequate lighting and ventilation, adequate basic infrastructure and adequate location with regard to work and basic facilities - all at a reasonable cost". Para. 8 lists the basic conditions in which a shelter can be considered an 'adequate housing'. These are: Legal security of tenure; Availability of services, materials, facilities and infrastructure; Affordability; Habitability; Accessibility; Location; and Cultural Adequacy.

One of the basic needs of man is sanitation and water, which are essential to human well-being. Sanitation has been defined to mean "the collection, transport, treatment and disposal or reuse of human excreta or domestic waste water, whether through collective systems or by installations serving a single household or undertaking" (Smets, 2010). The right to sanitation is composed of individual and collective rights, which governments should ensure are well taken care of. Good sanitation should be provided and should be made accessible to those in the rural areas. Neglect of sanitation can affect health and should therefore not be taken for granted. In 2010, it was estimated that about 61 percent of Africans had access to portable water and just 34 percent have access to healthy environment. These figures have been claimed to remain constant and not increasing (Toebes et al 2014:28). The right to water as interpreted in Para.2 of General Comment 15 2002, is one that "entitles everyone to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses".

It is said that health care and health systems ought to incorporate a holistic approach in the sense that it must be centered on the people (Hunt and Backman 2013:64). This means that the wellbeing of individuals should be of utmost importance and at the forefront of any health

system, which further relates to both the processes and outcomes by which it can be achieved. The process involves what the state does such as providing access to quality medical care, safe water and other health determinants. The outcome is how the state does it such as transparency, participation and equality/equity. Accessing health care and health systems using human rights standards implies that it must be available, accessible, acceptable and have quality. States should ensure their health systems are accountable. The accountability should be for both the public and private sector of health, because in most states, their private health sector is left unmonitored (Hunt and Backman 2008:89).

Looking at WHO Global Expenditure database 2014, one would see that the budgetary allocation to health care in most states in West Africa is very low, less than 5 percent of the Gross Domestic Product (GDP). Payment for health care is mostly made out-of-pocket by private individuals, and just a minimal percentage of the entire population are covered by private insurance. The WHO Global Health Expenditure Database 2014 estimated about 68.7 percent of government expenditure on health care in Gambia, 60 percent in Ghana, while Nigeria an estimate of 25 percent expenditure on health care by the government. Public Health facilities in most West African countries are in poor conditions and the equipment are not of good quality. People are left with no choice than to seek health care in private hospitals, which are paid for by the private individuals and are very expensive. The poor are now left at the mercy of those dilapidated hospitals, which therefore creates a problem of accessibility.

Furthermore, it has been acknowledged that poverty is a major obstacle to improving health and reducing health inequality (MacNaughton 2011:63). About 500,000 maternal mortality deaths occur yearly and about 95 percent of it come from the region of Asia and Africa (Para.33 Special Rapporteur 2007). Para. 34 of the Special Rapporteur Report 2007 asserts further that

"avoidable maternal mortality violates women's rights to life, health, equality and non-discrimination".

Para.2 of CESCR General Comment 11 1999, asserts that the right to education represents the indivisibility and interdependence of human rights because it connects to other rights such as civil and political rights and socio-economic rights. Para.6 highlights that education must be compulsory and must be adequate in quality. Para.7 highlights that it must be free of charge; in Para.8, states are to adopt a detailed plan that will include participation of every person in the society; in Para.9 states cannot escape their obligations and finally; in Para.10, states are required to progressively implement the right to education. The UNESCO Global Monitoring Report 2014 estimated that about 30 million children in Sub-Saharan Africa are out of school. Education is unaffordable to those who are poor (Ssenyonjo 2016:621).

The right to work was defined by the African Commission on Human Rights in the case of Annette Pagnoulle ex rel. Abdoulaye Mazou v Cameroon (1996/97) "as the right of everyone for an opportunity to gain a living by work that he or she freely chooses or accepts". Employment is embedded in the right to work, and the right to work is a human right because human survival depends on it (Udombana 2006:187). The right to work is covered in the ICESCR and its Optional Protocol, which includes the right to full employment, to fair wages, right to an adequate standard of living, and safe and healthy working conditions. The provision of the right to work in the ICESCR intersects with the right to work provided by the International Labor Organization (ILO) Decent Work Agenda and other ILO conventions on Labor rights (MacNaughton and Frey 2011:444-5). Para.13 of General Comment 18 2006 emphasizes the right of women to work and to equal pay. Para.14 emphasizes the right of young persons to access jobs as a means of escaping poverty. Para.32 of General Comment 18 states that

"violations of the right to work can occur …, through the lack of adequate measures to promote employment".

I will proceed to the next section to review the whole concept of health and human rights and how much they are connected to each other, and more so how health is intertwined with socio-economic rights.

iii. Literature on Health and Human Rights

Human rights have been classified into two broad categories (Mann et al 1999:25; Gruskin and Tarantola 2005:10). They are:

1. "Civil and Political rights, which includes the right to life, liberty, security, movement, not to be tortured, not to be arbitrarily arrested and detained".
2. "Economic, Social and Cultural rights, which includes rights to the highest attainable standard of health/right to health, social security, food, clothing and housing, education, scientific progress". The underlying determinants of health are linked to socioeconomic rights contained in the International Bill of Rights, which includes the right to education, adequate housing, clean water and adequate sanitation, social security, full employment and decent work, and the right to health. The enjoyment of all these rights improve the health of every person.

The link between health and human rights was first found in the preamble to the constitution of the World Health Organization (WHO) 1946 in its definition of health. It is further stated in its preamble that the highest attainable level of health is the fundamental right of every human being. Thereafter, the link between the health and human rights was captured in Article 12 of the ICESCR as the "enjoyment of the highest attainable standard of physical and mental health".

From the definition of health as the highest attainable standard of living given by the ICESCR, it is evident that the health of the entire population goes beyond medical care. It is on this notion that the international human rights law (particularly General Comment 14 2000 of UN CESCR) views the right to health as an inclusive right, not limited to health care but including the underlying social determinants of health (Hunt, P.84).

Three frameworks have been established to link health to human rights (Gruskin et al 2007:449; Mann et al 1994:6,13). These are:

1. The Effect (positive and negative) of health policies and programs on human rights;
2. The effect on health of the promotion and violation of human rights; and
3. The effect on health on the delivery of human rights.

In the first, where a state fails to take cognizance of the health needs of certain marginalized groups of the population, then there will be a violation of the right to non-discrimination, resulting in the deprivation of basic services that consequently affect other rights (Mann et al, P.13-14). The second occurs when the government prioritizes certain health issues against another, giving it a lower priority that results in discrimination against certain individuals based on sex, race, religion and even health conditions. Then the third concerns the assurance that health policy will be related to the right to non-discrimination. Therefore, Mann et al (1994:15) opine that "when health and social services do not take logistic, financial, and socio-cultural barriers to their access and enjoyment into account, intentional or unintentional discrimination may readily occur". The right to health can be breached when there is a substantial difference in the standard of living between two regions, example urban and rural (Wilson 2009:61).

States must ensure that there is equal access to the provision of health care and the underlying determinants of health care. MacNaughton (2009:48) classifies inequality into two

categories, which are individual and bloc inequality. Individual inequality pertains to the unequal access to health care and its underlying determinants suffered by the individual, while bloc inequality pertains to gross inequalities experienced within different blocs. The blocs could be based on social status, ethnicity, or religion. The CESCR is usually more perturbed about bloc inequality especially the rich-poor divide, where the poor are mostly neglected. The CESCR has in a couple of countries expressed its concern on the allocation of GDP to health sector and other basic social determinants, and on the gap in access to these facilities existing between a sector of the population against another (MacNaughton 2009:53). There should not be any form of discrimination in the allocation of health facilities to members of the population. There must be even distribution across all localities and regions.

States are responsible for ensuring that their citizens achieve adequate health by respecting, protecting and fulfilling the right to health and its underlying determinants (Para.33 General Comment 14 2000). Respecting rights implies states should not interfere with the full enjoyment of right to health; protecting rights means that states should take measures to ensure that third parties do not interfere with the right; and fulfilling rights means that states should adopt all mechanisms and measures towards the realization of the right to health.

The obligation placed on states is subject to progressive realization and resource availability. These are the factors I consider in this research paper and they determine how the attainment of the right to health can be measured. Article 2.1 of the ICESCR states that state parties "*undertake to take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the covenant*". Para.31 of General Comment 14 states that progressive realization means that states must move expeditiously and

effectively as possible towards the full realization of the right to health. This means that states are expected to continuously improve the right to health and its underlying determinants, and to avoid any regressive measures (Ssenyonjo 2016:90). Para.32 states that retrogressive measures are not permitted by the covenant. Backman et al (2008:6) assert that progressive realization does not give states the liberty to choose any sort of measures they wish to choose in realizing the right to health, the measures chosen must be guided by their core obligations required in line with the right to health. Monitoring progressive realization of the right to health entails the use of human rights impact assessment and budgetary analysis. Human rights impact assessment is the "process of predicting the potential consequences of a proposed policy, program or project on the enjoyment of human rights" (MacNaughton and Hunt 2009:304). Budgetary analysis entails monitoring budget spending on health. Ssenyonjo (P.94) asserts that a decrease in the proportion of allocation of budgetary expense towards the rights recognized in the ICESCR, in comparison with an increasing GDP growth, constitutes a deliberate act of retrogression. Maximum resources entail budgetary appropriations and foreign assistance as stated in Article 2 of the ICESCR. Budgetary allocation should be adequate, low budgetary allocation to health and other determinants could portray inadequate appropriation of resources to the rights enshrined in the covenant (Ssenyonjo P.97). To determine whether states are progressively maximizing available resources, states must regularly evaluate the amount of allocation of budget to all the rights provided in the covenant. Hence, an indicator that would be used to determine progressive realization with maximum resources is the budgetary expenditure towards these rights (Ssenyonjo P.102). Another indicator that can be applied is to compare resources spent by other states at the same period or states on the same comparable level (Ssenyonjo P.103).

Paras. 47 and 48 of the General Comment 14 2000 terms it a violation of the right to health where states fail to utilize their maximum available resources for the realization of the right to health. Their provisions state as follows:

> *47. "A State which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the obligations outlined above. It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are nonderogable".*
>
> *48. Violations of the right to health can occur through the direct action of States or other entities insufficiently regulated by States. The adoption of any retrogressive measures incompatible with the core obligations under the right to health, outlined in paragraph 43 above, constitutes a violation of the right to health".*

The right to health and its underlying determinants must be based on equality and non-discrimination. To determine whether it is based on such, the standards of availability, accessibility, acceptability and quality will be applied (Para. 12 General Comment 14 2000). Health systems must be available to everyone in sufficient quantity and without discrimination; must be physically accessible within a close distance to all population; must comply with medical ethics, and must be take cognizance of culture, communities and gender; and must be up

to date with scientific and technological standards (MacNaughton 2011:210). The quality of health services must spread across all regions in the state. If a health facility, good or service has been declared to be of poor quality in one region, it should not be sent to another region (Hunt and Backman 2008:85).

The cause of the deprivation of the right to health is linked to insufficient financial resources. It has been asserted that health systems in Africa face an impediment of lack of resources (Toebes et al 2014:14; Wilson 2009:61). The lack of health services and other health related factors in Africa has been described as a "a resource curse" rather than it is a "resource scarcity" (Toebes et al 2014:68). They argued by relying on the African Human Development report 2012, that most parts of the Sub-Saharan Africa which are known for food insecurity, do have abundant resources. This they further attributed to the institutional decision making system of the states concerned.

Most states in Africa, which includes Nigeria who spearheaded the UN summit for the adoption of the Declaration of Commitment to HIV/AIDS in 2001, failed to meet their commitment in allocating at least 15 percent of their annual budget to health (Toebes et al, P.14). It is premised on this lag that Toebes et al (P.17) attributed the cause of inadequacy in health care in Nigeria, to the "misallocation and misalignment of resources". Citing an example of Nigeria's National Health Policy, they could emphasize the fact that such policy which aims to provide a comprehensive Primary Health care system is just a mirage. They further believe that proper utilization of resources will create an avenue for considerable advancement. The cause is also attributed to "natural or man-made disaster" (Wilson 2009). Notwithstanding what is the cause, it is not to be disputed that poverty is a major obstacle to the enjoyment of the right to health and its underlying determinants.

iv. **Literature on Human Rights, Health and Development**

There is a firm relationship between human rights, health system and progressive development approaches. This relationship is showcased through a spectrum of views, which includes but is not limited to: "human rights; their human value; social relevance; and instrumental application" (Tarantola et al 2013:155). The right to development is recognized as a human right by Article 1 of the 1986 Declaration on the Right to Development by the UN General Assembly (though not an international law but is a declaration made by a well-recognized and accepted international body, which most states are parties to). It states that "the right to development is an alienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized". Here the individual is the beneficiary of the right to development and can therefore be invoked by individuals. It also imposes obligations on states to provide "equal access to essential resources; and on the international community to develop fair policies, and to ensure effective cooperation" (Tarantola et al 2013:159). Development, health and human rights, all refer to policies and programs geared towards improving human conditions when they are being employed as policy objectives of society, governments, and international institutions.

Health is the most measured component of well-being. It is a condition precedent to the fulfillment of the other rights. The World Bank 1993 Report stated that health is directly correlated to economic development. Health is also related to poverty and both variables have a causal relationship on each other. The WHO commission on Macroeconomics in its 2001 report stated that poverty leads to ill health, as well as ill health leads to poverty. Poverty has been found to be strongly correlated with disease and disability, which affects health (Annas 2005:66).

One central impediment to health and human rights is how to advance the benefit of the right to health for those living in poverty (Para.20 Special Rapporteur 2007). Various human rights relate to the issue of poverty such as the right to food, education, housing, health services, and certain civil and political rights (Hunt 2009:36).

Gruskin et al (2005:71) see a difference in the objectives between development and health in relation to human rights. While the objectives of development focus on material conditions arising from economic processes that create benefits for the people, that of health focuses on the underlying conditions for human well-being. However, the right to health and development are interconnected because both rights are human rights and both seek to achieve development. Development in relation to health has a vast scope of literature that focuses on developing countries, and that covers issues of poverty reduction in relation to health, health care and health systems. However, literature that pertains to human rights and development, with a major focus on health is quite limited. Most scholars tend to separate these approaches. However, I seek to use an approach that incorporates all three approaches that is human right, health and development, as one factor, which is the human right based approach. Development is not limited to the confines of economic progress, it is inclusive of human need and well-being such as adequate standard of education, health care, better work opportunities.

The next section in this paper, which I proceed to will be a review of the basic international instruments that provide for the right to health and its underlying determinants.

v. Literature on International Instruments

The international instruments that provide for the right to health in relation to human right are the United Nations Charter 1945, UDHR 1948, the ICESCR 1966 and its Optional Protocol 2008, which altogether constitute the International Bill of Rights (Mann et al 2013:18). We have

the General Comment 14 on the right to health and other General Comments on the underlying determinants, issued by the United Nations Committee on Economic, Social and Cultural Rights (UN CESCR). We also have regional and sub-regional charters such as the European Social Charter of 1961 as revised, African Union Charter on Human and Peoples' Rights 1981, the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988, Arab Charter on Human Rights 2004, Association of Southeast Asian Nations (ASEAN) Human Rights Declaration 2012 and the Economic Community of West African States (ECOWAS) Treaty 1993, a sub-regional treaty for West Africa.

Charter of the United Nation (1945)

The UN Charter 1945 states in its preamble a proviso for human rights, which states: "to reaffirm faith in fundamental rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small". Article 55 declares that the UN shall promote:

a. *Higher standards of living, full employment, and conditions of economic and social progress and development;*
b. *Solutions of international economic, social, health and related problems.*

Articles 57 and 62 of the UN Charter recognizes the responsibility of the Economic and Social Council of the UN in respect of right to health. These provisions give the UN the power to take coercive actions such as imposing sanctions on member states for violation of the provisions of its Charter (Karns et al 2015:501).

The Universal Declaration on Human Rights 1948

The UDHR was adopted in 1948 as a common understanding for all peoples and nations. The UDHR makes provision for the right to health in Article 25.1 that "*everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and the necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*". Article 23 provides for the right to the right to work and the Article 26 provides for the right to education. The UDHR is a declaration not a law, therefore, it is not legally binding. It is an authoritative interpretation of the human rights in the UN Charter that UN members pledge to promote and respect. The UDHR applies to all 193 members of the UN. Though the UDHR is not a law, it could be viewed as an International Customary Law, since its member states have accepted it and abide by it. Most of the member states have domesticated most parts of the UDHR in their national laws.

International Covenant on Economic, Social and Cultural Rights 1966 and Optional Protocol 2008

The ICESCR was adopted in 1966. It focuses on the well-being of individuals. It is the basic legal and enforceable provision for the right to health and economic and social rights. The provision for the right to health is found in Article 12, which I had referred to in the context of this paper. Article 6 of the ICESCR provides for the right to work, "which includes the right of everyone to the opportunity to gain his living by work which he freely chooses or accepts…." Article 11 provides for the right to an "adequate standard of living, which includes food, clothing and housing, and to the continuous improvement of living conditions". Article 13 provides for

the right to education. The ICESCR seeks to encourage better standards of living as envisaged by the UDHR (Oloka-Onyango 1995:13).

The Optional Protocol to the ICESCR was adopted by the UN General Assembly in December 2008. It provides a complaint mechanism for the violation of social and economic rights including the right to decent work.

United Nations Committee on Economic, Social and Cultural Rights, General Comments

The UN CESCR General Comment 14 2000 on the right to health is the basic legal interpretation of Article 12 of the ICESCR. Para. 4 links the right to health to the underlying determinants such as food, housing, water and sanitation, healthy working conditions and healthy environment. The provisions of the General Comment 14 are basically to interpret the provisions of Article 12 of the ICESCR, therefore, it is not a binding law.

There are other General Comments that interpret other Articles of the ICESCR, which I referred to in the section on my review of social services. There is the General Comment 3 1990 on the nature of state parties' obligation in respect of Article 2 of the ICESCR. General Comment 4 1991 on the right to adequate housing, as an interpretative guide to Article 11.1 of the ICESCR. General Comment 9 1998 on the domestic application of the covenant. General Comment 11 1999 on plans of action for primary education, as an interpretative guide to Article 14 of the ICESCR on the progressive implementation of compulsory education. General Comment 12 1999 on right to adequate food, as an interpretative guide to Article 11 of the ICESCR. General Comment 13 1999 on the right to education, as a legal interpretation of Article 13 of the ICESCR. General Comment 15 2002 on the right to water, as a legal interpretation of Articles 11 and 12 of the ICESCR. General Comment 18 2006 on the right to work, as a legal

interpretation of Article 6 of the ICESCR. Finally, General Comment 20 2009 on the right to non-discrimination.

European Social Charter 1961 (Revised 1996)

The European Social Charter is the European regional treaty that provides for the right to health. Article 11 of the charter states that parties undertake to take measures to "*remove as far as possible the causes of ill-health; to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health; and to prevent as far as possible epidemic, endemic and other diseases*". Article 1 provides for the right to work – "*parties undertake to accept as one of their primary aims and responsibilities the achievement and maintenance of as high and stable a level of employment as possible, with view to the attainment of full employment*". Article 31 provides for the right to housing – "*to promote access to housing of an adequate standard*".

African Charter on Human and Peoples' Right 1981

The African Charter on Human and Peoples' Rights was adopted by the AU (formerly Organization for African Union) on June 27, 1981. Article 30 of the African Charter on Human and Peoples' Rights established the African Commission on Human Rights in charge of enforcing human rights provisions contained in the Charter. Article 45(2) raises an obligation for the protection of human rights. Articles 47 and 55 raises an obligation on state parties and third parties to report the violation of another state party to the commission. The African Charter recognizes economic and social cultural rights and the right to health. The provisions for the right to health and its social/underlying determinants are as follows:

Article 15 – The right to work- “Every individual shall have the right to work under equitable and satisfactory conditions, and shall receive equal pay for work.”

Article 16 – Right to health – “1. Every individual shall have the right to enjoy the best attainable state of physical and mental health. 2. State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick”.

Article 17- Right to Education – 1. “Every individual shall have the right to education”.

Article 19 – Right to equal enjoyment of rights.

Article 16 of the African Charter places an obligation on states to take measures to actualize the fulfillment of the rights. However, before the inception of the African Charter, the ICESCR had already made provision for the right to health to which most states in Africa were already bound. Welch (1992:45) views the African Charter to have borrowed a lot in terms of language and provisions form the international instruments on human rights such as the UDHR and the ICESCR.

American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988

The American Convention of 1988 also known as the ‘Protocol of San Salvador’, made explicit reference to the right to health in Article 10. Art. 10.1 states emphatically that “*everyone shall the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being*”. Article 10.2 lists the measure to be adopted by member states to ensure the right to health. Article 6 provides for the right to work, which includes “*the opportunity to secure the means for living a dignified and decent existence by performing a freely elected and accepted*

lawful activity". Article 11 – right to a healthy environment, Article 12- right to food, and Article 13 – right to education.

Arab Charter on Human Rights 2004

Article 39 of the Arab Charter provides for the right to health. It states that "*state parties recognize the right of every member of the society to the enjoyment of the highest attainable standard of physical and mental health and the right of the citizen to free basic health care services and to have access to medical facilities without discrimination of any kind".* Other provisions for the underlying determinants of health are: Article 34- the right to work; Article 38 – right to an adequate standard of living including food, clothing, housing, services and the right to a healthy environment; and Article 41 – right to education.

Association of Southeast Asian Nations (ASEAN) Human Rights Declaration 2012

Article 26 of the ASEAN declaration reaffirms the provisions of the UDHR on economic and social rights. Article 29 provides for the right to health that "*every person has the right to the enjoyment of the highest attainable standard of physical, mental and reproductive health, to basic and affordable health care services, and to have access to medical facilities".* Other provisions on the underlying determinants of health are: Article 27 – right to work; Article 28 – right to an adequate standard of living including food, clothing, housing, medical care and social services, water and sanitation, safe, clean and sustainable environment; and Article 31 – right to education

Economic Community of West African States (ECOWAS) Revised Treaty 1993

Article 4 (g) of the ECOWAS Revised Treaty 1993, recognizes the provisions on human rights contained in the African Charter on Human and Peoples' Right. It states categorically that there

will be a "recognition, promotion and protection of human and peoples' rights in accordance with the provisions of the African Charter on Human and Peoples' Rights". Furthermore, Article 3 of the Supplementary Protocol of the ECOWAS Court of Justice 2005 amended Article 9 of the Protocol of the ECOWAS Court of Justice 1991. The amendment introduced the provision for the enforcement of human rights. It states in the new Article 9(d) that: "*Access to the Court is open to the following: Individuals on application for relief for violation of their human rights; the submission of application for which shall:*

i) not be anonymous; nor

ii) be made whilst the same matter has been instituted before another International Court for adjudication;

Summary of Literature

The review section gave a deeper understanding of the key concepts employed in this research paper. It also defined social services, which in the context of this paper is centered on the underlying determinants of health revealed in Paras. 4 and 11 of General Comment 14. It discussed how health relates to human right, socio-economic rights, and right to development, epitomizing the interdependence of human rights. Finally, this section also revealed various international instruments that provide for the right to health and its underlying determinants. The international instruments were drawn from various sources ranging from international to regional, emphasizing the universal nature of the right to health and its underlying determinants.

Having established the connection between socio-economic rights and the right to health, and further showing its universal nature, the next section will apply the methods that I will use to establish that there is a deprivation of these social services/underlying determinants that has resulted in a violation of right to health (or human rights in general terms).

RESEARCH: METHODS, ANALYSIS, FINDINGS, AND LIMITATIONS

Measurement of Deprivation

Human right is a complex concept that creates some measure of difficulty in measurement.

Udombana (2006:241) opines that it is difficult to measure living in Africa because it is engulfed by poverty. He equated poverty with deprivation. However, the right to health demands progressive realization, which uses indicators and benchmarks to measure progress. Cross-country comparison is also used to measure the achievement of rights amongst countries. An indicator is defined as "a variable with the characteristics of quality, quantity and time used to measure, directly or indirectly, changes in a situation and to appreciate the progress made in addressing it" (Gruskin and Ferguson 2013:203). Indicators provide a medium of evaluating progress, setting goals for social action and development of policies, and there are two types of indicators relevant to this research. These are the health indicator and the human rights indicator; the former is used to measure changes in health situation and ascertain the attainment of the goals of health programs, while the latter is used to measure the extent to which human rights norms and standards are applied in a context (Gruskin and Ferguson 2013:203). Some indicators that have already been developed such as the Human Development Index, WHO indicators, and World Development indicators will be used to measure progress in relation to human rights development. All the indicators employed show levels of progress and levels of deprivation in relation to the availability of resources marked by the Gross Domestic Product, which is the main foci of this paper. The cross-country comparison that I seek to rely on has been criticized by human rights activists that human rights compliance ought not to be measured between countries because same factors cannot apply to two countries (Fukuda-Parr 2012:82). However, I would

state that cross-country comparison is essential to objectively assess progressive realization of human development within socio-economic duties.

The human right based approach to health indicator is what I apply here in measuring. The Special Rapporteur's report to the UN General Assembly (2004) listed certain features a human right based indictor to health should possess as follows:

1. *It must correspond with some precision to a right to health norm*
2. *It must be disaggregated by at least sex, race, ethnicity, rural/urban, and socio-economic status*
3. *They are supplemented by additional indicators that monitor five essential and interrelated features of the right to the highest attainable standard of health:*
    - *i.* *A national strategy and plan of action that includes the right to the highest attainable standard of health*
    - *ii.* *The participation of individuals and groups, especially the most vulnerable and disadvantaged, in relation to the formulation of health policies and programs*
    - *iii.* *Access to health information, as well as confidentiality of personal health data.*
    - *iv.* *International assistance and cooperation of donors in relation to the enjoyment of the right to the highest attainable standard of health in developing countries.*
    - *v.* *Accessible and effective monitoring and accountability mechanisms.*

It is important to note that one may not need to have several indicators to reflect all these features. If one selected indicator possesses all these features, it suffices. Furthermore, human right based approach to health indicator should be grouped into three categories: Structural, process, and outcome (Special Rapporteur Report 2003). Structural indicators measures structures and mechanisms in place that support the realization of the right to health. For

example, checking whether a country has ratified an international treaty on the right to health or has some policy in place that promotes the right to health is a structural indicator. Process indicator measures the activities or measures in place to achieve the realization of the right to health. An example is the proportion of people covered by national health insurance. Outcome indicator measures the impact of structures, activities and measures on the health of the population. An example is maternal mortality rate.

The measurement would also incorporate the framework of progressive realization and resource availability. My indicators displayed by the numbers that would be reflected in my tables are:

1. Have both countries signed and ratified the ICESCR, as well as the regional charters that contain the right to health?
2. Have both countries recognized the right to health and its underlying determinants in their constitutions?
3. Are there health information programs available?
4. Is there a provision for monitoring?
5. What percentage of budget per GDP is being allocated to health?
6. Is there equal access throughout the countries of sanitation (underlying determinant of health)?
7. Is there equal access throughout the countries of water (underlying determinant of health)?
8. What percentage of the population are experiencing multidimensional poverty?
9. What is the Life expectancy?
10. What is the Maternal mortality rate?
11. Is the level of progression consistent with the available resources?

Numbers 1 and 2 indicators are structural indicators. Knowing whether the countries have signed and ratified the ICESCR and the African Charter shows that they have taken steps towards progressive realizing the right to health and its underlying determinants by recognizing its provision in the international instruments. Furthermore, I want to know whether the states have taken steps to recognize such right as a fundamental right in their constitutions that would give citizens the leverage to seek redress in their domestic courts if they neglect their obligations. Numbers 3, 4, 5, 6 and 7 indictors are process indicators. Knowing whether there is a health information system, and a structure for monitoring, and health will let me know whether the health system is participatory as required by the human rights based approach. Knowing the amount of budgetary allocation to health will help to determine the importance these countries place on heath policies and programs, and the activities involved in realizing the right to health. Numbers 8, 9, and 10 are outcome indicators. Multidimensional poverty, life expectancy, and maternal mortality rate would let me know the level of impact of deprivation on health. Multidimensional poverty would let me determine whether the citizens are materially deprived of the right to health and its underlying determinants. Number 11 indicator shows the level of progression realized. Looking at the level of progression in terms of the right to health and its underlying determinants within the time frame of **10-15 years**, while considering the level of growth of the country's GDP, I determine whether the country is moving forward in actualizing this right or being stagnant or retrogressing. Kalantry et al (2009:51) assert that to set a benchmark to determine whether a state is progressively realizing the rights in the covenant, if that state in the current year, in realizing any of the rights for example, is 80 percent, then in ten years' time, it ought to be a least 90 percent.

Human Rights Based Approach

Para.64 General Comment 14 2000 spells out a duty of the UN to adopt a human right based approach to facilitate the implementation of the right to health. Human Rights Based Approach has been defined by the WHO and Office of the High Commissioner for Human Rights 2009 as an approach that "aims to support better and more sustainable development outcomes by analyzing and addressing the inequalities, discriminatory practices (dejure and defacto) and unjust power relations which are often at the heart of development problems". The UN Common Understanding 2003 gave three basic components for the application of the Human Rights Based Approach. These are:

1. The goal must be to realize human rights
2. The process used to actualize human rights must conform to human rights principles and mechanisms.
3. The outcome is the capacity building of both duty bearers (states) and right holders (individuals).

The movements for the underlying/social determinants of health are embedded in the Human rights based approach. It strengthens all other approaches through its demand on the application of the principles of transparency, accountability, monitoring, participation, and equitable access (Hunt 2009:39). It further induces "political and moral urgency" (Hunt, P.39). It further aims to effectuate the realization of "right to health and other health related rights" (WHO and OHCHR 2009). The rights based approach provides a framework for which policies geared towards the realization of rights can be evaluated. A right based approach incorporates issues of health in relation to development. Relying on the right based approach would incorporate the following elements (Marks 2005:103):

1. It will define socioeconomic issues in terms of rights, which includes health, education, housing and other issues pertaining to development.
2. It will refer to the General Comments issued by the UN Treaty body.
3. It will refer to treaty obligations contained in major human rights treaties.
4. It will focus on state obligation to respect, protect and fulfill rights
5. It will adopt a participatory method that will involve everyone.

MacNaughton and Frey (2011:451) view the human right based approach in terms of a holistic human rights approach, which considers all aspects of human rights without leaving some out. A holistic human rights approach therefore, emphasizes that all human rights are universal, interdependent and equal. This means that states should not pick and choose which categories of right they would favor above another. Most states are guilty of this act, whereby civil and political are given much preference and adopted as fundamental rights in their constitutions but no provision is made for socio-economic rights and right to health.

Human rights based approach seeks to ensure that all health programs and policies are designed to progressively benefit all through the improvement of the right to the enjoyment of health and health related factors such as the underlying determinants of health. It achieves this objective by monitoring the standards in which health policies and programs can be achieved. The standards include availability, accessibility, acceptability and quality.

Statistical Data on Social Services

The statistical measurement of deprivation of social services as highlighted earlier is captured as follows:

Table 1

Countries	1.Ratified ICESCR and African Charter	2.Right to health recognized in constitution	3. Availability of health Information	4. Health Monitoring
Gambia	Yes, ratified ICESCR 29 Dec, 1978 and ratified African Charter on June 8, 1983	No provision on right to health.	Yes, HMIS	Yes, M&E Plan
Ghana	Yes, ratified ICESCR on Sept 7, 2000 and, ratified African Charter on Jan 24, 1989	No provision on right to health. Work and Education listed as fundamental rights.	Yes, CHIM	Yes, M&E Dept.
Nigeria	Yes, ratified ICESCR on July 29, 1993, and African Charter on June 22, 1983	Yes, but health and all other determinants listed as a policy directive	Yes, NHMIS	Yes, NHMIS

Sources: 1996 Constitution of Gambia; 1996 Amended Constitution of Ghana; 1999 Constitution of Nigeria;

Table 2

Countries	5.Percentage of Budget per GDP allocated to health				6. Access to improved sanitation facilities % of population Urban – Rural				7. Access to improved water supply % of Population Urban - Rural				8. % Population Intensity of Multidimensional poverty 2005 - 2015	9. Life Expectancy				10. Maternal Mortality (Per 100,000 live births)			
	2000	2005	2010	2014	2000	2005	2010	2015	2000	2005	2010	2015		2000	2005	2010	2015	2000	2005	2010	2015
Gambia	3.61	4.97	5.75	7.34	59.8 – 59.7	60.5 – 57.7	61.2 – 55.8	61.5 - 55	89.6 – 76.3	91.5 – 79.7	93.5 - 83	94.2 – 84.4	50.5	63.6	64.9	66.5	68.1	887	510	460	706
Ghana	3.00	4.51	5.33	3.56	15.9 – 5.9	17.6 – 6.9	19.2 - 8	20.2 – 8.6	87.6 – 57.1	89.3 – 66.1	90.6 – 73.3	92.6 - 84	45.4	60	60.8	62.9	65.3	467	470	410	319
Nigeria	2.84	4.11	3.47	3.67	35.8 – 33.1	34.8 – 30.6	33.8 - 28	32.8 – 25.4	78.2 – 37.7	78.9 – 42.9	79.8 – 49.4	80.8 – 57.3	54.8	55.2	56.8	61.2	64.6	1170	740	610	489

Sources: World Development Indicators 2016; WHO Global Observatory Data 2016; Human Development Index 2016

Table 3

Countries	11.Level of Progression																									
	Food: % Dietary Energy Supply				Housing proportion of population living in Urban Slums		% of population with improved water source				% of population with improved sanitation facilities				Education (Primary Completion rate % of relevant age group)				Employment % of population 15+				GDP Growth in PP $ million			
	2000	2005	2010	2015	2005	2014	2000	2005	2010	2015	2000	2005	2010	2015	2000	2005	2010	2015	2000	2005	2010	2015	2000	2005	2010	2015
Gambia	115	113	129	132	45.4	34.8	82.7	85.9	88.9	90.2	59.7	59.2	58.8	58.9	71.8	71.6	73.4	69.3	53.9	54.4	54.4	54.4	800	624.1	951.8	939
Ghana	115	124	139	150	45.4	37.9	70.5	77	83.1	88.7	10.3	12	13.7	14.9	71.7	74.5	-	101	66.9	66.1	70.2	72.7	5889.1	10731.8	32174.8	37543.3
Nigeria	121	126	125	123	65.8	50.2	51.8	57.8	63.4	68.5	34	32.2	30.5	29	-	82.9	76.0	76	52.2	51.0	51.5	53.8	30757.1	112248.3	228637.9	481066.1

Sources: World Development Indicators Database 2016; FAO Database 2016

Cross-Country Comparison Ghana Vs. Nigeria

In measuring through the structural indicator, all countries have ratified the ICESCR and the African Charter showing that they all recognize the right to health. However, recognition of the right to health is not reflected in only the constitution of Nigeria, but as a policy directive and not a fundamental right. Ghana nevertheless made provision for the right to work and education as fundamental rights. This goes to explain why the realization of the right to education is high compared to the two other countries. Using process indicators, all countries have a health information system, and a system of monitoring, which signifies participation as required by the human rights based approach. Gambia has the Health Management Information System (HMIS) for health information and the Monitoring and Evaluation Plan for monitoring implementation of health policies. Ghana has the Center for Information Management (CHIM) and the Monitoring and Evaluation Department, while Nigeria has the National Health Management and Information System for health information and monitoring. The results further reveal that allocation of budget to health per GDP is very low and not encouraging, the benchmark required being at least 15 percent of GDP, as stated in the UN Abuja Declaration of HIV/AIDS in 2001. But, it is very intriguing to see that Gambia a country with a very low GDP compared to Ghana and Nigeria, spends a whole lot more on health than them. To comply with the requirement of equality and non-discrimination required in fulfilling the right to health, I measured for the access to sanitation and water in urban and rural areas and I discovered first, that the access to sanitation in all countries to the various segments of the population is low; second that all countries had considerable differences in accessibility to sanitation between the urban and rural areas, with the rural areas having lower access than the urban areas; and third, Gambia and Nigeria were seen to have retrogressed in the provision of access to sanitation in both segments. In accessibility to

water, there was a little progress made by all parties, but disparities between the urban and rural areas were still evident, particularly in Ghana and Nigeria.

Using outcome indicator, I measured effect of multi-dimensional poverty, which was defined by the Human Development Index 2016 as the "percentage of population that is multidimensionally poor adjusted by the intensity of deprivations in education, health, and living standards". It showed that an average number of population of people in all countries are affected by multi-dimensional poverty. I also measured outcome using life expectancy defined by the World Development Indicator as "the number of years an infant would be expected to live if the prevailing patterns of age specific mortality rates at the time of birth stay same throughout the infant's life". Life expectancy in Gambia, was higher than that of Ghana and Nigeria, however, all countries made progress in life expectancy. Lastly, all countries experienced some level of progress for maternal mortality ratio.

Looking at the level of progress as indicated in table 3, Gambia and Ghana made a considerable progress in the provision of food, but Nigeria retrogressed in 2010 and 2015. Housing indicator was focused on the percentage of population living in urban slums in the year 2005 and 2014 and from the data available Gambia seems to be progressing more than Gambia and Nigeria since it is a country with the lowest GDP amongst the other two. In terms of percent of population with improved access to water, all countries made progress, but the progress made by Ghana and Nigeria was low compared to that made by Gambia. Ghana and Nigeria ought to have been better off considering that they both have higher GDPs compared to Gambia, and they further experienced stable GDP growth. It is important to note that Gambia experienced slow GDP growth in 2005 where its GDP fell from $800 million to $624 million, yet they still made considerable progress. In terms of sanitation, only Ghana made a little progressive improvement

as shown on the data, while Gambia and Nigeria retrogressed as the percentage dropped rather than improved. Health expenditure per head of both countries is not sufficient compared to their GDP that tripled within the same time frame. For education, I used the percentage of primary completion based on the percentage of children with the primary school age. Using this indicator is very necessary since Goal two of the Millennium Development goals is to achieve universal primary education. Employment rate in all countries was considerably stagnant, and depreciating and appreciating.

So far, I have measured the level of deprivation, using maximum resources and progressive realization. It is therefore necessary to find out whether right to health and its underlying determinants can be enforced by international institutions and other forms of mechanisms.

Enforceability under International Law

Human rights require accountability, which is an important component of human rights. Accountability implies that the conduct, performance and outcomes of states' actions would be monitored (Hunt 2008: 87). Through accountability, citizens can judge the outcomes of the actions of the state to see if it has discharged its responsibilities. It creates an avenue to seek redress against the state and enforce such obligations on the state in the event it fails to do so. Accountability gives rise to two issues. First, there must be a provision for human rights in national law, which includes domestic and international law. Second, states must make provisions such as laws, regulations and guidelines as to what is specifically required of them to do (Hunt 2008:89). Right to the highest standard of health is a legal obligation with which states are bound to comply. Para. 1 of General Comment 14 states that the right to health includes certain components that are legally enforceable.

Applying human rights to health means that all international and domestic instruments and mechanisms will be adopted to ensure compliance (Gruskin et al 2013:36). Heupel (2011:776) lists four major mechanisms for enforcing sanctions. These are shaming, defiance, litigation and learning. Shaming involves publishing human rights violations by states to the public for the violating state to be shamed. International organizations, NGOs, and human rights activists are usually involved in this process, which entails the publishing of reports and the use of indicators. Defiance involves instigating opposition against the government in the form of mobilizations and campaigns. Litigation refers to the act of taking violating states to the appropriate judicial bodies to seek redress and enforce binding decisions on the state. Learning involves the act of changing beliefs of the both the state and the individuals through information sharing. These four mechanisms are all embedded in the two basic approaches for holding states accountable for the right to health. These are the violators and policy approaches. The violators approach or in some cases referred to as the judicial approach entails enforcing through the court, tribunals and other various forms of judicial and quasi-judicial processes. The policy approach entails enforcing human rights through policy making processes by ensuring that human rights are being protected through policies and programs (Hunt 2006:18).

Shaming and Defiance

The UN CESCR is a monitoring team made up of independent experts created by state parties to enable them to fulfill their obligations under the ICESCR (Gruskin et al 2005:469). The UN CESCR General Comment 14 proposes a framework for monitoring the application of Article 12 of the ICESCR.

The UN special Rapporteur on the right to health created in 2002 and appointed by the UN Human Rights Commission (HRC), is another body responsible for monitoring the right to

health all around the world. He/she submits thematic reports each year to the UN. He/she undertakes two country missions each year, and receives individual complaints. The work of the Special Rapporteur is not legally binding on states; however, it creates an avenue for the right to health to be monitored. There are also Special Rapporteurs appointed to monitor the implementation of the underlying determinants of health. The UNCHR Resolution 2002 lists the following duties to be carried out by the Special Rapporteur:

a. To gather and exchange information concerning the realization of the right to health in countries.

b. To create an avenue for dialogue and cooperation between governments and intergovernmental and non-governmental bodies

c. To report on the status of the realization of the right to health in accordance with the instruments listed in para 4 of the resolution, and on developments relating to this right, including laws, policies and good practices, most beneficial to the enjoyment of this right.

d. To make recommendations on appropriate measures to promote and protect the realization of the right to health.

In respect of enforcing legal sanctions on states to ensure compliance with international instruments, there are few available, hence, states are being monitored by other states, Non-governmental organizations, the media and private persons to ensure compliance. Civil society has a role to play in monitoring, reporting and campaigning on issues on the right to health (CSDH Executive Summary 2008). This method includes "naming and shaming, letter writing campaigns, taking test cases, sloganizing" (Para. 25 Report of Special Rapporteur 2007). NGOs play a crucial role in monitoring states compliance to treaty obligations within the countries through their advocacy efforts (Gruskin and Tarantola 2005:21). Through shadow reporting,

NGOs can supply international institutions with more information other than that made available to them by states. Various indexes and reports from both international and non-governmental bodies on the right to health in Ghana and Nigeria serves as a medium of ensuring compliance of these states to their right to health obligations.

Litigation

The right to health can be enforced in domestic courts where provision has been made in its constitution or state laws. Using the provisions of domestic law in South Africa in the case of *Minister of Health & Others v Treatment Action Campaign & Others SA/2002*, Treatment Action Campaign a locally based NGO in South Africa could enforce the right to treatment and access to medicines for those affected with HIV. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal 1996 SCJ 25, p. 29,* the Supreme Court of India decided that the government could not rely on the non-availability of funds as an excuse to fail to meet its obligations. Litigation can be used to enforce against states based on their obligations to international instruments in the event no provision is made in their domestic laws (Meier et al 2012:3).

Since the right to health cannot be enforced through the constitution in Nigeria and Ghana being listed as a state directive, recourse can be made to international instruments. It is also a medium for individuals to be entrusted with an avenue to bring their claims against the state. International and regional bodies have been used to enforce the right to health by individuals. Article 2 of the Optional Protocol to the ICESCR empowers individuals or anyone acting on their behalf to submit communications to the committee. Para.59 of the General Comment 14 2000 empowers individuals whose right under the provisions of the ICESCR and General Comment 14 to seek redress before any national or international judicial tribunal. This said paragraph further lists certain forums where individuals can seek redress for violations of their

right. These are “National ombudsmen, human rights commissions, consumer forums, patients’ rights associations or similar institutions”.

The provisions of the African Charter have been domesticated into the Ghanaian and Nigerian law by virtue of the African Charter on Human and Peoples’ Rights (Ratification and Enforcement) Act 1990. This gives room for the provisions of the African Charter to be enforced through courts in member states. In a judgement delivered by the Court of Appeal in Nigeria in *Oruk Anam L.G .Vs. Ikpa (2003) 12 NWLR 558,* the court stated that the provisions of the African Charter are enforceable in Nigeria. The African Commission in the case of *Annette Pagnoulle ex rel. Abdoulaye Mazou v Cameroon (1996/97)* could enforce the right to work based on the provision of Article 15 of the African Charter. Another breakthrough case is *Social and Economic Rights Action Center (SERAC) and the Center for Economic and social Rights (CESR) v. Nigeria (*Communication 155/96 (2001). It was the first time that the African Commission was deciding a case on economic and social rights. Its decisions had primarily been on civil and political rights. The commission decided the case against Nigeria holding that the violations alleged were violations of Articles 2 (non-discrimination), 16 (right to health), 21 (right to free disposal of wealth and natural resources), and 24 (right to satisfactory environment favorable to development) of the African Charter, amongst others. Another interesting part of the judgement is the fact that the commission decided that though it is a requirement for states or organizations bringing a communication to exhaust all available local remedies before bringing it to the commission, however, if local remedies are non-existent then it will be deemed by the commission to have been exhausted. This action is consistent with Meier et al (2012:3) view that “experience has shown that human rights are justiciable for health, litigation before national, regional, or international courts (or quasi-judicial bodies, such as the United Nations Human

Rights Committee and the Inter-American Commission on Human Rights) allows individuals to seek impartial adjudication from a formal institution with remediation authority". It is also important to note that litigation for the right to health also incorporates other health related rights such as socio-economic rights (Meier et al 2012:4).

In terms of enforcing rights under the African Charter, it places much emphasis on states and one would imagine how possible it will be for individuals to address their human rights violations (Ojo and Sesay 1986:96). It authorizes a member state to report another, not individuals.

Learning

One of the duties of the special rapporteur as highlighted above, is information sharing. Through information sharing and human rights education, capacity building of both duty bearers (states) and right holders (citizens) would be achieved. Most NGOs such as the Treatment Action Campaign a South African based NGO, use education to empower grassroots to enforce their rights.

Findings and Discussion

The findings that can be drawn from the measurement section is the fact that though Gambia seems to be making more progress relative to Ghana and Nigeria, which both have the resources to do better. Progressive realization implies that it must be a full progressive realization of the right to health. This means that all components must be progressively met and with equal distribution. The realization of the rights must be as effective and efficient as possible. States do not have the leverage to pick and choose which component they should fulfill in preference for others. This seems to be consistent with Backman et al (2008:6) that asserted that states do not

have the leverage to choose whatever measure they choose to in progressively realizing the right to health. The GDP of Ghana and Nigeria were shown to have tripled, yet very slow progress and in some cases, no progress was made, which is not commensurate with their percentage of GDP. This seems to be consistent with the findings of Toebes et al (2014:68) that the lack of health care and health related services in Africa cannot be ascribed to resource scarcity. As stated earlier in my review section, an indicator to determine whether maximum resources are utilized, is to compare with states of similar comparable standing. In this case, there seems to be no justifiable reason about the low performance of Ghana and Nigeria compared with Gambia. Both countries ought to have been far ahead of Gambia in the realization of their obligation but it is not the case. All countries retrogressed on certain indicators. Consequent upon such, they are not meeting the requirements of Article 2.1 of the ICESCR and are in violation of the right to health based on the interpretation in Paras. 47 and 48 of General Comment 14 2000. This research creates a gap for further research which is knowing the mechanisms for monitoring states compliance with their obligations.

Limitations

The basic problem facing the enforcement of social and economic rights as well as the right to health, is the issue of measurement and resource constraint (Ocran 2007:4). One would be faced with the puzzle on deciding when you can say a violation has occurred, how to figure out if there is violation, and how one can decide if states are progressively meeting their obligation especially in circumstances of slow growth. The challenge with using the progressive realization as a framework for measurement is the fact that it provides an avenue for states to claim that they could not provide the enjoyment of rights more than they have done because they do not have the means to do so. More so, this framework for measurement cannot capture the entire population

to determine if the basic services are dispersed within the state or concentrated to one aspect. Cross-Country comparison also may not be very sufficient to draw conclusions since both countries may have different systems and different ways in which human rights are being approached. Besides, it is also not sufficient data to generalize among other countries within the region.

Furthermore, this research paper is limited by the fact that the data relied on were secondary data and not primary data gotten directly from field work through personal surveys. Getting access to very recent data was a big challenge. Time was a factor that was considered in writing this research paper, as the limited time frame did not permit much work to be done hence creating more gaps for further study. This research creates a gap for further research, which is role of international institutions in governing the right to health. It would be necessary to know the governance structures and mechanisms employed by international institutions.

POLICY RECOMMENDATIONS

International Cooperation

International institutions have an obligation to assist and cooperate with states to achieve their obligations (Para.64 General Comment 14 2000). They can do so through monitoring the implementation process within states. Ensuring that policies and programs are made towards the realization of the right to health. International institutions should avoid making policies that would affect the human rights of individuals in their member states. For example, the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) 1994, is a policy that is very much averse to the individual rights of citizens in member states. Such kind of policies affect human right and should not be encouraged.

More Financial Aid

States have an obligation to assist other states through humanitarian or financial aid and other forms of assistance (Para.40 General Comment 14 2000). They should assist the developing states in achieving their core obligations under the right to health, through monitoring and pressure. Likewise developing states have an obligation to demand assistance from developed states to enable them to achieve their obligations (Hunt and Backman 2008:86). They have a right to demand aid and apply this aid effectively towards the achievement of the right to health.

Grass root participation through NGOs

More NGOs should be involved in right to health and socio-economic rights campaigns and activisms. They should not focus so heavily on civil and political rights but should incorporate all other human rights which includes right to health and socio-economic rights. They should educate both states about their obligations under the covenant and individuals about the right to seek redress. More monitoring mechanisms should be established by the NGOs because we seem to have few on the right to health.

CONCLUSION

Provision of social services are economic and social rights. As much as they are the socio-economic rights, they are also components of the right to health, having been linked to the right to health by the underlying determinants. The right to health just like economic and social rights is subject to progressive realization and resource availability. Using two countries from West Africa with high GDP, this research paper showed how states can be said to be in violation of human rights where it deprives its citizens of social services, where it fails to utilize its maximum available resources in progressively realizing the right to health and socio-economic rights.

This research paper further noted that the right to health can be enforced against states who violate such right. Furthermore, it is challenging to prove that a state has the resources and has deliberately refused to meet its responsibilities. Measuring a state's resources requires a whole deal of factors and variables. Therefore, the conditionality placed towards the fulfillment of the obligation makes it an issue to enforce accountability.

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